

**Questioning the Patient, Questioning
Hippocrates: Rufus of Ephesus and the
Limits of Medical Authority**



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ABSTRACT

Rufus of Ephesus's *Quaestiones Medicinales* is an under-studied work by one of the most respected doctors of Greco-Roman antiquity. This thesis presents a new translation – the first in English of the complete work – and a reassessment of the treatise. I propose that, far from being a simple handbook teaching doctors how to take a patient history, as has hitherto been assumed, *QM* is an ardent plea for doctors to recognise the limits of their own knowledge and the indispensability of questioning the patient. I argue that *QM* articulates the idea that the aim of medicine cannot be achieved through medical knowledge alone, and that, in constructing the patient as an essential partner in diagnosis and decisions about treatment, Rufus implies a sharing of authority between doctor and patient that is noticeably different from the emphasis that other authors, particularly the determinedly hierarchical Galen, place on securing patients' obedience, a subject on which Rufus is noticeably silent. I argue that Rufus is unusual in the clarity and candour with which he perceives and acknowledges the limits of medical knowledge, in his conceptualisation of questioning as a discursive rather than a formulaic activity, in his explicit insistence that it must be addressed directly to the patient, in his psychological concept of habits, and in his recommendation of questioning as a strategy for resolving the tension between universal theory and individual experience. I look at modern cross-cultural research into the factors that drive patient compliance, and note that chief among them is patients feeling they are partners in the treatment process. This raises the question whether and to what extent the features that drive compliance are diachronically as well as cross-culturally consistent, and whether Rufus's shared authority model is more likely to have produced successful treatment outcomes than the autocratic paradigm promoted by Galen, and subsequently absorbed into Western medical tradition, that seems to have met with so much resistance.

Preface

Rufus of Ephesus's *Quaestiones Medicinales* originally attracted my attention because, in the three decades between my undergraduate classics degree and my return to Oxford in 2009, I had spent twenty years in the leadership of UK advocacy organisations working on behalf of people with long-term conditions, persuading health care professionals and policy makers to recognise the unique and transformative effect of the patient's narrative on the clinical encounter. On coming back to classics I was naturally drawn to ancient medicine, and on a January afternoon in 2010, browsing through materials in the Sackler Library in Oxford, I came across an intriguing entry in volume 12 of *Brill's New Pauly*. Rufus of Ephesus – of whom I had never heard – had, it said, had written a work that provided 'a rare glimpse into the bedside manner of ancient doctors'. If it was rare, it must, I reasoned, already have been much studied. My discovery that this was not the case was the well-spring of five years of doctoral work that, in uniting my major intellectual passion, classics, with the central interest of nearly a quarter of a century of my working life – the politics of healthcare – allowed me to come to my topic with a fairly wide frame of reference.

That my work has stretched out over five years reflects both the generosity of my nearest and dearest and the patience of my supervisors. During the long gestation of this thesis, my daughter Isobel has completed her A-levels, travelled round South East Asia, read Politics and History at Newcastle University, and returned to Cambodia to work for a children's charity; and my son Fergus has read Classics at Oxford, married our much-loved son-in-law Eli, and become a New Yorker working for *The New Yorker*. These two successful passages into adulthood are the truly important legacies of the past five years and I thank Fergus and Izzie, together with my husband Neil McIntosh, for their (largely)

ungrudging forbearance on the (I hope few) occasions when I have failed to provide them with as much care and attention as they deserved. To my supervisors, Chris Pelling and Helen King, I am indebted for wise advice, stimulating conversations, bottomless funds of knowledge, and a seemingly unlimited capacity for rapid response to lengthy chapters landing in their inboxes at unpredictable moments.

The final stages of the thesis were undertaken in exceptionally difficult circumstances. During this time the support of friends – whether moral or practical – has been invaluable. I thank especially Sue and Paul Davies, Brian Dunnigan and Hetty Einzig, Fred Woods, Helen Woods, and my sister Penny Rawlinson. They all know how much they were needed, and I hope they know how much they were appreciated. Above all I thank Neil, without whom none of this would have been possible – not least because I would have had nothing to eat for five years but peanut butter sandwiches. All the other reasons are known to him: ἀνδρὶ φιλότατῳ.

Conventions followed

It will be seen from the list of editions given in the Bibliography that the definitive edition of Rufus's *Quaestiones Medicinales* (*QM*) is Gärtner's, published first in 1962, as *CMG* Supplement 4, and again, with some revisions, by Teubner in 1970. This thesis uses the 1970 Teubner edition, which, for ease of reference, is reproduced on pages 11-28 below. All quotations from *QM* are given simply by § number; very occasionally a page and line number have been quoted, to enable precise location of a word or phrase, and these refer to the 1970 Teubner edition.

Referencing of ancient texts is done by means of the abbreviations used in LSJ (for Greek works) and the Oxford Classical Dictionary (for Latin works), except for Galen's corpus, for which I use the Latin titles and abbreviations given by Hankinson (2008:391-97, Appendix 1).

Hippocratic quotations are normally accompanied by Littré references in order to provide a central point of reference, but, because the translations used are mainly Loeb ones, the Greek quotations themselves match the Loeb texts unless otherwise specified. Quotations from Galen are accompanied by Kühn references for the same reason, and where another edition exists (usually *CMG*) that has normally been supplied as well. Other quotations from ancient texts are generally taken either from the Oxford Classical Text or, if a Loeb translation is supplied, from the relevant Loeb edition.

English titles of Galen's works are taken from Hankinson 2008:399-403, Appendix 2, and of Hippocratic works from Craik 2015, *singulatim*. The English title *On Questioning the Patient* for Rufus's *Quaestiones Medicinales* is my own choice. Any other English titles employed for ancient works are those in common use.

References to previous translations of *QM* by Daremberg (1879; French), Brock (1929; English, partial), Gärtner (1962; German) and Haak (2013; Dutch) are made by the translator's name alone. Loeb translations quoted are cited by translator's name and (where applicable) Loeb volume of the author concerned. Other translations, and Loeb translations consisting of only one volume, are cited by translator's name and date of publication. Unattributed translations are my own.

The dating of Hippocratic texts is a notoriously uncertain business which defies academic consensus. My policy in this thesis is to use the dates given by Craik (2015).

The edition of LSJ referred to throughout is the 9th edition with revised supplement (1996).

Part I: Text and Translation

Text: *Quaestiones Medicinales*

Two 15th century manuscripts of *Questiones Medicinales* survive, M and V; the latter was judged by Gärtner to be clearly derived from the former.¹ Each comprises an eclectic collection of ancient, Byzantine and medieval works including medical texts and excerpts, the (pseudo)-Aristotelian *De Mundo*, the Hellenistic numerological work *Petosiris to Nechepso*, and a *Lexicon Botanicum*.² Among the medical texts is the (tentatively) 9th century Meletius the Monk's *De Natura Hominis*, which, like Rufus's own *Onomasticon*, consists of a simplistic but detailed description of the parts of the body *a capite ad calcem*.³ In M, bought in Asia by Minoides Myna in 1842, a disordering of the manuscript pages has divided the text of QM into two parts, §§27-73 and §§1-26, in that order and separated by several other works.⁴ V was bought in Constantinople in the 16th century by Augerius Bousbecq; it contains everything that M does, though in a different order, as well as works by Paul of Aegina, other medical excerpts and fragments, and other material including excerpts from the 5th century Cyril of Alexandria's *Contra Iulianum*.⁵ Gärtner's 1970 text, which follows below, is based on M.⁶

¹ Gärtner 1970:vii.

² Gärtner 1970:vi.

³ Holman 2008:81, quoting Rufus in comparison. The dating is also Holman's (*ibid.*)

⁴ Gärtner 1970:v-vi.

⁵ Gärtner 1970:vi.

⁶ Gärtner 1970:viii.

CONSPECTVS LIBRORVM

- E. D. Baumann, Über die Hundswut im Altertum, Janus 32, 1928, 172.
- W. Crönert, Sprachliches zu griechischen Ärzten, eine Untersuchung über den Verfasser des griechischen Papyrus Lond. Nr. 155, Archiv für Papyrusforschung 2, 1903, 475sq.
- H. Diller, Die Überlieferung der Hippokratischen Schrift ΠΕΡΙ ΑΕΡΩΝ ΥΔΑΤΩΝ ΤΟΠΩΝ, Philologus Suppl. 23, 3, Leipzig 1932, 144–146.
- L. Edelstein, ΠΕΡΙ ΑΕΡΩΝ und die Sammlung der hippokratischen Schriften, Problemata 4, Berlin 1931, 6–8.
- H. Flashar, Melancholie und Melancholiker in den medizinischen Theorien der Antike, Berlin 1966, inprimis 84–100.
- H. Gärtner, ΤΗΡΗCΙC ΤΟΥ ΕΛΚΟΥC. Ein Nachtrag zu Rufus von Ephesos, CMG Suppl. IV 41, 10f., Hermes 94, 1966, 251sq.
- H. Gärtner, Zum ersten Kapitel des Paulos Nikaios, Hermes 95, 1967, inprimis 370–372.
- J. Ilberg, Rufus von Ephesos. Ein griechischer Arzt in trajanischer Zeit, Abh. d. phil.-hist. Kl. d. Sächs. Akad. d. Wiss. 41 Nr. 1, Leipzig 1930, inprimis 12–16.
- F. Kudlien, Wie erkannten die antiken Ärzte einen Simulanten?, Das Altertum 7, 1961, 230sq.
- J. Tüncher, Der Ersatz des Genetivs durch präpositionale Wendungen bei Galen und anderen griechischen Prosaikern des zweiten nachchristlichen Jahrhunderts, Diss. Gießen 1935, 35sq.
- M. Wellmann, Zur Geschichte der Medizin im Altertum XI, Hermes 47, 1912, 4–17.

EDITIONES

Œuvres de Rufus d'Éphèse. Texte collationné sur les manuscrits, traduit pour la première fois en Français, avec une introduction. Publication commencée par le Dr. Ch. Daremberg, continuée par Ch. Émile Ruelle, Paris 1879 (Amsterdam 1963), 195–218.

CONSPECTVS LIBRORVM

Rufus von Ephesos. Die Fragen des Arztes an den Kranken. Herausgegeben, übersetzt und erläutert von Hans Gärtner, Berlin 1962 (Corpus Medicorum Graecorum Suppl. IV).

De hac editione rettulerunt:

J. Kollesch, Spektrum 9, 1963, 122
H. Schipperges, DLZ 85, 1964, 824sq.
U. Fleischer, Gnomon 36, 1964, 768-772
F. Kudlien, Anz. f. d. Alt.-Wiss. 19, 1966, 65sq.
F. Lasserre, Erasmus 21, 1969, 620sq.

Der Arzt im Altertum. Griechische und lateinische Quellenstücke von Hippokrates bis Galen mit der Übertragung ins Deutsche. Herausgegeben von Walter Müri, München 1962, 64-75 (§§ 1-11, 21-23, 28-29, 41-42, 55-58, 72).

VERSIONES

Greek Medicine. Being Extracts illustrative of medical writers from Hippocrates to Galen, translated and annotated by Arthur J. Brock, London and Toronto 1929 (Library of Greek Thought edited by Ernest Barker), 112-124 (§§ 1-12, 15-60a, 61-62, 63b-73).

NOTARVM INDEX

M = Cod. Paris. Suppl. Gr. 637, s. XV
Da. = Daremberg
Deichgr. = Deichgräber
Gae. = Gärtner
K. = Kühn
Kudl. = Kudlien
L. = Littré
Nachm. = Nachmanson
Schubr. = Schubring

ΡΟΥΦΟΥ ΤΟΥ ΙΑΤΡΟΥ

ΙΑΤΡΙΚΑ ΕΡΩΤΗΜΑΤΑ

Ερωτήματα χρη̃ τὸν νοσοῦντα ἐρωτᾶν, ἐξ ὧν ἂν καὶ δια- ^{195 D.-R.}
 γνωσθῇ τι τῶν περὶ τὴν νόσον ἀκριβέστερον καὶ θεραπευ- ^{1 1}
 5 θεῖν κάλλιον. πρῶτον δὲ ἐκεῖνο ὑποτίθημι τὰς πεύσεις 2
 αὐτοῦ τοῦ νοσοῦντος ποιῆσθαι. μάθοις γὰρ ἂν ἐνθένδε
 ὅσα τε κατὰ γνώμην νοσεῖ ἢ ὑγιαίνει ὁ ἄνθρωπος καὶ
 ῥώμην αὐτοῦ καὶ ἀσθένειαν, καὶ τίνα ἰδέαν νόσου καὶ τίνα
 τόπον πεποιηκ[οτ]ῶς <εἶη>. εἰ μὲν γὰρ ἐφεξῆς τε ἀποκρί-
 10 νοιτο καὶ μνημονικῶς καὶ τὰ εἰκότα καὶ μηδαμῇ σφαλλό-
 μενος μήτε τῇ γλώττῃ μήτε τῇ γνώμῃ καὶ εἰ καθ' ὁρμὴν
 τὴν οἰκείαν καί, εἰ μὲν ἐστὶν ἄλλως κόσμιος, πρῶως καὶ
 κοσμίως, ὁ δ' αὖ φέσει θρασὺς ἢ δειλὸς θρασέως ἢ δεδοι- 196
 κ<ότ>ως, τοῦτον μὲν χρη̃ νομίζειν τὰ γούν κατὰ γνώμην
 15 καλῶς ἔχειν. εἰ δὲ καὶ ἄλλα σὺ μὲν ἐρωτᾷς, ὁ δὲ ἄλλα
 ἀποκρίνοιτο, καὶ εἰ μεταξὺ λέγων ἐπιλανθάνοιτο, αἱ δὲ
 τρομώδεις καὶ ἀσαφεῖς γλῶσσαι καὶ αἱ μεταστάσεις

3 aegrotos interrogandos esse docent Hipp. Aff. 37 (VI 246 L.);
 Epid. 6, 2, 24 (V 290 L.) et Gal. in Comm. ad loc. (CMG V 10, 2, 2,
 p. 115–117); Marcellin. De puls. p. 459, 138–145 Schoene; cf.
 Plut. Mor. 129 d. de Paulo Nic. cf. quae disserui Herm. 95, 1967,
 366sq. || 7 κατὰ γνώμην νοσεῖ] cf. Hipp. Aph. 2, 6 (IV 470, 18 L.) ||
 8 ἰδέαν νόσου] cf. Hipp. Nat. hom. 2 (VI 36, 4 L.) || 11 μήτε¹ u.
 ad γνώμην] cf. Hipp. Off. 1 (III 272, 4 L.) || 12. 13 καὶ εἰ – δεδοι-
 κ<ότ>ως] cf. Hipp. Prorrh. 1, 44 (V 522 L.) = Coac. 51 (V 596 L.);
 Gal. Comm. in Prorrh. ad loc. (CMG V 9, 2, p. 59, 16–22) et in
 Epid. 1, 10 (CMG V 10, 1, p. 104, 1–6)

1 ἱατροῦ M: Ἐφεσίον Da. || 3 [ἐρωτήματα] Deichgr. | ἐρῶν M:
 ἐξ ὧν Da. || 3. 9 καὶ τίνα i. v. καὶ τίνα τόπον πεποιηκῶτος M: corr.
 Deichgr. || 9 ἀποκρίνοιτο M: corr. Da. || 13 ὁ δ' M: εἰ δ' Da., fort.
 recte | δεδοικῶς M: corr. Da. || 15 καλῶς Da.: πρῶως M || 16 αἱ
 δὲ <αὐ> Da.: αἱ τε Diller || 17 καὶ αἱ σαφεῖς M: corr. Da.

ἀπὸ τοῦ ἀρχαίου τρόπου πρὸς τὸ ἐναντίον, πάντα ταῦτα
 παρακρουστικά. καὶ κώφωσις δὲ τοῦ κάμνοντος οὕτως τι
 3 σημαίνεται. χρὴ δὲ εἰ μὴ ἀκούει[ν] προσανερωτῶν τοὺς
 παρόντας, ἄρα γε καὶ πρόσθεν ὑπόκωφος ἦν ἢ διὰ τὴν
 παροῦσαν νόσον· τοῦτο γὰρ πρὸς τὴν διάγνωσιν μέγα δύνά- 5
 4 ται. ῥώμην δὲ καὶ ἀσθένειαν τοῦ κάμνοντος καταμάθοις
 ἄν, ἣν ὁ μὲν τις ἱκανὸς τῷ φθέγματι καὶ ἐφεξῆς λέγει τὰ
 συμβεβηκότα, ὁ δὲ οἷο[ν] ἀναπαύων τε πολλάκις καὶ λεπτῇ
 τῇ φωνῇ. νοσήματος δὲ ἰδέαν^(***) ἄνευ μελαγχολίας βράγ-
 χωσιν, γλώττης παραπληξίας καὶ τιν(α τ)ῶν κατὰ θώρακα 10
 καὶ περὶ πνεύμονα εἰθισμένων γίνεσθαι. τὰ μὲν γὰρ μελαγ-
 χολικά διασημαίνει θρασύτης τε καὶ ἀκαιρος λύπη· μάλιστα
 197 δὲ <ὁ> ἄνθρωπος καταφανής ἐστι καὶ θαρρῶν καὶ ἀνιῶ-
 μενος οἷς λέγει, καταφανής δὲ καὶ ἐτέρως ἐστίν· ἀλλὰ [καὶ]
 <εἰ> ἢ δ' ἢ πείρα αὐτῷ προσγένοιτο, σαφῶς ἂν ἤδη διαγι- 15
 5 νόσκοιτο ἢ νόσος. καὶ ληθάργω δὲ τις καθέξεσθαι μέλλον
 δῆλός ἐστιν ἀποκρινόμενος λήθῃ τε ὧν λέγει καὶ ἀσαφεία
 6 γλώττης. οὕτω μὲν οὖν ἐν πυρετοῖς· ἄνευ δὲ τούτων σπα-
 σμὸν καὶ ἐπιληψίαν προσδοκᾷ. ὅλως δὲ σύμπαντα, [τ]ᾶ
 τοῦ παρακρουστικοῦ τρόπου ἐστίν, ἐνθένδ' ἂν τις ῥᾶον 20

2 παρακρουστικά] vox Hippocrat.; cf. Erot. p. 69, 6 Nachm. ||
 9 νοσήματος ... ἰδέαν] cf. ad I, 8 | βράγχωσιν] vox apud Graecos,
 ut videtur, inusitata. invenies autem vocem βραγχίασις apud auc-
 tores infimae Graecitatis: cf. Thes. Gr. Ling. s. v. βραγχία; Matth.
 Sylvaticus, Pandect. Opus f. 42^{ra} ed. Taurin. a. 1526 || 11—14 cf.
 Hipp. Aph. 6, 23 (IV 568 L.). de melancholia agit Ruf. ap. Aet.
 Amid. 6, 9 = Frg. 70; cf. Frg. 127 || 16—18 cf. Ruf. Frg. 139, 1 ||
 19 ἐπιληψίας] cf. Ruf. ap. Aet. Amid. 6, 23 = Frg. 75, 17 || 20 πα-
 ρακρουστικοῦ] cf. ad I, 2

1 ἐπὶ τοῦ M: corr. Da. || 2.3 κώφωσιν ... σημεινῆται M: κώ-
 φωσις ... σημαίνεται Gae.: κώφωσιν ... σημαίνεσθαι Da.; fort.
 σημαίνοντ' ἂν? || 3 ἀκούειν M: ἀκούει Gae.: ἀκούοι Da. || 8 οἷα M:
 οἷον Gae. cl. 3, 21. 6, 4. 13, 27 || 9 lac. indic. Gae.; desideratur ver-
 bum || 9.10 ἄνευ μ. βράγχωσις γλ. π. καὶ τινων M: ἄνευ μ. βράγ-
 χωσιν, γλ. π. καὶ τιν(α τ)ῶν Gae. (cf. CMG Suppl. 4, 50—53): <ἰδοις>
 ἂν εὖ μ., βραγχώσεως, γλ. π. καὶ τινων Kudl.: [ἄνευ — παραπλη-
 ξίας] Da., qui lac. indic. ante vocem κατὰ || 13 <ὁ> Da. || 14.15
 καὶ ἤδη ἢ πείρα αὐτῷ M: [καὶ] <εἰ> ἢ δ' ἢ πείρα αὐτῷ Schubr.:
 καὶ ἤδε ἢ πείρα εἰ τῷ Da. || 17 ὑποκρινόμενος M: corr. Da. ||
 19 δὴ M: δὲ εἰ Da. | τὰ M: ᾧ Gae.: [τά] Da.

ἢ ἄλλως καταμανθάνοι. τὰ δὲ κατὰ θώρακα καὶ ὀξύτητι 7
φωνῆς καὶ τραχύτητι· τῷ μὲν γὰρ φθίνοντι καὶ ὀρθο-
πνοϊκῷ ὀξεῖα ἢ φωνή, τῷ δὲ ἐμπύῳ καὶ τῷ βραγχώδει καὶ
τῷ ὑπὸ κατάρρον πιεζομένῳ τραχύτερα. οἱ δὲ τῇ γλώσσῃ 8

5 παραπληκτικοὶ παντελῶς ἄφωνοὶ εἰσι.

Πρῶτον μὲν δὴ, ὥς εἴρηται, αὐτόν τινα χρὴ τὸν νοσοῦντα 9
ἐρωτᾶν περὶ ὧν χρὴ εἰδέναι, ἔπειτα δὲ καὶ τοὺς παρόντας,
εἰ κωλύματα εἴη παρὰ τοῦ νοσοῦντος μανθάνειν. τὰ δὲ 10
κωλύματά ἐστιν ἢ σφοδρῶς παρακρούων τις ἢ ἀπόπληκτος 198
10 ἢ ληθαργικὸς ἢ κάτοχος ἢ ἄφωνος ἢ ἄλλως ἡλίθιος ἢ
ἀσθενὴς παντάπασιν ἢ ᾧ[ς] συμφέρον ὅτι ἥμισυ φθέγ-
γεσθαι, ὥσπερ τῷ ἐκ πνεύμονος αἰμορροϊκῷ. καὶ ὑπὲρ
παιδίου καὶ ἄλλον ἐρωτητέον καὶ ὑπὲρ τοῦ ἄγαν πρεσβύτου,
καὶ ὑπὲρ τοῦ μὴ ὁμογλώσσου τὸν ὁμογλώσσου.

15 Ἐρωτητέον δὲ πρῶτον μὲν τὸν χρόνον, ἀφ' οὗ νοσεῖν ἤρ- 2 11
ξατο· καὶ γὰρ πρὸς τὴν ἴασιν συμφέρει καὶ πρὸς τὴν τῶν
κρίσιμων διάγνωσιν· ἐξαρκοὶ γὰρ ἂν εἰς τὸ τὰς περιόδους
αὐτῶν φυλάσσειν. καὶ μὲν δὴ πρὸς τὴν ὅλην διάγνωσιν τῆς 12
νόσου μέγα ὄφελος τὸν πρῶτον χρόνον εἰδέναι. τὰ γὰρ αὐτὰ
20 συμπτώματα ἐπὶ τοῖς ἀνιδρῶ(τ)οῖς χρόνοις σημαίνουσιν
ἄλλα, οἷον ἱκτερος πρὸ μὲν τῆς ἑκτῆς καὶ τῆς ζ' ἐπιφανεῖς
πυρετῷ κακός, μετὰ τοῦτο δὲ ἤδη κρίσιμος, καὶ οὖρα καὶ
διαχωρήματα κατ' ἀρχὰς μὲν ὑδατώδη καὶ ὠμὰ ἦσσαν
κακόν, προεληλυθόσι δὲ ὑποπτότερον· ὥς ἀπὸ τῶν ῥινῶν
25 στάξεις χαλεπαὶ αἱ τεταρταῖαι καὶ ἀπλαῖ, λάβροι δὲ αἱμορ- 199
ραγαὶ τεταρταῖαι δύσκριτοι, καίτοι ὕστερον κρίνονσαι.

6 ὥς εἴρηται] § 2 || 15 cf. Hipp. Acut. 2, 9 (22) (II 436, 5-8 L.) ||
22 Hipp. Aph. 4, 62; 64 (IV 524 L.); Coac. 118 (V 608 L.); cf.
Iudic. 13 (IX 280 L.); Ruf. ap. Orib. Coll. med. 45, 30, 31; ap. Aet.
Amid. 10, 17 = Frg. 79, 1-5 || 22.23 Hipp. Epid. 1, 5 (11) (II 634,
2-5 L.); cf. Coac. 565 (V 712 L.) || 24-26 Hipp. Epid. 2, 3, 9 =
6, 2, 8 (V 112 = 282 L.); cf. Gal. Comm. ad loc. (CMG V 10, 1,
p. 283-284)

1 καταμανθάνειν M: corr. Da. || 11 ὥς M: corr. Deichgr. ||
12 αἰμορροῖχω M: αἰμορροϊκῷ (vel αἰμορραγικῷ) Gae.: αἰμορροχόω
Da. || 14 μὴ ὁμογλώσσου M: corr. Da. || 18 δὴ <καὶ> Da. || 20 ἀνι-
δρῶις M: corr. Da. || 22 κρίσιμα M: corr. Da. || 24 <καὶ> ὥς Gae. ||
25 ἀπλαῖ] vox dubia

13 ταῦτα δὴ μαθήσῃ τὴν πρώτην ἡμέραν, ἐν ᾗ νοσεῖν ἤρξατο, ἐρόμενος, καὶ ὀξύτητα καὶ μέγεθος νόσου, εἰ τὰ μὲν ταχέως καὶ ἀθρόως φαίνοιτο τῶν δεινῶν προεκρηγνόμενα, τὰ δὲ σχολῇ τε καὶ ἐν χρόνῳ.

Καὶ περιόδῳ δὲ ὡσαύτως μαθήσῃ καὶ εἰ εὐθὺς τεταγμέ- 5
νως παροξύνει ἢ νόσος [τ]ῇ κατὰ μὲν ἀρχὰς ἀτάκτως, ὕστερον <δὲ> εἰς τάξιν τινα ἰδρύεται. καὶ τριταίου δὲ λύσιν καὶ τινῶν ἄλλων νοσημάτων μεταβολὴν τε καὶ ἀσφάλειαν
14 μαθήσῃ ἐνθένδε. τὴν μὲν οὖν ἀρχὴν τῆς νόσου, ὁπηνίκα ὁ ἄνθρωπος νοσεῖν ἤρξατο, εἰς τοσαῦτά φημι χρηστῶς ἂν 10
ἐρωτηθῆναι.

15 3 Τὸ δὲ μετὰ τοῦτο ἐρωτητέον, εἰ τῶν συνήθων τι τῶ[ν]
ἀνθρώπων[ν] νοσημάτων ἐστὶ τὸ νῦν συμβεβηκὸς ἢ οὐ,
καὶ <εἰ> πρότερον γεγεννημένον. πολλοὶ γὰρ τοῦτέστιν ὑπὸ
τῶν αὐτῶν ἀλίσκονται καὶ πάσχουσι δὴ τὰ αὐτὰ καὶ 15
θεραπεύονται ὡσαύτως· ἅπερ ἂν καὶ δεῖσαι ὁ ἰατρός <ὥς>
χαλεπώτατα [καὶ] διακωλύσαι καὶ οὐ[τε] προσφόρως थे-
200 ραπευόμενα οὔτε χαλεπὰ τούτῳ <γε> τῷ ἀνθρώπῳ ὄντα
οὔτε ἀνεπιτηδείως τῇ παρούσῃ νόσῳ θεραπεύόμενα. μέ-
γιστον γὰρ ἐν ἅπασιν ἐθισμὸς πρὸς τε τὸ ῥᾶον τῶν 20
16 δεινῶν ἀνασχέσθαι καὶ πρὸς τὴν ἴασιν. διό μοι δοκῶ καλῶς
ἂν τινα καὶ φύσιν τὴν ἐκάστων πρὸς ἑκάστα ἐρωτῆσαι. οὐ
γὰρ πάντες πεφύκαμεν τρόπῳ τῷ αὐτῷ, ἀλλὰ καὶ πάνυ
ἀλλήλων διαφέρομεν εἰς ὅτιον χρῆμα. τοῦτο μὲν γάρ, εἰ
ἐθέλεις σκοπεῖσθαι ὅπως πρὸς τὰς πέψεις ἔχει, εὐρήσεις 25
ἕτερα ἑτέροις καὶ εὐπεπτα ὄντα καὶ δύσπεπτα· τοῦτο δὲ

1-4 cf. Hipp. Epid. 2, 1, 6 (V 74, 12-16 L.) || 10 χρηστῶς] vox Hippocrat.; cf. Erot. p. 94, 5 Nachm. || 19.20 cf. Hipp. Aph. 2, 49 (IV 484 L.) || 22-24 doctrina Hippocrat.; cf. VM passim || 26 - p. 5, 3 cf. Hipp. Loc. hom. 41 (VI 332, 3-5 L.); De medicam. p. 440, 1-10 Schoene. haec fusius tractat Ruf. ap. Orib. Coll. med. 7, 26, 33-34

6 νόσος τῇ μὲν κατ' ἄ. M: corr. Da. || 7 <δὲ> Da. || 8 μεταβο-
λῆς τε καὶ ἀσφαλείας M: corr. Da. || 11 <ἀν>ἐρωτηθῆναι Kudl. ||
12.13 τῶν ἀνθρώπων M: corr. Da. || 14 <εἰ> Schubr. | πολλά M:
corr. Da. || 16 <ὥς> Da. || 17 καὶ δ. ὥς οὔτε M: δ. καὶ ὥς οὔτε
Da., qui post vocem θεραπεύόμενα add. οὔτε ἀνεπιτηδείως· ἀλλὰ
εὐρίσκονται: corr. Deichgr. || 18 <γε> Da. || 25 ἐθέλεις Da.

- τὰ φάρμακα, ὅσα πίνουσι καθάρσεως ἕνεκα καὶ οὐρούμενα, ἄλλα ἄλλοις, τὰ δὲ καὶ εἰς ἔμετον ὁρμῶντα τῶν κατωτερικῶν, τὰ δὲ καὶ κάτω ὑπιόντα τῶν ἀνωτερικῶν. ὅλως δὲ οὐδὲν τῶν τοιούτων καθεστηκός, ὥστε εἰς ἓνα ἐλθεῖν λόγον
- 5 τῷ ἱατροῦ. χρὴ οὖν καὶ παρὰ τοῦ κάμνοντος μανθάνειν, 17 ὅπως πρὸς ἕκαστον διάκειται ἢ πόμα ἢ σιτίον· καὶ εἰ δὴ τινος φαρμάκον πείραν ἔχοι σαφῆ, μηδὲ ταύτην παραλιπεῖν. οὕτως γὰρ ἂν τις τὰ πολλὰ ἐπιτυχῶναι, εἰ πύθοιτο 201 καὶ τοῦ κάμνοντος ἐπὶ τοῖς ἀτόπως αὐτῷ συμβαίνουσι.
- 10 Τὸ δὲ σύμπαν ἐρωτάτω, ἄρα γε εὖσιτος ἢ ἀπόσιτός ἐστι 18 καὶ διφώδης ἢ ἄδιφος καὶ τοὺς ἐφ' ἑκάστοις ἐθισμούς· μέγα γὰρ καὶ τόδε οὐχ ἥσσον τῆς φύσεως καὶ τῶν ἐθισμῶν ἔμπειρον εἶναι. καὶ γὰρ σιτίον τὸ σνῆθες ἀλυπότερον προσαίρονται τοῦ ἄλλως ἂν δόξαντος εἶναι βελτίστον,
- 15 καὶ ἐν τῷ δὴ τρόπῳ μεμελετήκασιν αὐτὸ λαμβάνειν καὶ πλῆθος καὶ σκευασίαν. καὶ τὰ σνῆθη πάντα ἀμείνω καὶ 19 τῷ νοσοῦντι καὶ τῷ ὑγιαίνοντι. καὶ προγνωσθεῖν δ' ἂν τι[ς] 20 ἀκριβέστερον ἐκ τῶν ἐθισμῶν περὶ τε κρίσιν [καὶ κλήσιν] τοῦ ἀνθρώπου καὶ διάλεξιν καὶ ῥαθυμίαν καὶ ἡγνιασὸν
- 20 ἄλλην ἐνέργειαν· τὰ γὰρ ὑγιαίν(οντι) ὄντα δι' ἔθους οὐδὲν ἐν ταῖς νόσοις ἐπίσημον δηλοῖ.
- Κάν τοῦτοις οὐκ ἔστιν, ὃ τι παρ' (ἐ)αυτοῦ δύναιτ' ἂν 21 μαθεῖν ὁ ἱατρός, εἰ μὴ πυνθάνοιτο ἢ τοῦ νοσοῦντος ἢ ἑτέρου τινὸς τῶν παρόντων. ὥστε ἔγωγε θαυμάζω 202
- 25 Καλλιμάχον τοῦ ἱατροῦ, ὃς μόνος τῶν ἐμπροσθεν, ὢν γε δὴ καὶ λόγον ἂν τις ποιήσαιτο, οὐκ ἔφασκε δεῖν ἐρωτᾶν οὐδὲν οὔτε περὶ τὰς ἄλλας νόσους οὔτε περὶ τὰ τραύματα, καὶ μάλιστα τὰ τῆς κεφαλῆς· ἀρκεῖν γὰρ καὶ τὰ

10-17 Hipp. Aph. 2, 50 (IV 484 L.); Acut. 1, 9 (28) (II 282, 4 u. ad 284, 6 L.); 10 (36) (II 298-302, 5 L.); Erasistr. ap. Gal. De consuet. 1, 16 (CMG Suppl. 3, p. 12, 10-11) || 25 de Callimacho cf. CMG Suppl. 4, p. 64-66

2 ἔμετα M: corr. Da. || 5 περὶ τοῦ M: corr. Da. || 8 ἐπιτυχά-
νειν M: corr. Da. || 15 [ἐν] Da. || 17 τις M: corr. Da. || 18 [καὶ
κλήσιν] Da. || 20 ὑγιαίνοντα M: ὑγιαίν(οντι) ὄντα Gae.: ὑγιαίνοντι
Da. || 21 ἐπίσημα M: corr. Da. || 22 καὶ M: κἂν (vel κἀπὶ) Gae. |
τούτων Da. | αὐτοῦ M: corr. Da.

- ἐφ' ἐκάστῳ σημείῳ τό τε πάθος σημῆναι καὶ τὴν αἰτίαν αὐτοῦ, ἐξ ὧν καὶ προγινώσκεισθαι πάντα καὶ θεραπεύεσθαι ἄμεινον. ἐπεὶ μὴδὲ τὰς ἡγούμενας προφάσεις τῷ(ν) νόσω(ν) [καὶ] ἀναγκαίως ἐρωτᾶσθαι, οἷον διαίτης τε ἀγωγῆν καὶ τὰ ἄλλα ἐπιτηδεύματα καὶ εἰ κοπιάσαντι συνέβη νοσῆσαι καὶ εἰ φηγέντι· μὴδὲν γὰρ ἂν τούτων μαθεῖν <δεῖν> τὸν ἱατρὸν, εἰ τὰ σημεία ἀκριβῶς ἐκμελετήσαι
- 22 τὰ συμπίπτοντα ταῖς νόσοις. ἐγὼ δὲ ἡγοῦμαι μὲν καὶ παρ' <ἐ>αυτοῦ δύνασθαι τινα πολλὰ τῶν ἐν ταῖς νόσοις ἐξευρίσκειν, κάλλιον δὲ γε καὶ σαφέστερον ἐν τοῖς ἐρωτήμασιν. 10 εἰ γὰρ ταῦτα ὁμολογεῖ τοῖς συμπτώμασι, ὅσον τὰ παρόντα εἰδέναι. τοῦτο μὲν γὰρ, εἰ φαίη ὁ νοσῶν τὴν διαίταν, οἷα
- 203 ἦν ἐμπροσθεν, ὑπερβεβληκέναι σίτου καὶ ποτοῦ προσφορᾶ, πάσχει δὲ οἷα εἰκὸς ἐπὶ πλησμονῆς, σαφῶς ἂν γιγνώσκοιμεν, ὅτι πλησμονή ἐστίν ἡ νόσος, καὶ πρὸς τοῦτο 15 ἐξευρίσκοιμεν ἂν τὴν ὅλην ἴασιν. τοῦτο δέ, εἰ πονῆσαι μὲν πολλὰ φαίη, πάσχει δὲ οἷα εἰκὸς τὸν πονήσαντα, κἀνθένδε εὐπετέστερον τὴν τε νόσον, ὅτι κόπος ἐστίν, εἰσόμεθα καὶ τὴν εὐκυΐαν τῷ κόπῳ θεραπείαν προσάξομεν.
- 23 Καὶ τὰ μὲν τοιαῦτα ἔχει [ἔχει] τινὰ καὶ παρὰ τῶν συμπτωμάτων ἐνδειξίν τοῦ γινώσκεισθαι· χρόνον δὲ τῆς νόσου καὶ ἐθισμόν τὸν πρὸς ἕκαστα καὶ φύσιν τὴν ἐκάστου ἐξαίρετον, ταῦτα οὐ μοι δοκεῖ γινῶναι τις μὴ ἐρωτήσας καὶ εἶναι παντός ἄλλον καιριώτερον τῇ τέχνῃ εἰδέναι.
- 24 4 Καὶ μὲν δὴ ἑτέρα τῶν νοσημάτων ἢ διάγνωσις ἐπὶ τοῖς 25 ἐνδοθεν καὶ τοῖς ἔξωθεν συνισταμένοις· καὶ πῶς δοκεῖ χαλεπώτερον εἶναι <ἢ> τῶν ἐνδοθεν ἢ τῶν ἔξωθεν. καὶ γὰρ εἰ τρέμοι ὁ ἄνθρωπος, τὸ μὲν διὰ ψυχῆς ἢ φόβου
- 204 τρέμειν δεινὸν ἦσσαν, τὸ δ' ὑπὸ τῆς εἰσῶ αἰτίας χαλεπώ-

3-6 cf. Ruf. ap. Alex. Trall. 11, 7 = Frg. 106, 2. isdem exemplis utitur Gal. De caus. procataret. 1, 8 (CMG Suppl. 2, p. 3, 7-13) || 18 εὐπετέστερον] vox Hippocrat.; cf. Erot. p. 35, 3 Nachm.

3.4 τῷ νόσω καὶ M: corr. Da. || 7 <δεῖν> Kudl. || 9 αὐτοῦ M: corr. Da. || 10 [ἐν] Da. || 14 φλεγμονῆς M: corr. Da. || 15 φλεγμονή M: corr. Da. || 20 [ἔχει] Da. || 25 ἑτέρον M: corr. Da. || 26 συνισταμένου M: corr. Da. || 27 <ἢ> Da.: <τό> Kudl.

τερον. καὶ εἰ παραφρονοίη, τὸ μὲν ἐπὶ μέθῃ καὶ φαρμάκῳ
 τινὶ παρακρουστικῷ εὐδιατότερον, τὸ δὲ ἄλλως δυσχερέ-
 στερον. οὕτως δὲ ἐπὶ πάντων εὐρήσεις καὶ τὸν τρόπον 25
 τῆς θεραπείας οὐδὲν εἰκότα. κόπων γὰρ δὴ γινόμενων,
 5 τῶν μὲν διὰ πολλῶν ταλαιπωρίαν, τῶν δὲ ὑπὸ πλησμονῆς,
 τοῖς μὲν οὖν συμφέρει ἀνάπαυσις καὶ ὕπνος καὶ τρίψις
 μαλακῇ καὶ λουτρὰ θερμά, τοῖς δὲ πόνος καὶ ἐργήγορσις
 καὶ ἡ ἄλλη κένωσις πᾶσα. εἰς τοσόνδε διαφέρει τῷ ἱατρῷ 26
 καὶ τὰς αἰτίας ἀνερωτᾶν, καὶ οὐκ ἔστιν εἰδέναι μὴ ἐρωτή-
 10 σαντα. ὥστε καὶ ἐπὶ τῶν σημείων ἐρωτητέον, εἰ μὲν τι
 πελιδνὸν εἴη, μὴ διὰ πληγὴν ἢ δι' ἡλικίαν ἢ δι' ὥραν
 ἔτους· τὰ γὰρ ἄλλως ἐν πυρετοῖς πελιδνὰ θάνατον σημαί-
 νει· εἰ δὲ γλῶσσα ξηρά, μὴ δεδιηκότι ἢ ἰσχυρῶς δια-
 κεχωρηκότι, καὶ εἰ μέλα(ι)να, μὴ τι μέλαν ἐδηδοκότι· οὐ
 15 γὰρ ἂν εἴη τὰ τοιάδε ὑποπτα. ὡσαύτως δὲ καὶ περὶ τῶν 27
 ἐκκρινόμενων ἐν ταῖς νόσοις ἐρωτάτω οὖρων τε καὶ δια-
 χωρημάτων καὶ πτυέλων. μέγα γὰρ καὶ ἐν τούτοις διενή- 205
 νοχεν εἰς τὸ πλῆθος αὐτῶν καὶ σέστασιν καὶ χροίαν καὶ τὰ
 προσάσματα αὐτῶν εἰδέναι, πόσα τε καὶ ποταπὰ καὶ
 20 πτηνίκα προσήρθη.
 Ἐρωτᾶν δὲ καὶ περὶ ὕπνων, εἰ ἐκοιμήθη ἢ οὐ, καὶ ὅπως 5 28
 πρὸς τε ὕπνον καὶ ἀγρυπνίαν συνήθως ἔχει καὶ εἴ τινα
 φάσματα αὐτῷ ἢ ἐνόπνια γίγνοιτο, ὥς καὶ τούτων δυνα-
 μένου τοῦ ἱατροῦ συλλογίζεσθαι. πάντα μὲν οὖν ἐπὶ πᾶσιν 29
 25 οὐκ ἔστιν γράφειν, ἀλλ' ὅσον σημῆναί τε τῷ λόγῳ καὶ
 ὑπομνήσαι τὸν ἱατρὸν μηδὲν παραλιπεῖν τῶν τοιούτων.
 Μόρῳ μὲν γὰρ τῷ Ἐφεσίῳ παλαιστῇ ὑγιαίνειν δοκοῦντι

4-8 Hipp. Nat. hom. 9 (VI 52, 4-7 L.); Aph. 2, 22 (IV 476 L.);
 cf. Vict. 2, 66 (VI 584, 15-19 L.) || 11. 12 δι' ὥραν ἔτους cf. Ruf.
 ap. Aet. Amid. 6, 9 = Frg. 70, 15 || 12 θάνατον σημαίνει cf. Hipp.
 Progn. 2 (II 118, 3-5 L.); 9 (II 132, 11-13 L.) || 19 προσάσματα]
 vox Hippocrat.; cf. Erot. p. 70, 14 Nachm. || 24-26 cf. § 71 ||

6 [οὖν] Deichgr. || 8 τόσον δὲ M: corr. Da. || 13 μηδὲ διηκότι M:
 corr. Da. || 14 μέλανα M: corr. Da. || 18 δύναμιν M: σέστασιν Gae.
 cl. frg. 106, 2: σμήνην Da.

- ἐφάνη τοιόνδε ἐνύπνιον· ἐδόκει εἶναι δι' ὅλης νυκτός ἐν
λίμνῃ μελαίνῃ ποτίμον ὕδατος. καὶ τοῦτο ἀναστὰς εἶπε
πρὸς τὸν γυμναστήν. ὁ δὲ ἐν οὐδενὶ θέμενος τὸ ἐνύπνιον
ἤγαγεν αὐτὸν πρὸς τοὺς πόρους· καὶ οὐκ ἔμεσύντι αὐτῷ
ἄσθμιά τε ἐπιπίπτει καὶ ἀπορία καὶ παλμός ὅλου τοῦ
στήθους, καὶ αὐτίκα μὲν ἀκρατὴς ἦν χειρῶν καὶ ποδῶν,
30 αὐτίκα δὲ ἄφωνος· οὐ πολὺ δὲ ὕστερον ἀποθνήσκει. οὐκ
206 ἂν μοι δοκεῖ ἀποθανεῖν, εἰ σοφοῦ του γυμναστοῦ ἔτυχε
καὶ τινα κένωσιν αἵματος ἀθρόαν αὐτῷ πρὸ τῶν πόρων
31 ἐμηχανήσατο. ἄλλω δὲ τινι ἐν πυρετῷ ὀξεῖ πολλάκις 10
ἄνθρωπος Αἰθίοψ ἐπιφοιτῶν κατὰ τοὺς ὕπνους παλαίειν ἐδόκει
καὶ ἄγειν αὐτόν. καὶ οὗτος εἶπε πρὸς τὸν ἰατρὸν τὸ ἐνύπ-
νιον. ὁ δὲ οὐδ' αὐτὸς ἐνεθυμήθη οἷόν τι ἦν, πρὶν αἰμορραγίᾳ
32 λάβρω ἐκ ῥινῶν ἐκρίθῃ ἡ νόσος. τῷ δὲ δοκοῦντι ἐν τῷ
Καύστρω ποταμῷ νήχεσθαι εἰς ὕδρον ἐτελεύτησε χρό- 15
νίζουσα ἡ νόσος.
33 Πάνυ δὲ ἐμαντὸν πείθω κατὰ τοὺς χυμοὺς τοὺς ἐν τῷ
σώματι δόξας ἐνυπνίων ἐγγίγνεσθαι σημαινούσας καὶ ἀγα-
θὰ καὶ κακὰ τῷ ἀνθρώπῳ, ὧν κατάληψις ἄλλη οὐκ ἔστι
μὴ ἀκούσαντι. 20
34 6 Τί δὲ τὰ συγγενῇ τῶν νοσημάτων; ἄρα γε ἐτέρωθεν
ἔστιν εἰδέναι ἢ καὶ ταῦτα ἐρωτήσαντι δῆπον; καὶ οὐκ ἂν
τις φαίῃ φαῦλον τὸ ἐρώτημα, εἰ μὴ καὶ τὸ διαγνῶναι τὸ
εὐμεταχειρίστον νόσημα καὶ τὸ δυσμεταχειρίστον, ὥς
ὀρθῶς ἐπιλέληται πᾶν τὸ συγγενὲς δυσιατότερον εἶναι 25
35 τοῦ μὴ συγγενοῦς. καὶ μὴν καὶ περίοδον γεγεννημένην καὶ
207 μετάσταςιν καὶ συμπτώματα, ὅποσα ἔμπροσθεν συμπε-
π(τ)ώκει, καὶ ταῦτα χρὴ πυνθόμενον εἰδέναι· καὶ ἔστιν οὐ

1—10 respiciunt doctrinam Hippocrat.; cf. Vict. 4, 90 (VI 658, 1 u. ad 4 L.); cf. Artemid. 1, 64 (p. 70, 13—17 Pack); 2, 27 (p. 148, 17 u. ad 20 Pack) || 10—12 cf. Hipp. Vict. 4, 93 (VI 660, 1—3; 18—20 L.); Artemid. 1, 60 (p. 67, 6—10 Pack) || 15 νήχεσθαι] cf. ad l. 1 sqq. || 24—26 Hipp. Proorrh. 2, 5 (IX 20, 18—19 L.)

4 μεσύντι αὐτοῦ M: corr. Da. || 8 δοκῶ M: corr. Da. | τοῦ M (def. Hansen): του Gae. || 9 αὐτῷ M: αὐτῷ Gae. | πρὸ τῶν πόρων M: πρὸ τῶν πόρων Kudl.: πρὸς τὸν πόρον Da. || 27 συμπεπ(τ)ώκει M: corr. Da.

μικρὸν ὄφελος καὶ εἰς πρόρρησιν καὶ εἰς θεραπείαν ἐπι-
σκεφθέντα.

Ἐρωτητέον δὲ καὶ τρόπον διαίτης, ἥ κέχρηται ὁ νοσῶν, 7 36
οὐχ ὅποτε ὑγιαίνει· τοῦτο μὲν γὰρ εἴρηται πρότερον ὑπὲρ
5 αὐτοῦ· τὰ νῦν δέ, ὅπως ἐν τῇ νόσῳ διητᾶτο, καὶ φάρμακα,
εἴ τινα προσενήνεκτο, καὶ τὴν θεραπείαν τὴν σύμπασαν,
ἥντινα τεθεράπεται, καὶ ὅπως ἐφ' ἐκάστοις διατιθέμενος
φαίνεται. καὶ γὰρ πρὸς τὸ μεθαρμόσασθαι τὰ παρόντα
καὶ πρὸς τὸ μηδὲν κινῆσαι τῶν πρὶν ὄντων καὶ πρὸς
10 τὸ ἐξευρεῖν εἴ τι παραλέλοιπε τῶν δεόντων χρήσιμον τὰ
τοιαῦτα εἰδέναι.

Ἐρωτητέον δὲ καί, εἰ προσήρτο τὸ σιτίον ἢ οὐ. καὶ γὰρ 37
οὐδὲ τοῦτο φημι δυνατόν εἶναι παρ' ἑαυτοῦ γινώσκει(ν)·
καίτοι καταγελαστότατον δοκεῖ τῶν ἐρωτημάτων παρὰ
15 τοῖς δημοτικοῖς, εἰ μὴ εὐθὺς τις ἀψάμενος τοῦ νοσοῦντος
εἰδείη ὅτι ἐδήδοκεν, ἀλλὰ ἐτέρου πυνθάνοιτο. ἐμοὶ δὲ καὶ 38
τοῦτο ἀδύνατον δοκεῖ διαγνῶναι μὴ ἐρωτήσαντα, ὥσπερ
καὶ πηρὶ καὶ προσήρατο καὶ ποῖόν τι καὶ πόσον. ὁ γὰρ τῇ 208
ῥώμῃ καὶ τῇ ἀσθενείᾳ τεκμαιρόμενος ἐπὶ πολλοῖς πολλὰ
20 κίς ἐξαπατηθήσεται· καὶ γὰρ τὸ ἱκανὸν προσαράμενος
οὐχ ἱκανῶς ἐρρώσθη καὶ τὸ μὴ προσάρασθαι τινα πλέον
ἔρρωσεν ἂν, μάλιστα εἰ διὰ πλησμονὴν ἀσθενεῖ.

Ἐρωτητέον δὲ καί, τί τὸ ἰδίωτον αὐτῷ τῶν σιτίων. τοῦτο 39
γὰρ ἔσθ' ὅπῃ πρὸ τοῦ κρατίστου ὤνησεν, ἐπεὶ καὶ πέτ-
25 τεται ῥᾶν τοῦ ἀηδοῦς. οὐ γὰρ δὴ μασωμένῳ μὲν τὸ ἀηδὲς
καὶ καταπίνοντι ἀσθενῇ παρέχει τὴν† ἐκατέρου ἐνέργειαν,
πέττοντι δὲ καὶ ἀναδιδόντι οὐχ ὁμοίαν ἂν παράσχοι.

Καὶ τὸ εὐδιαχώρητον δὲ ἐρωτητέον καὶ τὸ οὐρούμενον 40
καὶ τὸ ὀξυνόμενον καὶ τὸ ἄλλως πως φθειρόμενον· ἐκά-
30 στω γὰρ ταῦτά ἐστι καὶ οὐ καθόλου. ὥστε ἐπαινέσαιμι

4 πρότερον] §§ 18.19 || 5 cf. Hipp. De medicam. p. 441, 42 u. ad 442, 67 Schoene || 18—20 cf. Hipp. Aph. 2, 38 (IV 480 L.); Ruf. Frg. 363

9 τῶν παρόντων M: corr. Da. || 12 [τὸ] Kudl. || 13 γινώ- σκει M: corr. Da. || 14 καίτοι <τὸ> Gae. || 20 ἱκανόν <τις> Gae.: προσαράμενός <τις> W. Richter || 26 ἐκάστον? Gae.

- ἂν καὶ ἰατροὺν τὸν νῦν πρῶτον ἐντυγχάνοντα τῷ νοσοῦντι,
 εἰ μὴ ἂφ' ἑαυτοῦ μόνον ποιοῖτο τῆς θεραπείας τὴν εὐρεσιν,
 209 ἀλλὰ τινα καὶ τῶν ἐμπείρων τοῦ κάμνοντος εἰς συμβουλήν
 καλοῖ, μάλιστα μὲν ἰατρον, εἰ δὲ μή, καὶ ἰδιώτην. οὕτω
 γὰρ οὐ διαμαρτήσεται τοῦ συμφέροντος. ⁵
 41 8 Ὅσα τε ἀλγῆματά ἐστιν ἐπὶ ταῖς νόσοις γιγνόμενα, καὶ
 ταῦτα ἐρωτᾷ. ἔστι μὲν γὰρ καὶ ἐτέρωθι συντεκμαιρεσθαί
 τινα ἀλγοῦντα, καὶ στενάγματι καὶ βοῇ καὶ ῥιπτάσματι
 καὶ ἀπορία καὶ κλίσει σώματος καὶ χροῖα καὶ λεπτότητι
 καὶ χειρῶν ἄφει, ἣν τε σὺ ἐθέλης ἀπτεσθαι^{***}· δηλοῖ γὰρ ¹⁰
 τὸ ὀδυνώμενον ἐνθὺς· καὶ αὐτὸς δὲ ὁ κάμων πιέζει μάλ-
 ιστα τὰ ἀλγοῦντα, ὥστε καὶ τὰς ἀφώνων ὀδύνας ἐκ τῶν
 τοιούτων οὐκ ἂν ἀμαρτάνοις συλλογιζόμενος. ἀλλὰ ἔστι
 μὲν καὶ τῶν <οἰκτων> διαγιγνώσκειν τοὺς πόνοὺς τῶν
 νοσοῦντων, χρὴ δὲ καὶ διαπυνθάνεσθαι· καὶ οὐδὲ τοῦτό ¹⁵
 πως ἐξαρκεῖ [καί] πρὸς τὴν ὅλην διάγνωσιν, ὥς πολλοὶ
 ἤδη μαλακίᾳ καὶ τρυφῇ οὐδέν τι πον <ἀ>κομψότερον ὁδύ-
 42 νην ὑπεκρίναντο τῶν ἐν ταῖς τραγωδαῖς οἰμωζόντων. χρὴ
 δὲ καὶ τὰ ἄλλα ἐπιβλέπειν, εἰ σώφρων καὶ ἀνδρεῖος καὶ
 ἐγκρατὴς ὁ ἄνθρωπος· οὐ γὰρ ἂν οὗτός γε τι ψεύδοιτο ²⁰
 210 43 τῶν περὶ τὴν νόσον. ἐπεὶ δὲ καὶ περιόδους τὰ πολλὰ ἔχου-
 σιν οἱ πόνοι, καὶ τοῦτο ἐρωτητέον. οὐ γὰρ δήπου τοὺς μὲν
 ἄλλους παροξυσμοὺς ἀναγκαῖον πυνθάνεσθαι πηνίκα γί-
 γνονται, τοὺς δὲ [ἄλλους] τῶν ἀλγημάτων παραλείπειν.
 44 9 Ἐχοι δ' ἂν τινα χρεῖαν καὶ τὰ κατὰ κοιλίαν ἐρωτᾷ ²⁵
 ὅπως διάκειται τῷ ἀνθρώπῳ, ἅρᾳ γε εὐδιαχώρητός ἐστιν
 45 ἢ οὐ· καὶ τὰ περὶ τὰς ἄλλας ἐκκρίσεις ὡσαύτως. καὶ γὰρ

8.9 ῥιπτάσματι καὶ ἀπορία] cf. Hipp. Epid. 5, 43 (V 232, 20 L.) ||
 9 κλίσει σώματος] cf. Hipp. Progn. 3 (II 118, 7–120, 9 L.) || 15–21
 de aegrotis dolorem simulantibus agit Gal. in Comm. in Hipp.
 Epid. II (CMG V 10, 1, p. 206–213, 9 = V 10, 2, 4, p. 113–116)

9 στόματος M: corr. Da. || 10 lac. indic. Gae.: [ἦν – ἀπτεσθαι]
 Da.: ἦν γε κτλ. C. J. Classen || 12 ἀφώνους M: corr. Schubr. ||
 14 καὶ τῶν M: suppl. Gae.: καὶ <οἰκ>των Da.: καὶ <τού>των
 Hansen || 16 [καί] Da. || 17 κομψότερον M: corr. W. H. Friedrich ||
 21 περίοδοι M: corr. Da. || 24 [ἄλλους] Da.

ιδρώς καὶ οὔρον καὶ ἔμετος τοῖς μὲν ῥαδίως, τοῖς δὲ χα-
λεπώτερον δίδεισι.

Εἰς μὲν οὖν τὰς κοινὰς νόσους, καὶ μάλιστα τὰς πυρετώ- 10 46
δεις, ταῦτά τε καὶ τὰ ὅμοια ἐρωτητέον. εἰς δὲ τὰ ἔλκη, εἰ
5 μὲν ἀπὸ κινῶς εἴη τὸ ἔλκος, μὴ ἔτυχε δὴ ὁ κύων λυσσῶν·
πολὺ γὰρ διαφέρει. τῷ μὲν γὰρ ἔναιμόν τι ἐξαρκεῖ φάρ-
μακον ἢ σπόγγος ὅξει βεβρεγμένος, τῷ δὲ καῦσίς τε, καὶ εἰ
πάνυ μικρὸν εἴη τὸ ἔλκος, καὶ δριμέων φαρμάκων προσ-
αγωγή καὶ τήρησις τοῦ ἔλκους εἰς πολὺ καὶ πόμα ἀφίν-
10 θιον καὶ ἀριστολόχια καὶ λύκιον καὶ τῶν ποταμίων καρδί-
νων τὸ ἀφένγημα καὶ σκόρδιον καὶ πετροσέλινον καὶ ἡ 211
γεντιανὴ καλουμένη ῥίζα. μέγα δὲ ὄφελος καὶ εἰ μεταξὺ
τῷ ἔλλεβόρῳ καθήραις. εἰ δὲ μὴ, κίνδυνος σπασθῆναι καὶ
παραφρον(ῆσαι) καὶ δεῖσαι τὸ ὕδωρ καὶ ἀπολέσθαι.

15 Οἶδα γοῦν τινα δηχθέντα μὲν ὑπὸ λυσσῶντος κυνός, ἐν 47
οὐδενὶ (δὲ) λόγῳ θέμενον τὸ ἔλκος, καίτοι πολλὰ μὲν τῶν
ιατρῶν παρακελευομένων, πολλὰ δὲ τῶν οἰκείων. ἐκεῖνος 48
μὲν δὴ ἀπέθανεν οὐ πολὺ ὕστερον παθὼν, οἷάπερ ἐν τῇ
νόσῳ ταύτῃ πάσχουσιν· ἡ δὲ γυνὴ αὐτοῦ τρίμηρος κνοῦσα
20 (ἐμῖν γὰρ αὐτῷ ἔτι τὸ ἔλκος ἔχοντι) ἔδευσε καὶ αὐτὴ τὸ
ὕδωρ, ὥστε, εἰ μὴ διὰ ταχέων ἐκελεύσαμεν ἐκβαλεῖν τὸ
ἔμβρυον, δοκεῖ μοι ἂν ἀπολέσθαι τρόπῳ τῷ αὐτῷ.

Τὰ δὲ τῶν ἄλλων θηρίων δήγματα καὶ πληγὰς ἄριστα 49
μὲν εἰ καὶ ταῦτα ἀνακρίνομεν. πρὶν γὰρ ἐπελθεῖν τὰ συμ-
25 πτώματα μηχανώμενοι τὸ ἐκάστῳ πρόσφορον ῥᾶον θερα-
πεύσομεν[ος]. ὁμῶς δ' οὖν ἔστι καὶ τούτων διὰ σημείων

4-14 hydrophobiae exemplo utitur etiam Gal. De sect. 4 (Scr. min. III 7,23-8, 4); 8 (ibid. 18,24-19, 18) = Deichgraeber, Empirikerschule Frg. 19, 29; [Gal.] De Theriac. 16 (XIV 277, 18 u. ad 280, 10 K.) || 9 τήρησις τοῦ ἔλκους] cf. quae exposui Herm. 94, 1966, 251sq. || 13 ἔλλεβόρῳ] cf. Ruf. ap. Orib. Coll. med. 7, 26, 177

1 ἔμετον M: corr. Da. || 5 δὲ ὁ M: corr. Da. || 8 προσαγωγή M: corr. Da. || 10 ἀριστολόχην M: corr. Da. || 14 παράφρων M: suppl. Da. || 16 (δὲ) Da. || 25 μηχανώμενος M: corr. Da. | τῷ M: corr. Da. | θεραπευσόμενος M: corr. Da. || 26 τούτων καὶ? Gae.

- 212 τέκμαρσις καὶ μὴ λέγοντος τοῦ δηχθέντος· ἐπὶ δὲ τῷ
 κυνὶ οὐκ ἔστι, πρὶν ἂν τὸ πάθημα ἔλθῃ[ν].
- 50 11 Ὅσοι δὲ ἐν πολέμῳ τιτρώσκονται τοξεύμασιν ἢ λόγχαις,
 τὰ μὲν ἔξω διασχόντα καὶ ὅσα ἐπὶ τὸ δέρμα κορυπτεται
 ἰδόντι καὶ ἀφαιμένῳ κατάδηλά ἐστι· τὰ δὲ εἰσω κορυφθέντα 5
 ἐρωτητέον, εἰ τὰ βέλη τόχοι [αὐτοῖς] τις αὐτοῖς ἐξελκύσας,
 ἄρα γε σὺν τῇ ἀκίδι ἐξείλκυσεν ἢ μόνον τὸν οἰστόν. λάθοι
 51 γὰρ ἂν καὶ τὸν πᾶν ἔμπειρον ὑποῦσα ἡ ἀκίς. διόπερ
 καλῶς παρακελεύονται τοῖς στρατιώταις οἱ ἱατροὶ φέρειν
 τὰ τοξεύματα ἐμπειρηγότα, ὥς ἂν εἶδειεν αὐτοὶ κομίζόμε- 10
 νοι, μὴ τι ἐγκαταλειφθεῖ(ν) τῷ ἔλκει, καὶ ἅμα ἐμπειρῶς
 52 κομίζονται. ἀναγκαῖον δὲ πον καὶ περὶ χρίσματος προ-
 πυνθάνεσθαι τῶν τοξευμάτων. πολλοὶ γὰρ ἐξευρόντες
 φάρμακα, οἷς τὰ βέλη χρίονται, κἂν πᾶν μικρὸν τρώσῃ,
 53 ἀποκτείνουσιν. εἰ δὲ προειδείμεν, τάχα τι καὶ πορίσασθαι 15
 54 ἂν ἐκάστου φαρμάκου ἱαμα. τοῦτο μὲν δὴ τὸ ἐρώτημα
 οὐ τοῦ τραυματίου ἐστίν, ἀλλὰ τινος αἰχμαλώτου ἢ αὐτο-
 μόλ(ον).
- 213 55 Τὰ δὲ ἐν κεφαλῇ τραύματα ὧδε χρὴ ἀνακρίνειν, καὶ
 μάλιστα, εἰ μηδὲν φανερόν κακὸν εἴη τῷ ὅστῳ, ἄφρονος 20
 δὲ ὁ πληγεὶς γένοιτο καὶ ἐμέσαι τὸ μὲν αὐτίκα σιτίον ἢ
 φλέγμα, χολήν δὲ ὑστερον, καὶ ἐπιπυρέξαι πυρετῷ ὀξεῖ
 καὶ παρακρουστικῷ· κίνδυνος δὲ ὄψημα ἔχειν τὸ ὅσπου ἢ
 56 κατὰ αὐτὸ τὸ ἔλκος ἢ ἐτέρω(ν). τοῖς δὲ οὐδὲ ἔλκος τὸ
 παράπαν γίγνεται, ἀλλ' ὑπορρήγνυται τὸ ὅσπτεον καὶ πά- 25
 σχουσιν ὅλα εἴρηται.
- 57 Κατὰ γούν τὸν Σάμιον οὕτως ἔσχεν· ἦν μὲν ἐπιχώριος
 αὐτοῖς ἡ ἐορτή, ἐν ᾗ διαστάντες ἀλλήλους βάλλονσι λίθοις.
 ἐνταῦθα δὲ πληγεὶς οὗτος ὁ ἄνθρωπος τραῦμα μὲν οὐδὲν

2 ἐλθεῖν M: corr. C. J. Classen || 5 κατάδηλον M: corr. Da. ||
 6 αὐτοῖς τις αὐτῷ M: corr. Da. || 10 εἶδοιεν M: εἶδειεν Da.: ἴδοιεν
 Schubr. || 11 ἐγκαταλειφθέν M: corr. Gae. || 13, 14 ἐξευρόντες ...
 χρίοντες M: ἐξεύρον ... χρίοντες Da.: ἐξευρόντες ... χρίονται C. J.
 Classen || 17 αὐτομόλ M: corr. Da. || 21 ἐμέσοιτο μὲν M: corr. Da. ||
 23 δέ M: γὰρ Da., fort. recte || 24 ἐτέρω M: corr. Da. || 27 τὸν M:
 τινά W. Richter || 28 [ἢ] Latte

ἔσχεν [οὗτος] φανερόν, ἄφρωνος δὲ γίνεται καὶ ἰλιγγιᾶ·
καὶ μετ' οὐ πολὺ μὲν ὑγιῆς εἶναι ἐδόκει, εἰκοστῇ δὲ μετὰ
τοῦτο ἡμέρᾳ παραφρονεῖν ἄρχεται. ὥς οὖν εἰσεκλήθη καὶ
εἶδον συνεχῶς μὲν ἀπτόμενον αὐτὸν τῆς κεφαλῆς τρομώδη
5 τε ὄντα καὶ παρακρουστικόν, ἡρόμην, <μῇ> ἐπλήγη τὴν
κεφαλὴν οὗτός ποτε, τῶν δὲ φησάντων θαρρῶν <ν> ἔφην
συντετριῖσθαι τὸ ὁστέον αὐτοῦ. ἔπειτα μεγάλῃν τομὴν 58
τεμόντες καθ' ὃ μάλιστα ἤπτετο ταῖς χερσὶ μέρος εὖρο- 214
μεν ἐρρωγὸς ἐπὶ μήκιστον τὸ ὁστοῦν, καὶ τὸ λοιπὸν ἰώμεθα
10 ὥσπερ τὰ κεφαλόκλαστα. τοῦτο μὲν δὴ οὕτως ἔσχε.

Χρὴ δὲ τὸν ἐν κεφαλῇ τραυματίαν ἀνερωτᾶν τὸ σχῆμά 59
τε τοῦ βέλους καὶ μέγεθος καὶ σκληρότητα. ἀπὸ γὰρ τῶν
ἴσων βολῶν τὰ περιφερῆ καὶ μεγάλα καὶ στερεὰ μᾶλλον
ῥήσσουνσι, τὰ δὲ ὀξέα μᾶλλον τιτρώσκει. καὶ ἰσχὺν δὲ τοῦ 60
15 βάλλοντος ἐρωτᾶν καὶ προθυμίαν εἰς τὴν πληγὴν, καὶ εἰ
τὸ βέλος ἄνωθεν εἴτ' οὖν παλιμβληθὲν ἔτρωσεν. ἐν πᾶσι
γὰρ εὐρήσεις μέγα τὸ ὄφελος ἢ τι καὶ διάφορον πρὸς τε
τὰ ἀφανῆ καὶ τὰ ἐμφανῆ ἐξαράγματα. καὶ τὰ μὲν σφεν- 61
δόνη [τὰ δὲ] τῶν ἐκ χειρὸς ἰσχυρότερα, <τὰ δὲ> [καὶ]
20 αὐ[τα] ἀπὸ μηχανωμάτων ἰσχυρότατα, ὥστε οὐκ ἂν εἴη
παραιτητέον οὐδὲ ταῦτα. τέλος γε μὴν ἐρωτητέον καὶ τὰ 62
ἐπὶ τῇ πληγῇ σημεῖα τὰ ἐμπροσθεν εἰρημένα. εἰ γὰρ τι
ἐκείνων συμβαίνει, πάνυ χρὴ πιστεύειν κακόν τι ἐνεῖναι
τῷ ὁστέῳ.

25 Τὰ μὲν οὖν τοῦ νοσοῦντος καὶ τῶν παρόντων ἐρωτήματα 12 63
ταῦτα καὶ ὃ τι τούτων ἐγγυτάτω ἐστίν. ἄλλα δὲ καὶ κατὰ 215
ἔθνη ἐστίν. οἷον εἴ τις ἀφίκοιτο εἰς τὴν ξένην, πυνθάνεσθαι
χρὴ περὶ τῶν ὑδάτων, ὁποῖά ἐστι καὶ εἴ τινας ἐξαιρέτους

11-16 respiciunt Hipp. VC 11 (III 214-220, imprimis 220, 13
u. ad 17 L.) || 13 ἐξαράγματα] vox Hippocrat.; cf. Gal. Gloss.
Hipp. s. v. ε.· σύντριμμα (XIX 98 K.) || 22 ἐμπροσθεν] § 55

1 [οὗτος] Da. || 2 ἐδόκει M: δοκεῖ Gae. || 5 <μῇ> Gae.: <εἰ> Da. ||
6 θαρρῶ M: corr. Da. || 13 βελῶν M: corr. Da. || 16 ἤρουν M: εἴτε
οὖν Da. || 17 διαφέρειν Da., fort. recte || 18-20 σφενδόνη· τὰ δὲ
τῶν ἐκ χ. l. καὶ αὐτὰ ἀπὸ. μ. ἰσχυρότερα M: corr. Da. || 26 κατὰ
καὶ M: corr. Da. || 28 τινα Da.

ἔχει δυνάμεις, οἷαι εὐρίσκονται πολλαί, αἱ μὲν γαστέρα
 ὑπάγουσαι, αἱ δὲ τὴν οὖρησιν, αἱ δὲ τινες πρὸς πέψιν
 πονηραί, αἱ δὲ κατὰ ἥπαρ καὶ σπλῆνα κακουργοῦσαι, αἱ δὲ
 τινες καὶ λίθον ἐν νεφροῖς καὶ κύστε[σ]ι τίκτουσαι, ἄλλαι
 δὲ ἄλλα παρεχόμεναι, αἱ μὲν κακά, αἱ δὲ ἀγαθά. τὸ μὲν γὰρ ⁵
 ἐν Λεοντίνοις τῆς Σικελίας ὕδωρ ἀποκτείνει τοὺς πίνοντας
 καὶ τὸ ἐν Φερεῶ τῆς Ἀρκαδίας τὸ καλούμενον ὕδωρ
 Στυγός. τὸ δὲ ἐ(ν) Κλείτορι τῆς Ἀρκαδίας, εἴ τις ἐν αὐτῷ
 λούσαιοτο, οὐκ ἂν οὐδὲ ὁσμῆς ἀνάσχοιτο οἶνον. τὸ δὲ ἐν
 64 τῇ Λυγκηστίδι εἰς μέθην ἐμβάλλει· τὸ δὲ ἐν Χαλκίδι τῆς ¹⁰
 Ἀρεθούσης ποδάγραν ἐμποιεῖ. ὅσαι δὲ ἕτεραι φύσεις εὐρί-
 σκονται παρ' ἐκάστοις τῶν ὑδάτων καὶ καρπῶν καὶ ἀέρων
 οὐδὲ(ν) εἰκνύται ταῖς ὡς ἐλίπαν καθεστηκύναις, [ἄς] χρη-
 πυνθανόμενον παρὰ τῶν ἐπιχωρίων ἢ πειράζοντα ἐν χρόνῳ
 216 εἰδέναι. διάγνωσις γὰρ ἀκριβὴς ἄλλη οὐκ ἔστιν, ἐπεὶ οὐδὲ ¹⁵
 νόσήματα ἐπιδήμια ἔστιν ἑτέρως εἰδέναι· πολλὸς γὰρ κἂν
 65 τούτοις ὁ παράλογος καθ' ἐκάστην χώραν. ἐν γοῦν τῇ
 Ἀραβ(ι)ων γίγνεται νόσημα ὄφιν(***), ὃ σημαίνει ἐλληνι-
 66 στὶ νεῦρον. ἔστι δὲ πάχος ὅσον χορδή, καὶ κινεῖται καὶ

5—11 *plura exempla affert Ruf. ap. Orib. Coll. med. 5,3,28—35 || 5.6 Antig. Caryst. Hist. mir. 159; Plin. NH 31,27 || 7 Antig. Caryst. 158; Strab. 8,389; Vitruv. 8,3,16; Plin. 2,231; 31,26 || 8 Sotio De flum. 12; 24 = Anon. Florent. 12; 24 Oehler; Vitruv. 8,3,12; Ov. Met. 15,322sq.; Plin. 31,16; Athen. 2,43 F; Vib. Sequ. 168 Gels. || 9.10 Antig. Caryst. 164; Aristot. Meteor. 359 b 17—18; Sotio 20 = Anon. Florent. 20; Vitruv. 8,3,17; Ov. Met. 15,329—331; Sen. Qu. nat. 3,20,6; Plin. 2,230 || 18 ὄφιν] de dracunculo cf. Agatharch. ap. Plut. Mor. 733 BC (= GGM I 195); Gal. Loc. aff. 6,3 (VIII 392, 17—393, 5 K.); [Gal.] Introd. 19 (XIV 790, 18 u. ad 791, 2 K.); Def. med. 437 (XIX 449 K.); Aet. Amid. 14,85; Paul. Aeg. 4,58*

3 *πονηράν M: corr. Da. || 4 κύστεσι M: corr. Da. || 4.5 ἄλλας δὲ M: corr. Da. || 7 φαίνεω M: corr. Da. || 8 ἐκλήτορι M: ἐν Κλείτορι Gae.: ἐν Κλείτορι Da. | ἐν αὐτοῖς M: corr. Da. || 10 λιγγιστηνῇ M: corr. Da. || 13 οὐδὲ M: corr. Da. | [ἄς] Da.: (ταύτ)ας Gae. || 18 ἀραβίων M: corr. Deichgr. | lac. indic. Gae.; excidisse videtur nomen barbarum dracunculi || 18.19 δ — νεῦρον ut glossesema del. Kudl.; sed cf. [Gal.] Def. med. 437: δρακόντιόν ἐστιν ἔλκος φορὰν ἐπ' αὐτὸ ἔχον νεῦρον . . . || 19 δ κινεῖται M: καὶ κ. Gae.*

ἀναστρέφεται ἐν τῇ σαρκὶ ὥσπερ τὰ ἐρπετά, μάλιστα δὲ
κατὰ μηρὸν καὶ κνήμας, ἀτὰρ καὶ ἄλλη τοῦ σώματος.
ἐγὼ γοῦν ἐν Αἰγύπτῳ εἶδον ἄνθρωπον Ἀράβιον ἔχοντα 67
τὴν νόσον τήνδε, καὶ ὁπότε ἔξω προκύπτειν μέλλοι, ὠδυ-
5 νάτο καὶ ἐπύρεσσε, καὶ ἀνῶδει ὥσπερ τὰ ἐμπνήματα,
μέχρι δὴ διελθὼν ἐμύδησέ τε καὶ διεσάπη. ἐκεῖν[ο] μὲν 68
κατὰ κνήμην οὕτως ἔσχε, <τ>ῇ θεραπεΐνῃ δὲ αὐτοῦ κατ'
ὀμφαλόν, ἄλλη δὲ τινι κατὰ βουβῶνα. πυνθανομένων δέ 69
μοι, εἰ συνήθης ἐστὶν Ἀραβίο(ι)ς ἡ νόσος, ἔφασκον μὲν
10 καὶ Ἀραβίους οὕτως νοσεῖν καὶ τῶν ἀφικνουμένων δὲ
ξένων πολλοὺς ἐνίσχεσθαι τῇ νόσῳ πίνοντας τοῦ ὕδατος.
τοῦτο γὰρ μάλιστα αἴτιον εἶναι.
Μυρία δ' ἂν καὶ ἄλλα τοιοῦτότροπα ἱστορεῖν ἐξεύροις, 70 217
εἰ μόνον πρόθυμος <εἴης> εἰς τὸ ἐξευρεῖν καὶ βοηθήματα
15 <τά> ἐπιχώρια ἐκάστοις, ὥσπερ Αἰγυπτίοις <εἰσὶ> συρμα-
ῖσμοί τε καὶ ἔμετοι καὶ κλυσμοί, τοῖς δέ γε καὶ αἵματος
ἀφαιρέσεις, τοῖς δὲ αἰ διὰ τῶν ἐλλεβόρων καθάρσεις.
Ἦδη οὖν μοι σαφὴς ἡ γνώμη ἐστίν, ὅτι ἂν ἀφικέσθαι 71
βούληται †. τὰ μέντοι σύμπαντα οὔτε λόγος αὐτάρκης
20 οὔτε χρόνος ἱκανὸς σημῆναι τε καὶ ἐξευρεῖν. τὸ δὲ κεφάλαιον
τῆς γνώμης εὐρεθὲν καὶ ὑποβληθὲν τῷ ἱατρῷ ἔχοι
ἂν πάμπαν τὸ δέον.
Εἰ δέ τις φήσειέ με ἐναντίον γινώσκειν Ἱπποκράτει, 13 72
ὃς δὴ τέχνην ἔλεγεν ἐξευρηκέναι, δι' ἧς δυνήσεται ὁ ἰα-
25 τρὸς ἀφικόμενος εἰς πόλιν, ἧς ἁπειρώς ἐστι, περὶ τε τῶν

15 *συρμαῖσμοι*] vox Hippocrat.; cf. Erot. p. 24, 20 Nachm. — de re cf. Herod. 2, 77, 2; Gal. Comm. in Hipp. Artic. 2, 48 (XVIII A 484 K.); [Diocl. Caryst.] ap. Paul. Aeg. 1, 100, 3 || 23 — p. 16, 12 respiciunt Hipp. Aër., in primis c. 1 et 2 (II 12 — 14 L.)

6 *ἐκεῖνων* M: corr. Da. || 7 ἡ post spatium litterae T curatius exarandae, sed omittae destinatum M: suppl. Kudl. || 9 *ἀρράβιος* M: corr. Da. || 11 *πολλοὶ . . . πίνοντες* M: corr. Da. || 14 *προθυμεῖν εἰς* M: *πρόθυμος <εἴης> εἰς* Gae.: *προθυμοῖο εἰς* Da. || 15 <τά> Da. | <εἰσὶ> Da. || 15.16 *συρμαῖσμούς τε καὶ ἔμετους καὶ κλυσμούς* M: corr. Da. || 18.19 *ὅτι ἂν ἀφικέσθαι* β. Da.: *ὅποι ἂν ἀφ. β.?* Hansen: <ἐφ'> ὅσον γ' ἀφικέσθαι (βε)βούλημαι vel sim. subesse videntur || 23 *φήσει ἐμέ* M: corr. Da. | *ἱπποκράτους* M: corr. Da.

