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Article - Version of Record

Suggested Citation:
Fangerau, H. (2026). What is History of Medicine About and Why Do We Need It? On the Institutionalisation and Professionalisation of the History of Medicine in Germany. Journal of Cultural Interaction in East Asia / Society for Cultural Interaction in East Asia, 16(1), 3–24.
https://doi.org/10.1515/jciea-2025-0018

Research Article

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What is History of Medicine About and Why Do We Need It? On the Institutionalisation and Professionalisation of the History of Medicine in Germany

https://doi.org/10.1515/jciea-2025-0018
Received November 17, 2025; accepted January 3, 2026; published online January 28, 2026

Abstract: This essay examines the institutionalisation and professionalisation of the academic discipline of the history of medicine within German medical faculties over the last 120 years, with a view to facilitating comparisons with East Asian developments. It traces the evolution of the field through periods of specialisation, deinstitutionalisation and interdisciplinary integration, exploring the productive tensions between its medical and historical dimensions. The unique German context is analysed, including the integration of medical history into university curricula and its pivotal role in the education of medical ethics, especially since the introduction of the subject "History, Theory and Ethics of Medicine" in 2002. Key phases of the development include responses to scientific medicine, post-war humanisation efforts and reckoning with medical crimes commited during the Nazi era (1933–1945). These have all contributed to the transformation of the discipline into a vital site for reflection and cultural memory. It is demonstrated how German medical historians have legitimised their academic niche, contributed to interdisciplinary discourse, and fostered coherence amidst growing thematic diversity. Ultimately, the German experience exemplifies the field's role as a bridge between science and the humanities, offering essential orientation and critique for contemporary medical practice and education.

Keywords: history of medicine; Germany; specialisation; professionalisation; 20th century

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1 Introduction

This article concerns the institutionalization and professionalisation of the academic discipline "History of Medicine" in Germany. So why is it published in a journal dedicated to cultural interaction in East Asia? This requires explanation, particularly given the journal's aim to "oppose Eurocentrism" in global history (https://www.degruyterbrill.com/journal/key/jciea/html, 7.11.2025).

The history of medicine is as broad in its conceptual and institutional manifestations as medicine itself. Its objective, globally shared, is to deepen understanding of past conceptualisations of health and disease, historical practices and cultures of healing and prevention, social contexts, path dependencies, and the emotional and sensory dimensions of medical experience. To comprehend the diversity of approaches to medical history, it is essential to examine and compare the professionalisation and institutionalisation of the history of medicine as an academic endeavour across various regional, national, and political contexts (Huisman and Warner 2006).

In order to encourage such a comparative exchange and to provide a specific example for comparison, this paper outlines the rather unique situation of the discipline in Germany. This differs from the situation in East Asian states. Japan, for example, also has a strong tradition in this field. However, there are few institutions devoted to the topic, and even fewer of these are located in medical faculties (Lee 2023). In China, there is a long tradition of researching and promoting Traditional Chinese Medicine in particular, with scholars and practitioners often turning to historical texts and case studies to support their research and promote their practices. This establishes links with modern biomedicine and botany (see for example for an overview Lo et al. 2022). Large interdisciplinary centres such as the Center for the History of Medicine at Beijing University exist, conducting research and teaching on all aspects of the history of medicine and healthcare from an overarching perspective (https://shh.bjmu.edu.cn/english/Research/affiliated/historymp/index.htm). Nevertheless, it is rarely represented in medical faculties committed to biomedicine.

Unlike in other countries, most German medical faculties have a department dedicated to the history of medicine. This form of institutionalisation is distinctive in that the object of research (medicine) simultaneously serves as the institutional seat (the faculty). Typically, history resides within faculties of philosophy and the humanities, so medical history often finds itself in a precarious position – applying methods from its reference discipline, history, within the context of a medical faculty addressing medical questions and topics. This tension occasionally generates goal conflicts, yet more often it has proven highly productive, inspiring, and innovative. Additionally, history of medicine has been embedded into the German medical

curriculum as an independent subject since 1970, also in the last Licensing Regulations for Physicians from 2002, which mandated that medical students undertake a course in "History, Theory and Ethics of Medicine" ("Geschichte, Theorie und Ethik der Medizin") ("Approbationsordnung für Ärzte vom 27.06.2002" 2002). This interdisciplinary course reflects both the strong institutional embedding and a growing interest in medical ethics among these faculties.

