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Learning Medical History in Oslo: Training for Medical Practice

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The teaching in medical history at the University of Oslo, Norway, is given as an integrated part of the student training for practical work in health care and community health. I summarize here the underlying argumentation and the teaching experiences, concluding that this is felt as an effective way to convey relevant medical historical knowledge and skills to the future doctors.

Key words: community medicine; curriculum; education, medical; history of medicine; medical education; modern medicine; Norway; problem-based learning

Teaching Medical History: Yes, but Why and How?

There has been a permanent discussion going on in many medical schools and faculties and among medical historians as to the learning objectives in medical history: when, how, and by whom the subject should be taught and what the interrelationship to other disciplines should be. The longevity of this discussion obviously suggests that there are no general answers: the local role of medical history depends on the variations in the overall setups and aims of different medical curricula. At the University of Oslo, Norway, the idea of adapting the teaching in medical history as closely as possible to the general objectives of the training program for the medical students and the demands facing them as future doctors, has been systematically pursued for the last three decades.

Medical History in the Curriculum for Medical Students: A Reflection of Shifting Demands

At the University of Oslo, the discipline of medical history has a long tradition, as it was already put on the first curriculum, when the medical faculty of the first Norwegian university founded in 1811 in Christiania (now Oslo) started its teaching in 1814.

However, the scope, contents, and extent of the teaching varied over the decades to come, and there were periods without any regular teaching. This fact must also be taken as a part of a well-known deeper discussion: should the emphasis in medical training be laid on theory and science, or on the practical needs of a physician for hands-on skills in the solving of practical medical problems?

But there is another question: in what way do the shifting needs for different types of medical services in society require medical historical knowledge among the doctors, and if so, what type of historical skills is required? For example, health services of a country where general practice and public health work are core functions, will ask for deeper insights into the history and dynamics of the society, including the developments in the health situation and medical care system, than health services with a stronger emphasis on specialization, and with public health activities placed more as the responsibility of bodies outside medicine.

After the passing of a law regulating the public health services in 1860, the state-employed district physician got a special position in the Norwegian health planning and primary health care. Primary care physicians constituted the basis of the health services; among them, district physicians in their combined function as first line doctors and public health officers were the cornerstones.

The importance of the district physicians was even reinforced after the Second World War, when Karl Evang (1902-1981), powerful Director General of the Health Services 1938-1972, reorganized and modernized the Norway health care system (1). Public health thinking and social responsibility became even more important constituents of the knowledge and attitudes which had to be conveyed to the future doctors.

After the death of Adolf Mauritz Fonahn (1873-1940), a physician, arabist, and orientalist who had been working in the field of medical history at the University of Oslo since 1909 on a fellowship basis, and held the chair of medical history as an associate professor since 1917, there was a vacancy until a position for a research fellow was granted in 1964. In the meantime, medically relevant historical topics, historical demography, and related subjects had also been taught as part of the course in social medicine. In the lecture series in hygiene, the development of the public health services and the care for the environment throughout history were given a lot of space. Medical history as a separate discipline with its prime focus on the relationship between health and society, fit very well into this general framework.

With this in mind, it was not surprising that, in 1964, the new research fellow (author of this article) was allocated to the Institute of Hygiene at the University "of Oslo, now a part of the Institute for General Practice and Community Medicine.

The teaching of medical history at the University of Oslo since the sixties has been heavily influenced by utility discussions, especially those concerning the training of the students in public health thinking, as well as to make them understand general principles from the history of science. General medical historical orientation has been encouraged, but objectives and topics for the teaching have been carefully selected to meet the presumed future demands.

Problem-Related Medical History

When the chair for medical history was established again in 1971 as a position for an associate professor (converted to a full professorship in 1985), an apparently insignificant decision strongly set the direction to be followed in future: the discipline was named "medical history" and not the usual "history of medicine". Medical history can be defined as a field which covers those elements of history which are of medical interest, including not only the traditional history of the medical science, but also the history of diseases and the attitudes towards them; relevant topics from the development of populations, from social history, economic history, etc.

Since the introduction of a numerus clausus system (limitation of the number of admitted students) in 1940, the medical curriculum at the University of Oslo has always been very tight. Practically all teaching has been more or less compulsory, offering only very few options to the students. The teaching in medical history had to be put into this framework. A custom-built selection of topics had to be made from the wide range of possible themes, tested out, and adjusted.

In the autumn of 1973, a lecture program was presented to the students, using a sociological approach and putting the medical historical topics against a background of the relationship between health and society (Table 1). The different headings were related to practical issues, but the contents covered the main points of history leading up to the present day situation for each of those issues.

The philosophy behind this course structure was to make the students accustomed to take the time dimension into account, also when working with contemporary problems.