ὕδατων εἰδέναι καὶ περὶ τῶν ὥρων, ὅπως τε τοῖς ἀν-
 θρώποις αἱ κοιλίαι ἔχουσι, καὶ εἰ φιλοπόται εἰσὶ καὶ εἰ
 ἐδωδοί, καὶ περὶ τῶν νοσημάτων ὅποια ἐπιδημεῖν εἴθισται,
 καὶ αἱ γυναῖκες ὅπως πρὸς τοὺς τόκους διάκεινται, καὶ
 218 ὅσα ἄλλα ἐκεῖνος ὑπέσχετο τῇ τέχνῃ, μηδένα ἐρωτῶν τῶν 5
 ἐπιχωρίων, ἀλλὰ παρ' ἑαυτοῦ, μαθάνειν· ταῦτα δὲ εἴ τις
 προ[σ]φέρων ἐπιμέμφοιτό μοι ὥς τῷ ἀρίστῳ τῶν ἱατρῶν
 περὶ τῶν μεγίστων (οὐ) συγγιγνώσκοντι, λέγω πρὸς ἐκεῖ-
 νον οὐδέν με[ν] τῶν ἐκείνου ἀτιμάζειν, ἀλλὰ τὰ μὲν τινα καὶ
 οὕτως εὐρεθῆναι περὶ τε ὥρων καταστάσεως καὶ φύσεως 10
 σώματος καὶ διαίτης τρόπων καὶ ὕδατων τὴν κοινὴν ἀρε-
 τήν τε καὶ κακίαν καὶ νοσημάτων τὴν κοινὴν [καί] ἰδέαν,
 τὰ[ς] δὲ [δι'] ἱστορίας τῆς παρὰ τῶν ἐνοικούντων εἰς τὴν
 διάγνωσιν χρήζειν, καὶ μάλιστα ὅσα ἄτοπα καὶ ξένα ἐκά-
 73 στοις ὑπάρχει. τοῦ μὲν σοφίσματος καὶ πάντο ἄγαμαι 15
 τὸν ἄνδρα καὶ πολλαχῇ καλῶς αὐτῷ ἐξεύρεται, παρα-
 κελεύομαι δὲ μηδὲ τῶν ἐρωτημάτων ἀφίστασθαι τὸν
 μέλλοντα ὀρθῶς ὑπὲρ πάντων γνῶσεσθαι.

2 φιλόποτοι M: φιλοπόται Gae. cl. Hipp. Aër. 1 || 5 ἐρωτῶν M:
 corr. Da. || 7 προσφέρων M: corr. Da. || 8 (οὐ) Gae.: (μή) Da. ||
 9 μὲν M: corr. Da. || 10 καταστάσεων M: corr. Da. | φύσιν M:
 corr. Da. || 12 καὶ ἰδίαν M: corr. Da. || 13 τὰς δὲ δι' M: τὰ δὲ
 Kudl.: τῆς δὲ Da.

Translation: *On Questioning the Patient*

Translation conventions

The translation of ancient medical texts offers particular challenges concerning the rendition of familiar terms that convey apparently simple ideas that are in fact fraught with complexity.⁷ For example, every beginning learner of Greek quickly discovers that νόσος means ‘illness’. But is what I mean by ‘illness’ the same as what the person sitting next to me in the doctor’s waiting room means, or the same as what the doctor means, let alone the same as what a first century Greek meant? A further dimension of difficulty attends the translation of Greek words that have been directly assimilated into modern medical discourse, such as διάγνωσις, σύμπτωμα and πρόγνωσις, cloaked as they are in the mantle of ‘false friendship’. Every translator must make his or her own decisions about how best to render these words, and whether and when to vary those translations. The notes below explain how I have decided to deal with the following words that are particularly significant in the context of this thesis. It should be noted that the policies explained in this section apply only to the translation; I have not attempted to maintain them throughout the thesis, as it would have been artificial to do so.

διάγνωσις, διαγιγνωσκεῖν ‘Recognition’, ‘to recognise’. I have avoided the words ‘diagnose’ and ‘diagnosis’ in the translation because of their modern association with labelling an actual syndrome or disease.

νόσος ‘Sickness’. Rufus’s concept of νόσος includes wounds (see §21 and below, p.39 n.35) and is therefore wider than our own generally accepted concept of disease as an

⁷ On this problem with specific reference to mental illness, see van der Eijk 2013:312.

organically occurring illness or disorder. What he means by it is the state of not being well. Cf. *Gal.Symp.Diff.1*, VII.43.17 K: ἡ νόσος δὲ τὸ ἐναντίον τῇ ὑγείᾳ; 47.4-5, defining ὑγεία as διάθεσις κατὰ φύσιν ἐνεργείας ποιητική; and 11-12, where νόσος is defined as διάθεσις παρὰ φύσιν, ἐνεργείας ἐμποδιστική. On the term ‘sickness’, and for insight into my avoidance of the terms ‘disease’ and ‘illness’ in my translation, see discussion below, Chapter 2.1 ‘The meaning of health and sickness’, and especially p.76.

νόσημα ‘Disorder’. This concept does not, probably, differ significantly from νόσος, and certainly Galen suggests that the two are synonymous (compare, for example, *Symp.Diff.1*, VII.49.7-8 K νόσημα διάθεσις τις ἥν παρὰ φύσιν τὴν ἐνέργειαν βλάπτουσα, with *id.*47.11-12, quoted above s.v. **νόσος**). Indeed he explicitly declares in *MM* 2.3, X.91.6-7 K that there is no difference between the two (διοίσει δ’ οὐδὲν ἢ νόσον, ἢ νόσημα λέγειν, ὥσπερ οὐδὲ πάθος, ἢ πάθημα), and that ‘the ancients’ used all these terms interchangeably. My decision to translate νόσημα differently from νόσος is influenced by the fact that Anonymus Londinensis distinguished between them (III.32-45), on the basis that νόσος affects the whole body and νόσημα only a part; perhaps Rufus had some such distinction in mind.

νοσεῖν ‘To be unwell’.

πάθος and **πάθημα** ‘Affection’. Each word occurs only once in *QM*, the former in §21 and the latter in §49, but because in §21 Rufus may be quoting Callimachus directly rather than making his own choice of word we cannot infer anything about his own

conceptualisation of πάθος from that passage. I have therefore chosen to translate both words in the same way. Cf. Gal.*MM* 2.3, X.91.6-7 K, quoted above (s.v. νόσημα).

πρόγνωσις ‘Prognosis’. Because it is common to do so in ancient medicine scholarship, and because Rufus barely touches on the concept, I have retained the English homonym even though it has a significantly narrower significance than that of the Greek word: see below, pp.224-225.

σύμπτωμα ‘*Sumptōma*’. This is perhaps the most sensitive term for my purposes, since the connotations of the English word ‘symptom’, whose defining characteristic is subjectivity,⁸ have a particular relevance to the issues explored in this thesis. The word was defined by Galen as a bodily condition consequent upon a disease: εἰ δ’ ἔποιτο τις ἄλλη τῷ νοσήματι περὶ τὸ σῶμα διάθεσις, αὕτη σύμπτωμα ὀνομασθήσεται, *Symp.Diff.* 1, VII.50.12-14 K; the ἄλλη distinguishes σύμπτωμα from νόσημα and αἴτιον νοσήματος; cf. *id.* 51.17-18 K: ‘the particular characteristic of a σύμπτωμα is that it is contrary to nature’ (τὸ γὰρ τοι τοῦ συμπτώματος ἴδιον αὐτὸ τοῦτ’ ἔστι, τὸ παρὰ φύσιν). Rufus uses συμπτώματα in the same sort of way: to mean the undesirable phenomena that appear with an indisposition (thus §§12, 22, 23 35, 49). Gärtner *ad QM* 26 (1962, 72) suggests that Rufus used σύμπτωμα and σημεῖον interchangeably, but this does not seem right: σημεῖα appear in §§21 (where Rufus is quoting Callimachus), 10 and 49 (where they are explicitly contrasted with things the doctor cannot know without asking), and 62 (where they seem to refer back to the observable phenomena described in §57, the patient

⁸ See for example MedicineNet: a symptom is ‘Any subjective evidence of disease. In contrast, a sign is objective. Blood coming out a nostril is a sign; it is apparent to the patient, physician, and others. Anxiety, low back pain, and fatigue are all symptoms; only the patient can perceive them’. <http://www.medicinenet.com/script/main/art.asp?articlekey=5610> Accessed 4th January 2016.

touching the sore spot, trembling and raving). To Rufus, then, σημεῖα and συμπτώματα are conceptually distinct, and the difference makes sense semantically – with σύμπτωμα meaning something that ‘befalls’ a person ‘together with’ the sickness (συμπίπτω), and σημεῖον meaning something that ‘signifies’ (cf. σημαίνω) – even though he does not explicitly formulate the distinction, nor relate it to the subjective/objective difference that pertains today.

Galen observes that ‘the Greeks’ (wrongly, in his view) tend to use the words σύμπτωμα, πάθημα and πάθος interchangeably.⁹ In *QM* 49 Rufus uses συμπτώματα, σημείων and πάθημα in close proximity. Brock and Daremberg translate both συμπτώματα and σημείων as ‘symptoms’, and πάθημα as ‘disease’ (Brock) and ‘maladie’ (Daremberg). But actually it seems clear that, for Rufus, it is πάθημα and συμπτώματα that are interchangeable, while σύμπτωμα and σημεῖον are different. Rufus’s point in §49 is that in rabies cases the doctor has two chances to make a diagnosis: (1) ideally (because it allows early intervention) through questioning before any συμπτώματα attack and (2) through σημεῖα if the patient cannot speak. Therefore σημεῖα are things the doctor can observe without being told, which is obviously a potentially narrower field than συμπτώματα; they also, by implication, appear comparatively late, which is in fact pathologically accurate.¹⁰ I conclude that for Rufus the following apply: σημεῖα may overlap with, but are not necessarily co-extensive with, συμπτώματα; the doctor has to diagnose from σημεῖα alone only if the patient is incapable of telling him anything; and

⁹ τοῦτο μὲν οὐ πάνυ τι σύνηθές ἐστι τοῖς Ἑλλήσι τοῦνομα, σύμπτωμα δὲ καὶ πάθημα καὶ πάθος ὀνομάζουσι συνήθως ἅπαντα τὰ τοιαῦτα, where τοῦτο refers to ἐπιγέννημα. *Gal.Symp.Diff.* I, VII.43K.

¹⁰ See <http://www.vaccineinformation.org/rabies/> (accessed 4th January 2016).

the patient (as opposed to a beast) can convey information that is as important as the things the doctor can observe for himself.

In eschewing the translation ‘symptom’ I find myself in disagreement with Johnston (2006, *passim*) but in agreement with Hankinson (1991:152), who chooses to transliterate *sumptōma* on the grounds that ‘there is no obvious modern English rendering’ and that though it often ‘reasonably approximates’ to its ‘general’ (ie non-technical) usage there are insufficient grounds for translating it ‘symptom’.

In general, I have tried to maintain a high level of fidelity to the Greek while rendering Rufus’s thought in intelligible and reasonably natural English. If at times the tension has remained unresolved, I take heart from Richard Bett’s comment on the task of translating Sextus Empiricus: ‘I have not always been greatly concerned about naturalness: it seems to me that an author whose time and place was very different from our own *should* sound a little odd to us, even in translation’.¹¹

¹¹ Bett 2012:xxvi.

1. Introductory statement

[1] You must ask the patient questions. By doing this you will more accurately recognise¹² anything connected with the sickness,¹³ as well as providing better treatment.

2. Focus on the patient

[2] That is my first principle: put your enquiries to the patient himself. From this source you can learn the extent of the person's mental sickness or health,¹⁴ as well as his physical strength or weakness, and at the same time the type and location of the sickness he has been suffering. If he answers coherently, appropriately and with good recall, without stumbling either vocally or mentally, and in a way that corresponds to his own natural inclination – mildly and moderately if he is otherwise moderate, or again boldly if he is naturally bold or fearfully if he is naturally timid – then you should regard his mind¹⁵ at any rate as being in good order. But if you ask one question and he answers another, if in the middle of speaking he forgets what he is saying, if his speech is tremulous¹⁶ and

¹² **διαγνωσθεῖν** Rufus concentrates on διάγνωσις and mentions prognosis only twice in *QM*, (one of those re Callimachus). We find a similarly worded concern for diagnosis and treatment in *Ren.Ves.12.15*: αὕτη [μὲν] σαφεστάτη διάγνωσις καὶ θεραπεία τῶν ἐν κύστει λίθων, καὶ οἱ γε πολλοὶ οὕτω ποιοῦντες ἐπιτυχάνουσιν.

¹³ **τῶν περὶ τὴν νόσον** The accusative emphasises the circumstantial nature of what Rufus wants to learn. For the same use, see *Hp.Epid.1.23* (10) = II.668-70 L: τὰ δὲ περὶ τὰ νοσήματα, ἐξ ὧν διεγινώσκομεν ('the circumstances attending the disease, from which I framed my judgments', tr. Jones, Loeb I.181); see discussion below, p.196. Brock and Daremberg both translate as if περὶ were followed by the genitive rather than the accusative ('certain aspects of the disease', and 'des choses qui concernent la maladie'). Gärtner captures the breadth of the Greek with 'manches was mit der Krankheit zusammenhängt'. Cf. πολλὰ τῶν ἐν ταῖς νόσοις, *QM* 22 (see below, p.40 with n.38).

¹⁴ **ὅσα τε κατὰ γνώμην νοσεῖ ἢ ὑγιαίνει** Rufus's interest in mental factors is immediately signalled. See below, pp.163-166. On the linguistic parallels between this part of *QM* and Galen's *Commentary on Hippocrates' Epidemics* 6.2.24, see below, pp.188-189.

¹⁵ **γνώμην** For γνώμη in this sense (*cognitio, ratio, mens*) – its commonest Hippocratic use, according to Kühn and Fleischer s.v. – see for example *Acut.17* = II.260.6 L, οἱ ... τὴν γνώμην βλάβεντες ('delirium', tr. Jones, Loeb II.75); *Epid.3* = III.112.11 L, τὰ περὶ τὴν γνώμην μελαγχολικά ('the mind being affected by melancholy', tr. Jones, Loeb I.263); *Epid. 3* = III.118.13 L, παρακοπή ... τῆς γνώμης ('derangement of the intellect', tr. Jones, Loeb I.267); *Prorrh. 2.12* = IX.34.12 L, τὰς γνώμας θορυβώδεις ('a disturbed mind', tr. Potter, Loeb VIII.249); *Prorrh.1.36* = V.518.12-14 L, τι ... γνώμης παράπορον ... πόνοι ... γνώμης παράφοροι ('some disturbance of the mind ... Pains ... disturbing to the mind', tr. Potter, Loeb VIII.177).

¹⁶ **τρομώδεις γλῶσσαι** Cf. *Hp.Prorrh.1.20* = V.516 L: αἱ τρομώδεις γλῶσσαι σημεῖον οὐχ ἰδρυμένης γνώμης.

unclear and there are shifts from the original mood to the opposite, all these are associated with derangement.¹⁷ Deafness in the patient is indicated in the same way. [3] If he does not hear, one must additionally ask the bystanders if he was at all deaf before or is so because of the present sickness; for this has a great bearing on understanding the situation. [4] You can comprehend the patient's physical strength or weakness from how he tells you what has happened, whether coherently, in adequate voice, or with frequent pauses, for example, in a thin voice. <You can similarly discover> the type <and location> of disorder, <if he speaks rapidly, lisps, stammers from inability to control his tongue, and suffers the usual symptoms of melancholy or,>¹⁸ if there is no melancholy, hoarseness¹⁹ or paralysis of the tongue or some of the things that tend to arise in the chest and lungs. For the melancholy state is clearly indicated by over-boldness²⁰ and uncalled-for sadness, both of which are particularly evident in the things the patient says (they are evident in other ways too, but the addition of this empirical test²¹ will allow the sickness to be clearly recognised); [5] while an imminent case of lethargy is obvious if, when responding to questions, the patient forgets what he is saying and speaks without clarity. [6] That is certainly so when there is a fever; where there is none, expect convulsions and seizures. In sum, all conditions that are to do with mental disturbance can be detected through questioning more easily than in other ways. [7] Chest complaints are identifiable from both sharpness and roughness of the voice: if the person has consumption and can breathe only in an upright posture, the voice is sharp, but in cases of abscess, sore throat²² and

¹⁷ **παρακρουστικός** According to Thumiger (2013:71), this is 'one of the key terms for mental affection in the Hippocratic texts' and is used 'exclusively with reference to conditions and causes, not to patients'.

¹⁸ **ἰδέαν < ... > ἄνευ** For my hypothesis about the contents of this textual lacuna, see Chapter 5, p.189.

¹⁹ **βράγχωσιν** Gärtner comments *vox apud Graecos, ut videtur, inusitata* (1970, 2, *testimonia*). The word does not appear in LSJ, Durling or Kühn and Fleischer.

²⁰ **θρασύτης τε καὶ ἄκαιρος λύπη** See below, pp.123, 164.

²¹ **πεῖρα** A combination of trial and experience, and a standard component of Empiricist diagnostics. My translation 'empirical test' follows Hankinson (2009:228 cf. 230).

²² **βραγχώδει** subject to hoarseness (LSJ, with two Hippocratic citations and one from Galen). The phrase τῷ βραγχώδει καὶ does not appear in Gärtner's *CMG* text, though his Teubner edition offers no explanation for its presence.

severe catarrh it is rougher. [8] As for those with paralysis of the tongue, they have no voice at all.

[9] First, as I have said, you must question the patient himself about the things you need to know; but then, if there are obstacles to learning things from the patient, you must question the bystanders as well. [10] By obstacles I mean when someone is very mentally disturbed, or has had a stroke, or is suffering from lethargy, catalepsy or aphasia, or is generally simple-minded or completely physically debilitated, or needs to keep speaking to a minimum, for example in a case of bleeding from the lung. Questioning someone else is also necessary on behalf of a child or a very old person, and in the case of someone who does not speak the same language one must question someone who does.

3. The three most critical things to know

11-14: Timing

[11] The first thing to ask is the point in time when the patient began to be unwell;²³ this is useful not just for treatment but also for identifying critical days, since it is all you need to know to keep an eye on their cycles. [12] Indeed knowing when the sickness began helps considerably in every aspect of recognising it. For the same *sumptōmata*²⁴ mean different things at varying times; for example, jaundice manifesting before the sixth and the seventh day is bad in a fever; after that, it indicates a crisis; and urine and faeces that are watery and crude are less bad at the beginning but more suspicious as time goes by.

²³ ἐρωτητέον δὲ πρῶτον μὲν τὸν χρόνον cf. Hp.Aff.37: ὅταν δὲ ἐπὶ νοσέοντα ἀφίκη, ἐπανερωτᾶν χρὴ ἅ πάσχει, καὶ ἐξ ὅτου, καὶ ποσάϊος; and cf. Gourevitch (1998:114) on the importance of periodicity in Methodism.

²⁴ συμπτώματα In this passage Rufus differentiates *sumptōmata* from the contextual details that may help to explain the indisposition.

Similarly, dripping from the nose in a four-day pattern, when limited, is dangerous, while violent nosebleeds in a four-day pattern mean a difficult crisis, yet later they bring the crisis.²⁵ [13] These things you will certainly learn by asking about the day the sickness first began, and you will learn its acuteness and severity if some of its ill effects break out early, appearing quickly and all at once, and others slowly over time. Similarly, knowing the pattern of recurrence will tell you if the sickness is intensifying in a straightforwardly predictable way, or at first chaotically and then in a more settled fashion; it will tell you too about remission from three-day fever, and changes in and recovery from certain other disorders. [14] That is how important I say it is to ask about the beginning of the sickness, the exact point at which the person began to be unwell.

15-22: *Habits and constitution*

15-17: the individual constitution

[15] The next thing to ask is whether or not the current problem is among the disorders from which the person commonly suffers, and whether it has happened before. Very often people succumb again to the same things, suffer the same effects and receive the same treatment, and the physician might be worried by something on the grounds that it is hard to resist and not susceptible to treatment when in fact it is not difficult in this patient's case, at least, or not unsuitable for treatment in the present episode of sickness. In all cases familiarity makes it very much easier both to endure unpleasantness and to treat it.²⁶ [16] So I think that one will do well to ask about every aspect of each patient's constitution as well. For we are not all constituted the same, but are completely different from each other in every respect whatsoever. So – to take the digestion as an example –

²⁵ δύσκριτοι ... κρίνουςαι Cf. Hp.Aph.3.8 (δύσκριτοι of diseases that 'have a difficult crisis', tr. Jones, Loeb IV.125) and Aph.5.22 (κρίνον, of heat that 'conduces to a crisis', tr. Jones, *id.*163); also Gal.Nat.Fac.1.13. (Alternatively 'hard to interpret' (Daremberg, cf. LSJ) and 'decisive'; but cf. §31 below.)

²⁶ ἐθισμός See below, p.207 n. 590.

you will find that some things are easily digested by some people and poorly by others. Again, medicines that people drink for laxative or diuretic purposes have different effects on different people: purgatives can encourage vomiting, and emetics can encourage bowel movements. In short, none of these things is fixed, so that it conforms to a single theory for²⁷ the physician. [17] This is why it is necessary to learn, actually from the patient, how he is affected by each item of drink and food, and not to overlook any obvious experience he may have of a medicine.²⁸ Indeed one will very often hit the nail on the head by asking the actual patient about events that are unusual for him.

18-20: habits

[18] In general, we must ask if he has a good appetite or is off his food, whether he is thirsty or doesn't want to drink, and what his habits are in every area; for it is important to be as well acquainted with his habits as with his constitution. People consume familiar foods, served in the familiar quantity and style, less unhappily than those which might otherwise seem to be best, [19] and familiar things are always better, whether a person is sick or well. [20] We can also give a more accurate prognosis by knowing the patient's habits²⁹ with respect to power of judgement, conversational style, inactivity³⁰ and any

²⁷ ὥστε εἰς ἓνα ἐλθεῖν λόγον τῷ ἱατρῷ 'that the physician can place it in a single category' (Brock); 'que le medecin puisse les ranger dans des categories toujours identiques' (Daremberg); 'dass es für den Arzt auf einen Nenner zu bringen wäre' (Gärtner). My translation of λόγος as 'theory' reflects the fact that Rufus now moves on to explain the value of questioning in terms of πείρα (§17).

²⁸ πρὸς ἕκαστον διάκειται ἡ πόμα ἢ σιτίον Cf. §40: the effects of drugs and foods are 'specific to the individual and do not apply across the board'. Cf. Gal.SMT, XI.380 K: 'anything which has the power to alter our nature we call a drug, just as anything which has the power to increase it we call nutrition; and both of these terms are relative'.

²⁹ περὶ I make this depend on ἐθισμῶν, as do Gärtner and Haak; Brock and Daremberg both interpret it as following προγνώσθῃ (forecasting about habits), as does Abou-Aly (1992, 201). Gärtner: 'Und es könnte aus den Gewohnheiten hinsichtlich der Urteilskraft des Patienten, hinsichtlich seiner Unterhaltung, seiner Zerstreuung und jeder beliebigen seiner sonstigen Tätigkeiten eine genauere Prognose gestellt werden. Denn was schon beim Gesunden gewohnheitsmäßig vorhanden war, gibt in Krankheitsfällen keinen typischen Hinweis'. Haak (2013, 45): 'Men kan ook nauwkeuriger voorspellen als men weet hoe de patiënt gewoon is besluiten te nemen, zijn spreekvaardigheid, zijn wijze van ontspanning en iedere andere bezigheid kent. Wat in gezondheid gewoon is, is bij ziekten geen duidelijk voorteken'.

³⁰ ῥαθυμία It is not immediately obvious what Rufus means by this. LSJ offers four classes of meaning: 'easiness of temper, taking things easily; recreation, relaxation, amusement; indifference, sluggishness, laziness; heedlessness, rashness'. The other translations between them cover much of this territory:

other function³¹ whatsoever. For what is habitual in a healthy person indicates nothing noteworthy when he is unwell.

21-23: Signs are not enough

[21] In these matters too the physician will be able to understand nothing by himself if he does not enquire of either the patient or some other person present. I am amazed,³² therefore, that the physician Callimachus,³³ alone of earlier doctors – or at least of those one can take seriously – denied the need³⁴ to ask questions about sicknesses, including wounds,³⁵ especially head-wounds. He claimed that the signs in each individual case were enough to indicate both the condition and its cause, and should preferably be used as the

‘whether he is careless’ (Brock), ‘état de bien-être’ (Daremberg), ‘Zerstreuung’ (Gärtner) and ‘wijze van ontspanning’ (‘manner of relaxation’) (Haak). Gärtner points out (*ad loc.* 1962:63) that the sense in which ἔθῃ is used here is ‘orientated towards the mental-emotional perspective of the patient’ (‘Der Gesichtspunkt der ἔθῃ wird hier auf den geistig-seelischen Bereich des Patienten bezogen’), and that the examples given must therefore be qualities of the patient; thus κρίσις means the patient’s power of judgement, not the judgement the physician makes of the patient, and διάλεξις means the patient’s conversational style, not the dialogue between patient and doctor. He makes no comment on ῥαθυμία, but if we are to align the concept categorically with ‘power of judgement’ and ‘conversational style’ we need a meaning that denotes a habitual mental characteristic, a personal trait, not an occasional behaviour or event. The noun ῥαθυμία and cognate verb forms occur 17 times in the Hippocratic Corpus, mostly signifying inactivity, whether rest prescribed as a treatment (9 times in *Regimen*) or the state of indolence – a state which, according to the author of *On Regimen*, is not caused by physical mixture and therefore cannot be changed through regimen (other such traits include being ὀξύθυμος, ... δόλιος, ἀπλοῦς, δυσμενής, εὖνους: ‘irascibility, ... craftiness, simplicity, quarrelsomeness and benevolence’: Hp. *Vict.*36 = VI.522 L, tr. Jones, Loeb IV.293); see van der Eijk (2013:314-315). In a non-medical context ῥαθυμία can be a positive attribute (as when Pericles characterises the Athenians as having become ready to meet danger ‘by taking our ease rather than by laborious training’: ῥαθυμια μᾶλλον ἢ πόνων μελέτη, Thuc.2.39.4, tr. Smith, Loeb II.327) or a negative one (Solon made it compulsory to engage in politics because he saw that ‘some of the citizens through slackness were content to let things slide’: τῶν δὲ πολιτῶν ἐνίους διὰ τὴν ῥαθυμίαν ἀγαπῶντας τὸ αὐτόματον, Arist.*Ath. Pol.*8.5, tr. Rackham, Loeb XX.31; cf. Demosthenes on the Athenians’ ‘excessive and inopportune apathy’: τῆς πολλῆς καὶ ἀκαίρου ῥαθυμίας, *de Corona* 18.46, tr. Vince & Vince, Loeb II.47). Rufus’s familiarity with Hippocratic works (see below, p.156) means that he knew the Hippocratic uses of the term, but in view of his intellectual independence (below, pp.112, 144-156) we should not assume that he necessarily applied it in exactly the same way. The ‘mental-emotional perspective’ of the passage makes it less likely that he means how a person spends his periods of inactivity than whether he has a propensity to inactivity, or even where on the spectrum from easy-tempered to apathetic the person normally resides, though he could well mean a fusion of all three.

³¹ ἐνέργειαν Daremberg translates ‘facultés’, Gärtner ‘Tätigkeit’. See below, p.208.

³² θαυμάζω For ‘I am amazed at’ introducing criticism of others, cf. Gal.*HNH*, CMG V.9.1.8.20-22 = XV.11 K: διὸ καὶ θαυμάζειν ἔφην ...; and Gal.*MM*, X.250 K: ἐγὼ μὲν γὰρ καὶ θαυμάζω τὴν ἀναισθησίαν τοῦ Θεσσαλοῦ, γράφοντος ὡδί πως ὑπὲρ τῆς τῶν κακοηθῶν ἐλκῶν ἰάσεως.

³³ Καλλιμάχου τοῦ ἱατροῦ See below, pp.146-153.

³⁴ οὐκ ἔφασκε δεῖν See below, pp.147, 153.

³⁵ οὔτε περὶ τὰς ἄλλας νόσους οὔτε περὶ τὰ τραύματα The syntax tells us that Rufus’s concept of νόσος includes wounds.

basis of all prognosis and treatment. Questioning was unnecessary, he said, even about the antecedent causes³⁶ of sickness – such as the patient’s way of life,³⁷ including the regimen being followed, and whether the person was tired or cold when he became unwell – on the grounds that the physician had no need to learn anything from these factors if he gave careful and accurate consideration to the signs that occur together with sicknesses. [22] In my opinion, however, although one can indeed discover many of the factors connected to sicknesses³⁸ on one’s own, questioning enables that to be done better and more clearly, for if it reveals things that correspond with the *sumptōmata*³⁹ it is easier to know what is going on. Thus if a patient suffering what we would expect in a case of satiety says that he has exceeded his previous regimen in intake of food and drink, we can recognise the sickness as satiety and work out its entire treatment. Or take someone who says he is working very hard: if he is suffering what we would expect in a case of over-work, it will be easier to tell that the sickness is fatigue and apply the appropriate treatment.⁴⁰ [23] The *sumptōmata*⁴¹ in such cases can take us some way towards an indication⁴² as well; but as to the timing of the sickness, and the patient’s habits in every respect, and the singular constitution of each person, these are things that one cannot, in

³⁶ τὰς ἡγουμένας προφάσεις See below, pp.150-152.

³⁷ διαίτης τε ἀγωγὴν καὶ τὰ ἄλλα ἐπιτηδεύματα Cf. Hp.Epid.1.23 (10) = II.668-70 L (below, p.196), where διαίτη and ἐπιτηδεύματα are both included in the long list of things ἐξ ὧν διεγινώσκομεν.

³⁸ πολλὰ τῶν ἐν ταῖς νόσοις Cf. τι τῶν περὶ τὴν νόσον (§1). Others translate ‘beaucoup de choses dans les maladies’ (Daremborg); ‘vieles was mit der Krankheit zusammenhängt’ (Gärtner); ‘a great deal about disease’ (Brock).

³⁹ συμπτώμασι We infer that what the doctor learns from the patient is supplementary to the *sumptōmata*, and that *sumptōmata* are therefore not necessarily subjective.

⁴⁰ These illustrations recall Rufus’s case studies of melancholics who have over-indulged in dinners and/or work (*On Melancholy* FF68, 71); cf. also Cels.Pr.7 on how medicine was initially of interest to philosophers *qui corporum suorum robora inquieta cogitatione nocturnaue vigilia minuerant*. See below, pp.166-168.

⁴¹ τῶν συμπτωμάτων Here again *sumptōmata* are clearly differentiated (μὲν ... δέ) from what is learnt through questioning, reinforcing the impression that for Rufus a *sumptōma* is not necessarily subjective. His distinction is between the unfortunate occurrences that characterise the indisposition, and the contextual details that may help to explain it.

⁴² ἔνδειξις This is the only use of this word in *QM*. For Galen, it is a key concept and one which depends heavily on logic (Gal.MM, X.127 K); he accepts, van der Eijk points out (2008b:293), that anyone can achieve ‘common’ indications but regards his method as superior because of its specificity. Rufus’s idea of the concept is perhaps of the ‘common’ sort. See below, p.187 n.526.

my view, know without asking, while knowing them is more critical to medical judgement⁴³ than anything else.

4. Questions concerning the patient

4.1. Common sicknesses

24-26: identifying the right cause

[24] Moreover the recognition of disorders varies depending on whether they are attacking from within or from without, and is somehow harder, I think, in the case of internal than external ones. If the person is shivering, for example, it is less serious if it is due to cold or fear but more challenging if it has arisen from some internal cause. Again, if someone is out of his mind,⁴⁴ it is easier to remedy if caused by strong drink or a hallucinogenic drug, but harder if due to another cause. [25] Thus you will find that the treatment method differs in all cases. Some cases of fatigue, for example, are due to exertion⁴⁵ and others to satiety; the former patients need rest, sleep, soft massage and warm baths, while the latter require work, wakefulness and every other kind of depletion. [26] This is how much difference it makes to the physician to enquire thoroughly⁴⁶ even into the causes, and without questioning there is no knowledge. This means that one must ask questions even when there are signs:⁴⁷ if there is lividity, whether it is because of a

⁴³ **καιριώτερον** My translation ‘critical to medical judgement’ is informed by Jouanna’s explanation of the concept (1999, 344): ‘the physician had to know how to measure the proper degree of change to be introduced into the body, and to seize upon the appropriate moment for introducing it, if he wished to restore health without causing damage. The notions of suitable quantity and apt timing were expressed in Greek by a single word, *kairos*; though this has traditionally been rendered as “opportunity”, it denoted both the right measure and the opportune moment.’ Cf. below, pp.126, 199-200 with n.566.

⁴⁴ **παραφρονοίη** See Thumiger (2013:73): *παραφρονέω* in post-Hippocratic medical literature denotes ‘general, unqualified impaired cognitive abilities’.

⁴⁵ **ταλαιπωρίαν** ‘Exertion’: thus Jones, translating *Hp.Acut.*47 (Loeb II.103).

⁴⁶ **ἀνερωτᾶν**: LSJ gives only ‘inquire into’ (*ἀνερωτάω* A2), but *ἀνα* in compound verbs suggests thoroughness of asking (LSJ *ἀνα* F2, F3).

⁴⁷ **καὶ ἐπὶ τῶν σημείων** On Rufus’s view that signs are not sufficient for identifying the problem, see below, pp.166-168.

blow or the patient's age or the time of the year (for otherwise lividity in fever signifies death); if the tongue is dry, whether the patient has been thirsty or has had a major evacuation, and, if it is black, whether he has eaten something black; things like that would not be cause for suspicion.

27: food intake and excretion

[27] Similarly one must ask about the urine, faeces and saliva being excreted during the sickness; for another thing that it makes a great difference to know is, in relation to the quantity, consistency and colour of these excretions, how much food the patient has taken, of what kind, and exactly when.

28-33: dreams

[28] One must ask also about sleep: whether he is sleeping or not, and what his normal habits are regarding sleep and sleeplessness, and if he is having any visions or dreams, since the physician can draw conclusions from these too. [29] I cannot deal with dreams comprehensively, but just enough to point out the subject in principle and to remind the physician not to overlook any of these kinds of things. Myron of Ephesus, a wrestler, when seemingly well, had a dream of the following kind: all night long he thought he was in a black marsh of drinkable water. When he got up he mentioned it to his trainer, who thought nothing of the dream and set Myron to his labours. Before Myron is halfway through, he is attacked by breathlessness, weakness and palpitation of the entire chest, immediately after which he loses the use of his hands and feet, and then the power of speech. Shortly thereafter he dies.⁴⁸ [30] He would not, I think, have died if he had had a wise trainer and had managed to get himself a complete evacuation of blood before his training. [31] Another man who was acutely feverish kept being visited in his sleep by an

⁴⁸ ἐπιπίπτει, ἀποθνήσκει Note Rufus's momentary use of a vivid narrative register to tell the story. On the use of the present tense to mark something that is 'of decisive importance for the story', see Rijksbaron 2006, 22. Cf. §57 (below, p.48, with n.62).

Ethiopian man who seemed to be wrestling with him and getting him in a tight throat-hold. This man told his physician the dream, but the physician did not himself give much thought to what it meant, until the sickness was brought to a crisis by a violent nose-bleed. [32] There was also the man who thought he was swimming in the River Cayster, whose sickness became chronic and culminated in dropsy. [33] I am quite convinced that dream-visions arise in accordance with the body's humours,⁴⁹ and that they indicate things for the patient – whether good or bad – which someone who does not listen has no other means of apprehending.

34: congenital complaints

[34] And what of congenital disorders? Surely these too cannot be known in any other way than by questioning? And nobody could say that this was a minor question, unless it is also a minor matter to distinguish a disorder that is easier to deal with from one that is more difficult; for it is rightly assumed that all congenital sickness is harder to treat than that which is acquired.

35: history of symptoms

[35] One must also enquire to find out about patterns of recurrence, any movement of the sickness,⁵⁰ and all the *sumptōmata* that have befallen the patient earlier; it is of

⁴⁹ τοὺς χυμοὺς τοὺς ἐν τῷ σώματι The only reference to humoral theory in *QM*; for the theory as used in *On Melancholy*, see p.114, with note 281. Here Rufus shows himself to be an adherent of Hippocratic dream theory as described in *Hp.Vict.4* (see below, p.118, with n.303). Myron's experience closely matches the advice given at the end of *Vict.4.90*, that dreams of being in water are generally bad because they indicate excessive moisture. In Myron's case, what Rufus says should have happened corresponds exactly with what *Vict. 90.64-7* suggests: drying out, and then continuing with exercise.

⁵⁰ μετέστας Gärtner comments that this term had two medical meanings: relocation of a disorder from one part of the body to another, and the cessation of sickness (*ad loc.* 1962:79, citing *Gal.Hipp.Aph.V.7, K.XVIIB.790.10-12*). Since the sickness is continuing, the former is, as Gärtner points out, obviously what is intended here.

considerable help to both prognosis and therapy to take all these things into consideration.⁵¹

36-40: diet and medication during the illness, and their effects

[36] One must also ask about the regimen the patient has observed while unwell – not the one he follows when he is well, about which I have already made this point,⁵² but his current one: what regimen he has been following during his sickness, whether any medicines had been prescribed, the whole treatment he has taken, and in what condition he appears after each of these things. All this is useful to know, whether for adjusting present arrangements, avoiding disturbance of previous arrangements, or discovering if anything essential has been overlooked. [37] We must also ask if the patient has taken food or not. Even this, I say, the physician cannot know by himself; though if one does not know what a patient has eaten as soon as one touches him, but asks someone else, ordinary people find it a most absurd question.⁵³ [38] But in my view this is another example of what you cannot recognise without asking – just like the timing, type and quantity of food consumed. If you make a conjecture about this on the basis of the patient's strength and weakness you will be frequently deceived on many counts; for often a man who has eaten a sufficient amount is not sufficiently strengthened, while another man may be strengthened by not eating, especially if his debilitation was due to surfeit. [39] We must ask too what food tastes best to the patient; somehow this brings even more benefit than the most excellent food, since he digests it more easily than what he finds disagreeable. For just as disagreeable food impairs both the function of chewing

⁵¹ ἐπισκεφθέντα I follow Gärtner in making the participle qualify ταῦτα; both Daremberg and Brock translate it as if it qualifies πρόρρησιν καὶ .. θεραπείαν, which seems unlikely to be right since both nouns are feminine.

⁵² τοῦτο μὲν γὰρ εἴρηται πρότερον ὑπὲρ αὐτοῦ Cf. §18. Brock translates 'enquiry has already been made about this', but neither the Greek nor Rufus's thought process seems to justify his choice. Gärtner agrees that Rufus is here referring to the regimen being pursued by the sick person (*ad loc.* 1962:79-80).

⁵³ See below, pp.144-145.

and that of swallowing, so too it has the same effect on digestion and nutritional distribution. [40] We must ask, as well, what is being easily excreted and what has a diuretic effect and what is provoking acidity and what is causing other problems; for these are all things that are specific to the individual and do not apply across the board. So I would also praise the physician who, in his first encounter with the sick person, does not work out the treatment by himself alone, but invites someone who knows the patient for consultation as well – preferably a physician, but if not, even a layman. He will not fail to find this advantageous.

41-43: pain

[41] How much pain attends the sickness is another thing about which we need to ask. One can indeed conjecture that someone is in pain from other signs: from groans and cries and thrashing about,⁵⁴ distress, bending of the body, the complexion, thinness, the touch of the hands; and if you wish⁵⁵ to touch ... ; for the painful part is plain immediately, and the patient himself presses the sore areas in particular; and so you will not be mistaken – even about the pains of people who don't speak – if you draw your conclusions from such things. Cries can certainly be used as a basis for recognising pain in sick people, but it is essential to ask searching questions as well; and even that is not quite sufficient for full recognition, since weakness and delicacy make many people act out pain more elaborately, one might say, than tragic actors groaning on the stage. [42] One must give careful consideration to the other factors too: whether the person is of sound mind, and vigorous, and self-controlled; such a person, at least, would not dissemble about any aspect of his sickness.⁵⁶ [43] Since pain tends to have recurrences,

⁵⁴ ῥιπτάσματος This word does not appear in LSJ. I have translated by association with ῥιπτασμός.

⁵⁵ σύ εθελῆς Gärtner argues that this indicates that the missing text meant something like 'the patient but he asks for another to touch him' (*ad loc.* 1962:84).

⁵⁶ χρῆ δὲ καὶ τὰ ἄλλα ἐπιβλέπειν Rufus emphasises that if the doctor relies too heavily on signs, or is too ready to take at face value what the patient says, he may be deceived. Instead, he must probe carefully in

we must ask about this too. For we cannot say that it is essential to enquire about the timing of other acute attacks and yet overlook that of episodes of pain.

44-45: ease of excretion

[44] There is also some value in asking about the state of the patient's bowels – whether or not defecation is easy – and the same applies to the other discharges. [45] For sweat and urine and vomit come readily in some cases and with more difficulty in others.

[46] So in the case of common sicknesses, and especially feverish ones, we must ask about these and similar things.

4.2. Wounds

46-49: animal bites

When it comes to wounds, if the wound is made by a dog, we must ask whether the dog happened to be rabid; for it makes a great difference. If it was not, a haemostatic drug or a sponge soaked in vinegar will do, but if it was then we must cauterise, no matter how small the wound may be, and apply pungent drugs, conserve⁵⁷ the wound for a long time, and administer a drink of wormwood, birthwort, buckthorn, boiled river-crabs, garlic, parsley and the root called gentian. It is also a great help if from time to time you wash it with hellebore. Unless you do all this, there is a danger of convulsions, derangement, hydrophobia and death. [47] I at any rate know a man who was bitten by a mad dog, and

an attempt to understand the patient's subjective experience, and then – Rufus recognises that the truth of a person's experience is ultimately closed to the observer – set that alongside the other things he has discovered about the patient.

⁵⁷ τήρησις Gärtner (1966:251) interprets this as a 'stark verkürzte Fassung einer häufig wiederkehrenden Formel der medizinischen Fachsprache': keeping the wound of a rabid dog's bite open for as long as possible to prevent scarring and allow the poison to be evacuated, as recommended by, for example, Damocrates ap. Gal.*de Antid.*2.1, XIV.200,11-12 K; Gal.*Sect.Int.*4, SM III.8,11-18 = I.74 K, and *Sect.Int.*8, SM III.19,3-9 = I.88 K; further references including Dioscorides and Philumenus are provided (1962:252). He translates 'Offenhalten der Wunde auf lange Zeit'.

did not take the wound seriously, despite strong encouragement from physicians as well as from his family. [48] He suffered what people suffer in that sickness, and died not much later. His wife, who had had intercourse with him when he already had the wound, and was three months pregnant, developed a fear of water herself, and in my view she would have perished in the same way if we had not told her to get rid of the embryo.⁵⁸ [49] Bites and wounds inflicted by other beasts will also do best if we enquire carefully about them. For if we devise what is suitable for each individual⁵⁹ before the *sumptōmata* attack, the treatment will be easier. Even in animal bites, however, judgement from signs is possible, even if the person who has been bitten does not speak. In the case of the dog this is not possible before the affection comes.⁶⁰

50-54: arrows and spears

[50] When men are wounded in war by arrows or spears, weapons that stick out or are lodged in the flesh will be obvious to the sight and touch; as for those that are hidden inside, if someone happens to have pulled the weapon out for the patient, we must ask if

⁵⁸ **δοκεῖ μοι ἂν ἀπολέσθαι** Gärtner (*ad loc.* 1962:93) comments that this case history, with its economic attention to key details and its lack of boasting about the successful result, is – like the Samian case reported at §§57-58 – characteristic of Rufus. See below, p.49 n.63 and below, p.107.

⁵⁹ **τὸ πρόσφορον** Cf. Arist.*EN* 1180b,10.9.15, illustrating the superior quality of individualised medical treatment: δόξειεν ἂν μᾶλλον τὸ καθ' ἑκαστον ἰδίας τῆς ἐπιμελείας γινομένης· μᾶλλον γὰρ τοῦ προσφόρου τυγχάνει ἑκαστος ('it seems that treatment in particular cases is more exactly right when each person gets special attention, since he then more often gets the suitable treatment.' Tr. Irwin 1999:169).

⁶⁰ **ἐπὶ δὲ τῷ κυνὶ** The question arises whether Rufus is contrasting a dog (which cannot speak) with a human (who can), or dog bites (on the basis that they reveal their nature before the affection develops) with other animal bites. Brock and Gärtner suggest the former ('in the case of the dog it is impossible to judge', and 'In dem Fall des Hundes aber besteht diese Möglichkeit nicht'); Daremberg the latter ('quand il s'agit de la morsure d'un chien'). Pathology supports the former interpretation, since Rufus's concern here is with the identification of rabies, which is transmitted by other beasts as well as by dogs; but the Greek is not conclusive, and the δὲ in this phrase has no corresponding μέν to help (the seven μέν ... δὲ pairs in sections 46-49 are as follows: (i) μέν line 3, δὲ line 4; (ii) μέν line 5, δὲ line 23; (iii) μέν line 6, δὲ line 7; (iv) μέν line 15, δὲ line 16; (v) μέν line 16, δὲ line 17; (vi) μέν line 18, δὲ line 19; (vii) μέν line 24, δὲ line 26). It seems more plausible that Rufus is using the dog's inability to speak as a way of underlining his message about the importance of the information that patients can supply than that he is offering a veterinary comment on the difficulty of treating rabid dogs. I have therefore interpreted τούτων (p.11, line 26 Gärtner) as referring to the whole discussion about animal bites, and the comment about the dog as making a contrast simply with the sentence that immediately precedes it. It is worth noting that *Saunders Comprehensive Veterinary Dictionary* defines a symptom as 'any indication of disease perceived by the patient and a term therefore not applicable to animals'. The definition begs a rather large question about the nature of perception, but makes an interesting point in the present context.

he pulled it out complete with its tip or only got the shaft. [51] For a buried tip might escape the notice of the most experienced person. This is why physicians give good advice when they tell soldiers to carry arrows lodged in their flesh, so that those tending them can, at the same time as using their skill to treat them, see for themselves that nothing is left in the wound. [52] It is necessary, I suggest, before treating it, to ask about ointment on the arrow. For many people have discovered poisons which they smear on their arrows, allowing even a small wound to be fatal. [53] If we know of this beforehand, we have a chance of providing some antidote for the individual poison. [54] This is a question for some prisoner of war or deserter rather than for the wounded man.

55-62: head wounds

[55] We must similarly enquire carefully about wounds in the head, especially if, with no obvious damage to the bone, the wounded man becomes unable to speak, vomits first food or phlegm and then bile, and is acutely feverish and delirious; there is a risk that the bone is broken, either at the site of the wound itself or elsewhere. [56] In other cases there is no wound at all, but the bone is broken beneath the skin, and the patient suffers as described. [57] This is what happened in the case of the Samian, at any rate. They were holding their local festival in which men stand apart and throw stones at each other.⁶¹ The man was struck during this activity, and had no obvious wound, but becomes⁶² speechless and dizzy; a little later he seemed well, but on the 20th day afterwards he begins to be

⁶¹ ἐπιχώριος ... ἡ ἐορτή Though ritual sham fights including the throwing of stones are known from other ancient cities, including Troezen and Eleusis (Paus.2.32.2; Athen.9.406d; and Gärtner *ad loc.* 1962:95), this Samian example is not otherwise recorded, according to Professor Robert Parker (personal communication, 2012); a short article is currently therefore in preparation. Similar rituals are known today in parts of India.

⁶² ἔσχεν, γίγνεται, etc. As in §29, Rufus goes in and out of the present tense, imparting narrative flavour to the case history and identifying key moments in the story. Whatever his intentions, his use of the device is not consistent enough to be regarded as particularly accomplished (though self-evidently it has attracted the reader's attention).

deranged. So I was called in.⁶³ I saw immediately that he was touching his head, trembling and delirious, and asked if he had ever been struck on the head; when they said that he had, I said confidently that his bone had been broken. [58] Then we made a large cut through the part which he was particularly touching with his hands, and found a very long fracture of the bone, which we subsequently treated as one does a fractured skull. This was what happened in that case. [59] In the case of a wound to the head one must ask carefully about the shape and size of the weapon, and how hard it was. For, from similar throws, weapons that are round, large and hard are likely to cause fractures, while those that are sharp are more likely to cause wounds. [60] We must ask, too, about the strength of the man who threw it, and how vigorously he struck, and whether the weapon caused the wound from above or when ricocheting.⁶⁴ You will find all this very helpful, or at least that it will make some difference, with regard to both obvious and hidden fractures. [61] Slingshot weapons have more force than those thrown by hand, while catapulted ones are the most forceful; so even these considerations must not be overlooked. [62] Finally we must also ask about signs consequent on the blow, which I have previously described; for if any of them occurs, we must believe there to be some damage to the bone.

⁶³ **εἰσεκλήθη** Perhaps Rufus was nearby at the time for some personal or professional reason, or perhaps he was called from Ephesus when expert help was deemed to be required; Ephesus is geographically near enough to Samos – and certainly regionally significant enough – to be an obvious place to turn to for expert medical help. Explaining his presence would have added colour to the narrative, and describing a summons from Ephesus would have added grandeur; his silence on the matter is in line with his general tendency not to write about himself; cf. Gartner (1962:93) and see above, p.47 n.58, and below, p.107. There must also be the possibility that he had merely heard of rather than personally handled the case, which, given the claim ‘I was called in’ (rather than something vaguer like ‘I know a man who ...’), would have to be counted a deliberate falsehood.

⁶⁴ **παλιμβληθέν** LSJ cites this instance only.

5. Questions concerning the locality

63-64: *Airs, waters, foodstuffs*

[63] These and others very like them, then, are the questions for the patient and those around him. There are others too that concern populations. For example, if we go to a foreign place we must find out what the waters are like and if they have any special powers, such as are frequently found, some acting on the stomach, some on the bladder, some efficacious to the digestion, some doing harm to the liver and spleen, some causing kidney- or gall-stones, and others with other effects, some bad, some good. So for example the water at Leontini in Sicily kills those who drink it, as does the water of Pheneus, in Arcadia, which is called Stygian. As for the water of Cleitor in Arcadia, anyone who washes in it is unable to bear the smell of wine. The water of Lyncestis causes intoxication, [64] while that of Arethusa in Chalcis induces gout. All the different characteristics that are found in the waters, food crops and climate in individual areas, that do not resemble the generally established characteristics, must be learned either by enquiring of local inhabitants or through personal experience over time. There is no other way to know the local disorders, and thus no other way of achieving accurate recognition; for the incalculable is a major factor in these very disorders, area by area. [65] So, for example, in the land of the Arabs we find a disorder called ‘guinea-worm’,⁶⁵ which in Greek is called ‘nerve’. [66] It is as thick as a lyre-string, and moves and turns in the flesh in a reptilian manner, particularly in the thighs and legs but also elsewhere in the body. [67] I myself saw an Arab man in Egypt with this sickness. When it was about to emerge, he developed pain and fever, and a swelling developed, like an abscess, until it came through the skin, became clammy, and putrefied. [68] He had it on his leg, but in the case of his serving girl it was on the belly, while another girl had it in the groin. [69] When I

⁶⁵ ὄφις With this sense, here only; elsewhere ‘guinea-worm’ is δρακόντιον (LSJ, ὄφις VI).

asked if the sickness was endemic to the Arabs, they said that it afflicts not only Arabs but also many foreigners who come to the country and drink the water, which they say is the principal cause. [70] You could find thousands of things like this to explore,⁶⁶ just by being keen to find out also the remedies that are specific to each place; thus the Egyptians use emetics and vomiting and enemas, while others have blood-letting, and others again have purging with hellebore.

6. Concluding remarks

[71] So now I think my idea is clear, <so far as I wanted to go>.⁶⁷ Discourse⁶⁸ is not, of course,⁶⁹ sufficient for explaining or learning everything, nor is there enough time. But the doctor⁷⁰ who grasps the essence of my thinking and bases his work on it will find in it everything he needs. [72] And if anyone says that my thinking is opposed to that of Hippocrates, who as you know⁷¹ said he had discovered an art enabling a doctor, on arrival at a new city,⁷² to know about the waters, the seasons, the condition of the inhabitants' bowels, whether they enjoy drinking and eating, what disorders are endemic there, how the women experience childbirth, and everything else that Hippocrates

⁶⁶ **ἱστορεῖν** Daremberg translates 'raconter', and Swain (2008:136) interprets it in the same way; cf. Frede (1985:xxvi). Brock and Gärtner both take it in its sense of making an investigation (Gärtner: 'erforschen').

⁶⁷ **§71** The textual corruption here left Gärtner at a loss as to Rufus's meaning (*ad loc.* 1962:102). My translation rests on Gärtner's suggestion <ἐφ'> ὅσον γ' ἐφικέσθαι <βε>βούλημαι (see *apparatus criticus*), which is persuasive in light of Rufus's tendency, in both *QM* and *On Melancholy*, to provide illustrative rather than comprehensive guidance (see below, pp.176-179).

⁶⁸ **λόγος**: Brock and Daremberg translated 'treatise' and 'un gros livre' respectively. Gärtner thought it referred to rational capacity ('der menschliche Verstand'). Haak goes for 'verhaal' ('narrative'). The suggestion 'discourse' was made by P.N. Singer (personal correspondence, 2015).

⁶⁹ **μέντοι** Emphatic rather than adversative (LSJ B.II.4.b).

⁷⁰ **τῷ ἱατρῷ** Brock makes the physician in this sentence the author rather than the reader: 'when the physician has discovered and set forth his main idea, this is all that is necessary'. My interpretation resembles those of Daremberg and Gärtner in its syntactic interpretation of the dative τῷ ἱατρῷ, but makes the physician a more active recipient of the ideas. (Daremberg: 'le principe de la connaissance trouvé et soumis au médecin renferme tout ce qui'il faut'; Gärtner: 'Die Hauptsache meines Anliegens ist gefunden und dem Arzt vor Augen geführt: Das dürfte wohl vollauf genügen'.)

⁷¹ **ὅς δῃ** See Denniston 1954:218 for the use of δῃ with relatives to emphasise 'the importance of the antecedent or its exact identification with the consequent'.

⁷² **ἀφικόμενος εἰς πόλιν ἧς ἄπειρός ἐστι** R. quotes directly from Hp.Aer.1.12-13: ἐς πόλιν ἐπειδὴν ἀφίκεται τις ἧς ἄπειρός ἐστι.

professed to find out by the art, on his own, without questioning any of the inhabitants; if anyone, citing this, finds fault with me for disagreeing with the greatest of doctors about the most important matters, this is my reply: I do not disparage any of Hippocrates' theories, but while some things certainly do get discovered by his method – things to do with the state of the seasons and the natural state of the body⁷³ and modes of life, as well as the general advantages and disadvantages of the waters and a general picture of disorders – there are other things that cannot be clearly recognised without making enquiries among the inhabitants, especially anything unusual or strange in them individually.⁷⁴ [73] I admire the man unreservedly for the cleverness of his method, by which he made good discoveries in many cases, but I urge⁷⁵ anyone who aspires to full and accurate⁷⁶ knowledge not to refrain from questioning.

⁷³ In other words: topographical features can tell you something about the physical constitution of the inhabitants, but this is not enough; universal characteristics cannot on their own provide the answer.

⁷⁴ **ἐκάστοις** LSJ II. Brock and Daremberg both apply the adjective to the places ('in each place'; 'à chaque pays'), but πόλιν is a long way back. Smith (1979:241) also translates 'in each place', but the validity of his translation is undermined by the fact that he omits to translate τὰ[ς] δὲ [δι'] ἱστορίας τῆς παρὰ τῶν ἐνοικούντων εἰς τὴν διάγνωσιν χρῆζειν. If οἱ ἐνοικοῦντες is understood collectively, to mean a population, ἐκάστοις could mean 'in individual populations'; otherwise it must mean 'the inhabitants, all and each of them severally'. My translation, 'in them individually', aims to reproduce the slight ambiguity of the Greek by not specifying a noun; Gärtner does something similar: 'manches aber von den Einheimischen für die Diagnose erforscht werden muß, besonders die Fälle wo etwas Ungewöhnliches und Fremdartiges bei den einzelnen vorliegt'.

⁷⁵ **παρακελεύομαι** Rufus uses this word on two other occasions: in §47, of relatives urging the man bitten by the rabid dog not to ignore the wound, and §51, of doctors advising soldiers not to pull weapons out of wounds. He means it to be a strong word, therefore, and one that conveys knowledgeable advice in serious circumstances.

⁷⁶ **ἀκριβῶς** a favourite word of Galen's in the context of picking out symptoms carefully, not hastily. See Ballester 1979:25 and 1979:43 n.102, citing *Praen.*14, *CMG* V.8.1.140 = XIV.671 K; *Loc.Aff.*2.10, VIII.124 K; *MMG* 1.2, XI.11 K.

Part II: Context

Chapter 1 - Introduction

Rufus of Ephesus invites attention for many reasons. Much sought after in his time for his medical skills, and for many centuries regarded as one of the great names in Greek medicine, he is today an intriguingly shadowy figure. His known corpus, though far from complete in its present form, betrays a considerable range of medical interests and expertise;⁷⁷ his geographical and historical location impart rich contextual interest; his interest in listening to the patient speaks to modern sensibilities; and his influence on the Arab and medieval European medical traditions testifies to the enduring power of his legacy. He has not, however, tended to be associated with controversy. It is probably fair to say that his general reputation is that of a competent, essentially practical physician who, despite attracting praise from Galen, was effaced by his overpowering successor.⁷⁸ Yet this unshowy, thoughtful and popular doctor did something that no-one else did, so far as we know: he wrote a treatise on the importance of questioning patients as an essential supplement to medical knowledge. The subject matter of this work, *Quaestiones Medicinales* (hereinafter *QM*), is unique in the known corpus of ancient medical writing,⁷⁹ and, of Rufus's undoubtedly prolific output, it is one of only four treatises to have remained extant in Greek.⁸⁰

⁷⁷ Abou-Aly 1992:16. See below, p.109.

⁷⁸ See for example van der Eijk 2008:159-60 and Nutton 2008, 140.

⁷⁹ Gärtner 1962:19-20 and 106; Abou-Aly 1992:192-3; cf. Jouanna 1999:135. A hypothesis advanced by both Wellmann and Gossen that two Herophileans, Callimachus and Callianax, wrote works on the same topic that have not survived is dismissed by Gärtner (1962:19-20) and von Staden (1989:478).

⁸⁰ Nutton 2008:139-40.

Though the details of his life remain largely unknown, there is no doubt about Rufus's standing in the pantheon of ancient medical authors. The compilers of the Greek medical encyclopedias of late antiquity considered him one of the pre-eminent ancient physicians: he was cited often and at length by Oribasius in the 5th century, Aëtius in the 6th, and, in the 7th, Paul of Aegina, whose *Medical Compendium in Seven Books* was for many years regarded as containing the sum of all medical knowledge. This high esteem persisted through the early Islamic period and into medieval England, where Chaucer ranked him alongside the most famous physicians of antiquity:

With us ther was a Doctour of Phisyk, ...
 Wel knew he th' olde Esculapius,
 And Deiscorides, and eek Rufus,
 Old Ypocras, Haly,⁸¹ and Galien ...⁸²

Arab physicians made extensive use of Rufus's writings, thus furnishing the basis of much of our knowledge of his work. To the 13th century Arab physician Ibn Abī Uṣaibi'a he was 'the great Rufus, hailing from the city of Ephesus', and 'in his time ... second to none in the art of medicine'.⁸³ Some three centuries earlier, Ishāq ibn 'Imrān, a court physician who seems to have treated his sultan for melancholy, pronounced Rufus's *On Melancholy* the only 'pleasing book' or 'clear treatise on this disease by any of the old authors' and praised his 'excellent and expert research on [melancholy], its symptoms and the method of treating it'.⁸⁴ Still earlier, indeed not long after Rufus's own time, Galen, a man whose references to other doctors are usually characterised more by

⁸¹ Chaucer probably refers here to either Haly filius Rodbon (Ali ibn Ridwan, fl. Cairo, C11) or Haly Abbas (Ali Abbas, C10, in south-western Persia and 'one of the three greatest physicians of the Eastern Caliphate'): see Andrew 1993:378-9.

⁸² Chaucer, *Canterbury Tales*, *Prologue*, 411 and 429-31. He continues with *Serapion, Razis, and Avicen, Averrois, Damascien and Constantyn, Bernard, and Gatesden, and Gilbertyn*, i.e. famous names right down to his own day. The list of earlier physicians is considered by Chaucerian commentators to be canonical (Andrew 1993:373-6).

⁸³ Ruf.*On Melancholy* F2.1-2. On Ibn Abī Uṣaibi'a, see Pormann *ad loc.*(2008:81).

⁸⁴ Ruf.*On Melancholy* F4.1, 3. On Ishāq ibn 'Imrān. see Pormann 2008a:14.

criticism than by praise, judged Rufus to have written ‘the best work on melancholy of the recent physicians’;⁸⁵ though to conclude from this, as some have done, that Galen was a warm admirer of Rufus’s may be an over-interpretation: as Hankinson points out, the term νεώτερος is ‘nearly always pejorative’ in Galen’s work,⁸⁶ and the praise may have been intended to be no more than relative. If imitation is the truest form of flattery, however, Galen’s action speaks louder than his words, since when it came to writing about melancholy in *On the Affected Parts* he seems to have made use of large quantities of Rufus’s work, and he also appears to have claimed at least one of Rufus’s cases as his own.⁸⁷

These bare facts alone would be enough to compel examination of *QM*’s content and provoke speculation about its original purpose. But there is more; for it is curious, to say the least, that the enquiring and ground-breaking discipline of ancient medicine produced no other such discussion. Two caveats are in order here. First, the idea that an ancient text is ‘unique’ demands qualification, since it can mean only that no other such work is extant or known of. That said, if some other work dedicated to the importance of questioning the patient did ever exist, it is surprising that there should be no mention of it elsewhere in the historical record. Secondly, it must be possible that the self-contained form in which we know *QM* does not accurately reflect its origins and that what we now

⁸⁵ τῶν δὲ νεωτέρων ἱατρῶν ἄριστα γέγραπται περὶ μελαγχολίας τῷ Ἐφεσιῷ Ρούφῳ. *Gal.At.Bil.*, V.105,3-5 K.

⁸⁶ Hankinson 1991:xxiii.

⁸⁷ On the possibility that Galen’s discussion of melancholy in *On the Affected Parts* is ‘little more than a Galenic summary of Rufus’ ideas on the topic without proper acknowledgement’, see van der Eijk and Pormann 2008:265. The Atlas patient described by Galen (*Loc.Aff.*10,VIII.190 K) was originally Rufus’s case, according to Agnellus of Ravenna (*Lectures on Galen’s De Sectis*, section 26). See Pormann 2014:652-53. Galen used the case three times altogether, the other two instances being at *Hipp.Epid.*3.1, *CMG* V.10.1.107 = XVIIA.213-4 K, and *Hipp.Epid.*6, *CMG* V.10.2.2.487,3-12. On Galen’s synthesising tendencies see Hankinson 1998:7 and, for a discussion of his compilatory and excerpting activities in the context of contemporary literary tradition, see Mattern 2008:37. On the differences between ancient and modern ideas about what we would today call plagiarism, see Long 2001:10-12 and 28-29.

regard as a stand-alone treatise once formed part of a longer work. This too seems unlikely given the structural completeness of the piece,⁸⁸ but, even if it were true, the amount of attention it gives to the topic would still be unparalleled. There are odd remarks in other works, such as that of the Hippocratic author of *Precepts* who urged the doctor not to ‘hesitate to inquire of laymen, if thereby there seems likely to result any improvement in the timing of treatment’,⁸⁹ but only Rufus, it seems, considered questioning the patient a topic worthy of treatment at any length.

The physician and bio-ethicist Linus Geisler has written:

I have spoken rather than listened. I have been given wrong answers because I have not asked the right questions. I have misunderstood my patients because I have not recognized or have confused the various messages that they have sent to me. ... I have treated patients as if they were ‘difficult’. ... I have not understood that reality for the patient was not identical to that which I believed to be true. ... I am now aware that the right dialogue between doctor and patient can bring about almost anything, but that incorrect dialogue achieves almost nothing.⁹⁰

Geisler goes on to describe his realisation that ‘the good question is already part of therapy’ and the benefits that this brought to his own practice of medicine.⁹¹ Kirsti Malterud, a Norwegian professor of general practice, has similarly described how her practical experience as a family physician taught her that ‘the clinical problems presented by my patients were noncompatible with the “authorised” medical knowledge’.⁹² Eighteen hundred years earlier, Rufus asserted that the physician’s knowledge could not be fully effective unless supplemented by information gained through questioning αὐτὸν τὸν νοσοῦντα;⁹³ intermediaries might have to be involved if for some reason the patient

⁸⁸ See below, pp.133-135.

⁸⁹ μὴ ὀκνεῖν δὲ παρὰ ἰδιωτέων ἱστορεῖν, ἥν τι δοκῇ συνοίσειν εἰς καιρὸν θεραπείης (Hp.*Praec.*2 = IX.254.4-5 L; tr. Jones, Loeb I.315, adapted).

⁹⁰ Geisler 1991:1.

⁹¹ Geisler 1991:8.

⁹² Malterud 1995:184.

⁹³ QM 9.

was unable to communicate, but Rufus makes it clear that this is very much a second-best option. Despite the gulf of culture, time and space separating Rufus from Geisler and Malterud, and mindful though we must be of the risk of reading the past through anachronistic modern perceptions, it is not inconceivable that they are dealing in essentially the same idea. Vivian Nutton is right to warn that Western patterns of medicine and healing cannot be projected backwards to serve the needs of modern hypotheses,⁹⁴ but there is no reason not to use the preoccupations, experiences and insights of our own generation as a prompt for new questions to put to ancient material, and these may yield insights with potentially diachronic relevance.⁹⁵

QM has in fact received very little scholarly attention. This is surely a surprising fate for one of only a handful of extant works by one of the most highly regarded physicians of the ancient world. The neglect cannot be blamed on doubts about authenticity: the attribution to Rufus is considered secure.⁹⁶ Nor is it due to transmissional problems, or shortage of editions: two good manuscripts exist, one clearly derived from the other, and Charles Daremberg's 19th century *editio princeps* was available for the best part of a century before Gärtner produced his authoritative edition in 1970.⁹⁷ There is perhaps another reason. Initiatives to improve the delivery of care routinely attract less attention and fewer resources than pushing back the frontiers of medical knowledge;⁹⁸ and something similar applies to the study of medicine. Richard Zaner sums the point up neatly:

⁹⁴ Nutton 2004:16.

⁹⁵ The preoccupations of patients in the ancient world might not, in any case, have been so very different from those of their modern counterparts. See Mattern 2008:162.

⁹⁶ Gärtner 1962:14; Daremberg (1876:xxvi) points out that his name appears on the manuscript.

⁹⁷ Daremberg's edition appeared in 1876 as part of his comprehensive collection of Rufus's treatises and fragments; Gärtner's was published first in 1962 as *CMG Supplement IV* and again, with revisions, by Teubner in 1970.

⁹⁸ See for example Westfall et al. 2007.

While it is true that medicine's centrepiece, so to speak, is the clinical event, ... very few of those who have written about medicine focus on the encounter, the meeting of doctor and patient, itself. ... medicine has only rarely been apprehended in light of the ontological and most important epistemological themes which, more than anything else, reveal what medicine is.⁹⁹

The study of ancient medicine is not immune from this tendency; indeed a noticeable feature about the field, until fairly recently, has been the comparative shortage of work focusing on patients' experience, their perspectives on health and sickness, and the transactional aspects of the clinical encounter. Ballester puts it thus:

One of the themes least studied by medical historians is that of medical practice ... during the first two centuries of our era. We know of names, schools of thought, tendencies and so forth, but we hardly know of the realities of medical praxis as it was in actual practice: what doctors, as healers, did faced with patients and to their patients.¹⁰⁰

The under-studied status of Rufus's treatise is a case in point.¹⁰¹

QM is usually described in terms that locate it in the realm of the procedural or the transactional: 'a short treatise explaining how a physician should take the patient's history',¹⁰² for example, or 'a handbook for doctors on the questions to ask their patients' that offers a 'rare glimpse into the bedside manner of ancient doctors'.¹⁰³ Certainly what there is of Rufus's work suggests that he was not an overtly philosophical author; he is, to quote Philip van der Eijk, 'generally regarded as a thoroughly practical physician and not known for any explicitly philosophical or theoretical interests'.¹⁰⁴ Yet there is, as van

⁹⁹ Zaner 2000:vii.

¹⁰⁰ Ballester 1979:13. Cf. van der Eijk 2005:1-8; Borst (2015:61) comments: 'With only a few exceptions, we know very little about the actual interaction between doctors and patients in the past', adding that in her view it was a relationship that was 'particularly important in the prebacteriological era'.

¹⁰¹ As Haak observes (2013:265), *QM* received no attention before Daremberg edited it, together with the rest of Rufus's then known works, in 1879. The only detailed scholarship on the treatise to date is Gärtner's edition (1970, superseding his 1962 edition) and commentary (1962); the latter includes a translation into German.

¹⁰² Pormann 2008:108.

¹⁰³ Nutton, 'Rufus [5]', in *Brill's New Pauly* Vol.12:756.

¹⁰⁴ Van der Eijk 2008:159; cf. Haak 2013:264.

der Eijk goes on to concede, evidence that he was both learned and well acquainted with contemporary and prior medical literature, interested in and influenced by Aristotelian thinking, celebrated for his treatise on melancholy – a topic where philosophy and medicine explicitly overlap – and unafraid to go out on a limb in formulating a perspective that seems to be uniquely his. None of this should surprise us; on the contrary, the chronological and cultural circumstances of Rufus's life¹⁰⁵ mean that it would be far more surprising if a man of his class had not had wide-ranging intellectual interests and accomplishments.

What, then, was Rufus trying to achieve in *QM*? Was his objective simply to impart the necessary techniques, or was he tackling a point of principle such as the place of questioning in medical practice? Despite the received wisdom that he was a doer rather than a thinker, Rufus's writing cannot be free of the influences of contemporary thought, any more than his clinical work can have been. His 'tacit knowledge', that set of influences which according to Michael Polanyi informs and helps to shape our understanding of the world and the work we do,¹⁰⁶ will have reflected the debates *du jour*, such as the relationship between philosophy and medicine, the proper preoccupations of a serious physician, and the respective roles of theory and experience in the creation of medical knowledge. In the circles in which he moved, there will have been both explicit and tacit discourse that will, whether consciously or otherwise, have coloured his practice and his writing.¹⁰⁷ Any line of thought against which he might have wished to argue will

¹⁰⁵ See below, pp.109-110.

¹⁰⁶ Polanyi's theory, which combines functional and phenomenal aspects, is that 'we know more than we can tell' (1967:4). See especially his Chapter 1, 'Tacit Knowing' (1967:3-25), and cf. Raad 2008:155; Malterud (1995:188) glosses tacit knowledge as 'the fact that we know more than we can tell'.

¹⁰⁷ On Rufus's cultural milieu, see for example Nutton 2008:141-143; Swain 2008:114-117; and Ruf. *On Melancholy* FF68, 70, 71, with Pormann *ad locc*.

to some extent be detectable from this general discourse. Here, as in so many matters concerning ancient medicine, Galen proves instructive. Not only do his writings, which were to dominate and shape medical thinking and practice for the best part of two millennia,¹⁰⁸ betray a somewhat different attitude from Rufus's to dialogue with patients, but he explicitly articulates the view that 'things that can be known even by laymen' are incompatible with the art of medicine and out of place in a medical treatise.¹⁰⁹ This sharp conceptual distinction between what we might today call 'expert' and 'common' knowledge is of a piece with the competitive intellectualism of the period, suggesting that circumspection on the part of a doctor about information acquired from patients might not have seemed incongruous at the time. In this thesis I argue that Rufus articulates a view that is conceptually alternative, in which supplementing medical observation and theory with information acquired from patients (or, if necessary, intermediaries) is an essential characteristic of a fully effective doctor.

This is, then, a thesis about Rufus's ideas, not his life. The latter is not well documented and, though I shall, for contextual purposes, provide a brief review of the facts, such as they are – as well as the rather more numerous hypotheses – I have no aspiration to add to the sum of that knowledge, nor shall I be arguing the case for any particular biographical or bibliographical theory. The claim that I make is a philosophical one. My thesis is that, in *QM*, Rufus articulates an idea that reflects a profound universal truth about the medical art: namely, that the aim of medicine¹¹⁰ cannot be achieved through

¹⁰⁸ Galen's long influence on medical knowledge and training is summarised by Siraisi (1990:5-6) and treated fully by Temkin (1993, especially Chapters II and III, pp.51-133).

¹⁰⁹ See below, pp.160-161.

¹¹⁰ Nordin defines the aim of medicine as 'aiding the help-seeking patient with his health problems' (2000:297), and argues that this holds true for both doctors and patients, and across different cultures and different periods (1999:106). Other teleological definitions of medicine include Pellegrino's (1976:15), 'cure of illness or promotion of health'; Stoeckle's (1987:1), 'patient care'; and Schaffner and Engelhardt's

medical knowledge alone but requires recognition that the patient is an essential partner in diagnosis and treatment decisions. First, I argue that this is the idea behind *QM*, and that his repeated impassioned assertion that the doctor cannot know enough on his own may be due to the failure of others to share his view. Next, I address the striking fact that *QM* betrays no concern at all about something that Galen and other ancient doctors found deeply troublesome: disobedience, or failure to follow doctors' orders. It is risky, of course, to make an argument from silence, but the issue was, as we shall see in Chapter 6, a significant one, and a number of medical writers including Galen connected it with the nature of the doctor-patient dialogue; it is, then, barely conceivable that a work focusing on the importance of that dialogue could have simply overlooked it by chance. Instead, I suggest, Rufus did not see a need to address it; in other words, the omission is significant. I then quote research published by the World Health Organization (WHO) in 2003, looking at patient compliance world-wide, which suggests that one factor universally affecting the likelihood of patients carrying out an agreed course of action was the quality of their relationship with the doctor. It seems, then, that, though the concepts and even the experience of 'health' and 'sickness' are culturally conditioned, the quality of the relationship between healer and sufferer may be a universally constant factor in achieving effective therapy. The cross-cultural universalism revealed by the WHO report may, in other words, be not simply horizontal (global) but vertical

(1998:section 3, 'Models of medicine'), 'helping the patient with the care of their health'. Cf. *QM* 1, where Rufus implies that diagnosis and treatment encompass the doctor's job. For the author of *On the Art*, medicine is defined as τὸ δὴ πάντα ἀπαλλάσσειν τῶν νοσεόντων τοὺς καμάτους καὶ τῶν νοσημάτων τὰς σφοδρότητας ἀμβλύνειν, καὶ τὸ μὴ ἐγχειρεῖν τοῖσι κεκρατημένοις ὑπὸ τῶν νοσημάτων, εἰδότας ὅτι ταῦτα οὐ δύναται ἱητρικὴ (*Hp.de Arte*.3 = VI.4-6 L; 'to do away with the sufferings of the sick, to lessen the violence of their diseases, and to refuse to treat those who are overmastered by their diseases'; tr. Jones, Loeb II.193). Galen, explaining the purpose of his work *On the Therapeutic Method*, declares it to be 'nothing other than what we have frequently said already in the preceding pages, that the first and most particular concern of doctors, indeed the thing which is pretty well the defining feature of their business, is the removal of illnesses' (οὐκ ἄλλο τοῦ πολλάκις ἤδη καὶ πρόσθεν εἰρημένου, τοῦ πρῶτόν τε καὶ μάλιστα τοῦτο σπουδάζειν τοὺς ἰατροὺς, καὶ τοῦτο σχεδὸν αὐτῶν ἔργον ὑπάρχειν ἴδιον, ἐκκόπτειν τὰς νόσους. *Gal.MM* 2.3, X.92 K; tr. Hankinson 1991:46); cf. *Cur.Rat.Ven.Sect.*4, XI.259,3-6 K; *Thras.*5, *SM* III.36 = V.810 K.

(diachronic) as well. Exploring whether or not, or to what extent, that is true is beyond the scope of this thesis but may be a valuable topic for further research.

I have no wish to over-interpret Rufus, to lionise him, or to fall into the trap of simplistically reconstructing ancient doctors in images conformable with the prejudices and preferences of our own culture. The risks inherent in trying to understand another society from outside, which beset all historical and anthropological enquiries, are paradoxically all the greater when the enquiry focuses on territory with which we feel some affinity – a universal human attribute like health – as opposed to what is clearly alien. But the correct response to this kind of risk is alertness rather than paralysis; to quote G.E.R. Lloyd, it ‘must always be assumed in any discussion of the ancient world ... that some progress towards understanding is possible, even if at a quite modest level and subject to the reservations implied by ... problems of interpretation’.¹¹¹ The fact is that no other ancient doctor (so far as we know) dedicated a treatise to the dialogue between doctor and patient; and my analysis of *QM* finds in that work a paradigm of the doctor-patient relationship that differs in important ways from the one about which we have most evidence: Galen’s. The significance of the difference lies not so much in what it tells us about Rufus and Galen as individual physicians as in the faultline it reveals in the substructure of assumptions about the medical encounter in their culture, and that is something that, with all due caution observed, merits our thoughtful attention.

¹¹¹ Lloyd 1999:2; see also Tecusan 2004:36.

Chapter 2 – Theoretical and conceptual framework

Among the major questions facing philosophers of medicine are issues about the meaning, nature and causation of health and disease, the origins, nature and use of medical knowledge, and the structure and conduct of the patient-doctor relationship.¹¹² These metaphysical, epistemological and ethical inquiries relate to practical and political challenges such as how to judge whether or not a particular physical or mental state constitutes a departure from a given norm, how to conceptualise and talk about disease, the dilemmas arising out of the need to apply universal rules to individual cases, the balance of individual and community benefit in health care decision making, and the distribution of power between experts and lay people – questions that range widely across the field of modern medical discourse and that, when examined historically or cross-culturally, offer almost unparalleled scope for comparative insight, because of the shared human experience they reflect. Health affects everyone, wherever and whenever they live, at the most intimate levels of their existence, and the pursuit of strategies to preserve it is a preoccupation common to humanity;¹¹³ all societies resort to some form of medicine,¹¹⁴ and so medicine offers unique insights into what Edmund Pellegrino calls ‘man’s encounters with his body, his world, and his psyche’.¹¹⁵ At the heart of medicine lies the encounter between healer and sufferer. *QM*, with its focus on the dialectic of that encounter, thus offers a direct line of sight into the heart of ancient medicine and enables

¹¹² See Huneman et al. 2015:viii-ix; Marcum [no date]:sections 2, ‘Epistemology’, and 3, ‘Ethics; Schaffner and Engelhardt 1998:section 1, ‘Definition and scope’. On the unresolved debate as to whether philosophy of medicine constitutes a distinct discipline, see Schaffner and Englehardt 1998: section 6, ‘Relation of philosophy of medicine to philosophy of science’, and, for a fuller discussion, Pellegrino 1976:13-18.

¹¹³ Sontag 2002:3 grimly observes: ‘Everyone who is born holds dual citizenship, in the kingdom of the well and in the kingdom of the sick’. See also Radley 1994:1, and cf. *Gal.Opt.Med.Cogn.1.1*, *CMG Suppl.Or.IV.41*.

¹¹⁴ Eisenberg 1977:13-14, citing Leslie 1976.

¹¹⁵ Pellegrino 1976:8; cf. Porter 1985:192: ‘Health is the backbone of social history ... the sick cannot possibly be regarded as a class apart’.

a unique perspective on the philosophical, sociological and historical questions that that entails.

This is a big claim for what has hitherto been regarded as an essentially practical treatise of only marginal scholarly interest. Before we proceed to examine it, two important assumptions that underlie the arguments to be presented in this thesis need to be introduced, and some deceptively simple concepts need to be explained. It is worth stating at this point that the word ‘health’, unless qualified by an adjective limiting its scope, is to be understood in its absolute sense of soundness of condition¹¹⁶ (however one chooses to define that, which we will come to shortly). When qualified by an adjective the word will signify the general condition of body or mind, which may be good, bad, delicate, weak, fluctuating, and so forth.