The aim of this paper is to overview the institutionalised history of medicine in Germany during the last 120 years in order to elucidate its unique academic positioning, its specific tasks, challenges, and opportunities. Many of the following reflections have already been published elsewhere by me together with Mariacarla Gadebusch, Igor Polianski and Fabio De Sio, in German (Fangerau and De Sio 2020; Fangerau and Gadebusch-Bondio 2015; Fangerau and Polianski 2012; Polianski and Fangerau 2012b). These earlier thoughts are included here, translated, summarised and expanded for an international readership.

This essay reconstructs how medical historians negotiated their professional niche between medicine as a reference point and historiography as a methodological foundation since ca. 1900. The institutional development of the discipline is briefly sketched. It will be shown, on the one hand, how medical historians responded to the challenges posed by developments of biomedicine, and, on the other hand, how they endeavoured to align with methodological trends emerging from the arts and humanities. Strategies of self-legitimation will be reconstructed, and conflict zones, along with mechanisms of dispute resolution within and beyond the discipline, will be analysed.

Over the past two decades, alongside works on the history of medical historiography, research trends and structural dimensions of medical history in Germany have been systematically explored in several substantial edited volumes and journal articles (Gradmann 2006; Labisch 2002; Paul and Schlich 1998; Roelcke 1994; Rütten and Metzger 2009; Schnalke and Wiesemann 1998; Thießen 2013). Additionally, elements of an historical sociology and self-reflective contextualisations of the discipline in Germany have also been made visible (Bröer 1999; Bruns 2014; Frewer and Neumann 2001; Frewer and Roelke 2001; Meinel and Voswinckel 1994; Schütz and Sommer 2025; Söderfeldt and Krischel 2020; Toellner and Wiesing 1997). Many of the more recent works appear to have emerged from a reflexive impulse: on one hand, the formation of a medical ethics discourse – often in the framework or in competition for resources with the history of medicine, and on the other, the emergence of new thematic focal points crystallising in the 1990s. As will be shown in the following, both catalysts gained relevance recently during periods when medical history was redefining itself in response to shifting contextual conditions like the abovementioned establishment of the subject "History, Theory and Ethics" in German medical schools or the new developments fostered under the framework of Medical

Humanities or Health Humanities, which encompasses a broad spectrum of subjects at the interface between medicine and the humanities as well as the cultural sciences, and is transitioning from "medical" to "health humanities" through its broadening from medicine alone to the entirety of all health professions and actions (Bates et al. 2014; Berry et al. 2024). But let us begin in the nineteenth century.

2 Institutionalisation

2.1 Early Institutionalisation

In the early nineteenth century, the history of medicine was part of medical propaedeutics and was taught by the chair of "theoretical medicine." Although individual universities – such as Berlin since 1834 – had established dedicated chairs in the history of medicine, these were not widespread before 1906 (Hirsch 1880; Schneck 1999). The role of medical history in the medical canon declined throughout the century as medicine became increasingly self-conceived as mechanistic and oriented towards physics and chemistry rather than history and philosophy. Technoscientific progress was the prevailing ethos, and the past was, accordingly, devalued. However, after the turn of the century, the history of medicine experienced a sustained resurgence in at least two forms and for at least two reasons.

First, with the triumph of scientific medicine, medical faculties and physicians began to recall the history of medicine as a unifying narrative bridging their increasingly specialised and dichotomised discipline (Brocke 2001). This was true not only in Germany but also in the United States, where prominent physicians such as William Welch advocated for the unity of the medical sciences (Welch 1906). To preserve both the scientific and artistic dimensions of medical practice, physicians argued for counterbalancing the rational, objective gaze of the physician with culture, the arts, and the humanities (Warner 2013, p. 326). The history of medicine was perceived as the appropriate discipline to represent these domains within medical faculties. Against this backdrop, physicians with philological and historical interests and impetus – such as the prominent Karl Sudhoff (1853–1938) – were able to initiate the re-establishment of chairs in the history of medicine as its own discipline at German (and international) medical faculties (Bickel 2000; Stein 2013).

Second, in the era of nation-states, medicine and the sciences were viewed as potential arenas for national prestige. History could legitimise a nation's role in the global order. Thus, the history of medicine occasionally functioned as a vehicle for promoting the achievements of a nation's scientists and physicians. For example,

during the first half of the twentieth century, thousands of biographies celebrating the accomplishments of the 'great men' of medicine were published. Their academic utility was sometimes questioned. During the interwar period, the Romanian historian of medicine Valeriu Bologa, for instance, wrote an essay on the value of such national historiographies. He rejected nationalist approaches but strongly advocated for a national standpoint as a means to achieve an “optimum” and “maximum” of results from researchers familiar with a specific context. However, for Bologa, the national perspective was merely a starting point. He pursued a broader objective: the idea that national perspectives should contribute, brick by brick, to a larger, general understanding of medical history. Consequently, he called for international cooperation and synthesis (Bologa 1931).

