CHAPTER 9

Health and Disease, Illness and Well-Being

Once again the title of my chapter already suggests the range of complex issues to be discussed. Where health and disease are concerned, we tend to focus on the diagnoses and treatments of modern biomedicine, although as we shall be noting those are a good deal less confident where psychiatry is concerned than when the doctor faces physical pathologies. But we use the terms 'health' and 'healthy' in many other contexts, even though the temptation there is to dismiss much or even all of that as mere metaphor. Illness is often distinguished from disease as a matter more of the subjective feelings of the patient, even though that distinction may be anything but clear-cut. Conversely well-being depends on far more than the absence of any diagnosable pathological condition.

The aim of this chapter is to review this whole congeries of issues and in particular to examine the consequences of the dominance, in our modern Western societies, of the discourse of biomedicine. Expanding our horizons here means looking beyond that discourse to see what other views of well-being can contribute to our understanding. In plenty of societies past and present there was no equivalent to modern evidence-based medicine with its battery of diagnostic tools, sophisticated methods of collecting and evaluating enormous masses of data, and extraordinary techniques of intervention. Yet of course practically every human group that has ever lived has had, we may presume, some idea, even if maybe profoundly different ones, about health and well-being, and their opposites, disease and illness, whether or not they recognised any distinctions between the members of each pair.[1]

[1] The medical anthropological literature that has served to bring to light the immense variety of ideas that have been and still are entertained in different societies about health and illness, both physical and mental, is vast. Among still useful surveys are Kleinman and Good 1985, Lindenbaum and Lock 1993, Good 1994, Nichter and Lock 2002, Wiley and Allen 2009, Good et al. 2010 and Hsu and Potter 2016. The multiple discourses that intersect in modern talk of the body in medical contexts are well brought out by Mol 2002.

Once again in our investigation we are faced with a double task. When we find diverse beliefs on what seem to be the same topics, what are we to say? Is there a single set of criteria to which appeal can be made to distinguish correct from incorrect perceptions? Where, on the other hand, do the differences in the solutions on offer suggest that the very problems to which they are the proposed solutions themselves differ? What consequences does that have for our understanding of the key terms in which we state those problems?

Modern biomedicine, we said, presents us with a vast array of complaints and disorders of different types, identifying some caused by specific pathogens, others where an abnormality is defined as a deviation from a norm determined by statistical analysis. Modern psychiatry too has its taxonomy of abnormalities of varying degrees of severity, ranging from bipolar disorder through manic depression to schizophrenia. Yet here, as we said, the confidence with which causes can be identified for these is considerably less than in the purely biomedical sphere. As Foucault, especially, showed in a series of brilliant studies (1967, 1973, 1977), there were dramatic changes in the early modern period in both the understanding and the treatment of those labelled 'demented', 'deranged', 'irrational' or 'insane'. In Greco-Roman antiquity those diagnosed as suffering from *mania*, madness, were regularly submitted to treatments many of which were indistinguishable from the punishments meted out on criminals: they could be chained up, drugged, starved, kept in the dark and flogged. Even though Caelius Aurelianus in the fourth century CE criticised these as excessively violent and advocated some gentler treatments such as listening to music, he himself acknowledged that patients need restraining (*Chronic Diseases* I 144ff., 155ff., 171ff., cf. Lloyd 1987: 25–6 and notes 80–1).

Even the most positivist of modern commentators has to concede that still today there is a good deal that we do not yet know about what causes a particular disease, whether mental or physical, and that in many instances we continue to be at a loss to produce a cure or even an alleviation of the condition. The anthropologist Gilbert Lewis who was also a qualified medical practitioner records one moving account of a Gnau patient who could not be saved by modern Western methods or by Gnau traditional ones, which serves as a graphic reminder of the limitations of both (Lewis 2000). I drafted this at a time (April 2020) when doctors across the world were in the early stages of battling the ravages of the pandemic caused by the new coronavirus Covid-19. The difference from historical plagues is that research had already revealed the precise genetic constitution of the

virus: the similarity lies in the fact that there was, at that date, no vaccine to guard against it, nor cure once it infected a patient.