2.1. The meaning of health and sickness

My first underlying assumption is that health and sickness mean different things to different people. They do not have fixed or predictable meanings; on the contrary, they are, for any practical purpose, notoriously difficult to define.¹¹⁷ I propose two principal reasons for this, the first being that they are to a large extent culturally determined. How we understand them as concepts, and how we experience them as phenomena, are what Roy Porter calls ‘constitutive parts of whole cultural sets’.¹¹⁸ According to Edmund Pellegrino,

In every culture, medicine rests on a substructure of concepts that determine its character; that is to say, its method and practice as well

¹¹⁶ See *OED* s.v.

¹¹⁷ On defining disease, see for example Sontag 2002; Porter 1985; King 2005a; Boyd 2000; Lloyd 2004. A good short summary of the different positions and arguments is given by Emson (1987).

¹¹⁸ Porter 1985:193. See also Kleinman, Eisenberg and Good 2006:141 and Stacey 1988.

as its ethos, ethics and ideology. These are the ideas used to justify the expectations and behaviour of physicians, patients, and society. They are the source, too, for an idea or image of man which inevitably flows from medicine to color the whole of culture.¹¹⁹

Among the main influences on Pellegrino's 'substructure of concepts' must be how a society conceptualises health and sickness. This means that to understand the 'expectations and behaviour of physicians, patients and society' we need to be alert to the various connotations that health and sickness may have in the culture under scrutiny. For example, in Western cultures these concepts are very often imbued with ideas about morality. A quick idea of the extent to which the use of the English language reflects this association can be gained from glancing at the ways in which dictionaries tell us they have been used. In the *Oxford English Dictionary*, the word 'sick', for example, provides metaphors for spiritual or moral weakness and corruption through sin or wrong-doing, and can signify repugnance and disgust, corruption and despoilment, and, when applied to humour, 'amusement by reference to something thoroughly unpleasant'.¹²⁰ 'Health' can signify 'spiritual, moral or mental soundness or well-being';¹²¹ while 'disease' signifies among other things 'derangement' and 'depravity' of 'mind, disposition or the affairs of a community', and 'an evil affection or tendency'.¹²²

Some kind of association between health, sickness and morality is common in Western cultures, but its precise expression is subject to much variation, making the decoding of allusions a delicate business. Disease as a punishment for wrongdoing, for example, may result from deliberate transgression, as when Apollo brings down plague on the Greeks

¹¹⁹ Pellegrino 1976:7.

¹²⁰ OED s.v., A3, A4.a-b, A7.a, A7.f.

¹²¹ OED s.v. 4.

¹²² OED s.v. 3.

at Troy as retribution for Agamemnon's dishonouring of Chryses,¹²³ or from unwitting infringement of moral laws, as in the pestilence endured by Thebes thanks to the presence of 'a pollution nurtured in this country'.¹²⁴ Sickness may be a vehicle of moral decay, as in Thucydides' account of the plague in Athens,¹²⁵ or a metaphor for guilt, as in the Church of England's General Confession: 'We have left undone those things which we ought to have done; and we have done those things which we ought not to have done; and there is no health in us'.¹²⁶ As Susan Sontag argues in *Illness As Metaphor*, the 'idea of the morbid' changes with time and culture,¹²⁷ and the gradations may be very precise; she draws a contrast, for example, between the romantic glamour which the 19th century imagination conferred on tuberculosis, with its etherealising and individualising qualities, and the squalid universalism of epidemic diseases such as cholera.¹²⁸ Disease may even represent a sort of state of grace; using the example of tuberculosis again, Sontag notes its Janus-like ability both to arrest the development of sexuality altogether (in the case of child fatalities) and to absolve adult patients of its undesirable aspects by deflecting blame for the associated sins onto the patient's 'objective, physiological decadence'.¹²⁹ Sickness may be regarded as something that one has brought on oneself through moral corruption or failure to take evasive action – which can in itself amount to a blameworthy failure of will.¹³⁰ Health, by contrast, may be equated with particular types of virtue; thus the

¹²³ *Il.* 1.9-12.

¹²⁴ μῖασμα χώρας, ὡς τεθραμμένον χθονὶ / ἐν τῇδ'. *Soph.OT* 97-98.

¹²⁵ *Thuc.* 2.52.3-53. See also Sontag 2002:42 on Boccaccio's account of how plague undermined Florentine morals in 1348.

¹²⁶ Church of England, *Book of Common Prayer*, General Confession. Cf. St Paul's advice to the Corinthians that their unworthiness is the reason why 'many are weak and sickly among you' (1 Cor. 11.29-30).

¹²⁷ Sontag 2002:20.

¹²⁸ Sontag 2002:38.

¹²⁹ Sontag 2002:26.

¹³⁰ Sontag cites Mme de Merteuil's smallpox in Laclos' *Les Liaisons Dangereuses* as an example of disease as punishment (2002:44). On illness as a manifestation of weakness of will, see *id.* 58; and see below, pp. 234-235.

Victorian concept of muscular Christianity aligned physical health with moral standards: ‘games conduce, not merely to physical, but to moral health’, as Charles Kingsley put it.¹³¹ To the later inheritors of this tradition, too great an interest in one’s state of health could tip over into distasteful hypochondria, as witness the response of many 19th and 20th century scholars to Aelius Aristides’ detailed accounts of his chronic illness.¹³²

Culture can profoundly influence how we judge sick people and how we experience sickness ourselves. The same 19th century culture that attributed such blameless angelic purity to sufferers of tuberculosis also applied intense social stigma to what is after all just another individualising bacterial disease, leprosy.¹³³ Cultural rules dictate whether the sick are expected to ‘grin and bear it’, to submit to things beyond their control, or to search every possible avenue for ways of taking control. Indeed the desirability of taking control permeates much of the rhetoric of the self-management of sickness in modern Western culture; yet Sontag warns that this can cause those who nevertheless succumb to become vulnerable to accusations of moral insufficiency.¹³⁴ Individual subjective perceptions of distress can be influenced by cultural factors to a quite remarkable degree: Eisenberg cited three different studies showing ‘strikingly different’ patterns of complaint in people of different cultural backgrounds who experienced ‘similar degrees of organ pathology’.¹³⁵ That said, individual experience is also coloured by sensations and emotions that can be taken to be universal, such as pain, fear and uncertainty.¹³⁶ Thus

¹³¹ Kingsley 1887:86.

¹³² The varying reception of Aristides’ *Hieroi Logoi* provides a neat example of how contemporary morals influence perceptions of sickness (see below, pp.260-261).

¹³³ The difference in response cannot be attributed simply to the physically repellent nature of leprosy, since, as Sontag points out, TB had its own well attested disgusting characteristics such as foul breath (2002:30-31).

¹³⁴ Sontag 2002:48.

¹³⁵ Eisenberg 1977:11. See also Lloyd 1999:2, emphasising ‘the crucial importance of the distinction between “actor” and “observer” categories’ in any such discussion.

¹³⁶ Cf. Stacey 1988:2-3.

an ancient inhabitant of Asia Minor suffering from malaria probably thought he had quartan fever that would be relieved by having the doctor re-balance his mixture;¹³⁷ his explanatory and therapeutic models were different from ours, but his human response was surely one that we would recognise, as witness the Hippocratic patient who, experiencing an ultimately fatal fever, fell into a depression and despaired of herself.¹³⁸ As Keith Hopkins has shown, the fact of living in a world where sudden and catastrophic illness was common did not provide immunity from the pain of loss.¹³⁹

Appreciating the meaning of sickness in another culture, then, requires the ability to penetrate and differentiate between a variety of mythologies as well as actual manifestations of disease. Failure to do so can cause lasting misunderstanding, as a western doctor working among the Zulu in 1940 discovered when he lost all credibility for a while by explaining the bacterial transmission of TB in a way that created the impression that he was attributing inappropriate powers to the carrier.¹⁴⁰ It is also crucial to be aware that, as Kenneth Boyd has pointed out, although a society can be taken to have ‘a common core of ideas about what disease is or health is’, in practice individuals make different judgements about what belongs in those categories.¹⁴¹ For example, in July 2014 the English National Health Service decided to offer weight reduction surgery to obese adults, and in so doing unleashed a storm of controversy; the government assumed obesity to be a disease worthy of treatment at public expense, while many public

¹³⁷ On balance in ancient medicine, see below, pp.112-116.

¹³⁸ δυσθυμία, ἀνεπίστωτος ἐωυτῆς εἶχεν Hp.Epid.3, I, case 6 = III.50.10 L, Loeb I.230. For the concept of explanatory models, see below, pp.86-88.

¹³⁹ Hopkins 1983:224-5.

¹⁴⁰ Stacey 1988:20.

¹⁴¹ Boyd 2000:12.

and individual commentators and patient groups, saw it as the consequence of individual gluttony and therefore undeserving of public funding. Comments such as

The general public will see [obese people's] problems as self-inflicted. They will not have sympathy with overweight people getting expensive surgery on the NHS when people are being denied cancer drugs and other treatments¹⁴²

reflect both the lack of a commonly agreed concept of disease and the way that morality bleeds into health policy debates and causes individuals to adapt their own personal concepts of health and sickness to suit different circumstances: it would be hard, on any definition of disease, to argue that being grossly overweight was a healthy state, while the choice of cancer treatment as a comparandum highlights the lack of similar outcry about cancer treatment for smokers, who apparently merit different judgement for what is arguably an equally self-inflicted disease. This episode illustrates both the need for public institutional definitions of health and the difficulty of arriving at such definitions.

The other major reason that health and sickness are hard to define is the multiplicity of perspectives from which they are perceived and interpreted. The words themselves represent both the subjective experiences of individuals and objective judgements made by others. Their meanings are not fixed in the way that, for example, the meanings of 'height' or 'weight' are fixed; instead, like 'tallness' and 'heaviness', they are essentially relative concepts. They are also deeply personal: as Nietzsche observed in the course of rejecting the concept of physical and psychic normality,

there is no health as such, and all attempts to define a thing that way have been wretched failures. Even the determination of what is healthy for your *body* depends on your goal, your horizon, your energies, your

¹⁴² Roger Goss of Patient Concern, quoted in *The Times* online, 10th July 2014 ('Obese will get free weight-loss surgery on the NHS'. Available at <http://www.thetimes.co.uk/tto/health/news/article4144537.ece>. Accessed 16th December 2015).

impulses, your errors, and above all on the ideals and phantasms of your soul. Thus there are innumerable healths of the body.¹⁴³

Different cultures and medical systems attach varying amounts of weight to the subjective and the objective – the actor and the observer perspectives. For example, Eastern medicine systems, with their holistic methodologies, emphasise subjective experience as essential to both understanding and ameliorating sickness, while Western biomedicine, with its biological basis and high technologies, tends to privilege objective judgement. The objective orientation of Western medicine, often ascribed to the Cartesian disjunction of mind and body, has been critiqued – both theoretically, by thinkers as weighty and diverse as Foucault, Illich, Pellegrino, Eisenberg, Beveridge and others, and empirically, by modern patient organisations – for its mechanical concept of the body and its construction of the patient as simply a conglomeration of symptoms, stripped of humanity, with accompanying diminution in and respect for patients and their experience.

It was in the light of this dichotomy between ‘professional and popular ideas of sickness’, and arguing that the Cartesian disjunction, originally so liberating, had ‘caused soul or mind to recede so far into the background of contemporary medical thought as to yield so narrow a perspective on problems of patient care as to seriously hamper the physician’s efforts to provide that care’, that Eisenberg formulated an important conceptual distinction:

patients suffer ‘illnesses’; physicians diagnose and treat ‘diseases’. ... illnesses are *experiences* of disvalued changes in states of being and in social function; diseases, in the scientific paradigm of modern medicine, are *abnormalities* in the *structure* and *function* of bodily organs and systems.¹⁴⁴

¹⁴³ Nietzsche 1974/1887:176: III.120.

¹⁴⁴ Eisenberg 1977:11. Eisenberg uses the example of asymptomatic hypertension to illustrate the point that ‘disease may occur in the absence of illness’, and only the appearance of acute symptoms may cause the person to ‘become a patient and agree with his doctor that he is sick; even then the agreement may be

In practice this means, as Helen King puts it, that ““disease” conventionally refers to symptoms that can be objectively measured or seen, while “illness” represents the patient’s feelings about the significance of the symptoms extending to their moral and social implications’.¹⁴⁵ The two perspectives – both of them ‘culturally specific’, in King’s view – may deliver radically different opinions of the same situation. For example, someone with a respiratory condition might be judged by a doctor to be unhealthy (where health is absence of disease) on the grounds of poor bronchial function and consequent risk of hospitalisation, but judge herself to be healthy (where health is absence of illness) on the grounds that she is able to do everything that is important to her without noticeable impediment.¹⁴⁶ Both judgements employ normative thinking, though on different dimensions: the doctor’s judgement uses population norms, such as hospitalisation data, alongside objectively measurable individual norms such as peak flow readings,¹⁴⁷ while the patient’s judgement is based on a subjective personal norm: the ability to participate in valued activities. In the latter scenario the patient transcends the theoretical norm by creating her own norm. As Canguilhem argued, a person ‘feels in good health’ when he or she feels ‘more than normal’, that is ‘normative, capable of following new norms of life’.¹⁴⁸ It must be added that objective judgement is not the preserve of professionals alone: friends and family, for example, may observe changes in social or physical

limited to a common perception that a *problem* exists which each is likely to formulate in quite different terms’. See Cutter 2003, 1-3 for an informative summary of varying positions as to the role of biology in definitions of disease.

¹⁴⁵ King (ed.) 2005:5; cf. Helman 1985:293, with a rich list of further references.

¹⁴⁶ Gradual deterioration in a chronic condition is often imperceptible to the patient, so that objective measurement of vital functions can be essential to pre-empting a medical emergency; on the other hand, the patient’s subjective assessment of his or her own ability to participate in valued activities is crucial to pitching therapy at a safe and appropriate level. On health as the opposite of illness, see King 2005a:6. On illness in the absence of disease, and vice versa, see Radley 1994:4.3-4.

¹⁴⁷ Peak flow meters track patterns of airway function over time. They are designed for home use to allow individual self-monitoring, but this example assumes the common scenario of routine neglect of the meter and over-reliance on subjective criteria. Willingness to combine the subjective and the objective is a quality that is often wanting in patients as well as in doctors.

¹⁴⁸ Canguilhem 1978:117.

function of which the subject has been unaware; but however close these other observers may be, only the patient knows his or her own subjective norm.¹⁴⁹

There are many complex issues surrounding any attempt to define disease, including whether it exists at all;¹⁵⁰ whether disease is by definition physical, so that the idea ‘mental disease’ is a misconception;¹⁵¹ what aspects of human functioning and behaviour a society chooses to label as disease;¹⁵² whether disease is an entity or consists in deviations from physical norms, and if so how those norms are set; and so on. Stimulating discussions of these and related questions can be found in, for example, Cutter (2003) and Reznek (1987). In a useful summary of the different philosophical approaches, Cutter distinguishes three main sets of presuppositions about the character of disease: metaphysical (what disease is), epistemological (how we recognise it) and axiological (whether or not defining disease requires situating it in any discussion of values).¹⁵³ Metaphysical presuppositions include ontological and physiological concepts of disease – that is, the idea that disease is a distinct entity in itself, and the idea that it consists in deviations from given physical norms. Epistemological presuppositions concern whether it is reason or sensory experience that underpins knowledge of disease, a debate that raged in antiquity. The axiological debate asks whether disease concepts can be value-neutral (asking merely whether or not typical species functions are being satisfactorily

¹⁴⁹ See for example *QM* 17, 23, and discussion below, pp.198-212. As Rufus implies when he warns against relying on σήμεῖα (see below, pp.166-168), objectively measurable phenomena may have to be relied on, if circumstances prevent discussion with the patient, but they are not infallible – see King (ed.) 2005:5 and 7; cf. Kellert 1976:225 on the ‘tremendous differences ... between the universal medical criteria used by the examining physician and the relativistic sociocultural standards employed by lay people to identify the presence of illness’.

¹⁵⁰ Illich, for example, claims that ‘all disease is a socially created reality’ (1976:172).

¹⁵¹ See for example Szasz 1962, 1972, and 1974:esp. 87-105; also Reznek 1987:13-14, on the anti-psychiatry movement sparked by the writings of Szasz.

¹⁵² See for example Reznek 1987:2-11.

¹⁵³ Cutter 2003:4-5. These categories are not of course mutually exclusive, though the oppositions within them are. We can, and do, think about disease metaphysically, epistemologically and axiologically all at the same time.

undertaken) or are understandable only in normative or evaluative terms (as a disvalued state of affairs), and, if so, whether the values that frame disease are universal (as value objectivists maintain) or specific to individuals and cultures (as value subjectivists claim). Cutter also points to the difference of view between contextualists and relativists. Contextualists, Cutter explains, argue that ‘disease is a function of specific thought-styles and thought collectives’ and do not believe a single definition of disease to be feasible because the boundaries between different ‘thought collectives’, e.g. medical scientists, health professionals and patients, cannot be crossed;¹⁵⁴ this has raised the counter-argument that contextual definitions of disease risk being fatally relativist.¹⁵⁵ This tension is particularly relevant given the historical nature of this enquiry.

Cutter freely acknowledges that her work tends to proceed from the standpoint of the clinician, because clinicians have written more about the questions she addresses than patients have, and that ‘more work is needed from the perspective of patients’.¹⁵⁶ In this, her field parallels our evidence from Greco-Roman antiquity, the vast majority of which was written by doctors.¹⁵⁷ For the purposes of this thesis I make the assumption that particular manifestations and experiences of sickness are indeed culturally and socially constructed – and that therefore as we are addressing issues of health and disease in an alien culture we need to be aware of that – but that bodily and psychic pain are constants of the human condition, and it is those discomforts that I choose to call (depending on the perspective from which they are being discussed) ‘disease’ or ‘illness’.¹⁵⁸ My interest is in how individuals claiming to be able to bring relief in a professional capacity

¹⁵⁴ Cutter 2003:5.

¹⁵⁵ See Rezneck 1987.

¹⁵⁶ Cutter 2003:12.

¹⁵⁷ See below, pp.96-97.

¹⁵⁸ I make the assumption that a degree of subjective framing of disease is a cross-cultural constant, even though its precise articulation may vary considerably between societies and individuals.

(‘doctors’, whether qualified or otherwise accredited or not) to those suffering such discomforts (‘patients’) constructed themselves and their patients, and what effect that had on the success of the treatment provided. Questions about the definition of disease may arise in the course of the discussion but are not its central concern.

It will be seen, then, that interpreting discussions of health and disease as perceived and understood in other cultures requires allowing for multiple viewpoints: the author’s, the reader’s, those of any doctors, patients and other lay people involved, and any general assumptions deriving from the cultures of all those parties. Understanding health and sickness in a space so remote from us as the Greco-Roman world is particularly challenging because the nature of our evidence is so one-dimensional. Material evidence allows us to imagine and shudder at procedures we are glad not to have to endure: rusty forceps, saws and scalpels that must have given countless microbes easy passage into wombs, stumps and wound sites; fearsome looking vaginal and rectal specula; levers for manoeuvring fractured bones into position and decaying teeth out of painful jaws.¹⁵⁹ These things tell us that disease was something to be fought with a battery of weapons – the doctor’s armour in the martial combat conjured up by various Hippocratic authors.¹⁶⁰ But the same is true today – the technology has merely got smarter – and while these items may indicate what techniques doctors employed, as well as suggesting something of the danger and discomfort involved in consulting a doctor, they do not convey anything of the meaning of health and disease apart from suggesting that people had good reason to prize the former and fear the latter.

¹⁵⁹ Museum collections worth seeing include those of Ephesus and Pergamum; there are also many fine online collections such as those of the University of Virginia and the University of Indiana (<http://exhibits.hsl.virginia.edu/romansurgical/#intro> and <http://www.indiana.edu/~ancmed/instr1.html>). .

¹⁶⁰ Hp.*Hebd.*46 = VIII.663.14-15 L; cf. *Morb.Sacr.*21 for the recommendation to apply what is ‘most hostile’ (πολεμιώτατον) to the disease; and see von Staden 1990:97-99.

For conceptual understanding we are dependent on written records including tombstones, epistolary papyri, literary works and medical and philosophical treatises. These yield a series of partial and sometimes highly subjective accounts, all of which contribute to a picture (the desirability of good health, its often fleeting nature, the discomforts of illness, theories and concepts of disease) but often raise more questions than they answer. Inevitably the main literary evidence comes from medical and medico-philosophical treatises. In drawing on this material to build our understanding of ancient ideas about health and sickness it is important to remember that the doctor's perspective is that of an observer, not an actor. Furthermore, no matter how detailed and focused an account it is, it illuminates only part of the observer picture. As a recent correspondent to the *British Medical Journal* put it, 'There is a biomedical component to health, but it also exists in a setting that includes biological, personal, relational, social, and political factors'.¹⁶¹ Medical treatises cannot be assumed to encompass all these factors. What they do reflect is the knowledge and interests of their authors, and the assumed interests and contextual knowledge of their intended audiences. Ancient medical writing, in other words, reflects the preoccupations and perspectives of educated, therefore elite, men, and even within that charmed circle most voices have been muffled by the Galenic boom reverberating through the centuries. Outside the circle, the silence of women, illiterate people, poor people and so on is not a problem unique to ancient medicine, but here it is compounded by the general paucity of patient testimony. Some clues can be detected in literature, but on the whole the perceptions and experiences of those who endured the illnesses

¹⁶¹ Peter G. Davies, 'Why the definition of health matters'. Letter to *BMJ* 2009;338:b28. (Published 09 January 2009). Available at: <http://www.bmj.com/content/338/bmj.b28>. Accessed 6th January 2016.

described by ancient doctors and were on the receiving end of their attentions are unavailable to us.

Explaining Foucault's antipathy to existentialism, Marianne Oksala says:

We cannot understand homosexuality solely by analysing the first-person experiences of those labelled homosexual, for example. Rather we have to study the homophobic power relations operative in the society, the culturally specific views and scientific theories that circulated about it, as well as the concrete practices of punishment and cure. All these different axes construct the subjective experience of a homosexual, but could not themselves be revealed through it in any transparent manner.¹⁶²

Similarly, we cannot understand health and sickness in antiquity simply by analysing first-person accounts (such as they are) or those of doctors and philosophers. We must create the picture from diverse angles, studying the relationship between doctors and patients, the various views and theories of health and sickness, and diagnostic and therapeutic practices – all of which construct the subjective experience of a patient, but could not themselves be revealed through it – allowing for varying receptions of all these things in secondary material that we consult, and always being ready to accept changes to the picture. By way of working definitions for my purpose, I use the word 'sickness' to denote a physical and/or mental state that impedes normal functioning, however that norm is defined, 'health' to mean a state in which no such condition is present, and 'disease' and 'illness' in the way that Eisenberg does: sickness as conceptualised by the doctor and as perceived by the patient respectively. All these definitions aim to admit and accommodate the dual perspective of actor and observer.

¹⁶² Oksala 2007:15.

2.2. Constructing the patient

The words ‘doctor’ and ‘patient’ are used throughout this thesis, and they are difficult labels to work with. First, they are not categorically comparable. In modern medical discourse ‘doctor’ is a title conferred on a person after many years of study and training, to advertise their competence to the world, and it is a title that serves to identify, distinguish and confer status on its holder wherever they are, a title that, once earned, tends to be used in many circumstances, not just medical ones. ‘Patient’ on the other hand is a descriptor that has meaning only in the context of a healthcare transaction, a label that is often gladly shaken off once the transaction is over. A key difference is that, though there have always been patients, and it is safe to assume that there always will be, there have not always been doctors in the current western model, and it is not safe to assume that there always will be or that the particular type of medicine that is favoured at any given point in history will remain favoured. For the sake of discussion I shall use the terms to mean people who are ill and those they turn to in a professional rather than familial capacity.

In this thesis, then, the term ‘patient’ means a person who is sick and either seeking or receiving some form of health care. It may occur in a specific sense – denoting a particular individual in a particular case – or in a collective or hypothetical sense, and in any of these senses it may or may not be accompanied by the definite article. Sometimes the formula <definite article plus singular noun> (‘the patient’) will be used with deliberate intent, to signify the abstract idea of ‘the patient’ along with all the generalising connotations that this entails. This brings me to my second underlying assumption, which is that this idea of ‘the patient’ is a medical construct, which reflects and perpetuates the perceptions and expectations doctors have about the sick people they treat as well as those

that sick people themselves have about their position in society and particularly in relation to doctors. What doctors say about patients helps to illuminate their conception of ‘the patient’. For example, it would appear from their writing that, for Galen and for some of the Hippocratic authors, ‘the patient’ was somebody who tended towards disobedience; and that Rufus conceived ‘the patient’ as a repository of information without which the doctor’s knowledge was incomplete. The accuracy of these and other related impressions will be explored in the course of this thesis.

A very clear exposition of the theory of ‘the patient’ as a medical construct can be found in David Armstrong’s influential 1984 article ‘The Patient’s View’. Armstrong used medical training manuals to trace the development of the concept of ‘the patient’ through several decades of the 20th century. Showing how the questions doctors ask patients, the answers patients give, and the ways in which doctors receive and understand patients’ utterances all reflect and influence the culture within which the transaction takes place, Armstrong argues that, during the period he examined, it was not what patients said that changed, but what doctors heard them to say. He begins with Foucault’s medical gaze, which signifies a situation in which the doctor’s task was to diagnose the illness on the basis of observed signs. The doctor was encouraged to ‘interrogate’ the patient in order to elicit the patient’s own story, as part of his – the doctor’s – process of interpreting the signs generated by the sickness. The patient delivered up his personal history and so ‘the lesion spoke through the patient, though it only finally yielded its secret in the physical examination’; thus ‘the patient’s view was, in essence, the unformed words of the disease’, and the patient’s only function was as vehicle and historian of the disease.¹⁶³

¹⁶³ Armstrong 1984:738.

The growing interest in psychiatry and psychology that characterised the first half of the 20th century, including the recognition that neurosis was widespread, generated a shift in the process so that doctors began to see sickness as something located in a social space, something that could be best understood by eliciting not just a personal history of the patient but a social, emotional and psychological history. Awareness that the lesion might yield no signs at all, but might be detectable only through the patient's words, meant that the doctor had to learn to study the patient as well as the disease, asking questions about such things as marital history and personal anxieties. 'Illness was being transformed from what was visible to what was heard', and the patient's view was increasingly an essential illuminatory technique. The medical gaze was gradually being extended to embrace other disciplines working alongside medicine to deliver socio-medical solutions.¹⁶⁴

Armstrong now identifies a change in the concept of illness: no longer a lesion which the doctor could identify and treat, it had become any experience that prompted the seeking of formal medical advice – a 'behaviour pattern', in other words, rather than an organic abnormality. Individual perceptions of what constituted discomfort and sickness now came to the fore, with the recognition that certain symptoms would cause some people to visit the doctor, while others would be unconcerned by them. Illness was 're-aligned in a multi-dimensional conceptual space ... which could only be monitored by constant elicitation of the patient's view'. Concomitantly, psycho-social models of causation were developed and the success of treatment began to be judged through the patient's attitudes – such as satisfaction levels and ability to cope – rather than simply by the disappearance of physical signs.¹⁶⁵

¹⁶⁴ *Id.* 739.

¹⁶⁵ *Id.* 741.

Finally the privileging of subjectivity that occurred in the late 20th century meant that the experience of illness came to be seen as so intensely personal that it could not be properly understood at a purely objective level. The patient's view, in the form of such things as ability to cope, was transformed from a measure of success to the site of the problem, and the doctor's job became that of making sense of the complex web of 'problems, symptoms and worries' that had emerged in the consultation, itself transformed over the course of the century from an 'interrogation' in which patients were discouraged from talking about anything the doctor considered irrelevant to an 'interview' in which 'lay theories' might emerge that could be helpful to the diagnosis.¹⁶⁶ This change in attitudes to the patient's view is illustrated by the training materials Armstrong studied. In 1928, the patient's view of anything not directly related to the lesion was to be excluded (including possible diagnosis)¹⁶⁷ – this recalls Galen's stout declaration of the irrelevance to medical literature of 'things that can be known even by laymen';¹⁶⁸ in 1967, the patient's view on possible diagnosis was to be tolerated, as stemming from an understandable desire to identify the cause of the illness¹⁶⁹ – an interesting echo of Rufus's insistence that causation cannot be understood unless one questions the patient; by 1978, the patient's view was potentially part of the problem, and understanding it could be central to both diagnosis and therapy.¹⁷⁰ Illness had evolved in tandem with the construct of the patient, becoming by 1981 'a social phenomenon constituted by the meanings actors employ to make sense of observed or experienced events'.¹⁷¹

¹⁶⁶ *Id.*741-2.

¹⁶⁷ *Id.*738.

¹⁶⁸ See below, pp.160-161.

¹⁶⁹ *Id.*742.

¹⁷⁰ *Id.*742.

¹⁷¹ *Id.*742, quoting Locker; Armstrong notes that patient and doctor no longer had 'separate realms of experience' and their meeting had ceased to be an encounter between 'an enquiring gaze and a passive object' and had become instead 'an interaction between two subjects'.

Armstrong argued that this succession of changes masked a consistent truth: that ‘investigation can only reveal what is heard, not what is said’, and therefore (by implication) that ‘the patient’ is always a construct of the socio-medical structures within which she or he seeks help. What doctors hear, he argues, is shaped by ‘the structure of perception’, a concept related to Foucault’s idea of ‘codes of knowledge’: epistemological structures and practices that influence both how the observer sees (the ‘gaze’) and how what is seen (the ‘field’) presents itself. Patients begin to present themselves in a new way at the same time as doctors begin to perceive and attach importance to new aspects of ‘the patient’. Thus the ‘patient’s view’, as he puts it, ‘is an artefact of socio-medical perception’. What doctors ask (or do not ask) is symbiotically bound up with what patients say (or do not say). The gaze constitutes the field, and ‘the field confirms and consolidates the gaze’. A meaningful dialogue can take place only when the doctor’s questions occupy the space in which the patient conceives of the illness¹⁷² – an idea that mirrors Kleinman’s theory of explanatory models.¹⁷³ We learn from this that the questions a doctor asks are indicative not just of his or her personal style and preferences but of the field over which his or her gaze roams. Therefore when we see a change in what is being asked – such as the narrowing of the concept of questioning that this thesis proposes can be seen in Galen’s work compared to some other medical authors including Rufus – it is reasonable to hypothesise a discursive change, positing a ‘field’ in which the doctor is expected to know more and ask less, and a corresponding alteration in the socio-medical construction of the patient.

¹⁷² *Id.* 743 and note 77.

¹⁷³ See below, pp.86-88.

The construction of the patient through the perception of doctors returns us to the subjective/ objective dichotomy discussed earlier. As Eisenberg points out, the hysterical patients exhibited by Charcot in 19th century Paris, though undeniably ill, came to produce uniform patterns of symptoms in line with the expectations of the professor and his ‘attentive medical audiences’.¹⁷⁴ Perhaps paradoxically, given Charcot’s sensitivity to psychological events, this is an example of what Allan Beveridge, arguing that ‘the observer has an influence on what is being observed’, warns may happen ‘if the doctor is unable to see the patient as anything other than an object; if he or she loses sight of the patient as a human being’.¹⁷⁵ Beveridge argued that the subjective/ objective dichotomy was ‘untenable and unhelpful’, because either an integrated model is achievable and the divide is therefore artificial, or integration is impossible and the dichotomy privileges the objective at the expense of the subjective.¹⁷⁶ Beveridge was writing about psychiatry, but his arguments are equally applicable to physical medicine. An overly objective approach promotes a model of the patient as a collection of symptoms, and the body as a machine that goes wrong and needs to be repaired by a specialist, while a wholly subjective approach risks neglect of important medical knowledge. How doctors’ objective professional knowledge and patients’ subjective experiential knowledge can enrich and inform one another provides the focus for the next part of this chapter.

¹⁷⁴ Eisenberg 1977:12.

¹⁷⁵ Beveridge 2002:101-2.

¹⁷⁶ *Id.*103.

2.3. Knowledge and authority

Knowledge

By ‘medical knowledge’ I mean the combination of empirically and theoretically acquired personal, procedural and propositional knowledge used by doctors for professional purposes including diagnosis, prognosis and therapy.¹⁷⁷ Thomasina Borkman calls this ‘knowledge of truth developed, applied and transmitted by an established specialized occupation’, and contrasts it with experiential knowledge, ‘truth learned from personal experience with a phenomenon rather than truth acquired by discursive reasoning, observation or reflection on information provided by others’.¹⁷⁸ Both, Borkman argues, are ‘sources of truth’, ‘neither inherently conflicting nor antithetical’, essentially contrasting and yet complementary:

experiential knowledge is (1) pragmatic rather than theoretical or scientific, (2) oriented to here-and-now action rather than to the long-term development and systematic accumulation of knowledge, and (3) holistic and total rather than segmented.¹⁷⁹

The contrast between these two ecologies of knowledge, and their potential for co-operation, will feature prominently in my interpretation of *QM*, and indeed provided some of the original stimulus for my research. What we must ask is whether it was a meaningful contrast for Rufus. Even if this question cannot be definitively answered, the enquiry will surely serve a historical purpose; for, as Tamsyn Barton says, ‘understanding knowledge as rooted in social practice changes the way one writes the history of science’.¹⁸⁰ Asking whether the distinction between expert and experiential knowledge

¹⁷⁷ This thesis contains no aspiration to address the meaning of knowledge itself, but follows Berger and Luckmann’s definition of knowledge as ‘the certainty that phenomena are real and that they possess specific characteristics’. As Berger and Luckmann point out, although this definition is ‘admittedly simplistic’ it has the merit of having ‘relevance both to the man in the street and to the philosopher’ (1967:13).

¹⁷⁸ Borkman 1976:446-7.

¹⁷⁹ Borkman 1976:448-9.

¹⁸⁰ Barton 2002:2.

made sense in the social context of 1st century Ephesus should thus have at least two benefits. Studying Rufus's argument will not just cast a useful light on the ideas with which he disagreed, thus enriching our understanding of contemporary approaches to healing, but also help to encourage a fuller appreciation of Galen's effect, both on medical knowledge itself and on its dominant place in Western medicine. To quote Barton again: 'a better historical account will be given by an attempt to recover a fuller picture of what was accepted as knowledge and, indeed, the nature of the cultural norms that shaped the epistemic field'.¹⁸¹

At present, a dominant school of thought in Western medical discourse holds that achieving the aim of medicine depends on a fusion of doctors' and patients' knowledge.¹⁸² In this paradigm, the doctor's professional knowledge, though it may be a necessary condition for successful treatment, is insufficient on its own and needs to be augmented with the patient's experiential knowledge – whether that be hard knowledge (indubitable facts about his or her body, health history, lifestyle and the like) or soft knowledge (intangible things such as feelings, beliefs, preferences, and so forth).¹⁸³ Rufus's own declarations as to the inherent limits of doctors' knowledge – for example, ἐγὼ δὲ ἡγοῦμαι μὲν καὶ παρ' <ἐ>αυτοῦ δύνασθαι τινα πολλὰ τῶν ἐν ταῖς νόσοις

¹⁸¹ Barton 2002:6.

¹⁸² I have rejected the perhaps more obvious formulation 'expert and non-expert knowledge' to avoid confusion with the modern idea of the 'expert patient', a concept that is often misinterpreted to mean a patient who has acquired a quantity of technical knowledge about a particular illness. In fact the original idea behind the concept was to signal that, while doctors are experts in medicine, 'people with chronic diseases have considerable knowledge and experience of their own illness ... [and] ... that with proper training this can be turned into practical skills to enable the patient to play a bigger part in managing their own condition' (Sir Liam Donaldson, quoted on 14th Sept. 2001, <http://www.palgrave-journals.com/sth/journal/v6/n4/full/sth200811a.html>; accessed 8th January 2016). The misconception casts them inevitably as junior partners.

¹⁸³ This follows the distinction between 'hard' and 'soft' knowledge suggested by Hall, Clegg and Sillince (2008:68), which depends on the existence or not of 'alternative perspectives and values'. Soft knowledge is differently defined by, for example, Hildreth, Wright and Kimble, who base the distinction on whether or not the knowledge can be easily 'captured, codified and stored' (1999:348-9). On expert knowledge as a necessary but insufficient condition of treatment, see Nordin 2000:303.

ἐξευρίσκειν, κάλλιον δέ γε καὶ σαφέστερον ἐν τοῖς ἐρωτήμασιν (‘In my opinion, although one can indeed discover many of the factors connected to sicknesses on one’s own, questioning enables that to be done better and more clearly’)¹⁸⁴ – do not necessarily, therefore, strike the modern reader as unusual; but historically the healing professions have not been known for the tendency to proclaim the limits of their own knowledge. From shamans and priests to consultants in white coats and stethoscopes, healers have cultivated a reputation for deep and potent learning and the ability to understand patients’ ailments in ways that transcend the ordinary.¹⁸⁵ Writing in the *British Medical Journal* in 1998, one GP observed: ‘The incalculable number of medical problems and questions to which the medical profession has no certain answer is balanced by the incalculable number of times that its members none the less provide one’.¹⁸⁶ Rufus is not alone in admitting the fallibility of his profession, as witness the Hippocratic author who remarks, ‘that physician who makes only small mistakes would win my hearty praise. Perfectly exact truth is but rarely to be seen’.¹⁸⁷

The use of specialist knowledge as a carapace to reassure patients, fend off doubt and mistrust and keep competitors at bay is in many ways understandable. For the very great majority of its existence medicine has been largely impotent in the face of serious illness. As Roy Porter pithily observes, until the 20th century ‘the “disease empire” ... called the shots’ and ‘the pharmacopoeia resembled a box of blanks’.¹⁸⁸ Physiological understanding was slow to develop. Human anatomy did not begin to be properly

¹⁸⁴ *QM* 22.

¹⁸⁵ Leslie 1976:3. The healer’s claim to power is rooted, Eisenberg argues (1977:14), in the fact that he must ‘expose himself to, and overcome, the dark forces that produce illness’.

¹⁸⁶ Pickering 1998:1729.

¹⁸⁷ καὶ ἐγὼ τοῦτον τὸν ἡτρὸν ἰσχυρῶς ἐπαινέοιμι τὸν σμικρὰ ἁμαρτάνοντα. τὸ δ’ ἀτρεκέες ὀλιγάκις ἐστὶ κατιδεῖν. *Hp.VM.9* = I.590 L, tr. Jones, Loeb I.27. Blaming other doctors for mistakes is more common than praising them: see von Staden 1990:86-88.

¹⁸⁸ Porter 2003:37 and 39; cf. Horstmanshoff 2004:328-9; and see below pp.246-248.

explored until the sixteenth century, and the full potential of pathology remained unrecognised till the eighteenth. Circulation of the blood was not understood till the seventeenth and the role of oxygen in respiration went unrecognised till the eighteenth, while the part played by microbes in disease causation was not proven till the late nineteenth century. Such bywords of modern biomedical health care as nutrition, endocrine functions and the immune system had to wait for the twentieth century to come into their own.¹⁸⁹ In the crowded medical marketplaces of pre-modern times, where healers of innumerable persuasions plied their trade in the absence of any form of accreditation or regulation, the possession of knowledge was a way of compensating for lack of proven effectiveness. Such badges of respectability as seven years of university learning, membership of protectionist guilds and colleges, the trustworthiness implied by the Hippocratic oath, the ability to use and understand special equipment,¹⁹⁰ and so on, functioned as instruments of exclusivity, enabling doctors to distinguish themselves from rival healers and gradually consolidating what Pellegrino calls the medical profession's 'claims to preciousness and sacerdotal privilege'.¹⁹¹

Eisenberg has described how, as a society's medical culture becomes more sophisticated and biomedical techniques start to edge out traditional remedies, a gradually widening

¹⁸⁹ See Porter 2003, as follows. Anatomy: Vesalius's challenge to Galen in 1543 (57); circulation: Harvey's announcement in 1628 that Galen had been mistaken (60) and, later in the same century, Lower's demonstration of the role of the lungs (64); the role of oxygen in respiration: Black and Lavoisier (70); pathology: the autopsical work of Morgagni, Baillie and Bichat, ushering in a new ontological as opposed to physiological theory of disease (71-74); microbiology: Pasteur's demonstration of the aetiological relationship between particular microbes and particular diseases (86) and the publication of Koch's Postulates in 1879 (89); nutrition: the discovery of 'essential food factors', or 'vitamins', by Eijkman, Funk, Hopkins and others (94-95); early endocrinological research by Bayliss and Starling in 1900, the first insulin injections by Banting and Best in 1922, and the isolation of sex hormones by the 1930s (94-96); immunology elucidated by Burnet and others in the 1950s and 1960s (93).

¹⁹⁰ Porter quotes a doctor who urged his colleagues 'working with the microscope [etc] will not only bring fees and lead to valuable information ... but will also give you reputation and professional respect' (2003:42, cf. 39).

¹⁹¹ Pellegrino 1976:8.

gap appears ‘in shared belief, in social class and in effective communication between patient and practitioner’.¹⁹² This can be compared to the loss of shared ‘visionary space’ that Foucault identified when patient and doctor ceased to share a common – if fantastical – language (when what the patient described had as much reality for the doctor as the things the doctor ‘saw’) and the doctor’s observational power came to be assumed capable of penetrating the mystery of the body and discovering interior truths.¹⁹³ It was this discursive gap, and the recognition that patient and doctor may have very different ideas about what has caused an episode of illness and how it can best be remedied, that Arthur Kleinman addressed in the latter part of the 20th century with his theory of explanatory models. Kleinman, arguing that ‘all attempts to understand illness and treatment can be thought of as explanatory models’,¹⁹⁴ asserted an equivalence between the patient’s perspective and that of the doctor, a point he illustrated with case studies such as one in which visits to indigenous healers in Taiwan caused the majority of patients to report that they felt better even when there was no significant improvement in physical symptoms.¹⁹⁵ Conversely, when different explanatory models are not recognised or respected, patients may reject prescribed therapies, or even exhibit hostile behaviour, frustrating the doctor and denying themselves possible relief from both their ‘illness’ and their ‘disease’.¹⁹⁶ The solution proposed by Kleinman is for doctors to bring patients’ health beliefs and cultural expectations to the surface by asking them questions such as ‘What do you think has caused your problem?’, ‘Why do you think it started when it did?’, and ‘What kind of treatment do you think you should receive?’.¹⁹⁷

¹⁹² Eisenberg 1977:14, citing the work of Arthur Kleinman.

¹⁹³ Foucault 2003:x-xi. (For this analysis see Shawver 1998).

¹⁹⁴ Kleinman 1987:274.

¹⁹⁵ Kleinman et al. 2006:143.

¹⁹⁶ For the distinction between these concepts see above, pp.70-72.

¹⁹⁷ Kleinman et al. 2006:147. For one practitioner’s assessment of the transformative power of using such questions, see Kandula 2013.

Kleinman shows how eliciting the patient's explanatory model allows the doctor to recognise elements of illness as well as disease, and to design therapy that is not just appropriate but likely to be adhered to. Disobedience (what modern doctors call non-compliance) is a frequent complaint on the part of some Hippocratics, as well as Galen and, by implication, Aelius Aristides' doctors, as we shall see in Chapters 6 and 7. How much this had to do with dissonant explanatory models we cannot ultimately know. We do not know what dialogues they or other doctors actually held with their patients, what sorts of questions they asked, or how they framed them.¹⁹⁸ We know that in some cases specific questions were recommended for specific circumstances or to produce specific effects,¹⁹⁹ but we do not know how many a given consultation involved, or what type, or whether consultations were typically question-led or instruction-based. What we do know from *QM* is that one doctor saw a need to assert the importance of questioning patients, and to declare that doctors could not know enough unless they did. Concepts such as visionary space and explanatory models offer a framework for understanding the significance of this. Acknowledgement of medical fallibility collapses the boundaries between professional and individual explanatory models, and explicitly enables doctors and the sick people they treat to find a shared visionary space. This is the light in which I propose that Rufus's ability to admit that he needed the patient to help him work out what was wrong and how to treat it should be read. The fact that he decided to compose a treatise insisting upon that point implies something in his cultural discourse to which *QM* seemed to him to be an necessary response.

¹⁹⁸ Doctors' questions to patients can range from the cursory (what hurts and how long has it been hurting?) to the probing (what sorts of things might in your view cause this sort of problem?); see below, p.184.

¹⁹⁹ See below, pp.169-173 and 180-185.

Our ability to assess compatibility between the explanatory models of ancient patients and their doctors is very limited, since we cannot interview them (though we can see traces of opposing explanatory models in, for example, Aelius Aristides' repeated defiance of medical advice and the horrified reactions of his doctors, who are convinced he will cause himself serious harm by swimming in icy water or refusing removal of a tumour).²⁰⁰ Discursive change is perhaps easier to detect. Foucault asks if the 'more meticulous gaze, ... more measured verbal tread [and] ... more delicate ... choice of adjective' are not simply an extension of the 'style which, since the days of Galenic medicine, has extended whole regions of description around the greyness of things and their shapes'.²⁰¹ Thanks to the restrictions of his culture, Galen did not conduct anatomical dissections of the human body – if he had, Foucault might have ended up placing his discursive shift 1500 years earlier – but he analysed, divided, classified and systematised in a way that indisputably altered the terms of medical thought, and in his vision of himself and his calling we can see lay people being excluded from the doctor's intellectual space. For example, in *To Thrasybulus*, opining that it is not worth his while to reply to those who promote extreme gymnastic training because they lack the necessary critical faculties to engage with the subject, he demands:

τί μάθοιεν ἂν οὗτοι βαθὺ καὶ σοφὸν καὶ ἀκριβὲς ἀκούσαντες θεώρημα; θαυμαστὸν μέντ' ἂν ᾗν, εἰ τοῖς μὲν ἐκ παίδων ἀσκουμένοις ἐν τοῖς ἀρίστοις μαθήμασιν οὐχ ἅπασιν ὑπάρχει κριταῖς ἀγαθοῖς εἶναι τῆς τοιαύτης θεωρίας, ὅσοι δ' ἀσκοῦνται μὲν, ὥστ' ἐν ἄθλοις νικᾶν, ἀφυεῖς δ' ὄντες κακεῖ στεφάνων μὲν ἡτύχησαν, ἐξαίφνης δ' ἀνεφάνησαν γυμνασταὶ, τούτοις ἄρα μόνοις ὑπάρξει νοῦς περιττός.²⁰²

What would such people learn, even if they heard some proposition of great profundity, wisdom, and accuracy? It would be remarkable if even men trained from childhood in the best of disciplines do not always make good judges in this type of scientific enquiry, and persons who were trained to win competitions, but who had so little natural

²⁰⁰ See below, pp.264-267.

²⁰¹ Foucault 2003:xii.

²⁰² Gal.*Thras.*37, *SM* III.84-5 = V.878 K; tr. Singer 1997:88 (adapted). The discussion concerns the ill effects of over-indulgence in athletic training.

talent that they failed even there – before one day turning up as gymnastic trainers – were the only individuals endowed with such prodigious understanding.

Thus he locates himself in a rarefied specialist space from which the majority of laymen are excluded, and implies a way of understanding the body that is not available to most. Admittedly this occurs in a polemical context, but it must be noted that this section of the treatise contains plenty of other derogatory remarks about the trainers who are his particular target; this more general remark, which is being used to strengthen the invective rather than in specific relation to the context, reveals a distinct separation between how Galen the doctor thinks about people's bodies and how, he claims, everyone else does.

In *QM* Rufus identified a number of crucial pieces of information essential to diagnosing a patient's illness and treating it correctly, and argued that it was impossible for a doctor to know any of them 'by himself'. The identification of causes will suffice as an example at this stage. Rufus criticised the (probably) second century physician Callimachus for having 'denied the need to ask questions about sicknesses' and 'claimed that the signs in each individual case were enough to indicate both the condition and its cause, and should preferably be used as the basis of all prognosis and treatment'.²⁰³ Rufus objects to this on the grounds that signs can take the doctor only so far. One can learn a certain amount from them, he says, but by questioning the patient one acquires a context in which to understand and treat the individual illness, and knowing those contextual things, which can only be discovered through questioning the patient, is 'more critical to medical judgement than anything else'.²⁰⁴ Galen, as we shall see below, articulates a distinctly different view: 'we, as you know, attempt to tell them the antecedent cause without

²⁰³ See below, pp.146-153.

²⁰⁴ *QM* 21-23. For a full discussion see Chapter 5.5, 'The individual and the universal', pp.197-212.

waiting to ask the patient, and the acquisition of such an ability is the best indication that one is not wrong in any way'.²⁰⁵ Galen's medical hegemony lasted for hundreds of years, not encountering sustained challenge until the anatomist Vesalius began openly to question his theories in the 16th century.²⁰⁶ His clinical paradigm is in some ways still with us, in the stereotype of the all-seeing doctor who delivers diagnoses and instructions for the ignorant and vulnerable patient to obey,²⁰⁷ though since the latter part of the 20th century a paradigm shift has got underway, the doctor metamorphosing from a figure who issues 'orders' into a kind of facilitator proffering expert technical advice for the patient to use in making decisions about his or her treatment and lifestyle.²⁰⁸

Lloyd's observation that discussions of the ancient world must permit some 'progress towards understanding'²⁰⁹ is surely right; and the understanding we can thereby acquire may be as much about ourselves and our own culture as about the ancient culture under consideration. In a re-evaluation of the contemporary relevance of the social history of medicine, Roger Cooter issues a call to historians for 'hard reflection on how the conceptual and material edifices built around the human body serve critical understanding of the human condition' and argues for the need 'to engage seriously not just with what

²⁰⁵ ἡμεῖς δὲ, ὥς οἶσθα, πειρώμεθα λέγειν αὐτοῖς τὸ προηγησάμενον αἷτιον, οὐ περιμεΐναντες ἐρέσθαι τὸν κάμνοντα, καὶ ἔστι μέγιστον σημεῖον εἰς τὸ μηδὲν σφάλλῃσθαι τὸ τοιαύτην τινὰ πεπορίσθαι δύναμιν Gal.MMG 1.2,13-16, XI.10 K. See below, p.205.

²⁰⁶ See for example Temkin 1973:134-140. On the enduring popularity of some Galenic remedies even into the 20th century, see Powell 2003:1. According to Porter (1983:54-55), even after human dissection began in 1315 (receiving Papal approval in 1482) doctors continued to believe that the body was constructed like that of an animal rather than believing the evidence of their own eyes. In Park's view (2006:349 n.39), Vesalius 'substantially understated Galen's engagement with human bodies' for polemical effect. Sylvius, a 16th century Galenist and contemporary of Vesalius, explained the anomaly between Galen's descriptions and the new anatomical evidence by claiming that the human body had changed since antiquity, becoming smaller, shorter-lived, and differently constructed, so that 'the same things that the ancients observed are not still found in all our bodies' (King 2013a:189, note 45).

²⁰⁷ The stereotype reached its apogee with the mid-20th century caricature Sir Lancelot Spratt, the irascible all-powerful consultant surgeon played by James Robertson Justice in the series of films based on Richard Gordon's 1954 novel *Doctor in the House*.

²⁰⁸ For the idea of the doctor as health care facilitator, see for example Fishwick and Letts 2002:55-56.

²⁰⁹ Lloyd 1999:2. See above, p.62.

it is to be human in a world in which the corporeal is prioritised and in which power in and around the body seems more dispersed than ever before, but also with the question of how we as historians within the somatic postmodern world can further the critique of it'.²¹⁰ The impetus for my enquiry was the fact that no other ancient doctor dedicated a treatise to the dialogue between doctor and patient, and the epicentre of my case is my perception that *QM* implies a clinical paradigm that differs from Galen's in important ways. The false certainties that composed Galen's theoretical legacy lasted for the best part of a millennium and a half. The template he cast for the clinical encounter was much sturdier. Declarations of certainty on the part of a strong paternalistic figure have a powerful appeal for people made vulnerable by the pain and terrors of sickness, but, as we shall now see, medical self-belief does not guarantee the best outcome.

Authority

Ludwig Edelstein has remarked that the question of the physician's authority is implicated in all medical treatment, while Jay Katz describes Western medicine as having for most of its existence been characterised by a belief that the physician's authority is paramount and deserves unquestioning obedience.²¹¹ Both these views are unexceptionable. Yet the complaint that patients fail to follow instructions has been a common refrain from the earliest Greek medical texts onwards; Galen was particularly vociferous on the subject, for example, as we shall see in Chapter 6. Medical authority is a fragile thing, in other words, and perhaps part of the reason for that can be found in the unilateral approach betrayed by those complaints, for mutuality is, as Hannah Arendt and

²¹⁰ Cooter 2007:458.

²¹¹ Edelstein 1987:386; Katz 2002:7-28.

Anthony Giddens both emphasise, integral to any meaningful definition of authority.

According to Giddens:

Following Max Weber, many sociologists have argued that authority is the legitimate power which one person or a group holds over another. The element of legitimacy is essential to this understanding of authority and is the main means by which authority is distinguished from the more general concept of power. Power can be exerted by the use of force or violence. Authority, by contrast, depends on the acceptance by subordinates of the right of those above them to give them orders or directives.²¹²

For Arendt, authority always commands obedience but is distinguished from power (the use of coercion) and persuasion (a process of argumentation based on a presupposition of equality) by the fact that ‘the authoritarian relation between the one who commands and the one who obeys rests neither on common reason nor on the power of the one who commands’ but on ‘the hierarchy itself, whose rightness and legitimacy both recognize and where both have their predetermined stable place.’²¹³ Arendt was analysing the disappearance of a social order characterised by unquestioned hierarchy, which she regarded as the prerequisite for authority to exist; the persistence of doctors’ complaints of non-compliance must make us question whether the doctor-patient relation has ever reliably been one of mutually recognised hierarchy in which both parties have ‘their predetermined stable place’. To test the proposition, let us now apply Arendt’s account of authority to the different ways in which a doctor (D) may respond to a help-seeking patient (P). There are three main options: D may impose or withhold treatment regardless of or directly against P’s will, issue an instruction or recommendation in the expectation of compliance, or set out the treatment options for discussion with P.²¹⁴ The first of these is self-evidently an expression of power rather than authority. The third involves shared

²¹² Giddens and Griffiths 2006:1008.

²¹³ Arendt 1961:93.

²¹⁴ There are potential variations depending on the nature and extent of any dialogue that ensues, but any professional response to a request for help must fall into one of these three broad categories.

authority, which will be discussed below. In the second scenario – the issuing of an instruction or recommendation – it is P who decides whether or not to comply; theoretically D has no reliable expectation of obedience, and in practice obedience often does not ensue, but if P does decide to comply – whether in recognition of D's superior technical knowledge or in deference to his/her status – then a hierarchical relation has *de facto* been mutually acknowledged.²¹⁵ We can call this a manifestation of medical authority.²¹⁶

In practice, of course, it is rarely as clear-cut as the straightforward issuing of an instruction followed by compliance or refusal. Patients vacillate, need more information, feel vulnerable, indicate uncertainty. Doctors on the other hand are very likely to try to persuade patients of the advisability of this or that course of action, because they want to treat sickness and have a great deal of technical knowledge that enables them to offer solutions that patients cannot conceive of, or gain access to, by themselves. But that very asymmetry undermines any presupposition of equality and allows persuasion easily to become manipulation. If (as Katz believes is often the case)²¹⁷ D does not give P all the necessary information – e.g. by deliberately withholding information about one or more treatment options, for no matter how well-meant a reason – or in similar vein gives P all the necessary information but then exerts undue pressure in favour of one particular treatment, or shows little or no interest in hearing what P wants or believes or hopes for, P is being manipulated rather than persuaded by means of argumentation based on equality. If, on the other hand, D gives P all the available relevant information and then

²¹⁵ Whether P's action in this scenario really constitutes 'obedience' is a moot point, since it involves freedom of action and possibly even freedom of will.

²¹⁶ If D makes a recommendation to P, the same things apply, except that, in issuing a recommendation rather than an instruction, D cannot be assumed to have expected obedience.

²¹⁷ Katz 2002:99, arguing that economy with the truth on the part of physicians means that 'informed consent in today's world is largely a charade'.

invites P to reciprocate, the process becomes one of shared decision-making. This speaks of a different relationship between P and D, in which each accepts the validity and relevance of the other's knowledge: D's theoretical and empirical knowledge of medicine; P's experiential knowledge of his or her lifestyle, values, priorities, personal history, symptoms, recent aggravating factors and so forth. Each needs the other's knowledge to form a complete picture of what is wrong and assess the options for dealing with it. In this relation two hierarchies co-exist, shifting to accommodate each other's authority in particular domains. The transaction is rooted in discussion between equals, in the course of which either party may try to persuade the other of the rightness of a particular view, but at the end of which P makes an informed decision about treatment. Because authority has been shared, both parties understand the reasoning behind the decision, and their mutual trust and commitment to the plan can be assumed to be all the stronger.²¹⁸

I have argued that 'medical authority' is a tightly circumscribed concept that is meaningful in two possible circumstances: one, when a patient's compliance with a doctor's instruction reflects a mutually recognised hierarchy rooted in the doctor's superior medical knowledge and/or professional status; and two, when medical and patient authority co-exist, creating a condition of shared authority rooted in mutual recognition of the validity of each other's knowledge. Clarifying the nature of medical authority in this way sheds a helpful light on the phenomenon of 'non-compliance', which on the face of it is a puzzle. Why would people who are suffering discomfort or pain, and who have obtained the advice of a qualified professional, then proceed to ignore that advice? Doctors' response to the problem has often been simply to assert their authority

²¹⁸ See Katz Chapter IV, 'Sharing Authority: the Willingness to Trust' (2002:85-103).

more loudly – like the stereotypical tourist shouting at foreigners as if they are unable to hear, rather than simply people who speak a different language – without giving sufficient consideration to the possible reasons why non-compliance occurs. Modern research shows conclusively that the ‘shouting loudly’ response is doomed to failure, based as it is on at least two erroneous assumptions: that patients are passive followers of doctors’ orders, and that their illness will motivate them to obey instructions.²¹⁹ What motivates people to stick to a treatment plan is, as we will see in Chapter 6, whether or not they perceive in it value to themselves, and the chief enabling factor in the construction of such a plan is the quality of the communication between doctor and patient – an idea that seems to be fairly stable across different cultures today. To adopt the ‘shout loudly’ model is, it seems, to misconceive medical authority.

2.4. Patients and silence

The history of ancient patients is of necessity mostly an imagined history of the silent, for we simply do not have their voices. Both patients and ‘the patient’ are largely absent from the history of ancient medicine. To the researcher seeking to learn more about them, the minimal, or even absent, indexing of the word ‘patient’ in important scholarly books comes as something of a surprise, but may simply reflect what the likely interests of readers and researchers were assumed to be.²²⁰ In ancient accounts, patients’ voices are almost always ventriloquised through the persona of the doctor. Hardly ever do they speak directly to us, and the one who does so most informatively and at greatest length, Aelius Aristides, has in modern scholarship often been dismissed as a repellent

²¹⁹ See WHO 2003 and, for a full discussion, Chapter 6 below.

²²⁰ See for example Nutton 2004, Hankinson ed. 2008, and Pormann ed. 2008.

hypochondriac even though there is no evidence that he was seen as such in his own time.

Edelstein puts it thus:

Hardly ever are the feelings of patients recorded in literature or on stone; honorary decrees erected by cities are eloquent in their expression of gratitude, but formal and stylized. The same is true of the literary appraisals of medicine and the physician, be they written in praise or as caricatures.²²¹

All this reflects, as history so often does, the prejudices and perspectives of those who write it. The study of ancient medicine was initially the province of medical men, who, according to Wesley Smith, ‘led the way, generating medical “history” out of their own current scientific interests instead of out of historical study’; not till later did ‘philologists and historians, infected by the progressive attitude and euphoria of the scientists, set out to find the evidence with which to sustain the medical men’s views’.²²² As late as the middle of the 19th century, editions of ancient medical works were being produced by physicians for the benefit of other physicians: thus Carl Gottlob Kühn, whose monumental (but flawed) early 19th century edition of Galen is still the only complete one, was a professor of physiology and pathology who designed his work for professional medical use and provided a parallel Latin translation to increase its usefulness, while the medically trained Émile Littré’s stated purpose in editing and translating the complete works of ‘Hippocrates’ was ‘de mettre les oeuvres hippocratiques complètement à la portée des médecins de notre temps’.²²³ The pool of scholarly interests to which ancient medicine appealed gradually widened, so that the current Brill Studies in Ancient Medicine series is described as being ‘intended for readers with interests in Classics,

²²¹ Edelstein 1987:389.

²²² Smith 1979:4. Smith devotes the whole chapter from which this quotation is taken to a useful account of the history of the study of ancient medicine. Cf. Hankinson 1991:ix, on Kühn.

²²³ Littré, Vol.I.ix. On the perceived contemporary relevance of Hippocrates to 19th century doctors, see Smith 1979:31-32. See also ‘History of CMG’, <http://CMG.bbaw.de/project-office/history> (accessed 6th January 2016). Kühn’s Galen appeared between 1821 and 1833, and Littré’s Hippocrates between 1839 and 1862.

Ancient History, Ancient Philosophy, Late Antiquity and the Middle Ages, History of Medicine and Science, Intellectual History, Byzantium, Islam, as well as for those whose professional involvement in medical practice gives them an interest in the history and traditions of their field',²²⁴ but even so it is only in comparatively recent years that the social history of ancient medicine has started to broaden the scope of the discipline to encompass the people on whose indispositions the whole edifice of medicine rests.²²⁵

Penetrating the silence that shrouds ancient patients is no straightforward matter, not simply because of the lack of evidence but also for methodological reasons. Roger Cooter, for example, argued passionately in 2007 that medical history, in its first attempts to right the perceived wrong, had become mired in a simplistic, dualist world-view that put doctors as an integral part of the Establishment in one corner and patients – disempowered and pathologised – in the other, unconsciously and unreflectingly reinforcing the power of the former by sentimentalising the latter.²²⁶ Cooter quotes Palladino's assertion that 'a more ethical and politically reflective engagement with the silenced might begin with the historian's acknowledgement of the power of the hegemonic discourse that silenced them in the first place',²²⁷ a remark that encapsulates Palladino's argument that discourses and structures of power cannot be challenged unless they are understood and named. The problem with 'Doing Medical History from Below', as Roy Porter titled his 1985 plea for a broader concept of medical history, is that (as Palladino observes) it does not subvert anything but simply perpetuates the established order. Patients are characterised as inhabiting the lowest rung of the hierarchy of

²²⁴ Brill Studies in Ancient Medicine, <http://www.brill.com/publications/studies-ancient-medicine> (accessed 8th January 2016); see also van der Eijk 2005:1-8 .

²²⁵ See for example Graumann and Horstmanshoff 2016:25. The volume in which the latter is published epitomises the change in perspective that is currently underway.

²²⁶ Cooter 2007:443.

²²⁷ Palladino 2001:549, quoted by Cooter (2004:444 n.15).

witnesses. Palladino hits an important nail squarely on the head when he says that if we really want to write about the history of the silenced we need to start by recognising, and naming, the forces that caused them to be silenced in the first place.

It must be acknowledged that we do not know if patients in Greco-Roman antiquity were silenced or are simply silent; there is a yawning gap where patient testimony might be, and that gap might be eloquent or it might merely reflect any number of contributing factors including limited levels of literacy, a less confessional era than our own, and transmissional loss. It is the case, though, that the complaint articulated by antiquity's most communicative patient, Aelius Aristides, that doctors did not listen to him, reflects a form of silencing that is sadly pervasive in diachronic accounts of doctor-patient interactions. Silence will be something of a theme in this thesis. Galen, as we shall see, proudly proclaims his own silence in one of the most important cases of his career, and valorises the ability to identify causes of illness without having to ask patients questions, while Rufus, with his repeated claim that 'he who does not listen cannot know', opposes and challenges the validity of silence. Aelius Aristides proclaims the significance of silence: 'I decided to submit to the god, truly as if to a doctor, to do in silence whatever he wishes' – thus drawing an explicit parallel between god and doctor.²²⁸ In earlier representations the doctor is not such an unequivocally powerful figure;²²⁹ nor is he in Rufus's construction. A key signifier in these relationships often seems to be the presence or absence of dialogue.

²²⁸ See below, p.263.

²²⁹ See below, p.221 n.628.

It is interesting, too, to note that the medical sects that were a significant feature of post-Hellenistic medicine derived their arguments (as least as we receive them today) entirely from the physician's perspective.²³⁰ However formal or informal the different schools of thought were, the point is that they indicate no evident consideration of how to make use of patients' experiential knowledge in the search for the truth about illness and how to treat it. We recall the early 20th century position described in Armstrong's article, when the patient's only function was as vehicle and historian of the disease.²³¹ The focusing of epistemological effort from the physician's perspective reveals a structure of perception in which what patients said to doctors was heard by them as informational detail rather than essential messages from the site of the problem.

None of the above is to suggest that ancient doctors did not ask patients questions. Obviously they did, and it would be absurd to suggest otherwise. What I mean to suggest is that many of them did not conceive of the things that patients could tell them as comparable to the products of their own capacity for reason or observation. In this context, Rufus's emphatic repetition that 'the doctor cannot know' what he needs to 'by himself', and his insistence that questioning patients is essential to the acquisition of 'complete and accurate knowledge', command attention. Such ideas resonate with the theories of Kleinman, Eisenberg and Borkman, as well as with the work of philosophers such as Kay Toombs, who argues that 'physician and patient encounter the experience of illness from within the context of different "worlds", each "world" providing a horizon of meaning'.²³² According to Toombs,

The phenomenon of illness-as-lived is quite distinct from the phenomenon of the disease state and ... the two cannot be identified with one another. Thus, when physician and patient talk about 'illness'

²³⁰ On the sects, see below, Chapter 3.2, 'Medical knowledge', pp.110-112.

²³¹ See 'Constructing the patient', above pp.77-82.

²³² Toombs 1987:abstract.

they are not discussing a shared ‘reality’. ... The phenomenological analysis of the body provides the insight that illness is fundamentally experienced as the disruption of lived body rather than as the dysfunction of biological body,

and it is towards the former, rather than exclusively towards the ‘objective pathophysiology of the disease state’, that attention must be directed ‘if therapeutic goals are to be optimally effective – and if suffering is to be relieved’.²³³ In other words, careful and thorough exploration of the patient’s perspective is a *sine qua non* of medical understanding, and questioning the patient is the crucial explicatory element of the consultation. It is my contention that the scope and nature of the dialogue Rufus wants doctors to have with patients is consonant with this mode of thought.

2.5. Conclusion

Medicine teaches us that our bodies are complex and that there is much about them that only specialists can understand. It brings people face to face with the paucity of their technical knowledge, and thus places a unique strain on the connection between person and body. There is a kind of inevitability about this: the body is full of invisible spaces, pain comes and goes, what attacks us cannot be seen, and the vulnerability and disempowerment that we feel when we are ill make us susceptible to claims of ability to understand the mystery and offer relief²³⁴ – whether those claims are based on magic, religion, science or just other patients’ experience. Brooke Holmes, in *The Symptom and the Subject*, argues that in Greece the physical body ‘emerges’ as an object of control and care during the classical period. She charts the journey that the body made from an unquestioned, uncomplicated presence, its indispositions explained by personal and daemonic factors or obvious external attack, to a medical entity whose illnesses stem

²³³ Toombs 1993:xv-xvi.

²³⁴ On the infantilisation of patients by doctors, see Katz 2002:100-101 and 210-11.

from natural causes explained in terms of invisible physical qualities and powers acting in the hidden interior of the body, comprehensible only by physicians and philosophers.²³⁵ Thus began the tension between the clinical body and the lived body – between the body as object of medical knowledge and the body as subjective locus of experience – that still infuses the culture and practice of Western medicine today.²³⁶

In this chapter we have seen that health and illness and the idea of the patient mean different things to different people at different times, partly because of cultural construction and partly because of focal multiplicity, and we have adopted working definitions of both terms that attempt to encompass both participant and observer perspectives. We have considered evidence that doctors construct the idea of the patient, and that patients present themselves according to what doctors suggest is important, so that the questions that doctors put to patients can be regarded as both reflecting the doctor's idea of the patient and helping to consolidate and perpetuate it. Similarly, the self-construction of the medical profession as a repository of sophisticated knowledge undermines effective communication between patient and practitioner and broadens the gap between what may be quite widely differing explanatory models, thus helping to create the conditions for patients' non-compliance with medical instructions or advice. Finally I argued that authority is not a foregone conclusion of expert knowledge, and that when the latter co-operates with experiential knowledge the scope and effectiveness of medical authority is greatly extended. In the remainder of this thesis I shall first demonstrate and then interpret the difference between Rufus's insistence on thorough and wide-ranging dialogue with the patient, and Galen's highly directive style, within the

²³⁵ Holmes 2010: Chapters 1-2, and cf. 38-39.

²³⁶ Cf. Holmes 2010:118.

framework of these ideas and in the light of modern evidence about the factors that have been found to influence patients' willingness to follow the advice of their doctors.

Part III - *On Questioning the Patient*: an individual perspective

Preamble

As a treatise composed by a doctor on the subject of questioning patients, *QM* sits firmly within the tradition of ancient technical writing – that is, literature that ‘transmits knowledge and has a didactic goal’.²³⁷ But the written text that we have is just words on a page. To make meaningful sense of those words, and to grasp their historical significance, we need to ask how and why this short treatise came into being, what perceived need it was designed to address, what audience its author hoped to reach, and so forth. Our reception of the text is immediately influenced by knowing that, in the extensive corpus of known medical writing from antiquity, it is the only work dedicated to the topic of doctor/patient dialogue.²³⁸ In itself this fact is highly suggestive, and it makes the treatise especially valuable to the social history of ancient medicine; as Thorsten Fögen reminds us, technical works were ‘not written in a vacuum ... [but] ... frequently expose an explicit or implicit social, political or ethical agenda that can be related to the historical circumstances in which they originate’.²³⁹ Yet, as noted above, *QM* has attracted little scholarly attention.²⁴⁰ Gärtner suggests that this trend began in antiquity and may be at least partly due to its atypicality as a technical work, in that it provides illustrative examples rather than systematic instruction.²⁴¹ Gärtner’s own

²³⁷ Fögen 2015:267.

²³⁸ See above, pp.55-56.

²³⁹ Fögen 2015:277.

²⁴⁰ See above, p.58, with n.101.

²⁴¹ Gärtner 1962:12-13.

assessment, ‘ein Vademecum der Anamnesetechnik für der praktischen Arzt’, like that of Nutton who calls it ‘a handbook for doctors on the questions to ask their patients’ and an explanation of ‘how best to gain information from a patient by means of questions’,²⁴² all beg a rather important question. To compose a work explaining how to question patients is to assume that the reader is ready to ask questions and is seeking procedural guidance on how best to go about it. *QM* does not make this assumption. It appears to be motivated as much by ethical concerns (the case for questioning patients) as by pragmatic ones (how the questioning should be done); and in dealing with the latter it entirely eschews the prescriptive Hippocratic tradition expounded in *Prognostic* and various other ancient discussions of questioning.

QM is identifiably part of a tradition, in other words, and yet it is different: unique in its subject matter, and distinctive in its treatment of the topic. The same can be said of its author, for if we set Rufus in his historical and intellectual context we see that his ideas about health, sickness and medical practice, though in many ways typical of his time and place, are in other ways unusual and different. The next three chapters bring out these various differences and suggest some ways of interpreting them. Bearing in mind Fögen’s dictum that the intention and function of a text consist in both internal and external factors,²⁴³ I use both kinds of evidence to enhance our understanding of the text and to allow it to shed light on the circumstances in which it was composed. First, in Chapter 3, I set Rufus in his cultural context, illustrating the ways in which the things he says conform to assumptions that were widely held in his culture, and the ways in which he departs from these norms. Next, in Chapter 4, I analyse the work’s form and register, and

²⁴² Nutton, ‘Rufus [5]’, in *Brill’s New Pauly* Vol.12:756; Nutton 2004:209; Gärtner 1962:12 ; cf. Bynum and Porter 1993:11, calling it a ‘manual of Hippocratic diagnosis.’

²⁴³ Fögen 2015:267.

offer a hypothesis about its audience and intention. Finally, in Chapter 5, I focus in on the content of the work, highlighting five aspects of it which all, I argue, derive from and exemplify Rufus's construction of the patient as a psychologically as well as physically complex entity: the structural priority he gives to mental factors, his model of questioning, the purpose of questioning, his explicit preference that doctors should question the patient himself rather than an intermediary, and his vision of how questioning the patient helps in the perennial challenge of distinguishing individual cases from universal theories.

Chapter 3 – Intellectual Context

3.1. ‘The great Rufus, hailing from the city of Ephesus’²⁴⁴

Information about Rufus’s life is on the whole highly speculative. So far as biographical data is concerned, the most detailed work carried out recently is to be found in the unpublished doctoral dissertation of Amal Abou-Aly,²⁴⁵ and even that, despite the effort that was put into it, yields little that can withstand more than fairly cursory scrutiny. The main problem is the dearth of contemporary information. Unlike Galen, his gleefully self-publicising successor, Rufus tells us little about himself in his extant works.²⁴⁶ Most of what can be pieced together must therefore be drawn from what is said about him by others, and the unsatisfactoriness of this is increased by the fact that his chronologically nearest witness is Galen, a man not known for impartiality when it comes to what he chooses to say about other doctors. Very little of the available material is biographical in any case; most of it consists of critical assessments at second, third or fourth hand. The situation is further complicated by the fact that ancient and medieval medical sources refer to more than one Rufus and there is no firm ground on which to base a supposition as to whether they are the same or different individuals. Thus Galen refers twice to pharmacological recipes attributed to ‘Rufus’: in *On the Composition of Drugs According to Kind*, quoting Asclepiades Pharmacion (last quarter of the first century),²⁴⁷ where the reference is to Μήνιος Ῥοῦφος,²⁴⁸ and in *On Antidotes*, quoting Servilius Damocrates, a

²⁴⁴ Ibn Abī Uṣaibi‘a, *Ruf. On Melancholy* F2.

²⁴⁵ Abou-Aly, Chapter 1 (1992:15-55).

²⁴⁶ Abou-Aly (1992, 29); Nutton (2008:139).

²⁴⁷ Nutton, ‘Asclepiades [9] A. Pharmakion’, in *Brill’s New Pauly* Vol.2:99.

²⁴⁸ *Gal. Comp. Med. Gen.* 7.12, XIII.1010 K.

mid-first century poet,²⁴⁹ on 'Ροῦφος ... ἀνὴρ ἄριστος ἐκτικός τ' ἐν τῇ τέχνῃ.²⁵⁰ According to Nutton, identification with either of these Rufi is 'anything but certain', and with reference to the former he, like Abou-Aly, says that the name Menius is not among known Ephesian personal names;²⁵¹ a fragment published in *Die Inschriften von Ephesos*, however, records the name Μήνιος written twice on a piece of marble from the imperial period.²⁵²

Fortunately, the interpretation of QM does not depend on precise biographical details about its author. Of potentially more significance is Rufus's chronology, since if we do not know when something was written we lose the opportunity for its interpretation to be informed by our knowledge of contemporary intellectual and cultural factors.²⁵³ Here again we are on thin ice, and scholarly opinion is far from unanimous. Rufus himself offers no clues; Galen simply describes him as one of his more recent predecessors; and the Arab authors from whom our pre-modern evidence of dating is drawn believed, variously, that he lived before Aristotle, in the time of Cleopatra, or – most convincingly, in modern scholarly opinion²⁵⁴ – at the time of Trajan (98-117), which is also the date given in the 10th century Byzantine encyclopedia the Souda.²⁵⁵ According to Nutton, he was no longer alive by 140.²⁵⁶ Other information that can be patched together from a

²⁴⁹ Bowie, 'Damocrates', in *Brill's New Pauly* Vol.4:64.

²⁵⁰ *Gal.Ant.*2.2, XIV.119 K ('an excellent man and practised in the art').

²⁵¹ Nutton, 'Rufus [5]', in *Brill's New Pauly* Vol.12:75; Abou-Aly 1992:26-7. See also Nutton 2008:140.

²⁵² See *LGPV* Vol. A.302 (Μήνιος nos. 19 and 20) and *IEph.*VI.336, no. 2555.

²⁵³ Swain makes a similar observation in relation to *On Melancholy*, remarking by way of consolation that 'the cultural practices of elite Greek society during the first and second (and indeed the third) century AD were fairly stable' (2008:113).

²⁵⁴ Swain argues for acceptance of the Souda's dating on the grounds that the Souda author clearly knew Crito's history of Trajan's Dacian Wars and therefore the reference to Rufus's having been an associate of Crito's can be taken seriously (2008:114).

²⁵⁵ 'Ροῦφος, Ἐφέσιος, ἰατρός, γεγονώς ἐπὶ Τραιανοῦ σὺν Κρίτωνι. Φέρεται αὐτοῦ βιβλία πλεῖστα, ἐξ ὧν καὶ ταῦτα· Περὶ διαίτης ε, Περὶ διαίτης πλεόντων α, Περὶ τραυματικῶν α, Περὶ τραυματισμοῦ ἄρθρων α, Περὶ σύκων α, Περὶ τῆς ἀρχαίας ἰατρικῆς βιβλίον α, Περὶ γάλακτος βιβλίον α, Περὶ οἴνου α, Περὶ μέλιτος.

²⁵⁶ Nutton 2008a.

diverse range of sources tells us that he was a ‘teacher, a Hippocratic exegete, anatomist, pharmacologist, practitioner, gynaecologist and paediatrician’.²⁵⁷ He was probably educated partly in Alexandria, spent a fair amount of time in Egypt but almost certainly never went to Rome (unlike his probable contemporary, Soranus, or, a couple of generations later, Galen), and wrote prolifically on a wide range of subjects, covering, as Nutton puts it, ‘almost everything in medicine from the cradle to the grave’.²⁵⁸ Besides *QM* only three other authentic, complete treatises survive in Greek, along with a considerable quantity of fragmentary material in Greek, Latin and Arabic;²⁵⁹ the latter includes *On Melancholy*, published, for the first time, in 2008 by Peter Pormann in an edition that incorporates six case histories detailing the symptoms, diagnosis and treatment of melancholy patients.²⁶⁰

Rufus lived in what was the wealthiest, most cosmopolitan city of Asia Minor, at the height of its prosperity under the Pax Romana. Already one of the largest cities of the Mediterranean world in the first century BC, when Strabo described it as ‘growing by the day’ and ‘the largest market in Asia this side of the Taurus’,²⁶¹ Ephesus had shot up the prosperity index after being made the capital of proconsular Asia (western Asia Minor) by Augustus in 29 BC. The first and 2nd centuries AD saw the city at its peak, with a

²⁵⁷ Abou-Aly 1992:6.

²⁵⁸ Nutton 2008:140.

²⁵⁹ For recent discussions of Rufus’s oeuvre, see Abou-Aly 1992:42-49, Nutton 2008:139-40, and Haak 2013:264-8. Precise estimates of its size are impossible because of the fragmentary nature of much of the evidence; Haak refers to ‘over 90 books’ and Nutton to ‘over 102 separate works’. The other three authentic treatises in Greek are *On the Bladder and Kidneys*, *On Satyriasis and Gonorrhoea*, and *On the Naming of Parts of the Human Body*.