2.2 Nazi era (1933–1945)

In Germany, Bologa’s words went unheard. After 1933, when the Nazi party (NSDAP) came to power, the focus of German medical history shifted towards what its proponents considered to be a distinctively ‘German’ approach to medicine. Prominent scholars such as Henri Sigerist (1891–1957) and Owsei Temkin (1902–2002) had already left Germany the previous year. Following Hitler’s appointment as chancellor of Germany in January 1933, further colleagues such as Walter Pagel (1898–1983) and Erwin Heinz Ackerknecht (1906–1988) also faced political and racial persecution and were forced to emigrate as well. However, the remaining medical historians embraced the regime as an ally. They saw the new regime as an opportunity to expand their influence and achieve institutional consolidation (Diepgen 1936). Medicine played an important role in the Nazi (NS) ideology and the political agenda. It formed the basis of the NS regime’s racist politics, which considered public health policies a means of “cleansing the fatherland” of lives deemed unworthy of living (Aly et al. 1994). NS health policy regarded the health of the collective population as the supreme goal, neglecting individual well-being. This approach contradicted traditional medical ethics, which were oriented towards the individual patient. Against this background, German medical historians hoped to assume the role of advocates and educators of a specifical historically grounded German concept of medicine and a new ethical order among physicians. Their attempts were in part successful: In 1939, the history of medicine became a compulsory subject within medical education, but this did not automatically lead to an increase in academic positions. After the Frankfurt chair was established in 1938, only three additional chairs were founded until 1945 (Bruns 2009; Kümmel 1994).

2.3 Post-War Developments

In the late 1940s, following the war, a reintegration of a social perspective into medical history began. This perspective had been neglected almost entirely after its main proponents were forced to leave the country. Medical history and medical ethics were again thought to take on the role of 're-humanising' medicine. Erwin Ackerknecht for example was of the conviction "that the history of medicine, which is bound to emphasise the character of medicine as an art, can contribute towards forming the humanistic physician who is the ideal of all of us" (Ackerknecht 1947, p. 145). In a climate of widespread criticism directed at established authorities in the Western world, institutionalised medical history with a focus on medical ethics was seen as a possible remedy against the allegedly dehumanising effects of scientific medicine (Warner 2013, p. 326). This also had implications for the discipline's conceptual re-orientation (see the next chapter).

A second wave of institutionalisation followed in Western Germany after the National Science Council, established in 1957, demanded a chair in the history of medicine at every medical faculty in the 1960s (Wissenschaftsrat 1960, p. 111). This was a period of general expansion among the Western German universities, shaped also by the Cold War and the East–West German competition. It is speculative but plausible that the demand for a history of medicine in the West was also a response to the integration of Marxism and Leninism into the curriculum of Eastern German universities. Johannes Steudel (1901–1973), an historian of medicine from Bonn, recalled mixed feelings about the recommendations. He and his colleagues welcomed the recommendations as a significant opportunity for the field, hoping for a gradual increase in institutions and personnel. However, when institutionalisation occurred more quickly than expected, he feared that medical faculties had established these institutes instead of more challenging positions, such as a second competing chair of physiology within a faculty, thereby taking "the easy road" to fulfil the Science Council's recommendations. This would have implied that faculties took the history of medicine less seriously than other disciplines (Steudel 1970, p. 204f.).

By the late 1980s, chairs in the history of medicine had been established at nearly every West-German medical faculty, and the medical curricula allocated time for teaching the subject in various institutions (Brocke 2001, p. 191; Kuhn 1986; on an East German perspective see Tutzke 1981).

This development was also due to the inclusion of independent medical historical content in the First Medical Examination (Ärztliche Prüfung) under the Licensing Regulations for Physicians from 1970. Medical Terminology also became part of the didactic responsibilities of medical historians ("Approbationsordnung für

Ärzte vom 28.10.1970" 1970). This new field was an additional safeguard for positions, jobs and institutional resources for the respective institutes. From 1978 onward, the history of medicine was assigned a dedicated quota of examination questions in the first section of the medical examination, thereby making it relevant for the final exam grade. This curricular presence as an explicit examination subject may have contributed to the second wave of institutionalisation in the 1980s (Fangerau and Gadebusch-Bondio 2015, p. 38f.).