Table 1: Medical history - contents of lectures in Oslo and Tromsø, Norway in the seventies (Historical developments covered under each paragraph. Slight variations from year to year) [\[view this table\]](#)

The series amounted to approximately 30 lectures and was integrated in the first year of study. Some of the issues covered were accompanied by patient demonstrations, e.g., illustrating the shifting attitudes towards conditions like alcohol abuse and epilepsy. In addition, some seminars and study groups were arranged for students with special interests.

A special emphasis was laid on the history of the recent 3-4 generations, and especially on the times and living conditions when the elderly patients encountered by a Norwegian doctor of today, still were young. Giving reference to the parents' and grandparents' generations and to geographical and social variations in Norway, proved to be a good way to attract students' interests.

The innovation that the Oslo approach introduced, was the concentration on issues of prime interest for health care and public health, with other topics from medical history presented as a background for understanding. An opportunity arose to test it out in a different setting: in January 1973, a new sort of medical study was introduced as an addition to the usual training of physicians at the newly opened University of Tromsø in Northern Norway. It offered a one-year basic curriculum focusing on community health for non-medical students in need of an introductory understanding of medicine for their future work in health administration, health insurance, or as journalists, etc. The teaching in medical history for these Tromsø students was set up as a blueprint of the teaching program given for the ordinary medical students in Oslo, but extended to a series of approximately 40 lectures.

Teachers were recruited from Oslo, and the course in medical history within the one-year "medisin grunnfag" ("basics of medicine") in Tromsø in fact was an Oslo satellite for some years.

In 1976, a symposium about teaching in medical history and history of medicine in the Nordic countries was organized in Oslo. Discussions were engaged and lively, and one of the outcomes was the recommendation to teach history of medicine mainly in line with the principles from Oslo (2).

Adjusting to New Trends

In Norway, the seventies were the years when the doctor-patient relationship became a prime issue. The traditional role of the doctor was subject to criticism and attacks from the public. Reductionistic medical specialization was opposed, partly based on general antiauthoritarian trends of the time. As costly hospital treatment threatened health economy, and also seemed to alienate patients with less serious complaints from their local social networks, family medicine was upgraded. These changes

also affected medical teaching. The first Norwegian academic institute for general practice with teaching duties had been founded at the University of Oslo in 1968, followed by other Norwegian faculties.

Behavioral sciences in medicine also became a new basic subject at the University of Oslo in the seventies, replacing a tiny course in medical psychology.

When new elements were introduced into an already overfilled timetable, other disciplines had to yield, collaborate and adjust. This also applied to medical history.

For years, the medical history section had fruitful teaching interaction with colleagues from family medicine on topics such as attitudes towards disease. However, some of the more sociological and psychological issues from the medical history program had to be transferred to the behavioral sciences. Medical history exam was arranged in connection with the exam in behavioral sciences as a separate compulsory written test for approximately 20 years. The students got separate marks in medical history before these were combined with the marks from the behavioral medicine test for the final mark. This provided a feedback to the teachers in medical history and secured reasonable standards of knowledge among the medical students, whose number rose to 165 per year in the nineties.

The question of when medical history should be taught in the medical curriculum, has also been discussed in Oslo, and different models have been tried out over the years. As to this point, comments are only of limited general interest, because they depend on the main objectives and the setup of the curriculum in total. As all medical students at the University of Oslo have to pass introductory examinations that covers philosophy and medical terminology, a need for an introduction to medicine by means of medical history is not at hand. However, to give a compressed but comprehensive course in medical history in the third year of study, just preceding the written examination, proved to be successful.

From the seventies, the general idea of interaction with practical medicine has still been hailed and even further developed. Within the framework of fourteen lectures it was possible to rely heavily on the general medical knowledge that had already been acquired by the students, allowing teaching medical history on a fairly advanced level. Table 2 shows headings from the timetable which was in force up to 1997, with yearly variations and adaptations.

Table 2: Medical history - contents of lectures at the University of Oslo, Norway, in the eighties and nineties (Main topics; slight variations in contents and teaching mode from year to year) [\[view this table\]](#)

In this program ample opportunities existed to discuss methodological problems in depth and to cover demographical and sociological day-to-day problems which were familiar to the students from a historical angle.

The discipline of medical ethics was established as a separate subject at the University of Oslo in the nineties. Although there is a linkage between medical history and ethics at some universities, this was not the case in Oslo, as such an arrangement would not fit into the profile of medical history. Nor has it ever been any connection to the introductory training in medical terminology.

New Organization of the University – An Advantage for Medical History

Effective from January 1, 1990, the Oslo medical faculty was reorganized. The old subdivision into an impressive number of 106 separate departments of different sizes was obviously obsolete. The number of departments was reduced to only six, which was a dramatic and partly painful operation. Medical history was included into what later was named Institute of General Practice and Community Medicine, a unit with a staff of 145 members (1998), covering a wide range of intermingled subjects, presently (1998) with the professor of medical history as its elected academic head.