Yet most positivists, and not just they, will remain adamant that very considerable progress has been made in recent decades and many will be inclined to dismiss pretty well all earlier attempts to understand diseases and to offer treatments as just so many tragic failures. Earlier practitioners may have claimed to know and to be in control, but that was just wishful thinking – to be replaced by more securely grounded modern confidence.

But while, at the biomedical end of the spectrum, such an account can be supported by reference to the remarkable advances that have been made, my mentioning ongoing limitations, especially in the field of psychiatry, opens the door to a wider appreciation of the problems and their history. Unlike disease, illness is, we said, a matter far more of how one feels. Conversely a person may register a deep sense of well-being even though suffering (an outside observer may say) from considerable misfortune, discomfort and even pain. Some Greek thinkers maintained that the wise person, fortified by their philosophy, will be happy even when undergoing torture on the rack.[2] That is, to be sure, an extreme claim. But lesser ones make my point. The record contains many examples of ascetics who have expressed their joy even when suffering from extreme deprivation. It is worth opening up the whole subject, then, to closer scrutiny.

Given the obvious difficulties both in diagnosis and in therapy, it is not at all surprising that the actual theories of disease and the provision for treatment that we find in the historical record are so diverse. In part this reflects the competitive situation in which ancient healers worked. In ancient Babylonia, Greece and China several different categories of persons lodged some claim to be able to treat the sick. Sometimes these groups coexisted well enough, each having a particular sphere of activity,

[2] Diogenes Laertius X 22 (Long and Sedley 1987: 24D, 150–1) quotes from a letter that Epicurus is said to have written to a friend at the end of his life: 'I wrote this to you on that blessed day of my life which was also the last. Strangury and dysentery had set in, with all the extreme intensity of which they are capable. But the joy in my soul at the memory of our past discussions was enough to counterbalance all this. I ask you, as befits your lifelong companionship with me and with philosophy: take care of the children of Metrodorus.' Whether or not this has any basis in fact, such a statement served as powerful propaganda for the thesis that the Epicurean philosophy trumped all manner of apparent misfortunes. The Stoics made similar claims, as did the followers of other sects, though the plausibility of any of them was rather undermined, in the eyes of ordinary folk, by the inconsistency between their various conceptions of what the good consisted in, pleasure for the Epicureans, virtue for the Stoics, tranquillity (*ataraxia*) to be achieved by suspension of judgement (*epochē*) for the Sceptics.

a distinctive brand of expertise.[3] But in both Greece and China especially there were considerable disputes in which one group laid claims to be the true practitioners while their rivals were charlatans and frauds. In China the second-century BCE physician Chunyu Yi, whose biography is recorded in the *Shiji* (ch. 105), distances himself from those he calls the 'ordinary doctors' whom he criticises as ignorant. His own claim to have diagnosed the cases he describes correctly depends on a mastery of pulse lore which we shall consider again in the next chapter. We have mentioned before (Chapter 1) the polemic that some naturalist Hippocratic physicians launched against the so-called purifiers who saw the gods as responsible for diseases and claimed to be able to control them. Here the Hippocratic pretensions to superiority rested on the principle that every disease has a natural cause, though this was axiomatic, rather than a claim that could be shown empirically. I shall have more to say about these rivalries in due course.

But as to ideas about what causes diseases, there was great variety, dispute and room for misunderstanding between competing theorists. One common view, found in ancient India as well as in Greece, was that the so-called humours were to blame. Yet even in that context there was no agreement, starting with the issue of the nature and number of the principal humours that have to be taken into account.[4] For some the humours were themselves pathogens or capable of causing diseases if the balance between them was disrupted; for others they were rather the outcomes and so the signs of diseases, while yet others saw them as natural constituents of the human body and not normally pathogens at all. The latter idea, found in certain Hippocratic treatises, especially *On the Nature of Man*, was elaborated by Galen, and in much later European theorising became the foundation not just of a taxonomy of human physiological constitutions but also of their corresponding emotional dispositions, the phlegmatic, the bilious, the melancholic and so on. We no longer generally believe the emotions arise from specific substances in the body: but we still grope