3 Content Shifts

Alongside institutional developments, an increasingly professional need for thematic and methodological reorientation emerged. The main impulses for a renewal especially after the 1960s came from outside the discipline and outside of Germany. A fierce methodological debate unfolded within general historiography around the emerging historical social science, as coined by Hans-Ulrich Wehler (Wehler 1966, 1973), while in England a flourishing social history of medicine had already taken root, centred in Oxford around the authoritative figures of Charles Webster (Webster 1975) and Paul Weindling, who was then editor of the Journal of the Social History of Medicine. Influences from the French *Annales* school, particularly from quantitative social history and the history of mentalities, were added to this matrix (Bloch et al. 1977; Burke 1991). Additionally, historical epistemology, with Georges Canguilhem as its leading figure, offered an interpretation of the life sciences that revealed the scientific structure, philosophical significance and political impact of medicine. Ludwik Fleck's work was revisited, and the applicability of Thomas Kuhn's theories on paradigm shifts in science to medicine was discussed (Rothschuh 1977). During this opening phase, gender history, body history and the so-called "history from below" gained prominence (Hüntelmann et al. 2022).

The multifaceted stimuli were typically adopted after some delay. Once adapted to local research questions, they often triggered controversial debates in which scholars accused one another of ignorance, outdated methodologies, or clinging to obsolete paradigms. The reception of Michel Foucault (incidentally not consulted in his original French, but years later by way of American translations) or debates about the social history of medicine may serve as an example here. The core of the debate revolved around structure- and process-oriented theoretical approaches and the social history of medicine was positioned as a counterpoint to classical historism (focussing on politics and "great men of science") or to a one-sided intellectual history (implemented as the literary history of scientific works) (Fangerau and Polianski 2012; Jütte 1992; Labisch 1996; Mildenberger 2006; Roelcke 1994).

These developments gave rise to a productive era of new approaches, centred around Düsseldorf (Alfons Labisch) and Stuttgart (Robert Jütte). Since the 1980s, an increasing number of topics have been integrated into a social history of medicine, including: medicine as a passive reflection of and an active agent in broader societal transformations, the professionalisation of medicine and its attendant power structures, health and illness as socially constructed categories, population policies and regimes of individual and public health, patient history and the history of everyday medical experience, medicine, labour and industrial modernity, the circulation of medical knowledge beyond the institutional boundaries of medicine, including naturopathy and homeopathy, and not least, recurring methodological debates on the relationship between the reference disciplines: on the one hand, medicine – particularly the shift from iatrotechnical to molecular-biological paradigms – and on the other hand, general history and historical sociology (Jütte 1992; Labisch 1980; Labisch and Spree 1997a, 1997b).

During the late 1990s, a variety of new developments emerged that transcended the framework of the social history of medicine. These developments were triggered by the general historical debate between social and cultural historians (Oexle 1996; Wehler 1998). A pronounced theoretical and methodological reorientation occurred in general historiography, as well as in the history of science and medical history, considerably widening the analytical horizon. A "New Cultural History of Medicine" emerged, which convinced many specialists through its "incisive critique of the scope of social scientific models" (Paul 1999; also see Schnalke and Wiesemann 1998). This critique addressed explicitly theoretical applications of (social) theory without empirical grounding. To this was added a renewed focus on, for example, classical source-based studies, pathographies, and biographies, incorporating approaches from patient history and new forms of science studies (Paul and Schlich 1998). The most influential trends included actor-centred history of science, spatial studies (especially laboratory studies), materiality studies, historical anthropology, experience and everyday history, environmental and technological history, postcolonial and global perspectives, gender and body history, historical epistemology, memory and the history of remembrance, and media and visuality studies (Hüntelmann et al. 2022).

These approaches coalesced into a broad, multifaceted research field which views medicine as an integral social, material, cultural and political aspect of societal development. These approaches also sparked interest in the transfer or circulation of medical knowledge. Social networks fostering the transfer of knowledge, the adaptation of theories, technologies, and practices, and the processes of intercultural exchange in medicine became major topics in the international and German-speaking communities of medical historians. The associated methodological need to

overcome eurocentric perspectives was further nurtured by postcolonial studies and approaches such as the history of knowledge (De Sio and Fangerau 2019).