The objective behind the reorganization was not only to take out administrative advantages: a closer cooperation with related disciplines was thought to be scientifically stimulating. This was an obvious success for medical history of the Oslo type, both for research and teaching. The interdisciplinary approaches in the teaching of medical history could now be even better integrated and implemented. In comparing, e.g., the impact of the demographic transition, the industrialization and urbanization in Norway in the nineteenth century, and the build-up of a national health service, to that in other countries, a close collaboration between teachers in medical history, general practice, community medicine, and international community health proved to be of great value. As a part of their curriculum, approximately 25% of the students spend four weeks with medical teachers in other countries to gain insight into medical practice, social conditions, and health services in foreign communities. At the moment (1998) teaching agreements exist with colleagues in Latvia, the United States of America, Middle East, and Africa.

The students are requested to submit reports on return. As a rule, a comparison of some given medical problem which they are familiar with from Norway, with the extent, appearance and handling of the same problem in another cultural setting, and perhaps on another stage of a developmental process, may be extremely instructive from the viewpoints of general practice, community medicine and medical history. For example, students will never forget it, if they once have met and talked to patients admitted to the leprosy hospital of Talsi in the Latvian countryside. The history, prejudices, and the social connotations of the disease become real to them. Likewise, to look down the throats of diphtheria patients, or to see stages of tuberculosis or tropical diseases which only seldom occur in Norway, widen their perspectives. In the same way, learning about the development and present situation of the Norwegian health care system, and reflecting on its function, is strongly enhanced when the students get the possibility to supplement their knowledge with personal experiences from other settings.

The Textbook Problem

There has been no international textbook of medical history covering just the tailor-made teaching offered in Oslo. However, the students are advised to visit the library to look into standard textbooks, historical reference works and the volumes presenting picture material from medical history and the history of medicine. For their basic reading, German or English editions of Ackerknecht's short and precise descriptions of the history of medicine (3) and the history of diseases (4) have been recommended.

There is a certain demand for Norwegian books concentrating on Norwegian health problems and their handling, but this has been difficult to meet for publishing reasons, as the local market is small. However, a textbook was introduced in 1981 (5), and a conference proceedings' book covering modern medical history was also used for some years (6). An anniversary volume for The Norwegian Medical Association was written not only to tell the history of the association, but to provide students with a textbook in medical history as well (7). A special booklet has been published covering the teaching about the blood circulation (8), a topic used as an illustration from the history of the medical science. The standard textbook in public health and community medicine was designed also to serve medical historical teaching purposes (9). From 1996, a textbook in English on the development of the medical profession in Norway is a recommended reading (1), together with an introduction to the general medical history written by professor Roy Porter in London (10).

New Teaching Principles

In the nineties, the medical faculty in Oslo decided to introduce quite a new curriculum, based on the problem-based learning (PBL) principles. After years of preparations, this new teaching system was put into force when the new students arrived in the autumn of 1996. They were faced with a curriculum where most previous teaching principles had been abandoned, and most traditional disciplines were mixed up with each other. The number of lectures was reduced to a minimum and replaced by extensive group work.

Some topics from medical history have proved to be well suited for PBL-work, while others were obviously better conveyed by means of lectures. However, a PBL discussion of, for example, a tuberculosis case implies a need for the students to make thorough acquaintance with the disease, not only from the clinical perspective, but also with the historical and cultural aspects.

Apart from some introductory presentations in the first year, the main course in medical history will be given in the fifth year of the new medical curriculum. At this point the previously acquired knowledge and skills among the students about medicine, health, and society will allow medical historical teaching at a higher and more interesting level than in the introductory phases of the study. As the first group of students following the 1996 curriculum not will not be in their fifth year until 2001, no general experiences on this important shift in education policy are at hand at the moment.

Conclusion: The Oslo Experience

An overruling objective of the teaching in medical history has been to give a sense of totality and overview of medicine, health, and society to the students. The intention is to give the students a thorough understanding of the doctor's role, to counteract professional narrow-sightedness, and to internalize a feeling of being part of a bundle of parallel historical processes when doing professional work.

There is a possibility that through such a teaching policy medical history may lose its own profile. An opposite interpretation is that medical history in this way shifts to a profile where it more efficiently becomes a part of medicine as such. Nevertheless, the experiences from the seventies up to 1998 are felt as good. At least in terms of stimulating the interest and the historical understanding among the students, the teaching principles have been felt as well chosen.

The present organization model of the medical faculty at the University of Oslo is well suited for a

fruitful integration of medical history with similar subjects, but it remains to see what changes will be necessary in order to comply successfully with the PBL-centered teaching principles.

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The goal of specialist training in medicine and dentistry is to familiarise physicians and dentists with the scientific knowledge and information acquisition in their speciality, as well as to provide them with the knowledge and skills necessary for the duties of a specialist in medicine or dentistry, the maintenance of professional competence, the further development of the speciality as well as the work. of a medical or dental specialist in the social and healthcare service system. 1. All applicants must have a licence to practice medicine/dentistry in Finland. The University of Helsinki will consider a person's admission to a specialization program only after he/she has been granted a permit to practice medicine in Finland.