²⁶⁰ The case studies come from an Arabic manuscript discovered in 1971 by Manfred Ullmann, containing, among other works, 21 clinical reports which, after detailed analysis, Ullmann concluded were all by Rufus. Despite some disagreement, scholarly opinion generally concurs with Ullmann’s attribution, on linguistic, stylistic, medical and methodological grounds. For a concise summary of the arguments, see Pormann 2008a, 19-20. For the case studies themselves, see Ullmann 1978.

²⁶¹ ἡ δὲ πόλις τῇ πρὸς τὰ ἄλλα εὐκαιρία τῶν τόπων αὐξεται καθ’ ἐκάστην ἡμέραν, ἐμπόριον οὐσα μέγιστον τῶν κατὰ τὴν Ἀσίαν τὴν ἐντὸς τοῦ Ταύρου. Strabo 14.1.24.

population now estimated to have been the third largest in Roman Asia,²⁶² a grand, populous and commercially vibrant place whose name was invoked by Seneca in the same breath as that of Alexandria to epitomise somewhere particularly crowded and rich in dwellings.²⁶³ Its present-day archaeological site – authentically enough still teeming with visitors – reflects the wealth and importance of the ancient city, with its busy harbour, its famed Temple of Artemis (one of the Seven Wonders of the Ancient World), 25,000-seat theatre, vast agora, temples of Hadrian and Domitian, gymnasium, sports field, several bath complexes, advanced system of aqueducts, and other impressive public and private buildings. As a doctor, Rufus belonged to the social and intellectual elite of this proud metropolis. Archaeological and inscriptional evidence from the Imperial period bears witness to the existence of a thriving medical community, whose members enjoyed a considerable degree of wealth and status and whose collegiate assemblies and competitions reflect a major aspect of the general culture of the time, the so-called Second Sophistic, a period characterised by a marked predilection for epideictic oratory and other displays of intellectual prowess.²⁶⁴

3.2. Medical knowledge

Rufus worked at a time when there was a strong tendency for doctors to identify themselves with a sect, or school of thought. The point of difference between these sects,

²⁶² Hanson (2011:252-258) estimates a range of 50,000-90,000, dismissing Beloch's earlier much larger estimate of 225,000 on the grounds that it relied on dubious methodology and erroneous reading of epigraphic evidence. The two cities above Ephesus in Hanson's list are Sardis and Alexandria Troas (Antigoneia), with Pergamum in fourth position.

²⁶³ *Humanus animus ... humilem non accipit patriam, Ephesum aut Alexandriam aut si quod est etiamnunc frequentius accolis laetiusve tectis solum.* Sen.Ep.17.2.21 (102.21).

²⁶⁴ See Nutton 2008:141-3, Samama 2003:69-71 and, for the epigraphic evidence, cf. below, pp.139-140. On the Second Sophistic, see Mattern 2008:7, with note 15 (a detailed set of references for discussions of the Second Sophistic from Philostratus to the 21st century) and 9-11 (a vivid account of the performative culture in Rome); also Hankinson 2009. Swain uses 'Second Sophistic' to describe an historical period (for different uses of the term see Whitmarsh 2005:4).

whose origin dated back to 3rd century Alexandria, was not therapeutic or methodological but epistemological: how best to proceed towards ‘the discovery of remedies (τὴν τῶν ἰαμάτων εὔρεσιν)’.²⁶⁵ Danielle Gourevitch describes the position thus:

The true issue was not the choice of therapy, which was debatable but never worth fighting over; the question was rather the method by which medical knowledge was acquired, the nature of this knowledge, its origin, and its final purpose. How should a physician, in such or another case, determine the appropriate treatment for a given illness?²⁶⁶

The three best known groupings are the Empiricists, Rationalists (or Dogmatists) and Methodists,²⁶⁷ but there were also minor schools such as the Pneumatists and the Asclepiadians. Empiricists rejected theoretical knowledge as unattainable and the search for hidden causes as ultimately speculative, relying instead on a combination of personal observation and accumulated knowledge of comparable cases to develop appropriate therapies. Methodists (including Rufus’s probable contemporary and fellow Ephesian, Soranus) focused on the current, holistic state of the body they were being asked to treat, and regarded questions of causation as irrelevant. Rationalist medicine is best understood as a broad doxographical category denoting those who did not adhere to either school but were committed to theoretical physiology and pathology and the search for hidden causes.²⁶⁸ Galen refused to align himself with any sect, preferring to take a syncretic approach²⁶⁹ (though he utterly abhorred Methodism), and so powerful thereafter was the

²⁶⁵ Gal.*Sect.Int.*1, I.65.9-10 K.

²⁶⁶ Gourevitch 1998:107.

²⁶⁷ For the traditional tripartite classification, see for example Gal.*Lib.Prop.*1, SM II.4.4-7 = XIX.12.7-10 K: τὰ δὲ τῶν τριῶν αἰρέσεων ὀνόματα σχεδὸν ἅπαντες ἤδη γινώσκουσιν [τὴν μὲν τινα δογματικὴν τε καὶ λογικὴν ὀνομάζεσθαι, τὴν δὲ δευτέραν ἐμπειρικὴν, τὴν τρίτην δὲ μεθοδικήν]. For a cynical account, see Plin.*HN*.29.iii-iv.4-9.

²⁶⁸ See Hankinson 1998a; Frede 1987:261-62; Gourevitch 1998:104-121; von Staden 1989:58-9; Tecusan 2004:4, 7-9; also Galen, *On Sects for Beginners*, a far from impartial account.

²⁶⁹ For a succinct account, see Hankinson 1998:28. See also Gal.*Lib.Prop.*1, XIX.13.15-18, SM II.955-8; *Loc.Aff.*, VIII.143-44 K.

impact of ‘Galenism’ that, in Vivian Nutton’s colourful phrase, ‘other medical sects passed peacefully away’.²⁷⁰

Strikingly absent from the accounts that we have of these epistemological differences is discussion of how to make use of the patient’s perspective in the task of building medical knowledge. It is as if the patient’s role was seen as essentially passive, a source of purely factual details for the doctor to interpret using whatever mix of theory, observation and experience his epistemological convictions recommended. Rufus did not align himself with a sect.²⁷¹ Indeed it is possible to read into *QM* 15-21 a subtle dismissal of each of them. He does not explain his non-adherence, at least in any of his extant works, though there is a possibility that he wrote a treatise on sects.²⁷² But his emphatic repetition in *QM* that ‘the doctor cannot know’ what he needs to ‘by himself’, and his insistence that questioning patients is essential to the acquisition of ‘full and accurate knowledge’, suggest that his concern may have been less with whether medical knowledge is best obtained through theory or experience than with its inherent shortcoming: that on its own it is not adequate for its presumed purpose.

3.3. Ideas about health and sickness

Balance and mixture

It is clear that Rufus entertained some fairly conventional ideas about health and sickness. His frequent references to patients’ balance and mixture reflect an idea that occurs in

²⁷⁰ Nutton 1984:4. On Galen’s intense distrust of Methodism, see Gourevitch 1998:113, and Tecusan 2004:3, 5, 18-21.

²⁷¹ Van der Eijk 2008a:159; Gourevitch 1998:121.

²⁷² Abou-Aly 1992:46-7 n.97.

Greek medicine from the pre-Socratics through to Galen; indeed Peregrine Horden has recently argued that it is balance, rather than (as often assumed) humoral theory, that most truly epitomises Greek thinking about the body, health and illness.²⁷³ According to Galen, every school of thought regarded health as ‘definitely a balance of some kind’,²⁷⁴ even if they disagreed as to what exactly the proper components of that balance were:

καθ’ ἡμᾶς μὲν ὑγροῦ καὶ ξηροῦ καὶ θερμοῦ καὶ ψυχροῦ, κατ’ ἄλλους δὲ ὄγκων καὶ πόρων, κατ’ ἄλλους δὲ ἀτόμων ἢ ἀνάρμων ἢ ἀμερῶν ἢ ὁμοιομερῶν ἢ ἀνομοιομερῶν ἢ ὅτου δὴ τῶν πρώτων στοιχείων, ἀλλὰ κατὰ πάντας γε διὰ τὴν συμμετρίαν αὐτῶν ἐνεργοῦμεν τοῖς μορίοις.

In my view it is a balance of wet, dry, hot and cold, while others hold that it is a balance of masses and channels, others a balance of atoms, or *anarmoi*, or *indivisibles*, or *homogeneous* or *non-homogeneous* parts - or any such primary element. But certainly all agree that it is through the balance of these that we perform our activities with different parts of the body.²⁷⁵

Whether or not Galen was right to claim that the conception of health as ‘a good-mixture or balance of the elements from which we have come about’ was shared by ‘nearly all my predecessors’²⁷⁶ – Singer, for example, points to the ‘historiographically dubious’ nature of the assumption that a particular term carries the same meaning in the hands of different authors and in different contexts, and thinks it unlikely that the Asclepiadeans

²⁷³ Horden 2013:7. On the exaggeration of the importance of humours in the Hippocratic Corpus, see Craik 2015:208. On health as balance, and disease as disruption of that balance, see also Edelstein 1967:70. King (2013:25) remarks that the notion that health is ‘essentially ... a matter of balance’ knits together many different ideas about the body. According to Allan Young, the idea that sickness results from ‘a disturbed natural equilibrium which curers must try to restore’ is common to many cultures (1976:47).

²⁷⁴ συμμετρία γὰρ δὴ τις ἡ ὑγεία κατὰ πάσας ἐστὶ τὰς αἰρέσεις. Gal.San.Tu.1.5, VI.15K.

²⁷⁵ Gal.San.Tu.1.5, CMG V.4.2.9-13 = VI.15 K.10-15 (tr. Singer, unpublished). See also van der Eijk 2008a:298. Cf. Gal.Ars Med.2, I.310-11 K, and 4, I.314-5 K; Opt.Corp.Const.1, IV.737 K. König (2005:275) notes Galen’s ‘determination that no sphere of human activity can be allowed to escape from subjection to the principles of balance and self-knowledge which are the central features of his own philosophical medicine’.

²⁷⁶ τό τε γὰρ εἶναι τὴν ὑγίαν οὐχ ἀπλῶς εὐκрасίαν ἢ συμμετρίαν τῶν στοιχείων, ἐξ ὧν ἐγενόμεθα, καθάπερ οἱ πρὸ ἡμῶν ὀλίγου δεῖν ἅπαντες ἐνόμιζον, ἀλλὰ μόνον τὴν τῶν ὁμοιομερῶν σωμάτων, ἀποδεδειγμένον ἡμῖν ἐν ἐτέροις, ὑπόθεσις ἔστω πρὸς τὰ παρόντα (San.Tu.1.4, CMG V.4.2.7 = VI.11-12 K). Admittedly he says this in the course of criticising those who held that view, but Singer argues that his motive is not to dismiss the significance of balance but to show that his own concept is a more fully developed version of what his predecessors thought (Singer 2014:977-9).

and Methodists embraced the concept of balance, while Nutton takes a different view²⁷⁷ – it was certainly a dominant idea. The earliest extant definition of health and disease, attributed to the early sixth century philosopher Alcmaeon of Croton, describes the former as ‘conserved by egalitarianism among the powers – wet and dry, hot and cold, bitter and sweet, and the rest’, and the latter as the result of ‘monarchy among them’;²⁷⁸ Plato tells us in *Timaeus* that disease results from unnatural imbalance or disharmony in the body’s ‘four component elements: earth, fire, water and air’, and in *Symposium* uses medicine as an important illustration of eternal truths about harmony and balance;²⁷⁹ Aristotle refers to the health-giving effects of proportionate quantities of food, drink and exercise and the deleterious effects of the wrong quantities.²⁸⁰ As an adherent of humoral theory, Rufus believed that health depended on a balance of the four humours: phlegm, blood, yellow bile and black bile.²⁸¹ Thus he opines that ‘brain fever’ is caused by ‘a great quantity of bile in the stomach, because of which brain is damaged’ and in case studies talks of ‘a melancholic superfluity in one of [the] arteries’.²⁸² Balance of qualities (dry and moist; hot and cold) is also important in Rufus’s pathology: ‘The humour sometimes becomes black because it gets excessively hot, and sometimes because it gets excessively

²⁷⁷ Singer 2014:977; Nutton 2004:168; cf. Nutton 2000:252, on Aretaeus’s concept of good health as a balance between *pneuma* and the four elements of matter.

²⁷⁸ τῆς μὲν ὑγείας εἶναι συνεκτικὴν τὴν ἰσονομίαν τῶν δυνάμεων, ὑγροῦ, ξηροῦ, ψυχροῦ, θερμοῦ, πικροῦ, γλυκεοῦ καὶ τῶν λοιπῶν, τὴν δ’ ἐν αὐτοῖς μοναρχίαν νόσου ποιητικὴν (DK24b4, tr. Barnes 2001:37). The application of this political metaphor to health is unique in the Greek medical tradition and may have originated with Alcmaeon, who was perhaps drawing on earlier Crotonian medical tradition; the definition is said to be the earliest extant, though the extract is a later *testimonium* rather than a direct quotation from Alcmaeon himself. See Jouanna 1999:262 and 327-28, and Huffman 2013.

²⁷⁹ *Ti.*82a-b; *Smp.*186-188, where the doctor’s task is described by Eryximachus in terms of ensuring ‘concord and love’ between opposing elements, like music and ‘all other domains, in matters divine as well as in human affairs’ (187e, tr. Nehamas and Woodruff, Cooper 1977:471). Cf. *Smp.*187c (the ‘good practitioner ... must be able to make friends and happy lovers of the keenest opponents in the body’, tr. Lamb, Loeb III.124-7). On the centrality to Plato’s argument of his assumption that health involves balance, see Kraut 1992:333 n.11.

²⁸⁰ *Arist.EN* 1104a, 2.2.6; cf. *Pr.*1.1-3.

²⁸¹ See for example *QM* 33, as well as *On Melancholy*, *passim*. On humoral theory, for concise discussions see Powell 2003:10-13, Pormann 2008a:4-5, and Nutton 2008:146-7. For fuller treatment, see for example Grmek 1998a:247-50 and Jouanna 2012:335-359.

²⁸² Ruf. *On Melancholy* FF8.3, 67.18.

cold’;²⁸³ in one case study he observes that the patient’s ‘body had become dry. So I prescribed a moistening diet’ and in another he reports having ‘moistened [the patient] and evened out the sharpness of his humour’.²⁸⁴

In ancient medical writing the idea of balance in the human body is often articulated in terms of κρᾶσις, ‘mixture’; as Galen put it in *On Mixtures*, ‘the well-balanced mixture is superior to all others in both excellence and power’ (τὴν εὐκρατον ... ἀπασῶν ... ἀρετῇ θ’ ἅμα καὶ δυνάμει προὔχουσιν).²⁸⁵ The notion goes back to the earliest Hippocratic writing. The author of *On the Nature of Man*, for example, explains that man ‘enjoys the most perfect health’ when the four elements of which he is composed – that is, ‘blood, phlegm, yellow bile and black bile’ – are ‘duly proportioned to one another ... and when they are perfectly mingled’, while ‘pain is felt when one of these elements is in defect or excess, or is isolated in the body without being compounded with all the others’.²⁸⁶ For the author of *Ancient Medicine* the crucial elements are different – ‘salt and bitter, sweet and acid, astringent and insipid, and a vast number of other things, possessing properties of all sorts’ – but the importance of their being correctly mixed is the same: ‘these, when mixed and compounded with one another are neither apparent nor do they hurt a man; but when one of them is separated off, and stands alone, then it is apparent and hurts a man’.²⁸⁷ Here again Rufus’s views are entirely conventional. For example he reproaches

²⁸³ Ruf. *On Melancholy* F11.18.

²⁸⁴ Ruf. *On Melancholy* FF67.10-22, 71.21.

²⁸⁵ Gal. *Temp.* 1.3, 7, 6-7 Helmreich = I.519, 1-2 K.

²⁸⁶ τὸ δὲ σῶμα τοῦ ἀνθρώπου ἔχει ἐν ἑωυτῷ αἷμα καὶ φλέγμα καὶ χολὴν ξανθὴν τε καὶ μέλαιναν, καὶ ταῦτ’ ἐστὶν αὐτῷ ἡ φύσις τοῦ σώματος, καὶ διὰ ταῦτα ἀλγεῖ καὶ ὑγιαίνει. ὑγιαίνει μὲν οὖν μάλιστα, ὅταν μετρίως ἔχη ταῦτα τῆς πρὸς ἀλλήλα κρήσιος καὶ δυνάμειος καὶ τοῦ πλήθους, καὶ μάλιστα μεμιγμένα ἢ· ἀλγεῖ δὲ ὅταν τούτων τι ἔλασσον ἢ πλεον ἢ ἢ χωρισθῇ ἐν τῷ σώματι καὶ μὴ κεκρημένον ἢ τοῖσι σύμπασι. Hr. *Nat. Hom.* 4, tr. Jones, Loeb IV.11-13.

²⁸⁷ Ἐνὶ γὰρ ἐν ἀνθρώπῳ καὶ ἀλμυρὸν καὶ πικρὸν καὶ γλυκὺ καὶ ὀξύ, καὶ στρυφνὸν καὶ πλαδαρὸν, καὶ ἄλλα μυρία, παντοίας δυνάμειος ἔχοντα πληθὺς τε καὶ ἰσχύν. ταῦτα μὲν μεμιγμένα καὶ κεκρημένα ἀλλήλοισιν οὔτε φανερά ἐστιν, οὔτε λυπεῖ τὸν ἄνθρωπον. ὅταν δὲ τι τούτων ἀποκριθῇ καὶ αὐτὸ ἐφ’ ἑωυτοῦ γένηται,

a rival for having ‘neglected to balance his [the patient’s] mixture’, and reports that he himself ‘cured many of the patients suffering from this disease by balancing the mixture’.²⁸⁸

Regimen

As Galen explained, keeping a patient’s mixture balanced involved ‘continually substituting what is missing for what is excessive, so as to bring about a state that is well balanced and median’ (ἀντεισάγοντες ἀεὶ ... τῷ πλεονάζοντι τὸ λείπον, ὡς εὐκρατόν τινα καὶ μέσῃν ἐργάσασθαι κατάστασιν).²⁸⁹ Adjustments were made through a variety of means, including medicines, bloodletting (a delicate and risky therapy which demanded great skill and which Galen considered particularly useful in almost any serious situation), purging, and changes to the patient’s regimen. Faith in regimen – the theory that a person’s health is materially affected by elements of his or her daily life, such as diet, exercise, physical environment and a range of personal habits including bathing, sleep and sexual behaviour²⁹⁰ – was a central pillar of Greco-Roman health beliefs.²⁹¹ It first became fashionable, Plato tells us, in the fifth century BC, when a physical trainer called Herodicus²⁹² introduced ‘the kind of modern medicine that plays nursemaid to the

τότε καὶ φανερόν ἐστι καὶ λυπεῖ τὸν ἄνθρωπον. Hp.VM 14, tr. Jones, Loeb I.39. Cf. Gal.Ars. Med.4, I.315 K.

²⁸⁸ Ruf.*On Melancholy* FF 68.7, 69.4, 70.5, cf. 71 *passim*. Rufus emphasises that it is achieving a balanced mixture that is important (F70); other doctors who purged without ensuring balance were unsuccessful (FF68, 69).

²⁸⁹ Gal.*Temp*.1.3, 7,17-18 Helmreich = I.519,13-14 K; disease defined as imbalance, *ib.*, 8 Helmreich = I.521 K.

²⁹⁰ This definition largely echoes that of Jouanna (1999:162).

²⁹¹ See van der Eijk 2008a:297-8; Holmes 2010:177-182; Edelstein 1987:358-9; Powell 2003:2-6; Cels.*Pr*.9-11; and *De Alimentis Facultatibus*, Galen’s detailed description of the effects of foodstuffs on the body and vice versa (VI.453-748 K).

²⁹² Generally identified as Herodicus of Selymbria (c.500-c.430), credited by some scholars with authorship of the Hippocratic *On Regimen* – erroneously so, according to Joly (1960:203-205); see also Touwaide, ‘Herodicus [1]’, in *Brill’s New Pauly* Vol.6:263-64. For Herodicus’s theory of regimen, see *Anonymus Londinensis* IX, p.48 Jones. At *Epidemics* 6.18 one Herodicus – who may or may not be the same, according

disease ... and wore out first himself and then many others as well' thanks to the constant demands of his regimen.²⁹³ Plato's dating is corroborated by the evidence of contemporary Hippocratic treatises including *Regimen in Acute Diseases*, *On the Nature of Man*,²⁹⁴ *On Ancient Medicine*²⁹⁵ and *On Regimen*, a lengthy and extraordinarily prescriptive work setting out an ambitious programme of rules for 'the great mass of mankind, who of necessity live a haphazard life without the chance of neglecting everything to concentrate on taking care of their health',²⁹⁶ followed by an extra layer of even more detailed advice for those who are well enough off to spend their time monitoring themselves for the slightest sign of any alteration in balance.²⁹⁷

Rufus's medical practice fully incorporates the use of regimen. In *QM* he reminds doctors of the importance of asking about the patient's food intake – both the regimen he normally follows, when well, and what he has been eating and drinking while unwell.²⁹⁸ He repeats this advice in *On Melancholy*, recommending that the reader 'ask about the initial cause

to Galen – is said to have 'killed fever patients with running, much wrestling, hot baths. A bad procedure.' See Smith *ad loc.* (Loeb VII.231).

²⁹³ Pl.R.III.406a-b; cf. 407d: Asclepius stuck to drugs and surgery rather than dragging out patients' suffering with regimen, 'drawing off a little here and pouring in a little there' (tr. Grube and Reeve, Cooper 1997:1042 and 1044).

²⁹⁴ αἱ δὲ νοῦσοι γίνονται, αἱ μὲν ἀπὸ τῶν διαιτημάτων, αἱ δὲ ἀπὸ τοῦ πνεύματος, ὃ ἐσαγόμενοι ζῶμεν ('Diseases arise in some cases from regimen and in other cases from the air by the inspiration of which we live'. Hp.Nat.Hom.9 = VI.52.11-13 L, tr. Jones, Loeb IV.25).

²⁹⁵ καὶ νῦν οἱ τῶν γυμνασίων τε καὶ ἀσκησίων ἐπιμελόμενοι αἰεὶ τι προσεξευρίσκουσιν ... ζητέοντες ὃ τι ἐσθίων τε καὶ πίνων ἐπικρατήσῃ τε αὐτοῦ μάλιστα, καὶ ἰσχυρότερος αὐτὸς ἐωυτοῦ ἔσται ('even at the present day those who study gymnastics and athletic exercises are constantly making some fresh discovery by investigating ... what food and what drink are best assimilated and make a man grow stronger.' Hp.VM 4 = I.580 L, tr. Jones, Loeb I.21).

²⁹⁶ τῷ πλήθει τῶν ἀνθρώπων, ὁκόσοισιν ἐξ ἀνάγκης εἰκὴ τὸν βίον διατελεῖν ἐστὶ, μὴδ' ὑπάρχει αὐτοῖσι τῶν ἄλλων ἀμελήσασιν τῆς ὑγίειας ἐπιμελεῖσθαι. Hp.Vict.3.69 = VI.604 L, tr. Jones, Loeb IV.381.

²⁹⁷ For the dating of *On Regimen*, see Joly, its most recent editor (1960:206-9), and Jouanna 1999:162. Holmes, accepting Joly's dating and drawing on other evidence from the Hippocratic Corpus, argues that the theory gained ground quite rapidly in the late 5th century, and that Plato's treatment of the topic in *Republic* tends to corroborate that hypothesis (2010:177 with n. 120). Whether or not it was at that stage considered to be a medical, rather than a self-help, technique is less clear; Plato's reference to it in *Republic* indicates controversy at that time as to whether or not it did actually belong to medicine (R.407d-408b).

²⁹⁸ *QM* 18 and 36.

and [the patient's] regimen, and counteract them through treatment',²⁹⁹ and his various physical and behavioural therapies include dietary prescriptions, travelling and country air, bathing, drinking cold or tepid water, and plenty of wine and sex.³⁰⁰ In his case studies we find him adjusting patients' diet and sometimes the time of day at which they eat: 'I ordered that he not eat late .. but rather take at lunchtime bread soaked in warm water, and that in the evening he eat what he was used to'.³⁰¹ He is particularly pleased to have been able to cure people 'by balancing the mixture without purging' – presumably by concentrating on changes to the patient's regimen.³⁰²

Somatic bias

The ancient concept of disease was strongly somatic, even when mental symptoms were involved. Mind and body were so closely linked that not only could the mind, in Hippocratic dream theory, shed light on the body's symptoms through dreams,³⁰³ but the

²⁹⁹ *On Melancholy* F40.20.

³⁰⁰ 'Fine and tasty food such as semolina bread, chicken and kite meat, and small rock fish' (F40.16); 'those who can tolerate to drink wine have no need for any other medication, for it alone is all they need in order to treat this illness' (F40.18, cf. FF61, 63-65); 'long and extended journeys are beneficial ... for they change their mixture, improve digestion, distract them from thinking, and amuse them' (F40.19); 'fresh air and the cold countryside are quite helpful for [stimulating] appetite' (F50.2); cold water (F50.1); tepid water (F51); sex (FF58-60); baths (F62).

³⁰¹ Dietary adjustments, F67.11-15; eating at a different time of day, F71.23.

³⁰² *On Melancholy* F70.4.

³⁰³ See Hp.*Vict.*4, in which the author explains how his method of 'forecasting an illness before the patient falls sick, based upon the direction in which there is excess' (καὶ πρὸ τοῦ κάμνειν τὸν ἄνθρωπον ἀπὸ τῆς ὑπερβολῆς, ἐφ' ὁκότερον ἂν γένηται, προδιάγνωσις. *Vict.*1.2 = VI.472 L, tr. Jones, Loeb IV.231, adapted) applies to dreams. The author distinguishes between divine dreams, which must be interpreted by people with the appropriate skill, and dreams about the state of the body, which should be interpreted by doctors on the general principle that those featuring μάχη, as opposed to normal quotidian activity, indicate 'a disturbance in the body' (τάραχον ἐν τῷ σώματι) (*Vict.*4.88, tr. Jones, Loeb IV.425, VI.642 L). Unlike Rufus (*QM* 30), the Hippocratic author is not certain that the illness can thereby be averted, but it can, he says, be treated (περὶ μὲν οὖν τῆς πρήξιος εἴτ' ἀποτρέπειν δεῖ εἴτε μή, οὐ κρίνω· τὸ δὲ σῶμα θεραπεύεσθαι συμβουλευώ (*Vict.*IV.88, VI.642-44 L). Remarkably detailed instructions are provided for how to respond to very specific dreams, the general theme being that the more unusual things appear in the dream, the sicker the patient is or will become. Galen wrote a lost work on 'dreams, birds, omens, and the whole of astrology' (τῶν ὀνειράτων καὶ τῶν οἰωνῶν καὶ τῶν συμβόλων καὶ πασῆς ἀστρολογίας), and was critical of those who 'despised' (καταφρονοῦσι) such things (*Gal.Nat.Fac.*1.12, II.29 K, tr. Brock 1916:47). He emphasises that his view follows that of Hippocrates (*id.*12-13).

body's mixture could influence the functioning of the mind. It must be said at this point that interpreting ancient discussions of mental disorders is beset with linguistic and conceptual difficulties, for it is impossible to be sure what ancient authors mean by, for example, melancholy, let alone assume that it meant the same to all of them or that conceptually it resembled what would today be called a mental illness.³⁰⁴ It is clear, however, that appreciation of the psychological dimensions of mental illness developed only gradually. Medical authors of the late fifth and early fourth centuries, like the epic and tragic poets, make no categorical distinction between physical and mental illness, instead presenting the soul and its activities as physical phenomena whose malfunctions were correctable by diet and drugs.³⁰⁵ Thus for example the author of *Regimen* explains at length how the body's mixture affects the soul's intelligence (φρόνησις ψυχῆς),³⁰⁶ and how the latter responds to various aspects of regimen, including walks, vomiting, oiling the body, bathing and sexual intercourse. He concludes:

περὶ μὲν οὖν φρονίμου καὶ ἄφρονος ψυχῆς ἡ σύγκρησις αὕτη αἰτία
ἐστίν, ὥσπερ μοι καὶ γέγραπται· καὶ δύναται ἐκ τῆς διαίτης καὶ βελτίων
καὶ χείρων γίνεσθαι.

It is this blending, then, that is ... the cause of the soul's intelligence or want of it; regimen can make this blending either better or worse.³⁰⁷

For this author, even the emotional and behavioural characteristics that do not respond to mixture – 'irascibility, indolence, craftiness, simplicity, quarrelsomeness and benevolence' – are affected by a different physical factor, 'the nature of the passages

³⁰⁴ For a summary of the difficulties inherent in any attempt to understand how mental illness was conceived, defined, discussed, diagnosed and treated, see van der Eijk 2013, 308-310. On the comparative lack of specialised technical terms available to the writers who dealt with the subject, see Harris 2013:22; cf. Letts 2013:1014-15. On the vocabulary of mental illness, see Thumiger 2013.

³⁰⁵ Hp.Vict.35 = VI.512-522 L. See also van der Eijk 2013:310-13.

³⁰⁶ Jones glosses his translation of φρόνησις, 'intelligence', as 'the power of the soul to perceive things, whether by the mind or by the senses' (*ad loc.* Loeb IV.281 n.2).

³⁰⁷ Hp.Vict.1.36 = VI.522.17-19 L.

through which the soul passes'.³⁰⁸ The same materialist concept can be seen in Plato's theory that διὰ δὲ πονηρὰν ἔξιν τινὰ τοῦ σώματος καὶ ἀπαίδευτον τροφήν ὁ κακὸς γίγνεται κακός;³⁰⁹ and, as van der Eijk puts it, Aristotle's concept of mental health as 'a combination of natural and cultural factors, physical and environmental as well as psychological and moral' is based on 'the notion of *krasis*, the physical mixture or proportion of elementary qualities that Aristotle adopted from the Greek medical theory' of regimen.³¹⁰ Galen had a well developed theory of the interdependence of body and soul, an idea on which he touches frequently and to which he ultimately dedicated an entire treatise, *The Faculties of the Soul Follow the Mixtures of the Body*.³¹¹ Bad physical habits destroy the character of the soul (τὸ τῆς ψυχῆς ἥθος), he explains in *On the Preservation of Health*, and, conversely, emotional distress triggers physical illness (πυρετοὺς ἀνάπτουσι καὶ νοσημάτων μεγάλων ἀρχαὶ καθίστανται),³¹² a theory that also surfaces in certain of his case studies,³¹³ along with the idea that disturbance to the soul can be identified from the pulse.³¹⁴

The physical nature of mental illness is, then, a tenacious idea in ancient medicine. That Rufus shared this somatic concept is clear from both *QM* and *On Melancholy*. He was 'convinced that the humours of the body engender dreams that signify both good things

³⁰⁸ Τῶν δὲ τοιούτων οὐκ ἐστὶν ἡ σύγκρησις αἰτίνη· οἷον ὀξύθυμος, ῥάθυμος, δόλιος, ἀπλοῦς, δυσμενής, εὖνους· τῶν τοιούτων ἀπάντων ἡ φύσις τῶν πόρων δι' ὧν ἡ ψυχὴ πορεύεται, αἰτίνη ἐστί. Hp.Vict.I.36 = VI.522-524 L, tr. Jones. Loeb IV.293. For discussion of all these ideas see van der Eijk 2008:161 and 166; 2013:310-11; and Thumiger 2013:62-70.

³⁰⁹ Pl.Ti.86e ('the wicked man becomes wicked by reason of some evil condition of the body and unskilled nurture', tr. Bury, Loeb VII.5).

³¹⁰ Van der Eijk 2013:322.

³¹¹ Gal.QAM, IV.767-822 K, a late work (Singer 1997:li). On the mind-body connection in Galen, see Donini 2008.

³¹² Gal.San.Tu.I.53, CMG V.4.2.19,24-26 and 31-33 = VI.40 K. Edelstein (1987:356-57) emphasises that the theory is not crudely deterministic.

³¹³ Gal.Praen.6.15, CMG V.8.1.104,16 = XIV.634,15-16 K; see also below, pp.185-187.

³¹⁴ Gal.Hipp.Prog.1.8, CMG V.9.2.218 = XVIII.40 K.

and bad for the patient',³¹⁵ and, as we have seen, believed that balancing the patient's mixture was crucial to the successful treatment of melancholy. But he also brought another important perspective. Like other afflictions that subsequently came to be seen as psychological, melancholy had been conceptualised by Hippocratic authors in physical terms, with such psychological implications as it did have indicating some general kind of insanity rather than anything specifically depressive;³¹⁶ in non-medical literature of the classical period too, its psychological symptoms are not depressive but manic.³¹⁷ The first evidence of a more complex psychological concept is the pseudo-Aristotelian discussion that links mania and depression as different pathological manifestations of the same disease, both still proceeding from physical causes – that is, extremes of temperature in black bile: too much heat and the patient manifests manic ἐκστάσεις; too much cold and ἄθυμια and φόβοι ensue.³¹⁸ Rufus not only agreed that melancholy could present psychologically as well as physically, but he believed that it had causes and potential remedies in both realms. He provides a much fuller set of psychological symptoms than is found in earlier discussions, including irrational fears, delusions, food cravings, alcohol abuse and suicidal thoughts (F11), anxiety, 'suspicion aimed at one particular thing' and obsessive washing (F13), unwarranted withdrawal from social contact (F14), moodiness, lack of joy and 'bad character' (F18), 'frequent wet dreams' (F29), and damage to the

³¹⁵ πάνυ δὲ ἐμμετὸν πείθω κατὰ τοὺς χυμοὺς τοὺς ἐν τῷ σώματι δόξας ἐνυπνίων ἐγγίγνεσθαι σημαινούσας καὶ ἀγαθὰ καὶ κακὰ τῷ ἀνθρώπῳ *QM* 33, preceded by three case studies featuring admonitory dreams (*QM* 29-32); cf. *On Melancholy* F29, where 'frequent wet dreams' are said to indicate melancholy.

³¹⁶ Thumiger 2013:62-70. The single exception is the Hippocratic aphorism 'if fear or sadness lasts for a long time, and continues, this is melancholic' (ἢν φόβος ἢ δυσθυμία πολὺν χρόνον ἔχουσα διατελῇ, μελαγχολικὸν τὸ τοιοῦτον. *Hp.Aph.VI.23*, 184 Jones = 4.568 L), an observation whose ambiguity (μελαγχολικός can mean either 'a symptom of melancholy' or 'a cause of melancholy') is itself indicative of the relatively unformalised state of thinking at this time about mental disorder and its causes and symptoms. Jouanna argues that μελαγχολικὸν here certainly means 'characteristic of' rather than 'caused by' melancholy (2012:234-5).

³¹⁷ Kazantzidis 2013:245-6.

³¹⁸ Kazantzidis 2013:246, referencing ps.-Ar. *Problemata Physica* 30.1; cf. van der Eijk 2008:163-4.

thoughts and poor self-opinion (F70).³¹⁹ The mental causes that he proposes are too much thinking (FF 34, 36, 68) social stress (F68), fear consequent on nearly drowning (F69), and an ascetic lifestyle (F70).³²⁰ As van der Eijk observes, this line of thought reverses the Aristotelian correlation between excess of black bile and the tendency to overwork: while (ps.-)Aristotle says that the mixture leads to the behaviour, Rufus – while agreeing that the mixture responsible for melancholy (FF11, 21) can be either innate (F11 §22) or acquired³²¹ – sees the behaviour as causing the imbalance in the mixture.³²² He thereby indicates a new level of understanding of the nature of mental illness.

Rufus's ideas about melancholy, and their influence on the concept as it developed in later medical and philosophical thought, are discussed in detail in the collection of essays accompanying Pormann's 2008 edition. The extent of his originality and the exact relationship of his thinking to preceding philosophical and medical traditions remain uncertain, as does the question as to how fully developed his concept of psychological factors actually was. Further difficulty arises from the fragmentary nature of *On Melancholy* and from Galen's probable appropriation of Rufus's work,³²³ both of which make it hard to identify his ideas with complete certainty. Despite these difficulties,

³¹⁹ Cf. FF12, 17, 67, 68, 69. Physical symptoms include wind (FF9 and 10), indigestion and constipation (F11), black stools, ulcers, 'dull-white leprosy', pimples, mange, bleeding haemorrhoids, varicose veins (F21), ringing in the ear, heaviness of the head (F29), pain and shivering (F71).

³²⁰ Physical causes include 'extreme heat of the liver and the stomach' (F7), dry belly (F6), coldness of the 'orifice of the stomach' and lightness of the head (F11); correlations with old age, time of year, and male gender are also mentioned (FF17 and 18). Physical treatments involve balancing the patient's mixture through dietary regimen, purging and venesection (FF8, 28, 37-40). His psychotherapeutic measures include putting something heavy on the head of a patient who imagines himself to be headless (F12), amusement (F67), cheering the patient up (F69), and an end to late dining (F71), and protecting the patient from worrying ideas or excessive thinking (F40.37-38). The 'heavy headgear' therapy described in F12 may or may not be one of Rufus's own cases: see Pormann *ad loc.* (2008:87). Rufus describes the same pathology in F11, but without mentioning treatment.

³²¹ See Pormann 2008a:6-7; van der Eijk 2008:173; and cf. Rufus's own emphasis at *QM* 34 that it is essential to ask the patient about 'congenital disorders' (τὰ συγγενῇ τῶν νοσημάτων).

³²² van der Eijk 2008:164, cf. 169.

³²³ See above, p.55 with n.87.

Rufus's work on melancholy is widely regarded as seminal, combining, as Pormann observes, a physiological and a psychological understanding of the condition 'like [that of] no other physician from Antiquity'.³²⁴ And as I shall argue in Chapter 5, his innovative theoretical approach to melancholy is borne out by the keen interest in mental factors that he demonstrates in *QM*, where he says that the melancholy state (τὰ μελαγχολικά) is particularly indicated by θρασύτης 'over-boldness' and ἄκαιρος λύπη 'uncalled-for sadness'³²⁵ – mania and depression, in other words – and locates his references to melancholy firmly within his discussion of the psychological benefits of questioning the patient.

Individuality

One important theme in ancient medical discourse with which Rufus seems at first glance to be aligned in an unremarkable way is that of concern with the individuality of the patient. As he says, οὐ ... πάντες πεφύκαμεν τρόπῳ τῷ αὐτῷ, ἀλλὰ καὶ πάνυ ἀλλήλων διαφέρομεν εἰς ὅτιοῦν χρῆμα ('we are not all constituted the same, but are completely different from each other in every respect whatsoever').³²⁶ The need for constant negotiation between the universal and the particular – between general theories and rules, and the individual case at hand – is one of the commonplaces of ancient medical writing, from the earliest Hippocratic texts through to Galen and his epitomisers and commentators.³²⁷ Medically speaking, 'health' meant a state of conformity with nature (κατὰ φύσιν) and illness a state contrary to nature (παρὰ φύσιν);³²⁸ so the doctor's task

³²⁴ Pormann 2008a:3.

³²⁵ *QM* 4. See below, p.164.

³²⁶ *QM* 16.

³²⁷ See Edelstein 1987:108-9 for a series of illustrative references.

³²⁸ See Jouanna 1999:345, referencing *Hp.Loc.Hom.2* = VI.278 L: φύσις δὲ τοῦ σώματος, ἀρχὴ τοῦ ἐν ἱητρικῇ λόγου ('the nature of the body is the beginning point of medical reasoning', tr. Potter, Loeb VIII.23;

was to recognise the unnatural state and restore the natural one. But ‘nature’ is a thing of infinite variety: there is universal human nature, and there is the nature of the individual person, and the latter – in itself changeable³²⁹ – affects the form and course of the disease.³³⁰ What is *κατὰ φύσιν* for one person is not the same for another, and what looks worrying is, as Rufus says, not necessarily so (and, by implication, vice versa):

ἄπερ ἂν καὶ δεῖσαι ὁ ἱατρὸς <ὡς> χαλεπώτατα [καὶ] διακωλύσαι καὶ οὐ[τε] προσφόρως θεραπευόμενα οὔτε χαλεπὰ τοῦτω <γε> τῷ ἀνθρώπῳ ὄντα οὔτε ἀνεπιτηδείως τῇ παρουσίᾳ νόσῳ θεραπευόμενα.
(QM 15)

The physician might be worried by something on the grounds that it is hard to resist and not susceptible to treatment when in fact it is not difficult in this patient’s case, at least, or not unsuitable for treatment in the present episode of sickness.

Even the highly systematising Galen acknowledged that health could not be precisely specified or measured in universal terms, but was peculiar to the individual, and that the line between health and illness had to be judged by the doctor on a case by case basis.³³¹

This presents the physician with a major practical challenge: the need to take into consideration ‘both universal nature and the nature of each individual’ (*μαθόντες ἐκ τῆς κοινῆς φύσιος ἀπάντων, καὶ τῆς ἰδίης ἐκάστου*).³³² As Aristotle famously put it:

οὐ γὰρ ἄνθρωπον ὑγιάζει ὁ ἱατρεύων ἀλλ’ ἢ κατὰ συμβεβηκός, ἀλλὰ Καλλίαν ἢ Σωκράτην ἢ τῶν ἄλλων τινὰ τῶν οὕτω λεγομένων ὃ συμβέβηκεν ἀνθρώπῳ εἶναι· ἐὰν οὖν ἄνευ τῆς ἐμπειρίας ἔχη τις τὸν λόγον, καὶ τὸ καθόλου μὲν γνωρίζῃ τὸ δ’ ἐν τούτῳ καθ’ ἕκαστον ἀγνοῇ,

cf. Gal.*San.Tu*.1.4, VI.12 K: ταῖς κατὰ φύσιν ἐνεργείαις ἡ ὑγιεινὴ κατασκευὴ κρίνεται (‘the healthy constitution is assessed on the basis of the activities [functioning] according to nature,’); cf. Pl.*R*.IV 444d.

³²⁹ Edelstein 1987:304; there is also the natural power possessed by various elements of regimen (Hp.*Vict*.2, Loeb IV.226).

³³⁰ Frede 1987:267, cited by Dickson (1998:21 n.2).

³³¹ See van der Eijk 2008a:298. For further discussion of Galen’s approach to the tension between universal and individual nature, see Chapter 5.5.

³³² Hp.*Ep*.1.23 (10) = II.668 L; cf. Hp.*Vict*.3.67 = VI.594 L; Gal.*MMG* 1, XI.1 K and Stephanus *ad loc.*: ‘who could discover the quantity or quality of the nature peculiar to each person?’ (τίς γὰρ ἂν δύναίτο τὸ πόσον ἢ τὸ ποιὸν τῆς ἐν ἐκάστῳ ιδιότητος φωρᾶσθαι; Steph.*in Gal*.1, 20 Dickson; tr. Dickson 1998:21). See discussion below, pp.201-205.

πολλάκις διαμαρτήσεται τῆς θεραπείας· θεραπευτὸν γὰρ τὸ καθ’ ἕκαστον.

For the physician does not cure a man, except in an incidental way, but Callias or Socrates or some other called by some such individual name, who happens to be a man. If, then, a man has theory without experience, and knows the universal but does not know the individual included in this, he will often fail to cure; for it is the individual that is to be cured.³³³

Ancient responses to this challenge often give the impression that the individuality of the patient is the biggest problem. The same foodstuff strengthens some but makes others ill;³³⁴ the same medicine works on one person in one way and on another in another.³³⁵ General criteria are elusive. ‘Medicine cannot be learned quickly because it is impossible to create any established principle in it, the way that a person who learns writing according to one system that people teach understands it fully’ says the author of *Places in Man*.³³⁶ Accuracy in treatment is difficult, if not impossible: ‘We need to aim at some measure. But there is no measure to be found – whether quantity or weight – by reference to which we can know exactly what is right, other than bodily feeling’, says the author of *Ancient Medicine*.³³⁷ Galen thought that the challenge of individuality demanded superhuman abilities:

³³³ Arist.*Metaph.*981a. Text: Ross, Oxford 1924; tr. Ross, Barnes 1984(2):1552-3. Cf. Cels.Pr.63: *vix ulla perpetua praecepta medicinalis ars recipit*.

³³⁴ τυρὸς ... οὐ πάντας ἀνθρώπους ὁμοίως λυμαίνεται, ἀλλ’ εἰσὶν οἵτινες αὐτοῦ πληρούμενοι οὐδ’ ὅτι οὖν βλάπτονται ... εἰσὶ δ’ οἱ χαλεπῶς ἀπαλλάσσουσι. διαφέρουσιν οὖν δὲ τούτων αἱ φύσεις, διαφέρουσιν δὲ κατὰ τοῦτο, ὅπερ ἐν τῷ σώματι ἔνεστι πολέμιον τυρῷ ... εἰ δὲ πάσῃ τῇ ἀνθρωπίνῃ φύσει ἦν κακὸν, πάντας ἂν ἐλυμήνατο Hp.VM.20 = I.624.1-10 L (‘Cheese does not harm all men alike; some can eat their fill of it without the slightest hurt ... others come off badly. So the constitutions of these men differ, and the difference lies in the constituent of the body which is hostile to cheese ... If cheese were bad for the human constitution without exception, it would have hurt all’. Tr. Jones, Loeb I.55.).

³³⁵ ἡ δὲ ἱητρικὴ νῦν τε καὶ αὐτίκα οὐ τὸ αὐτὸ ποιεῖ, καὶ πρὸς τὸν αὐτὸν ὑπεναντία ποιεῖ, καὶ ταῦτα ὑπεναντία σφίσις ἐκαστοῖσι. Hp.Loc.Hom.41 = VI.332.1-3 L (‘medicine ... does not do the same thing at this moment and the next, and it does opposite things to the same person, and at that things that are self-contradictory’, tr. Potter, Loeb VIII.81).

³³⁶ ἱητρικὴν οὐ δυνατόν ἐστι ταχὺ μαθεῖν διὰ τόδε, ὅτι ἀδύνατόν ἐστι καθεστηκός τι ἐν αὐτῇ σόφισμα γενέσθαι, οἷον ὁ τὸ γράφειν ἓνα τρόπον μαθὼν ὃν διδάσκουσι, πάντα ἐπίσταται. Hp.Loc.Hom. 41 = VI.330 L, tr. Potter, Loeb VIII.81(adapted).

³³⁷ δεῖ γὰρ μέτρον τινὸς στοχάσασθαι. μέτρον δὲ οὔτε ἀριθμὸν οὔτε σταθμὸν ἄλλον, πρὸς ὃ ἀναφέρων εἴση τὸ ἀκριβές, οὐκ ἂν εὖροις ἄλλ’ ἢ τοῦ σώματος τὴν αἴσθησιν. Hp.VM.9 = I.588-590 L tr. Jones, Loeb I.27.

ἡ ὄντως ἰατρικὴ τῆς τοῦ κάμνοντος ἐστόχασται φύσεως· ὀνομάζουσι δὲ, οἶμαι, τοῦτο πολλοὶ τῶν ἰατρῶν ἰδιοσυγκρασίαν, καὶ πάντες ἀκατάληπτον ὁμολογοῦσιν ὑπάρχειν· καὶ διὰ τοῦτο καὶ αὐτὴν τὴν ὄντως ἰατρικὴν Ἀσκληπιῷ καὶ Ἀπόλλωνι παραχωροῦσιν.³³⁸

The true art of medicine makes conjectures about the nature of the patient; many of the physicians, I think, call this ‘individual mixture’, and all of them agree that it is impossible to grasp, which is why they concede the true art of medicine to Asclepius and Apollo.³³⁹

For Celsus, the only solution was ‘to have a friend rather than a stranger as one’s doctor’: their medical knowledge might be the same, but knowledge of the individual was a vital extra ingredient.³⁴⁰

In these responses we see the patient constructed as the embodiment of the problem – as a physically complex, not to say bewildering, entity that makes the application of medical knowledge difficult and obliges doctors to fall back on complicated systems of division and diversification,³⁴¹ to dwell on the importance of conjecture, and to valorise the ability to judge the *kairos*, or right moment for intervention – a crucial skill in ancient medicine.³⁴² But another way of looking at the situation is to see the individuality of the patient as something positive – not an insurmountable hurdle that blocks the satisfactory application of universal principles, but the key that unlocks another level of

³³⁸ Gal.MM 3.7, X.209 K

³³⁹ Cf. Gal.MMG1.1, XI.1-2K, discussed below, p.202; MM 3.3, X.181-2 K (the patient’s individuality is ineffable); Aristides declares that if doctors did not have to rely on conjecture and probability, they would be on a par with ‘the god whose domain is Epidauros’ (οὐ μέντ’ ἄν τοσοῦτον ἐλείποντο τοῦ τὴν Ἐπίδουρον ἔχοντος θεοῦ, φαίης ἂν, καὶ μάλα ἐμοὶ γοῶν κατὰ νοῦν. Aristid.Or.2.153, 190.9-10 Behr, tr. Behr 1968:100-101).

³⁴⁰ *conicio ... cum par scientia sit, utiliore tamen medicum esse amicum quam extraneum*. Cels.Pr.73. Cf. Edelstein 1987:371.

³⁴¹ One way of trying to ‘bridge the gulf that exists between universal insight and particular instances’, as Edelstein puts it, was to understand each disease entity as having multiple forms, thus diversifying abstractions and bringing them closer to reality (1987:370). Another way was to diversify on a multiple basis: the individual, the ὥρη of the disease, the patient’s constitution (including age, sex and physique), time of year, place of treatment, occupation of patient etc. (e.g. Hp.Nat.Hom.9). For Galen’s extremely complicated system of *diaeresis*, see below, pp.203-204.

³⁴² See QM 23, with p.41 n.43 above. According to Jouanna, ‘To intervene in the right way and at the right time was seen as being unquestionably the most difficult aspect of the whole art of medicine’ (1999:344). Cf. Edelstein 1987:109; and see below, pp.199-200.

understanding and gives medical knowledge (both theoretical and empirical) its final value. The patient's individuality then becomes something to be explored on every possible dimension. Understood in this light, Rufus's voice comes through as fresh and insightful, a note of common sense amid a plethora of elaborate, contrived methodologies. He articulates familiar examples – foods, drinks and medicines have varied and unpredictable effects;³⁴³ 'none of these things is fixed, so that it conforms to a single theory for the physician'³⁴⁴ – but, rather than try and find ways of lessening the doctor's dependence on unravelling the mystery of individuality, he embraces and extends the concept, dwelling on the psychological aspects of the patient's nature and, as we shall see in Chapter 5, repeatedly asserting that questioning the patient is essential to the task of identifying and treating the individual case with which the doctor is confronted. This is what he means when he insists that medical knowledge is inadequate on its own. Rufus constructs the patient as psychologically as well as physically complex, and for that reason a crucial partner in illuminating the puzzle of his indisposition. For, as Edelstein asks, in a question to which we shall return in Chapter 7, 'if it is the individuality of the patient itself that counts most in the treatment, who could know the patient better than the patient himself?'³⁴⁵

³⁴³ *QM* 16-17, 40.

³⁴⁴ οὐδὲν τῶν τοιούτων καθεστηκός, ὥστε εἰς ἓνα ἐλθεῖν λόγον τῷ ἱατρῷ. *QM* 16.

³⁴⁵ Edelstein 1987:390.

Chapter 4 - Intention

Technical literature is a notably heterogeneous genre. *QM* exhibits many of the general characteristics of such writing: a simple written style, linguistic clarity, absence of ambiguity, polemical attacks on opponents, a tightly circumscribed scope focusing on the essential, and an assertive authorial presence.³⁴⁶ Whether or not it is helpful to call it a ‘handbook’ is less clear, for that could mean a number of things. The semantic range of modern English usage of the term extends from ‘a book small enough to be easily portable and intended to be kept close to hand’ to any book, not necessarily concise, giving information, guidance or instruction;³⁴⁷ while what a modern scholar of 1st century technical writing calls a ‘handbook’ might be a practical technical guide, a compilation or summary of existing knowledge on a specific topic, or perhaps a transcript of a lecture or classroom discussion made available for personal use.³⁴⁸ Into which, if any, of these categories are we to place *QM*?

4.1. Target audience

The primary target audience for *QM* is plainly physicians (practising, trainee or perhaps both). We can infer this not simply from the fact that it is doctors’ behaviour that Rufus

³⁴⁶ Fögen points out that, though united by the possession of a didactic goal, technical literature is characterised by a marked diversity of form, being found in many different types of text ranging from tables, notes and jottings through comprehensive handbooks to dialogues, letters and poetry (2015:267-71).

³⁴⁷ Oxford English Dictionary s.v.

³⁴⁸ For an illuminating discussion of ‘practical manuals and handbooks’ – technical guides on a wide range of subjects, produced in large numbers between the C5 BC and C1 AD and mostly lost – and ‘praxis writings’, designed to supply elite men with encyclopaedic, non-technical knowledge of particular disciplines such as agriculture, military tactics and strategy, history, politics and natural history, see Long 2001:16-45. For a discussion of ‘epitomes and handbooks’ see Snyder 2000:107-11. As he points out, there was a ‘rich (and very untidy) vocabulary’ for such abbreviated literature (2000:12, and, for many examples, 231 n. 31).

wants to influence, but from his frequent use of second person verbs to encourage that behavioural change,³⁴⁹ and from direct references such as those at §§29, 40 and 71:

πάντα μὲν οὖν ἐπὶ πᾶσιν οὐκ ἔστι γράφειν, ἀλλ' ὅσον σημῆναί τε τῷ λόγῳ καὶ ὑπομνῆσαι τὸν ἰατρὸν μηδὲν παραλιπεῖν τῶν τοιούτων. (§29)

I cannot deal with dreams comprehensively, but just enough to point out the subject in principle and to remind the physician not to overlook any of these kinds of things.

ἐπαινέσαιμι ἂν καὶ ἰατρὸν τὸν νῦν πρῶτον ἐντυγχάνοντα τῷ νοσοῦντι, εἰ μὴ ἀφ' ἑαυτοῦ μόνον ποιοῖτο τῆς θεραπείας τὴν εὔρεσιν, ἀλλὰ τινα καὶ τῶν ἐμπείρων τοῦ κάμνοντος εἰς συμβουλήν καλοῖ. (§ 40)

I would also praise the physician who, in his first encounter with the sick person, does not work out the treatment by himself alone, but invites someone who knows the patient for consultation as well.

τὸ δὲ κεφάλαιον τῆς γνώμης εὐρεθὲν καὶ ὑποβληθὲν τῷ ἰατρῷ ἔχει ἂν πάνπαν τὸ δέον. (§71)

The doctor who grasps the essence of my thinking and bases his work on it will find in it everything he needs.

4.2. Compositional form

Though the medical nature of Rufus's target audience is clear, it is less easy to decide whether they encountered *QM* as readers or as listeners, in other words whether the work originated as a literary production or was first delivered orally before a live audience. No definitive answer is possible, though a number of factors encourage the latter view. Jouanna has identified three key linguistic markers that imply oral delivery in a Hippocratic work:

³⁴⁹ For example, μάθοις γὰρ ἂν (§2); εἰ ... σὺ μὲν ἐρωτᾷς (§2); καταμάθοις ἂν (§3); μαθήσῃ (§13); εἰ ἐθέλεις ... εὐρήσεις (§16); etc. The usage is not exclusive – there are plenty of impersonal constructions as well: for example, χρὴ ἐρωτᾶν (§1), χρὴ νομίζειν (§2), χρὴ προσανερωτᾶν (§3), χρὴ ἐρωτᾶν (§4), χρὴ ... μανθάνειν (§17). ἐρωτητέον (§§4, 15); ἐνθένδ' ἂν τις ... καταμανθάνοι (§6), ἐξαρκοῖ γὰρ ἂν (§11), φημι χρηστῶς ἂν ἐρωτηθῆναι (§14), καλῶς ἂν τινα ... ἐρωτῆσαι (§16), ἐρωτάτω (§18) – but the second person verbs make it clear that he envisages practising doctors among his audience.

- i) the use of terms related to λέγειν for internal references to things the author has already said or intends to say (as opposed to terms related to γράφειν, which indicate a written work);
- ii) frequent use of first person verbs, sometimes reinforced by ἔγω or ἔγωγε, to ‘reinforce the presence of the speaker before his audience’; and
- iii) frequent use of φήμι ‘emphasising the affirmations of the author’.³⁵⁰

Judging *QM* against these criteria we find the following.

Internal references

Internal references and the author’s references to his own compositional process are made in terms related to λέγειν five times, and once using γράφειν:

Πρῶτον μὲν δὴ, **ὥς εἴρηται**, αὐτόν τινα χρὴ τὸν νοσοῦντα ἐρωτᾶν περὶ ὧν χρὴ εἰδέναι. §9.

τοῦτο μὲν γὰρ **εἴρηται** πρότερον ὑπὲρ αὐτοῦ. §36.

τοῖς δὲ οὐδὲ ἔλκος τὸ παράπαν γίγνεται, ἀλλ’ ὑπορρήγνυται τὸ ὀστέον καὶ πάσχουσιν **οἷα εἴρηται**. §56.

τέλος γε μὴν ἐρωτητέον καὶ τὰ ἐπὶ τῇ πληγῇ σημεῖα **τὰ ἔμπροσθεν εἰρημένα**. §62.

ταῦτα δὲ εἴ τις προ[σ]φέρων ἐπιμέμφοιτό μοι ... **λέγω** πρὸς ἐκεῖνον οὐδέν με[ν] τῶν ἐκείνου ἀτιμάζειν. §72.

πάντα μὲν οὖν ἐπὶ πᾶσιν οὐκ ἔστι **γράφειν**, ἀλλ’ ὅσον σημῆναί τε τῷ λόγῳ καὶ ὑπομνῆσαι τὸν ἱατρὸν μηδὲν παραλιπεῖν τῶν τοιούτων. §29.

Use of the first person

There is fairly frequent use of the first person, with and without the reinforcement of ἔγω or ἔγωγε:

διό **μοι δοκῶ** καλῶς ἂν τινα καὶ φύσιν τὴν ἐκάστου πρὸς ἕκαστα ἐρωτῆσαι. §16.

ὥστε **ἐγωγε θαυμάζω** Καλλιμάχου τοῦ ἱατροῦ. §21.

³⁵⁰ Jouanna 2012:41-44 (quotations both taken from p.43).

ἐγὼ δὲ ἡγοῦμαι μὲν καὶ παρ' ἑαυτοῦ δύνασθαι τινα πολλὰ τῶν ἐν ταῖς νόσοις ἐξευρίσκειν, κάλλιον δέ γε καὶ σαφέστερον ἐν τοῖς ἐρωτήμασιν. §22.

Πάνυ δὲ ἐμμαντὸν πείθω κατὰ τοὺς χυμοὺς τοὺς ἐν τῷ σώματι δόξας ἐνυπνίων ἐγγίγνεσθαι σημαινούσας καὶ ἀγαθὰ καὶ κακὰ τῷ ἀνθρώπῳ, ὧν κατάληψις ἄλλη οὐκ ἔστι μὴ ἀκούσαντι. §33.

ὥστε ἐπαινέσαιμι ἂν καὶ ἱατρὸν τὸν νῦν πρῶτον ἐντυγχάνοντα τῷ νοσοῦντι, εἰ μὴ ἀφ' ἑαυτοῦ μόνον ποιοῖτο τῆς θεραπείας τὴν εὔρεσιν. §40.

Οἶδα γοῦν τινα δηχθέντα μὲν ὑπὸ λυσσῶντος κυνός. §47.

ὥς οὖν εἰσεκλήθην καὶ εἶδον συνεχῶς μὲν ἀπτόμενον αὐτὸν τῆς κεφαλῆς τρομώδη τε ὄντα καὶ παρακρουστικόν, ἡρόμην, <εἰ> ἐπλήγη τὴν κεφαλὴν οὗτός ποτε, τῶν δὲ φησάντων θαρρῶ<ν> ἔφην συντετρίφθαι τὸ ὀστέον αὐτοῦ. ... ἔπειτα ... εὔρομεν ἐρρωγὸς ἐπὶ μήκιστον τὸ ὀστοῦν, καὶ τὸ λοιπὸν ἰώμεθα ὥσπερ τὰ κεφαλόκλαστα. §57-58.

ἐγὼ γοῦν ἐν Αἰγύπτῳ εἶδον ἄνθρωπον Ἀράβιον ἔχοντα τὴν νόσον τήνδε. §67.

ταῦτα δὲ εἴ τις προ[σ]φέρων ἐπιμέμφοιτό μοι ... λέγω πρὸς ἐκεῖνον οὐδέν με[ν] τῶν ἐκείνου ἀτιμάζειν. §71.

πάνυ ἄγαμαι τὸν ἄνδρα ... παρακελεύομαι δὲ μηδὲ τῶν ἐρωτημάτων ἀφίστασθαι τὸν μέλλοντα ὀρθῶς ὑπὲρ ἀπάντων γνώσεσθαι. §73.

Use of φημί

The use of φημί in the first person is infrequent but certainly emphatic:

εἰς τοσαῦτά φημι χρηστῶς ἂν ἐρωτηθῆναι. §14.

καὶ γὰρ οὐδὲ τοῦτό φημι δυνατόν εἶναι παρ' ἑαυτοῦ γινώσκειν. §37.

Jouanna claims no wider applicability for his criteria than the Hippocratic Corpus, and they need therefore to be used with circumspection in relation to *QM*. Nevertheless the Hippocratic works were well regarded and Rufus was familiar with them,³⁵¹ so it would not be surprising if his work had been influenced by their compositional patterns and

³⁵¹ See below, p.156.

conventions. It is also worth noting Snyder's observation that even works strongly marked by 'oral features' may have been composed thus deliberately in order to convey the immediacy of a classroom or lecture hall. Jouanna concurs, warning that systematic use of λέγειν words cannot absolutely guarantee that a work was composed for oral delivery, though works that do not use such terms are unlikely to have been orally delivered.³⁵² All that said, it seems, on the evidence considered, reasonable to posit that *QM* originated as an oral piece, and that the text that we have is either the script Rufus used or a version that was written up subsequently for wider dissemination.³⁵³

4.3. Discursive register

If we assume *QM* to have been an oral composition addressed to an audience of doctors, the question then arises whether its purpose was primarily to instruct or to persuade. Here again Jouanna's analysis of Hippocratic works is helpful. He distinguishes between a 'course', that is an instructional piece such as a lecture, and a 'discourse', or epideictic performance. He suggests two main criteria:

- i. length: the Hippocratic works which Jouanna identified as epideictic discourses, *The Art* and *Breaths*, both take about half an hour to deliver, their authors' aim being to win over the audience by their brevity and brilliance, while the 'lectures', whose pedagogical purpose demanded much more detailed content, all take between 70 and 90 minutes;
- ii. the presence or absence of rhetorical features: the 'lectures', including *On Airs, Waters and Places*, *On the Sacred Disease*, *On Generation* and *On the Nature of the Child*, and *On Diseases 4*, open with a very brief introduction, perhaps as little as a single phrase, they eschew rhetorical effect in the interests of explanation,

³⁵² Snyder 2000:82; Jouanna 2012:42.

³⁵³ This could account for the use of γράφειν in §29, where it is perfectly possible to envisage a note being added to the effect that dreams are a big subject that cannot be entered into fully in the present work. For the practice of writing up lectures for distribution, whether to members of the original audience or to people who had missed the original performance, see Snyder 2000:81-2; 106; 252 n. 81.

and they end abruptly; each of the ‘discourses’, on the other hand, opens with a comparatively lengthy scene-setting reflection, uses a variety of rhetorical composition techniques, and closes with an elegant conclusion, in conformity with Platonic principle.³⁵⁴

On these criteria *QM* appears to be much closer to a ‘discourse’ than a ‘lecture’. It is short, taking less than half an hour to read out; it avoids prescriptive detail, as we shall see below;³⁵⁵ and, though it lacks any formal rhetorical structure, its internal arrangement shows signs of careful attention, proceeding from statement of intent through repeated affirmation of principle to a recognisably rhetorical conclusion. The opening statement is brief but strongly programmatic:

ἐρωτήματα χρή τὸν νοσοῦντα ἐρωτᾶν ἐξ ὧν ἂν καὶ διαγνωσθεῖ τι τῶν περὶ τὴν νόσον ἀκριβέστερον καὶ θεραπευθεῖ κάλλιον. (§1).

You must ask the patient questions. By doing this you will more accurately recognise any of the factors to do with the sickness, as well as providing better treatment.

With its emphatic positioning of ἐρωτήματα, followed immediately by the verb of obligation χρή, with the infinite promise implied by τι, and with the totality of the physician’s art encompassed by accurate diagnosis and fine treatment, this simple statement encapsulates Rufus’s whole message: questioning the patient is a *sine qua non* of medical success. Then comes the main, confirmatory part of the treatise, arranged in four sections: first, Rufus explains why the doctor must make every effort to address his questions to the patient him- or herself (§§2-10); next, he dwells in some detail on what are, in his opinion, the three things that are most critical for the doctor to know, namely the chronology of the illness and the patient’s constitution and habits (§§11-23); thirdly he provides an illustrative survey of topics about which doctors need to question patients

³⁵⁴ Jouanna 2012:44-50. The reference is to Pl.*Phdr.*267d: a speech should end with ‘recapitulation’ (ἐπάνοδος), in other words τὸ ἐν κεφαλαίῳ ἕκαστα λέγεις ὑπομνήσαι ἐπὶ τελευτῇ τοὺς ἀκούοντας περὶ τῶν εἰρημένων (‘summarising everything and reminding the audience, at the end, of what has been said’).

³⁵⁵ See below, pp.140, 176-179.

(§§24-62), sub-divided into those appropriate to ‘common ailments’ (§§24-45) and those that apply in cases of wounds (§§46-62); fourth, he broadens his focus out from individuals to localities, emphasising that theoretical knowledge of the effects of environmental factors is essentially limited, and true understanding of their impact on a given population, and indeed of localised disorders, can come only from questioning the locals (§§63-70). The work closes with a rousing peroration in which he first rebuts a hypothetical charge of anti-Hippocratic thinking (§§71-72) and finally closes with a sentence that pithily recalls and reinforces the opening one:

παρακελεύομαι δὲ μηδὲ τῶν ἐρωτημάτων ἀφίστασθαι τὸν μέλλοντα
ὀρθῶς ὑπὲρ πάντων γνῶσεσθαι.³⁵⁶

I urge anyone who aspires to full and accurate knowledge not to refrain from questioning.

It must be noted here that Gärtner (1970) structured his edition differently, dividing the work into 13 chapters, which, although unexceptionable in themselves, merely reflect the immediate subject matter of each segment; the result is a simple linear arrangement that lacks any obvious coherence, occluding the thematic and rhetorical structure of the piece. The differences between this structure and my own are shown in the following table (§ numbers are Gärtner’s).

³⁵⁶ QM 73.

Gärtner		Letts	
Chapter	§§	Chapter	§§
1. General principles of questioning (<i>Allgemeine Grundsätze der Befragung</i>)	1-10	1. Introduction	1
		2. The importance of focusing on the patient	2-10
2. Time of onset of illness and periodic developments (<i>Der Zeitpunkt des Beginns einer Krankheit und periodische Abläufe</i>)	11-14	3. The three key things to find out	11-23
3. Individuality and habit (<i>Individualität und Gewohnheit</i>)	15-23		
4. Internal and external causes of disease (<i>Innere und äussere Ursachen von Krankheiten</i>)	24-27	4. How questioning supports diagnosis and treatment of: (a) common ailments (24-45)	24-62
5. Sleep, insomnia and dreams (<i>Schlaf, Schlaflosigkeit und Träume</i>)	28-33		
6. Congenital diseases (<i>Angeborene Krankheiten</i>)	34-35		
7. Diet during illness. Food intake and its effect. Preferred food. (<i>Diät während der Krankheit. Nahrungsaufnahme und ihre Wirkung. Bevorzugte Speisen</i>)	36-40		
8. The importance in diagnosis of pain and signs of pain (<i>Die Bedeutung von Schmerzen und Schmerzäußerungen für die Diagnose</i>)	41-43		
9. The condition of the bowels and the digestive system (<i>Die Beschaffenheit des Leibes und die Verdauung</i>)	44-45		
10. Animal bites, particularly rabid dog bites with subsequent hydrophobia (<i>Tierbisse, besonders Bisse tollwütiger Hunde mit nachfolgender Hydrophobie</i>)	46-49		
11. War wounds (<i>Kriegsverletzungen</i>)	50-62		
12. Geographic and ethnographic peculiarities (<i>Geographische und ethnographische Besonderheiten</i>)	63-71	5. Local peculiarities	63-70
13. Rufus and Hippocrates (<i>Rufus und Hippokrates</i>)	72-73	6. Conclusion	71-73

QM certainly could not be compared to the clever and showy compositions of the orators of the Second Sophistic, but Rufus indulges in the occasional rhetorical flourish, such as the following tricolonial figure:

καὶ γὰρ πρὸς τὸ μεθαρμόσασθαι τὰ παρόντα καὶ πρὸς τὸ μηδὲν κινῆσαι
τῶν πρὶν ὄντων καὶ πρὸς τὸ ἐξευρεῖν εἴ τι παραλέλοιπε τῶν δεόντων
χρήσιμον τὰ τοιαῦτα εἰδέναι.³⁵⁷

All this is useful to know, whether for adjusting present arrangements,
avoiding disturbance of previous arrangements, or discovering if
anything essential has been overlooked.³⁵⁸

Throughout, he is careful to help the reader (and perhaps the speaker too) keep track of the argument by means of the simple but effective techniques of recapitulation and retrospective and prospective transitions. The mutual reinforcement of the opening and closing sentences, noted above, is an obvious example, and this mirroring of phrases or sentences is a technique that Rufus uses frequently: for example, the section on the importance of questioning the patient himself rather than others present begins at §2 with ‘That is my first principle: put your enquiries to the patient himself’ and closes in §9 with ‘First, as I have said, you must question the patient himself’; the section on timing begins in §11 with ‘The first thing to ask is the point in time when the patient began to be unwell’ and concludes in §14: ‘That is how important I say it is to ask about the beginning of the sickness, the exact point at which the person began to be unwell’; the section on causes begins in §24 with ‘the recognition of disorders varies depending on whether they are attacking from within or without’ and closes in §26 with ‘This is how much difference it makes to the physician to enquire thoroughly, even into the causes’; the discussion of dreams is similarly topped and tailed, beginning in §28 with ‘One must ask also about sleep ... and if he is having any visions or dreams’, and finishing in §33: ‘dream-visions

³⁵⁷ QM 36.

³⁵⁸ Gärtner calls this ‘den dreidiegigen Bau rhetorischer Prosa’, and comments: ‘Solche glatten Gefüge sind bei Rufus nicht oft zu finden’ (*ad loc.* 1962:80).

arise in accordance with the body's humours, and ... they indicate things for the patient ... which someone who does not listen has no other means of apprehending'. Retrospective and prospective transition, enhanced by the use of μέν and δέ, is used to achieve a smooth change of topic; thus for example Εἰς μὲν οὖν τὰς κοινὰς νόσους, καὶ μάλιστα τὰς πυρετώδεις, ταῦτά τε καὶ τὰ ὅμοια ἐρωτητέον. εἰς δὲ τὰ ἔλκη ... (§46)³⁵⁹ signals the conclusion of the long chapter on 'common ailments' and the change of topic to wounds; and Τὰ μὲν οὖν τοῦ νοσοῦντος καὶ τῶν παρόντων ἐρωτήματα ταῦτα καὶ ὅ τι τούτων ἐγγυτάτω ἐστίν. ἄλλα δὲ καὶ κατὰ ἔθνη ἐστίν (§63)³⁶⁰ takes us from questions for individuals to questions for populations.

Jouanna offers as examples of 'lecture' conclusions the endings of *Airs, Waters, Places* ('From these observations you may judge the rest without error') and *Nature of the Child* ('This speech, spoken in full, is ended'), contrasting them with the lengthier endings of the 'discourses' *Breaths* and *The Art*, both of which adhere to Plato's principle of recapitulation.³⁶¹ *QM* approaches its conclusion in three phases. First, at the beginning of §71, Rufus uses a recapitulatory formula to signify transition to the epilogue: ἤδη οὖν μοι σαφὴς ἡ γνώμη ἐστίν, ὅτι ἂν ἀφικέσθαι βούληται ('So now I think my idea is clear, [so far as I wanted to go]'). Then he offers a sort of minor *refutatio*, confessing that his task has actually been impossible: τὰ μέντοι σύμπαντα οὔτε λόγος αὐτάρκης οὔτε χρόνος ἱκανὸς σημῆναί τε καὶ ἐξευρεῖν ('Discourse is not, of course, sufficient for explaining or learning everything, nor is there enough time') and defending the methodological validity of his approach: τὸ δὲ κεφάλαιον τῆς γνώμης εὐρεθὲν καὶ

³⁵⁹ 'So in the case of common sicknesses, and especially feverish ones, we must ask about these and similar things. When it comes to wounds ...'

³⁶⁰ 'These and others very like them, then, are the questions for the patient and those around him. There are others, too, that concern populations'.

³⁶¹ See above, p.133 n.354.

ὕποβληθὲν τῷ ἱατρῷ ἔχει ἂν πάντα τὸ δέον (‘But the doctor who grasps the essence of my thinking and bases his work on it will find in it everything he needs’).³⁶² He then launches into the peroration, in which, as I argue below, he makes procataleptic use of the name of Hippocrates for maximum effect and memorability before re-stating his case one final time.³⁶³ Just as Jouanna remarks of the endings of *The Art* and *Breaths*, this conclusion to *QM* not only reminds the audience of the points that have been made by the author, but also manifests an unmistakeable ‘desire to convince’.³⁶⁴

Though one could not call *QM* a particularly polished piece of oratory, the features discussed above do seem to lift it above the level of a teaching lecture, and this impression is strengthened by comparing it with Rufus’s *On the Naming of Parts*, which is quite obviously a lecture. This systematic, pragmatic composition resembles *QM* in neither tone nor internal arrangement. Its explicitly instructional tone is clear from the outset:³⁶⁵

Βούλει οὖν καὶ τὰ ἱατρικὰ ἀπὸ τῶν ὀνομάτων ἀρξάμενος μανθάνειν, καὶ πρῶτον μὲν ὃ τι χρή καλεῖν ἕκαστον τοῦ σώματος μόνιον, ἔπειτα τὰ ἄλλα ὅσα ἂν ἔπεται τῷ λόγῳ, ἢ δοκεῖ σοι ἰκανὸν εἶναι δεικνύντα δηλοῦν ὥσπερ κωφὸν ὃ τι χρήσεις διδάξαι;³⁶⁶

Do you want to learn medicine too by beginning with the naming of parts, starting first with what we must call each part, and then everything else that follows the words; or do you think it is enough if I simply demonstrate to you what you want me to teach, as if I were dumb?

There follows a wealth of detail in the form of a long list of anatomical terms, arranged in a plain linear structure, starting at the head and working downwards, each accompanied

³⁶² *QM* 71. The language used here echoes, perhaps deliberately, the Platonic principle articulated in *Phaedrus* (see above, p.33 n.354).

³⁶³ See below, p.155.

³⁶⁴ Jouanna 2012:47.

³⁶⁵ Both Abou-Aly (1992:19 n.10) and Haak (2013:265) concur.

³⁶⁶ Ruf.*Onom.*6, 134.3-6 Daremberg.

by a very few words of explanation as the speaker points out the relevant anatomical detail on a living slave or a dissected animal:

ἀκούων δὴ καὶ ἀποβλέπων εἰς τὸν παῖδα τοῦτον διαμνημονεύσεις τὰ ἐπιφανῆ πρώτον· εἶτα ὡς χρὴ καλεῖν τὰ ἔνδον, ζῶόν τι, ὃ μάλιστα ἀνθρώπῳ ἔοικε, διελόντες, διδάσκειν σε πειρασόμεθα.³⁶⁷

First, if you look carefully at this slave while listening to me, you will commit to memory the visible parts; next, I shall dissect an animal that particularly resembles a human, in an attempt to teach you what names you must use for the internal parts.

The motivational element is confined to the beginning (naming of parts is, Rufus explains, a prerequisite for practising any *technē*, such as playing the lyre, literacy, blacksmithing, leather-working carpentry and geometry), and makes no further intrusion into the text. Its written length is about twice that of *QM*, and, once pauses for indication of parts on the body of the slave and the dissected animal are taken into account, it might well have reached the 70-90 minutes suggested by Jouanna.

An alternative delivery scenario for *QM* is suggested by epigraphic evidence from Ephesus that records the holding of regular medical meetings and contests in the Asclepieion in the early to mid second century.³⁶⁸ Although these inscriptions date from slightly later than the period generally proposed for Rufus's life, they may point to a more chronologically extensive tradition. One, dated between 138 and 161,³⁶⁹ records a two-day event involving four contests at the Great Asclepieia: σύνταγμα (perhaps 'prescribing'),³⁷⁰ χειρουργία (surgery), ὀργάνων (perhaps the organisation and

³⁶⁷ Ruf.*Onom.* 9, 134.9-11 Daremberg..

³⁶⁸ Meetings of a college of doctors at the Asclepieion to sacrifice to Asclepius: SEG 4.521, IEph. 3.719 = Samama no. 205 (AD 102-114): medical contests: SEG 31.954, IEph 7.4101B = Samama no. 210 (dated AD 135 in SEG and IEph, and 153/154 by Samama), and IEph 4.1162 = Samama no. 211 (AD 138-161); cf. Samama nos. 212-215. For a discussion of the medical competitions, see Samama 2003:70-71; see also Nutton 1977:205, rejecting an earlier suggestion by Josef Keil that the contests constituted an examination by means of which doctors qualified for fiscal privileges on a renewable basis.

³⁶⁹ Samama no. 211.

³⁷⁰ LSJ συντάσσω A.II.4.b.

maintenance of medical instruments),³⁷¹ and πρόβλημα, which according to Samama ‘consisterait en un exposé oral sur un sujet imposé, sorte de leçon magistrale incluant éventuellement des discussions ou des débats, dans la tradition rhétorique’.³⁷² This latter category provides a plausible context for the oral delivery of a composition like *QM*. I suggest, then, that Rufus’s treatise was originally composed as some sort of contribution, whether as part of a debate or in a competitive context, to a gathering of doctors. It was then presumably considered sufficiently useful to be written up, thereby entering circulation as a piece of (admittedly atypical) technical literature.

4.4. Didactic goal

Even if it is not a teaching lecture, *QM* has a clear didactic goal: to inculcate in its audience a commitment to questioning the patient. But rather than instructing by demonstration, it aims to persuade and illustrate. The reader does not come away armed with a set of questions to ask in specific circumstances, but will, if the author has achieved his aim, be convinced that questioning patients is essential in every clinical encounter, and aware of an illustrative list of topics about which to ask that can be adapted to the particular circumstances in which the encounter takes place. This concentration on principle and illustration rather than systematic instruction sets it apart from such discussions of questioning as appear in other ancient medical works, and also, Gärtner argued, from other technical writing.³⁷³ A similar view was recently expressed by Haak:

My analysis leads to the conclusion that [*QM*] was written as an emphatic plea for the physician to ask patients extensive questions about their way of life before and during their illness. In Rufus’ time this kind of questions [*sic*] was not commonly asked; this practice was

³⁷¹ LSJ ὄργανον A.I.4.

