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## Who is afraid of constructionism?

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In a recent issue of *Social History of Medicine* David Harley made a very cogently argued and exceedingly erudite case for social constructionism and especially for its linguistic aspects.[1] Given its scholarly value it was surprising to find it was allocated the comparatively obscure slot of 'Discussion Point' within this journal; but this reflected perhaps the editors' own ambiguous attitude to the subject matter or at least their anticipation that it would provoke hostile reactions, correctly as it toumed out. The subsequent issue of the journal contained a strongly worded critique by Paolo Palladino who dismissed many of Harley's suggestions as resting 'on a logic which (. . .) cannot but undo any notions of history as an objective (re)presentation of the past'. Most importantly, Palladino opposed social constructionism for its, as he claimed, inability to account for historical change;[2] this is tantamount to condemning the constructionist approach as ahistorical. But do other historians concur?

Many medical historians do indeed not take kindly to constructionism. Certainly, Charles Rosenberg regards the social construction of illness as 'no more than a tautology, a specialized restatement of the truism that men and women construct themselves culturally'.[3] His reference to 'truism' is, however, problematic, not just in the sense that every so-called 'truism' is itself constructed and therefore only a relative 'truism', just as gender differences need to be historicised, but it is also disproved by the lack of attention constructionism has received from medical historians. They may 'pay lip service to the idea that medical knowledge is socially constructed', but they fail to engage with it seriously.[4] This is abundantly clear, for example, if we search for the entry of this term in the indexes of most medical histories where it is very rarely listed. It is an equally elusive concept in historiography. When Peter Wright and Andrew Treacher tried to consolidate the role of constructionism in medical history, they wanted to demonstrate how 'medicine' adapted models from the wider society in which it was practised and in its turn, how it also influenced that society. They called for the exploration of the changing

1 David Harley, `Rhetoric and the social construction of reality', *Social history of medicine* 12.3 (1999), 407-435.
2 Paolo Palladino, `And the Answer is ...42', *Social History of Medicine* 13 (2000), 147-151.
3 Charles Rosenberg, `Framing disease: illness, society, and history', in: Charles Rosenberg & Janet Golden (eds), *Framing disease. Studies in cultural history* (New Brunswick: Rutgers University Press, 1992), xiv. A slightly edited version of this essay appeared in: Charles Rosenberg, *Explaining epidemics and other studies in ther history of medicine* (Cambridge: Cambridge University Press, 1992), 305-318.
4 Ivan Dalley Crozier, `Taking prisoners: Havelock Ellis, Sigmund Freud, and the construction of homosexuality, 1897-1951', *Social History of Medicine* 13.3 (2000), 447-466, quotation 448.

meanings of medicine over time and for identifying ‘the political forces which may form it and the ideological ends which it may serve’. In short, they called for an understanding of ‘how medicine mediates broader social forces’.[5] This programme was probably too ambitious and at the same time too limited in scope. It was too ambitious because, as Roy Porter has pointed out, ‘doing "social constructionism" is hard’; ‘the hub of the problem lies in being able to fashion structured analysis of social situations, of medical ideas, practices, and information, and above all of the concrete relations linking the two.’[6] This is of course easier to proclaim theoretically than to achieve practically. But Wright’s and Treacher’s project was also not comprehensive enough as it did not really intend to redefine ‘medicine’ as an arena open to historical interrogation and one which should be defined by the very people studied. The authors were well aware of the boundaries of medicine; but they did not primarily see these as indicating different, possibly exotic kinds of ‘medicine’, but merely as divisions between medicine and the rest of society. This combination of radical theory and limited empirical research may well have contributed to the poor reputation of constructionism among social historians of medicine. But even when historians do apply constructionist methods they may well be reluctant to label them as such. Porter’s pathbreaking paper on the patient’s view undoubtedly contains important constructionist notions but he has refrained from using the term.[7]