This global turn was somewhat contradictory, as it was paralleled by the persistence of a national focus (a trend observable throughout European medical historiography) (Majerus 2021). In Germany, this latter trend was triggered by a closer examination of the relationship between medicine and Nazism. The "Aufarbeitung" (re-appraisal) of medicine's role during the Nazi rule and the collective assumption of responsibility for the profession's crimes like the abovementioned expulsion of colleagues, participation in inhumane medical research, and killing patients in the NS euthanasia programmes profoundly transformed medical history. The unprocessed Nazi past of medicine became a central task of critical medical history. Since the 1980s, German medical historians have made decisive contributions to elucidating this history. The history of medicine additionally contributed to the discussion about and development of a culture of remembrance in research, teaching and public debates. Medical historical work was thereby legitimised as a foundation for critique and self-critique which, in turn, could protect medical morality and consolidate professional ethics (for a recent overview of the state of research see e.g. Jütte et al. 2011; Rauh et al. 2022; Sammer and Rath 2025). In this regard, experiences from examining medicine during the Nazi era have inspired studies engaging with the historical experience of suffering and injustice in other medical contexts, for example the medical abuse of children in nursing homes, psychiatric clinics and other institutions after 1945 (Fangerau et al. 2021). Next to the historical investigations, these studies are also directed at re-appraising and consolidating professional ethics (as will be examined in the next section).

This thematic diversity indicates that, around the turn of the millennium, the debate over old and new medical history began to gradually dissolve. The search for integrative approaches gained importance, paving the way for engagement in interdisciplinary discourse with other arts and humanities linked to medicine, such as medical ethics, philosophy and sociology. A notable development was the publication of textbooks on the history, philosophy and ethics of medicine (see among others e. g. Schulz et al. 2006).

4 Medical Ethics

The next phase coincides with history's relationship to medical ethics. Since the mid-1980s, a growing group of scholars and practitioners interested in medical ethics had coalesced in Germany, largely due to the active involvement of medical historians who have pushed for the professionalisation of this field within German medical

faculties. Their intense engagement with the burden of the Nazi past demonstrated that ethical reflection could not be understood or even considered outside its historical and political context: medical history has investigated the hubris of medicine in its entanglement with biopolitics, documenting its genesis, development, and transformations even after the war, and revealed disturbing continuities. The decision to systematically confront the past of a medicine that had fallen into moral vacuum significantly strengthened awareness of the necessity for ethics training among physicians. This need extended beyond merely preventing a repetition of medical power abuse. The expansion of medico-technical possibilities – such as intensive care medicine, transplantation and (assisted) reproductive medicine – had already significantly broadened the boundaries of what was medically feasible. Decision-making frameworks and the responsibilities of all involved parties had to be redefined. The demand for ethics in medicine aligned with the growing desire of patients and physicians since the late 1970s to define and protect the moral framework of medical practice in terms of patient rights. Although this general trend was shared by many Western societies, the European continental philosophical tradition resulted in slightly different interpretations and institutionalisation of ethics and its relationship to the history of medicine in Germany (and other European states) (Scher and Kozlowska 2018; Wiesing 1995).

While on the educational level the Licensing Regulations for Physicians had only implicitly referenced medical ethics until the 1980s, ethics became explicit in §34c of the 1987 version. Physicians in their first two years of practical training were now required to participate in a specified number of courses dedicated to medical ethics ("Approbationsordnung für Ärzte vom 28.10.1970" 1987, p. 1604). Almost simultaneously, in 1986, the association Academy for Ethics in Medicine was founded in Germany, with significant involvement from medical historians (Schlaudraff 2006).

In the following years, medical and bioethics advanced as research and teaching domains within medical history institutions. However, this coexistence was initially marked more by apprehension than collaboration. Medical history had to undergo a reorganisation involving personnel and content changes. The "difficulties of cooperation" (this was the subtitle of a book reflecting on the new developments (Toellner and Wiesing 1997)) had already been sufficiently discussed. Medical historians had warned against the instrumentalisation of history by ethics (Schulz 1997). The pitfalls of anachronistic references to supposed key sources – such as the Hippocratic Oath – were illustrated by medical historians through historical examples (Leven 1997). At the same time, the importance of sound historical scholarship for a context-sensitive understanding of the present was emphasised, because this stance, in the eyes of some authors, enabled a well-grounded ethical debate (Schlich 1997; Wiesing 1995). The potential for integrating ethics and the history of medicine lay in their reciprocal enrichment (Paul 1997, p. 62). Critics of the viability of medical history

expressed concern – paraphrasing Stephen Toulmin – that ultimately, ethics might be the only force capable of "saving" the history of medicine from death by irrelevance, by carrying it along as an historical burden (Maio 1997, p. 107).