³⁷² Samama 2003:70. The test might, she suggests, have involved resolving a problem or providing a prognosis (n. 24). According to Nutton, σύνταγμα and πρόβλημα ‘may relate to pharmacology’ (2008:142).

³⁷³ Gärtner 1962:12-13, arguing that this unconventional aspect of *QM* helped to impede its dissemination.

not considered part of the art of medicine by both doctors and patients.
Rufus was well aware of the eccentricity of his view.³⁷⁴

Rufus's core belief is that the doctor does not know enough on his own (παρ' ἑαυτοῦ) (QM 21, 22, 37, 72) and that unless he asks questions his knowledge will be inadequate to his task. The idea is articulated in a variety of ways, but the running theme is clear: any doctor who fails to incorporate questioning into his clinical practice must necessarily operate in ignorance of a range of crucial factors, none of which can be discovered by any other means, and, even when there are indicative signs (σημεῖα) to point the way, he will greatly improve the quantity and quality of his knowledge by asking questions. He builds his case through a combination of positive and negative rhetoric: that is, frequent repetition of his core belief, laced with criticism of other doctors. His core belief is spelt out eleven times:

§21: κὰν τούτοις οὐκ ἔστιν, ὃ τι παρ' <ἐ>αυτοῦ δύναται ἄν μαθεῖν ὁ ἰατρός, εἰ μὴ πυνθάνοιτο ἢ τοῦ νοσοῦντος ἢ ἑτέρου τινὸς τῶν παρόντων. In these matters too the physician will be able to understand nothing by himself if he does not enquire of either the patient or some other person present.

§22: ἐγὼ δὲ ἡγοῦμαι μὲν καὶ παρ' <ἐ>αυτοῦ δύνασθαι τινα πολλὰ τῶν ἐν ταῖς νόσοις ἐξευρίσκειν, κάλλιον δέ γε καὶ σαφέστερον ἐν τοῖς ἐρωτήμασιν. In my opinion, although one can indeed discover many of the factors connected to sicknesses on one's own, questioning enables that to be done better and more clearly.

§23: καὶ τὰ μὲν τοιαῦτα ἔχει [ἔχει] τινὰ καὶ παρὰ τῶν συμπτωμάτων ἔνδειξιν τοῦ γινώσκεισθαι· χρόνον δὲ τῆς νόσου καὶ ἔθισμόν τὸν πρὸς ἕκαστα καὶ φύσιν τὴν ἐκάστου ἐξαίρετον, ταῦτα οὐ μοι δοκεῖ γνῶναι τις μὴ ἐρωτήσας καὶ εἶναι παντὸς ἄλλου καιριώτερον τῇ τέχνῃ εἰδέναι. The *sumptōmata* in such cases can take us some way towards an indication as well; but as to the timing of the sickness, and the patient's habits in every respect, and the singular constitution of each person, these are things that one cannot, in my view, know without asking, while knowing them is more critical to medical judgement than anything else.

³⁷⁴ Haak 2013:265.

§26: εἰς τοσόνδε διαφέρει τῷ ἱατρῷ καὶ τὰς αἰτίας ἀνερωτᾶν, καὶ οὐκ ἔστιν εἰδέναι μὴ ἐρωτήσαντα. ὥστε καὶ ἐπὶ τῶν σημείων ἐρωτητέον.

This is how much difference it makes to the physician to enquire thoroughly, even into the causes, and without questions there is no knowledge. This means that one must ask questions even when there are signs.

§33: πάνυ δὲ ἐμαυτὸν πείθω κατὰ τοὺς χυμοὺς τοὺς ἐν τῷ σώματι δόξας ἐνυπνίων ἐγγίγνεσθαι σημαινούσας καὶ ἀγαθὰ καὶ κακὰ τῷ ἀνθρώπῳ, ὧν κατάληψις ἄλλη οὐκ ἔστι μὴ ἀκούσαντι.

I am quite convinced that dream-visions arise in accordance with the body's humours, and that they indicate things for the patient – whether good or bad – which someone who does not listen has no other means of apprehending.

§34: τί δὲ τὰ συγγενῇ τῶν νοσημάτων; ἄρα γε ἐτέρωθεν ἔστιν εἰδέναι ἢ καὶ ταῦτα ἐρωτήσαντι δήπου;

And what of congenital disorders? Surely these too cannot be known in any other way than by questioning?

§37: ἐρωτητέον δὲ καί, εἰ προσῆρτο τὸ σιτίον ἢ οὐ. καὶ γὰρ οὐδὲ τοῦτό φημι δυνατόν εἶναι παρ' ἑαυτοῦ γινώσκει<v>.

We must also ask if the patient has taken food or not. Even this, I say, the physician cannot know by himself.

§38: ἐμοὶ δὲ καὶ τοῦτο ἀδύνατον δοκεῖ διαγνῶναι μὴ ἐρωτήσαντα, ὥσπερ καὶ πηνίκα προσῆρτο καὶ ποῖόν τι καὶ πόσον.

In my view this is another example of what you cannot recognise without asking – just like the timing, type and quantity of food consumed.

§40: ὥστε ἐπαινέσαιμι ἂν καὶ ἱατρὸν τὸν νῦν πρῶτον ἐντυγχάνοντα τῷ νοσοῦντι, εἰ μὴ ἀφ' ἑαυτοῦ μόνον ποιοῖτο τῆς θεραπείας τὴν εὖρεσιν, ἀλλὰ τινα καὶ τῶν ἐμπείρων τοῦ κάμνοντος εἰς συμβουλήν καλοῖ, μάλιστα μὲν ἱατρόν, εἰ δὲ μή, καὶ ἰδιώτην. οὕτω γὰρ οὐ διαμαρτῆσεται τοῦ συμφέροντος.

So I would also praise the physician who, in his first encounter with the sick person, does not work out the treatment by himself alone, but invites someone who knows the patient for consultation as well – preferably a physician, but if not, even a layman. He will not fail to find this advantageous.

§64: ὅσαι δὲ ἕτεραι φύσεις εὐρίσκονται παρ' ἐκάστοις τῶν ὑδάτων καὶ καρπῶν καὶ ἀέρων οὐδὲ<v> ἐοικυῖαι ταῖς ὡς ἐπίπαν καθεστηκυίαις, [ἂς] χρὴ πυνθανόμενον παρὰ τῶν ἐπιχωρίων ἢ πειράζοντα ἐν χρόνῳ εἰδέναι. διάγνωσις

All the different characteristics that are found in the waters, food crops and climate in individual areas, that do not resemble the generally established characteristics, must be learned either by enquiring of local inhabitants or through personal experience over time. There is no

γὰρ ἀκριβῆς ἄλλη οὐκ ἔστιν, ἐπεὶ οὐδὲ νοσήματα ἐπιδήμια ἔστιν ἑτέρως εἰδέναι.	other way to know the local disorders, and thus no other way of achieving accurate recognition.
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§73: παρακελεύομαι δὲ μηδὲ τῶν ἐρωτημάτων ἀφίστασθαι τὸν μέλλοντα ὀρθῶς ὑπὲρ πάντων γνῶσεσθαι.	I urge anyone who aspires to full and accurate knowledge not to refrain from questioning.
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Clearly Rufus felt the need to press his point, and with vigour. He does not tell us why, perhaps because the debate was a familiar one, or maybe because *QM* was originally delivered in circumstances that made the context clear. The strong impression, though, is that it constitutes a counter-argument to ideas with which Rufus disagreed. This could perhaps have been something as simple and timeless as poor practice: sloppy, lazy doctors not bothering – or perhaps lacking the time – to do something that Rufus considered a priority. Alternatively there could perhaps have been some weightier point of principle at stake, a methodological or epistemological difference involving disagreement over what sorts and sources of knowledge were relevant to understanding the workings of the body. Thus the repeated claim about the limits of medical knowledge could be designed to jar lazy doctors out of their complacency; alternatively, if Rufus's concern was doctrinal, it could be a response to the rise of Methodism in Ephesus,³⁷⁵ for Rufus's profound belief that thorough dialogue with the patients is an indispensable part of the medical encounter is clearly at odds with key tenets of Methodism, such as lack of interest in aetiology and the belief that both diagnosis and therapy could be determined simply by observation of symptoms.³⁷⁶ The fact is, of course, that we cannot know for

³⁷⁵ Rufus's probable contemporary and fellow Ephesian, Soranus, was a Methodist, albeit one who has been characterised as 'flexible and pragmatic' (Nutton 2000:950-1) and managed to secure Galen's respect – no mean feat for a Methodist. Nutton points out that in a city as large and busy as Ephesus there could have been considerable merit – for both patient and doctor – in keeping consultations short by following Methodist principles (2004:201).

³⁷⁶ For these and other key features of Methodism see Tecusan 2004:10-12.

sure what motivated Rufus to compose *QM*. In the circumstances, his criticisms of other doctors constitute important evidence, and it is to these that we now turn.

4.5. Criticism and polemic

Though there is no evidence that Rufus indulged in diatribes of the kind that Galen turned into an art-form – indeed Nutton calls him ‘eirenic’ – he was a markedly independent thinker, and was certainly not averse to censuring his fellow physicians: von Staden notes, for example, his ‘polemical posture’ towards some of the Alexandrians, citing his attack on ‘Egyptians who speak Greek poorly’.³⁷⁷ Polemical attacks on opponents are among the characteristics of technical literature identified by Fögen.³⁷⁸ The shortcomings he disparages in *QM* – pretending to diagnose through touch, trying to solve new cases without taking advice, and taking signs or topographical observations at face value – all serve his argument that doctors cannot know enough on their own.

Rufus’s contemporaries

Rufus’s critique of contemporary practice is implied rather than explicit. His emphatic and repeated insistence that doctors cannot know enough on their own strongly implies that at least some of his contemporaries said or practised the opposite. Specifically, he suggests first that there are those who claim to be able to detect a patient’s food intake by touch rather than by asking:

ἐρωτητέον δὲ καί, εἰ προσῆρτο τὸ σιτίον ἢ οὐ. καὶ γὰρ οὐδὲ τοῦτό φημι
δυνατὸν εἶναι παρ’ ἑαυτοῦ γινώσκειν· καίτοι καταγελαστότατον

³⁷⁷ Nutton 2007:14. On Rufus’s independence of thought, see Wellmann 1912:4: ‘einer der wenigen wirklich selbständigen Ärzte der nachchristlichen Zeit’; von Staden 1989:481 with note 3); Flemming 2008:346-7; and Pormann’s view that his practice was to follow Hippocratic teachings but interpret them ‘to suit his own ideas’ (2008a:4). On Galen’s criticisms of others, including Hippocrates, see Lloyd 1991:398-401.

³⁷⁸ Fögen 2015:267.

δοκεῖ τῶν ἐρωτημάτων παρὰ τοῖς δημοτικοῖς, εἰ μὴ εὐθύς τις ἀψάμενος τοῦ νοσοῦντος εἰδείη ὅτι ἐδήδοκεν, ἀλλὰ ἐτέρου πυνθάνοιτο. ἐμοὶ δὲ καὶ τοῦτο ἀδύνατον δοκεῖ διαγνῶναι μὴ ἐρωτήσαντα, ὥσπερ καὶ πηνίκα προσήρατο καὶ ποῖόν τι καὶ πόσον.³⁷⁹

The complaint that ‘if one does not know what a patient has eaten as soon as one touches him, but asks someone else, ordinary people find it a most absurd question’ probably refers to the belief that the pulse was affected by the quantity and quality of food consumed, which appears in Galen’s work on pulses but not in *Synopsis de pulsibus*, the short treatise on pulses attributed to Rufus.³⁸⁰ Gärtner (who does not refer to pulse theory) remarks that Rufus’s wording here suggests that ‘Es war offenbar nicht alltäglich, danach zu fragen’, and that his evident irritation shows that he ‘derartigen Unverstand offenbar weit verbreitet vorfand’.³⁸¹ Despite Rufus’s dismissal of the notion in *QM*, we see Galen putting it to both diagnostic and awe-inspiring use in his diagnosis of Marcus Aurelius’s indigestion³⁸² and elsewhere. Secondly, it seems that there are some who fail, or perhaps even refuse, to co-operate with others even when they are new to a case:

ὥστε ἐπαινέσαιμι ἂν καὶ ἱατρὸν τὸν νῦν πρῶτον ἐντυγχάνοντα τῷ νοσοῦντι, εἰ μὴ ἄφ’ ἑαυτοῦ μόνον ποιοῖτο τῆς θεραπείας τὴν εὔρεσιν,

³⁷⁹ *QM* 37-38.

³⁸⁰ On the detection of food intake from the pulse, see *Gal.Puls.ad Tir.*, VIII 469 K (quoting Archigenes, a likely contemporary of Rufus’s) and, on heaviness, 490. Pulse theories, first developed in earnest by Herophilus and Erasistratus, feature in medical writing from the Hippocratic Corpus onwards: see for example *Epid.* IV.20 = V.158 L (in the navel, indicating critical illness); *Epid.* VII.3 = V.368 L (in the temples, during fever); *Epid.* VII.3 = V.370 L (strong abdominal pulse in fever with emaciation); *Epid.* IV.20 = V.158 L (fever increases the pulse rate); *Loc.Hom.* 3 = VI.280 L (constant pulses in the head due to collision of upward and downward blood flow) (references supplied by Haak, 2013:137). A treatise on pulses, *Synopsis de Pulsibus*, is attributed, though not conclusively, to Rufus: see Daremberg & Ruelle 219-232 and, for a recent discussion, Haak 2013:139-153, including a survey of scholarly opinion on its authorship (2013:139-40). Despite identifying a number of features that are characteristic of Rufus’s work, including lack of interest in prognosis and expression of views not shared by contemporaries, Haak concedes that the attribution must remain uncertain (2013:152-53). Perhaps Rufus’s decision to single out those who misused pulse theory as targets for criticism strengthens the attribution. See also Snyder 2000:194 n.21, on philosophers who are compared to ‘the magician who heaps up the names of gods and demigods or the doctor who makes superfine distinctions in the kinds of pulse’.

³⁸¹ Gärtner (*ad loc.* 1962:80), comparing Rufus’s tone here to that of the Hippocratic author who complains about the credulousness of δημόται ἀσυνετώτατοι (*Hp.Acut.*6).

³⁸² See below, pp.225-227.

ἀλλά τινα καὶ τῶν ἐμπείρων τοῦ κάμνοντος εἰς συμβουλήν καλοῖ,
μάλιστα μὲν ἱατρόν, εἰ δὲ μή, καὶ ἰδιώτην.³⁸³

Both these passages, with their elliptical references to undesirable conduct, achieve their effect through assertive first person statements (καὶ γὰρ οὐδὲ τοῦτό φημι δυνατόν εἶναι in §37 and ὥστε ἐπαινέσαιμι ἂν in §40), strong denial of the alternative (καὶ γὰρ οὐδὲ τοῦτό φημι δυνατόν εἶναι in §37 and ἐμοὶ δὲ καὶ τοῦτο ἀδύνατον δοκεῖ διαγνῶναι in §38), and, in the second passage, language that has been judged ‘particularly ... agonistic’, suggesting that Rufus is ‘taking on an opposite view that may explicitly have been formulated’.³⁸⁴ Like the attack on Callimachus (§21), which we shall come to shortly, it is introduced by a first-person statement of result (ὥστε ἔγωγε θαυμάζω, §21; ὥστε ἐπαινέσαιμι ἂν, §40) following an unequivocal statement of a strongly held opinion: κὰν τούτοις οὐκ ἔστιν, ὅ τι παρ’ <ἐ>αυτοῦ δύναται’ ἂν μαθεῖν ὁ ἱατρός, εἰ μὴ πυνθάνοιτο ἢ τοῦ νοσοῦντος ἢ ἑτέρου τινὸς τῶν (§21) and καὶ τὸ εὐδιαχώρητον δὲ ἐρωτητέον καὶ τὸ σούρουμένον καὶ τὸ ὀξυνόμενον καὶ τὸ ἄλλως πως φθειρόμενον· ἐκάστῳ γὰρ ταῦτά ἐστι καὶ οὐ καθόλου (§40).³⁸⁵

Callimachus

Disapproving though he is of aspects of current practice, Rufus reserves his strongest censure for an earlier doctor, identified only as Callimachus:

ὥστε ἔγωγε θαυμάζω Καλλιμάχου τοῦ ἱατροῦ, ὃς μόνος τῶν
ἐμπροσθεν, ὧν γε δὴ καὶ λόγον ἂν τις ποιήσαιτο, οὐκ ἔφασκε δεῖν
ἐρωτᾶν οὐδὲν οὔτε περὶ τὰς ἄλλας νόσους οὔτε περὶ τὰ τραύματα, καὶ
μάλιστα τὰ τῆς κεφαλῆς· ἀρκεῖν γὰρ καὶ τὰ ἐφ’ ἐκάστῳ σημεῖα τό τε
πάθος σημῆναι καὶ τὴν αἰτίαν αὐτοῦ, ἐξ ὧν καὶ προγινώσκεισθαι πάντα

³⁸³ QM 40. It is interesting to note in the context of this latter criticism Jay Katz’s proposition that that the ability to admit uncertainty is an important precondition for the sharing of authority between doctor and patient – something which, Katz claims, doctors find particularly hard to do (2002:198-99).

³⁸⁴ Professor C. Pelling, personal communication, 2012.

³⁸⁵ ‘We must ask, as well, what is being easily excreted and what has a diuretic effect and what is provoking acidity and what is causing other problems; for these are all things that are specific to the individual and do not apply across the board.’

καὶ θεραπεύεσθαι ἄμεινον. ἐπεὶ μὴδὲ τὰς ἡγουμένας προφάσεις τῶν νόσων [καὶ] ἀναγκαίως ἐρωτᾶσθαι, οἷον διαίτης τε ἀγωγὴν καὶ τὰ ἄλλα ἐπιτηδεύματα καὶ εἰ κοπιᾶσαντι συνέβη νοσῆσαι καὶ εἰ ψυγέντι· μὴδὲν γὰρ ἂν τούτων μαθεῖν <δεῖν> τὸν ἰατρὸν, εἰ τὰ σημεῖα ἀκριβῶς ἐκμελετήσαι τὰ συμπίπτοντα ταῖς νόσοις.³⁸⁶

I am amazed, therefore, that the physician Callimachus, alone of earlier doctors – or at least of those whom one can take seriously – denied the need to ask questions about sicknesses, including wounds, especially head-wounds. He claimed that the signs in each individual case were enough to indicate both the condition and its cause, and should preferably be used as the basis of all prognosis and treatment. Questioning was unnecessary, he said, even about the antecedent causes of sicknesses – such as the patient’s way of life, including the regimen being followed, and whether the person was tired or cold when he fell ill – on the grounds that the physician had no need to learn anything from these factors if he gave careful and accurate consideration to the signs that occur together with sicknesses.

This is the closest Rufus comes to polemic,³⁸⁷ and it therefore constitutes a particularly valuable piece of evidence as to his own beliefs and those that he wanted to rebut. It touches on an important issue in contemporary medicine: aetiology was a source of fundamental doctrinal disagreement, with rationalist physicians considering causes to be extremely important, Empiricists regarding knowledge of causation as unattainable, and Methodists rejecting all causal explanation as irrelevant.³⁸⁸ Yet it is a tantalisingly elliptical reference. Not only are we hearing of Callimachus’s opinion at second hand and from the mouth of a detractor, but the Greek, οὐκ ἔφασκε δεῖν ἐρωτᾶν, shorn of explanatory detail, leaves us uncertain whether Callimachus’s claim was that doctors did not need to ask questions or that they ought not to do so, or perhaps even failed to say that they should.³⁸⁹ (The latter is theoretically possible but examples are extremely

³⁸⁶ *QM* 21.

³⁸⁷ Cf. Gärtner *ad loc.* (1962:64). For the language, ‘I am amazed at’ as a mark of polemical criticism, cf. *Gal.HNH*, *CMG* V.9.1.8,20-22 = XV.11 K: διὸ καὶ θαυμάζειν ἔφην. Also *Gal.MM*, X.250 K: ἐγὼ μὲν γὰρ καὶ θαυμάζω τὴν ἀναισθησίαν τοῦ Θεσσαλοῦ, γράφοντος ὥδι πως ὑπὲρ τῆς τῶν κακοηθῶν ἐλκῶν ἰάσεως.

³⁸⁸ Doctrinal disagreement: Hankinson 1998:24-25. On the various positions see Hankinson 1998a, and cf. van der Eijk 2008a:291-2.

³⁸⁹ On the ambiguity of δεῖν, see Barrett 1964, on *Eur.Hipp.*41, pointing out that δεῖν, having originally predominated for ideas of need and necessity, ultimately came to convey morality as well, as it gradually ‘ousted χρή from the spoken language’.

rare,³⁹⁰ and as Rufus is not prone to linguistic or syntactic innovation I shall assume that he intended one of the first two meanings.)

To take the question of identity first, Rufus's failure to identify Callimachus more precisely must mean that the reference is to someone who was well known at the time. According to Gärtner it was probably the late 3rd/early 2nd century BC Alexandrian Callimachus of Bithynia.³⁹¹ Hard facts about this physician and his ideas are thin on the ground – even his Bithynian provenance rests on what von Staden calls an 'audacious emendation' by Wellmann of an anonymous 11th century Florentine codex³⁹² – but, depending on the accuracy and pertinence of the *testimonia*, it seems safe to say that he was a close associate of Herophilus, that like Herophilus his name is associated with an early Rationalist school, and that there may have been some doctrinal difference between them.³⁹³ His name is coupled with that of Herophilus in a passage of Polybius criticising the clinical skills of the Alexandrian Rationalists:

οἷον εὐθέως τῆς ἰατρικῆς, ἐνὸς μὲν μέρους αὐτῆς ὑπάρχοντος λογικοῦ, τοῦ δ' ἐξῆς διαιτητικοῦ, τοῦ δὲ τρίτου χειρουργικοῦ καὶ φαρμακευτικοῦ γένους, ὁλοσχερῶς ***³⁹⁴ τὸ δὲ λογικόν, ὃ δὴ πλεῖστον ἀπὸ τῆς Ἀλεξανδρείας ἄρχεται παρὰ τῶν Ἡροφιλείων καὶ Καλλιμαχείων ἐκεῖ προσαγορευομένων, τοῦτο μέρος μὲν τι κατέχει τῆς ἰατρικῆς, κατὰ δὲ τὴν ἐπίφασιν καὶ τὴν ἐπαγγελίαν τοιαύτην ἐφέλκεται φαντασίαν ὥστε δοκεῖν μηδένα τῶν ἄλλων κρατεῖν τοῦ πράγματος· οὐς ὅταν ἐπὶ τὴν ἀλήθειαν ἀπαγαγὼν ἄρρωστον ἐγχειρίσῃς, τοσοῦτον ἀπέχοντες εὐρίσκονται τῆς χρείας ὅσον [καὶ] οἱ μηδὲν ἀνεγνωκότες ἀπλῶς ἰατρικὸν ὑπόμνημα. οἷς ἤδη τινὲς τῶν ἀρρώστων ἐπιτρέψαντες αὐτοὺς διὰ τὴν ἐν λόγῳ δύναμιν οὐδὲν ἔχοντες δεινὸν τοῖς ὅλοις

³⁹⁰ Theoretically the negative in οὐκ ἔφασκε could be either nexal (with contradictory effect) or special (with contrary effect); in practice the former is highly unlikely and rare: see Moorhouse 1959:6-8, especially 7 with note 1, and 122-3.

³⁹¹ Gärtner *ad loc.* (1962:64-65).

³⁹² Von Staden 1989:482.

³⁹³ Erotian (*Praef.* p. 4 Nach.) describes him as ἀπὸ τῆς Ἡροφίλου οἰκίας, a phrase which, it has been argued, indicates the existence of a direct master-pupil relationship rather than mere adherence to a school: see Fraser 1972 (1):357, and, for not unqualified support, von Staden 1989:479. It is not clear that Polybius is definitely referring to two schools, for the καὶ in παρὰ τῶν Ἡροφιλείων καὶ Καλλιμαχείων ἐκεῖ προσαγορευομένων may be exegetical; but see von Staden 1989:480 on Callimachus's proto-Empiricist tendencies.

³⁹⁴ The text is badly mutilated at this point.

πολλάκις ἐκινδύνευσαν. εἰσὶ γὰρ ἀληθῶς ὅμοιοι τοῖς ἐκ βύβλου κυβερνῶσιν.

To begin with medicine, for example, one of its parts is theoretical, the next dietetic, and the third the surgical and pharmacological kind ... The theoretical part, which has its origins mostly from Alexandria – from those who there are called Herophileans and Callimacheans – this theoretical part in some respect has a controlling hold on medical science, and by its ostentation and its claims it gets itself such a reputation that no-one else [of those engaged in other branches of medicine] appears to be master of the subject. But when you lead them [sc. these theorists] back to reality and put a patient in their hands, you discover that they fall just as far short in their service as people who have not read a single medical treatise. In fact, some patients who entrusted themselves to these physicians, persuaded by their powers of reasoning, have often thereby endangered their lives, although they had nothing terribly wrong with them at all. For they [sc. ‘theoretical’ doctors like the Herophileans and Callimacheans] really resemble pilots who steer by the book.³⁹⁵

Polybius can hardly be considered an impartial witness – in an earlier book he has expressed a dim view of ‘all such superfluous acquirements in a profession as serve but for ostentation and fine talk’,³⁹⁶ and in the passage just quoted he is using medicine to make a point about historiography – while the charge of excessive devotion to theory and corresponding practical ineptitude ‘does not’, according to von Staden, ‘hold up in the case of Herophilus’.³⁹⁷ Nevertheless it was obviously possible in Hellenistic times to use ‘the Callimacheans’ as exemplars for doctors whose therapeutic capability fell somewhat short of their theoretical pretensions, and by Rufus’s day it may not have mattered very much whether one used the idea ‘Callimachus’ or the idea ‘Callimachean’ to create that association.

³⁹⁵ Polyb.12.25d3-6 = T56 von Staden, tr. von Staden 1989:128-9.

³⁹⁶ τὰ μὲν ἐκ περιττοῦ παρελκόμενα τοῖς ἐπιτηδεύμασι χάριν τῆς ἐν ἐκάστοις ἐπιφάσεως καὶ στομυλίας. Polyb. 9. 20.6, tr. Paton, Loeb IV.53.

³⁹⁷ Von Staden 1989:135, accusing Polybius of polemical negativity. See Walbank *ad loc.* (1967:388-9), and cf. Gal.MM 3, X.184 K for an account of Herophilus and Erasistratus curing wounds badly because they try to do so by theory.

Turning to Callimachus's beliefs, we note that Rufus is particularly exercised by his denial of the need to ask questions about τὰς ἡγουμένας προφάσεις, which I translate 'the antecedent causes'. The phrase calls for some discussion, not least because it is apparently unique; a *Thesaurus Linguae Graecae* search yields just this single occurrence, and only two of προηγουμένη πρόφασις; nor is ἡγούμενον αἴτιον commonly found. The usual phrase is προηγούμενον αἴτιον.³⁹⁸ To take the noun first, πρόφασις, in Hippocratic usage, was according to Hankinson only loosely distinguished from αἴτια/αἴτον, and sometimes meant 'something very like "antecedent cause"'; Galen puts it thus:

ὀνομάζει δὲ προφάσεις ὁ Ἱπποκράτης ἐνίοτε μὲν, ὡς ἔθος ἐστὶ τοῖς πολλοῖς, ἐπὶ τῶν ψευδῶς λεγομένων αἰτιῶν φέρων τοῦνομα, πολλάκις δὲ τὰς φανεράς αἰτίας οὕτως καλεῖ, καὶ ποτε καὶ πάσας <αὐ>τὰς ἀπλῶς.
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Sometimes Hippocrates uses the term πρόφασις of those things that are falsely called αἴτια, as is the general custom, but he often applied it to evident causes, or sometimes to any sort of cause in general.⁴⁰⁰

The epithet ἡγουμένας undoubtedly reflects ancient philosophical debate about the temporal relationship between causes and their effects, but it is not clear exactly what it means. The original distinction, made by the Stoics, was between causes that occur in advance of their effect (αἴτια προκαταρκτικά, usually translated 'antecedent' causes) and those occurring at the same time as the effect (αἴτια συνεκτικά, variously translated 'containing', 'cohesive' or 'sustaining' causes).⁴⁰¹ A third kind of cause, αἴτια

³⁹⁸ TLG proximity searches, each search within 15 words and conducted for all inflections.

³⁹⁹ Gal.*Hipp.Epid.*1.11, , CMG V.10.1.30.28-31 = XVIIA.52 K.

⁴⁰⁰ Cited and translated by Hankinson 1998:156. Galen also discusses the interchangeability of these words by 'ancient doctors' in CP 1.6 (CMG Suppl. II.2 = 72 Hankinson). This treatise survives only in a 14th century Latin translation by Niccolo of Reggio di Calabria, recently edited, with commentary and English translation, by Hankinson (1998); see also the edition of Bardong, with retro-translation into Greek, in CMG Suppl. II (1937). Galen's original terminology is therefore lost; the Latin translation has *procatarticas causas, quae utique et occasiones multi antiquorum nominant*, and Hankinson sees 'absolutely no doubt that πρόφασις is the correct rendering here' for *occasiones* (*ad loc.* 1998:156), but Bardong was less sure and suggests ἀφορμή as an equally plausible alternative (*ad loc.* 1998:2). Hankinson himself translates *occasiones* as 'revealing causes' (1998:73).

⁴⁰¹ Hankinson 1998:23-25; cf. 2008b:229 with n. 49.

προηγούμενα ('preceding' causes), seems to have been first posited in the late 1st century BC by the physician Athenaeus of Attalia, founder of the Pneumatist doctrine.⁴⁰² It is hard to determine what exactly the role of αἷτια προηγούμενα was thought to be. Galen sometimes uses the term προηγούμενα αἷτια to mean any cause that occurs in advance of its effect (e.g. *MM* X.84-5), but he also sometimes distinguishes them from προκαταρκτικά in a way that makes it reasonably clear that – to quote Hankinson – 'part at least of what distinguishes an antecedent (προκαταρκτικόν) from a preceding (προηγούμενον) cause is that the former must be open to inspection, or evident in the sense of the Empiricists, whereas the latter operates inside the body, but is not yet the containing (συνεκτικόν) cause of the final event'.⁴⁰³ Celsus distinguishes simply between 'hidden and containing' causes (*abditarum et morbos continentium causarum*) and those that are 'evident' (*evidentium*);⁴⁰⁴ interestingly, he illustrates the latter with examples that are recognisably similar to Rufus's ἡγουμένας προφάσεις ('the regimen being followed, and whether the person was tired or cold when he fell ill'):

Evidentes vero has appellant, in quibus quaerunt, initium morbi calor attulerit an frigus, fames an satietas, et quae similia sunt: occurrentum enim vitio dicunt eum, qui originem non ignorarit.

But they call evident those causes, concerning which they enquire, as to whether heat or cold, hunger or surfeit, or such like, has brought about the commencement of the disease; for they say that he will be the one to counter the malady who is not ignorant of its origin.⁴⁰⁵

⁴⁰² *Differentie vero, quas dicebat Athineus esse tres, sunt hoc: prima quidem coniunctarum, secunda vero antecedentium, tertia autem in procatarticarum materia continetur* ('Athenaeus said there were three different kinds of cause, consisting respectively in the matter of containing causes, preceding causes, and antecedent causes'): *Gal.De caus.cont.* II.1-3, *CMG* Suppl. Or. II.134.3-19. See Hankinson 1998:43, 24 n. 104, and (for Athenaeus's probable date) 44 n. 200. Cf. Steph.*In Gal.*6, 42 Dickson: τῶν δ' αἰτίων, τὰ μὲν ἐστὶ προκαταρκτικά, τὰ δὲ προηγούμενα, τὰ δὲ συνεκτικά.

⁴⁰³ Hankinson 1998:43, cf. 47-48 and 38-39 with note 174. Examples of antecedent causes (ὑπόγονοι δὲ αἷτια νοσημάτων), according to Galen, include ἐγκαύσεις, ψύξεις, ἀγρυπνίαι, λῦπαι, φροντίδες, ἀπεψίαι, σκληροκοιτίαι, κάματοι, μέθαι καὶ τᾶλλα τὰ τοιαῦτα ('heat, cold, insomnia, griefs, anxieties, indigestion, hard beds, overwork, strong drink and such like'. *Gal.HNH.*17, *CMG* V.9.1.82.23-30 = XV.162.1-10 K).

⁴⁰⁴ *Cels.Pr.* 13.

⁴⁰⁵ *Cels.Pr.*18, tr. Spencer (Loeb I.11); the whole passage on causes, hidden and evident, begins at 1.pr.13. Gourevitch (1998, 108), discussing Celsus's account, explains 'evident causes' as those that 'immediately precede or even trigger the disease'. According to Celsus, the 'adherents of *rationalis medicina*' considered

And Hankinson asserts that evident causes are ‘standardly identified’ with antecedent causes.⁴⁰⁶

The distinctions between different types of causes are self-evidently very fine, and often confusing.⁴⁰⁷ We should remember that Galen’s detailed contribution to the discussion postdates Rufus, and cannot be used to colour our understanding of what he meant (or thought Callimachus meant, if he was quoting him directly rather than paraphrasing) by ἡγουμένας προφάσεις. Perhaps he was simply following Hippocratic tradition in using πρόφασις for ‘cause’, and chose ἡγουμένας rather than προηγούμενας or προκαταρκτικὰς for reasons of euphony, avoiding a repeated προ- prefix. In any event, we can be fairly sure that what concerned Rufus was not the precise type of cause that Callimachus was reluctant to discuss but the fact that there are things the patient needs to tell the doctor, which no amount of observation of signs can reveal, and that these include causes. To exemplify the diametric opposite of his opinion he chose Callimachus. In other words, Rufus – in this respect at least – followed rationalist principles, and Callimachus served as an exemplar of the sort of views espoused by Empiricists and Methodists. Rufus’s discussion may therefore lend credence to Galen’s accusation that Herophilus gave insufficient priority to causes (though Hankinson argues that this was a misrepresentation

causae evidentes to be as important as hidden causes (*De Med.* I pr. 13). External causal agents formed a bone of contention: Erasistratus’s alleged rejection of their causal validity on the grounds that their effect was not invariable forms the impetus for Galen’s *On Antecedent Causes* (Gal.CP.8.102-4, *CMG* Suppl.II.24-5; Hankinson 1998:32-33, 45-48), a work whose main clinical preoccupation, as Hankinson puts it, is to validate ‘the notion that antecedent, external factors operating upon a patient’s body are causally relevant to that patient’s subsequent condition’ (1998:45-48).

⁴⁰⁶ Hankinson 1998:39 n.174, citing Gal.MM.4.3, X.242-9 K (where we learn that μηδὲν τῶν προκαταρξάντων τῆς διαθέσεως αἰτίων ἐνδείκνυσθαι τὴν θεραπείαν, ἀλλὰ τὴν μὲν ταύτης ἐνδειξιν ἀπ’ αὐτῆς ἄρχεσθαι τῆς διαθέσεως (‘the antecedent causes of the condition provide no indication of the therapy, but the indication of the therapy begins from the condition itself’).

⁴⁰⁷ Even Hankinson is challenged by the complexity: ‘these distinctions are at times infuriatingly vague and confusing, not to say incoherent’ (1998:23).

of Herophilus's position);⁴⁰⁸ it may also suggest that Callimachus was among the Herophileans who developed Empiricist beliefs (though according to von Staden, Callimachus did not go so far as to embrace Empiricism).⁴⁰⁹ But resolving the complexities of Alexandrian epistemological differences is beyond the scope of this thesis. It must remain an open question whether οὐκ ἔφασκε δεῖν ἐρωτᾶν is a strong statement, suggesting that Callimachus's position was one of injunction against questioning ('he said that they ought not to'), or a weaker one conveying lack of necessity ('he said they did not need to'). My translation 'denied the need to' attempts to capture the ambiguity. Either way, Callimachus's beliefs were at odds with Rufus's view that doctors cannot identify causes without the patient's help: εἰς τοσόνδε διαφέρει τῷ ἱατρῷ καὶ τὰς αἰτίας ἀνερωτᾶν, καὶ οὐκ ἔστιν εἰδέναι μὴ ἐρωτήσαντα. ὥστε καὶ ἐπὶ τῶν σημείων ἐρωτητέον.⁴¹⁰

Hippocrates

There is a final, important piece of criticism. In the concluding section Rufus defends himself against a putative charge of un-Hippocratic thinking with the counter-charge that the method outlined in *Airs, Waters, Places* (from which he quotes directly)⁴¹¹ did not go far enough:

εἰ δέ τις φήσείε μὲ ἐναντίον γινώσκειν Ἱπποκράτει, ὃς δὴ τέχνην ἔλεγεν ἐξευρηκέναι, δι' ἧς δυνήσεται ὁ ἱατρὸς ἀφικόμενος εἰς πόλιν, ἧς ἄπειρός ἐστι, περὶ τε τῶν ὑδάτων εἰδέναι καὶ περὶ τῶν ὥρων, ὅπως

⁴⁰⁸ Gal.CP 16.197-8, CMG Suppl.II.53; Hankinson regards Galen's counter-argument as 'unsatisfactory, even fraudulent', arguing that the apparent inconsistency in Herophilus's arguments may well be deliberate, designed 'to jar us out of our causal complacency, to make us realise that the offering of causal explanations is a difficult and inherently unstable enterprise' (*ad loc.* 1998:279). For different views, see von Staden 1989:136-7, arguing that the apparent contradiction 'can be explained by reference to the provisional status Herophilus ascribes to causal explanation', and Touwaide ('Herophilus [1]', in *Brill's New Pauly* Vol.6:275), claiming that Herophilus 'attempted to explain the reasons for ill health primarily by reference to symptoms'.

⁴⁰⁹ Von Staden 1989:480-483.

⁴¹⁰ QM 26.

⁴¹¹ See above, p.51 n.72.

τε τοῖς ἀνθρώποις αἱ κοιλίαι ἔχουσι, καὶ εἰ φιλοπύται εἰσὶ καὶ εἰ ἐδώδοί, καὶ περὶ τῶν νοσημάτων ὅποια ἐπιδημεῖν εἴθισται, καὶ αἱ γυναῖκες ὅπως πρὸς τοὺς τόκους διάκεινται, καὶ ὅσα ἄλλα ἐκεῖνος ὑπέσχετο τῇ τέχνῃ, μηδένα ἐρωτῶν τῶν ἐπιχωρίων, ἀλλὰ παρ' ἑαυτοῦ, μανθάνειν· ταῦτα δὲ εἴ τις προ[σ]φέρειν ἐπιμέμφοιτό μοι ὡς τῷ ἀρίστῳ τῶν ἰατρῶν περὶ τῶν μεγίστων <οὐ> συγγινώσκοντι, λέγω πρὸς ἐκεῖνον οὐδέν με[ν] τῶν ἐκείνου ἀτιμάζειν, ἀλλὰ τὰ μὲν τινα καὶ οὕτως εὗρεθῆναι περὶ τε ὥρων καταστάσεως καὶ φύσεως σώματος καὶ διαίτης τρόπων καὶ ὑδάτων τὴν κοινὴν ἀρετὴν τε καὶ κακίαν καὶ νοσημάτων τὴν κοινὴν [καὶ] ιδέαν, τὰ[ς] δὲ [δι'] ἱστορίας τῆς παρὰ τῶν ἐνοικούντων εἰς τὴν διάγνωσιν χρήζειν, καὶ μάλιστα ὅσα ἄτοπα καὶ ξένα ἐκάστοις ὑπάρχει. [73] τοῦ μὲν σοφίσματος καὶ πάνυ ἄγαμαι τὸν ἄνδρα καὶ πολλαχῇ καλῶς αὐτῷ ἐξεύρηται, παρακελεύομαι δὲ μηδὲ τῶν ἐρωτημάτων ἀφίστασθαι τὸν μέλλοντα ὀρθῶς ὑπὲρ πάντων γνώσεσθαι.⁴¹²

If anyone says that my thinking is opposed to that of Hippocrates, who as you know said he had discovered an art enabling a doctor, on arrival at a new city, to know about the waters, the seasons, the condition of the inhabitants' bowels, whether they enjoy drinking and eating, what disorders are endemic there, how the women experience childbirth, and everything else that Hippocrates professed to find out by the art, on his own, without questioning any of the inhabitants; if anyone, citing this, finds fault with me for disagreeing with the greatest of doctors about the most important matters, this is my reply: I do not disparage any of Hippocrates' theories, but, while some things certainly do get discovered by his method – things to do with the state of the seasons and the natural state of the body and modes of life, as well as the general advantages and disadvantages of the waters and a general picture of sicknesses – there are other things that cannot be clearly recognised without making enquiries among the inhabitants, especially anything unusual or strange in them individually. I admire the man unreservedly for the cleverness of his method, by which he made good discoveries in many cases, but I urge anyone who aspires to full and accurate knowledge not to refrain from questioning.

Recent authorities have disagreed as to how strong a criticism this is. Nutton sees it as 'an extension, not a criticism, of Hippocrates' views'; Gärtner, on the other hand, calls it a 'slight criticism', and Jouanna goes further, describing Rufus's wish to defend himself against a hypothetical accusation of un-Hippocratic thinking as 'significant'.⁴¹³ The latter two are surely right; Rufus's concession that some things can be learnt about local

⁴¹² QM 72-73.

⁴¹³ Nutton 2004:210; Gärtner 1962:65; Jouanna 1999:135. It is interesting also to wonder if Rufus is engaging in a pure thought experiment or sketching a realistic potential scenario. Even if it were the former, the latter must be feasible in order for it to arise in the first place.

conditions through observation rather than questioning is characteristically polite,⁴¹⁴ but the whole point of *QM* is that neither diagnosis nor treatment will be optimal unless the doctor recognises the limits of medical knowledge, whether that knowledge is derived from theory or from observation, and it is difficult in the light of that to see how he could not be criticising the Hippocratic method as inadequate. Interestingly, Smith suggests that his criticism may be aimed at contemporary perpetrators of ‘some sort of current tyranny in Hippocrates’ name’, men who arrogantly made a virtue out of practising in an allegedly Hippocratic fashion.⁴¹⁵ Criticism of other doctors, including Hippocrates, was perfectly normal practice, and, as we have seen, Rufus is not averse to engaging in it elsewhere.

Rufus’s handling of the issue is worthy of remark. In an apparent attempt to deal with the matter diplomatically he becomes entangled in an uncharacteristically long and convoluted conditional sentence in which the protasis is followed by so many subordinate clauses that it has to be restated before the apodosis can be given.⁴¹⁶ The impression created is of an author who protests a little too much. Perhaps he was genuinely concerned at the possibility of being judged anti-Hippocratic; but the trenchant manner in which he has expressed his views on questioning throughout the treatise, and his general independence of mind,⁴¹⁷ suggest the possibility of a more provocative tactic in the form of a deliberately procataleptic use of Hippocrates’s name for rhetorical effect. Although Hippocratism was not the dominant orthodoxy that later historicising traditions represented it as having been, the name ‘Hippocrates’ was freighted with significance in

⁴¹⁴ As Smith puts it, Rufus does not hesitate to disagree with the Hippocratic Corpus, but he always expresses ‘reverence’ (1979:241). Pormann notes that he interpreted the teachings of Hippocrates ‘to suit his own ideas’ (2008a:4); cf. Smith 1979:241.

⁴¹⁵ Smith 1979:241; cf. Abou-Aly 1992:206-207.

⁴¹⁶ *QM* 72: the protasis is stated at Gärtner 1970:15,23 and restated at p.16,6-8; the apodosis begins at p.16, 8. On the length and complexity of this sentence, see Gärtner *ad loc.* (1962:104).

⁴¹⁷ See above, pp.112, 144, 156.

Rufus's time: the figure of Hippocrates had been under reconstruction since the Hellenistic era, when the Empiricists began to claim his authority to support their doctrinal ends, and although in the first century Galen's hagiographical recreation was still to come,⁴¹⁸ Hippocratic works were widely read and the man himself had become, according to Smith, 'in popular romance, and even in sophisticated accounts, ... *the father of medicine, who was to be revered, though it was not necessary to know in detail what his doctrines were*'.⁴¹⁹ It was at around Rufus's time too that the Hippocratic Corpus was first assembled in literary form by Dioscorides and Capiton,⁴²⁰ and Rufus himself had, as Galen put it, a 'not insignificant acquaintance with the writings of Hippocrates'.⁴²¹ He wrote Hippocratic commentary,⁴²² and he referred frequently to Hippocrates in his own work.⁴²³ Rufus knew his Hippocrates very well, in other words, and was well aware of the weight the name carried. This is a calculated rhetorical flourish designed to attract attention, assert the author's independence and ensure that Rufus's core belief about the indispensability of questioning the patient is the final impression left in the reader's mind.

4.6. Conclusion

In this chapter I have argued that *QM* probably originated as an oral composition, with doctors as its target audience; that its lack of systematic instructional content suggests that it was not conceived as a pragmatic lecture; that its simple but logical structure enhances the impact of its strong didactic message, which in turn is reinforced by

⁴¹⁸ Nutton 2008:148.

⁴¹⁹ Smith 1979:178. On the historicising of Hippocrates from Galen to Littré, *id.*13-31.

⁴²⁰ Smith 1979:179.

⁴²¹ Σαβίνου καὶ Ρούφου τοῦ Ἐφεσίου, τοῖς Ἱπποκράτους συγγράμμασιν ὠμιληκότων ἀνδρῶν οὐ παρέργω: *Gal.Hipp.Epid.*, *CMG* V.10.2.2.32 = XVIIA.849 K.

⁴²² *Gal.Ord.Lib.Prop.*, XIX.57-58 K; *Hipp.Prorrh.*2.23, *CMG* V.9.2.73 = XVI.636 and 637 K; *Hipp.Epid.*, *CMG* V.10.2.2.93 = XVIIA.956 K; *CMG* V.10.2.2.139 = XVIIIB.29 and 30 K; *CMG* V.10.2.2.174 = XVIIIB.93 K; *CMG* V.10.2.2.186 = XVIIIB.113 K. See also Smith 1979:179.

⁴²³ E.g. *Onom.*20, 33, 77, 88, 120, 155, 193, 195; *Ren.Ves.*2.36.2.

criticisms of peers and famous predecessors; and that it contains sufficient rhetorical features to justify the hypothesis that it was originally delivered in some sort of performative context, perhaps in the πρόβλημα section of one of the medical competitions that took place in Ephesus at the time. It is a work that defies easy categorisation, and this is probably one reason why it has been assumed to be some kind of ‘handbook’. Functionally, *QM* in its written form may well have been useful to ancient physicians as a handy work of reference, but to call something a ‘handbook’ today is to suggest a procedural manual serving an essentially operational purpose. *QM*, I shall argue in the next part of this chapter, is not a ‘handbook’ in that sense. Its tone is not instructional but exhortatory. With its lucid and insistent message that doctors cannot properly understand and treat illnesses unless they supplement their own knowledge by questioning patients, Rufus’s work articulates a profound appreciation of the singularity of each patient’s experience and reveals itself to be a treatise about the place of questioning in the clinical encounter, rather than a mere operational guide.⁴²⁴

⁴²⁴ For a fuller discussion, see Letts 2014.

Chapter 5 – Interpretation

All medical consultations involve at least some questioning of the patient. At the very least a doctor needs to know what the presenting problem is – why the consultation is taking place. In extreme circumstances this may not be possible (if for example a person has been found unconscious and alone), and today technology allows for diagnosis without any consultation at all; but most personal consultations will begin with some sort of basic enquiry about symptoms. But there can be great differences between doctors in how they conceptualise questioning, in other words how they think about it and its role in the clinical encounter. Should it be schematic or discursive? Is it a routine exercise or something that lies at the heart of the clinical encounter? Is a checklist useful or constraining? Is asking many questions a sign of ignorance or of confidence? Is the doctor's primary role to ask or to tell, to learn from the patient or to teach and instruct? These are matters of great significance to the medical encounter. As J.T. Dillon observes, 'the way [physicians] ask questions can clearly affect both the information-gathering and therapeutic value of the interview', yet they 'commonly believe that questioning skills are unnecessary'.⁴²⁵ And Elizabeth Loftus has shown that the content and timing of a question can materially affect the answer.⁴²⁶ We saw in Chapter 1 how the information gathering process changed through the 20th century as the dominant model of the medical interview changed from one in which the doctor's job was to interrogate patients, ensuring that their contributions at all times conformed to a medical definition of 'relevance', to a fairly open-ended dialogue in which understanding the patient's view was conceived as central to diagnosis and successful therapy. David Armstrong's seminal

⁴²⁵ Dillon 1990:54.

⁴²⁶ Loftus 1975.

work in this field revealed the extent to which ‘the patient’ is a construct of his or her socio-medical environment. Thus the apparently simple and timeless act of questioning a patient is loaded with sociological and cultural significance.

As we saw in Chapter 4, it is clear that Rufus saw a real need to defend and promote the use of questioning in medical consultations. The word he chooses at the end of the treatise (§72), ἀφίστασθαι, is a strong one, which suggests (like the Callimachus polemic in §21) that there are doctors who positively avoid asking questions, behaviour that would stand in direct opposition to Rufus’s belief that the doctor’s art is incomplete without the information that only the patient can supply. And indeed it is possible to detect a significant vein of doubt and disagreement in ancient medical texts about how much the patient’s experiential knowledge can and should contribute to medicine. The idea that patients are unreliable informants is present in some of the earliest Hippocratic works; the author of *Decorum*, for example, warns that patients often ‘tell lies about the taking of things prescribed’,⁴²⁷ while in *On the Art* we read that ‘even the attempted reports of their illnesses made to their attendants by sufferers from invisible diseases are the result of opinion, rather than of knowledge. If indeed they understood their diseases they would never have fallen into them, for the same intelligence is required to know the causes of diseases as to understand how to treat them’.⁴²⁸ In *On the Affected Parts* Galen says that

⁴²⁷ πολλάκις διεψεύσαντο ἐν τοῖσι προσάρμασι τῶν προσφερομένων (Hp.*Decent.* 14 = IX.240 L; tr. Jones, Loeb II.296-7). See also Hp.*Mul.* 1.62 = VIII.126.12ff L: doctors are sometimes deceived because women are inhibited about discussing their problems; *Epid.* IV.6 = V.146.11ff L; *id.* 20g = VI.160.6 L; *id.* 22 = V.162.5 L: doubts cast on the veracity of self-reported miscarriages.

⁴²⁸ καὶ γὰρ δὴ καὶ ἃ πειρῶνται οἱ τὰ ἀφανέα νοσέοντες ἀπαγγέλλειν περὶ τῶν νοσημάτων τοῖσι θεραπεύουσιν, δοξάζοντες μᾶλλον ἢ εἰδότες ἀπαγγέλλουσιν· εἰ γὰρ ἠπίσταντο, οὐκ ἂν περιέπιπτον αὐτοῖσιν· τῆς γὰρ αὐτῆς συνέσιός ἐστιν ἥσπερ τὸ εἰδέναι τῶν νούσων τὰ αἷτια, καὶ τὸ θεραπεύειν αὐτὰς ἐπίστασθαι (Hp.*de Arte* 11 = VI.20.7-12 L, tr. Jones, Loeb II.211, adapted). Rufus takes a very different view: for him, internal affections are one of the examples of the difficulties faced in medicine if the doctor does not question the patient: see *QM* 24 and discussion below, pp.167-168. Stephanus, commenting on *MMG*, explains that Galen provides a list of preceding causes ‘so that we will not be deceived by sick

diagnosis of affections of the gullet can be helped by questioning the patient, ‘at least whenever he is not foolish and unable to explain what he is feeling’.⁴²⁹

Perhaps the earliest such critic that we have is the Hippocratic author of *Regimen in Acute Diseases*, who rebukes the authors of the (now lost) *Cnidian Maxims* for having focused too much on patient-reported accounts:

οἱ συγγράψαντες τὰς Κνιδίας καλεομένας γνώμας ὅποια μὲν πάσχουσιν οἱ κάμνοντες ἐν ἐκάστοισι τῶν νοσημάτων ὀρθῶς ἔγραψαν καὶ ὁποίως ἔνια ἀπέβαινεν· καὶ ἄχρι μὲν τούτων, καὶ ὁ μὴ ἱητρὸς δύναται· ἂν ὀρθῶς συγγράψαι, εἰ εὖ παρὰ τῶν καμνόντων ἐκάστου πύθοιτο, ὅποια πάσχουσιν· ὅποσα δὲ προσκαταμαθεῖν δεῖ τὸν ἱητρὸν μὴ λέγοντος τοῦ κάμνοντος, τούτων πολλὰ παρεῖται, ἄλλ’ ἐν ἄλλοις καὶ ἐπίκαιρα ἔνια ἐόντα ἐς τέκμαρσιν.⁴³⁰

The authors of what we call the Cnidian Maxims correctly recorded the sorts of things patients experience in individual diseases, and the outcomes of some of them; even a non-doctor would be able to do that, if he was well informed by each patient about the kind of things they experienced. But much of what the doctor ought to know besides, without a word from the patient, is omitted – different things in different cases, including some that are vital for the timely interpretation of symptoms.

Galen wrote a commentary on this latter passage, reinforcing and developing the Hippocratic author’s view, and making it clear that he regarded laymen’s knowledge as unlikely to be relevant in a medical context:

οὐ μόνον οὐδὲν ὧν οἱ κάμνοντες πάσχουσι παρέλιπον οἱ τὰς Κνιδίας γράψαντες γνώμας, ἀλλὰ καὶ περαιτέρω τοῦ προσήκοντος ἐνίων ἐμνημόνευσαν, ὥς ὀλίγον ὕστερον δείξω. καὶ οὐπω τοῦτο τῆς τέχνης ἔργον, εἰ μὴδὲν παρέλιπον τῶν καὶ τοῖς ιδιώταις γνωσθῆναι δυναμένων· οὐ γὰρ οὗτος ὁ σκοπὸς τοῖς τεχνίταις ἐστίν,⁴³¹ ἀλλὰ τὸ τὰ χρήσιμα πρὸς τὴν θεραπείαν ἅπαντα γράφειν, ὥστε καὶ προσθεῖναι τινα δεήσει πολλάκις, ὧν μὴ γινώσκουσιν οἱ ιδιώται πάντως, ἀφελεῖν

patients and fall into error in our treatment’ (ὅπως ἂν ... μὴ ὑπὸ τῶν ἀρρώστων ἀπατώμενοι περὶ τὰς θεραπείας ἀποτυγχάνωμεν. Steph.in Gal.9, 60 Dickson, tr. Dickson 61).

⁴²⁹ ὅταν γε μὴ παντάπασιν ἡλίθιος ὑπάρχων ἀδυνατῇ σαφῶς ἐρμηνεύειν ἃ πάσχει. Gal.Loc.Aff.5.5, VIII.335,9-10 K.

⁴³⁰ Hp.Acut.1 = II.224 L.

⁴³¹ The text quoted is Kühn’s; Helmreich’s is the same, but he punctuates differently: γνωσθῆναι δυναμένων, (οὐ γὰρ οὗτος ὁ σκοπὸς τοῖς τεχνίταις ἐστίν), ἀλλὰ τὸ τὰ χρήσιμα (CMG V.9.1.117.15).

τε πολλὰ τῶν γινωσκομένων αὐτοῖς, ἐὰν μηδὲν φαίνεται συνεργοῦντα πρὸς τὸ τῆς τέχνης τέλος.⁴³²

Not only did the authors of the Cnidian Maxims include every detail of what patients experience, but they actually mentioned more than was appropriate, as I shall show a little later.⁴³³ This is not at all the job of the medical art, if they omitted none of the things that can be known even by laymen; the aim⁴³⁴ for practitioners of the art is not this, but recording everything that is useful for therapy. This means that one will often need to include things of which laymen have absolutely no knowledge, and to exclude much of what they do know, unless it seems to contribute something to the fulfilment of the art.

As noted above,⁴³⁵ Galen's claim that 'things that can be known even by laymen' have no place in a medical treatise is in tune with the intellectually competitive atmosphere of the first and second centuries.⁴³⁶ But his comments here are part of a debate that stretched over 17 centuries, from the 5th century BC, when the author of *Regimen in Acute Diseases* took issue with the Cnicians, through to the late thirteenth century, when Taddeo Alderotti, celebrated professor of medicine at the University of Bologna, used that criticism and Galen's commentary on it to illustrate a series of *quaestiones*⁴³⁷ concerning the epistemological role of patients and lay people in the production of medical knowledge. Taddeo's questions included 'Whether the doctor ought to question the patient about all his symptoms and write a book about them' (*utrum medicus debeat interrogare infirmum de omnibus accidentibus et de eis facere librum*) and 'Whether any of the things that are known to laymen ought to be added to the art of medicine' (*utrum*

⁴³² Gal.HVA 1, CMG V.9.1.117.11-19 = XV.419 K.

⁴³³ See CMG V.9.1.121. 22 = XV.427 K: εἶπον ὀλίγον ἔμπροσθεν κατ' ἀρχάς, ὅτι ἀπὸ τῆς Κνίδου, after which the text is irrecoverably corrupt.

⁴³⁴ On Galen's use of ἔργον and σκοπός in these senses 'job' and 'aim' respectively, see van der Eijk 2008a: 283.

⁴³⁵ See p.60.

⁴³⁶ The intellectual competitiveness of the 'Second Sophistic' is succinctly described by Mattern (2008:9-11). See also above, p.110. On competitiveness between doctors specifically, see Hankinson 2009:239-242.

⁴³⁷ The use of *quaestiones* to explore important matters of principle was a standard technique of medieval scholasticism.

aliqua nota vulgo, arti medicinali addenda sint).⁴³⁸ Taddeo defended the inclusion in learned medical tracts of information acquired from patients, and considered both Hippocrates and Galen mistaken on this point,⁴³⁹ but his contemporaries felt conflicted about the matter, considering the patient's narrative valuable but feeling 'obliged to mistrust it' because laymen lacked medical training.⁴⁴⁰

It is, then, an enduring debate. Yet the uniqueness of *QM* among ancient medical treatises suggests that Rufus understood the validity of the patient's narrative particularly clearly. In this chapter I argue that the key to understanding the full scope of what Haak calls 'this intriguing work'⁴⁴¹ is appreciating another unusual aspect of Rufus's thinking: his interest in probing all aspects of the patient's experience, whether psychological or physical. This, I suggest, gave him a particular perspective on the doctor-patient dialogue that can be posited as an explanatory influence on his decision to compose *QM*. My argument is structured around five striking, and multiply overlapping, features of the work: the structural priority given to mental factors in the first part of *QM*, Rufus's model of questioning, the purpose and value he attaches to questioning, his explicit insistence that the doctor's interlocutor should be the patient him- or herself, and the use of questioning to loosen the tension between the universal and the particular. Comparisons will be drawn with Hippocratic evidence and also with Galen, for, although the latter postdated Rufus by a generation or two, he is close enough in time to stand witness to broadly contemporary patterns of medico-philosophical thinking.

⁴³⁸ *Thaddei Florentini Expositio in arduum aphorismorum Ipocratis volumen, In divinum pronosticorum Ipocratis librum, In preclarum regiminis acutorum Ipocratis opus, In subtilissimum Joannitii Isagogorum libellum* (Venice, 1527), fol. 247v, cited and discussed by Siraisi (1981:124-5). On medieval academic medicine more generally, see Siraisi 2001.

⁴³⁹ Siraisi 1981:125.

⁴⁴⁰ Siraisi 1990:124.

⁴⁴¹ Haak 2013:265.

5.1. Priority given to mental factors

Rufus's interest in mental factors is evident from the beginning of *QM*. The first chapter, as we saw,⁴⁴² begins with an explanation of why it particularly matters that it is the patient him- or herself to whom the doctor addresses his questions.

μάθοις γὰρ ἂν ἐνθένδε ὅσα τε κατὰ γνώμην νοσεῖ ἢ ὑγιαίνει ὁ ἄνθρωπος καὶ ῥώμην αὐτοῦ καὶ ἀσθένειαν, καὶ τίνα ἰδέαν νόσου καὶ τίνα τόπον πεπονηκ[οτ]ῶς <εἶη>|. ⁴⁴³

From this source you can learn the extent of the person's mental sickness or health, as well as his physical strength or weakness, and at the same time the type and location of the sickness he has been suffering.

We notice that it is the patient's mental health that Rufus mentions first, before the physical. This sets a standard for the rest of the chapter, in which, I shall now show, mental factors are consistently put before physical considerations. First, as Rufus moves on to illustrate his principle, he offers a long explanation of the insights into the patient's mental state that can be gained from questioning:

εἰ μὲν γὰρ ἐφεξῆς τε ἀποκρίνοιτο καὶ μνημονικῶς καὶ τὰ εἰκότα καὶ μηδαμῇ σφαλλόμενος μήτε τῇ γλώττῃ μήτε τῇ γνώμῃ καὶ εἰ καθ' ὁρμὴν τὴν οἰκείαν καὶ, εἰ μὲν ἐστὶν ἄλλως κόσμιος, πράως καὶ κοσμίως, ὁ δ' αὖ φύσει θρασὺς ἢ δειλὸς θρασέως ἢ δεδοικ<ότ>ως, τοῦτον μὲν χρὴ νομίζειν τὰ γούν κατὰ γνώμην καλῶς ἔχειν. εἰ δὲ καὶ ἄλλα σὺ μὲν ἐρωτᾷς, ὁ δὲ ἄλλα ἀποκρίνοιτο, καὶ εἰ μεταξὺ λέγων ἐπιλανθάνοιτο, αἱ δὲ τρομώδεις καὶ ἀσαφεῖς γλῶσσαι καὶ αἱ μεταστάσεις ἀπὸ τοῦ ἀρχαίου τρόπου πρὸς τὸ ἐναντίον, πάντα ταῦτα παρακρουστικά. ⁴⁴⁴

If he answers coherently, appropriately and with good recall, without stumbling either verbally or mentally, and in a way that corresponds to his own natural inclination – mildly and moderately if he is otherwise moderate, or again boldly if he is naturally bold or fearfully if he is naturally timid – then you should regard his mind at any rate as being in good order. But if you ask one question and he answers another, if in the middle of speaking he forgets what he is saying, if his speech is

⁴⁴² See above, p.133.

⁴⁴³ *QM* 2.

⁴⁴⁴ *QM* 2.

tremulous and unclear and there are shifts from the original mood to the opposite, all these are associated with derangement.⁴⁴⁵

Only after this does Rufus proceed to explain, much more briefly, how the patient's manner of speech supports the diagnosis of physical conditions:

ῥώμην δὲ καὶ ἀσθένειαν τοῦ κάμνοντος καταμάθοις ἄν, ἣν ὁ μὲν τις ἱκανὸς τῷ φθέγματι καὶ ἐφεξῆς λέγει τὰ συμβεβηκότα, ὁ δὲ οἷο<v> ἀναπαύων τε πολλάκις καὶ λεπτῇ τῇ φωνῇ.⁴⁴⁶

You can comprehend the patient's physical strength or weakness from how he tells you what has happened, whether coherently, in adequate voice, or with frequent pauses, for example, in a thin voice.

Next, Rufus explains how questioning helps to reveal the type and location of the illness; the text at this point is corrupted, unfortunately, but emendation along the lines proposed below⁴⁴⁷ would make the missing passage conform to the pattern of both the previous and the ensuing discussions: a longer passage on mental symptoms followed by a short one on physical problems. The same pattern is seen for a third time as Rufus continues:

τὰ μὲν γὰρ μελαγχολικὰ διασημαίνει θρασύτης καὶ ἄκαιρος λύπη· μάλιστα δὲ <ὁ> ἄνθρωπος καταφανὴς ἐστὶ καὶ θαρρῶν καὶ ἀνιώμενος οἷς λέγει, καταφανὴς δὲ καὶ ἐτέρως ἐστίν. ἀλλὰ [καὶ] <εἰ> ἢ δ' ἢ πεῖρα αὐτῷ προσγένειτο, σαφῶς ἂν ἤδη διαγινώσκοιτο ἡ νόσος. καὶ ληθάργω δέ τις καθέξεσθαι μέλλων δῆλός ἐστιν ἀποκρινόμενος λήθη τε ὧν λέγει καὶ ἀσαφεῖα γλώττης. οὕτω μὲν οὖν ἐν πυρετοῖς ἄνευ δὲ τούτων σπασμοὺς καὶ ἐπιληψίας προσδοκᾷ. ὅλως δὲ σύμπαντα, [τ]ᾶ τοῦ παρακρουστικοῦ τρόπου ἐστίν, ἐνθὲν δ' ἂν τις ῥᾶον ἢ ἄλλως καταμανθάνοι. τὰ δὲ κατὰ θώρακα καὶ ὀξύτητι φωνῆς καὶ τραχύτητι· τῷ μὲν γὰρ φθίνοντι καὶ ὀρθοποϊκῷ ὀξεῖα ἡ φωνή, τῷ δὲ ἐμπύῳ καὶ τῷ βραγχώδει καὶ τῷ ὑπὸ κατάρρου πιεζομένῳ τραχυτέρα. οἱ δὲ τῇ γλώσσει παραπληκτικοὶ παντελῶς ἄφωνοί εἰσι.⁴⁴⁸

For the melancholy state is clearly indicated by over-boldness and uncalled-for sadness, both of which are particularly evident in the things the patient says (they are evident in other ways too, but the addition of this empirical test will allow the sickness to be clearly recognised),[5] while an imminent case of lethargy is obvious if, when responding to questions, the patient forgets what he is saying and

⁴⁴⁵ On the meaning of παρακρουστικός, see Thumiger 2013:71.

⁴⁴⁶ QM 4.

⁴⁴⁷ See p.189.

⁴⁴⁸ QM 4-8.

speaks without clarity. That is certainly so when there is a fever; where there is none, expect convulsions and seizures. In sum, all conditions that are to do with mental disturbance can be detected through questioning more easily than in other ways. Chest complaints are identifiable from both sharpness and roughness of the voice: if the person has consumption and can breathe only in an upright posture, the voice is sharp, but in cases of abscess, sore throat, and severe catarrh it is rougher. As for those with paralysis of the tongue, they have no voice at all.

The chapter then closes with Rufus's reiteration of his strong preference for questioning the patient rather than οἱ πάροντες at §§9-10.

It would be hard, after this opening chapter, for the reader to be unaware that the author regards the mental condition of the patient as something that it is crucial to explore if one is to arrive at an accurate picture of what is wrong and thus apply the right treatment. We have learned that the health of the γνώμη is a primary reason for addressing questions to the patient himself; it has been mentioned before physical health; and that relative priority has been maintained consistently throughout the chapter. We have also been given a clear idea of what Rufus means by mental symptoms: uncharacteristic behaviour, forgetfulness, distractedness, inability to hold a conversation, volatility, and inappropriate extremes of emotion including ἄκαιρος λύπη – a phrase whose straightforward translation, 'untimely sadness', does not capture its meaning; what Rufus refers to, surely, is sadness for which there is no obvious reason, a sort of endogenous depression. Perhaps he had in mind patients like the melancholy intellectual who 'had social intercourse with kings',⁴⁴⁹ a rich and successful man suffering from sadness that, to the less privileged, would doubtless seem inexplicable. With his insistence that the best way to detect melancholy, and indeed any mental illness, is by listening to what the

⁴⁴⁹ Ruf. *On Melancholy* F68. This patient, Swain explains, probably frequented the imperial court, perhaps Hadrian's travelling court: Swain 2008:124-5, also citing Julia Domna's 'circle of geometers and philosophers' (τοῖς περί τὴν Ἰουλίαν γεωμέτραις τε καὶ φιλοσόφοις. Philostr. VS.2.30, Ol.622).

patient says (οἷς λέγει),⁴⁵⁰ Rufus makes it clear that the physical dimension is insufficient and that the picture must be completed by exploration of the psychological. His view that ‘everything that has to do with mental disturbance can be perceived through questioning more easily than in other ways’ may well have been unusual; it seems at odds, for instance, with Galen’s advice that the condition of a person with mental problems is best understood by watching the patient sleep.⁴⁵¹ But, as we shall now see, the idea that σημεῖα are insufficient for diagnosis – an important point of principle which, as we have seen, provides the impetus for his strongest piece of polemic⁴⁵² – is one of Rufus’s major themes in *QM*.

The observation of signs was a particularly important aspect of ancient medicine. As Jouanna puts it, ‘prognosis, like diagnosis, was only possible given a set of signs’.⁴⁵³ Yet Rufus explicitly warns against relying on σημεῖα (§§4, 21, 26, 41 and 49) and expresses similar views on συμπτώματα (§§12, 22 and 23).⁴⁵⁴ He illustrates the diagnostic inadequacy of signs with three examples. First, the limitations of ἔνδειξις are exemplified by reference to satiety (πλησμονή) and fatigue (κόπος), showing how both these diagnoses are safer if confirmed through questioning.

τοῦτο μὲν γάρ, εἰ φαίη ὁ νοσῶν τὴν δίαιταν, οἷα ἦν ἔμπροσθεν, ὑπερβεβληκέναι σίτου καὶ ποτοῦ προσφορᾶ, πάσχει δὲ οἷα εἰκὸς ἐπὶ πλησμονῆς, σαφῶς ἂν γινώσκοιμεν, ὅτι πλησμονή ἐστὶν ἢ νόσος, καὶ πρὸς τοῦτο ἐξευρίσκοιμεν ἂν τὴν ὅλην ἵασιν. τοῦτο δέ, εἰ πονῆσαι μὲν

⁴⁵⁰ *QM* 4.

⁴⁵¹ παραφυλάττειν οὖν χρὴ τοὺς ὕπνους τῶν ἀπολωλεκότων τὴν μνήμην, ἢ τὴν σύνεσιν, ἀπώλεια γὰρ τῆς συνέσεως ἢ μώρωσις ἐστὶ, πότερον ὑπνώδεις ἰκανῶς οἱ κάμνοντές εἰσιν, ἢ μετρίως ὑπνώδεις, ἢ τὴν ἀρχὴν οὐδ’ ὑπνώδεις, ἀλλ’ ὅσον ἐπὶ τούτῳ κατὰ φύσιν ἔχουσιν· οὕτω γὰρ ἂν ἐξεύροις τὴν ἐπικρατοῦσαν δυσκρασίαν. *Gal.Loc.Aff.*3.7, VIII.164-5 K. (You must observe the sleep of patients who have lost their memory or their power of comprehension – that is, those who are sluggish – to see if they sleep enough, or a moderate amount, or are completely sleepless but to the extent that is natural for them; for in this way you will discover the dominant mixture.)

⁴⁵² *QM* 21, and see pp.146-153 above.

⁴⁵³ Jouanna 1999:291. See also Holmes 2010a:90.

⁴⁵⁴ On Rufus’s view that *endeixis* is insufficient for accurate diagnosis, see *QM* 23 with Gärtner *ad loc.* (1962:68-9). On *endeixis* more generally, see below, p.187 n.526.

πολλὰ φαίη, πάσχει δὲ οἷα εἰκὸς τὸν πονήσαντα, κἀνθένδε εὐπετέστερον τήν τε νόσον, ὅτι κόπος ἐστίν, εἰσόμεθα καὶ τὴν ἐοικυῖαν τῷ κόπῳ θεραπείαν προσάξομεν.⁴⁵⁵

Thus if a patient suffering what we would expect in a case of satiety says that he has exceeded his previous regimen in intake of food and drink, we can recognise the sickness as satiety and work out its entire treatment. Or take someone who says he is working very hard: if he is suffering what we would expect in a case of over-work, it will be easier to tell that the sickness is fatigue and apply the appropriate treatment.

Secondly, he explains that the correct interpretation of an indisposition (νόσημα) depends on whether its cause is ‘internal’ or ‘external’ (ἐτέρα τῶν νοσημάτων ἢ διάγνωσις ἐπὶ τοῖς ἔνδοθεν καὶ τοῖς ἔξωθεν συνισταμένοις, §24). The former are of course much the harder to identify (καὶ πὼς δοκεῖ χαλεπώτερον εἶναι <ή> τῶν ἔνδοθεν ἢ τῶν ἔξωθεν, §24). He gives three examples; the first two are shivering and raving:

καὶ γὰρ εἰ τρέμοι ὁ ἄνθρωπος, τὸ μὲν διὰ ψυχρὸς ἢ φόβον τρέμειν δεινὸν ἦσσαν, τὸ δ’ ὑπὸ τῆς εἰσῶς αἰτίας χαλεπώτερον. καὶ εἰ παραφρονοίῃ, τὸ μὲν ἐπὶ μέθῃ καὶ φαρμάκῳ τινὶ παρακρουστικῷ εὐϊατότερον, τὸ δὲ ἄλλως δυσχερέστερον. ... εἰς τοσόνδε διαφέρει τῷ ἱατρῷ καὶ τὰς αἰτίας ἀνερωτᾶν, καὶ οὐκ ἔστιν εἰδέναι μὴ ἐρωτήσαντα.⁴⁵⁶

If the person is shivering, for example, it is less serious if it is due to cold or fear but more challenging if it has arisen from some internal cause. Again, if someone is out of his mind, it is easier to remedy if caused by strong drink or a hallucinogenic drug, but harder if due to another cause.⁴⁵⁷ ... This is how much difference it makes to the physician to enquire thoroughly, even into the causes, and without questions there is no knowledge.

For his third example, Rufus contrasts different causes of fatigue:

κόπον γὰρ δὴ γινομένων, τῶν μὲν διὰ πολλὴν ταλαιπωρίαν, τῶν δὲ ὑπὸ πλησμονῆς, τοῖς μὲν οὖν συμφέρει ἀνάπαυσις καὶ ὕπνος καὶ τρῖψις μαλακὴ καὶ λουτρὰ θερμά, τοῖς δὲ πόνος καὶ ἐγρήγορσις καὶ ἡ ἄλλη κένωσις πᾶσα.⁴⁵⁸

Some cases of fatigue, for example, are due to exertion and others to satiety; the former patients need rest, sleep, soft massage and warm

⁴⁵⁵ QM 22.

⁴⁵⁶ QM 24-26.

⁴⁵⁷ It is interesting here to note the fluidity in conception between diagnosis and treatment. In the physical example, δεινὸν and χαλεπώτερον combine the idea of difficulty in recognising the νόσημα with difficulty of treatment, while in the psychological example εὐϊατότερον places the emphasis on treatment.

⁴⁵⁸ QM 25.

baths, while the latter require work, wakefulness and every other kind of depletion.

The same pairing of fatigue (κόπος) due to overwork (εἰ πονῆσαι μὲν πολλὰ φαίη) and satiety due to over indulgence occurs in §22, where, as we have just seen, they illustrate the claim that ἔνδειξις is insufficient for diagnosis.⁴⁵⁹ Given Rufus's propensity for discussing the physical and the psychological in pairs, it seems at least possible that the idea 'fatigue due to overwork' refers to mental rather than physical fatigue in both §22 and §25. If that were so, it would strike another chord with the case history at F68, as well as with the case described in F71 where the patient's problem is put down to eating too late because he attends lengthy meetings; this sounds like a form of overwork, or what today would be called a poor work-life balance. The use of πονέω and κόπος for mental rather than physical labour and exhaustion would be unusual; but, given Rufus's appreciation that excessive intellectual exertion could cause undesirable changes in a patient's mixture,⁴⁶⁰ it is perhaps not completely impossible.

One final point deserves to be made about *QM* 24. In Fragment 11 of *On Melancholy* Rufus names raving (παρὰφροσύνη) as one of the symptoms of melancholy,⁴⁶¹ and this discussion in *QM* of the difficulty of identifying its cause resonates with his more general comment in *On Melancholy* that the causes of melancholy symptoms are very perplexing.⁴⁶² As we saw above,⁴⁶³ he believes that the causes of melancholy include mental factors; perhaps this is partly what he means by the unspecified ἄλλως, 'another

⁴⁵⁹ *QM* 22. See above.

⁴⁶⁰ See Ruf.*On Melancholy* F36. As discussed in Chapter 3.3, it is not the idea that particular bodily mixtures cause mental dysfunction that makes Rufus unusual but his suggestion that those mixtures could be the result of intellectual endeavour rather than, as proposed in the Aristotelian *Problem* 30.1, the cause. See van der Eijk 2008:161-164 and 169; cf. Pormann 2008a:6 and 2013:242.

⁴⁶¹ *On Melancholy* F11 §24.

⁴⁶² *On Melancholy* F11 §2. See below, p.178.

⁴⁶³ See pp.121-123.

cause', that he regards as so hard to identify and treat correctly unless one questions the patient.

5.2. Models of questioning

Though there is no Hippocratic treatise devoted to the subject,⁴⁶⁴ there are many references in the Corpus to questioning patients – or those around them; it is not always clear which, as we shall see below.⁴⁶⁵ Good Hippocratics question their patients in order to flesh out their own observations, enrich their interpretation of signs, and enlist the patient's co-operation.⁴⁶⁶ It is clear that for many doctors questioning is a normal part of the clinical process.⁴⁶⁷ We see physicians asking questions to establish the patient's history, support diagnosis and gauge the impact of their treatment.⁴⁶⁸ Hippocratic authors commonly prescribe specific questions to be asked at specific moments or under specific circumstances. Thus for example in *Regimen in Acute Diseases (Appendix)*:

⁴⁶⁴ Jouanna 1999:135.

⁴⁶⁵ See pp.192-193.

⁴⁶⁶ Jouanna 1999:134-6; cf. Nutton 2008:147. Jouanna remarks that physicians needed to be good speakers, whether in front of an audience or in persuading their patients to accept their advice; but they also needed to be able to conduct an effective dialogue with patients, and this involved not just knowing how to ask questions but how to listen. It is this, Jouanna suggests on p.135, to which Hp.*Epid.*6.2.24 (quoted and discussed below, p.193) refers.

⁴⁶⁷ E.g. καὶ ἢν ἐρωτᾷς αὐτὸν, φήσκει οἱ ἄνωθεν ἀπὸ τῆς κεφαλῆς κατὰ τὴν ῥάχιν ὁδοιπορεῖν οἷον μύρμηκας ('If you ask the patient, he will say that starting from his head he feels something crawling down his spine, like ants'. Hp.*Morb.*2.51 = VII.78 L, tr. Potter, Loeb V.285); ἐν ψηλαφήσει δὲ μάλιστα γίνεται δῆλον καὶ ἐρωτήσει περὶ τῶν εἰρημένων, and δῆλον δὲ ἐκάτερόν ἐστι τῇ ἐρωτήσει καὶ ἀποκρίσει ('It becomes especially clear in palpation and in asking about what has been said,' and 'each of the two things is clear in the question and answer session' Hp.*Mul.*213 = VIII.410.13-14, and 414.12 L.); ἢν ἐρωτᾷ τις αὐτὸν, ὀρθῶς ἀποκρίνεται, καὶ γινώσκει πάντα τὰ λεγόμενα ('If someone questions him, he answers correctly and understands everything that is said'. Hp.*Int.*48 = VII.286.12-13 L, tr. Potter, Loeb VI.235).