Why then such hesitancy? Apart from the problem of feasibility of writing in the constructionist mode, to which we will return later, there are the more fundamental problems of its reception. We have distilled four reasons why so many medical historians neglect or reject constructionism.[8] Firstly, they hold that illness should be regarded as an actor on a par with the doctor and the patient. Secondly, they adhere to the notion of the immutable body, or what could be called ‘somatic materialism’. Thirdly, they identify social constructionism with social compulsion which limits individual action. And forthly, they fear that social constructionism will lead to a chaotic relativism. These are the strongest charges made against constructionism and betray an ‘essentialist’ or ‘realist’ viewpoint which is generally taken as the opposite of constructionism. Underlying these differences is the fundamental problem of the relationship between historians and the fragments of the past they research. Social historians of medicine have too often ignored their own role and have therefore not sufficiently considered how their own

5 Peter Wright & Andrew Treacher, `Introduction', in: idem (eds), *The problem of medical knowledge. Examining the social construction of medicine* (Edinburgh: Edinburgh University Press, 1982), 1-22, cit. 13.

6 Roy Porter, [review of Wright & Treacher (eds), The problem of medical knowledge], *Medical history* 27 (1983), 97-99, cit. 98.

7 Roy Porter, `The patient's view. Doing medical history from below', *Theory and Society* 14 (1985), 175-198. Cf. Roy Porter (ed.), *Patients and practitioners. Lay perspectives in pre-industrial society* (Cambridge [etc.]: Cambridge University Press, 1985).

8 Cf. the slightly overlapping points discussed by medical sociologists fifteen years ago: M.R. Bury, `Social constructionism and the development of medical sociology', *Sociology of Health and Illness* 8 (1986), 137-169 and Malcolm Nicolson & Cathleen McLaughlin, `Social constructionism and medical sociology: a reply to M.R. Bury', *Sociology of Health and Illness* 9 (1987), 107-126.

preferences and prejudices may have influenced the way they selected, emphasised and finally interpreted the past. What Harley calls the 'description' under which historical actions take place, also applies to historians.[9]

As Thomas Schlich asserts, the majority of medical historians neglects historicising attitudes to illness and regards illness as self-evident which exists quite independently from ascriptions by physicians and remains somehow outside historical enquiry.[10] Although a number of studies have used a constructionist approach to good effect,[11] there is also a tendency, according to Schlich, to dilute the concept. Either medical historians restrict themselves to the social context of an illness which they do not consider as contested, or they conveniently single out illnesses which are no longer recognized by biomedical standards of today and must thereby per force have been 'socially' constructed.[12] Charles Rosenberg refers to such examples as hysteria, chlorosis, neurasthenia and homosexuality, 'in which a biopathological mechanism is either unproven or unprovable'.[13] But it is surely inconsistent to designate some illnesses and afflictions[14] as 'socially constructed' and others to be outside the social domain. The ultimate criterium for such a division would be to consider constructed illnesses as 'false beliefs', eg false according to the scientific, biomedical norms of today.[15] Similarly, there is the suggestion that medical theories of the past, for instance the humoral system, 'alternative' medicine or a belief in patients' own ability of diagnosis, should be regarded as mere constructs because they differed from 'true' medicine. Such an approach, however, renders constructionism as a concept ineffective and always subject to scientific laws.

Significantly Rosenberg replaces the verb 'to construct' with 'to frame' shortly after the start of his essay and his main objective is in fact not to advocate social constructionism but to reintroduce 'disease' into the social history of medicine. In the process he purports to exonerate scientific medicine from the charge of being culturally hegemonic and oppressive and medical historians of having neglected constructionism. As Rosenberg contends, medical history has indeed paid attention to it and gone further: it has also discussed patients' experiences, public health,

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9 Harley, `Rhetoric', 410.

10 Thomas Schlich, `Wissenschaft: die Herstellung wissenschaftlicher Fakten als Thema der Geschichtsforschung', in: Norbert Paul & Thomas Schlich (eds), *Medizingeschichte: Aufgaben, Probleme, Perspektive* (Frankfurt a.M/New York: Campus, 1998), 107-129, 114-115.