[3] Thus in ancient Babylonia there was a broad distinction between those called *Ašipu* (conventionally translated 'exorcist') and those labelled *Asû* ('physician'), but it is clear that there was some overlap between their ideas and their therapeutic practices, and we hear of several 'learned scholars' who managed to combine different roles, in both the medical and astronomical domains for instance: see Parpola 1993: xiii and 122, Rochberg 2000, Geller 2015. Robson 2019, especially ch. 7, provides an authoritative account of the different scholarly professions and the fluctuating fortunes of cuneiform culture in Mesopotamia over the centuries.

[4] Other views besides the one that became canonical with Galen, which focussed on blood, phlegm, yellow bile and black bile, are to be found in the Hippocratic Corpus, for example a two-humour theory based on bile and phlegm, found in *Affections* ch. 1 and *On Diseases I* ch. 1.

towards an adequate taxonomy of character traits, uncertain, indeed, as to whether or to what extent we are dealing with cross-cultural regularities.

On what basis did ancient practitioners assume that the humours or the other supposed causes of diseases could be diagnosed? Considerable attention was paid to the excreta, for they were relatively easy to observe. In both China and Greece variations in the pulse came to be seen as an important diagnostic tool and elaborate theories came to be developed to apply this in detail even though Chinese and Greeks gave very different accounts of what the pulse indicated was happening in the bodies of their patients. For the Chinese the anatomy of the vessels concerned, the *mai* or *mo* 脈, was of less concern than the free flow they permitted or that in pathological conditions was blocked (cf. below, Chapter 10). As to what those vessels contained, we find disputes on that subject between different Greek theorists, some claiming that the arteries are normally full of air and that the blood that flows out of them when cut originates not in the arteries themselves but in the veins. Once again controversy was the occasion, in Greece, for rival practitioners to attempt to impress.

More generally, the patterns of development of the complaints that individuals or groups suffered from came to be studied extensively by those who favoured what we may call an empirical approach. Both Chinese and Greek texts record detailed observations of the progress of individuals' diseases, in the Greek ones generally without specific pronouncements on causes.[5] In view of the competitive situation in Greek medicine it is particularly remarkable that the Hippocratic authors of these case histories have no hesitation in recording the deaths of many of their patients, in some instances even acknowledging that this arose from their own faulty treatment (e.g. *Epidemics* V 27, Lloyd 1987: 124). Elsewhere, however, for example in the cases described in the inscriptions set up in the shrines of Asclepius, it is 100% success that is claimed.[6] One possibility that I have argued for myself elsewhere (Lloyd 1987: ch. 3) is that the acknowledgement of failure by the Hippocratic naturalists was intended somewhat paradoxically as a reassurance to those who consulted them and especially to their patients. At least they could have confidence in their physician as

[5] Hsu 2010, Table 3: 114 sets out the main causes of the disorders of individual patients whose case histories are described in the Chunyu Yi biography in *Shiji* ch. 105. Behaviours that are morally reprehensible, such as excessive indulgence in sex, wine and inappropriate desires and emotions, figure prominently, as they do also, though to a somewhat lesser extent, in the Hippocratic Corpus. Most of the individual case histories recorded in the Hippocratic *Epidemics* leave open the nature of the disease that the authors thought their patients were suffering from.

[6] This is true in particular of the cases recorded in the inscriptions at the shrine of Asclepius at Epidaurus (Herzog 1931, LiDonnici 1995).

someone who would be totally honest and who would not make extravagant claims to infallibility like those made by the priests who were in charge of temple medicine in ancient Greece.