When it became clear, in the lead-up to the 2002 Licensing Regulations for Physicians, that a new interdisciplinary subject for teaching – "History, Theory and Ethics of Medicine" – would be established, a new conflict emerged within medical history regarding positioning and self-assertion within this triad. One question was whether medical ethics and theory should be integrated as part of historyfor structural-political reasons, or whether a clear demarcation was necessary. Another question concerned competencies: professors and staff at medical history institutions faced an expanded and intensified teaching mandate. Ethics and theory had to be taught alongside medical history under unchanged conditions. Institutes developed curricula according to their research focus and expertise. A fundamental challenge lay in integrating research and teaching within this multi-layered cross-sectional domain, where practitioners typically felt responsible for one or perhaps two of the three domains – rarely all three.

Against the tendency toward separate competencies and overlapping responsibilities within the same cross-sectional area, a long-standing tendency emerged to promote the bundling of historical, ethical, and theoretical dimensions of medical knowledge and medical expertise (Schott 2009; Wiesemann 2006, p. 336). The resulting teaching offerings ranged from integrative models, which highlighted intersections between historical, moral-philosophical, and epistemological dimensions of medicine and sometimes incorporated clinical subjects in interdisciplinary ways, to specialised or exclusive models, where emphasis varied according to the instructors' interests and competencies – either on ethics, medical history, or, rarely, on the theory of medicine (Fangerau and Gadebusch-Bondio 2015). A differentiated offering, shaped by course hours and thematic choices, emerged at former institutes for the history of medicine, some of which had already rebranded into institutes for history, theory, and ethics in various sequences, under a variety of names (Polianski and Fangerau 2012a, 2012b).

Nevertheless, efforts to mediate and integrate the cross-sectional "History, Theory and Ethics of Medicine" as a coherent and justifiable whole have so far been only partly successful. Whereas the history of medicine attempted to promote integration by researching and teaching history and ethics as joined entities, medical ethics instead encouraged pragmatic cooperation at institutional and conceptual levels, for example through interdisciplinary yet divided teaching sessions and institutional collaboration rather than unification (Schütz and Sommer 2025). While "History, Theory and Ethics of Medicine" does not guarantee cohesion in the future, it may be seen as a German version of the Medical or Health Humanities and the

history of medicine will again have to find and define its place both here and in the medical faculties.

5 Legitimisation Pressure and Medicine as an Object

5.1 Legitimisation Strategies

The process of consolidating the history of medicine within medical faculties was, in general, far from problem-free. This may (still) be due to the fact that medical historians, despite repeated calls for anchoring and securing the field, remained divided about their own role not only among the arts and humanities in medicine but also in medicine itself. They continually sought to define their position between medicine and history. Driven by what they perceived as a dual legitimisation pressure, they had to demonstrate their usefulness – or at least their relevance – to medicine to justify their continued funding within medical faculties. Simultaneously, they had to defend their competence and professionalism against the history discipline to avoid being dismissed as "hobby historians," amateurs, or celebratory orators.

By orienting themselves towards utility for medicine and physicians' interests, they risked losing touch with methodological and thematic developments in historiography and committing the "sins" of anachronism, essentialism, and traditionalism (Stocking 1965). This tension is one with which medical history has long grappled – often productively, as displayed above. The dangers were already recognised by the medical historian Hans-Heinz Eulner (1925–1980) who, from the very beginning of the field's professionalisation, saw these risks and directly transformed them into arguments for the legitimacy of its own expertise (Eulner 1970, p. 427). In the discourse on the role and function of medical history between specialists and interested laypersons, a distinction was drawn: only experts should conduct research and teach the subject. Otherwise, as Paul Diepgen noted as early as 1928, there was a danger of historical dilettantism (Diepgen 1928). At the same time, "laypersons" – including other colleagues in medicine – were encouraged to take interest in the subject and even to support its existence within medicine. While some regarded the problematic tensions arising from these conditions as inevitable for the discipline as a whole, others attempted to manage them through a focus on methodological specialisation and exclusive orientation towards historiography. Hans-Heinz Eulner, for example, in a comprehensive work on the "Development of

Medical Specialties at Universities in the German-speaking World," stated: "Thus, medical history, aside from a few full-time representatives, has become a kind of 'hobby' for physicians […]. In this way, the 'subject' acquires its particular character – it is not truly a 'specialty' in the sense of the others […]. Medical history remains, rather, a common area of work for all physicians" (Eulner 1970, p. 427). In this way, he transformed medical history into a collective medical project while simultaneously creating space for experts by distinguishing professional, full-time representatives from research-oriented laypersons who, though not necessarily evaluating their material in a scholarly historians' frame within an institutional framework (what one might today call participatory research), could still contribute valuable material.