11 Schlich singles out especially the very early study of Ludwik Fleck, *Entstehung und Entwicklung einer wissenschaftlichen Tatsache. Einführung in die Lehre vom Denkstil und Denkkollektiv*, 1st ed. Basle: 1935, repr. Frankfurt a.M., 1993.

12 Schlich, `Wissenschaft', 115, n. 11.

13 Rosenberg, `Framing disease', xv/307. Of course, a disease designation need not necessarily cover a single disease, cf. Harley, `Rhetoric', 418-419.

14 In this chapter we will not distinguish between `illness', `disease' or `sickness' indicarting, as it is held by sociologist, differences between `subjective' and `objective' notions of feeling unwell. We consider these concepts to by synonyms because every illness which is designated by the same name has biological as well as social and emotional aspects and these are all constructed.

15 Jonathan Potter, *Representing reality. Discourse, rhetoric and social construction* (London:Sage, 1996), 19; Harley, `Rhetoric', 411.

medical policy, ecology, demography and disease definitions. This suggests, oddly, that constructionism is somehow one subject and all the other areas listed above are other subjects for historians. A constructionist approach to the study of diseases is indeed needed but the other subjects cannot, or at least should not, be exempt from it either. How for example can we study the way experiences are voiced if we do not understand this as a social construct. One can go as far as asserting, as has been done by Sapir and Worf,[16] that expressions are a necessary condition for experiences.[17] As to the history of public health and statistical approaches to health and illness, these have indeed often ignored social constructionism, but at the peril of rendering statistics unreliable since they tend to reify certain concepts and classifications present in their source material and ignore others.

Curiously Rosenberg accuses constructionists to have neglected the 'process of disease definition' instead of addressing the failure of medical historians to pay attention to constructionism. 'We have, in general', he writes, 'failed to focus on the connection between the biological event, its perception by patient and practitioner, and the collective effort to make cognitive and policy sense out of this perception'.[18] Note here the way his syntax prioritises the 'biological event'. This concerns 'often physically manifest symptoms' that in the course of history have been subject to categorization and explanation, but, 'once articulated and accepted' are nevertheless, as Rosenberg elucidates in a note, 'independent factors, constraining the options of human actors in social situations'.[19] Thereafter Rosenberg stesses the relative autonomy of diseases. Henceforth they become 'social actors', they 'legitimate and guide social decision making', they 'mediate and structure relationships'. These are potent metaphors, based on the notion of agreement between all participants. By personalizing 'diseases' Rosenberg reduces the agency of the human actors, making them almost into non-persons. As soon as illness definitions are contested, the consensual structure falls apart and power relations within the 'collective' are revealed. Thus, we may infer, the argument in 'Framing disease', seems sufficiently sophisticated to acknowledge constructionist positions but this is not so; in the final analysis Rosenberg makes illness constructions dependent on a combination of biology and a consensual society. As Schlich argues many historians continue to regard our medical knowledge today as the timeless yardstick by which to judge the different views of the biological 'facts' in the past. 'But according to the social-constructionist perspective there are no concepts of illness which can be derived directly from nature, every disease definition including those of today, is dependent on a specific time and represents, according to the social and cultural context, a particular way to observe phenomena, to

16 Cf. Harley, `Rhetoric', 409.
17 Cf. Rom Harré (ed.), *The Social Construction of Emotions* (Oxford: Blackwell, 1986); Catherine A. Lutz & Lila Abu-Lughod (eds), *Language and the Politics of Emotion* (Cambridge: Cambridge University Press, 1990).
18 Rosenberg, `Framing disease', xvi, 309.
19 Rosenberg, `Framing disease', xxv, 314.

group them together, to label them and assign a specific meaning to them'.[20]