In assessing this material the further factor we must recover is one that we have mentioned elsewhere. We may assume that the only thing that counts in the medical domain is causal efficacy, the ability to produce a cure. But what counts as a cure or at least as a good result will depend on the assumptions made by whoever seeks one. If we look at the issues from the point of view of those who frequented the shrines of Asclepius, what they obtained from the experience was reassurance that the god was on their side.[7] Of course they generally wanted more, the actual restoration of their sight or the ability to walk again or to bear a child, which are the positive successes so often recorded in the inscriptions. But even in the absence of that kind of result believers could take comfort in the appropriateness, the felicity, of their appeal to god for support and in the assurance that he was on hand to help the faithful. The appeal of felicity no doubt remains a powerful factor, alongside reference to causal efficacy, in contemporary divine healing, including in such shrines as Lourdes, located in a nation state that boasts many of the most renowned scientific researchers.

My argument thus far is the obvious one that we would be mistaken to treat issues to do with health, disease, illness and well-being as solely matters on which biomedicine alone can pronounce. Now some would stake their claim for the validity of indigenous medical practices precisely on biomedical grounds. Even without modern laboratory tests to demonstrate efficacy, many successful treatments have been discovered. We owe quinine, curare and many other efficacious drugs to New World knowledge. In ancient China *Artemisia annua* was used as an effective cure for complaints that include what we identify as malaria. True, the method of preparation is important and it took modern techniques to pin these down and to identify the active ingredients, work that led to the awarding of a Nobel Prize to Tu Youyou in 2015. In the ancient Greco-Roman world *colchicum* (autumn crocus) was recognised as a specific for gout,[8] even though there would have been a good deal of unclarity about the limits of a safe dosage, and of course many other examples could be given.

[7] This is a recurrent theme in the *Sacred Tales* of the second-century CE orator Aelius Aristides, a notable advocate of the superiority of temple medicine over that afforded by merely mortal doctors. He gives detailed accounts of his own personal experiences of the extraordinary cures he attributes to the interventions of Asclepius.

[8] Cf. Riddle 1985: 44ff., who discusses the problems of identification where the condition labelled *podagra* is concerned, and the efficacy of the various drugs used in its treatment.

But the more important argument depends on problematising the notion of health itself. What pass as medical theories and practices in ancient societies and in many modern indigenous ones often belong to complexes of beliefs that implicate value-laden notions of the good, of correctness, of how humans should behave. If we are to understand what we call ancient, and modern indigenous, medicine, and learn from what our sources tell us about this, we should, as I said, broaden our horizons. Disease can be a way of conceptualising what is amiss not only in individual human beings but in society as a whole.[9] Over and over again in ancient as also in modern communities commentators use the vocabulary of sickness to talk about what and whom they disapprove of, and once that or they are labelled sick, it follows that treatment is needed, cures that will involve the removal of peccant, pathogenic items, to restore the body politic to health.

Among ancient authors, Plato is particularly prone to developing such ideas. Dealing with what he calls the 'purging' of undesirables, or as he puts it 'incurables', from the state, in the *Laws* 735e, he comments that the best variety of treatment, 'linking justice with vengeance', will not just be painful ('like all medicines of a drastic nature') but will involve exile and capital punishment to avoid damage to the state. He goes on to describe a 'milder form of purge', to be used when civil disturbance occurs when through lack of food the poor show signs of being prepared to attack the property of the wealthy. Here the lawgiver 'regarding all such as a plague inherent in the body politic, removes them abroad as gently as possible, giving the euphemistic title of "emigration" to their evacuation'. The gruesome modern echoes of such a policy are obvious.[10] The surprising thing is the pervasiveness of some appeal to medical analogues in an attempt to justify the punishment of political opponents. Yet the common feature of such appeals is clearly to give a veneer of objectivity to judgements about the threat those opponents presented.

Here the temptation is to dismiss all such talk as mere metaphor, as persuasive definition or as pure political rhetoric or ideology, but two considerations should give us pause. If we reflect on the range of the vocabulary of well-being, this is an area where it is particularly hard to be

[9] I reviewed the evidence for this in a wide variety of Greek and Roman sources in Lloyd 2003b. For a comparison between the Greek and the Chinese uses of this trope, see Lloyd and Sivin 2002: 221ff. The early Chinese evidence was surveyed by Sterckx in an as yet unpublished talk to the China Research Seminar Cambridge on 6 November 2019.