⁴⁶⁸ E.g. χρὴ δὲ καὶ ἐρωτᾶν τὸν τετραμένον ὅπως ἔπαθε καὶ τίνα τρόπον ('You should also ask the wounded man how he suffered the injury, and of what kind it was'. Hp.VC.10 = III.214.3-4 L, tr. Withington, Loeb III.21); σημεῖα δὲ τοῦ καλῶς ἰητρευμένου ταῦτα, καὶ ὀρθῶς ἐπιδεομένου, εἰ ἐρωτῶν αὐτὸν εἰ πεπιέκται, καὶ εἰ φαίη μὲν πεπιέχθαι, ἡσυχῶς δὲ, καὶ μάλιστα εἰ κατὰ τὸ κάτηγμα φαίη· τοιαῦτα τοίνυν φάναι χρὴ πεπρηγμένα διὰ τέλεος τὸν ὀρθῶς ἐπιδεόμενον ('These are the indications of good treatment and correct bandaging: if you ask the patient whether the part is compressed and he says it is, but moderately and that chiefly at the fracture. A properly bandaged patient should give a similar report of the operation throughout.' Hp.*Fract.*5 = III.432.8-12 L, tr. Withington, Loeb III.107.); cf. the questions that seem to have been addressed to the carers of epileptic children in Hp.*Prorrh.*2.10 (see below, p.191).

ὁπότεν δὲ ἔρη αὐτὸν καὶ διασκέψῃ ταῦτα πάντα, πρῶτον μὲν κεφαλὴν ὅπως ἔχει, εἰ ἀνάλγητος καὶ μὴ βάρος ἔχει ἐν ἑωυτῇ· ἔπειτα ὑποχόνδρια καὶ πλευρὰ, εἰ ἀνάλγητα· ὑποχόνδριον μὲν γὰρ ἢν ἐπίπονόν ἢ ἢ ἐπλημένον ἔχῃ τινὰ σκολιότητα ἢ κόρον, ἢ πλευροῦ ἀλγηδὼν ἐνείη, καὶ ἅμα τῷ ἀλγήματι ἢ βηχίον ἢ στρόφος ἢ πόνος κοιλίης· ὅταν δέ τι τουτέων παρῇ, ἐν ὑποχονδρίῳ μὲν μάλιστα, λύειν τὴν κοιλίην κλυσμοῖσιν· πινέτω δὲ μελίκρητον θερμὸν ἀφηψημένον.

When you question the patient and examine everything thoroughly, do so first with regard to the state of his head, whether it is free from pain and has no heaviness in it; then the hypochondrium and the sides, whether they are free of pain; for if the hypochondrium is painful or swollen with some unevenness or over-fullness, or if pain of the side is present, and with the pain a mild cough, colic or pain in the cavity – if any of these things is present, especially in the hypochondrium, open the cavity with enemata; also have the patient drink hot boiled-down melicrat.⁴⁶⁹

Sometimes the patient's answers are also supplied, as if the author is scripting both sides of the dialogue:

οἷσι δὲ περὶ τὰ ἄρθρα ὀδύναι τε γίνονται καὶ ἐπάρσιες καὶ καταπαύονται, οὐκ ἐν τῷ ποδαγρικῷ τρόπῳ, εὐρήσεις τὰ τε σπλάγχνα μεγάλα καὶ ἐν τῷ οὖρῳ λευκὴν ὑπόστασιν· καὶ τοὺς κροτάφους, ἢν ἐπέρη, φήσῃ πολλάκις ἀλγέειν· φήσῃ δὲ καὶ ἰδρωτὰς αὐτῷ γίνεσθαι νυκτερινούς. ... ἢν δὲ κακὸς χροὶ οἱ ἄνθρωποι οὗτοι φαίνονται, ἐπανερέσθαι καὶ κεφαλὴν, εἰ ὀδυνῶνται· φήσουσι γάρ. ... ἀλλ' ἐπανερέσθαι περὶ τοῦ αἵματος, εἰ νέφρ' ἐόντι ἔρρει, καὶ περὶ τοῦ ἀμβλυωσμοῦ, καὶ περὶ τοῦ στήθ' παχύνσιος <καὶ τῆς> χλωρότητος, καὶ ἀμφὶ τῶν ψόφων εἰ ἐγγίνονταιί τε καὶ ὠφελέουσιν ἐπιγινόμενοι· φήσουσι γὰρ πάντα ταῦτα.

In people in whom pains arise about the joints together with swellings, and then cease – but not in the manner of gout – you will discover that the inward parts are enlarged, and that there is a white precipitate in the urine; if you ask the person, he will say that his temples often have pains, and he will also say that he has night-sweats. ... If these people appear to have a poor colour, ask whether they have pains in the head; they will say they do. ... You must ask about the blood – whether the patient haemorrhaged when he was young – about the dimness of vision, about the thickening and greenness of the urine, and about the rumblings – whether they occurred and whether they gave any relief when they did occur; patients will say that all these things were so.⁴⁷⁰

One wonders what the doctor did if patients did not answer as predicted.

⁴⁶⁹ Hp.*Acut.*(Sp.) 22 = II.438 L, tr. Potter, Loeb VI.285.

⁴⁷⁰ Hp.*Prorrh.*2.42 = IX.72-74L, tr. Potter, Loeb VIII.289-291.

Probably the best known example of this systematic concept of questioning is the sequence of questions recommended in the Hippocratic *Prognostic* 2. Here we find a highly directive model, in which the questions to be asked are precisely specified, as are the stages and circumstances within the information-gathering process at which they are to be asked. Thus if the patient's face, on examination, meets certain specified criteria (abnormal facial appearance, sharp nose, hollow eyes, sunken temples, cold ears with the lobes turned outwards, hard, tense and parched facial skin coloured yellow or black) the physician must enquire about sleep pattern, bowel movements and appetite:

ἢν μὲν ἐν ἀρχῇ τῆς νόσου τὸ πρόσωπον τοιοῦτον ᾗ καὶ μήπω οἶόν τε ἢ τοῖσιν ἄλλοις σημείοις συντεκμαίρεσθαι, ἐπανερέσθαι χρὴ, μὴ ἡγρύπνηκεν ὁ ἄνθρωπος, ἢ τὰ τῆς κοιλίας ἐξυγρασμένα ἢν ἰσχυρῶς, ἢ λιμῶδές τι ἔχη αὐτόν. καὶ ἢν μὲν τι τούτων ὁμολογῇ, ἦσσαν νομίζειν δεινὸν εἶναι· κρίνεται δὲ τὰ ταῦτα ἐν ἡμέρῃ τε καὶ νυκτί, ἢν διὰ ταύτας τὰς προφάσιας τὸ πρόσωπον τοιοῦτον ᾗ. ἢν δὲ μηδὲν τούτων φῇ μηδὲ ἐν τῷ χρόνῳ τῷ προειρημένῳ καταστῇ, εἰδέναι τοῦτο τὸ σημεῖον θανατῶδες ἐόν. ἢν δὲ καὶ παλαιότερου ἐόντος τοῦ νοσήματος ἢ τριταίου τὸ πρόσωπον τοιοῦτον ᾗ, περὶ τούτων ἐπανερέσθαι, περὶ ὧν καὶ πρότερον ἐκέλευσα, καὶ τὰ ἄλλα σημεῖα σκέπτεσθαι, τὰ τε ἐν τῷ σύμπαντι σώματι καὶ τὰ ἐν τοῖσι ὀφθαλμοῖσιν.

If the face is like this at the beginning of the illness, and if it is not yet possible to make a conjecture on the basis of the other signs, you must additionally ask whether the patient has suffered from insomnia, very loose bowels or any hunger. If he agrees about any of these things, you must consider the danger to be less; if these are the things that have caused the face to have such an appearance, the crisis comes after a day and a night. But if none of these things is said to be the case, and if he does not recover in the aforementioned period of time, you must know that this is a sign of death. If the disease has been going on for longer than three days when the face has these characteristics, you must additionally ask about the things I have already instructed, as well as examining the other signs in the entire body and the eyes.⁴⁷¹

Similarly, fever accompanied by pain and swelling in the hypochondrium for more than 20 days, and sometimes also by nosebleed (a helpful sign), means that

⁴⁷¹ Hp.Prog.2 = II.114-116 L.

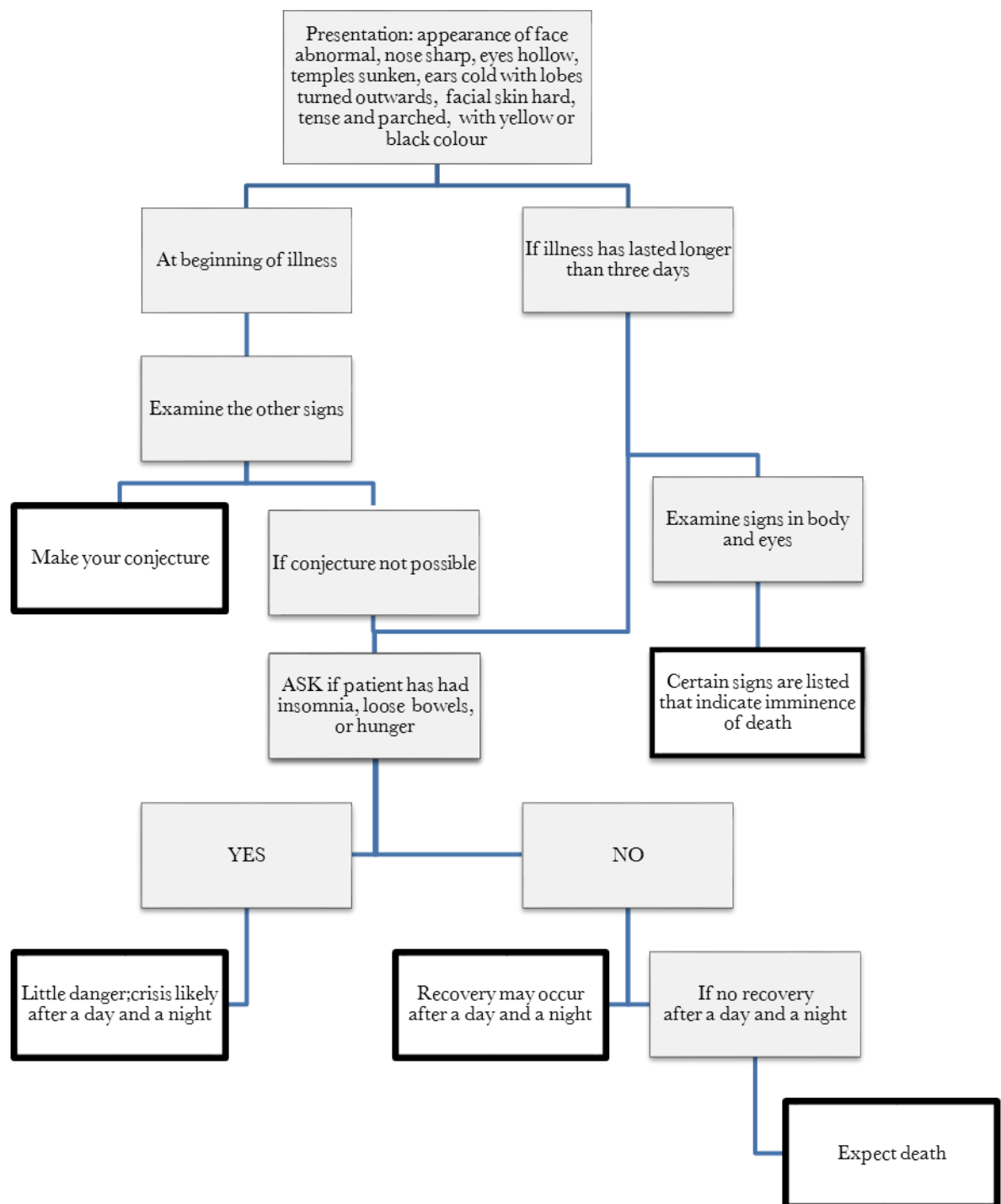
ἐπανερεσθαι χρή, εἰ κεφαλὴν ἀλγέουσιν, ἢ ἀμβλωσσοῦσιν· εἰ γὰρ εἴη
τι τούτων, ἐνταῦθα ἂν ῥέποι.

You must additionally ask if they have headache or dimness of vision,
for if any of these occurs, the illness will incline in that direction.⁴⁷²

Two things stand out to a modern eye: the schematic nature of the questioning model,
and the chronological relationship between examination and questioning. The first is
illustrated by showing the sequence of questions in diagrammatic form (below).⁴⁷³

⁴⁷² Hp.Prog.7 = II.128 L.

⁴⁷³ For similar advice from Galen, see for example his commentary on Hippocrates, *Epidemics* 6.2.24 (questions to be used if the patient has ‘a sharpened nose, hollow eyes and sunken temples’: *Hipp.Epid.*2.45, *CMG* V.10.2.2.117.5-11 = XVIIIA.998.7-13 K), and, in *Therapeutics to Glaucon*, a diagnostic model for cases of headache which adopts a similarly algorithmic approach: *MMG* 1.16, XI.61-2 K; see below, p.205, with n.582.



Current medical training discourages the use of this sort of formulaic approach in history-taking. Thus Hatton and Blackwood, in a widely used handbook for medical students, emphasise that when taking a patient's history the doctor should 'try, if feasible, to conduct a conversation rather than an interrogation, following the patient's train of

thoughts’.⁴⁷⁴ The UCL Medical School’s *Guide to History Taking and Examination* concentrates on general methodology and outline structure rather than specific content, using vocabulary like ‘explore’, ‘encourage’, ‘listen’, ‘notice’, ‘acknowledge’ and avoiding instructions to ‘ask’ or ‘say’ specific things.⁴⁷⁵ This publication urges its readers to gather information discursively, in a manner that responds to the patient’s individual situation, rather than in the order in which it will subsequently need to be recorded: the eventual report, it says, may need to be ‘a concise summary, presented in a logical, linear manner’, but the consultation itself should unfold slowly and with issues being covered in the different order that corresponds to the patient’s concerns and the ideas that occur to the doctor during the conversation.⁴⁷⁶ Schematic models have their place in modern medicine, for example in the form of clinical practice guidelines and in the sort of triaging algorithms used in situations ranging from emergency first response to general practice reception,⁴⁷⁷ but none of them, as Sriram and Rosenthal warn, is any substitute for ‘the physician’s best judgement’.⁴⁷⁸ clinical guidelines are difficult to design well and are criticised for such shortcomings as anti-intellectualism, impracticality, over-standardisation at the expense of clinical autonomy and discretion, and curtailment of patients’ choices,⁴⁷⁹ while triage algorithms are designed to facilitate rapid sifting of cases

⁴⁷⁴ Hatton and Blackwood 2003:8. For a summary of the structure of a patient history, see <http://www.gpnotebook.co.uk/simplepage.cfm?ID=-2120613880> (accessed 8th January 2016).

⁴⁷⁵ UCL Medical School 2012:5-6.

⁴⁷⁶ UCL Medical School 2012:4.

⁴⁷⁷ For discussion and explanation of the concept of a medical algorithm, see Sriram and Rosenthal 2009. For a classic emergency triage algorithm, see START (Simple Triage and Rapid Treatment), developed in Newport, California to deal with mass casualty events (<http://citmt.org/Start/flowchart.htm>; accessed 8th January 2016); and cf. the Emergency Severity Index (<http://www.esitriage.org/index.asp>; accessed 8th January 2016). On triage in general practice, see Dinwoodie 2013; on nurse triaging in hospital accident and emergency departments, see George et al 1993.

⁴⁷⁸ Sriram and Rosenthal 2009:135. Cf. Patel, Arocha and Zhang 2005:739-740 on the shortcomings of schematic approaches to diagnosis.

⁴⁷⁹ Sriram and Rosenthal 2009:138.

on the basis of standard criteria and in some settings are operated by people without any clinical skills at all.⁴⁸⁰

In the Hippocratic model, the importance attached to the interpretation of signs means that questioning the patient is secondary to examination. It forms a procedural protocol for the doctor to use at prescribed junctures when his own visual observations yield insufficient signs for diagnosis or prognosis ('if it is not yet possible to make a conjecture on the basis of the other signs, you must additionally ask ...').⁴⁸¹ Modern practice reverses this assumption, encouraging doctors to ask questions first and conduct the examination second. *GP Notebook* – 'an online encyclopaedia of medicine' that claims to be used by 'many doctors ... during the consultation' – puts it thus:

Listen to the patient – he's telling you the diagnosis. ... Diagnostic conclusions should ... be drawn from the history before embarking on the examination (and any investigations), which should be used to confirm or refute the history-based diagnosis.⁴⁸²

The scholarly basis for this advice consists in a series of articles that have investigated the relative contributions of history-taking and physical examination. In 1947, Platt, asserting that 'no sane physician' would examine a patient without taking a history first, reported an uncontrolled study in which 74% of history-based diagnoses had been proved by examination to be wholly or substantially correct; three decades later, Hampton and

⁴⁸⁰ START emphasises speed of decision making: 'If you are the initial START rescuer, you DO NOT stop to do other than the most basic intervention. If you attempt to treat every patient before completing the triage, you cannot assess the rest of the patients and identify the top priorities' (<http://citmt.org/Start/background.htm>; accessed 8th January 2016). Dinwoodie warns that 'Reception staff should not make any clinical judgment about patients' needs or attempt to make a diagnosis. If they are involved in preliminary triage or prioritisation they should follow a clear protocol with algorithms and be supported to default to a safer option of speaking to a clinician if unsure or if the patient is unhappy with a proposed plan' (2013, 15).

⁴⁸¹ *Hp.Prog.*2. See above, p.171.

⁴⁸² *GP Notebook/ General information/ History taking (general principles)/ History-taking (relative importance)*: <http://www.gpnotebook.co.uk/simplepage.cfm?ID=-2019950528&linkID=18062&cook=yes> (accessed 8th January 2016). The self-description quoted above is taken from the site's homepage.

colleagues subjected Platt's claim to stringent quantitative analysis and found that in 82% of patients (66 out of 80) 'medical history provided enough information to make an initial diagnosis ... which agreed with the one finally accepted', while 'physical examination was useful in making the diagnosis in only seven patients', i.e. 9%; and a further repeat study conducted in 1992 by Peterson and colleagues reported comparative figures of 76% and 12% respectively.⁴⁸³

Rufus does not adopt the *Prognostic* approach – which, given his familiarity with Hippocratic works, must have been well known to him. He does not specify questions, identify points at which to ask them, or believe that examination alone can deliver a diagnosis. On the contrary, signs are *de facto* insufficient, questioning is a primary and indispensable activity, and the process he implies is fluid and discursive, inviting a variety of question types. Where the author of *Prognostic* supplies a script, Rufus takes us on a tour of the areas the doctor ought to ask about, supporting each of his recommendations with an explanation of how the information thus acquired will enhance the doctor's knowledge. The questioning recommended in *Prognostic* starts from the disease and implies a kind of standardised mechanics of the body; Rufus's starts from the person and emphasises individuality.⁴⁸⁴ His purpose is not to provide a script or a check-list, but to outline a method that doctors can adapt for themselves:

Discourse is not, of course, sufficient for explaining or learning everything, nor is there enough time. But the doctor who grasps the essence of my thinking and bases his work on it will find in it everything he needs.⁴⁸⁵

⁴⁸³ Platt 1947:140; Hampton et al. 1975:489; Peterson et al. 1992:163, cf. 164. Peterson refers to two other studies that corroborate the concept that 'most diagnoses are made from the medical history' (1992:163).

⁴⁸⁴ See below, pp.197-212.

⁴⁸⁵ *QM* 71.

He makes no attempt to supply a comprehensive set of questions; on the contrary, as he puts it at the end of his chapter on questions for individuals, τὰ μὲν οὖν τοῦ νοσοῦντος καὶ τῶν παρόντων ἐρωτήματα ταῦτα καὶ ὅτι τούτων ἐγγυτάτω ἐστὶν (‘These and others very like them, then, are the questions for the patient and those around him’).⁴⁸⁶ An observation in similar vein rounds off his chapter on asking questions about localities: μυρία δ’ ἂν καὶ ἄλλα τοιουτότροπα ἱστορεῖν ἐξεύροις (‘You could find thousands of similar things to ask about’).⁴⁸⁷ And introducing his discussion of dreams he explains that:

I cannot deal with dreams comprehensively, but just enough to point out the subject in principle and to remind the physician not to overlook any of these kinds of things.⁴⁸⁸

This tendency to illustrate rather than prescribe, offering suggestions to serve as a springboard for enquiries and investigations tailored to each individual set of circumstances, is a hallmark of Rufus’s authorial, pedagogic and medical style. He uses the same approach in *On Melancholy*, to accommodate the methodological challenge posed by the multiplicity of possible signs and symptoms of that malady. Ishāq ibn ‘Imrān tells us that

[Rufus] said, having cut short his discussion: ‘In this treatise of ours we have just listed in a reliable fashion the symptoms occurring in melancholics, so that, if the reader understands our book well, he will [even] be able to comprehend all those symptoms present in those suffering from this disease which we have not mentioned in this work[, thus indicating] that the symptoms of this disease can hardly be ascertained or elucidated to their full extent.’⁴⁸⁹

A fragment from Aëtius, quoting Rufus, corroborates Ishāq’s report:

⁴⁸⁶ QM 63.

⁴⁸⁷ QM 70.

⁴⁸⁸ QM 29.

⁴⁸⁹ Ruf. *On Melancholy* F5.

[1] Πάντων μὲν οὖν τῶν παρεπομένων ἐκάστῳ συμπτωμάτων τὰς αἰτίας εἰπεῖν ἀδύνατον· [2] ἀπορίαν γὰρ πολλὴν ἔχει τὰ πλείστα, οἷον ... [3] τῶν πλείστων δὲ συμπτωμάτων εἰπεῖν τὰς αἰτίας τὸν ἱατρὸν οὐ χαλεπὸν, οἷον ... [17] εὐπετές μὲν τῷ βουλομένῳ καὶ τῶν λοιπῶν συμπτωμάτων ἀποδοῦναι τὰς αἰτίας ἐκ τούτων ὁρμωμένῳ.⁴⁹⁰

[1] It is impossible to list the causes for all the events that accompany each one [case of melancholy], [2] for most of them are very perplexing, such as the following. ... [examples] ... [3] On the other hand, it is not difficult for the physician to explain the causes of most symptoms. For instance ... [many examples.] ... [17] On the basis of this explanation, it is easy for anybody to interpret the reasons for the other symptoms as well.⁴⁹¹

The train of thought here is: it is impossible to provide a comprehensive list of causes that are constants in every case, because the symptoms of melancholy are on the whole very perplexing; most of them can in fact be explained; and doctors can use the given examples as a model for interpreting the symptoms they encounter, which Rufus clearly cannot list because they remain to be seen. It is the method that is εὐπετές,⁴⁹² not the relationship between symptom and cause.

He does something similar on two occasions in *On the Naming of Parts*. First, explaining his intention to teach internal human anatomy by reference to a dissected animal, he says:

οὐδὲν γὰρ ἐμποδὼν, εἰ μὴ καὶ παντάπασιν εἰκόασιν, τὸ γοῦν κεφάλαιον ἐκάστου διδάξαι.⁴⁹³

Even if it is not exactly like a human in every respect, there is nothing to prevent my teaching you the gist of it.

⁴⁹⁰ Ruf.*On Melancholy* F11.

⁴⁹¹ Tr. Pormann 2008:33-35, adapted. Van der Eijk has queried the sense of these two fragments, F5 because of apparent ambiguity as to whether Rufus is offering a diagnostic method or a means to understand the reasons for melancholy symptoms, and F11 on the grounds of inconsistency in that Rufus claims both that it is impossible to explain the causes of melancholy symptoms and that it is easy to do so (2008:175-77; cf. 169). It is true that in F11, if both ἀπορίαν (§1) and χαλεπὸν (§3) are translated as ‘difficulty’, then Rufus’s logic appears opaque. But the equally legitimate translation of ἀπορία as ‘perplexity’ resolves the apparent contradiction.

⁴⁹² Rufus uses the same word in *QM* 22 (Gärtner 1970:6,18), to characterise how asking questions makes it ‘easier’ to identify the patient’s illness.

⁴⁹³ Ruf.*Onom.*9 (134,12-13 Daremberg).

Secondly, he concludes that work with the following:

τὰ μὲν πλεῖστα τοῦ ἀνθρώπου οὕτω χρή καλεῖν· εἰ δέ τι ἐν τούτοις καὶ παραλέλειπται, οὐ μὴν δίκαιον τὰ πολλὰ ἀτιμάσαι διὰ τινὰ ὀλίγα παροφθέντα.⁴⁹⁴

Those are the names for most of the parts of the human body. If anything has been omitted from the list there is no reason to dishonour the many things you have been told because of some small thing overlooked.

Perhaps it was with some such formula that Rufus ‘cut short his discussion’ in *On Melancholy*, suggesting that the symptoms he had listed were insufficient as a guide to diagnosis and should be taken as illustrative rather than comprehensive. It was not unprecedented: the author of *Airs, Waters, Places* concludes his work with the implication that there is more that could be told: ἀπὸ δὲ τούτων τεκμαιρόμενος τὰ λοιπὰ ἐνθυμεῖσθαι, καὶ οὐχ ἁμαρτήσῃ (‘Take these observations as a standard when drawing all other conclusions, and you will make no mistake’).⁴⁹⁵ Even Galen was not averse to acknowledging that he had not fully addressed every point: the second book of *On Mixtures* finishes:

τὸ μὲν οὖν ἀληθὲς ὧδ’ ἔχει. δεῖ δὲ τοῖς εἰρημένοις ἀποδείξεως, ἣν μακροτέραν τ’ εἶναι νομίζων ἢ ὥστε προσγράφεσθαι κατὰ τόνδε τὸν λόγον ἔτι τ’ ἀκροατοῦ δεομένην ἐπισταμένου περὶ φαρμάκων δυνάμεως, ἀναβάλλομαι τό γε νῦν διελθεῖν.

That, then, is the full account. It requires a full demonstration, of course, but this would be too long to set down within the context of the present argument; besides, it would presuppose an understanding of the properties of drugs on the part of the audience. I therefore put it off to another occasion.⁴⁹⁶

We note, though, that Galen does not suggest that comprehensive coverage is unfeasible, simply that he is putting off the attempt for the time being.

⁴⁹⁴ Ruf.*Onom.*233 (167,10-12 Daremberg).

⁴⁹⁵ Hp.*Aer.*24 (CMG 1.1.2.82 = II.92 L, tr. Jones, Loeb I.137). Cf. Gal.*MMG*, XI.5.15-6.2 K, promising to set out a method of healing with reference to patients who are previously known to the doctor, after which ‘the rest will be understood as well, for it would not be difficult to use something that has been fully explained as the basis for discovering something that has not’.

⁴⁹⁶ Gal.*Temp.*2.6, 85.8-12 Helmreich = I.644-5 K, tr. Singer 1997:265; cf. *Hipp.Prog.*3.42, CMG V.9.2.23-25 = XVIIIIB.301K, where Galen refers to a longer discussion of his own elsewhere.

5.3. The declared purpose and value of questioning

As noted above,⁴⁹⁷ Galen too recommends specific questions for specific sets of circumstances. But rather than continue that discussion, the main point of comparison that I want to make next concerns the value attached to questioning the patient. Rufus, as we have seen, argues that it is essential to good diagnosis and treatment, in every case. Galen reveals other priorities. In his Commentary on Hippocrates' *Epidemics* 6.2.24 he discusses at length the value of questioning patients.⁴⁹⁸ He explains first that dialogue is useful for its ability to reveal the patient's state of mind, which allows the doctor to calibrate his bedside manner and maximise his chance of both being obeyed and being seen to be correct:

πολλὰ γὰρ εἰώθασιν οἱ κάμνοντες διηγεῖσθαι δυνάμενα τὴν γνώμην ἐνδείξασθαι τοῦ λέγοντος, ὥς, εἴ γε μὴ πρότερον εἰδείημεν αὐτόν, ἐξ αὐτῶν ὧν ἂν διηγήσεται συνιέντας, ὁποῖός τις ἐστίν, οὕτως αὐτῷ προσφέρεσθαι. φρόνιμον μὲν γὰρ εἰ γνωρίσαις εἶναι τόνδε τινὰ τὸν ἄνθρωπον ἔτι τε μὴ δειλόν, ἀληθεύειν πειραθήσῃ μηδὲν ὑποστελλόμενος τῶν κατὰ τὴν νόσον ἐσομένων· ἄφρονα δὲ καὶ δειλόν, ἐξ ὧν ἂν εὐθυμότερος γένοιτο, πάντα ταῦτα ἐρεῖν μετὰ τοῦ μηδὲν μέγα ψεύδεσθαι. κἂν ἀναγκασθῇς δὲ ποτε διὰ δειλίαν ἐσχάτην τοῦ κάμνοντος ἐπαγγεῖλασθαι σωτηρίαν αὐτῷ βεβαίαν, ἀλλ' ἐξελθὼν γε τοῖς κηδομένοις αὐτοῦ τάληθῃ φράζε. πειρῶ δὲ καὶ αὐτοῖς τοῖς κάμνουσι, κἂν ἄκρως ὦσι δειλοί, μὴ καθάπερ οἱ προχείρως ψευδόμενοι τὴν σωτηρίαν ἐπαγγέλλεσθαι χωρὶς τοῦ προσθεῖναι σε τὴν ἀρχὴν ἔσεσθαι ταύτην ἅπαντα πράττοντος αὐτοῦ καλῶς καὶ πειθομένου τοῖς προστάγμασι τῶν ἰατρῶν. οὕτω γὰρ οὐτ' ἐκεῖνος ἀθυμήσει καὶ σὺ πολλάκις ἀληθεύσεις.⁴⁹⁹

For patients customarily describe many things that have the power to reveal the mind of the speaker, so that – at least if we did not know him before – we can understand what sort of a man he is from the descriptions he gives, and behave towards him accordingly. If you find the patient has presence of mind and courage, by all means try telling the truth, holding back nothing of what is going to happen during the

⁴⁹⁷ See above, p.172 n.473.

⁴⁹⁸ *Gal.Hipp.Epid.*2.45, *CMG* V.10.2.2.115-117 = *XVIIA*.995-999 K. The references to these two texts in this discussion do not restate the volume numbers.

⁴⁹⁹ *CMG* 115,25-116,7 = 995-96 K.

illness; but if you find him witless and cowardly then say whatever will improve his spirits, without telling any major untruths. And if utter terror on the part of the patient forces you to promise certain safety to him, tell the truth to those who are caring for him when you leave his presence.⁵⁰⁰ But even when a patient is acutely scared, try not to promise him deliverance like those who lie casually, other than adding that that is what you will be, so long as he does all the right things and obeys the doctors' orders. In this way he will not lose heart, and as for you, you will often speak the truth.⁵⁰¹

Next Galen articulates something that lies at the heart of his own approach to medical practice:⁵⁰²

τὰ γὰρ πλεῖστα τῶν ἐπισφαλῶν νοσημάτων ἀνατρέπει τοὺς κάμνοντας ἀπειθοῦντας τοῖς ἰατροῖς, ὥς ὀλίγα πάνυ τὰ πάντως ἀναιροῦντα <γεν>ήσεται, ἐὰν μήθ' ὁ ἰατρὸς ἀμάρτη <τι> μήθ' ὁ νοσῶν μήθ' οἱ ὑπηρετάι, μήτ' ἄλλο τι τῶν ἔξωθεν ἐκ τύχης γένηται βλαβερὸν. ὅσοι γὰρ ἐν σφαλεροῖς νοσήμασι πλέον <τοῦ> προσήκοντος τοὺς κάμνοντας [τὰς] εὐθύμους ποιοῦσι, πολλαπλασίαν αὐτοῖς ἀθροίζουσι δυσθυμίαν ἐν ταῖς ἐξῆς ἡμέραις, ὅταν ἤτοι χεῖρον φαίνεται τὸ νόσημα γινόμενον ἢ χρονίζη παρὰ τὴν ἐπαγγελίαν τῶν ἰατρῶν. ἀλλὰ καὶ θαρρήσαντες, ὥς ἀκινδύνως νοσοῦντες, οἱ πλείους τῶν ἀνθρώπων οὐ πάνυ κατήκοοι γίνονται τῶν ἰατρῶν.⁵⁰³

For mostly it is the case that dangerous illnesses bring down patients when they disobey their doctors, since very few completely destructive things will occur unless some mistake is made by the doctor or the sick person or his attendants, or some other harmful thing occurs from outside by chance. People who in dangerous illnesses make the patient more encouraged than is proper, line up much more discouragement for them as the days go by, when either the disease is shown to be worse or it is going on longer than promised by the doctors. Furthermore if they become confident that they are not dangerously ill, the majority of people become less than obedient to their physicians.⁵⁰⁴

⁵⁰⁰ Galen abandons Hippocratic principle here; according to the author of *Diseases I*, it is wrong to dissemble with patients, for example by downplaying the severity of a disease or 'not telling a person who is going to die that he will die' (μέλλοντα ἀπολεῖσθαι μὴ φάναι ἀπολεῖσθαι, Hp.Morb. I.6 = VI.150 L). On nervousness induced in patients by the approach of the doctor, see Cels.3.6.6: *ob quam causam periti medici est non protinus ut venit adprehendere manu brachium, sed primum desiderare hilari vultu percontarique, quemadmodum se habeat, et si quis eius metus est, eum probabili sermone lenire, tum deinde eius corpori manum admovere*.

⁵⁰¹ On the reputational risk inherent in forecasting, see Hp.Prorrh.2.2 = IX.10 L: correct predictions arouse admiration in patients, but incorrect ones make the physician hated and perhaps even thought mad.

⁵⁰² For Galen's insistence on obedience, see Chapter 6.1 'Disobedient patients'.

⁵⁰³ CMG 116,7-20 = 996-997 K. For similar ideas in the Hippocratics: *de Arte* 7 = VI.10-12 L, and *Decent*.14 = IX.240 L; and cf. Mattern 2008:145-49.

⁵⁰⁴ Cicero suggests the opposite: *medici, quamquam intellegunt saepe, tamen nunquam aegris dicunt eos esse morituros* (Cic.Div.2.54).

The second benefit of questioning is the opportunity it affords to draw conclusions about the patient's mental stability from his manner, for example if he speaks differently from normal:

ἄμεινον μὲν οὖν ἐπίστασθαι τὸ τοῦ κάμνοντος ἥθος ἔμπροσθεν ὅθ' ὑγίαινε ἐπειραμένον. εἰ δὲ νῦν αὐτῷ πρῶτον ἐντυγχάνομεν, ἐξ ὧν διηγεῖται συνήσομεν ὁποῖός τις ἐστίν. ἐξ ὧν δὲ προγινώσκομεν, ἔξομέν τι πρὸς τὴν νόσον ἐξευρίσκειν. εἰ γάρ ≤τις> κόσμιος ὧν φύσει θρασέως ἀποκρίνοιτο καὶ φρόνιμος ὧν ἄφρων φαίνοιτο κατὰ τὴν διήγησιν,⁵⁰⁵ ἔνδειξις ἡμῖν ἐντεῦθεν ἔσται τοῦ βεβλάφθαι τὴν διάνοιαν αὐτῷ, καθάπερ εἰ καὶ νήφων καὶ φροντιστῆς ἢ ἀγρυπνητικὸς εἴη καὶ φύσει χαίρων τῷ διηγέσθαι μακρὰ νοθρὸς φαίνοιτο περὶ τὰς διηγήσεις ἢ τὰς ἀποκρίσεις.⁵⁰⁶

It is better therefore to know what the nature of the patient was as experienced before, when he was healthy; but if we are meeting him now for the first time, we will understand what sort of a person he is from the description he gives us. And from the things we know beforehand, we will be able to discover something relevant to the illness. For if someone who is naturally orderly answers boldly and someone who is in his right mind appears to be out of his mind in his description, this will reveal to us that his understanding has been harmed, and similarly if someone who is self-controlled and thoughtful, or wakeful and naturally takes pleasure in giving long explanations, appears sluggish in his descriptions or replies.

Thirdly, the voice itself can contain important diagnostic clues such as hoarseness, shrillness, lisping and hesitancy:

κάξ αὐτῆς δὲ τῆς φωνῆς ἔνεστί τι τεκμήρασθαι περὶ τῆς νόσου. τινὲς μὲν γὰρ μόγεις φθέγγονται, τινὲς δὲ βραγχῶδες ἢ ὀξὺ περὶ τὸν τῆς νόσου καιρὸν, ἔνιοι δὲ ψελλίζουσιν τε καὶ τραυλίζουσιν, ὧν ἕκαστον ὁποῖόν τι σημαίνει μεμάθηκας ἐν ἑτέροις. ἐκ μὲν δὴ τῶν τοιούτων ὁ ἰατρὸς γινώσκεται τι περὶ τοῦ νοσοῦντος, ὁποῖος τὴν γνώμην καὶ τὸ ἥθος, αὐτῆς δὲ τῆς νόσου τίς ἐστίν ἡ ἰδέα.⁵⁰⁷

And from the voice itself it is possible to deduce things about the illness. For some men speak with difficulty, and some hoarsely or shrilly around the crucial times in the illness, and there are some who falter and lisp, and you have learned what each of these signifies in other works.⁵⁰⁸ From such things, on the one hand, the doctor will learn

⁵⁰⁵ Cf. *QM* 2; *Hp.Prorrh.*1.44 = V.522 L: ἐκ κοσμίου θρασεία ἀπόκρισις κακόν. On the echoes between Galen's ideas here and some of Rufus's, see below, pp.188-189.

⁵⁰⁶ *CMG* 116,18-26 = 997 K.

⁵⁰⁷ *CMG* 116,26-117,3 = 997-98 K.

⁵⁰⁸ See *Gal.Hipp.Epid.*2.80, *CMG* V.10.94 = *XVIIA*.186-87 K; *Hipp.Prog.*2.21, *CMG* V.9.2.276,23; *Hipp.Prog.*3.42, *CMG* V.9.2.369,21-2.

something about the sick person, what his mind and character are like, and about the illness itself what its form is.

Finally, skilful choice of questions based on the patient's physical appearance will allow one to show off one's medical skill, and elicit the admiration and praise of those present, by asking questions which indicate a preternatural level of prior knowledge about his complaint and its attendant circumstances, while avoiding those that might suggest the opposite:

πάλιν δ' αὐτὸς ἐπιδείξεται τῷ τε κάμνοντι καὶ τοῖς ἄμφ' αὐτὸν ὅποῖός τις ἐστὶ τὴν τέχνην ἐξ αὐτῶν τῶν ἐρωτήσεων. καὶ ῥῖνα μὲν γὰρ ὠξυμμένην καὶ ὀφθαλμοὺς κοίλους καὶ κροτάφους συμπεπτωκότας ἰδὼν τις ἐν ὀξεί νοσήματι πεύσεται μή τις κένωσις αὐτῷ γέγονεν ἢ ἀγρυπνία καὶ λύπη, μὴ σιτίων ἐνδεια καὶ κόπος ἰσχυρός. τὸ δὲ <πρόσωπον> ἀσύμπτωτον θεασάμενος ἐρήσεται, μή τις <συνέπεσεν αὐτῷ τῶν> συνήθων ἐκκρίσεων ἐπίσχεσις ἢ παρὰ τὸ ἔθος ἀργῶς καὶ <ἐπὶ> πλησμονῆς διητήθη. δυνήσεται δὲ καὶ περὶ ψύξεως ἐγκαύσεώς τε καὶ οἰνοπόσεως πολλῆς, ὅσα τε ἄλλα τοιαῦτα, πυνθάνεσθαι κατὰ τρόπον, ὥστε ἐν αὐτῷ τούτῳ πρῶτον ἐπαινεθῆναι πρὸς τῶν παρόντων· ἐὰν γὰρ τὰ προγεγονότα καὶ τὰ προγινωσκόμενα τῷ τε κάμνοντι καὶ τοῖς ἄμφ' αὐτὸν ὁ ἰατρὸς πυνθάνηται, θαυμάζουσιν εὐθέως αὐτόν, ὥσπερ κἂν εἴ τινα τῶν ἐναντίων τοῖς γεγονόσιν ἐρωτῶη, καταγινώσκουσιν. ἀλλὰ καὶ τῶν συμβεβηκότων τοῖς κάμνουσιν ἔνια, πρὶν ἀκοῦσαι παρ' αὐτῶν, ἐν μέσῳ σχήματι λέξεως ἐρωτήσεώς τε καὶ ἀποφάσεως ἐὰν εἰπὼν ἐπιτύχη, θαυμάζεται. λέλεκται δ' ἅπαντα ταῦθ' ἡμῖν ἐτέρωθι.⁵⁰⁹

Furthermore, the doctor will, from his questions themselves, demonstrate to the patient and those around him what sort he is in respect of his art. A doctor who sees a sharpened nose, hollow eyes and sunken temples in acute illness⁵¹⁰ will enquire whether the patient has had some evacuation, or wakefulness and grief, or want of food and mighty fatigue. But if he sees the face is not sunken he will ask whether he has been afflicted by a hold-up of his normal secretions, or whether he is conducting himself with uncharacteristic laziness and satiety. He will furthermore be able to enquire in the same way about cooling of heatstroke and about over-indulgence in wine-drinking, and other such things, so that in this itself he earns the highest praise from those present. For if the doctor enquires about things that have already happened, and things that the patient and the bystanders already know, they immediately admire him; similarly, they condemn him if he asks about anything that is the opposite of what has happened. And if in the middle of the question-and-answer process he happens to mention

⁵⁰⁹ CMG 117,4-19 = 998-99 K.

⁵¹⁰ Cf. Hp.Prog.2, quoted and discussed above, pp.171-173.

some of the things that have befallen patients before they tell him themselves, he is marvelled at. All this I have said elsewhere.⁵¹¹

As a statement of Galen's attitude to dialogue with patients, this commentary is rich and revealing. There is heavy emphasis on opportunities to maintain control and excite admiration. For Galen, questions are tools through which the doctor can assert control, manipulate the patient's behaviour, secure obedience, conjure up signs (the patient's manner and voice) and, if he deploys them cleverly enough, demonstrate the accuracy of his initial suppositions. The skill extends to hedging one's bets when necessary, he explains in another of his Hippocratic commentaries:

ένίστε δὲ τὸ μὲν ἐν ἑξ αὐτῶν ἀφωρισμένως εἰπεῖν δύσκολον γίνεται, ποτὲ δ' ἐκ τῶν δυοῖν θάτερον ἢ ἐκ τῶν τριῶν γε πάντως ἐν τι δυνατόν ἐσται βεβαίως προγνῶναι. φέρει δὲ καὶ τοῦτο παρὰ τοῖς ἀκούσασιν ἔπαινον, ἐν ἐπερωτήσῃ τῆς προγνώσεως γινομένης ὡδί πως· ἄρα γε δι' ἀγρυπνίαν σφοδρὰν ἢ ἔνδειαν τροφῆς οὕτω λελέπτυνται; πολλάκις γὰρ ὁμολογοῦσιν ἀμφοτέρω καὶ θαυμάζουσι διττῶς τὸν ἱατρόν, ένίστε δὲ τὸ ἕτερον αὐτῶν ἀποκρίνονται θαυμάζοντες ἔτι καὶ οὕτως.⁵¹²

Sometimes it is difficult to name one prior factor definitively, though certain foreknowledge of one out of two factors, or just one of three, is often possible. But we earn praise from our audience when prognosis is done like this during the consultation: 'He's in this state because of excessive insomnia, or lack of food, isn't he?'; often they agree with both, and they are doubly amazed at the doctor, but sometimes they answer yes to just one thing and are still full of admiration.

A modern taxonomy of question types characteristically includes a range, such as open, closed, factual, probing, hypothetical, reflective and leading questions.⁵¹³ In Galen's analysis there is a marked bias towards closed, leading and factual questions, the latter to be asked in specific symptomatic circumstances, as opposed to using questions throughout the consultation as a way of probing from different angles in order to penetrate

⁵¹¹ It is indeed one of his favourite themes. For a fuller discussion, see below, Chapter 6.1 'Disobedient patients'. Being an object of amazement was particularly important: εἰ μὴ γὰρ ὥσπερ θεὸν αὐτὸν ὁ κάμνων θαυμάσειεν, οὐκ ἂν <εὐπειθὴς γένοιτο, εἰ δὲ μὴ> ἐκὼν εὐπειθὴς γένοιτο 'if the patient did not marvel at the doctor like a god, he would not be willing to obey him' (Gal.Hipp.Epid.4.10, CMG V.10.2.2.204,6-8 = XVIIIB.146 K). On Galen's theatricality, see Hankinson 2008a:12-13 for a succinct summary, and, for a highly detailed account, Mattern 2008, Chapter 3, 'The Contest: Rivals, Spectators and Judges'.

⁵¹² Hipp.Prog.1.8, CMG V.9.2.219 = XVIIIIB.41 K.

⁵¹³ See for example Dillon 1990, especially Chapters 5 and 10.

to the heart of the patient's complaint. The wariness about questions that might suggest poor prognostic ability is especially significant, for it precludes the use of process of elimination as a diagnostic tool. Questioning patients about their symptoms and the background to the illness was undoubtedly part of Galen's medical practice. Mattern, for example, quotes many cases where he has taken at least some of the patient's history and used it to inform his decisions. But when we compare what he says about questioning with what Rufus says in *QM*, two things stand out. The first is that, so far as the patient's answers are concerned, Galen expresses much more interest in delivery – the opportunity that questioning provides to observe the respondent's behaviour and voice (making them into σημεία) – than in content. And secondly, when he comes to discuss the value of questioning patients, what he chooses to emphasise are the ways it serves the doctor's need for obedience and enhances his reputation for omniscience, rather than the opportunity it presents to fill in gaps in his knowledge. In sum, his account of questioning as a clinical technique seems to a modern eye narrow and tendentious, not to say self-serving, and curiously silent on the usefulness of the patient's actual narrative.

Galen is nothing if not a consummate self-presenter, and his choice of factors to emphasise in writing about questioning patients cannot be insignificant. We can compare his presentation of the theory of questioning to his presentation of his own practice by looking at *On Prognosis*, which is, as Lloyd says, his 'most concentrated collection of case-histories',⁵¹⁴ assembled apparently in order to promote and justify his professional

⁵¹⁴ Lloyd 2009:15 n.1. Contrasting the case studies with those of the Hippocratic *Epidemics*, Lloyd argues that the collection was designed by Galen to serve the 'strategic purpose' of 'validat[ing] his claim as the most successful prognosticator and therapist of all time' (2009:130-131). Nutton, in the introduction to his authoritative edition (*CMG* V.8.1), also notes the 'great differences' between the *Epidemics* and *On Prognosis*: the extent to which Galen's personality 'obtrudes', the work's manifest failure as a 'general guide to prognosis', and the case histories' lack of any 'medical interest or value' lead him to conclude that

achievements. Here we find a similar bias. For example, two cases in which patients exhibit psychological symptoms concern a woman suffering from insomnia who turns out to be concealing a shameful passion for a dancer, and a slave assailed by anxiety who is found to have lost some of his master's money.⁵¹⁵ In both cases Galen boasts that he quickly realised the indisposition was due to some psychological disturbance, yet the only mention of questioning the patient is when he says, almost incidentally, that he asked the insomniac woman 'about each of the details that had happened to her from which we know the presence of insomnia'.⁵¹⁶ He tells us that he had a revealing conversation with the woman's maid,⁵¹⁷ but, on the evidence of the account he gives here, interaction with the patient herself is confined to taking the pulse and 'careful observation' over several days.⁵¹⁸ The slave's case is described much more briefly and is said to be 'similar' (ὁμοίως κάμνων).⁵¹⁹ 'What was it', Galen asks, 'that escaped the notice of earlier doctors who examined the aforesaid woman and slave? For such discoveries are made from common inductions, even if one has only the slightest acquaintance with medical science. I think that it is because they have no clear conception of how the body tends to be affected by mental conditions'.⁵²⁰ He highlights the psychosomatic nature of these cases, in other words, yet has nothing to say about probing the patient's mental state through questioning. Either he really did not think it worth questioning these patients to

the purpose of the work is primarily polemical, designed to record the truth of his achievements against the doubts of opponents, like the 'justificatory commentarii of politicians and public men' (1979:59-60).

⁵¹⁵ Gal.*Praen.*6, CMG V.8.1,100-104 = XIV.631-635 K.

⁵¹⁶ ἐπιθυόμεν ὑπὲρ ἐκάστου τῶν κατὰ μέρος αὐτῇ γεγονότων ἐξ ὧν ἴσμεν ἀγρυπνίας συμβαινούσας, *Praen.* 6.2, CMG V.8.1,100.17-18 = XIV.631,8-9 K. Cf. Galen's recommendation that the doctor should ask questions to which he already has a shrewd idea of the answer (see above, pp.183-184).

⁵¹⁷ *Praen.*6.6, CMG 102,8-10 = 632 K.

⁵¹⁸ *Praen.*6.8-10, CMG 102 = 633 K.

⁵¹⁹ *Praen.*6.10, CMG 102 = 633 K.

⁵²⁰ τί δὴ ποτ' οὖν ἐλάνθανε τοὺς ἔμπροσθεν ἰατροὺς τήν τε προειρημένην γυναῖκα καὶ τὸν προειρημένον οἰκέτην ἐπισκοπουμένους; ἐκ γὰρ κοινῶν ἐπιλογισμῶν εὐρίσκεται τὰ τοιαῦτα, κὰν βραχεῖαν ἐπιστήμην ἔχη <τις> τῆς ἰατρικῆς θεωρίας. ἐγὼ μὲν ἡγοῦμαι διότι μηδεμίαν ἔχουσι διάγνωσιν ὧν τὸ σῶμα διὰ τῆς ψυχῆς πάθη πάσχειν εἰώθει. *Praen.*6.15, CMG 104 = 634 K, tr. Nutton 1979:105.

understand their evident psychological distress, or he considered it not worth mentioning – or possibly unsuitable to the image he wished to present. In a third case, Boethus's son Cyrillus is suffering from mysterious fevers which Galen discovers are due to secret over-eating.⁵²¹ The boy's case is solved by a combination of instinct (Galen immediately suspects surreptitious food consumption),⁵²² pulse-taking⁵²³ and deduction. Again, there is no showcasing of any questioning skills; what he emphasises are his powers of observation, medical knowledge, natural intelligence and well trained logical faculty.⁵²⁴ Elsewhere in the same work we find the case of Marcus Aurelius's indigestion, in the account of which Galen emphasises his ability to solve the case without any conversation with the patient at all.⁵²⁵ The theoretical rationale for his interactions with patients is explained in *Therapeutics to Glaucon*: the way to resolve the tension between universal medical theory and messy individual reality is to employ logic, in the form of *diaeresis*, a rebarbatively complex process of which most doctors are incapable but which, if executed correctly, will lead to faultless *endeixis*.⁵²⁶ Questioning the patient can betray

⁵²¹ *Praen.*7, *CMG* V.8.1,104-110 = XIV.635-641 K.

⁵²² *Praen.*7.2, *CMG* 104 = 635-6 K.

⁵²³ *Praen.*7.6, *CMG* 104,6 = 637 K.

⁵²⁴ *Praen.*7.18, *CMG* 110, 641 K.

⁵²⁵ See below, pp.225-227. We might also expect him to mention the usefulness of questioning patients during his discussion of imperceptible indispositions that become 'sickness' only when they reach a perceptible level (*San.Tu.*1.5, *CMG* V.4.2.10,29-12,19 = VI.19-23 K); and, though he remarks often on the connection between mind and body – the mixtures of the body affect the soul; bad physical habits destroy the soul, and, conversely, emotional distress triggers physical illness; disturbance to the soul can be identified from the pulse (*QAM*, IV.767-822 K; *San.Tu.*1.53, *CMG* V.4.2,19-20 = VI.40 K; *Hipp.Prog.*8, *CMG* V.9.2.218,24-25 = XVIIIIB.40,13-15 K) – these do not trigger discussion of the need to question the patient.

⁵²⁶ *Gal.MMG* 1, K XI.4-5. This passage is discussed below (see p.203). The method of *diaeresis* is ascribed by Galen to Mnesitheus of Athens, a commentator on Hippocrates (XI.3,7-17 K). On *endeixis*, see also Hankinson 2009:231-233; and cf. Hankinson 1991. Powell, commenting on *Gal.Alim.Fac.*1.1, VI.457 K, explains that *endeixis* was 'used in a technical sense by those of Rationalist persuasion, to identify those signs that allowed one to make inferences from what can be observed to discover what cannot', as 'one of the two ways of accounting for phenomena, the other being insight' (2003:156). Powell quotes Galen's own assertion that 'men call "indication" the discovery of the truth about the thing in question arising out of the nature of the thing and made through following out the clues given by what is clearly observable' (*Gal.Inst.Log.*11.1, tr. Kieffer 1964:42). See Mattern 2008:243 with n.20: *endeixis* is 'a type of logical inference specifically banned in Empiricist doctrine'; she refers to *MM* 2.7, X.126-7 K, with Hankinson's commentary (Hankinson 1991:202-205).

weakness: ‘we, as you know, attempt to tell them the antecedent cause without waiting to ask the patient, and the acquisition of such an ability is the best indication that one is not wrong in any way’.⁵²⁷

Like Rufus, Galen values the insights that questioning the patient can provide into his or her γνώμη, though in a tellingly different sense: for Rufus, the patient’s state of mind is a key diagnostic indicator; for Galen it allows the doctor to adjust his behaviour towards the patient, as we have just seen in the passages from his *Commentary on Hippocrates’ Epidemics* discussed at the beginning of this section. There are in fact strong parallels in language and thought between those passages and QM 2 and 4, as illustrated by the paired extracts set out in the table below, where direct linguistic echoes are highlighted in bold.

μάθοις γὰρ ἂν ἐνθένδε ὅσα τε
κατὰ **γνώμην** νοσεῖ ἢ ὑγιαίνει ὁ
ἄνθρωπος καὶ ῥώμην αὐτοῦ καὶ
ἀσθένειαν, καὶ **τίνα ἰδέαν νόσου**
καὶ τίνα τρόπον πεπονηκ[οτ]ῶς
<εἶη>. QM 2

ἐκ μὲν δὴ τῶν τοιούτων ὁ
ίατρος γινώσεται τι περὶ τοῦ
νοσοῦντος, ὁποῖος τὴν
γνώμην καὶ τὸ ἦθος, **αὐτῆς**
δὲ τῆς νόσου τίς ἐστὶν ἡ
ἰδέα. CMG 117,1-3.

εἰ μὲν γὰρ ἐφεξῆς τε **ἀποκρίνοιτο**
καὶ μνημονικῶς καὶ τὰ εἰκότα καὶ
μηδαμῇ σφαλλόμενος μήτε τῇ
γλώττῃ μήτε τῇ γνώμῃ καὶ εἰ καθ’
ὁρμὴν τὴν οἰκείαν καί, **εἰ μὲν**
ἐστὶν ἄλλως κόσμιος, πράως καὶ
κοσμίως, ὁ δ’ αὖ φύσει **θρασύς** ἢ
δειλὸς **θρασέως** ἢ
δεδοικ<ότ>ως, τοῦτον μὲν χρὴ
νομίζειν τὰ γούν κατὰ γνώμην
καλῶς ἔχειν. εἰ δὲ καὶ ἄλλα σὺ μὲν
ἐρωτᾷς, ὁ δὲ ἄλλα **ἀποκρίνοιτο**
καὶ εἰ μεταξὺ λέγων
ἐπιλανθάνοιτο, αἱ δὲ τρομώδεις
καὶ ἀσαφεῖς γλῶσσαι καὶ αἱ
μεταστάσεις ἀπὸ τοῦ ἀρχαίου
τρόπου πρὸς τὸ ἐναντίον, πάντα
ταῦτα παρακρουστικά. QM 2.

εἰ γὰρ <τις> κόσμιος ὢν
φύσει θρασέως ἀποκρίνοιτο
καὶ φρόνιμος ὢν ἄφρων
φαίνοιτο κατὰ τὴν διήγησιν,
ἐνδειξίς ἡμῖν ἐντεῦθεν ἔσται
τοῦ βεβλάφθαι τὴν διάνοιαν
αὐτῷ, καθάπερ εἰ καὶ νήφων
καὶ φροντιστὴς ἢ
ἀγρυπνητικὸς εἶη καὶ φύσει
χαίρων τῷ διηγέσθαι μακρὰ
νωθρὸς φαίνοιτο περὶ τὰς
διηγήσεις ἢ τὰς ἀποκρίσεις.
CMG 116,21-26.

⁵²⁷ MMG 1.2, XI.10,13-16 K. See below, p.205.

ρώμην δὲ καὶ ἀσθένειαν τοῦ
κάμνοντος καταμάθοις ἄν, ἣν ὁ
μὲν τις ἱκανὸς τῷ φθέγματι καὶ
ἐφεξῆς λέγει τὰ συμβεβηκότα, ὁ
δὲ οἷο<ν> ἀναπαύων τε πολλάκις
καὶ λεπτῇ τῇ **φωνῇ**· νοσήματος δὲ
ιδέαν <***> ἄνευ μελαγχολίας
βράγχωσιν, γλώττης
παραπληξίας καὶ τιν<α τ>ῶν
κατὰ θώρακα καὶ περὶ πνεύμονα
εἰθισμένων γίνεσθαι. *QM* 4.

κάξ αὐτῆς δὲ τῆς **φωνῆς** ἔνεστί
τι τεκμήρασθαι περὶ τῆς νόσου.
τινὲς μὲν γὰρ μόγισ
φθέγγονται, τινὲς δὲ
βραγχῶδες ἢ ὁξὺ περὶ τὸν τῆς
νόσου καιρόν, ἔνιοι δὲ
ψελλίζουσιν τε καὶ
τραυλίζουσιν, ὧν ἕκαστον
ὁποῖόν τι σημαίνει μεμάθηκας
ἐν ἑτέροις. (*CMG* 116,26-
117,1.

There could be one further parallel depending on what the lacuna at *QM* 4 represents. Various emendations have been proposed by editors.⁵²⁸ My own hypothesis is that there is a line or two missing due to scribal error, caused perhaps by the repetition of the letters *αν* at the end of *ιδέαν* and the beginning of *ἄνευ*, and that what is lost corresponded in sense with what Aëtius quotes Rufus as having said about the speech-related symptoms of melancholy: *ταχύγλωσσοι δ' ὥς ἐπίπαν εἰσὶ καὶ τραυλοὶ καὶ ἰσχνόφωνοι τῷ ἀκρατεῖ τῆς γλώττης* ('They generally speak fast, they lisp, and stammer since they cannot control their tongue').⁵²⁹ I thus assume that the sense of the corrupted passage is something like ' <You can similarly discover> the type <and location>⁵³⁰ of disorder, <if he speaks rapidly, lisps, stammers from inability to control his tongue, and suffers the usual symptoms of melancholy, or,> if there is no melancholy, hoarseness or paralysis of the tongue or some of the things that tend to arise in the chest and lungs. '⁵³¹

⁵²⁸ See Gärtner's *apparatus criticus* (1970:2).

⁵²⁹ *Ruf. On Melancholy* F11 §15.

⁵³⁰ This is in accordance with the promise in §2 that questioning the patient enables the doctor to identify the type of illness and its location (τίνα ιδέαν νόσου καὶ τίνα τόπον πεπονηκ[οτ]ῶς <εἶη>).

⁵³¹ This hypothesis accords largely with that of Gärtner (1962, 50-53). Gärtner saw no point in trying to propose a specific emendation due to the impossibility of knowing how much text had dropped out, but an example might be: *νοσήματος δὲ ιδέαν <μάθοις ἄν, ἣν ταχυγλώσσος ἢ καὶ τραύλος καὶ ἰσχνόφωνος καὶ πάσχη οἷα εἰκὸς ἐπὶ μελαγχολίας, ἢ> ἄνευ μελαγχολίας βράγχωσιν ...*

These intertextual resonances suggest the possibility that Galen made use of Rufus's work in developing his own ideas about questioning. If this was indeed the case, the lack of any acknowledgement would be entirely in accordance with Galen's standard practice of absorbing the work of others without comment or reference when he agreed with it – in Rufus's case including large parts of *On Melancholy*⁵³² and the Atlas patient case history. It might of course be that the similarities in language and thought between Galen and Rufus mean simply that they drew on a common source, or were referencing a commonly held set of views; there can, however, be no doubt that Rufus was in Galen's mind when he wrote this, for he refers to him in the previous section of the same commentary.⁵³³ In light of this, and of Galen's tendency to merciless excoriation of those with whom he disagreed,⁵³⁴ the fact that he neither absorbs any of the rest of *QM* nor criticises it, but is simply silent about it, is at the very least worthy of remark. If he admired Rufus's very thorough work on questioning patients, it is surprising that he did not make more use of it in his own discussion of the same topic, or even mention its existence, as he mentioned Rufus's *On Melancholy* in his own work *On Black Bile*: τῶν δὲ νεωτέρων ἰατρῶν ἄριστα γέγραπται περὶ μαλγχολίας τῷ Ἐφεσίῳ Ῥουφῷ.⁵³⁵ Perhaps then he did not admire it – maybe because of its insistence on the limits of medical knowledge, or because of its disagreement with Hippocrates⁵³⁶ – in which case it is surprising that he missed an opportunity to criticise, since this is not something he normally passes up. Perhaps it is simply as Gärtner hypothesised: *QM* did not fit the

⁵³² See van der Eijk and Pormann 2008:265.

⁵³³ *Gal.Hipp.Epid.*2.44, *CMG* V.10.2.2.114, 21 = XVIII.993 K.

⁵³⁴ Hankinson 2008a:24; Strohmaier 2011:2.

⁵³⁵ 'Among the recent physicians Rufus of Ephesus has composed the best work on melancholy'. *Gal.At.Bil.*1, V.104 K, tr. Pormann 2008:27, F3.

⁵³⁶ On Galen's recreation of Hippocrates as 'to a large extent a hagiographical fiction', see Hankinson 2008:217. See also Lloyd 1991, ch. 17, and Roselli 1999.

standard model for a piece of technical writing and its anomalous status caused it simply to fall below Galen's radar.⁵³⁷

5.4. The doctor's interlocutor

I observed at the beginning of section 5.2 that it is not always clear in the Hippocratic texts who the doctor's interlocutor is meant to be. It might be objected that it is obvious; but to argue that is to take a 21st century Westernised view of healthcare. Friends and relations – οἱ παρόντες, or 'bystanders' – are a familiar feature of the ancient bedside scene,⁵³⁸ as indeed they still are today in many cultures. Sometimes they are explicitly drawn into Hippocratic texts by having questions addressed to them, as in the case of those caring for epileptic children:

οἱ μὲν πλεῖστοι τῶν τρεφόντων τὰ παιδιά ἐρωτώμενοι ὁμολογήσουσι,
τοὺς δὲ καὶ λανθάνει, καὶ οὐ φασὶν εἶδέναι τοιοῦτον οὐδὲν
γενόμενον.⁵³⁹

Most of those looking after these children, if asked, will confirm this [that the child had epilepsy already], but others do not notice it and deny all knowledge of any such occurrence.

Often the information used by the doctor has been supplied by unnamed others, as in the case of the unmarried daughter of Euryanax: ἔλεγον δὲ γευσάμενην βότρυος ('They said that she had been eating grapes').⁵⁴⁰ Of course the patient him- or herself is often named as the interlocutor: thus for example ὁπότεν δὲ ἔρη αὐτὸν καὶ διασκέψη πάντα ('when you are questioning him and examining everything carefully');⁵⁴¹ εἰδείη δ' ἂν τις τουτέων

⁵³⁷ See above, p.140 with n.373.

⁵³⁸ See for example *QM* 3, 9-10, 21 and 63; *Hp.Epid.* 6.2.24, =V.290 L; the case of Eudemus, *Gal.Praen.* 2.5, *CMG* V.8.1.76,1-2 = XIV.606 K, and 3.3, *CMG* V.8.1.82,19 = XIV.614 K; and Galen's interrogation of the patient's maid, *Praen.* 6.6, *CMG* V.8.1.102,8-10 = XIV.632 K. Those present were often other doctors, as in *Praen.* 1.8, *CMG* V.8.1.70.17-18 = XIV.602 K. Cf. Mattern 2008:88-92.

⁵³⁹ *Hp.Prorrh.* 2.10 = IX.30.7-9 L.

⁵⁴⁰ *Hp.Epid.* 3, I, case 6 = III.50.10 L. This information may of course have been volunteered without any question having been put. In any event there was definitely no questioning of the patient, who remained, according to the report, completely uncommunicative (σιγῶσα, οὐδὲν διελέγετο: III.52.7-8 L).

⁵⁴¹ *Hp.Acut.(Sp.)* 22 = II.436-8 L.

ἕκαστα, εἰ ἐρωτῶῃ ἀτρεκέως ταῦτα (‘One will recognise these various conditions in questioning the patient precisely’);⁵⁴² εἴρεσθαι εἰ γλυκύτερον τὸ σίαλον (‘ask him if his sputum is sweetish’);⁵⁴³ ἐρέσθαι οὖν χρή αὐτὴν τὸ ῥέον μὴ δάκνει τε καὶ ἐξελκοῖ (‘you must ask her if her flux irritates her and causes sores’);⁵⁴⁴ καὶ ἐρωτᾶν αὐτὴν, εἰ ὁδμὴ διὰ τοῦ στόματος δοκέει ὄζειν τῶν ἀρωμάτων (‘also ask her whether the odour of the aromatic herbs seems to be given off in her mouth’).⁵⁴⁵

Quite often, however, nobody is clearly specified. Thus the author of *Affections* advises:

Ὅταν δὲ ἐπὶ νοσέοντα ἀφίκη, ἐπανέρεσθαι χρή ᾧ πάσχει, καὶ ἐξ ὅτου, καὶ ποσταῖος, καὶ τὴν κοιλίην εἰ διαχωρέει, καὶ δίαιτην ἥντινα διαιτᾶται.

When you come to a patient, you must ask thoroughly⁵⁴⁶ about what he is suffering, from what cause, how long he has been ill, whether he has evacuated anything, and what regimen he is following.⁵⁴⁷

Though both Littré’s and Potter’s translations render the passage as an exhortation to question the patient,⁵⁴⁸ that cannot be unequivocally concluded from the Greek; none of the information required is necessarily subjective. The priority attached in ancient medicine to perceptible signs means that even an account of what someone is suffering can be given by an observer (e.g. ‘she’s had terrible stomach pains and vomited six times last night’). It is at least possible that what the author has in mind is questioning whoever is capable of providing the necessary information, which might be relatives and friends,

⁵⁴² Hp.*Mul.*1.21 = VIII.60.15-16 L.

⁵⁴³ Hp.*Morb.*2. 47 = VII.66.4 L, tr. Potter, Loeb V.268.

⁵⁴⁴ Hp.*Nat.Mul.*10 = VII. 326.3-4 L.

⁵⁴⁵ Hp.*Steril.*230 = VIII.440.12-14 L, tr. Potter, Loeb X.368. See also *Prorrh.*II.27, 34, 41, 42; *Progn.*16 = II.152 L (advice for assessing the location of pus in an internal cavity of the body); *Fract.*5 = III.432 L, cf. 434 (ask the patient if the binding of a broken bone is too tight). It is interesting that, apart from the first two, all these examples propose specific questions in specific circumstances.

⁵⁴⁶ ἐπανέρεσθαι (ἐπανερωτᾶν Littré): either ‘question again and again’, i.e. ask thoroughly, or (as in Hp.*Progn.*7 = II.128.1 L) ‘enquire further’ (LSJ svv). Rufus does not use this compound verb in QM; he has προσανερωτᾶν (§ 3), ἀνερωτᾶν (§§ 26 and 59), and ἐρωτᾶν (*passim*).

⁵⁴⁷ Hp.*Aff.*37 = VI.246 L.

⁵⁴⁸ ‘Quand vous visitez un malade, demandez-lui ce qu’il souffre’ (Littré VI, 247); ‘when you come to the patient, you must question him thoroughly’ (Potter, Loeb V.59).

as with the epileptic children mentioned above.⁵⁴⁹ Even in *Prognostic* it is not obvious that the person to be questioned must be the patient rather than others present, except possibly in §16, where the question ‘has there been dimness of vision’ demands at least a degree of subjectivity, though the answer could still come at second hand (e.g. ‘yes, she complained of that yesterday’).⁵⁵⁰ And the tantalising skimpiness of the note left by the author of *Epidemics* 6 makes it impossible to know whether it was the patient or his representative (or possibly both) who was to be questioned:

ἡ περὶ τὸν νοσέοντα οἰκονομία, καὶ ἐς τὴν νοῦσον ἐρώτησις· ἃ διηγείται, οἷα, ὡς ἀποδεκτέον, οἱ λόγοι· τὰ πρὸς τὸν νοσέοντα, πρὸς τοὺς παρόντας, πρὸς τοὺς ἔξω.⁵⁵¹

Arrangements around the sick person, and enquiry into the illness: what is narrated,⁵⁵² what sort of things, how it must be received, the words; things relating to the patient, to those present, and to those elsewhere.

Galen, in his commentary on this passage, assumes that the questioning is to be addressed to the patient, though he implicitly recognises, with his exegetical use of *δηλονότι*, that the Hippocratic author did not specify as much:

καὶ πρώτου γε μένεται κατὰ ταῦτα τῶν ἐρωτήσεων, ἃς ὁ ἰατρός *δηλονότι* ποιεῖται πρὸς τὸν κάμνοντα, δευτέρου δὲ τῶν διηγήσεων αὐτοῦ.⁵⁵³

The first of these things that he mentions is the questions, to wit the ones that the physician puts to the patient, and next he mentions the patient’s narrative.

That we wonder whether it was the patient or his friends who were intended, while the Hippocratic author did not see the need to specify, is suggestive of a significant feature

⁵⁴⁹ Opinions vary as to whether the primary audience for this treatise was physicians or lay people. Cañizares (2010) argues that it is addressed to lay people, and her view is widely shared. I disagree, as does Potter (1988:4-5).

⁵⁵⁰ See above, p.172.

⁵⁵¹ *Hp.Epid.6.2.24* = V.290 L.

⁵⁵² Littré makes *διηγείται* middle, with the patient as its subject: ‘ce qu’explique le malade lui-même, et comment’ (V.291 L). Smith opts for the impersonal passive: ‘what is explained’ (Loeb VII.235).

⁵⁵³ *Gal.Hipp.Epid.2.45*, CMG V.10.2.2.115,23-25 = XVIIA.995 K.

of the author's conceptualisation of the information the doctor requires, for if that information is equally able to be provided by the patient or by someone else then it must by definition be information that can proceed from observation rather than necessarily depending on the subjective dimension that is essential to the modern idea 'symptom'. Such information is far from lacking in value, but its epistemological function is essentially the same as that of a clinical sign: while it may broaden the scope of the enquirer's understanding, it cannot deepen it. The insertion of a rapporteur or interpreter into a dialogue – no matter how much integrity the intermediary brings to the task – alters its dynamic, circumscribing the scope of the doctor's enquiry and compounding the risk of misinterpretation by a factor of two. By way of illustration, if the question 'what has the patient been suffering?' is answered by a third party – e.g. 'yes, she complained of headache the night before the fever began' – the doctor can do little more than tick the question off on a check-list, or move to the next stage in a diagnostic algorithm; but in an unmediated conversation with the patient, supplementary questions can be posed, such as 'Had you done or felt anything unusual beforehand? Can you tell me more about what the pain felt like?' and so on.⁵⁵⁴ The mediated response forces a schematic approach to diagnosis, a model whose shortcomings have been discussed above.⁵⁵⁵ The patient's subjective response, on the other hand, may spark discussion of symptoms that might not otherwise have come to light and lead to unforeseen lines of enquiry,⁵⁵⁶ thus providing a potentially much richer base of factors from which the physician can draw inferences.⁵⁵⁷

⁵⁵⁴ Interestingly, headache (οἷον εἴ τις ἀλγοίῃ τὴν κεφαλὴν) is exactly the example that Galen chooses in *Therapeutics to Glaucōn* to illustrate the importance of 'examining each productive cause' (ἐπισκέπτεσθαι τὴν ἐργαζομένην ἕκαστον ... αἰτίαν) of patients' symptoms (*MMG* 1.16, XI.61.6-12 K). See below, p.205.

⁵⁵⁵ See pp.174-175.

⁵⁵⁶ See Geisler 1991, especially 'Introduction' and 'Discussion techniques: general principles', and Malterud 1995, especially 184 and 187-188.

⁵⁵⁷ This is one reason why retrospective diagnoses – though diverting both for the doctors who make them and for the rest of us, to whom they offer vicarious thrills and a frisson of human interest – are of limited value. Retrospective diagnosis is a one-way conversation, an example *par excellence* of traditional, top-down, evidence-driven medical process. It cannot be considered a form of narrative-based medicine, because the narrative on which it relies is static and incapable of being developed.

To a greater or lesser extent, then, relaying information via a third party compromises the subjectivity of that information. This casts an interesting light both on the lack of noticeable concern in Hippocratic texts as to who exactly supplies the answers to the doctor's questions and on Rufus's insistence that it is the patient himself to whom the questions must preferably be addressed. In *Medical Interpretation*, her study of the role of medical interpreters in situations where healthcare providers and patients do not speak the same language, Claudia Angelelli argues that the interpreter, far from being a passive conduit for language, has significant power over the medical encounter and the relationship between patient and provider. Even if the patient is present but simply unable to speak the language, there is an almost inevitable degree of contamination, given how hard it is for an interpreter's choice of words, or such factors as facial expression and body language, to have no impact on the tenor and direction of the conversation. Indifference in a medical text as to whether questions are answered by οἱ παρόντες or directly by the patient implies that the author assumes the answers to be materially equivalent. For Rufus there is no such equivalence. Questioning the patient is unequivocally preferable to questioning the bystanders. Emphasising the primacy of questioning the actual patient is the first thing he does. His opening declaration, 'You must ask the patient questions' (ἐρωτήματα χρῆ τὸν νοσοῦντα ἐρωτᾶν, §1), is swiftly followed at the start of the next sentence by 'That is my first principle: put your enquiries to the patient himself' (πρῶτον δὲ ἐκεῖνο ὑποτίθημι τὰς πύσεις αὐτοῦ τοῦ νοσοῦντος ποιῆσθαι, §2). It is only later, after reiterating the importance of questioning the patient, that he admits of the alternative, second-best option, a fall-back if there is some particular reason why dialogue with the patient is unfeasible:

πρῶτον μὲν δὴ, ὥς εἴρηται, αὐτόν τινα χρὴ τὸν νοσοῦντα ἐρωτᾶν περὶ
ᾧ χρὴ εἰδέναι, ἔπειτα δὲ καὶ τοὺς παρόντας, εἰ κωλύματα εἴη παρὰ τοῦ
νοσοῦντος μανθάνειν.⁵⁵⁸

First, as I have said, you must question the patient himself about the things you need to know; then, if there are obstacles to learning from the patient, you must question the bystanders as well.⁵⁵⁹

As we have seen, one reason to address one's questions to the patient himself, Rufus says, is that one can observe his voice and manner at the same time as listening to what he says (QM 2). Observational opportunism is not, however, the only reason for this preference. Let us remind ourselves of his overall declared purpose: 'You must ask the patient questions. By doing this you will more accurately recognise any of the factors to do with the illness, as well as providing better treatment'. (QM 1). 'Any of the factors to do with the illness' (τι τῶν περὶ τὴν νόσον) is a remarkably open-ended, imprecise formulation.

A similar phrase occurs at the beginning of the Hippocratic *Epidemics* 1.23:

Τὰ δὲ περὶ τὰ νοσήματα, ἐξ ὧν διεγινώσκομεν, μαθόντες ἐκ τῆς κοινῆς φύσιος πάντων, καὶ τῆς ἰδίης ἐκάστου, ἐκ τοῦ νοσήματος, ἐκ τοῦ νοσέοντος, ἐκ τῶν προσφερομένων, ἐκ τοῦ προσφέροντος – ἐπὶ τὸ ῥᾶον γὰρ καὶ χαλεπώτερον ἐκ τούτων –, ἐκ τῆς καταστάσιος ὅλης καὶ κατὰ μέρη τῶν οὐρανίων καὶ χώρας ἐκάστης, ἐκ τοῦ ἔθους, ἐκ τῆς διαίτης, ἐκ τῶν ἐπιτηδευμάτων, ἐκ τῆς ἡλικίας ἐκάστου, λόγοισι, τρόποισι, σιγῇ, διανοήμασιν, ὕπνοισιν, οὐχ ὕπνοισιν, ἐνυπνίοισι ...

The factors connected with diseases, that enable us to distinguish between them, are as follows: we must consider the nature of man in general and of each individual; the disease; the patient; what is being administered to him and by whom – for this may make it easier for him to take or more difficult – the conditions of climate and locality both in general and in particular, the patient's habits, mode of life, pursuits and age. Then we must consider his speech, his mannerisms, his silences, his thoughts, his patterns of sleep or wakefulness and his dreams ... [then a long list of physical signs].⁵⁶⁰

⁵⁵⁸ QM 9.

⁵⁵⁹ As Rufus explains, by 'obstacles' he means if the patient is deaf, or physically or mentally prevented from speaking, or is too young, too old, or speaks a different language (QM 3, 10).

⁵⁶⁰ Hp.Epid.1.23 (10), Loeb I.180 = II.668-70 L, tr. Chadwick and Mann 1983:100, adapted.

The Hippocratic author chooses to spell out in detail what he means by τὰ περὶ τὰ νοσήματα; Rufus does not. It may be that he had the *Epidemics* passage in mind and assumed that his audience would also be familiar with it. But perhaps the imprecision was deliberate. The pursuit of a potentially limitless set of data is the logical corollary of a therapeutics that, rather than responding to diagnosis as we know it today (attaching a label to a set of symptoms and treating accordingly), demands that the doctor understand how any number of external and internal factors have interacted to produce disorder and imbalance in the patient, and devise corresponding stratagems to restore healthy equilibrium. Rufus's presentation of his 'factors surrounding the illness' – which prove to include a range of external circumstances and individual personal characteristics – as examples rather than as a comprehensive list makes sense in this context. It also matches his decision not to specify exact questions or the order in which they should be asked but instead to provide a menu of topics predicated on the individuality of the patient.

5.5. The individual and the universal

The claim that questioning the patient is essential to distinguishing the individual from the universal is particularly important to Rufus's case. He links the two ideas repeatedly, as demonstrated in the following series of quotations.

1. Illness cannot be straightforwardly understood on the basis of signs because the meaning of these differs:

τὰ γὰρ αὐτὰ συμπτώματα ἐπὶ τοῖς ἀνδρύ<τ>οις χρόνοις σημαίνουσιν
ἄλλα ... [14] τὴν μὲν οὖν ἀρχὴν τῆς νόσου, ὁπνίκα ὁ ἄνθρωπος νοσεῖν
ἤρξατο, εἰς τοσαῦτά φημι χρηστῶς ἂν ἐρωτηθῆναι. *QM* 12-14.

2. A given symptom (e.g. shivering) may have several possible causes, and the treatment required will vary depending on what the cause was:

οὕτως δὲ ἐπὶ πάντων εὐρήσεις καὶ τὸν τρόπον τῆς θεραπείας οὐδὲν ἐοικότα. ... [26] εἰς τοσόνδε διαφέρει τῷ ἱατρῷ καὶ τὰς αἰτίας ἀνερωτᾶν, καὶ οὐκ ἔστιν εἰδέναι μὴ ἐρωτήσαντα. *QM* 25-26.