Here we come to the second objection: the adherence to the concept of a stable body. The sociologist Bryan Turner offers a variation of Rosenberg's theme; he suggests various degrees of construction: some things are 'more socially constructed than others' or, as it may be, 'more socially contested than others'.[21] The reason for this is that he finds it 'difficult to wholly reject the facticity of the instrumental-objective body'. In his view, 'the body provides the foundational potentialities upon which endless cultural practices can be erected'.[22] Essentially, Turner's adjustment is no more subtle than the whiggish declaration of 'false' illnesses, for he too, resorts to 'biological difference' and 'natural phenomena' as final foundations.[23] Turner is, however, not the only one to argue that the body restricts constructionism. Lachmund and Stollberg, for instance, also refer to 'unforeseen articulations of the body' in cases where somatic influences 'contradicted' the medical process.[24] Or as it was once remarked at a symposium: 'culture may shape the body, but we feel that the body has ways of pushing back'.[25] Undoubtedly many more examples can be found.[26] This belief in the immutability of the body posits the hegemony of materialism over language and possibly even reflects the attitude of those who consider speech as a mere social extra. As Joan Scott and other post-structuralists have argued language and (bodily) experience are mutually dependent; in Scott's words experience is a 'linguistic event' that 'doesn't happen outside established meanings' and as it has also been put, meanings which historical actors produce 'depend on the ways of interpreting the world, on the discourses available to [them] at any particular moment'.[27] Thus, the body has a discursive as well as an experiential dimension, it needs interrogation and deconstruction like any other concept.[28]

A social constructionist approach would analyse the various ways in which, for instance, near-death experiences are expressed and how they are related to a sense of the numinous in particular traditions, etc. In the more abstract words of Nicolson and McLaughlin: `We can never

20 Schlich, `Wissenschaft', 114-115.

21 Bryan S. Turner, *Regulating Bodies. Essays in medical sociology* (London/New York 1992), 26, 105, 106.

22 Turner, *Regulating*, 9, 118.

23 This is especially evident in Turner's interview by Richard Fardon where he said, among others: `...it still seems to me that male and female bodies are organically, physiologically biochemically different phenomena. (...) Biological difference is socially produced by the endless reproduction of human beings, but the classificatory systems can be seen as reflections upon differences in natural phenomena', *Regulating bodies*, 256.

24 Jens Lachmund & Gunnar Stollberg, `The doctor, his audience, and the meaning of illness: the drame of medical practice in the late 18th and early 19th centuries', in: idem (eds), *The social construction of illness. Illusion and medical knowledge in past and present* (Stuttgart: Steiner, 1992), 53-66, 59.

25 Quoted in Ann Snitow, `A gender diary', in: Joan Wallach Scott (ed.), *Feminism and History* (Oxford/New York, 1996), 505-544, cit. 513.

26 See for recent reviews of the history of the body: Roy Porter, `The history of the body, reconsidered', in: Peter Burke (ed.), *New Perspectives on Historical Writing* (Cambridge: Polity 2001), 232-260; Ute Planert, `Der dreifache Körper des Volkes: Sexualität, Biopolitik und die Wissenschaften vom Leben', *Geschichte und Gesellschaft* 26 (2000), 539-576.

27 Joan Scott, `The Evidence of Experience', *Critical Inquiry* 17.3 (1991), 773-797, 792ff.; Chris Weedon, *Feminist Practice and Poststructuralist Theory* (Oxford/New York: Blackwell, 1987), 79.

28 Kathleen Cannning, `Feminist History after the Linguistic Turn: Historicizing Discourse and Experience', *Signs: Journal of Women in Culture and Society* 19, nr. 21 (1994), 368-404, esp. 385ff.

hope for an unproblematic atheoretical correspondence between our knowledge and the natural world because each new experience of the world necessarily interacts with our prior beliefs about it'.[29] Social constructionism is not about what the body does, but what people say it does and how they react to it. As we know, there are people who believe that the dead can speak, or at least communicate, and that they can even be resurrected. Their 'knowledge' or 'beliefs' are part of our cultural reality, indeed, whole industries are based on it. They belong to the available repertoires of speech and as such they are valuable objects of study. Scepticism can hinder our understanding of such attitudes. From a relativist position (see below), there is no basic difference between studying 'scientific' or 'other' beliefs. Scientific knowledge 'is itself often group-specific, contrasting perspectives on the same physical phenomena being the products of the particular trainings, backgrounds and interests of the different groups of scientists involved'.[30]