[10] One such parallel is how, long before the Nazis arrived at the policy of the extermination camps and their 'final solution', they planned to exile the Jews from Germany to Israel.

at all confident as to where to draw any firm line between primary and secondary uses. Obviously what biomedicine classes as pathogens threaten well-being. But so too do emotional states, including whenever we register misfortune or unease. Is not our well-being affected by our feelings about the society in which we live? Would we say that anyone can be truly happy living under a dictatorship, or even in any society that does nothing to alleviate inequality or suffering? After all the term 'suffering' itself in ordinary usage evidently spans psychological disaffection as well as physical pain.

To that we may add a reminder that in practice the boundaries between the sick and the criminal are still highly contested. When can the mental state of an individual be invoked in mitigation for what will otherwise be described as criminal behaviour (Hacking 1995)? Nowadays we have different professionals dealing with different aspects of this question, police and judges responsible for law and order, as well as health workers and psychiatrists there to give their expert opinions on the mental states of the agents in question. Yet as Luhrmann (2001) extensively documented, those different types of authorities themselves often disagree on whether the case in hand falls within or outside their particular jurisdiction – where it is not just issues about the patients' own well-being that are at stake, but the prestige and status of the different medical authorities themselves. And if the experts themselves differ, ordinary lay persons may find it hard to make up their minds, even when called upon to do so as members of criminal juries.

We have, then, a spectrum. At one end there are physical conditions diagnosable as cases of tuberculosis, influenza, malaria, jaundice or whatever, even though some of those diagnoses are generic rather than fully determinate. At the other we have behaviour that society disapproves of as offensive by whatever criteria that society chooses to appeal to (not that everyone in any society will agree fully on those). Throughout, some conception of what is normal or what is 'natural' is being appealed to, openly or not, in order to arrive at some judgement concerning the abnormal. The slide between the descriptive and the normative uses of 'natural' is particularly striking, for as the regular product of 'natural' causes diseases are themselves natural, yet they demand measures to restore health, where it is the healthy that is natural and disease as its opposite unnatural. Moreover in the social domain tricky questions of responsibility are at stake. In China and some other ancient societies, when a crime has been committed, it is not just a single individual but the whole family or group to which he or she belongs that suffers the consequences. Does

responsibility stop at the point where human agents are no longer involved? In ancient Greece and later in Europe animals were sometimes brought to trial for what they had done. Provision for this is made in Athenian law (MacDowell 1978: 117–18): it figures in Plato's *Laws* (873de) no less, and we find similar ideas persisting in the European Middle Ages (Evans 1906).

We may start with cases where healers in different cultures may think that all that is needed is a dose of medicine or some reassuring words. But we end with issues that call into question the fundamental values by which a society lives. For historians of medicine (as we call ourselves) it is as well not to limit our gaze to the purely medical end of the spectrum even though that is precisely what some of the dominant forces of modern biomedicine encourage us to do. Health and well-being have been used by many societies as useful tools to think about other matters. It is important to recognise the very different issues that may be at stake, even while as we have observed the boundaries between different discourses are fluid and permeable. While these are topics on which manipulation, rhetoric and ideology have often been prominent, we may reflect that our own deployment of that vocabulary is still not immune to such.

We have here, then, a prime example of both the challenges and the benefits of cross-cultural comparison. The challenge lies in charting the commonalities and the divergences in the ways in which health and disease, illness and well-being, have been conceptualised, explained and treated. The positive outcome is hopefully a greater understanding of issues that cannot fail to be important to humans wherever and whenever they have lived. For all the differences between individuals and groups on the essential values to live by, we discern a recurrent appeal to a set of medical images to articulate notions of such values, all serving to cloak the subjective with a measure of claimed objectivity. We are all inclined to place more or less trust, with greater or less reservations, in those whom our particular community sets up as established authorities on the matter of physical or mental health, where the boundaries of such trust are nevertheless liable to constant contestation. But when it comes to values, it is as well to recognise the dangers inherent in any construction or appropriation of the status of expertise on the issue of how life is to be led. The widest possible comparative study of the history of medicine may serve as an antidote to the tendencies we would do well to resist.