3. Each person's experience of an illness is individual and distinct:

τὸ δὲ μετὰ τοῦτο ἐρωτητέον, εἰ τῶν συνήθων τι τῷ[ν] ἀνθρώπῳ[ν] νοσημάτων ἐστὶ τὸ νῦν συμβεβηκὸς ἢ οὐ, καὶ <εἰ> πρότερον γεγενημένον. πολλοὶ γὰρ τοῦπίπταν ὑπὸ τῶν αὐτῶν ἀλίσκονται καὶ πάσχουσι δὴ τὰ αὐτὰ καὶ θεραπεύονται ὡσαύτως· ἅπερ ἂν καὶ δεῖσαι ὁ ἱατρὸς <ὡς> χαλεπώτατα [καὶ] διακωλύσαι καὶ οὐ[τε] προσφόρως θεραπευόμενα οὔτε χαλεπὰ τοῦτω <γε> τῷ ἀνθρώπῳ ὄντα οὔτε ἀνεπιτηδεῖως τῇ παρούσῃ νόσῳ θεραπευόμενα. μέγιστον γὰρ ἐν ἅπασιν ἐθισμὸς πρὸς τε τὸ ῥᾶον τῶν δεινῶν ἀνασχέσθαι καὶ πρὸς τὴν ἴασιν. *QM* 15.

4. Each person's constitution is individual and distinct, with individual responses to food, drink and medicines:

διό μοι δοκῶ καλῶς ἂν τινα καὶ φύσιν τὴν ἐκάστου πρὸς ἕκαστα ἐρωτῆσαι. οὐ γὰρ πάντες πεφύκαμεν τρόπῳ τῷ αὐτῷ, ἀλλὰ καὶ πάνυ ἀλλήλων διαφέρομεν εἰς ὅτιοῦν χρῆμα. ... ὅλως δὲ οὐδὲν τῶν τοιούτων καθεστηκός, ὥστε εἰς ἓνα ἐλθεῖν λόγον τῷ ἱατρῷ. (17) χρὴ οὖν καὶ παρὰ τοῦ κάμνοντος μανθάνειν, ὅπως πρὸς ἕκαστον διάκειται ἢ πόμα ἢ σιτίον· καὶ εἰ δὴ τινος φαρμάκου πεῖραν ἔχοι σαφεῖ, μὴδὲ ταύτην παραλιπεῖν. οὕτω γὰρ ἂν τις τὰ πολλὰ ἐπιτυχάνοι, εἰ πύθοιτο καὶ τοῦ κάμνοντος ἐπὶ τοῖς ἀτόπως αὐτῷ συμβαίνουσι. *QM* 16-17.

5. The problem with the Hippocratic method described in *Airs, Waters, Places* is that it fails to allow for individuality:

τὰ μὲν τινα καὶ οὕτως εὐρεθῆναι περὶ τε ὥρων καταστάσεως καὶ φύσεως σώματος καὶ διαίτης τρόπων καὶ ὑδάτων τὴν κοινὴν ἀρετὴν τε καὶ κακίαν καὶ νοσημάτων τὴν κοινὴν [καὶ] ἰδέαν, τὰ[ς] δὲ [δι'] ἱστορίας τῆς παρὰ τῶν ἐνοικούντων εἰς τὴν διάγνωσιν χρῆζειν, καὶ μάλιστα ὅσα ἄτοπα καὶ ξένα ἐκάστοις ὑπάρχει. *QM* 72.

What is noteworthy is not Rufus's presentation of health and sickness as states specific to the individual patient and best understood by knowing the particular constitution of that individual – a common enough view in ancient medicine, as we saw in Chapter 3 – but his use of that principle to support his case for questioning the patient. He articulates a familiar concern, in other words, but from a distinctly unusual angle. Since *QM* is the

only ancient work on the subject of questioning the patient, we cannot compare it with other treatments of that topic; but we can say that other discussions of the tension between universal theory and individual experience do not propose questioning the patient as part of the strategy for resolving it.⁵⁶¹ To take a Hippocratic example, similarities of thought and language between *QM* and *Places in Man* 41-46 make the contrast between their authors' advice particularly noticeable. The Hippocratic author, illustrating how difficult it is to learn medicine (ἱητρικὴν ... μαθεῖν), declares that 'it is impossible for any established method to arise in it' (ἀδύνατον ἐστὶ καθεστηκός τι ἐν αὐτῇ σοφισμα γενέσθαι) because of the variability and unpredictability of how individuals respond to foods and medicines. Taking purgatives as an example, he explains that they 'do not always provoke evacuation of the cavity, they may provoke evacuation both upwards and downwards, and it is possible for laxatives not even to act in the opposite way from things that promote stasis'.⁵⁶² To achieve the desired effect, the doctor has to administer the purgative substance in exactly the right quantity to suit the individual he is treating: 'this is the opportunity the doctor must recognise',⁵⁶³ and indeed the precision with which it must be done is a defining feature of medicine: ἡ δὲ ἱητρικὴ ὀλιγόκαιρός ἐστιν ('the windows of opportunity in medicine are small').⁵⁶⁴ The author is at a loss, however, to explain how it is done: returning to the theme in §46, he first declares that medicine depends on knowledge of established principles rather than on the arbitrariness of luck, but then finds himself unable to deny that luck plays a part, and falls back on the conclusion that to have knowledge is to enjoy good luck.⁵⁶⁵ Rufus similarly notes the

⁵⁶¹ Besides the two examples discussed below, see also above, pp.123-127.

⁵⁶² ὑπεκχώρησιν κοιλίης τὰ ὑπεκχωρητικά οὐκ αἰεὶ ποιεῖουσιν, καὶ τὰ ὑπεκχωρητικά ἀμφοτέρω ποιεῖουσιν, τάχα δὲ οὐδ' οὕτως ἔχουσιν τὰ ὑπεκχωρητικά τοῖσι στασίμοις ὡς ὑπεναντία. *Hp.Loc.Hom.* 41 = VI.332 L, tr. Potter, Loeb VIII.81-83. Cf. *Hp.Vict.*39 = VI.534-36 L.

⁵⁶³ οὗτος ὁ καιρός ἐστιν ὃν δεῖ τὸν ἱητρὸν εἰδέναι. *Hp.Loc.Hom.* 44 = VI.338,15 L.

⁵⁶⁴ *Hp.Loc.Hom.*44 = VI.33,6 L.

⁵⁶⁵ *Hp.Loc.Hom.* 46 = VI.342 L. On the tension between *kairos* and *tyche* in medicine, see Cuomo 2007:18-21.

absence of fixed medical principle, using similar language (οὐδὲν τῶν τοιούτων καθεστηκός, ὥστε εἰς ἓνα ἐλθεῖν λόγον τῷ ἱατρῷ, §16), and a similar example, the variability in effect of purgatives from person to person (τοῦτο δὲ τὰ φάρμακα, ὅσα πίνουσι καθάρσεως ἔνεκα καὶ οὐρούμενα, ἄλλα ἄλλοις, τὰ δὲ καὶ εἰς ἑμετον ὀρμῶντα τῶν κατωτερικῶν, τὰ δὲ καὶ κάτω ὑπιόντα τῶν ἀνωτερικῶν, §16). Unlike the Hippocratic author, however, he does have a recommendation as to how to handle all this unpredictability: ask the patient about every aspect of his constitution: διό μοι δοκῶ καλῶς ἂν τινα καὶ φύσιν τὴν ἐκάστου πρὸς ἕκαστα ἐρωτῆσαι (§16). It is knowledge of the patient's constitution (as well as of his habits and the duration of the illness) that will allow the doctor to exploit the *kairos*, or right moment: ταῦτα οὐ μοι δοκεῖ γινῶναι τις μὴ ἐρωτήσας καὶ εἶναι παντὸς ἄλλου καιριώτερον τῇ τέχνῃ εἰδέναι (§23).⁵⁶⁶

When Rufus emphasises the need to ask when the illness began, he does so in very precise terms. After rounding off his introductory section with a reiteration of his insistence on questioning the patient rather than ‘the bystanders’ (9), he announces that ‘the first thing to ask is the point in time when the person began to be unwell’ (11). It is of the greatest importance, he continues, to ask about ‘the beginning of the sickness, the exact point (ὀπηνίκα) at which the person began to be unwell’ (14). His choice of interrogative is worthy of note, for ὀπηνίκα implies a particular concern with precision,⁵⁶⁷ and the initial sensation of illness is something that can be perceived only by the person experiencing it. It may be something as vague and ill-defined as ‘not feeling right’, or something as specific and uncomfortable as pain, but it is likely to be hard to measure or categorise

⁵⁶⁶ Cf. above, p.41 n.43, and p.126. Cuomo explains: ‘the fluidity of *technē*, which leads to conflicting views on its accuracy, also helps constitute expertise ... a doctor must be able to move comfortably between general and particular, and must be able to recognise the *kairos*’ (2007:21, cf. 18). See also van der Eijk 2008a:288, referencing Hp.*Aph.*1 and Gal.*MMG* 1.1, XI.1-2 K.

⁵⁶⁷ LSJ sv.

objectively; in the words of the British Pain Society, ‘Only the person in pain can really say how painful something is. Because pain is always personal, no two people experience it in the same way. This makes it very difficult to define and to treat’.⁵⁶⁸ Rufus discusses pain as a subjective phenomenon, and advises doctors, rather than relying on the objective evidence of their own senses, to probe the patient’s experience:

ἀλλὰ ἔστι μὲν κακῶν <οἶκ>των διαγιγνώσκειν τοὺς πόνους τῶν νοσούντων, χρὴ δὲ καὶ διαπυθάνεσθαι· καὶ οὐδὲ τοῦτο πως ἐξαρκεῖ [καὶ] πρὸς τὴν ὅλην διάγνωσιν, ὥς πολλοὶ ἤδη μαλακία καὶ τρυφῇ οὐδέν τί που <ἀ>κομψότερον ὀδύνην ὑπεκρίναντο τῶν ἐν ταῖς τραγωδίαις οἰμωζόντων. *QM* 41.

Cries can certainly be used as a basis for recognising pain in sick people, but it is essential to ask searching questions as well; and even that is not quite sufficient for full recognition, since weakness and delicacy make many people act out pain more elaborately, one might say, than tragic actors groaning on the stage.

A story related to me by a patient offers an instructive, if anecdotal, contrast to Rufus’s philosophy. Experiencing pain in her breast, the patient consulted her GP, was referred for investigation and was found to have early stage breast cancer. After surgery to remove the cancer, a hospital physician asked the patient how her cancer had come to light, and, on hearing her account, dismissed her experience with the response that she ‘must have been mistaken, because breast cancer never presents with pain’.⁵⁶⁹

For insight into how Galen approaches the task of marrying universal theory and individual reality, we turn to one of his major works on therapeutics, *Therapeutics to Glaucon*.⁵⁷⁰ In this work the tension between general and particular is highlighted from

⁵⁶⁸ British Pain Society 2015:7.

⁵⁶⁹ Personal communication from the patient, 2009.

⁵⁷⁰ Much of the text of *Ad Glauconem de Methodo Medendi* (*MMG*) is presented, together with parallel translation, within Dickson’s 1998 edition of Stephanus of Byzantium’s commentary on the work.

the start. Glaucon has asked Galen to set out ‘some universal method of healing’,⁵⁷¹ but this, Galen says, is impossible:

ὅτι μὲν οὐ τὴν κοινὴν μόνον ἀπάντων ἀνθρώπων φύσιν, ᾧ Γλαῦκων, ἐπίστασθαι χρὴ τὸν ἰατρὸν, ἀλλὰ καὶ τὴν ἰδίαν ἐκάστου, πάλαι τε πρὸς Ἱπποκράτους ὀρθῶς εἴρηται καὶ ἡμῖν δ’ ἐπ’ αὐτῶν, ὥς οἶσθα, τῶν ἔργων τῆς τέχνης ἱκανῶς ἐσπούδασται. οὐ μὴν γράφειν γε δυνατόν, ὥσπερ τὴν κοινὴν, οὕτως καὶ τὴν ἰδίαν ἐκάστου ὅταν οὖν εἰς μὲν τὸ καλῶς ἰᾶσθαι μέγα συντελεῖν φαίνοιτο ὁ τε καιρὸς καὶ ἡ ποσότης τῶν βοηθημάτων, ἴδια δὲ ταῦτα καθ’ ἕκαστον τῶν νοσοῦντων εὐρήσεις, μηδὲν δ’ ἴδιον ἐρμηνεύεσθαι λόγῳ δύναται, τὸ κοινὸν οὕτως ἀναγκαζόμεθα γράφειν, κἄν τῇ χρείᾳ δεύτερον ᾗ.

That it is not only the common nature of all human beings that the physician must know, Glaucon, but also the nature peculiar to each, was rightly said by Hippocrates long ago and has also been fully observed by us, as you know, in the actual practice of the art. Yet it is not possible – as it is with common nature – to make a written account of the nature peculiar to each person.⁵⁷² ... For since both the right moment and the quantity of the treatments clearly contribute much to proper healing – and inasmuch as you will find that these are peculiar to each patient, and yet nothing that is peculiar can be expressed in words – we are thus compelled to write about what is common, even though it is secondary in practice.⁵⁷³

What Galen says here is that there are some things that defy codification; these, we infer, are where the real art of medicine lies, in the doctor’s ability to find the right moment and to calibrate the quantity of treatment, a happy combination of skill and instinct that lifts the medical art beyond the level of the merely banausic and cannot be conveyed in words. It is all the more difficult, he continues, to treat a patient with whom one is not already familiar, given the impossibility of properly judging a state of illness without knowing the patient’s normal healthy state across a range of dimensions: colour, physical

⁵⁷¹ ἱαμάτων τινά ... καθόλου μέθοδον, *MMG* 1, XI.1.9 K. Other major discussions of his therapeutics include *On the Therapeutic Method (MM)* and *Art of Medicine (Ars Med.)*; but *MMG* is relatively concise and systematic. See van der Eijk 2008a:286 (calling *MMG* ‘Galen’s own synopsis of therapeutics’), and, on *MMG* and *Ars med.*, Hankinson 2008a:22.

⁵⁷² Stephanus asks at this point: ‘who could discover the quantity or quality of the nature peculiar to each person?’ (τίς γὰρ ἂν δύναίτο τὸ πόσον ἢ τὸ ποιὸν τῆς ἐν ἐκάστῳ ιδιότητος φωρᾶσθαι; *Steph.in Gal.* 1, 20 Dickson, tr. Dickson 1998:21).

⁵⁷³ *Steph.in Gal.* 1-4, 22-28 Dickson = *MMG* 1.1, XI.1-2 K; tr. Dickson 1998:21,25-29 (slightly adapted).

disposition (σχῆσις), temperature and pulse. Ignorance of these, Galen says, leads doctors to rely on universal rules rather than treating the illness on an individual basis:

τὸ δ' ὅσον ἐξίσταται, γινῶναι δυνατόν μόνῳ τῷ κατὰ φύσιν ἀκριβῶς ἐπισταμένῳ. τοῦτ' οὖν ἀγνοοῦντες ἐπ' αὐτῶν, ἵνα μὴ παντάπασιν ἀποροῦμεν, ἐπὶ τὸ κοινὸν ἀφικνούμεθα.

How much each departs [from his natural state] can be known only by someone who grasps the natural state accurately. So when we are ignorant of this, and so as not to be utterly at a loss, we take refuge in what is common.⁵⁷⁴

The solution, he continues, is to employ logic, in the form of *diaeresis* ('division'), a Platonic technique recommended by the fourth century BC physician Mnesitheus of Athens, whom he calls 'second to none in practising medicine by method, to the extent required'.⁵⁷⁵ *Diaeresis* is a way of distinguishing between various aspects of the presenting problem by 'analysis of the subject into species, genera, and differentiae, until the indivisible particular is finally reached',⁵⁷⁶ and incompetence in this skill is, Galen claims, the cause of 'whatever mistakes the majority of physicians make in the care of the sick'.⁵⁷⁷ This logical method is indeed the only way of resolving the challenges of diagnosis:

ὅστις δὲ καὶ κατὰ φύσιν ἅπαντα καὶ τὰ παρὰ φύσιν εἰς τὴν τοιαύτην ἀνάγων μέθοδον, ἐξ ἀπάντων τῶν κατὰ τὴν διαίρεσιν ἀνενδεῖ λαμβάνει τὴν ἐνδειξιν, μόνος ἂν οὗτος εἰς ἀνθρωπίνην δύναμιν ἀναμάρτητος εἴη περὶ τὰς ἰάσεις· καὶ τοὺς τε γινωσκομένους ἄμεινον

⁵⁷⁴ Steph.in Gal.4, 28-30 Dickson = MMG 1.1, XI.3,2-5 K; tr. Dickson 1998:29-31.

⁵⁷⁵ εἰς ὅσον χρή μεθόδῳ τὴν ἰατρικὴν τέχνην ἀσκεῖν, οὐδενὸς ἐπιγινῶναι δεύτερος (XI.3,11-12 K). Mnesitheus was an accomplished philosopher and polymath as well as a celebrated physician (Stephanus *ad loc.*, Dickson 1998:34).

⁵⁷⁶ Dickson 1998:33 n.6, noting that *diaeresis* was for Galen a constituent part of the logical structure of medicine and thus formed a 'fundamental aspect' of the philosophical basis of the art. For a clear summary and discussion of Galen's treatment of *diaeresis* in MMG, see van der Eijk 2008:286-297. For Galen's own explanation of *diaeresis* see MMG, XI.3,7-17 K.

⁵⁷⁷ καὶ γὰρ καὶ τὰ κατὰ τὰς ἄλλας αἰρέσεις σφάλματα καὶ ὅσα νῦν ἐπὶ τῶν νοσοῦντων οἱ πολλοὶ τῶν ἰατρῶν ἀμαρτάνουσι, πρώτην καὶ μεγίστην αἰτίαν ἔχει τὸ μοχθηρὸν τῆς διαίρέσεως (MMG 1.1, XI.4,7-10 K). See also Galen's *Against Lycus* (where Mnesitheus is mentioned alongside Aristotle, Theophrastus and Chrysippus) for Mnesitheus's adherence to Plato's view that 'it is in the recognition of the *differentiae* of each existing thing that the branches of expertise consist' (ἐν γὰρ τοι τῇ γνώσει τῶν διαφορῶν ἐκάστου τῶν ὄντων αἱ τέχναι συνίστανται. Gal.Adv.Lyc.XVIII.A.209,7-8 K, tr. Long and Sedley 1987(1):191).

ἂν ἄλλων ἰῶτο καὶ τοὺς ἀγνοουμένους εἰς ὅσον οἶόν τε καὶ τούτους ἐγγυτάτω τῶν γινωσκομένων.

If someone uses this method on everything that is normal and everything that is abnormal, and derives flawless indications from all that results from this division, he alone would be free from errors in healing as far as is humanly possible, he would heal patients whom he knows better than others [would], and he would, so far as possible, heal patients he did not now in very much the same way as those he did know.⁵⁷⁸

In his enthusiasm for logical method, Galen allocates questioning the patient a much lower priority than Rufus does. He puts examination first, and presents questioning as something that can be used to confirm the diagnosis thus reached:

εἰσελθόντας οὖν χρή περὶ τὸν ἀσθενοῦντα πρῶτον μὲν ἀπὸ τῶν μεγίστων σκοπεῖσθαι τὰ κατ' αὐτόν· ἔπειτα δὲ καὶ ἀπὸ τῶν ἄλλων μηδὲν ὡς οἶόν μηδὲ τῶν ἐλαχίστων παραλίποντας. ... κἄπειδ' ὥσπερ χορὸς συμφῶνος ἅπαντα φθέγγηται, θαρρεῖν τε ἤδη χρή καὶ, εἰ βούλοιο, προσανερέσθαι, μή τι προηγήσατο φανερόν αἴτιον.

When we visit a patient, we must first examine the signs that are most predominant in him, and then also the other ones, so that we do not miss even the least of them as far as is possible. ... [Galen explains that the lesser signs (facial appearance, position, breathing, evacuation) can help to confirm a diagnosis made from the more important ones (pulse and urine)] ... Then, when all chime together like a harmonious chorus, you must take heart and, if you like, question the patient in addition as to whether there was not some clear antecedent cause.⁵⁷⁹

Questioning the patient is not the first priority, as it is for Rufus, but the last, as it was for the Hippocratic author of *Prognostic* (see above). Signs are not *de facto* inadequate, as they are for Rufus, but represent the best chance of finding the right answer. Questioning is a supplementary activity (προσανερέσθαι),⁵⁸⁰ and it is optional rather than essential (εἰ βούλοιο). And it is also, by implication, indicative of a want of skill:

⁵⁷⁸ Steph.in Gal.6, 38 Dickson = MMG 1.1, XI.4,14-5,2; tr. Dickson 39 (adapted). For a very clear account of Galen's therapeutic principles, see van der Eijk 2008a, especially 288-297..

⁵⁷⁹ Steph.in Gal.8, 48-50 Dickson = MMG XI.8,3-6 and 9,7-10 K; tr. Dickson 49-51 (adapted).

⁵⁸⁰ We may wonder if this word implies asking the same person supplementary questions, or asking questions as a supplementary activity. Plato uses it in the former way (*Men.*74c), Rufus (*QM* 3) and

ἡμεῖς δὲ, ὥς οἶσθα, πειρόμεθα λέγειν αὐτοῖς τὸ προηγησάμενον αἷτιον,
οὐ περιμέναντες ἐρέσθαι τὸν κάμνοντα, καὶ ἔστι μέγιστον σημεῖον εἰς
τὸ μηδὲν σφάλεσθαι τὸ τοιαύτην τινὰ πεπορίσθαι δύναμιν.⁵⁸¹

But we, as you know, attempt to tell them the antecedent cause without waiting to ask the patient, and the acquisition of such an ability is the best indication that one is not wrong in any way.

When later in the work Galen advises questioning the patient about headache, it is in order to clarify and understand the symptoms – in other words, ensuring a strong grasp of the σημεῖα – rather than as part of an exploration of the wider circumstances.⁵⁸²

Clearly what Galen is struggling with in his clinical practice is a major challenge for any physician, as it was for the author of *Places in Man*, and as it remains to this day;⁵⁸³ a given symptom may, as Rufus noted in *QM*, may be cause for great concern in one patient and not at all dangerous in another, and doctors have to make fine judgements in uncertain territory with potentially enormous consequences.⁵⁸⁴ All too often, Galen notes in *On the Affected Parts*, diagnosis depends on ‘skill-based conjecture, which lies in the middle between exact knowledge and complete ignorance’.⁵⁸⁵ For Rufus, the insights gained from questioning the patient are essential to this difficult process; indeed the three things

Josephus in the latter way (the senators answer a question of Agrippa’s and then ask him one themselves, J.AJ 19.4.1, 240 Whiston). Galen uses it here and at XI.188.

⁵⁸¹ Steph.in Gal.9, 58 Dickson = MMG 1.2, XI.10,13-16 K. Stephanus comments: δεῖ τὸν ἱατρὸν <τὰ μὲν προγουμένα καὶ τὰ συνεκτικὰ> εἰδὸτα προαγορεύειν, τὰ δὲ προκαταρκτικὰ παρὰ τῶν καμνόντων πυνθάνεσθαι (‘The physician must recognize and predict <the antecedent and sustaining causes,> but discover the immediate causes by interrogating his patients’. Tr. Dickson 59). On the different types of cause, see above, pp.150-152.

⁵⁸² Steph.in Gal.218, 258 Dickson = MMG 1.16, XI.61,9-62,12 K.

⁵⁸³ As historian and blogger Nathaniel Comfort puts it, “‘Personalized medicine’ is both one of the hottest topics in biomedicine today and one of the oldest concepts in the healing arts’”. <http://genotopia.scienceblog.com/29/putting-the-person-in-personalized-medicine/> (accessed 8th January 2016).

⁵⁸⁴ QM 15.

⁵⁸⁵ τεχνικὸς στοχασμὸς, ὃς ἐν τῷ μεταξύ πῶς ἐστὶν ἀκριβοῦς τε γνώσεως καὶ παντελοῦς ἀγνοίας (*Loc.Aff.* 1.1, VIII.14.10-12, tr. van der Eijk, 2008a:302,n.19); Siegel translates τεχνικὸς στοχασμὸς ‘logical inference’ (1976:21). Cf. *Ars Med.*19, I.353 K. See also Hankinson 2009:236 n.98: for Galen, it is not medical theory that is stochastic, but its application. Stephanus comments that the ability to determine the right quantity of treatment sorts out good physicians from their slower witted peers, a remark, says Dickson, that constitutes a recognition that medicine, with its irreducible element of the inexact, must always be ‘a scientific art’ (his italics) (Stephanus *ad loc.*, Dickson 1998:31 with n.4).

that are most opportune for the doctor to know – the patient’s constitution, his habits, and the chronology of the illness – are unknowable without questioning the patient: χρόνον δὲ τῆς νόσου καὶ ἐθισμόν τὸν πρὸς ἕκαστα καὶ φύσιν τὴν ἐκάστου ἐξαίρετον, ταῦτα οὐ μοι δοκεῖ γινῶναι τις μὴ ἐρωτήσας καὶ εἶναι παντὸς ἄλλου καιριώτερον τῇ τέχνῃ εἰδέναι.⁵⁸⁶

Rufus’s linking of nature and habits as crucial dimensions of individuality deserves further comment. Habits are a common enough topic in ancient therapeutics,⁵⁸⁷ where we are used to finding them discussed in physical terms, reflecting the general belief that a person’s health could be affected by elements of his or her lifestyle such as diet, exercise, bathing, sleep and sex, and the conviction that a change of habits could upset the body’s equilibrium.⁵⁸⁸ Mental habits are rarely mentioned; Galen notes this disapprovingly, yet even his own reference to mental and intellectual habits in *On Habits* is simply by way of analogy, to illustrate the power of habit:

πάρεστι γοῦν αὐτῶν <ἀκούειν> ὅσημέραι λεγόντων εἰθίσθαι [φησὶ] τῷδε τῷ βρώματι καὶ τῷδε τῷ πόματι καὶ διὰ τοῦτο μὴ δύνασθαι καταλιπεῖν αὐτά· καὶ γὰρ καὶ βλάπτεσθαι κατὰ τὰς μεταβολάς. ὁμοίως δὲ καὶ περὶ τῶν ἐπιτηδευμάτων λέγουσιν, οἷον ἄλουσίας λουτρῶν,

⁵⁸⁶ QM 23.

⁵⁸⁷ Jouanna 1999:329-30 and 2012:148-9.

⁵⁸⁸ See for example Hp.Epid.1.23(10) = II.668-70 L (above, p.196); Aer.1, II.12 =18-21 L (local habits in food, drink and exercise); VM 10-11 = I.590-594 L (change of lunching habit harmful for some); Acut.28-37(10 L) = II.280-302 L (perils of change of diet, both food and drink); Aph.2.38 = IV.480 L (palatability of food and drink preferable to quality); Progn.3 = II.118-120 L (non-habitual bruxism a dangerous sign). Galen explains in *On Sects for Beginners* that rationalist medicine requires the doctor ‘to be knowledgeable about airs, waters, places, occupations (ἐπιτηδευμάτων), foods, drinks and habits (ἐθῶν), so that he may figure out the causes of all diseases and be able to compare and to calculate the forces of the remedies, i.e. that something which has such and such a force, if applied to this kind of cause, naturally produces that kind of effect’ (καὶ ἀέρων [φύσεις] καὶ ὑδάτων καὶ χωρίων καὶ ἐπιτηδευμάτων καὶ ἐδεσμάτων καὶ πομάτων καὶ ἐθῶν ἐπιστήμονα, φασίν, εἶναι δεῖ τὸν ἱατρόν, ὅπως τῶν τε νοσημάτων ἀπάντων τὰς αἰτίας ἐξευρίσκη καὶ τῶν ἱαμάτων τὰς δυνάμεις καὶ παραβάλλειν οἷός τ’ ἢ καὶ λογίζεσθαι, ὅτι τῷ τοιῷδε τῆς αἰτίας εἶδει τὸ τοιάνδε δύναμιν ἔχον προσαχθὲν [φάρμακον] τοῖόν τι ἐργάζεσθαι πέφυκε. Gal.Sect.Int.3, I.69 K, tr. Frede 1985:5-6. Erasistratus on doctors’ need to pay attention to habits: Gal.Cons.1, CMG Suppl.III.12,6-7 = SM II.16,5-7 (cf. Brock 1929:185); cf. Pl.Lg.7, 797e-798a, on the dangers of changing habits in medicine as in politics; see also Jouanna 2012:185 and 187, with further references including Soranus and Stephanus.

ἱππασίας κυνηγεσίων, δρόμου πάλης, ἀγρυπνιῶν <ὑπνῶν>, ἡλιώσεως ψύξεως, φροντίδων ὅσα τ' ἄλλα τοιαῦτα.⁵⁸⁹

One may daily hear these people saying that they have 'become used to' such and such food or drink, and that therefore they cannot give it up, since changes undoubtedly do them harm. And similarly also they speak about their activities, such as bathing, or abstention from bathing, horseback exercise, hunting, racing, wrestling, sleep or deprivation of sleep, exposure to sun and to cold, intellectual activities, and everything of the kind.

Rufus's view of the hermeneutic significance of habit is comparatively broad.⁵⁹⁰ For him, habits constitute an indefinite range (ἡντιναοῦν, §20) of individual behavioural characteristics:

καὶ γὰρ σιτίων τὸ σὺνηθες ἀλυπότερον προσαίρονται τοῦ ἄλλως ἂν δόξαντος εἶναι βελτίστου, καὶ ἐν ᾧ δὴ τρόπῳ μεμελετήκασιν αὐτὸ λαμβάνειν καὶ πλῆθος καὶ σκευασίαν. (19) καὶ τὰ σὺνήθη πάντα ἀμείνω καὶ τῷ νοσοῦντι καὶ τῷ ὑγιαίνοντι. (20) καὶ προγνωσθεῖη δ' ἂν τι[ς] ἀκριβέστερον ἐκ τῶν ἐθισμῶν περὶ τε κρίσιν [καὶ κλίσιν] τοῦ ἀνθρώπου καὶ διάλεξιν καὶ ῥαθυμίαν καὶ ἡντιναοῦν ἄλλην ἐνέργειαν· τὰ γὰρ ὑγιαίν<οντι> ὄντα δι' ἔθους οὐδὲν ἐν ταῖς νόσοις ἐπίσημον δηλοῖ. (21) Κὰν τούτοις οὐκ ἔστιν, ὅ τι παρ' <ἐ>αυτοῦ δύναται' ἂν μαθεῖν ὁ ἰατρός, εἰ μὴ πυνθάνοιτο ἢ τοῦ νοσοῦντος ἢ ἐτέρου τινὸς τῶν παρόντων. ὥστε ἔγωγε θαυμάζω Καλλιμάχου τοῦ ἰατροῦ ... (QM 18-22.)

People consume familiar foods, served in the familiar quantity and style, less unhappily than those which might otherwise seem to be best, [19] and familiar things are always better, whether a person is sick or well. [20] We can also give a more accurate prognosis by knowing the patient's habits with respect to power of judgement, conversational style, inactivity and any other function whatsoever. For what is habitual in a healthy person indicates nothing noteworthy when he is unwell. [21] In these matters too the physician will be able to understand nothing by himself if he does not enquire of either the patient or some other person present. I am amazed, therefore, that the physician Callimachus ...⁵⁹¹

⁵⁸⁹ Gal.*Cons.*1, *CMG* Suppl.III.14,17-22. Galen declares here that 'the consideration of habits furnishes a very great contribution towards the discovery of cures' (ὅτι μὲν οὖν μεγίστη μοῖρα πρὸς τὴν τῶν ἰαμάτων εὑρεσιν ἢ ἀπὸ τῶν ἐθῶν ἐστίν, ἐναργῶς φαίνεται. *Cons.*1, *CMG* Suppl. III.2,11-12, tr. Brock 1929:182). His observation that his predecessors should have paid more attention to intellectual habits comes at the end of an excursus on how such factors affect physical health: *Hipp.Epid.*6, *CMG* V.10.2.2.484-487.

⁵⁹⁰ Indeed, his perspective on habits appears to have been generally innovative. Gärtner (*ad loc.* 1962:60) comments that his transference of ἐθισμός from dietetics to therapy in *QM* 15 – which is echoed by Galen at *Cons.*30, *CMG* Suppl. III.32,22-24 – 'scheint in dieser Form auf Rufus zurückzugehen, mag aber auch nicht ganz unbeeinflusst von empirischer Lehre sein, deren Anschauungen Rufus sicher gekannt hat.'

⁵⁹¹ On Callimachus, see above, pp.146-153.

He recognises, in other words, that other types of habit than the purely physical are relevant to understanding illness, and, although he gives only three examples, he indicates that the field is potentially very wide ('any other function (ἐνέργειαν) whatsoever'). It would be helpful to know exactly what Rufus meant by ἐνέργειαν, but he does not explain; he uses the word a little later in *QM* to mean the 'function' of chewing and swallowing, and there are two similar uses in his *On the Anatomy of the Parts of the Body*.⁵⁹² What he does make clear is the following: 'habit' is very close to 'constitution' (§§15-16), but the two are distinct, though of equal significance (§18); in alimentary terms, 'constitution' means involuntary physical reactions (§§16 and 18) while 'habit' is to do with custom and practice (§18); 'habits' extend beyond the dietary to include an indefinite field of individual behavioural characteristics, exemplified by but not limited to the patient's critical faculties (κρίσις), conversational style (διάλεξις), and customs of inactivity (ῥαθυμία) (§20); 'habits' constitute one of the three most important things that the doctor needs to know, and cannot be discovered without questioning the patient (§23); the purpose of questioning the patient is to enable doctors 'to distinguish more precisely any of the factors surrounding the illness, and provide better treatment' (§1), and 'complete and accurate knowledge' depends on questioning (§73). Therefore the patient's habits of 'judgement', 'conversational style' and 'inactivity are among 'the factors to do with the illness' which it is essential that the doctor understand, and which can be discovered only by questioning the patient.

Galen's determination to find a way of reconciling universal principles with individual need was entirely laudable, and his sense that the discipline of logic had a part to play in

⁵⁹² *QM* 39 and *Anat.* 19 and 70.

this process was sound.⁵⁹³ Unfortunately it assumed a disproportionate importance in his outlook. Reading his work today, in a world of advanced biomedical knowledge and consumer-oriented healthcare, one cannot but be struck by how much faith Galen places in logic and science (identifying, analysing, categorising and classifying relevant information in the right ways), how cursory his reference to learning from the patient is, and how counter-intuitive that relative weighting appears, especially when we recall his opening statement of adherence to the Hippocratic idea that the individual nature is as important to know as the universal one. Galen was not, as Callimachus apparently was, opposed to questioning the patient; in *On the Affected Parts* he advises, when dealing with a case of urine retention, asking about all the previous symptoms as well as observing the present ones; he describes himself as having asked about the background to patients' complaints and so forth.⁵⁹⁴ But clearly it is secondary to logical method – and also, as we saw above, useful only if the patient is not foolish.⁵⁹⁵ This is symptomatic of what Ballester calls the 'pernicious withdrawal from reality' that Galen initiated through his 'tendency to typify' – itself born of the circumstances in which he found himself, 'a doctor obliged by circumstance to be a clinician, but who, if he wished to maintain his status as scientist, had to construct and elaborate a body of knowledge whose only guarantee lay in the correct application of certain logical rules which reduced complex reality to a rigorous scientific tree of genera and species'. Thus the patient's role was

⁵⁹³ Hankinson comments that Galen 'believes, passionately, that it is only by correctly applying the appropriate logical methods that the practical scientist can arrive at the proper explanatory understanding of things' (2009:206-8). As he put it himself: εἰς τὴν τῶν Πυρρωνείων ἀπορίαν ἐνεπεπτώκειν ἂν καὶ αὐτός, εἰ μὴ καὶ τὰ κατὰ γεωμετρίαν ἀριθμητικὴν τε καὶ λογιστικὴν κατεῖχον ('I should have myself fallen ... into the deadlock of the Pyrrhonists, had I not clung to the methods of geometry, arithmetic, and logic', *Gal.Lib.Prop.*XIX.40K, tr. Brock 1929:179). On Galen's preference for proceeding deductively from the universal to the particular, see Lloyd 2009:130, referencing in particular *Hipp.Epid.*3.17, *CMG* V.10.1.126,11-127,17 = *XVIIA*.251-3 K.

⁵⁹⁴ *Loc.Aff.*1.1, VIII.8 K; cf. *id.*3.14, VIII.213 K (Pausanias's damaged hand); *MMG* 1.16, XI.61,9-62,12 K (see above, p.205).

⁵⁹⁵ *Loc.Aff.*5.5, VIII.335,9-10 K. See above, p.160.

‘reduced to that of “example” of a knowledge unfettered by reality’.⁵⁹⁶ Syncretic as his approach to the great epistemological questions was, and insistent though he was that the logic used by practising physicians must be firmly rooted in empirical clinical knowledge, Galen’s enthusiasm for rational science altered the terms of the relationship between patient and doctor.⁵⁹⁷ This is what we see happening in *Therapeutics to Glaucon*, where it is the patient’s body, not his intellect, that speaks to the doctor: in van der Eijk’s words, ‘the body of the patient ... indicates what is wrong with it and how it should be treated’.⁵⁹⁸ We recall David Armstrong’s research into changing constructions of the patient during the twentieth century.⁵⁹⁹ Ancient doctors’ discussions of questioning illuminate the structures of perception within which they see the patient and, crucially, within which the patient presents him- or herself. If Armstrong’s argument is accepted, it follows that Rufus’s patients will have presented themselves to their doctor as people with information to provide about ‘anything connected with the illness’, information that is crucial to understanding the illness and getting the treatment right. The *Prognostic* doctor’s patients are people whose bodies provide signs and are to be questioned if the signs are right. Galen’s patients are people whose knowledge operates at a lower level than that of the doctor, and are likely to be foolish and disobedient. This narrowing of the concept of questioning that we see in Galen’s work compared to Rufus’s suggests an epistemic field in which the doctor knows more and asks less than in Rufus’s construct, where the doctor can never know enough and the patient has got a crucial contribution to make. Writing with second century practice particularly in mind, Alexia Petsalis-

⁵⁹⁶ Ballester 1979:23.

⁵⁹⁷ In different but in some ways comparable circumstances, those of the 19th century, the move towards an emphasis on science ‘changed the physician’s professional identity, which became linked with scientific knowledge instead of long experience with patients’ (Borst 2015:61).

⁵⁹⁸ Van der Eijk 2008a:292.

⁵⁹⁹ See above, pp.78-81.

Diomidis has said that the diagnostic gaze ‘resembled ... dissection in its dynamics of power: fundamentally the doctor visually penetrated the body of the patient who remained passive through the process, just as he cut into the body of a dead animal. In diagnostic narratives the patient never returns the penetrative gaze.’⁶⁰⁰ But this is not true for Rufus; as conceived in *QM*, the patient is not merely the inhabitant of the body or the vehicle of the symptoms but an active partner in uncovering the meaning of his indispositions.

What we have seen above is that Rufus conceived of an indefinite range of personal factors which are crucial to understanding a patient’s indisposition and thus to designing appropriate treatment, but which he did not have the conceptual vocabulary to explain concisely. He therefore had to convey the concept by illustration, using the overall category of ‘habits’, already a familiar idea in medicine. The three examples of habits that he chose to use – κρίσις, διάλεξις and ῥαθυμία – all belong to the psychological sphere; as Gärtner puts it, they are ‘orientated to the patient’s mental-emotional perspective’.⁶⁰¹ Together they form an illustrative set of highly individuating characteristics, drawn from three distinct spheres within which individuals function:⁶⁰² how a person exercises his critical faculties, how he presents himself in conversation, and how he rests. These spheres have no obvious direct general relevance to illness as commonly conceived in antiquity – as a fundamentally somatic phenomenon⁶⁰³ – and this prompts the question why Rufus should have included them among the three things that

⁶⁰⁰ Petsalis-Diomidis 2010:74.

⁶⁰¹ ‘Der Gesichtspunkt der ἔθῃ wird hier auf den geistig-seelischen Bereich des Patienten bezogen’. 1972:63.

⁶⁰² The Hippocratic author of *Epidemics* 1.23 may have something similar in mind when he refers to speech, mannerisms, silences and thoughts (see above, section 4.3), but he puts no comparable emphasis on questioning the patient himself in order to understand these characteristics.

⁶⁰³ See for example Ballester 1979:25.

it is ‘more critical to medical judgement than anything else’ to know.⁶⁰⁴ Perhaps the answer lies in the fact that they do have a profound relevance to what we might call ‘what it is like to be’ that person. If that is what he is attempting to articulate, it would be very much of a piece with his person-centred concept of questioning, his preference for questioning the patient rather than any intermediary, and his linking of these ideas to individuality.

5.6. Conclusion

In his book *The Silent World of Doctor and Patient*, Jay Katz tells the story of a medical intern who, asked by a senior consultant how much he knew about patients as ‘human beings’, rapidly became exasperated and replied, ‘I cannot answer your questions. You’re interested in patients, I’m interested in the disease in the body in the bed’.⁶⁰⁵ Rufus’s emphasis on individuality, the value he attaches to learning from the patient, and the kind of things he wants to know about the patient, all suggest that he would answer the consultant’s question in a very different way. But the contrast between his discussion of questioning and how it is presented by other ancient medical authors, and the insistence with which he seems to feel it necessary to press his point, suggest that he might also have recognised the intern’s mode of thinking among some of his contemporaries – and would certainly have encountered it had he lived to know Galen, who, as Ballester has said, ‘was more concerned to talk about disease than patients, or rather, preferred to talk of diseases in patients’.⁶⁰⁶ Rufus’s method permits a different, more nuanced order of investigation from the other questioning styles we find in ancient authors. Galen, despite emphasising the individuality of each patient’s constitution, the tension between the

⁶⁰⁴ *QM* 23.

⁶⁰⁵ Katz 2002:xlvi.

⁶⁰⁶ Ballester 1979:23.

individual and the universal, and the reciprocal impact of body and soul, bypasses opportunities to link such themes to the questioning of patients, and when he discusses the value of questioning he presents it as a process that serves the doctor's image more than his knowledge. From the Hippocratic texts there emerges often a sense of uncertainty, not to say perplexity, as authors wrestle to draw valid inferences from a bewildering plethora of possible signs.⁶⁰⁷ Neither corpus yields discussion of how doctors might probe the patient's subjective perspective through the kind of unstructured discussion advocated by Rufus. Against that background, Rufus's decision to compose a treatise about the power of questioning, the exhortatory tone in which he did so, and the phenomenological possibilities inherent in what he urges the doctor to explore, indicate that he thought carefully and insightfully about how the patient's perspective could help build medical knowledge.

⁶⁰⁷ See Lloyd 2009, especially 126-9.

Conclusion to Part III

Before *QM* became what it is for us now, a static one-dimensional object derived from a medieval manuscript harvested by a 19th century monastic library raider, it was the living expression of something its author believed it necessary to say. In the three chapters that make up Part III, I have explored the meaning of the work by examining both its content and the possible circumstances of its composition, allowing text and context to illuminate one another. We have seen that *Quaestiones Medicinales* was addressed to doctors in oral form, that it sets itself up in opposition to physicians – both contemporary and past – who fail to appreciate the importance or even the true nature of questioning the patient, and that in the process it displays considerable psychological insight which can profitably be compared with Rufus’s theoretical and clinical work on melancholy. Discussing the subjective character of experience, Thomas Nagel has remarked that it is ‘a mystery how the true character of experiences could be revealed in the physical operation of [the experiencing] organism ... [which] is a domain of objective facts *par excellence*’.⁶⁰⁸ Illness is one of the experiences to which this epistemic limitation must surely apply. For Rufus, helping a patient requires the doctor to probe various aspects of the patient’s experience. He does not use the language of subjectivity and objectivity, lived body and biological body, hermeneutics and phenomenology; perhaps he really was more inclined to praxis than to philosophy, and in any event such modes of expression were not available to him; but it is, of course, possible to entertain a perception while lacking the conceptual vocabulary to articulate it neatly. Certainly Fredrik Svenaeus’s claim that ‘the essence of medical practice’ is the meeting between doctor and patient, a meeting whose ‘hermeneutics ... first and foremost takes place through ... the dialogue that is spoken’⁶⁰⁹

⁶⁰⁸ Nagel 1974:442.

⁶⁰⁹ Svenaeus 2000:146-8.

seems to accord very closely with Rufus's core belief. It seems that Rufus's apparently practical treatise holds a greater philosophical significance than anyone – from Galen to modern scholars – has hitherto considered it capable of yielding.

Part IV: Authority and Silence

Chapter 6 – Doctors’ Orders

In the previous chapter we saw that Rufus makes his points – that it is imperative to question the patient and that doctors cannot know enough on their own – so insistently as to indicate the existence of rival views: other doctors, he implies, attach insufficient importance to learning from the patient, perhaps not bothering to ask enough questions, perhaps asking the wrong sort of questions, perhaps not appreciating the need to converse with the patient him- or herself rather than with an intermediary. We also noted Rufus’s preference for an open-ended, discursive method of the type that is capable of generating subjective information, as opposed to the prescriptive, check-list type Hippocratic model that simply extends the range of signs available to the doctor and thus further objectifies the patient’s body. We looked at these features of *QM* in light of the enduring debate over the medical validity of the patient’s knowledge. In this chapter – which necessarily, given the state of the evidence, relies heavily on Galen for an understanding of the second century environment – I aim to add texture to the discussion so far by situating *QM* in the wider context of what we know or can surmise about the doctor-patient relationship in antiquity, focusing especially on the tension between medical authority and patient autonomy as played out in doctors’ attempts to secure their patients’ compliance. Non-compliance is an enduring issue in medical practice, and superficially it is a puzzling one, for both parties want the same thing. Doctors want to help patients get better; patients want to get better and in many cases have actively sought the doctor’s assistance in doing so. Yet doctors commonly complain that patients do not follow instructions, while patients grumble that doctors do not give them useful advice. Why should this be? One

answer, as we shall see, is the fundamental asymmetry that often characterises the relationship, whereby one party is conceived as the knower and the other as the known.

‘All medical treatment’, Ludwig Edelstein says, ‘involves the issue of the physician’s authority’.⁶¹⁰ The idea of medical authority was discussed in Chapter 2.3, where I used Hannah Arendt’s idea of authority as a manifestation of mutually accepted hierarchy to argue that there are two circumstances in which the notion of medical authority is meaningful: one, when a patient acts in accordance with advice or instructions given by a doctor, thus acknowledging a hierarchical relation rooted in the doctor’s superior medical knowledge and/or professional status; and two, in co-existence with the patient’s authority, when each party recognises the superiority of the other’s knowledge in particular domains, so that treatment decisions proceed from a condition of shared authority. Other means by which doctors may secure patients’ compliance are, I argued, instances of either coercion or, to varying degrees, manipulation. In the first section of this chapter I look at how this theoretical proposition is borne out by what ancient authors – medical and non-medical – say about the obligation to obey and by ancient doctors’ often fruitless demands for obedience as they attempt to assert their authority over their patients. In the second, I identify some aspects of the professional environment that seem particularly likely to have encouraged doctors to feel defensive and perhaps even insecure about their authority, and to attempt to assert that authority through demands for obedience. Finally, I consider the issue of non-compliance diachronically, setting the ancient evidence alongside key findings from a major World Health Organization report which identified the demand for obedience as futile and argued that one of the main

⁶¹⁰ Edelstein 1987:386. See above, p.92.

drivers of compliance is shared decision-making that supports treatments in which patients perceive real value to themselves.

6.1. Disobedient patients

τοὺς δ' ἐν τῇσι τῶν ἀποθνησκόντων ξυμφορῇσι τὴν τέχνην ἀφανίζοντας θαυμάζω, ὅτεφ' ἐπαιρέομενοι ἀξιοχρέω λόγῳ τὴν μὲν τῶν ἀποθνησκόντων ἀκρησίην οὐκ αἰτίην καθιστᾷσι, τὴν δὲ τῶν τὴν ἱητρικὴν μελετησάντων ζύνεσιν αἰτίην• ὥς τοῖσι μὲν ἱητροῖσιν ἔνεστι τὰ μὴ δέοντα ἐπιτάξαι, τοῖσι δὲ νοσέουσιν οὐκ ἔνεστι τὰ προσταχθέντα παραβῆναι. Καὶ μὴν πολὺ γε εὐλογώτερον τοῖσι κάμνουσιν ἀδυνατέειν τὰ προστασσόμενα ὑπουργεῖν, ἢ τοῖσιν ἱητροῖσι τὰ μὴ δέοντα ἐπιτάσσειν.

Those who use the example of patients who die from their illnesses as an argument against the efficacy of medicine make me wonder what trustworthy reason leads them to absolve a patient's weakness of character, and impute instead a lack of intelligence on the part of his physician. As if doctors can prescribe the wrong remedies but patients can never disobey their orders! It is far more likely that the sick are unable to carry out the instructions than that the doctors prescribe the wrong remedies.⁶¹¹

Patients' failure to carry out physicians' instructions is a common grievance among ancient doctors. Complaints about disobedience are scattered through the Hippocratic Corpus and Galen's work.⁶¹² Patients lie about whether or not they have taken their medicine,⁶¹³ fail to stay in bed so that broken bones can mend,⁶¹⁴ disregard instructions

⁶¹¹ *De Arte* 7, II.12 L, tr. Chadwick and Mann 1983:142.

⁶¹² See Mattern 2013:178: obedience was 'always a challenge and potential source of frustration' for Galen and his colleagues; and cf. *id.*138.

⁶¹³ 'Keep a watch also on the faults of the patients, which often make them lie about the taking of things prescribed'. *Hp.Decent.*14 = IX.240 L, tr. Jones, Loeb II.297.

⁶¹⁴ *Hp.Fract.*9 = III.450,7-9 L; cf. *Art.*14 = IV.120,5-10 L, claiming that patients' carelessness makes doctors careless too.

about regimen,⁶¹⁵ ally themselves with the disease instead of the doctor.⁶¹⁶ Doctors complain that they get the blame, while themselves blaming non-compliant patients for incomplete recovery, for deterioration in their condition, even for their own death⁶¹⁷ – provoking reactions such as Pliny’s hyperbolic allegation that ‘only a physician can commit homicide with complete impunity. ... The victim ... gets the blame for want of self-control, and the dead are brought to account’.⁶¹⁸ Socrates, in *Gorgias*, introduces a moral element, comparing medical treatment with formal justice as something to be borne in the interests of self-improvement, not shirked out of cowardice:

οὗτοι, ὧ ἄριστε, τὸ αὐτὸ διαπεπραγμένοι εἰσὶν ὥσπερ ἂν εἴ τις τοῖς μεγίστοις νοσήμασιν συνισχύμενος διαπράττειτο μὴ διδόναι δίκην τῶν περὶ τὸ σῶμα ἀμαρτημάτων τοῖς ἰατροῖς μηδὲ ἰατρεύεσθαι, φοβούμενος ὥσπερ ἀνὴρ παῖς τὸ κάεσθαι καὶ τὸ τέμνεσθαι, ὅτι ἀλγεινόν.

Those who do so [i.e. evade justice after committing serious crimes] do pretty much the same thing as a person who has contracted very serious illnesses, but, by avoiding treatment, manages to avoid paying what’s due to the doctors for his bodily faults, fearing, as would a child, cauterisation or surgery because they’re painful.⁶¹⁹

The language of blame and moral dereliction persists, from the late fifth century *De arte* and Democritus’s roughly contemporaneous accusation of lack of self-control,⁶²⁰ through

⁶¹⁵ Acts of disobedience include ‘fail[ure] to eat some of their meal, ... eat[ing] something of a different kind, or [taking] too much to drink, or omitt[ing] part of their walk, or practis[ing] venery’ (ἦν τι ἢ τοῦ σιτίου ἀπολίπωσιν, ἢ ἑτεροῖόν τι φάγωσιν, ἢ ποτῶ πλεονί χρήσονται, ἢ τοῦ περιπάτου ἀπολίπωσιν, ἢ ἀφροδισίων τι πρήξωσι. Hp.*Prorrh.* II.1 = IX.6,16-18 L, tr. Potter, Loeb VIII.220).

⁶¹⁶ ‘And since there are three, the doctor, the illness and the patient, if the patient allows the doctor to fight the disease on his own, or even goes over to the disease and fights against the doctor, it will happen that the doctor is defeated by the illness’: Gal.*Hipp.Epid.* VI 4.10, CMG V.10.2.2.204,21-24 = XVII B.147 K.

⁶¹⁷ Incomplete recovery Hp.*Fract.* 9 = III.450,9-10 L. Deterioration: Gal.*MM* 14.16, X.1007-8 K; *MM* 13.15, X.909-16 K. Death: Hp.*Decent.* 14 = IX.240.14-15 L, cf. Hp.*de Arte* 7 = VI.12.9-11 L; Gal.*Hipp.Epid.* VI 2.45, CMG V.10.2.2.116,2-11 = XVII.1.996-97 K.

⁶¹⁸ *Medico ... tantum hominem occidisse impunitas summa est. quin immo transit convicium et intemperantia culpatur ultroque qui perire arguuntur.* Plin.*HN* 29.viii.18, tr. Jones, Loeb VIII.195. See below, pp.237-238.

⁶¹⁹ *Grg.* 479a-b, tr. Zeyl, Cooper 1997:824.

⁶²⁰ ὑγίειν εὐχῇσι παρὰ θεῶν αἰτέονται ἄνθρωποι, τὴν δὲ ταύτης δύναμιν ἐν ἑαυτοῖς ἔχοντες οὐκ ἴσασιν· ἀκρασίῃ δὲ τὰναντία πρήσσοντες αὐτοὶ προδότες τῆς ὑγείης τῆσιν ἐπιθυμίῃσιν γίνονται. (‘Men ask for health from the gods in their prayers; they do not realize that the power to achieve it lies in themselves; lacking self-control, they act contrary to it and themselves betray health to their desires’. DK68b234, tr. Barnes 2001:239).

Decorum, whose author complains that ‘what [lying patients] have done never results in a confession but the blame is thrown on the physician’,⁶²¹ to Galen’s insistence that ‘mostly when dangerous illnesses bring down patients it is because they disobey the doctors’.⁶²²

Though there were no formal reasons for doctors to fear getting the blame – medical malpractice was not a criminal offence in the ancient world⁶²³ – the healthcare market was competitive, as we shall see, and the status of medicine was not high; reputation was a fragile thing, as the author of *Prorrhetic* II made clear:

ἐπιτυχὼν μὲν ἂν τις τοῦ προρρήματος θαυμασθεῖη ὑπὸ τοῦ ξυνεόντος ἀλγέοντος, ἁμαρτῶν δ’ ἂν τις πρὸς τῷ μισεῖσθαι τάχ’ ἂν καὶ μεμνημένοι δόξειεν. ... καίτοι γε ἀκούω καὶ ὁρῶ οὔτε κρίνοντας ὀρθῶς τοὺς ἀνθρώπους τὰ λεγόμενά τε καὶ ποιούμενα ἐν τῇ τέχνῃ οὔτ’ ἀπαγγέλλοντας.

When you are successful in making a prediction you will be admired by the patient you are attending, but when you go wrong you will not only be subject to hatred but perhaps even be thought mad. ... And indeed I know both by what I hear and by what I see, that people neither judge correctly what is said and done in medicine, nor report it accurately.⁶²⁴

No doubt doctors genuinely did want patients to follow their instructions to the letter, but equally, given the likelihood of their being, as the *De arte* author noted, incapable of doing so, blaming them when things turned out badly was perhaps a convenient let-out

⁶²¹ καὶ αὐτῶν μὲν οὐ πρὸς ὁμολογίην τρέπεται τὸ ποιηθὲν, τῷ δὲ ἱατρῷ τὴν αἰτίην προσῆψαν. *Hp.Decent.*14 = IX.240 L (tr. Jones, Loeb II.297), dated any time between the fourth century and the Roman period.

⁶²² τὰ γὰρ πλεῖστα τῶν ἐπισφαλῶν νοσημάτων ἀνατρέπει τοὺς κάμνοντας ἀπειθοῦντας τοῖς ἱατροῖς: *Hipp. Epid.* VI 2.45, *CMG* V.10.2.2.116,7-11 = XVIIA.996 K. See above, p.181.

⁶²³ Jouanna 1999:140. According to Nutton, ‘Roman law provided for the punishment of certain transgressions, such as poisoning or the administration of love potions, but did not otherwise intervene in the doctor-patient relationship’ (‘Medical ethics’, Section C, in *Brill’s New Pauly* Vol.8:554). Doctors in Athens ‘could not normally be held responsible’ for a patient’s death (Gagarin 1997:160); see Antiphon 4.3.5 (= Tetralogy 3), with Gagarin *ad loc.* (1997:169), and cf. *Pl.Lg.* 9,865b (ἱατρῶν δὲ περὶ πάντων, ἂν ὁ θεραπευόμενος ὑπ’ αὐτῶν ἀκόντων τελευτᾷ, καθαρὸς ἔστω κατὰ νόμον).

⁶²⁴ *Hp.Prorrh.* 2.2 = IX.10.10-15 L, tr. Potter, Loeb VIII.223. Jouanna observes: ‘physicians paid for the faults of their patients before the court of public opinion’ (1999:139).

for some. One common arena for the battle of wills was the example used by Socrates: surgery. And indeed Aelius Aristides' friends, as we shall see,⁶²⁵ were not slow to accuse him of cowardice when he insisted on following divine instructions rather than letting doctors take the knife to him; though we might equally well interpret his behaviour as a way of taking control of his own healthcare, making his choice comparable morally if not physically to that of Xenophon's Athenians, who 'hand themselves over to doctors for trimming and cauterising, even though it is painful and uncomfortable, and think fit to thank and remunerate them for it'.⁶²⁶ Pliny's reference to Archagathus's 'savage use of the knife and cautery' (*saevitia secandi urendique*) comes to mind; this earned him, Pliny says, the sobriquet Carnifex and plunged the medical profession into general 'loathing' (*taedium*).⁶²⁷ Unsurprisingly, rhetoric was a key skill for the doctor; as Gorgias puts it:

πολλάκις γὰρ ἤδη ἔγωγε μετὰ τοῦ ἀδελφοῦ καὶ μετὰ τῶν ἄλλων ἱατρῶν εἰσελθὼν παρὰ τινα τῶν καμνόντων οὐχὶ ἐθέλοντα ἢ φάρμακον πιεῖν ἢ τεμεῖν ἢ καῦσαι παρασχεῖν τῷ ἱατρῷ, οὐ δυναμένου τοῦ ἱατροῦ πεῖσαι, ἐγὼ ἔπεισα, οὐκ ἄλλη τέχνη ἢ τῇ ῥητορικῇ.

Many a time I have gone with my brother or with other doctors to call on some sick person who refuses to take his medicine or allow the doctor to perform surgery or cauterisation on him. And when the doctor failed to persuade him I succeeded, by means of no other craft than oratory.⁶²⁸

⁶²⁵ See below, pp.264-266.

⁶²⁶ τοῖς ἱατροῖς παρέχουσι μετὰ πόνων τε καὶ ἀλγηδόνων καὶ ἀποτέμνειν καὶ ἀποκάειν καὶ τούτου χάριν οἶονται δεῖν αὐτοῖς καὶ μισθὸν τίνειν. X.*Mem.*1.2.54.

⁶²⁷ Plin.*HN* 29.vi,12-13, tr. Jones, Loeb VIII.191. Archagathus was 'the first physician to come to Rome' (*primum e medicis venisse Romam*), in 219 BC.

⁶²⁸ Pl.*Grg.*456b, tr. Zeyl, Cooper 1997:801. The need for persuasion crops up again in *Laws*, although there – because the image is being used to serve a different purpose – it is the doctor, not a supernumerary orator, who persuades the patient: Pl.*Lg.*4,720b-e: ὁ δὲ ἐλεύθερος ὡς ἐπὶ τὸ πλεῖστον τὰ τῶν ἐλευθέρων νοσήματα θεραπεύει τε καὶ ἐπισκοπεῖ, καὶ ταῦτα ἐξετάζων ἀπ' ἀρχῆς καὶ κατὰ φύσιν, τῷ κάμνοντι κοινούμενος αὐτῷ τε καὶ τοῖς φίλοις, ἅμα μὲν αὐτὸς μανθάνει τι παρὰ τῶν νοσούντων, ἅμα δὲ καὶ καθ' ὅσον οἷός τέ ἐστιν, διδάσκει τὸν ἀσθενοῦντα αὐτόν, καὶ οὐ πρότερον ἐπέταξεν πρὶν ἢ πῃ συμπίσῃ, τότε δὲ μετὰ πειθοῦς ἡμερούμενον ἀεὶ παρασκευάζων τὸν κάμνοντα, εἰς τὴν ὑγίειαν ἄγων, ἀποτελεῖν πειρᾶται. ('The free doctor mainly visits and treats the illnesses of the free. He examines these ailments from first principles and according to nature, communicates with both the patient and his friends, and learns from his patients himself at the same time as – so far as he is able – instructing the sick; he gives no orders without having first secured a measure of agreement, and then, using persuasion to keep the patient tame, he attempts to complete the task of leading him to health.')

A doctor might go to considerable lengths to try and enforce his will: according to the author of *Prorrhetic* 2, for example, some claimed to be able to spot non-compliance at a glance, maintaining that ‘none of these things escapes their notice, not even if the person disobeys in but little’.⁶²⁹ The *Prorrhetic* author, working probably in the late fifth century,⁶³⁰ disdains such methods, relying instead on τῇ γνώμῃ τε καὶ τοῖσιν ὀφθαλμοῖσιν (‘judgement and observation’) to spot transgressions in his patients; but he is in no doubt that one should expect τὰ διὰ τὴν ἀπειθήν γινόμενα κακά (‘evils that arise because of disobedience’), and he provides detailed advice on how to monitor patients for such failings.⁶³¹ Galen’s relentless pursuit of obedience has led Susan Mattern to characterise his relationship with his patients as ‘a power struggle ... for control over the person, and by extension the household ... of the patient himself’.⁶³² Demanding compliance is one of the things, he explains in *On Recognising the Best Physician*, that distinguish a proper doctor from a charlatan:

We alone call to come to us patients whose complete recovery from benign illnesses we guarantee on condition that they obey all our orders. Others who practise this art falsely will be found to be greatly esteemed among the households of wealthy men. In view of their inability to ensure anything valid (in therapy), they never request their patients to obey and follow their lead. Instead, they debase themselves to the status of the slaves of their patients. They obey and assist their patients in fulfilling their desires In doing so they become wicked slaves whose services are useless, and indeed harmful.⁶³³

Earlier in the same work he warns sternly, glossing Hippocrates: ‘you must not choose only to do your duty, thinking that what you have done is sufficient, without seeing that

⁶²⁹ τούτων πάντων οὐδὲν λανθάνει, οὐδ’ εἰ σμικρόν τι εἴη ἀπειθήσας ὄνθρωπος. Hp.*Prorrh.*2.1 = IX.6,18-19 L, tr. Potter, Loeb VIII.221.

⁶³⁰ Craik 2015:244.

⁶³¹ Hp.*Prorrh.*2.3 = IX.12,11 L and IX.14,4-5 L, tr. Potter, Loeb VIII.225 and 227; detailed advice, *id.*4 = IX.14-20 L.

⁶³² Mattern 2008:145-6; for many examples, see *id.*145-8.

⁶³³ Gal.*Opt.Med.Cogn.*5.16-17, CMG Suppl.Or.IV.77-79, tr. Iskandar; cf. MM 1.1, X.4.10-13 K.

patients, and likewise their servants, do all you tell them to do, and abstain from all you forbid them to do'.⁶³⁴

Galen recognised that disobedience reflected badly on the doctor's relationship with the patient:

οὓς γὰρ ἂν ἡδέως ὀρώσι, τούτοις μᾶλλον πείθονται. καὶ κατὰ τοῦτο μήτηρ καὶ πατήρ ἔπεισαν τέκνον ἀνόρεκτον καὶ αὐτὸ βιάσασθαι προσενέγκασθαι σιτίον, οὐδενὸς ἄλλου πείσαι δυνηθέντος· οὕτω καὶ τέκνον ἔπεισε πατέρα καὶ μητέρα καὶ ἀδελφὸς ἀδελφὸν καὶ φίλος φίλον. οὓς δ' ἂν ἀηδῶς ὀρώσιν οἱ ἄνθρωποι, κἂν τὰ συμφέροντα συμβουλευώσιν, <τούτοις> ἀπειθοῦσιν. πρὸς τὴν τοιαύτην οὖν εὐπειθειαν αὐτὸς ὁ Ἱπποκράτης ἔλεγε καὶ τὰς προρρήσεις ὠφελεῖν ἡμᾶς καὶ ὅλως τὸ θαυμάζεσθαι τὸν ἱατρὸν ὑπὸ τοῦ κάμνοντος. οὕτω γέ τοι καὶ παρ' ἡμῖν ἐν Περγάμῳ τοὺς θεραπευομένους ὑπὸ τοῦ θεοῦ πειθομένους ὀρώμεν αὐτῷ πεντεκαίδεκα πολλάκις ἡμέραις προστάξαντι μηδ' ὅλως πειῖν, οἱ τῶν ἱατρῶν μηδενὶ προστάττοντι πείθονται.

People are more likely to obey those for whom they have warm feelings. Thus a mother and father can get a fussy child to eat, where everyone else has failed; likewise a child can persuade a parent, a sibling a sibling, a friend a friend. Similarly people disobey those to whom they are ill disposed, even when the latter are giving them the right advice. It was in relation to that sort of obedience that Hippocrates himself said that we doctors are helped by prognosis and by winning the patient's total admiration. Thus even in our own town, Pergamum, we see people being treated by the god who obey his frequent instruction to drink nothing at all for a fortnight, yet don't obey the instructions of any doctor.⁶³⁵

His psychology in this passage is on the right track: non-compliance, as we shall see, is indeed – at least in the modern world, where research suggests that the finding is cross-cultural – correlated with the strength of the personal relationship between patient and doctor.⁶³⁶ It is all the more noticeable, then, that his instinct is not to ask what it is between friends or siblings that engenders the 'warm feelings' to which he refers, in order to try and bring some of those qualities to his interaction with patients, but to look instead for

⁶³⁴ Gal.*Opt.Med.Cogn.*5.11, CMG Suppl.Or.IV.75 (tr. Iskandar), glossing Hp.*Aph.*1.1 = IV.458.2-4 L.

⁶³⁵ Gal.*Hipp.Epid.* VI 4.8, CMG V.10.2.2.198,25-199,7 = XVIIIB.137 K.

⁶³⁶ See below, Chapter 6.3 'Understanding non-compliance'.

admiration of the sort engendered by divine healing. He is explicit about this elsewhere: ‘If the patient did not marvel at the doctor like a god, he would not be willing to obey him’.⁶³⁷ Galen regretted the popular preference for temple healing over the study of medicine,⁶³⁸ but its influence was inextricably woven into his own practice.

The manipulative potential of this general appetite for medical marvels is well illustrated in *On Prognosis*, the collection of case studies assembled by Galen to showcase his clinical skills.⁶³⁹ It should be noted that in ancient medicine the idea of prognosis had a scope that extended far beyond its modern sense of forecasting the outcome of an illness. It also, importantly, carried the sense of knowing something before one is told. The Hippocratic treatise *Prognostic* explains this very clearly, and shows how it helps the physician to secure patients’ co-operation while at the same time intensifying the importance of doing so:

τὸν ἰητρὸν δοκεῖ μοι ἄριστον εἶναι πρόνοιαν ἐπιτηδεύειν· προγινώσκων γὰρ καὶ προλέγων παρὰ τοῖσι νοσέουσι τὰ τε παρεόντα καὶ τὰ προγεγονότα καὶ τὰ μέλλοντα ἔσεσθαι, ὁκόσα τε παραλείπουσιν οἱ ἀσθενέοντες ἐκδιηγούμενος, πιστεύοιτο ἂν μᾶλλον γινώσκειν τὰ τῶν νοσεύντων πρήγματα, ὥστε τολμᾶν ἐπιτρέπειν τοὺς ἀνθρώπους σφᾶς αὐτοὺς τῷ ἰητρῷ. τὴν δὲ θεραπείην ἄριστα ἂν ποιέοιτο, προειδὼς τὰ ἐσόμενα ἐκ τῶν παρεόντων παθημάτων. ... οὕτω γὰρ ἂν τις θαυμάζοιτό δικαίως, καὶ ἰητρὸς ἀγαθὸς ἂν εἴη· καὶ γὰρ οὓς οἶόν τε περιγίνεσθαι ἔτι μᾶλλον ἂν δύναιτο διαφυλάσσειν, ἐκ πλείονος χρόνου προβουλευόμενος πρὸς ἕκαστα, καὶ τοὺς ἀποθανευμένους τε καὶ σωθησομένους προγινώσκων τε καὶ προλέγων ἀναίτιος ἂν εἴη.

I hold that it is an excellent thing for a physician to practise forecasting. For if he discover and declare unaided by the side of his patients the present, the past and the future, and fill in the gaps in the account given by the sick, he will be the more believed to understand the cases, so that men will confidently entrust themselves to him for treatment. Furthermore, he will carry out the treatment best if he know beforehand from the present symptoms what will take place later ... For in this way you will justly win respect and be an able physician. For the longer

⁶³⁷ See above, p.184 n.511.

⁶³⁸ See below, p.230, and, on temple medicine generally, 239-240.

⁶³⁹ Lloyd 2009:130-1. See discussion of three of the cases, above pp.185-187.

time you plan to meet each emergency the greater your power to save those who have a chance of recovery, while you will be blameless if you learn and declare beforehand those who will die and those who will get better.⁶⁴⁰

Galen was an enthusiastic advocate and exponent of prognosis, and, despite his readiness to milk its awe-inspiring capacities, was greatly put out when opponents accused him of using divinatory techniques.⁶⁴¹ He exploited what Lloyd calls the ‘psychological function’ of prognosis very skilfully;⁶⁴² a good example is his ‘really marvellous’ treatment of the Emperor Marcus Aurelius. When he was summoned to the patient’s bedside the case was already underway:

ὥς δὲ τριῶν ὄντων τῶν ἔωθέν τε καὶ περὶ τὴν ὀγδόην ὥραν ἑωρακότων αὐτόν, ἀψαμένων τε τῶν σφυγμῶν, ἐπισημασίας ἀρχὴ τις εἶναι πᾶσιν ἐφαίνετο, σιωπῶν <δ’> εἰστήκειν ἐγὼ ... καὶ αὐτοῦ μὲ κελεύσαντος ἄψασθαι, φανέντος μοι τοῦ σφυγμοῦ περὶ τὸ κοινὸν μέτρον ἀπάσης ἡλικίας τε καὶ φύσεως ἀφεστηκέναι τοῦ δηλοῦντος ἀρχὴν ἐπισημασίας, ἀπεφηνάμην εἰσβολὴν μὲν οὐδεμίαν εἶναι πυρετοῦ, θλίβεσθαι δὲ αὐτοῦ τὸν στόμαχον ὑπὸ τῆς εἰλημμένης τροφῆς, φλεγματοθείσης μὲν πρὸ τῆς ἐκκρίσεως, ἐμφαινούσης δε, ἔπαινόν τινα τῆς διαγνώσεως αὐτῇ λέξει τῇδε τρις ἐφεξῆς εἰπὼν <<αὐτό ἐστιν, αὐτὸ τοῦτο ὃ εἶπες ἔστιν· αἰσθάνομαι γὰρ ὑπὸ ψυχροτέρας τῆς τροφῆς βαρυνόμενος>>, ἤρετο τί ποιεῖν χρή. ἐγὼ δ’ ἀπεκρινάμην ἄπερ ἔγνων καὶ ἐλέχθη μοι πρὸς αὐτόν, ὥς, εἰ ἄλλος τις ἦν ὁ διακείμενος οὕτως, ἔδωκα ἂν αὐτῷ, καθάπερ εἶωθα, πιεῖν οἶνον πεπέρεως ἐπιπάσας. ἐφ’ ὑμῶν δὲ τῶν βασιλέων, ἀσφαλεστάτοις βοηθήμασιν εἰωθότων χρῆσθαι τῶν ἱατρῶν, ἀρκεῖ ναρδίνῳ μύρῳ θερμῷ δεύσαντα μαλλὸν ἐρίου, θεῖναι κατὰ τοῦ στόματος τῆς κοιλίας. ὁ δὲ καὶ ἄλλως εἰπὼν ἔθος ἐκείνῳ ὅταν ποτὲ μέμψηται τὸν στόμαχον, ἀνειλημμένον πορφυρέῳ ἐρίῳ τὸ νάρδιον μύρον ἐπιτιθέναι θερμὸν, κελεύσας τε Πειθολάῳ πρᾶξαι τοῦτο καὶ ἡμᾶς ἀπολῦσαι, ἐπιθέντος δ’ αὐτοῦ καὶ τῶν ποδῶν ἐκθερμανθέντων ὑπὸ τῶν ἀνατριβόντων θερμαῖς ταῖς χερσὶν, ἤτησεν

⁶⁴⁰ Hp.Prog.1 = II.110-112 L, tr. Jones, Loeb II.7-9; cf. Gal.Opt.Med.Cogn.2.1, CMG Suppl.Or.IV.47-49. For concise discussions of prognosis see Gourevitch 1998:133; Lloyd 2003:56-7; Jouanna 1999:67 and 101. On the role of prognosis in securing the trust and custom of patients, see for example Israelowich 2012:49-50, 68 and 183. For Hippocratic advice to avoid prognosis so as to avoid causing the patient to deteriorate, see Decent.16 = IX.242,5-8 L.

⁶⁴¹ Gal.Praen.3.7, 5.5, CMG V.8.1.84 and 94 = XIV.615 and 625 K. For perceptions of the overlap and distinction between divination and prognostication, see Hp.Acut.8 (3L) = II.242-244 L, and Gal.Opt.Med.Cogn.1.9, CMG Suppl.Or.IV.45, with Iskandar’s useful comment *ad loc.* and further references (1988:145). Gourevitch points out that Galen was at times assisted by luck, for example when a drug addict with a tongue stained by his habit tried to put Galen off the scent by making pills of the drug so as to continue ingesting it without causing further staining (1998:133-134, on Gal.Praes. Puls., IX.218-219 K).

⁶⁴² Lloyd 2003:56-7, identifying two functions for prognosis: the ‘psychological’ and the ‘defensive’.

οἶνου Σαβίνου καὶ πεπέρεως ἐπιβαλὼν ἔπιε· καὶ εἰπὼν τῷ Πειθολάῳ μετὰ τὸ πιεῖν ὡς ἱατρὸν ἔχων ἓνα καὶ τοῦτον ἐλεύθερον πάνυ.

Three doctors had already examined him at dawn and at the eighth hour, and had taken his pulse; and everyone believed the first signs of illness to be apparent. I stood by in silence ... He ordered me to take his pulse as well. Compared with the general norm for all ages and constitutions, it appeared to me to be some way from indicating the first signs of illness, and I proudly declared that there was no attack of fever, but that his stomach was overloaded with the food he had taken, which had turned to phlegm before being secreted but was now providing an indication.⁶⁴³ He praised my diagnosis in these words, three times: ‘That’s just it! What you said is exactly how it is. My feeling is that of being weighed down by rather cold food.’ Then he asked me what he ought to do. I told him what I knew and said that, had it been anybody else in that condition, I should have prescribed my usual dose of wine with pepper on top; but in the case of kings like him, when doctors should employ the safest remedies, it was enough to place over the mouth of the stomach a pad of wool impregnated with warm nard ointment. He replied that in any case, when he had a stomach complaint, he used to apply warm nard ointment smeared on scarlet wool, and he ordered Peitholaus to do that and then dismiss me. After the ointment had been applied and his feet warmed by the warm hands of the masseurs, he called for Sabine wine, sprinkled pepper on it, and drank it. After he had drunk it, he remarked to Peitholaus: ‘We have one doctor, and he is a very enlightened gentleman’.⁶⁴⁴

The thing that stands out here is not the Emperor’s delight – overjoyed patients are a common feature of Galen’s narratives – but the fact that what inspires his confidence is Galen’s ability to read his body with a mere touch.⁶⁴⁵ The story well illustrates Galen’s deployment of prognosis to impress not just the patient but the reader as well, for, though he carefully presents himself as a doctor who knows rather than one who has to ask, we find, if we look more closely, that he has been extremely clever. He begins by lowering the patient’s expectations – a classic technique if one hopes to make an impression. He

⁶⁴³ τῆς εἰλημμένης τροφῆς, φλεγματοθείσης μὲν πρὸ ἐκκρίσεως, ἐμφαινοῦσης δὲ. LSJ offers only transitive meanings for ἐμφαίνω, *pace* Nutton, who translates it ‘this was now quite clear’. Galen explains the effects of food consumption on the pulse in *On Pulses to Beginners* (*Puls.*9 and 12, VIII.469 and 490 K).

⁶⁴⁴ Gal.*Praen.*11, CMG V.8.1.126-8 = XIV.657-60 K, tr. Nutton 1979:127-29. ‘Really marvellous’: θαυμαστή δ’ ὄντως, CMG V.8.1.126,16.

⁶⁴⁵ Other examples of diagnosis by simply feeling the pulse: Gal.*Opt.Med.Cogn.*6.1, CMG Suppl.Or.IV.81 (‘a large visceral tumour’ – though this story is confusing because Galen describes the tumour as ‘apparent to the sight and the touch, (even) to non-medical men’); *id.*13.7, CMG Suppl.Or.IV.133 (incomplete miscarriage); *Praen.*12.1, CMG 8.1.130 = X.661-2 K (the young Commodus’s tonsillitis).

emphasises his silence, but has in fact gathered various crucial bits of information: the patient has had bitter aloes, theriac, a bath, a light meal and some thick gruel.⁶⁴⁶ Based on his knowledge of the expected norm for pulses, he can be fairly sure that there is nothing seriously wrong. In the circumstances, indigestion is a safe enough bet. What is more, he engineers the choice of therapy so that the only one he actually recommends is the ‘safest one’, which just happens to be a remedy that Marcus has used before, while the apparently more daring choice of wine and pepper is made by Marcus himself.

As has been noted above, the use of prognosis for both defensive and psychological purposes has a sound Hippocratic pedigree.⁶⁴⁷ So Galen was in one sense not doing anything new. But he did it with a certainty that the Hippocratics on the whole lacked, projecting an omniscient authority that is absent from their texts;⁶⁴⁸ and he regarded those who opposed prognosis as dull-witted or unschooled (ἀφουεῖς).⁶⁴⁹ It is interesting in this context to remember Rufus’s very specific rejection of the idea that a physician can make judgements about a patient’s food intake without asking questions, his criticism of the credulity of those who believe in such diagnostic feats, and his use of food intake to exemplify his opinion that ‘although one can indeed discover many of the factors connected to sicknesses on one’s own, questioning enables that to be done better and more clearly, for if it reveals things that correspond with the *sumptōmata* it is easier to know what is going on’.⁶⁵⁰ We should note too the lack of attention paid to prognosis in

⁶⁴⁶ *CMG* V.8.1.126,20-26.

⁶⁴⁷ See above, pp.224-225.

⁶⁴⁸ See Lloyd 2004:149 on the ‘paradox’ that while Plato uses the doctor as his model for the moral and political expert, real doctors (according to Hippocratic evidence) were very far from the ‘confident authority’ figure thus conjured up – ‘quite the reverse, in certain cases’.

⁶⁴⁹ *Gal.Praen.* 12.11, *CMG* V.8.1.133.32 = X.665 K.

⁶⁵⁰ Credulity: *QM* 37-38, and see discussion above, pp.144-145; food as an example of importance of questioning: *QM* 22.