In conclusion to the first two objections listed above, social constructionism can never be complementary to a so-called 'essentialism': logically the two concepts are mutually exclusive, incommensurable and belonging to different paradigms.[31] As Judith Butler asks rhetorically: 'Is materiality a site or surface that is excluded from the process of construction, as that through which and on which construction works?'[32] Social constructionists regard 'essentialism' as nothing more than another construction and would point out that people differ in their evaluation of it.[33] For essentialists, the body and corporal phenomena are immutably grounded in biology. There is no change and variation of single categories and there can thus be no history. Ultimately, essentialism is reductionist and deterministic. There are many ways to illustrate this and the way scientific medicine explains 'superstitions' is only one of them. Werewolves, for instance, can be a fascinating subject of a somatic history, as they were depicted as men who had taken on the body of an animal.[34] The essentialist approach, however, turns the werewolf into an ahistoric sufferer from lycanthropy.[35] It ignores the popular images, the ritual practices and the diverse and variable local meanings. There are thus two options for the social historian of medicine: to embrace social constructionism and historicise everything from illness definitions to treatments to the body or to revert to the study of elite medicine, or even biology. Because we cannot assume

29 Malcolm Nicolson & Cathleen MacLaughlin, `Social constructionism and medical sociology: a reply to M.R. Bury', *Sociology of Health and Illness* 9.2 (1987), 107-126, cit. 111.
30 Ibid.
31 Cf. Harley, `Rhetoric', 409.
32 Jodith Butler, *Bodies that matter. On the discursive limits of `sex'* (London/New York: Routledge, 1993), 28.
33 See, for instance, Christorpoher Lawrence, `Cullen, Brown and the poverty of essentialism', in: W.F. Bynum & Roy Porter (eds), *Brunonianism in Britain and Europe* (London 1988), 1-21.
34 Caroline Oates, `Metamorphosis and lycanthropy in Franche-Comté, 1521-1643', in: M. Feher (ed.), *Fragments for a history of the human body*, I (New York: Zone, 1989), 305-363; Cecil Helman, *Body Myths* (London: Chatto & Windus, 1991), 58-80.
35 Richard Noll, *Vampires, werewolves and demons. Twentieth century reports in the psychiatric literature* (New York: Brunner/Mazel, 1992); H. Sidkey, *Witchcraft, lycanthropy, drugs and disease. An anthropological study of the European witch-hunts* (New York [etc.]: Lang, 1997).

that current medical or scientific ‘truths’ will not be overturned in some future, it would serve little useful purpose to only assign outdated medical opinions as socially enhanced. In our view, a social history of medicine should be concerned with the way certain people at specific times and in specific places define illness or misfortune, how they categorise it, how they mediate it and finally how they attempt to find cures. This puts people into the foreground and focusses on the ways they agree with or differ from each other, how they excert power over each other and how they interact.

We can be brief about refuting the next objection by the opponents of social constructionism: the accusation that this approach downplays personal agency. This relates to the opinion that constructionism treats the ‘individual as an empty organism that is filled and shaped by culture and society and is derived of consiousness and intention’. In this view individuals are pressed into roles and forced into categories that do not always conform to their own ideas.[36] This concerns, however, more a critique of (historical) sociology in general which was never predominantly concerned with situated meaning than of social constructionism. It merely calls for a more open and balanced constructionist approach rather than for its abandonment. While adherents of constructionism do not negate individual agency they do regard the concept of automomous agency as an illusion stessing the different scope of individual actions and the discrepancies in access to social space and power.[37]