Turning to physicians as the target audience of medical history, one can identify several legitimisation strategies repeatedly advanced since the late nineteenth century which continue to be invoked in contemporary debates in each case adjusted to new developments of medicine. The following recurring (sometimes overlapping) argument categories can be identified (Eckerl 2015; Kümmel 1997, 2001):

1. Cultural-historical arguments, aiming to demonstrate that instruction in medical history contributes to students' general education and enhances their understanding of the cultural embedding of illness and health. The underlying idea is that cultural patterns in society result in different medical approaches.
2. Epistemological arguments, suggesting that understanding the history of medicine aids in better comprehending contemporary medicine including its methodology and scientific practice.
3. Integrative arguments, viewing medical history as an integrative perspective that counterbalances the increasing perception of medical specialisation as overwhelming and disorienting. Here, history should play the role of a humanising factor and remind scholars of the coexistence of medicine as a science and a practice directed at helping individuals in need, with their subjective experiences of suffering.
4. Arguments of methodological proximity, which conceive medicine itself as an historical discipline, given that the interpretation of individual patient histories already involves hermeneutics and source criticism – thus, the idea is that medical history could help students develop skills in this domain.
5. Pragmatic–epidemiological arguments, which see a direct benefit of medical history and historical source analysis for contemporary medicine – for example, in understanding public responses to epidemics/pandemics or their origins, or by promoting historical therapies as models for current treatment methods. Historical epidemiology itself would be considered a discipline that has developed from this argument.

6. Socio-historical arguments, based on the idea that knowledge of the socio-historical context of concepts such as illness and health, the medical market, or power relations within medicine is a prerequisite for understanding the social dimensions of medicine. This category includes understanding the origins, concepts and result of process descriptions such as biomedicalisation (Clarke et al. 2003) and ideas of biopower (Rabinow and Rose 2006).
7. Ethical arguments, which aim to show that ethical argumentation structures in medicine can only be understood if their historical conditions and developmental paths are reconstructed, and which also highlight the value of historical examples of moral failure for learning appropriate medical attitudes. From a philosophical perspective, this category would include descriptive ethics.
8. Arguments legitimising contemporary medicine, pointing out that medical history can help to justify and give meaning to current medical theory and practice by referencing historical path dependencies. This argument serves to explain and justify current practices on the basis of former decisions.
9. Arguments of learning from history, emphasising that medical history can contribute to solving current (similarly situated) medical problems through analogical reasoning and reference to historically successful or failed solutions.

All these arguments justify the existence of the history of medicine, yet they are defensive: the field does not try to stand for itself as a kind of fundamental medical research in its own right. To find a way of speaking for itself is to reflect again on the question: What is the object of medical history? The result is again a legitimisation, but one that is comprehensive and allows for the integration of all the arguments given above (for the following see De Sio and Fangerau 2019; Fangerau and De Sio 2020).

5.2 Medicine as an Object of History

Medicine is a broad term. Today, it encompasses everything related to illness, healing, individual and/or public health, epidemiology, social systems, health knowledge and practices, pharmaceuticals, or diets. Etymological considerations offer limited guidance. The term “medicine” derives from the Latin *mederi* (“to heal” or “to help”), while the Greek counterpart ἰατρικὴ τέχνη underscores a practical dimension. Since antiquity, medical knowledge has focused on the sick patient, aiming to be universal theoretical knowledge applied to the particular case. That is, abnormality and deviation from the norm – disturbances to universal truth – constitute precisely the core of medicine’s object. Aristotle already defined medicine additionally as a practice that shapes the entire life of the practitioner: it

was, for him, a βίος, a way of life (Gracia and White 1978, p. 7). He defined it primarily as τέχνη, productive knowledge with ethical, political, and economic dimensions, yet simultaneously as ἐπιστήμη, theoretical science with proximity to mathematics and physics. His nuanced definition has survived to the present day, though at different times one or the other aspect has gained prominence (Gracia and White 1978, p. 34f.). These elements should not be seen as extreme points on a continuum nor as alternatives to one another, but rather as a complex, shifting image that highlights different aspects depending on perspective, mood, and habits of seeing (Montgomery 2006, p. 31).

Although this concept reflects a distinctly European and, in certain emphases, iatrocentric model of medicine, it may have endured since Aristotelian times precisely because various medical cultures and epochs can relate to and substantially describe themselves through this complex image. It is precisely within these medical cultures – meaning all possible forms of medical practice – that medical history does not merely function as a translator or explanatory tool. Rather, as an historical discipline, it occupies a central position in contemporary medicine (a point I now adopt particularly from the fourth argument above, about methodological proximity, but further elaborate and complicate it using other mentioned arguments).