In constrast to the misgivings about a denial of individual agency, the fourth objection often cited against constructionism, relativism, is the most troublesome for social historians of medicine. Methodological relativism has been described as a suspension of judgement about what is true or false in scientific claims and as an incentive to investigate how particular scientific evaluations are arrived at.[38] This implies that constructionism embraces the notion of different, possibly conflicting meanings. Above all, it presupposes thinking with situated meanings. Indeed, according to Jordanova, social constructionism assigns intellectual priority to the creation of knowledge, without denying ‘materiality and physical embodiment’. Against certain ‘miscomprehensions’ she stresses ‘a variety of interpretations and meanings’ and notices that ‘behind consensus or "knowledge" lie social processes, and that such processes include negotions and conflict, both overt and implicit’.[39] A closer look at Palladino shows that it was his fear of relativism more than anything else which prompted his critical response to Harley.[40] Palladino

36 John P. De Cecco & John P. Elia, `A critique and synthesis of biological essentialism and social constructionist views of sexuality and gender', *Journal of Homosexuality* 24.3/4 (1993), 1-26, 1 and 12-13.

37 Cf. Canning, `History after the Linguistic Turn', 380, 397.

38 Potter, *Representing Reality*, 25-26

39 Ludmilla Jordanova, `The social construction', 368, cf. 375: `Medical ideas inform how people experience [healing and sickness], react to them, act upon them, and construct their significance.'

40 The rejoinder to Harley would be that pain `poses an obdurate resistance in cultural categories' and `defies language', see; Arthur Kleinman, Paul E. Brodwin, Byron J. Good & Mary-Jo DelVecchoi Good, `Pain as Human Experience: An Introduction', in: idem (eds), *Pain as Human Experience: An Anthropological Perspective*

states that ‘fragmentation of meaning’ would raise ‘serious problems for our understanding of history’. He seems to be situating meaning less among historical actors, where it would be certainly fragmented and challenged, but more among academics, where it would apparently undermine an objective interpretation of the past. He claims that instead of explaining change over time social constructionism would offer a ‘meaningless sequence of incomrnensurable linguistic systems’.[41] But Paladino’s rhetoric overlooks the possibility that constructionism may provide the core for understanding change: instead of a historical ‘master-narratives’ it offers a multi-layered and often contested perception of the world around the different historical actors.

The medical sociologist Bury is also concerned with relativism but his main concern is that it does not only relate to the object of study but also to the study itself. He wrote that ‘a thesis might then develop suggesting that constructionism reflects and contributes to tensions and dilemmas of late twentieth century social life, and so on.’ He is right of course; constructionists do reveal meanings which are often blurred, overlapping and contested and this is indeed one of the most important chracteristics of the method. But to Bury it seemed like the doorway to chaos: ‘Not far from here is the abyss of relativism, into which all arguments concerning the conventional character of knowledge, and the constitution of objects through the method of their enquiry, threaten to fall’.[42] Somehow constructionists seem to have given the impression that when knowledge is situated rules of evidence and source criticism no longer apply. Jordanova maps the intellectual derivations and theoritical status of constructionism very carefully and she also tries to counter accusations of relativism by concentrating on the production of ideas. For her ‘ideas are primal by virtue of their capacity to act as mediators, to shape both conscious and unconscious experience and to play a dynamic role in organizations of social life’.[43] We have reservations about prioritising ‘ideas’, or better medical knowledge, in this way. Jordanova seems to take for granted that all human actions concerning health and illness are informed by them but she risks neglecting the influence of wider social and political forces. As Harley remarked: ‘Medical knowledge is not merely representational: it is always praxis’. And: ‘The project for social constructivism in the history and sociology of medicine is surely not just to account for knowledge creation, but to integrate all aspects of health, sickness and healing’.[44] For example, it could be revealing to study body language or the meanings attached to objects and space.[45] But Jordanova tends to favour the models offered by the history of science and to value local research

(Berkely/Los Angeles/London: University of California Press, 1992), 7.

41 Palladino, `42', 149-150.

42 Bury, `Social constructionism', 152; cf. also Michael Bury, *Health and Illness in a Changing Society* (London/New York: Routledge, 1997), esp. 184-191.

43 Jordanova, `The social construction', 377.

44 Harley, `Rhetoric', 414, 415.

45 Cf. Lindsay Prior, `The local space of medical discourse. Disease, illness and hospital architecture', in: Lachmund & Stollberg (eds), *The Social Construction of Illness*, 67-84.

less. Thus she calls historians of local medical history as ‘social constructionists without knowing it’ and criticises that ‘they often stopped short of analysing how societies shape medical theories and beliefs’. Jordanova asserts that ‘a single instance or case study is a rather weak way, logically speaking, of demonstrating the claims upon which social constructionism rests’ and that ‘untempered localism will lead to anecdotal history’ and thus local studies for her cannot yield the desired results.[46] This is surely paradoxical: if one adheres to the adagium of situated knowledge then case-studies should be one of the prime examples of constructionism.

We would suggest, that a fundamental part of most medical historians' identity is defined by their sense of an ‘objectified’ body and consists of the conviction that modern medicine offers objective meaning. If the old medical history was written by doctors, the new one is indeed written by patients but unselfconscious ones at that. In other words, social historians of medicine have accepted and internalised the marginalisation of their own story and the dominance of the medical discourse, i.e. they are an embodiment of the loss of autonomy in the transition of the ailing individual to the passive object of medical attention. Given the strikingly low number of historical studies into modern ‘quackery’ and ‘alternative medicine’ most medical historians do not appear to regard themselves among those patients who question scientific medicine.[47] Thus, a historian’s choice of subject matter, emphasis and interpretation is likely to reflect present-day preoccupations. Compared to anthropology where the involvement of the researcher has been subject to thorough discussions,[48] history has largely escaped this confrontation with the writer’s own preoccupations and identity, partly because since Ranke history is meant to adopt rigorous scholarly methods of investigating and interpreting sources objectively according to agreed-upon rules to avoid subjective analysis;[49] partly because historical actors have a habit to remain conveniently silent and thereby appear to condone historians’ treatment of them. Historians achieve what has so far eluded physicians: to make dead people talk, whatever the latter feelings might have been when they were alive.[50]

As we have seen, many critics are worried that constructionism leads to a fragmented view of the past which would undermine the authority of historical knowledge. This implies a preference for history as a coherent narrative. They appear to be unable to appraise contructionism as a matter of principle, in that it defers to the complex processes of the ways

46 Jordanova, `The social construction', 366, 376, 377.
47 Cf. Willem de Blécourt & Cornelie Usborne (eds), *Alternative Medicine in Europe since 1800*, (special issue) *Medical History* 43.3 (1999).
48 See e.g.: Fran Markowitz & Michael Ashkenazi (eds.), *Sex, Sexuality, and the Anthropologist* (Urbana & Chicago: University of Illinois Press, 1999).
49 Cf. Joyce Appleby, Lynn Hunt & Margaret Jacob, *Telling the Truth about History* (New york/London: Norton, 1994); John Tosh, *The pursuit of History. Aims, Methods and New Directions in the Study of Modern History* (London/New York: Longman, 2nd ed. 1999).
50 Cf. Willem de Blécourt, `Time and the Anthropologist; or the Psychometry of Historiography', *Focaal* 26/27 (1996), 17-24.

people make sense of their experiences, to the fact that meanings are constructed: apprehended, applied, adapted and altered. Anthropologists who try to reconstruct the meanings they encounter during their field-work and to translate them into languages they and their public are more familiar with usually try to be as specific as possible about what exactly was done or said in which situation by whom, whithout ignoring their own position. Ideally, they have access to other indigenous concepts, classifications and presuppositions. They have learned the relevant boundaries of behaviour and rules of action --if they existed. For historians who interact with sources rather than with people this is more difficult, if not impossible to achieve, the more so if the focus is on specific topics rather than a whole society. Possible patterns of communication cannot be assumed beforehand and can only become comprehensible after careful reconstruction and discussion with colleagues. Meaning is not grasped out of thin air, however ‘thick’ a description might be.