Despite the increasingly natural-scientific orientation of medicine (a topic in itself), medical knowledge remains individual and interpretative today. During the diagnostic process, symptoms are collected and must be interpreted as signs of something (Fangerau and Martin 2015). This interpretative moment involves the patient's subjective (historically situated) experiences, the time-specific assessment of a sign's evidentiary value or the necessity for action, and the physician's evaluation of the sign (Montgomery 2006, p. 16). Moreover, a diagnosis, a therapy or a prognosis typically entail a consequential action, and here what is perceived as objective medical knowledge may inadequately address the needs of those affected. The dual character of medicine as generalisable knowledge and simultaneously intrinsically individual (existential) knowledge thus complicates medical practice. It is precisely this complexity that medical history engages with, as medicine exhibits a range of temporal aspects that can only be understood historically. Knowledge about patients and diseases is gained by establishing at least two time points as reference points for assessing illness. The present is measured against the past, and a future state is projected into an uncertain future. The retrospective gaze necessarily involves an historically situated assessment of past knowledge, past conceptions of normality, and past (health) political conditions (Duffin 2004; Labisch 2004).

Orientational knowledge is precisely what medical history can provide here. But it can do much more. It can reconstruct long-standing path dependencies, semantic networks, and medical structures, thereby offering a concrete (historical) framework for what is often termed "intuitive medical knowledge" (Toulmin 1993). Since

medical actions should always be based on the best available knowledge at any given time, historical knowledge in this reading also provides building blocks – albeit inherently partial – for explaining medical action and effect (Montgomery 2006, p. 39). This exemplary (and self-critically also recognisable as abbreviated and iatrocentric) perspective can be extended to all conceivable meaning fields of medicine mentioned above and also includes other medical cultures.

6 Conclusions

Such a comprehensive understanding of medicine makes the history of medicine a truly universal endeavour – it can be applied to any medical culture and any medical field and fulfil here the purposes given in the legitimisation strategies. In that sense, the history of medicine is not merely a repository of past events, nor a nostalgic reflection on medical achievements. It is a dynamic and indispensable field that interrogates the foundations, practices, and ethical dimensions of medicine across time and cultures.

This review shows that the German model of embedding the history of medicine within medical faculties has produced a distinctive academic ecosystem: a dense network of chairs, a compulsory "History, Theory and Ethics of Medicine" course, and a tradition of self-legitimisation that intertwines cultural, epistemological, and ethical arguments. While the discipline continues to negotiate its dual allegiance to medicine and the humanities, its methodological diversity – from social-history to post-colonial and materiality studies – demonstrates its capacity to generate 'orientational knowledge' for clinicians and scholars alike. Crucial is the consensus that empirical work and theory formation go hand in hand, which means that a sole (indispensable) focus on collecting sources, which had dominated the history of medicine during much of the 20th century, has been expanded.

The idea of promoting this broad conception of the history of medicine through international cooperation, as proposed by Bologa a century ago, is still relevant today. His idea that national perspectives can contribute to a general understanding of medical history when combined also seems valid. International cooperation and synthesis are necessary to truly understand medicine across time, space and cultures. Global and local perspectives are brought together in initiatives such as the "History of Medicine in South East Asia" association (https://homsea.net/history/) (Monnais and Cook 2012). Simultaneously, institutions for the history of medicine and medical ethics in South East Asia are also taking an inclusive, interdisciplinary approach. Physicians in the respective countries are interested in the history of medicine. However, in the light of the example given here these initiatives might be

strengthened by greater integration, institutionalisation and professionalisation within medical faculties.

Furthermore, the broad concept of "Health Humanities" or its German version "History, Theory and Ethics of Medicine" could provide interesting connections between medical specialties and traditions, and the humanities which might be of special interest for Asian medical cultures. In Asian academia, this field could serve as a bridge between different knowledge bases and epistemologies. The local German model of institutionalising and professionalising the field could at least serve as a useful reference point for comparative work in East Asia and elsewhere, where similar institutional and interdisciplinary challenges are emerging.

Acknowledgments: I would like to express my gratitude to the reviewers for their helpful comments and suggestions and to Alfons Labisch, Mariacarla Gadebusch, Fabio De Sio and Igor Polianski for our previous joint work on this topic and for the discussions we have had.
Research ethics: Not applicable.
Informed consent: Not applicable.
Author contributions: All authors have accepted responsibility for the entire content of this manuscript and approved its submission.
Conflict of interest: I am myself a professor for the History, Philosophy and Ethics of Medicine.
Research funding: None declared.

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