QM: Rufus uses the idea only three times, each time very clearly in its sense of forecasting the progress of the illness, with no suggestion that it might be used to impress or win the confidence of the patient.⁶⁵¹ Not wishing to make an argument from silence, I nevertheless note the anomaly that a treatise dedicated to the topic of doctors' communication with their patients should contain no reference to a technique that, for some Hippocratic authors and for Galen, lies at the heart of how that relationship functions. Certainly Gärtner considered it a significant omission; he speculated that distaste for τὸ θαυμάζεσθαι was, like the absence of personal detail in Rufus's writing, indicative of a generally unassuming professional persona.⁶⁵²

Exploiting sick people's credulity in order to build authority and secure co-operation may seem manipulative to us, but it did not necessarily look that way to patients in antiquity. Indeed they may on one level have enjoyed it and thought it entirely normal. But, as I shall argue below, it was probably not the best way to bring about the desired result. Indeed, since the power struggle continued despite his best efforts and strictures, we may wonder why Galen did not try a change of tack. One answer must lie in the Platonic idea of the doctor as an authority figure whom patients are morally obliged to obey – an idea that clearly fell on fertile ground and has ever since then served as a primary assumption in the demand for compliance, though the strength of the assumption is not borne out by modern research, as we shall see. Another answer that emerges clearly from Galen's work is his apparently unassailable belief in his own knowledge and skills. Again, research has

⁶⁵¹ QM 20 (προγινώσθῃ), 21 (προγινώσκεσθαι) and 35 (πρόρρησιν).

⁶⁵² 'Es ist vielleicht nicht unbezeichnend für Rufus' Verhältnis zu seinem Beruf, dass er die Prognose nicht mit berücksichtigt. Sie wird ja im Sinne des Hippokrates mindestens zum Teil im Hinblick auf die Prorrhesis gestellt, die ihrerseits wiederum nicht wenig auf das θαυμάζεσθαι abzielt. Mit Sicherheit lässt sich sagen, dass Rufus wie kein anderer Arzt seine eigene Person bescheiden und sachlich im Hintergrund hält und dass ihm das θαυμάζεσθαι im höchsten Grade unangenehm gewesen sein dürfte, soweit sich das aus seinen Schriften entnehmen lässt.' Gärtner 1962:48. See Abou-Aly 1992:201-210 for discussion of what she calls Rufus's 'retreat from prognosis' (1992:227).

shown that the ability to admit ignorance or uncertainty – itself one of the hallmarks of modern science – is an important feature of the kind of consultation style that supports compliance. Many different factors will have helped to shape Galen's extraordinarily self-serving personality. He cannot be psychoanalysed from a distance of 2000 years. But his professional environment was not such as to encourage any such admission; on the contrary, it was highly conducive to self-justificatory behaviour. We turn now to look more closely at that environment.

6.2. The limits of ancient medical authority

Rufus models an approach that accepts the validity of patients' knowledge, but it seems, from the vehemence with which he repeats his point, that not all his contemporaries shared his point of view. In the next part of this chapter, I want to explore a number of factors that seem likely to have helped create a professional environment in which ancient doctors found it hard to feel secure about their authority. Professional credibility was not a foregone conclusion. The status of the profession was low, there were no external guarantors of competence, and there was massive widespread unregulated competition. We now look at these factors in more detail.

The status of medicine

The first point is that medicine was not a high-status profession. Edelstein, contrasting the status of the average Hippocratic physician with that of modern doctors in advanced Western economies, has this to say: 'For the patient, the physician is not the doctor, the educated man to whose knowledge he defers and whom he recognises as an authority in his field; on the contrary, the physician is a craftsman who must prove that he knows his

business'.⁶⁵³ Even famous doctors could aspire to only limited status, Edelstein says, and he makes the important point that the relationship of physician to patient was therefore conditioned largely by the physician's need to establish authority.⁶⁵⁴ Galen was irked by the lack of respect for his profession:

In ancient times, ... virtuous kings ...educated their sons in this (art), and, at that time, none of them had ever thought that it was shameful to take up this art of Apollo and Asclepius. At present, its status has declined; it is suitable (only) for slaves and despicable men. Kings are now ashamed of being instructed in this art, and nowadays they seek recovery through divine medicine. We never find any country, or any city, without places where recovery is sought through divine medicine, some named after Asclepius, others after Apollo. None of the rich men of our time thinks it worthwhile to be instructed in this art: they all look upon it with disdain.⁶⁵⁵

Galen's irritation here is particularly directed at the fashion for divine healing,⁶⁵⁶ but it is interesting that he couches his complaint in terms of status. What he says accords with other evidence of disdain for the medical art, which he himself tells us has become demeaned by the poor calibre of many of its practitioners.⁶⁵⁷ Pliny characterises medicine as the province of reckless innovators and profiteers: 'the thought occurs at once that it is both a wonder and a shame that none of the arts has been more unstable, or even now more often changed, although none is more profitable'.⁶⁵⁸

Pliny's remarks about medicine, and his ensuing promotion of traditional Roman remedies, articulate an anti-Greek prejudice that is, as Astin puts it, 'strongly akin' to that

⁶⁵³ Edelstein 1987:87-88; cf. 90 n.9; 350-51; 385-86.

⁶⁵⁴ Edelstein 1987:88 with n.3.

⁶⁵⁵ *Gal.Opt.Med.Cogn.* 1.3-4, *CMG* Suppl.Or.IV.41-43, tr. Iskandar.

⁶⁵⁶ See below, pp.239-240.

⁶⁵⁷ *Gal.Praen.* 1.1-4, *CMG* V.8.1.68,3-21=XIV.599 K – a dig at Thessalus, the Methodist whom Galen particularly excoriated. See Nutton *ad loc.* (1979:149).

⁶⁵⁸ *Mirumque et indignum protinus subit nullam artium inconstantiorum fuisse aut etiamnunc saepius mutari, cum sit fructuosior nulla.* *Plin.HN* 29.i.2.; tr. Jones, Loeb VIII.183; cf. 29.vii.14 (Cato's claim that Greeks had conspired to murder all foreigners with medicine, for a fee) and viii.16 (Roman ancestors objected to doctors making a profit). The profit motive goes back, Pliny says, to the very early days of Hippocratic medicine (29.ii.4).

of the elder Cato, whose work he claims to be quoting verbatim;⁶⁵⁹ they must also reflect contemporary social phenomena, otherwise they would lack impact, something Pliny is surely too skilled a writer to risk.⁶⁶⁰ Roman aristocrats regarded practising medicine for gain as an activity ‘for tradesmen, not gentlemen’, as Nutton puts it,⁶⁶¹ and Mattern argues that professionalism in general was strongly associated with dependency and, at worst, slavery.⁶⁶² The problem was compounded by a degree of xenophobic resentment, a reaction to Greeks’ dominance of the medical profession in Rome. Nutton provides useful data:

All the doctors to the emperor came from the Greek East or from Marseilles, that little Athens beyond the Alps; ... ninety-three per cent of doctors recorded over three centuries on inscriptions from Rome and Italy bear non-Roman, and usually Greek, names; ... only fifteen of the almost 180 doctors named thereon in the first century A.D. can be shown beyond any doubt to come from citizen families.⁶⁶³

Many of these Greek doctors were either slaves – as Galen himself complained⁶⁶⁴ – or freedmen obliged by law to treat their patrons and patrons’ friends free of charge.⁶⁶⁵ We can see Galen’s sensitivity to this concatenation of demeaning factors in the way he describes episodes such as the casual insult to his intelligence flung at him by Martianus, whom he pointedly calls ‘an acknowledged philosopher as well as doctor’ (οὐκ ἰατρός

⁶⁵⁹ Astin 1978:171; see also Rawson 1985:170. After quoting Cato’s opinion of physicians (*nequissimum et indocile genus*. HN 29.vii.14) and delivering his own tirade against the medical profession (viii.16-28), Pliny devotes the rest of book 29 to an account of ‘the medical treatment by which Cato prolonged his own life and that of his wife to an advanced age’ (*qua medicina se et coniugem usque ad longam senectam perduxerit*: viii.15).

⁶⁶⁰ Cf. Nutton 1985:44: Pliny is ‘expecting to find some response’.

⁶⁶¹ Nutton 1985:28; cf. Israelowich 2015:18; Rawson 1985:84-86.

⁶⁶² Mattern 2008:22 and 2013:232.

⁶⁶³ Nutton 1985:44. See Plin.HN 29.viii.17: *solam hanc artium Graecarum nondum exercet Romana gravitas ... immo vero auctoritas aliter quam Graece eam tractantibus etiam apud inperitos expertesque linguae non est* (‘Medicine alone of the Greek arts we serious Romans have not yet practised; ... nay, if medical treatises are written in a language other than Greek they have no prestige even among unlearned men ignorant of Greek’. Tr. Jones, Loeb VIII.193-195); cf. Edelstein 1987:363. The tendency to regard professional medical practice as ‘something foreign’ continued, according to Ido Israelowich, ‘well into late antiquity’ (2015:18). On hostility to Greek doctors at Rome, see Isaac 2004:226-230.

⁶⁶⁴ See for example Gal.MM 1.4, X.48-9 K and *Protr.*6, I.9,13-15 K; cf. Nutton *ad Gal.Praen.*1.4 (1979:149).

⁶⁶⁵ Mattern 2008:22; cf. Rawson 1985:85.

μόνον ἀλλὰ καὶ φιλό<σοφο>ς),⁶⁶⁶ and perhaps too in his own determined adoption of the ideal of the philosopher doctor.⁶⁶⁷

The personal attributes of those who practised medicine are only part of the picture, though. A major and enduring problem was the nature of medicine itself. Was it an art (a τέχνη) or just a set of practical skills? And if a τέχνη, at what level did it operate? How much did it depend on intellectual prowess as opposed to hands-on know-how? Defending the τέχνη was one of Galen's great preoccupations, but the issue goes back to the fifth century. Hippocratic authors and Plato together provide rich evidence of intense debate about the nature of medicine, with much hingeing on intellectual as opposed to practical capability. Socrates argues in *Phaedrus* that being a doctor is not just a matter of knowing how to use a few techniques learned from books. The doctor has to know what technique to apply to whom, when, for how long and so forth. These fine judgements come from 'being an expert in the art' (ἐπαῖων τῆς τέχνης, *Phaedr.*268c) and cannot be learned from books or by having sketchy knowledge of a few potions; knowing an art, he says, involves determining the nature of something, not just applying drugs and dietary recommendations on the basis of practice and experience.⁶⁶⁸ Galen says the same thing: 'so far as the medical art is concerned, there is a difference between learning something

⁶⁶⁶ Gal.*Praen* 4.1, *CMG* V.8.1.88.16 = XIV.619 K. Mattern suggests that Martianus and his ilk regarded Galen as an 'upstart' (2013:239).

⁶⁶⁷ For the dignifying power of associating one's profession with philosophy, see Nutton *ad loc.* (1979:174), citing medical inscriptions (*IGR* IV.1359, III.733), Strabo (I.1.18), Vitruvius (I.1ff.), and Lucian's parodic association of philosophy with dancing (*De salt.*35.81); cf. Mattern 2008:21-27, arguing that Galen dealt with the social and ethnic ambiguities by 'blurring the distinction between the sophistic *pepaideumenos* and the professional physician' and constructing an ideal of the physician as identical with the educated gentleman.

⁶⁶⁸ δεῖ διελέσθαι φύσιν σώματος ... εἰ μέλλεις, μὴ τριβῇ μόνον καὶ ἐμπειρίᾳ ἀλλὰ τέχνη, ... φάρμακα καὶ τροφήν προσφέρων ὑγίειαν καὶ ῥώμην ἐμποιήσῃν (Pl.*Phdr.*270b). The verb he uses for 'determining' the body's nature, διελέσθαι, is cognate with διαίρεσις, the method espoused by Galen for distinguishing the particular from the universal (see above, pp.203-204).

and knowing how to put what one has learnt to proper use'.⁶⁶⁹ Again, in *Gorgias*, Socrates's argument that medicine is a τέχνη rather than an ἐμπειρία (knack) is based on the fact that it does not simply do things but understands why and how it does them:

ἡ δ' ἰατρικὴ ... τούτου οὗ θεραπεύει καὶ τὴν φύσιν ἔσκεπται καὶ τὴν αἰτίαν ὧν πράττει, καὶ λόγον ἔχει τούτων ἐκάστου δοῦναι.

Medicine ... has investigated both the nature of the person it treats and the cause of the things it does, and is able to give an account of each.⁶⁷⁰

Medicine is not, however, a *technē* of the kind that is reputed for wisdom, according to the pseudo-Platonic *Epinomis*: rather, it is one of the defensive arts, which 'lack measure, proceed by guesswork and are carried along by opinion'.⁶⁷¹ Plato seems ambivalent about its status: he is happy to give a central role in *Symposium* to a doctor, Eryximachus, but in *Phaedrus* medicine is only a middle-ranking destination for a reincarnated soul, sharing the fourth of seven tiers with gymnastic trainers, superior to prophets, poets and painters, manual labourers and farmers, sophists, demagogues and tyrants but inferior to philosophers, aesthetes, kings, politicians, financiers *et al.*⁶⁷² Things had not changed much by Galen's time: half a millennium after Plato, Cicero, despite appreciating the physicians who attended him personally, noted that the art of medicine was suitable only for 'those of an appropriate rank' (*eis quorum ordini convenit*), noble only by comparison with tax collection, small trade, carpentry, cooking and dancing, and lower ranked than oratory, politics and land-owning.⁶⁷³

⁶⁶⁹ κατὰ τὴν ἰατρικὴν οὐ ταῦτόν ἐστι τὸ μαθεῖν τὴν τέχνην τῷ χρήσασθαι προσηκόντως οἷς ἔμαθέ τις. *Gal.Hipp.Epid.VI* 2.45 (CMG V.10.2.2.118.6-8 = XVIIA.1000 K).

⁶⁷⁰ *Pl.Grg.*501a, tr. Zeyl, Cooper 1997:845. Medicine is contrasted with cooking: both care for the body, but a cook simply produces food in the interests of pleasure (ἡδονή), while doctor knows how to use that food for the benefit of the body and is concerned with the good (τὸ ἀγαθόν): *id.*500b. For medicine as a τέχνη cf. also *Clitophon* 408e-409b.

⁶⁷¹ ἄμετρα γὰρ δόξαις φορεῖται τοπαζόμενα: *Epinomis* 976a, tr. McKirahan, Cooper 1997:1620.

⁶⁷² *Phdr.*248d-e. Cf. *Grg.*517d where Socrates argues that, so far as the care of the body is concerned, medicine is superior to pastry making and shopkeeping.

⁶⁷³ *Cic.de Off.*1.150-1. See Rawson 1985:84-88 and cf. Long 2001:36.

Medicine had to contend with the fact that it encompassed not just high-flown theory but a range of sometimes fairly basic practical skills; thus Nutton points out that blacksmiths could reduce dislocations, cobblers might suture wounds, and almost anyone might have a favourite pharmacological recipe to share.⁶⁷⁴ But for Plato, medicine is problematic at a more profound level. In *Republic*, Socrates argues that needing a doctor is indicative of moral insufficiency. A man should be able to pursue a healthy life under the guidance of his own soul: ἐμοὶ μὲν γὰρ ... φαίνεται ... ψυχὴ ἀγαθὴ τῇ αὐτῆς ἀρετῇ σῶμα παρέχειν ὡς οἷόν τε βέλτιστον.⁶⁷⁵ So long as sufficient care is devoted to the mind (ἡ διάνοια), it can be entrusted with the detailed supervision of the body within certain general parameters such as temperance, a plain and sensible diet, and simple decent physical training.⁶⁷⁶ Medical care should properly be the resort only of the inferior classes:

τῆς δὲ κακῆς τε καὶ αἰσχρᾶς παιδείας ἐν πόλει ἄρα μὴ τι μείζον ἔξεις λαβεῖν τεκμήριον ἢ τὸ δεῖσθαι ἰατρῶν καὶ δικαστῶν ἄκρων μὴ μόνον τοὺς φαύλους τε καὶ χειροτέχνας, ἀλλὰ καὶ τοὺς ἐν ἐλευθέρῳ σχήματι προσποιουμένους τεθράφθαι;

Could you find a greater sign of bad and shameful education in a city than that the need for skilled doctors and lawyers is felt not only by inferior people and craftsmen but by those who claim to have been brought up in the manner of free men?⁶⁷⁷

It is particularly shameful to need medical help for self-inflicted problems:

τὸ δὲ ἰατρικῆς, ἣν δ' ἐγώ, δεῖσθαι ὅτι μὴ τραυμάτων ἔνεκα ἢ τινων ἐπετείων νοσημάτων ἐπιπεσόντων, ἀλλὰ δι' ἀργίαν τε καὶ δίαιταν οἷαν διήλθομεν, ῥευμάτων τε καὶ πνευμάτων ὥσπερ λίμνας ἐμπιπλαμένους φύσας τε καὶ κατάρρους νοσήμασιν ὀνόματα τίθεσθαι ἀναγκάζειν τοὺς κομποὺς Ἀσκληπιάδας, οὐκ αἰσχρὸν δοκεῖ;

And doesn't it seem shameful to you to need medical help, not for wounds or because of some seasonal illness, but because, through idleness and the life-style we've described, one is full of gas and

⁶⁷⁴ Nutton 1985:33. Nutton points out that Galen took recipes from 'a Bithynian barber, Euschemus the eunuch, Flavius the boxer, and Orion the groom'.

⁶⁷⁵ 'It seems to me that ... a good soul by its own virtue makes the body as good as possible'. Pl.R.3, 403d, tr. Grube, Cooper 1997:1040.

⁶⁷⁶ Pl.R.3, 403d-404e.

⁶⁷⁷ Pl.R.3, 405a, tr. Grube, Cooper 1997:1042.

phlegm like a stagnant swamp, so that sophisticated Asclepiad doctors are forced to come up with names like ‘flatulence’ and ‘catarrh’ to describe one’s diseases?⁶⁷⁸

Where medical attention is unavoidable, it must, however unpleasant, be borne for the benefit it brings, just as justice must be endured for the sake of the soul;⁶⁷⁹ conversely, avoiding medical care – ‘the penalty for one’s bodily transgressions’ (δίκην τῶν περὶ τὸ σῶμα ἀμαρτημάτων, 479a) – is akin to avoiding moral justice.⁶⁸⁰ Doctors are a necessary evil, not a simple desiderandum: austere servants of public as well as private morality, their existence is emblematic of what is wrong with the city, which ideally ought not to require them.⁶⁸¹

Susan Levin has recently suggested that Plato saw medicine as a rival to philosophy and that in *Gorgias*, *Symposium* and *Republic* we see him pursuing a project of proving philosophy’s superiority; by the time of *Laws*, she believes, Plato had resolved the tension to his own satisfaction.⁶⁸² This analysis has been rejected by Long, on the grounds that proving a critical or hostile attitude to medicine in the earlier dialogues is more of a challenge than Levin allows.⁶⁸³ Whether or not Plato was hostile towards medicine, his work certainly articulates an ambivalence about the profession and its practitioners that reflects similar indications in Hippocratic texts. In the late fifth century the author of the Hippocratic *Regimen in Acute Diseases* lamented that διαβολὴν γε ἔχει ὅλη ἡ τέχνη πρὸς

⁶⁷⁸ Pl.R.3,405d, tr. Grube, Cooper 1997:1042.

⁶⁷⁹ Pl.Grg.478b-e. The kind of treatment Socrates has in mind is ‘cautery and incision’ (τὸ κάεσθαι καὶ τὸ τέμνεσθαι). Xenophon talks of submitting to cutting and cauterisation (see above, p.221) and Aelius Aristides, as we shall see, is accused by some of his friends of fearing painful treatment when he insists on following the orders of Asclepius rather than the human doctors who want to treat him (see below, pp.264-265) – though we may wonder why someone should not prefer to seek a more congenial form of treatment, or even to avoid it altogether by adjusting his lifestyle. See Chapter 7. Cf. Holmes 2010:191 and 205.

⁶⁸⁰ See above, p.219.

⁶⁸¹ On the tension between patient autonomy and physician authority in *Republic*, see Holmes 2010:181-2.

⁶⁸² Levin 2014. See Pl.Lg.4,720b-e (above, p.221 n.628).

⁶⁸³ A. Long, Notre Dame Philosophical Reviews, Jan. 2015. <http://ndpr.nd.edu/news/55290-plato-s-rivalry-with-medicine-a-struggle-and-its-dissolution/>. Accessed 7th January 2016.

τῶν δημοτέων μεγάλην, ὥς μὴ δοκεῖν ὅλως ἰητρικὴν εἶναι (‘the art as a whole has a very bad name among laymen, so that there is thought to be no art of medicine at all’),⁶⁸⁴ while the author of *On the Art* felt the need to defend medicine against a variety of accusations including the claim that ταῦτα μὲν καὶ αὐτὰ ὑφ’ ἑαυτῶν ἂν ἐξυγιάζοιτο, ἃ ἐγχειρέουσιν ἰῆσθαι, ἃ δ’ ἐπικουρίας δεῖται μεγάλης οὐχ ἄπτονται, δεῖν δὲ, εἴπερ ἦν ἡ τέχνη, πάνθ’ ὁμοίως ἰῆσθαι.⁶⁸⁵

Professional boundaries

in hac artium sola evenit ut cuicumque medicum se professo statim credatur, cum sit periculum in nullo mendacio maius. non tamen illud intuemur, adeo blanda est sperandi pro se cuique dulcedo.

Anyone who calls himself a doctor is immediately believed, something that happens in no other profession, though in no other falsehood is there greater danger. Yet we disregard the danger, so alluring does each of us find the charm of wishful thinking.⁶⁸⁶

The world of the ancient doctor was rife with competition and devoid of formal training, qualifications, or any kind of regulatory system. There were no objective guarantors of competence, and the medical marketplace was large, noisy and uncontrolled. We have seen that Socrates distinguishes between proper doctors and ‘those who have read a few books’. The same concern is reflected in the Hippocratic *On the Art*:

Οἱ μὲν οὖν μεμφόμενοι τοῖσι κεκρατημένοισι μὴ ἐγχειρόντας ... ὑπὸ μὲν τῶν οὐνόματι ἰητρῶν θαυμάζονται, ὑπὸ δὲ τῶν καὶ τέχνη καταγελῶνται.

⁶⁸⁴ Hp.*Acut.*8 = II.240.9-10 L, tr. Jones, Loeb II.69.

⁶⁸⁵ ‘While physicians undertake cases which would cure themselves, they do not touch those where great help is necessary; whereas, if the art existed, it ought to cure all alike’ (Hp.*de Arte* 8 = VI.12.15-18 L, tr. Jones, Loeb II.203). On Hippocratic ideas about incurability, with a variety of reasons including medical and technological limitations and patient fault, see von Staden 1990:88-93.

⁶⁸⁶ Plin.*HN* 29.viii.17-18.

Those who blame physicians who do not undertake desperate cases ... are admired by those who are physicians in name but are a laughing-stock of physicians who have learnt the art of medicine.⁶⁸⁷

But how could a man prove that he had ‘learnt the art’? Galen had nothing to show for his ten years of medical education apart from his own self-presentation.⁶⁸⁸ The principal theatres of his long working life, Asia Minor and Rome, were full of healers of various persuasions. Anyone could set him- or herself up as a doctor,⁶⁸⁹ and the only arbiters of their competence were the people they treated, whose judgement was hardly likely to be objective.⁶⁹⁰ It was a case of *caveat emptor*, as Pliny unkindly pointed out:

nulla ... lex quae puniat inscitiam capitale, nullum exemplum vindictae. discut periculis nostris et experimenta per mortes agunt, medicoque tantum hominem occidisse impunitas summa est.

There is no law to punish criminal ignorance, no instance of retribution. Physicians acquire their knowledge from our dangers, making experiments at the cost of our lives. Only a physician can commit homicide with complete impunity.⁶⁹¹

Though doctors enjoyed certain privileges, such as tax concessions, military exemptions, and Julius Caesar’s grant of citizenship,⁶⁹² these should not be taken as evidence of any kind of systematic testing of fitness to practice: entitlement seems to have depended on activity rather than proof of competence.⁶⁹³ The author of the Hippocratic *Law*

⁶⁸⁷ Hp.*de Arte* 8 = VI.14,13-16 L, tr. Jones, Loeb II.205 (adapted).

⁶⁸⁸ On Galen’s lengthy medical education, see for example Iskandar 1988:139-40.

⁶⁸⁹ Nutton 2004:251-2; also 1985:27: ‘A doctor was a person, male or female, who carried out medical treatment for a fee, or who, like Galen, devoted much of his time to healing.’ Lloyd 2003:41: the ‘pluralism of Greek medicine’ extends beyond the Hippocratic and temple healing traditions to encompass ‘sellers of charms and incantations, ... root-cutters, drug-sellers, ... midwives, and ... other women healers’.

⁶⁹⁰ Cf. Nutton 1985:26-27: ‘In antiquity, the decision as to who was or was not to be called a doctor was, with very few exceptions, made either by the layman or by the individual doctor himself.’

⁶⁹¹ Plin.*HN* 29.viii.18, tr. Jones, Loeb VIII.195. Pliny continues by contrasting the regulation and control of judges (*decuriae*), who ‘are tested according to custom by the censorial powers of the Emperor’ (*pro more censuris principum examinantur*).

⁶⁹² Citizenship granted to all those who practised medicine at Rome, and all teachers of the liberal arts, to encourage them to live at Rome and *pour encourager les autres*: Suet.*Iul.*42.1 (Isaac 2004:228). Tax concessions: Nutton 1985:29; Iskandar 1988:144, *ad Gal.Opt.Med.Cogn.*42.2-3; Nutton 1979:149, *ad Gal.Praen.*1.4.

⁶⁹³ Nutton 1985:30, citing the case of a local doctor called Psasnis, heard before the Governor of Egypt in 142 AD; for a fuller account of this case, see Israelowich 2015:35-43.

complained that medicine was ‘the only science for which states have laid down no penalties for malpractice’ except for ill repute, which ‘does little harm to the quacks who are compounded of nothing else’;⁶⁹⁴ the Hippocratic *Oath*, with its promise to observe specified standards and confine instruction to those ‘who have taken the physician’s oath’, represents an early attempt at quality control through restrictive practice, but even in Galen’s time professional guilds and colleges were still a millennium away, and the reality of the ancient world was that policing healers’ claims was well-nigh impossible.⁶⁹⁵

‘Examinations should not be carried on as they are now’, Galen protested,

‘whereby physicians are honoured if they ride out in processions with the rich and serve them in matters which prevent them from devoting their time to the practice of medicine. On the contrary, physicians should be chosen and honoured if they devote all their time to the practice of medicine and nothing else’.⁶⁹⁶

The problem was not a new one: the author of one Hippocratic treatise complains of ‘magicians, purifiers, charlatans and quacks of our own day, men who claim great piety and superior knowledge’ but lack effective ability,⁶⁹⁷ and Socrates, as we saw, conjures up a similar scenario.⁶⁹⁸ If, he argues in *Phaedrus*, someone says

‘I know treatments to raise or lower ... the temperature of people’s bodies; if I decide to, I can make them vomit or make their bowels move, and all sorts of things. On the basis of this knowledge, I claim to be a physician; and I claim to be able to make others physicians as well by imparting it to them’,⁶⁹⁹

⁶⁹⁴ Hp.*Lex* I, Loeb II.262, tr. Chadwick and Mann 1983:68.

⁶⁹⁵ Systems to assess the competence of physicians, and to regulate their activities, began to develop in Italy in the mid 12th century, when King Roger of Sicily introduced a statute requiring medical practitioners to undergo examination by royal officials, and gravitated into the hands of professionals themselves in 1231. Northern Europe lagged behind: the College of Physicians in London was not founded till 1518. See Siraisi 1990, 17-18.

⁶⁹⁶ Gal.*Opt.Med.Cogn.* 9.8, CMG Suppl.Or.IV.105-107, tr. Iskandar.

⁶⁹⁷ οἱ καὶ νῦν εἰσι μάγοι τε καὶ καθάρται καὶ ἀγύρται καὶ ἀλαζόνες, οὗτοι δὲ καὶ προσποιέονται σφόδρα θεοσεβέες εἶναι καὶ πλέον τι εἰδέναι. Hp.*Morb.Sacr.* 2 = VI.354.13-15, tr. Jones, Loeb II.141.

⁶⁹⁸ See above, pp.232-233.

⁶⁹⁹ ἐγὼ ἐπίσταμαι τοιαῦτ’ ἅττα σώμασι προσφέρειν, ὥστε θερμαίνειν τ’ ἐὰν βούλωμαι καὶ ψύχειν, καὶ ἐὰν μὲν δόξη μοι, ἐμεῖν ποιεῖν, ἐὰν δ’ αὖ, κάτω διαχωρεῖν, καὶ ἄλλα ἀάμπολλα τοιαῦτα· καὶ ἐπιστάμενος αὐτὰ ἀξιώ ἱατρικὸς εἶναι καὶ ἄλλον ποιεῖν ὃ ἂν τὴν τοῦτων ἐπιστήμην παραδῶ. Pl.*Phdr.*268.

but does not know ‘to whom he should apply such treatments, when, and to what extent’,⁷⁰⁰ then his claim to be a doctor would amount to insanity: reading a book or happening to have come across a few potions is not enough; such a man ‘knows nothing of the art’.⁷⁰¹

Nor was the field limited to human healers. Incubation – sleeping in a temple to receive direct advice from the resident deity without the need for a priestly intermediary – was common practice throughout Greco-Roman antiquity and Byzantine Christianity, particularly (though not exclusively) in the context of healing cults⁷⁰² located at sanctuaries such as those at Epidaurus and in Galen’s home town, Pergamum,⁷⁰³ and during the 2nd century it was undergoing a ‘resurgence in popularity’.⁷⁰⁴ According to Alexander of Aphrodisias, writing at the turn of the second and third centuries,

πάντες γοῦν σχεδὸν ἄνθρωποι καταφεύγουσιν ἐπ’ αὐτόν, ἔνθα ἂν ἐπιφανέστατος ἦ, πεπιστευκότες ὅτι τοῖς σπουδάζουσιν αὐτὸν ἔχειν ἱατρὸν μᾶλλον τῶν οὐ σπουδαζόντων ἐπιδίδωσιν αὐτόν

‘Almost all men have recourse to him [Asclepius], where he is most fully manifested, believing that he bestows his [aid] more on those who are eager to have him as their doctor than on those who are not.’⁷⁰⁵

Aelius Aristides in his oration *To Sarapis*, which probably dates from 142, declares of Asclepius:

⁷⁰⁰ οὐστὶνας δεῖ καὶ ὅποτε ἕκαστα τούτων ποιεῖν, καὶ μέχρι ὅπου. Pl.*Phdr.*268.

⁷⁰¹ εἰπεῖν ἂν οἶμαι ὅτι μαίνεται ἄνθρωπος, καὶ ἐκ βιβλίου ποθὲν ἀκούσας ἢ περιτυχὼν φαρμακίοις ἱατρὸς οἶεται γεγονέναι, οὐδὲν ἐπαῖων τῆς τέχνης. Pl.*Phdr.*268.

⁷⁰² Graf (‘Incubation’, in *Brill’s New Pauly* Vol.6:766), pointing out that the advice received was not necessarily restricted to healing and might touch on other similarly personal concerns.

⁷⁰³ Epidaurus had a sanctuary associated with Apollo from the late archaic period; by the sixth century the sanctuary belonged to both Apollo and Asclepius, before the latter gradually ousted his predecessor; and in the fourth a Christian basilica was incorporated into the precinct (Graf, ‘Asclepius’, in *Brill’s New Pauly* Vol.2:102-4; Lafond, ‘Epidaurus’, in *Brill’s New Pauly* Vol.4:1086-89). The cult of Asclepius fanned out from Epidaurus from about the fifth century, often in response to major health disasters such as plague epidemics (Graf, *ibid.*), arriving, for example, in Athens in 420 BC (IG ii² 4960), and in Rome in 293 BC (Ov.*Met.*15.622-744). See also Rhodes (1988) *ad* Thuc.2.47.4; cf. Horstmanshoff 2004:328, and Dodds 1951:193, with 203 nn.83-6.

⁷⁰⁴ Petsalis-Diomidis 2012:52; cf. Harris 2009:185.

⁷⁰⁵ Alex.*Aphr.Fat.*32, tr. Sharples 1983:84-5; cf. Harris 2009:185.

τῶν μὲν γὰρ ἄλλων θεῶν διήρηνται αἱ δυνάμεις τε καὶ τιμαὶ, καὶ ἄλλους ἐπ' ἄλλα ἄνθρωποι καλοῦσιν, ὁ δὲ ὥσπερ κορυφαῖος πάντων ἀρχὰς καὶ πέρατα ἔχει. μόνος δὲ καὶ ἔτοιμος τῷ τινὸς δεομένῳ τοῦτ' ἐπιτελεῖν· ... τοῦτον δὲ μόνον πάντες ὁμοίως τοῖς σφετέροις νομίζουσιν.

‘Like a universal chorus leader, he is in charge of our beginning and our end. He alone is ready to help when one needs anything ... In him alone all men believe as in their own gods’.⁷⁰⁶

So when Galen complained that in Pergamum patients often followed divine advice rather than that of a doctor⁷⁰⁷ he was articulating a daily reality: human and divine healing co-existed in a much more integrated fashion than a positivist history of medicine might suggest. It was normal for patients to use a variety of different approaches to healing, and doctors had to accept – whether they liked it or not – that their services were just one option among many in the medical marketplace.

The challenge of identifying a competent physician in such a crowded market provides the backdrop to Galen’s treatise *On Recognising the Best Doctor*, composed probably in 175 when Galen was at the height of his powers and success in Rome.⁷⁰⁸ In it he sets out the characteristics of good physicians – which include accurate prognosis, adherence to the teaching of ‘Hippocrates and the Ancients’, belief in the importance of causation, and the ability to distinguish between natural and unnatural developments rather than, ‘like those without any medical knowledge, fear[ing] symptoms which laymen dread’⁷⁰⁹ – and explains how to check that a doctor’s practice conforms to these standards, a complicated

⁷⁰⁶ Aristid.Or.45.22, 358-59 Keil.

⁷⁰⁷ See above, p.223.

⁷⁰⁸ There is no Greek text of this work, *De Optimo Medico Cognoscendo*; it is available, in Arabic with parallel English translation, as *CMG Supplementum Orientale IV* (cited in the next 7 footnotes simply by section and *CMG* page number). On the date of composition, see Iskandar 1988:33-34.

⁷⁰⁹ Forecasting: §2.2-3, *CMG* p.49, cf. §5.5, *CMG* pp.69-71: ‘The complete physician foretells the nature of the disease at its onset, when it will reach the culmination, and the occurrence of its crisis. As to the one who is not so (accomplished), the more errors he makes on each of these (points), the more he will fall below the complete physician’. Hippocratic adherence: §3.4, *CMG* p.53, cf. §5.1, *CMG* p.69. Causation: §3.1-2, *CMG* p.53. Ability to distinguish natural from unnatural developments: §4.6, *CMG* p.65.

and demanding task that calls for both theoretical knowledge and the ability to critique the man's 'clinical diagnosis'.⁷¹⁰ The reader is advised, for example, to test the physician on his knowledge of the doctrines of Hippocrates, Erasistratus, Diocles, Pleistonicus, Phylotimus, Praxagoras, Dieuches, Herophilus and Asclepiades:

(A student) who has followed the right course of instruction will be able to describe the doctrines of each of these. If he is really perfect, he will be able to describe to you the doctrines of the Ancients, together with those of their successors, outlining their differences and agreements. Furthermore, he will be able to inform you of his own judgment on their differences, justifying correct doctrines and exposing those which are erroneous.⁷¹¹

Galen recognises that in order to carry out this sort of exhaustive (and exhausting) examination one needs 'training in the demonstrative science ... because nobody can understand demonstration unless he has had previous instruction'.⁷¹² One must pay careful attention to the task – 'A person must diligently test and examine the skill of a physician so that he can rely on him during any illness'⁷¹³ – using a twofold method: scrutinising his clinical skills by watching him at work,⁷¹⁴ and 'examin[ing] him in theory' beforehand, though the latter, Galen says, is beyond the capabilities of all the laymen he has met.⁷¹⁵

Galen's dig at laymen's knowledge points to another factor that doctors of this period had to deal with as they sought to assert their competence. The phenomenon of *paideia*,

⁷¹⁰ §9.1, *CMG* p.101: 'As I have repeatedly said, there are two types of examination: one is to examine a physician in clinical diagnosis, in which he must not make a mistake ...; the other is to examine him in theory before the clinical cases and practice and to find him acquainted with all that has been said on medicine, from which he should have selected the best doctrines.'

⁷¹¹ §5.3, *CMG* p.69.

⁷¹² §5.4, *CMG* p.69; cf. §9.1, *CMG* p.101 for the same thought; and §8.9, *CMG* p.99: 'If anybody wishes to examine physicians and put them to the test, this matter will be beyond his reach if pursued without any prior knowledge of medical principles and without the self-discipline to endure lengthy dialectical arguments'.

⁷¹³ §8.10, *CMG* p.101.

⁷¹⁴ §8.2, *CMG* p.93.

⁷¹⁵ §9.1, *CMG* p.101; cf. §5.5, *CMG* p.71; §9.23-24, *CMG* pp.115-117.

the ostentatious espousal of Greek culture through a very specific education, meant that educated men, *pepaideumenoι*, were expected to be knowledgeable about medicine.⁷¹⁶ Medicine was ‘fashionable’, as Nutton puts it, and ‘no literary symposium was complete without its physician, no collection of scientific problems without its medical theme’.⁷¹⁷ Many laymen doubtless thought they knew much more than they did, as witness the ‘wealthy youth’ who made the mistake of teasing Galen about a diagnosis which the youth, being insufficiently aware of the different presentations of tertian fever, thought incorrect. Galen puts him down in a patronising tone: ‘I am prepared to excuse you, for I am aware that you cannot (possibly) know of combinations of two tertian fevers because you do not devote time to caring about such important things’, and gives a detailed prognosis of the course of the illness. The youth retreats in alarm, ‘pricking up his ears just like an ass when it is scared’.⁷¹⁸ Others, though, seem to have been as well versed in medical theory as those who attended them, or more so. On one occasion a local physician attending Aulus Gellius, who had fallen ill on a visit to the country, managed to commit a major solecism when describing the case to ‘the philosopher Calvisius Taurus and some others who were disciples of his’ (*Calvisius Taurus philosophus et alii quidam sectatores eius*), who had come to visit Gellius.

Tum in eo sermone, cum iam me sinceriore corpusculo factum diceret, ‘Potes,’ inquit Tauro, ‘tu quoque id ipsum comprehendere, ἐὰν ἄψῃ αὐτοῦ αὐτοῦ τῆς φλεβός, quod nostris verbis profecto ita dicitur: ‘si attigeris venam illius’.

Then in the course of the conversation remarking that I was now getting better, he said to Taurus: ‘You too may satisfy yourself of this, ἐὰν ἄψῃ αὐτοῦ τῆς φλεβός’, which in our language certainly means: si attigeris venam illius; that is, ‘if you will put your finger on his vein’.

⁷¹⁶ See for example Mattern 2008:24 with n.83, instancing Plutarch, Aulus Gellius, Apuleius, Aelius Aristides, Marcus Aurelius and Fronto; Bowersock 1969:66-75; Swain 2008:115-6, explaining that *paideia* ‘means education in the broadest sense and may be translated as “culture”’. Galen’s patients exhibit all the familiarity with medical thought and discussion that is characteristic of their era and class.

⁷¹⁷ Nutton 2000:943.

⁷¹⁸ *Gal.Opt.Med.Cogn.*8.5-7, *CMG Suppl.Or.*IV.95-97, tr. Iskandar.

This was an embarrassing mistake; as Taurus pointed out to the doctor, he had confused veins with arteries, two very different things: *venae quidem suapte vi immobiles sint et sanguinis tantum demittendi gratia explorentur, arteriae autem motu atque pulsu suo habitum et modum febrium demonstrent* ('the veins have no power of motion and are examined only for the purpose of drawing off blood, but ... the arteries by their motion and pulsation show the condition and degree of fever'). Taurus spoke 'very mildly, as was his way' (*ut mos eius fuit, satis leniter*), but the rest of Gellius's learned friends, all ranged around the bedside, were less forgiving: *hanc loquendi imperitiam, quod venam pro arteria dixisset, cum in eo docti homines qui cum Tauro erant, tamquam in minime utili medico offendissent atque id murmure et vultu ostenderent* ('they were shocked by this careless language in calling an artery a vein, and looking on him as a physician of little value, showed their opinion by their murmurs and expression'). The incident prompts Gellius to look to his own medical education:

Hoc ego postea cum in medico reprehensum esse meminissem, existimavi non medico soli, sed omnibus quoque hominibus liberis liberaliterque institutis, turpe esse ne ea quidem cognovisse ad notitiam corporis nostri pertinentia, quae non altius occultiusque remota sunt et quae natura nobis tuendae valitudinis causa et in promptu esse et in propatulo voluerit; ac propterea, quantum habui temporis subsicivi, medicinae quoque disciplinae libros attigi, quos arbitrabar esse idoneos ad docendum, et ex his cum alia pleraque ab isto humanitatis usu non aliena, tum de venis quoque et arteriis didicisse videor.

Afterwards when I recalled this criticism of the physician, I thought that it was shameful, not only for a physician, but for all cultivated and liberally educated men, not to know even such facts pertaining to the knowledge of our bodies as are not deep and recondite, but which nature, for the purpose of maintaining our health, has allowed to be evident and obvious. Therefore I devoted such spare time as I had to dipping into those books on the art of medicine which I thought were suited to instruct me, and from them I seem to have learned, not only many other things which have to do with human experience, but also concerning veins and arteries.⁷¹⁹

⁷¹⁹ Gell.18.10, tr. Rolfe, Loeb III.331-335.

In another example from the same sort of time, Apuleius of Madauros in North Africa defends himself against a charge of sorcery by explaining that the woman whom he stands accused of bewitching is actually epileptic, that her collapse at his house was due to natural causes, and that the reason she was there was that the local doctor, Themison, had sought his assistance. Apuleius bolsters his case by showing off to the court his familiarity with the medical theories of Plato, Aristotle and Theophrastus:

Agnoscis, Maxime, rationem Platonis quantum potui pro tempore perspicue explicatam; cui ego fidem arbitratus causam diuini morbi esse, cum illa pestis in caput redundauit, haudquaquam uideor de nihilo percontatus, an esset mulieri illi caput graue, ceruix torpens, tempora pulsata, aures sonorae. et ceterum, quod dexteræ auris crebriores tinnitus fatebatur, signum erat morbi penitus adacti; nam dextera corporis ualidiora sunt eoque minus spei ad sanitatem relinquunt, cum et ipsa aegritudini succumbunt. Aristoteles adeo in problematis scriptum reliquit, quibuscumque caducis a dextero morbus occipiat, eorum esse difficiliorem medelam. longum est, si uelim Theophrasti quoque sententiam de eodem morbo recensere.

You recognise, Maximus, the theory of Plato, as far as I have been able to give it a lucid explanation in the time at my disposal. I put my trust in him when he says that the cause of epilepsy is the overflowing of this pestilential humour into the head. My inquiry therefore was, I think, reasonable when I asked the woman whether her head felt heavy, her neck numb, her temples throbbing, her ears full of noises. The fact that she acknowledged these noises to be more frequent in her right ear was proof that the disease had gone home. For the right-hand organs of the body are the strongest, and therefore their infection with the disease leaves less hope of recovery. Indeed Aristotle has left it on record in his Problems that whenever in the case of epileptics the disease begins on the right side, their cure is more difficult. It would be tedious were I to repeat the opinion of Theophrastus also on the subject of epilepsy.

He goes on to deliver himself of a learned disquisition on Plato's theory of disease causation, and the symptoms, presentation and treatment of epilepsy.⁷²⁰

The attitudes reflected in these two anecdotes were considered perfectly normal among 'cultivated and liberally educated men', as Gellius calls them. But although a local

⁷²⁰ *Apul. Apol.* 48-52; on this case see Nutton 2000:943.

provincial doctor may have been pleased to be able to call on a learned *philiatros* like Apuleius for advice, laymen's beliefs could present a challenge to the doctor. Galen had no trouble seeing off an impudent youth; Gellius's hapless country medic, on the other hand, cannot have enjoyed being corrected by the coterie of shocked intellectuals clustered round his patient. Plutarch, in *Advice on Keeping Well*, paints a vivid picture of the tensions that could arise, in Zeuxippus's anecdote of the doctor Glaucus complaining about laymen who 'have dared to confuse boundaries by discussing a healthy lifestyle' (σύγχυσιν ὄρων τετολμῆσθαι διαλεχθεῖσι περὶ διαίτης ὑγιεινῆς). When Glaucus declares that the boundaries of philosophy and medicine are as far apart as those of Mysia and Phrygia ('χωρίς' γὰρ ἔφη τὰ φιλοσόφων καὶ ἱατρῶν ὥσπερ τινῶν 'Μυσῶν καὶ Φρυγῶν ὁρίσματα'), Zeuxippus retorts that, on the contrary,

οὐ παράβασιν ὄρων ἐπικαλεῖν δεῖ τοῖς περὶ ὑγιεινῶν διαλεγόμενοις φιλοσόφοις, ἀλλ' εἰ μὴ παντάπασιν ἀνελόντες οἴονται δεῖν τοὺς ὄρους ὥσπερ ἐν μιᾷ χώρᾳ κοινῶς ἐμφιλοκαλεῖν, ἅμα τὸ ἡδὺ τῷ λόγῳ καὶ τὸ ἀναγκαῖον διώκοντες.

Philosophers who debate matters of health ought to be arraigned not for transgressing boundaries but rather if they fail to dismantle the boundaries in every way and to think that we should pursue honourable studies together, in the same territory as it were, pursuing pleasure and necessity in conversation at the same time.⁷²¹

The dilettante approach espoused by Gellius (*quantum habui temporis subsicivi, medicinae quoque disciplinae libros attigi*) encourages one to feel a degree of sympathy with the curmudgeonly Glaucus. And for Galen, whose entire identity was bound up with being a doctor, the slipperiness of the boundaries between physician and layman adds another layer of piquancy to an already complex mix of unregulated practice, human and divine competition, and status anxiety; if arguing about medicine is the province of all

⁷²¹ Plu.*Moralia* 122b-123b (*Advice on Keeping Well*).

educated men, and anyone can put you to the test in front of others, the doctor's expert identity stands on very uncertain ground.⁷²² It is, then, perhaps not surprising that his views on medically knowledgeable laymen reflect an undisguised tension: he disapproves of men who do not bother to learn about medicine so as to keep themselves well – 'I am ... extremely amazed that, although (health) is (highly valued), men are so remiss as to neglect it: they refrain from seeking instruction in an art by which they will regain (health)'⁷²³ – but later in the same treatise, and elsewhere, he is, as we have seen, insistent on obedience to doctors' orders.⁷²⁴ All cultured men should know about medicine, it seems, but not so much as to challenge the doctor's authority.

Ineffectiveness of medicine

The mixed economy of healthcare and doubtful status of the medical profession reflect, among other things, the limited and parlous state of medical knowledge. One of the striking things about ancient medicine is that, though it was not for want of trying, ancient doctors' effective knowledge about the human body and about diseases was actually very limited.⁷²⁵ Unlike legal professionals, doctors did not have the benefit of an agreed body of objective knowledge on which to draw – though some medical authors did think of medicine in precisely those terms.⁷²⁶ They did not diagnose in the modern sense of

⁷²² See Mattern 2008:18.

⁷²³ *Gal.Opt.Med.Cogn.2*, *CMG Suppl.Or.IV.41*, tr. Iskandar.

⁷²⁴ See above, pp.222-223.

⁷²⁵ See for example Lloyd 2004:238-9.

⁷²⁶ On jurists, see Crook 1967:25-7; 88), 'who could tell the praetor, the governor, the judge and the advocate what the law was? ... the *iuris prudentes* or *iuris consulti*'. Some early medical writing betrays the idea that medicine is completely discoverable: thus *Hp.Loc.Hom.46*, ιητρικὴ δὴ μοι δοκεῖ ἤδη ἀνευρηθῆναι ὅλη, ἥτις οὕτως ἔχει, ἥτις διδάσκει ἕκαστα καὶ τὰ ἔθεα καὶ τοὺς καιροὺς. ... βέβηκε γὰρ ιητρικὴ πᾶσα ('Medicine in its present state is, it seems to me, by now completely discovered, insofar as it teaches in each instance the particular details and the correct measures. ... For the whole of medicine has been established'. Tr. Potter, Loeb VIII.91-93); *Hp.VM 2*, ιητρικὴ δὲ πάλαι πάντα ὑπάρχει, καὶ ἀρχὴ καὶ ὁδὸς εὐρημένη, καθ' ἣν καὶ τὰ εὐρημένα πολλὰ τε καὶ καλῶς ἔχοντα εὐρηται ἐν πολλῷ χρόνῳ, καὶ τὰ λοιπὰ εὐρεθήσεται, ἣν τις ἰκανός τε ἐὼν καὶ τὰ εὐρημένα εἰδὼς, ἐκ τούτων ὁρμώμενος ζητῇ ('But medicine has long had all its means to hand, and both a principle and a method that has been discovered, through which

identifying a recognised biomedical entity for which a proven therapy could be prescribed. Instead they tried to understand the nature of the patient's illness by interpreting a range of signs and symptoms, so as to forecast its evolution and propose a treatment that would, they hoped, be effective.⁷²⁷ As we have seen, the arguments that divided the different schools of medical thinking were not therapeutic but epistemological.⁷²⁸ And in practice, therapy was often a hit-and-miss affair. *Aporia* among doctors is commonplace in Greek and Roman literature, and, Manfred Horstmanshoff points out, the laconic tag *derelictus a medicis* is a commonplace on funerary inscriptions.⁷²⁹ This is the reality of the circumstances in which doctors struggled to establish credibility for their craft and for themselves. The tensions are evident in the Hippocratic *On the Art*, whose author complains of people whose expectations of medicine are so unrealistic as to be akin to madness:

εἰ γάρ τις ἢ τέχνην ἐς ἃ μὴ τέχνη, ἢ φύσιν ἐς ἃ μὴ φύσις πέφυκεν, ἀξιόσκει δύνασθαι, ἀγνοεῖ ἄγνοϊαν ἀρμόζουσας μανίη μᾶλλον ἢ ἀμαθίη. ... ὅταν οὖν τι πάθῃ ὄνθρωπος κακὸν ὃ κρέσσον ἐστὶ τῶν ἐν ἱητρικῇ ὀργάνων, οὐδὲ προσδοκᾶσθαι τοῦτό που δεῖ ὑπὸ ἱητρικῆς κρατηθῆναι ἄν ... ἃ γὰρ πῦρ οὐ δημιουργεῖ, πῶς οὐ τὰ τοῦτω μὴ ἀλίσκόμενα δηλονότι ἄλλης τέχνης δεῖται, καὶ οὐ ταύτης, ἐν ἣ τὸ πῦρ ὄργανον; οὗτος δέ μοι λόγος καὶ ὑπὲρ τῶν ἄλλων ὅσα τῇ ἱητρικῇ συνεργεῖ, ὧν ἀπάντων φημὶ δεῖν ἐκάστου μὴ κατατυχόντα τὸν ἱητρὸν τὴν δύναμιν αἰτιᾶσθαι τοῦ πάθεος, μὴ τὴν τέχνην.

For if a man demand from an art a power over what does not belong to the art, or from nature a power over what does not belong to nature, his ignorance is more allied to madness than to lack of knowledge. ... Whenever therefore a man suffers from an ill which is too strong for the means at the disposal of medicine, he must surely not even expect that it can be overcome by medicine. ... When fire operates, surely

its many excellent discoveries have been made over a long period of time'. Tr. Jones, Loeb I.15, adapted); cf. Edelstein 1987:90; Jouanna 1999:238.

⁷²⁷ See for example Hp.*Epid.*1.23(10) = II.668-70 L (above, p.196); Gal.*Opt.Med.Cogn.*5.5, *CMG* Suppl.Or.IV.71: 'The complete physician foretells the nature of the disease at its onset, when it will reach the culmination, and the occurrence of its crisis' (tr. Iskandar). On prognosis, see above, pp.224-225.

⁷²⁸ See above, pp.110-112.

⁷²⁹ Horstmanshoff 2004:329, with examples; see also Nutton 1985:47, noting that the tone is often regretful rather than angry. Pliny refers to *illa infelix monumentis inscriptio, turba se medicorum perisse* ('that gloomy inscription on monuments: "It was the crowd of physicians that killed me"'). Plin.*HN*.v.11, tr. Jones, Loeb VIII.189).

affections not overcome thereby show that they need another art, and not that wherein fire is the means. I apply the same argument to the other agents employed in medicine: when any one of them plays the physician false, the blame should be laid on the power of the affection, and not on the art.⁷³⁰

Even Galen, for all his claims to knowledge, was not able to do very much in the face of serious illness. For example, he treats a patient who coughs up putrefied pieces of lung with ‘scents and drinks suitable for the purpose of drying the interior’, but ‘although the patient drank these things for a year he later died like those with consumption (φθίσις)’.⁷³¹ He knew perfectly well that certain cases were hopeless and probably should not be taken on without very careful thought.⁷³² But it was one thing to know this, quite another to admit it.⁷³³ As Plato had said, someone who made a mistake was not a true doctor. A fearsome burden of accountability lay on the doctor:

Provided that no external accident has engendered harm during the time between the physician’s forecast and that which he has fixed (for the crisis), if the patient has either died or not recovered from his illness on the seventh day, or (even) if he has recovered without a crisis, then his physician is accountable for every point in his faulty prognostication and whatever mistakes he may have made in any other forecast.⁷³⁴

There is no room here for admissions of uncertainty or incomplete knowledge. There may have been no legal redress,⁷³⁵ but the court of public opinion was none the less to be feared. The doctor needed to be able to prove his competence at all times.

⁷³⁰ *Hp.de Arte* 8 = VI.12-14 L, tr. Jones, Loeb II.203-205. Cf. above, p.235.

⁷³¹ *Gal.Loc.Aff.* 4.1, VIII.291-92 K. Galen presents himself as learning from the disease in this case, but not from the patient.

⁷³² See Mattern 2008:94, with 236 n.57, citing the following: wasting with hectic fever usually indicates a hopeless case (*MM* 10.10, X.720-21 K); one should not treat certain cancers for fear of hastening death (*Hipp.Aph.* 6.38, XVIII.A.60 K); doctors can avoid blame by predicting death and eschewing heroic remedies (*MM* 12.3, X.825 K).

⁷³³ On Galen’s reluctance to admit defeat, see Mattern 2008:94.

⁷³⁴ *Gal.Opt.Med.Cogn.* 5.13, *CMG Suppl.Or.* IV.75, tr. Iskandar.

⁷³⁵ See above, pp.237-238.

Agonistic display

Galen's advice on choosing the best doctor includes, as we have seen, watching physicians at work. Though this may strike the modern reader as a trifle strange, it will not have seemed so to his ancient audience, who were well aware that doctors had to be prepared to perform in order to convince their prospective clients of their competence and their superiority to others. The inevitable corollary of a system in which patients are obliged to satisfy themselves of the abilities and qualities of physicians is that physicians are obliged continually to advertise and defend those abilities and qualities, and to defend the honour of their profession. In the Imperial period this slotted readily into the competitive, display-orientated culture of the Second Sophistic; but performance and competition had been hallmarks of the professional life of a doctor for centuries: as Jouanna says of the early Hippocratic environment, 'in the practice of his art, the physician was always on stage',⁷³⁶ and this applied both in private situations – crowds of onlookers being a common feature of medical consultations – and in public, for example in front of the city assembly in contest for the position of public physician. Galen's own selection as surgeon to the gladiators when still in his 20s was based, he says, not just on his dedication to learning through constant study, but on his 'practical performance' in a series of anatomical demonstrations carried out at 'a public gathering where men had met to test the knowledge of physicians'. Here Galen challenged 'the Elders of the physicians to provide treatment, but they had nothing to offer. We then provided treatment, making it clear to the intellectuals who were present that (physicians) who possess skills like mine should be in charge of the wounded'; their trust was subsequently repaid, he says, by his high success rate and minimal quantity of deaths.⁷³⁷

⁷³⁶ Jouanna 1999:76; also 75-111, Chapter 5, 'The Physician and the Public'.

⁷³⁷ *Gal.Opt.Med.Cogn.*9.6-7, *CMG Suppl.Or.*IV.105, tr. Iskandar. See Barton 2002:148.

Rivalry and contest are leitmotifs of Galen's account of himself; he seems always to need to 'find opponents against whom to define himself', as Barton puts it.⁷³⁸ Competition at the bedside is a common ingredient in his case studies, which often feature the theories of rival doctors being dramatically discredited in front of the patient and an admiring crowd of friends and family,⁷³⁹ and Pliny talks of 'those wretched battles of opinion at patients' bedsides, no one agreeing with anyone else, lest he should appear to be someone else's appendage'.⁷⁴⁰ In public, the competitive display of elite knowledge is a well known feature of this period,⁷⁴¹ and Galen's account of his career has a strongly agonistic and performative theme, embracing medical contests, demonstrations, lectures and debates, in front of audiences who heckle and hurl questions from the floor.⁷⁴² For example, he gives daily public displays of his ability when he is first in Rome;⁷⁴³ he complains that his opponents used to go 'every day ... to the Temple of Peace – which ... was the general meeting-place for all those engaged in learned pursuits – and mock me continually';⁷⁴⁴ and he performs in front of an audience of 'all the intellectuals living in Rome', including three high-ranking senators and 'all others distinguished in both medicine and philosophy'.⁷⁴⁵ Whether in formal contest, at public lectures, in private gatherings or at the bedside in front of a retinue of friends, relatives and rival doctors, he

⁷³⁸ Barton 2002:147-8.

⁷³⁹ *Gal.Praecogn. (passim)*; Mattern 2008, many cases; Mattern 2013:239-242, pointing out that Galen 'makes no clear distinction' between bedside contests and public ones.

⁷⁴⁰ *Plin.HN* 29.v.11: *illae circa aegros miserae sententiarum concertationes, nullo idem censente, ne videatur accessio alterius*.

⁷⁴¹ On elite displays, see Swain 2008:116. The participation of doctors in this competitive culture 'derives from the Hellenistic custom of doctors giving public lectures and demonstrations in the gymnasium for the benefit of the citizens among whom they resided': Nutton 1979:187.

⁷⁴² On the influence of the Second Sophistic as reflected in *Gal.Opt.Med.Cogn*, see Iskandar 1988:141.

⁷⁴³ *Gal.Ven.Sect.Er.*, XI.194,6-7 K, and, for the date, *id.*187,1 (cf. Nutton 1979:187); cf. *Lib.Prop.*1, *SM* II.95,14 and 96,5 = XIX.14,5 and 15,3 K. See Barton 2002:147-9, and Mattern 2008:9-11.

⁷⁴⁴ οὐδὲ τοῦ σκώπτειν ἀπείχοντο καθ' ἐκάστην ἡμέραν εἰς τὸ τῆς Εἰρήνης τέμενος ἀφικνούμενοι, καθ' ὃ τι καὶ πρὸ τοῦ καυθῆναι πᾶσιν ἦν ἔθος ἀθροίζεσθαι τοῖς τὰς λογικὰς τέχνας μεταχειριζομένοις. *Gal.Lib.Prop.*2, *SM* II.101,10-14 = XIX.21,13-16 K, tr. Singer 1997:9.

⁷⁴⁵ *Praen.*5, *CMG* V.8.1.98 = XIV.629 K, tr. Nutton 1979:99.

presents himself as constantly defending his territory, debating with laymen as well as with physicians, on non-medical as well as medical topics.⁷⁴⁶ Lacking as they did the ‘magic wand’, as Edelstein has put it,⁷⁴⁷ of modern university degrees, membership of Royal Colleges, the scrutiny of the General Medical Council and so forth, Galen and his fellow physicians could not afford to let up on the task of continual self-promotion.

These days we are not obliged to carry out for ourselves the exhaustive, and exhausting, sort of enquiry recommended by Galen in *On Recognising the Best Doctor*. Though charlatans and quacks have not disappeared, and though no amount of regulation will prevent the occasional episode of malpractice, we are well protected. We live in a society in which medicine is a high status profession that can be entered only after many years of university education and practical training. In the UK we have the General Medical Council, an array of Royal Colleges, the Commission on Human Medicines and its regulator the Medicines and Healthcare Products Regulatory Agency, the Care Quality Commission and various other professional and government agencies to assure us that doctors are properly trained, that they are keeping up to date with new developments, and that they use safe and effective treatments in clean, controlled clinical environments. Yet still ‘non-compliance’ is a major issue in clinical practice. No matter how hard Galen and those who pursued similar methods tried to assert the status of their profession and the depth of their knowledge in pursuit of the chimera of compliance, they were, it seems, barking up the wrong tree.

⁷⁴⁶ Mattern 2008:9.

⁷⁴⁷ Edelstein 1987:386.

6.3. Understanding non-compliance

In their struggle to secure compliance Galen and his predecessors are no different from many other doctors through the ages, including those of our own era: according to a 2003 World Health Organization (WHO) report, 50% of people with chronic conditions in developed countries do not take medications as prescribed, while in some less developed countries figures as low as 26% have been reported.⁷⁴⁸ The reasons why people do not comply are explored extensively in this report, which argues strongly that simply blaming the patient is ill-directed and ultimately futile: ‘non-adherence is a behavioural problem observed in patients but with causes beyond the patient’.⁷⁴⁹ Successful interventions, it argues, are directed not at correcting fault in patients but at a range of social, economic, political and interpersonal factors; some of these are exclusively modern (e.g. medication distribution systems, health insurance payment failings), but others have universal applicability – poverty, for example, poor educational standards, lack of effective social support networks, age and gender of the patient and so on. These latter are theoretically capable of generating insights into the problem in antiquity, even though their usefulness is ultimately limited thanks to the generalised nature of the ancient non-compliance reports.⁷⁵⁰

One set of findings that we can perhaps apply to the issue of ancient non-compliance is that concerning the interaction between doctor and patient.⁷⁵¹ Caution about the risk of anachronism is of course in order, but the factors highlighted by WHO – time spent with the doctor, continuity of care, and the doctor’s interpersonal and communication style –

⁷⁴⁸ WHO 2003:7.

⁷⁴⁹ WHO 2003:145.

⁷⁵⁰ Any of them may have affected the ‘obedience’ of the patients whose behaviour is castigated, but we lack the detailed knowledge of individual cases that would allow us to make an informed judgement.

⁷⁵¹ WHO 2003:28.

are intrinsically independent of time or culture: we may not know how many of the disobedient patients of whom ancient doctors complain were old, for example, or female, or socially isolated, or financially embarrassed, but what they all have in common is the experience of interacting with a doctor, and, because the ancient evidence includes a good quantity of case histories as well as a number of different reflections on how to conduct a consultation, we are able to get some purchase on how that relationship was conceived by doctors. The WHO report underlines the importance of these factors, emphasising that ‘variables related to how health care providers interact and communicate with their patients are key determinants of adherence’.⁷⁵² Patients who ‘view themselves as partners in the treatment process’ are more likely than others to adhere to recommended treatment, and enjoy better outcomes;⁷⁵³ conversely, a sense of disempowerment in treatment decisions was correlated with negativity towards and lower adherence to prescribed therapy.⁷⁵⁴ Practitioners who share information and build partnerships achieve better results than those who do not,⁷⁵⁵ and those who do not take the time to establish the patient’s readiness to follow a treatment run the risk of prescribing treatments for which patients are not ready.⁷⁵⁶ In a separate study, Goold and Lipkin emphasise the importance of the latter: ‘actual time spent together is less critical than the perception by patients that

⁷⁵² WHO 2003:137 (a ‘provider’ in the WHO report means a ‘physician, nurse or other health practitioner’: 2000:3). Cf. Goold and Lipkin 1999:S26: the relationship between doctor and patient, particularly as articulated through the ‘medical interview’, ‘is the major determinant of compliance’; Dye and DiMatteo 1995:135; Platt and McMath 1979 on how ‘high control style’, one of five ‘defective interview syndromes’ they identified, prevents patients communicating their concerns and undermines the likelihood of adherence to treatment.

⁷⁵³ WHO 2003:137.

⁷⁵⁴ WHO 2003:20: those who feel ‘less empowered in relation to treatment decisions’ were found to be more negative towards prescribed therapy and less adherent. Cf. Abel and Browner 1998:310 on the tendency of African American, American Indian and European immigrant women in the United States in the first part of the 20th century to resist ‘the messages of biomedical advice givers’ and to express ‘contempt for knowledge derived from formal education rather than personal experience’.

⁷⁵⁵ WHO 2003:137.

⁷⁵⁶ WHO 2003:34.

they are the focus of the time and that they are accurately heard'.⁷⁵⁷ At the level of the individual patient, no particular sociodemographic attributes have been definitely associated with adherence, nor has any stable set of personality traits been identified; rather, adherence is associated with severity of symptoms and with the treatment's ability to 'effect a rapid and noticeable reduction in symptoms'.⁷⁵⁸ Motivation, which is what drives sustainable adherence,⁷⁵⁹ is 'influenced by the value that [the patient] places on following the regimen ... and the degree of confidence in being able to follow it'.⁷⁶⁰ 'Practitioners often assume', the report concluded, 'that the patient is, or should be, motivated by his or her illness to follow health recommendations. However, recent research in the behavioural sciences reveals this assumption to be erroneous'.⁷⁶¹

These findings provide an interesting framework within which to think about ancient doctors' complaints about disobedience. There are, of course, factors peculiar to pre-modern medicine that strongly discouraged compliance, such as the painful and fruitless, not to say positively harmful, practice of bloodletting,⁷⁶² and the absence of anaesthesia or effective analgesics, which presumably played a part in patients' reluctance to undergo certain treatments.⁷⁶³ But the desire to avoid discomfort cannot account for every instance of ancient 'disobedience'; indeed Aristides' desire to plunge into icy water in the middle of winter in defiance of medical opinion suggests quite the opposite.⁷⁶⁴ His doctors were

⁷⁵⁷ Goold and Lipkin 1999:S26-27. Cf. also Croker et al. 2013: a survey assessing patients' trust in general practitioners in the UK (1.5 million respondents, adjusted response rate 42%) found that 'the sense of "being taken seriously" had the strongest association with confidence and trust'.

⁷⁵⁸ WHO 2003:138-39.

⁷⁵⁹ WHO 2003:35.

⁷⁶⁰ WHO 2003:30.

⁷⁶¹ WHO 2003:145, cf. 34; cf. Katz 2002:88, quoting Parsons 1951:463: 'the physician is a technically competent person whose competence and specific judgments and measures cannot be competently judged by the layman. The latter must [take doctors'] judgments and measures on "authority".'

⁷⁶² On the distressing nature of bloodletting in Galenic medicine, see Mattern 2013:235-6.

⁷⁶³ As Socrates assumes in *Gorgias* (see p.219 above).

⁷⁶⁴ See below, p.266-267.

horrified by the suggestion, but, claiming Asclepius's authority, he persisted, and he clearly found the experience enormously valuable. In the next chapter it will be argued that Aristides, aware of the inefficacy of medicine but surrounded by a growing rhetoric of medical authority and control, used his dreams of divine instruction as a way of following his autonomous instincts about his sick body within the safety net of guidance from a trustworthy authority figure whom it was personally and culturally acceptable to obey. Modern research such as that contained in the WHO report offers us the insight that many instances of 'disobedience' to doctors' orders may be manifestations of the same kind of tension between patient autonomy and an attempted medical authority, and the cross-cultural nature of the findings quoted in this chapter suggests that it may be a factor that holds good across different social and cultural systems.

6.4. Conclusion

In this chapter I have linked the fragility of ancient doctors' authority to the circumstances in which they worked, arguing that these were such as to inspire defensiveness rather than candour about the limits of medical knowledge. The presence of such attitudes and anxieties among his fellow physicians doubtless helps to explain why Rufus felt the need to emphasise his point so strongly. But telling a profession that its knowledge is limited is unlikely to be well received, even if the person who delivers the message is himself a member of that profession. Galen does something much more ordinary – albeit with extraordinary vigour – in devoting his energies to building the image of his profession as an expert discipline based on an esoteric and exclusive knowledge set. His insistence on logical method as the only sure route to diagnosis, which was discussed in Chapter 5, changed the terms of the relationship between physician and patient. As noted above,

Luis Garcia Ballester accuses him of having ‘laid the foundations for a pernicious withdrawal from reality’:

Medical practice came to be an irritating necessity for the doctor obliged by circumstance to be a clinician, but who, if he wished to maintain his status as scientist, had to construct and elaborate a body of knowledge, whose only guarantee lay in the correct application of certain logical rules which reduced complex reality to a rigorous scientific tree of genera and species. The patient’s role, reduced to that of ‘example’ of a knowledge unfettered by reality, came to be something secondary.⁷⁶⁵

The research quoted in this chapter suggests that Galen, like others of his ilk, could have saved himself many of the power struggles of which he complains so bitterly. Listening to patients in order to learn what they believe, what they fear and what they value, rather than attempting to cow them into obedience, may be the best way of establishing the elusive authority that doctors have striven for since antiquity. In the next chapter we look at how one ancient patient’s descriptions of his experience bear this out.

⁷⁶⁵ Ballester 1979:23. See above, p.209.

Chapter 7 – ‘To do in silence whatever he wishes’: Aelius

Aristides and the patient’s experience

In Part III, I suggested that *QM* sets itself up in opposition to physicians, both contemporary and past, who fail to appreciate the importance or even the true nature of questioning the patient, and that in the process Rufus displays considerable psychological insight. Chapter 6 discussed ancient doctors’ complaints about disobedient patients in the light of circumstances that seem likely to have inspired a tendency to professional defensiveness, and interpreted Galen’s explicitly hierarchical model as in part a misguided attempt to secure obedience by claiming control over the patient’s body on the basis of the superior nature of medical knowledge. It must be acknowledged that the evidence is very one-sided; we have little in the way of direct patient testimony, and most of what we know about patients is recounted from the observer perspective. Seen through the Galenic lens, patients are something of a contradictory force: on the one hand invariably impressed by his medical skills, yet on the other hand all too rarely inclined to follow his advice. We have seen how modern research helps to explain this apparent contradiction, on the basis that proven competence is not a key determinant of compliance and that what actually encourages patients to ‘comply’ is believing that they have been listened to and that the recommended treatment reflects their concerns. One eloquent and very informative patient whose voice we do have is Aelius Aristides, and in this final chapter I want to use that research insight as an aid to interpreting what he tells us about his experiences of sickness and healing. Aristides offers us a rare opportunity to consider the tussle between medical authority and patient autonomy from a different angle: he too is engaged in a power struggle with his doctors, but in his stories the power in the

relationship rests with him. Reading Aristides' dream reports as reflections of the doubts and internal conflict he experiences about the control of his sick body, I argue that, as a chronically sick person living in a world where doctors claim authority over patients' bodies but are largely powerless in the face of real illness, he uses divine message dreams as a medium through which to project his own instincts about his body onto a trustworthy authority figure whom it is personally and culturally acceptable to obey. In this way he ensures that his concerns are listened to, and is able to reject dubious medical advice without causing doctors to lose face.

7.1. Aristides

Aelius Aristides is extraordinarily interesting in the study of ancient medicine. Not only is he our sole patient narrator of any detail,⁷⁶⁶ but because his illnesses were chronic he is able to provide insight into the experience of living with long-term sickness over a period of many years, in contrast to the researches and case studies of medical literature, which tend to focus on acute situations and are written from the doctor's perspective. Born just north of Pergamum, into a wealthy influential family, Aristides lived through much of the second century, from 118-180, meaning that he was a close contemporary of Galen's. After a traditional elite education, he embarked on a career as an orator, a life that involved delivering speeches in performance before large crowds and teaching oratory to other members of the elite – a life, that is, of high visibility, bringing with it the promise of elevated status and generous fees; ancient authors such as Lucian and Philostratus tell of the money, fame and influence that could accrue to sophists like Aristides, who, according to Mattern, were 'among the empire's most famous and

⁷⁶⁶ See above, Chapter 2.4.

influential men ..., and ... competed with one another ferociously for prestige and students'.⁷⁶⁷ Aristides fell sick in his mid-20s, on a visit to Egypt in 142, and was plagued by ill health for the rest of his life. His symptoms included chronic respiratory problems, intestinal disorders and persistent pain, all of which will have seriously undermined his ability to follow his chosen career; he points, for example, that the ability to travel depended on being in good health, and ⁷⁶⁸ The financial implications may or may not have been significant to Aristides – he boasts of not having had to accept fees for his oratory, and Behr believes him, though Philostratus suggests otherwise⁷⁶⁹ – but the emotional impact of being unable to engage in the life for which he had been prepared, with all the status and self-image that it conferred on men of his class, must have been considerable. He first turned to a healing cult, that of Sarapis,⁷⁷⁰ in Egypt in 142. In 144 he went to Pergamum where he had his first revelation from Asclepius. This began a protracted and intensely personal relationship with the god, which he documented at length, along with very detailed accounts of his illnesses, in the *Hieroi Logoi*, six orations out of an extant corpus of at least 44.⁷⁷¹

⁷⁶⁷ Mattern 2008:7. See also Bowersock 1969, especially Chapter III, and Behr 1968:7-8 with n.12. Income: Philostr. VS.1.23, Ol.526-7, on Lollianus of Ephesus, a 'seller of words' (λογοπώλης) who 'used to charge handsome fees' (μισθοὺς δὲ γενναίους ἐπράττετο) and, having raised a large sum to pay for a cargo of bread, was able to repay it by remitting his own fees; cf. 2.23. Ol.606, on Damianus's readiness to remit his fees if people clearly could not afford to spend too much; cf. Luc. *Apol.*15, *Par.*52, *Rh.Pr.*2, 6, 9. Reputation and influence: Luc. *Rh.Pr.*2.

⁷⁶⁸ ἐξῆν, εἴ τις ἔρρωτο, ἐπελθεῖν τὰς πόλεις. Aristid. *Or.*51.56. Petsalis-Diomidis, citing this and six other references from different Orations, argues that restrictions on Aristides' ability to travel will have driven down his income-generating capacity (2010:116). In Philostratus' account, however, Aristides travelled infrequently because he was not a crowd-pleaser and found it difficult to control his temper when people did not applaud (VS 2.9, Ol.582).

⁷⁶⁹ According to Philostratus, the magnificently wealthy Damianus of Ephesus attended the lectures of Aristides and another orator called Hadrianus 'and paid them fees of ten thousand drachmae, declaring that he found it more agreeable to spend money on favourites of that sort than on handsome boys and girls, as some prefer to do' (ἡκροάσατο ἀμφοῖν ἐπὶ μυρίασι εἰπὼν πολλῷ ἥδιον ἐς τοιαῦτα δαπανᾶν παιδικὰ ἢ ἐς καλοὺς τε καὶ καλὰς, ὥσπερ ἔνιοι. Philostr. VS 2.23, Ol.605, tr. WrightJ 1921:267). Behr, discussing Aristides' disregard for fees, calls this 'improbable contradictory evidence' (1968:8 n.12, cf. 142).

⁷⁷⁰ Sarapis was popular in Smyrna, where shortly afterwards Aristides delivered the oration *To Sarapis*: Behr 1968:21; Israelowich 2012:107-8.

⁷⁷¹ Bowie, 'Aristides [3]', in *Brill's New Pauly* Vol.1:1097.

Aristides has tended to be regarded in modern scholarship as an egregious hypochondriac, but he was not so judged by his contemporaries or in later antiquity. Various 20th century scholars accused him of having, at the very least, exaggerated his complaints under the influence of what Bowersock called ‘hypochondria ... of an advanced kind’ stemming from ‘possibly the most disquieting aspect of Antonine society’, the degeneration of robust manliness into ‘an inordinate obsession with bodily ailments’ as evidenced by an unhealthy interest in attending Galen’s lectures.⁷⁷² But unless Aristides was an uncannily clever fantasist with unusual insight into what it is like to live with long-term illness, he clearly had continuing health problems, and much of how he responded to this grim reality in his life is extraordinarily consonant with how people living with chronic illness are encouraged to manage their conditions today, through techniques such as telling stories, keeping diaries, learning to see their illnesses in terms of journeys, listening to their bodies, visualisation, and making discriminating therapeutic choices.⁷⁷³ The accusation of hypochondria seems wide of the mark, then, and reflective of the *mores* of the times in which it was fashionable. Our own era is of course equally prone to the influence of its own interests and preoccupations, and today’s increased tolerance of personal confessional literature, greater familiarity with chronic illness and more sophisticated understanding of the place of narrative in managing its distressing effects leave much less room for doubt that Aristides was genuinely ill. Galen, who claimed to

⁷⁷² Bowersock 1969:71-3, citing also the correspondence of Marcus Aurelius and Fronto as well as an Oxyrhynchus letter. See also Behr 1968:45 and 115; Harris and Holmes 2008:ix; Bonner 1937:126; Dodds 1951:116. For a sympathetic interpretation, see King 1998:126-31. The downturn in Aristides’ fortunes may have stemmed from Christian antipathy towards his religious beliefs; Petsalis-Diomidis cites ‘scornful scholia of Aretha, archbishop of Caesaria’ from the 10th century (2010:2). Downie ascribes it to a romantic distaste for the embarrassingly egotistical nature of the content of the *Hieroi Logoi* (2013:23).

⁷⁷³ The unforgiving critics of earlier academia who visited their own post-Victorian attitudes on Aristides’ testament of suffering might very well have found these techniques equally unappealing.

have met him personally and certainly knew of him,⁷⁷⁴ never questioned that he was; while Philostratus mentions his poor health as a matter of fact, with no hint of disapproval.⁷⁷⁵

7.2. Aristides' dream reports

The subject matter of the *Hieroi Logoi* is rooted in two major 2nd century cultural enthusiasms: temple medicine – discussed in Chapter 6 – and a fascination with dreams.

According to Juliette Harrison:

During the early Imperial period and especially during the second century AD, we see more dream reports appearing in historical literature, increasing numbers of dedicatory inscriptions apparently set up in obedience to commands received in dreams, the continuing popularity of literary works referring to dreams and dream divination and, of course, the works of Artemidorus [*Oneirocritica*] and Aelius Aristides.⁷⁷⁶

Sextus Empiricus, writing in the second half of the second century, put it thus:

εἰ μὴ εἰσὶ θεοί, οὐδὲ μαντικὴ ὑπάρχει, ἐπιστήμη οὕσα θεωρητικὴ καὶ ἐξηγητικὴ τῶν ὑπὸ θεῶν ἀνθρώποις διδομένων σημείων, οὐδὲ μὴν θεοληπτικὴ καὶ ἀστρομαντικὴ, οὐ θυτική, οὐχ ἡ δι' ὀνείρων πρόρρησις. ἄτοπον δὲ γε τοσοῦτο πλῆθος πραγμάτων ἀναιρεῖν πεπιστευμένων ἤδη παρὰ πᾶσιν ἀνθρώποις. εἰσὶν ἄρα θεοί.

⁷⁷⁴ Bowersock believed that they did meet, on the evidence of an Arabic translation of a passage of Galen (1969:60-62). Galen's claims to autopsy are at least questionable, as the story of the Atlas patient makes clear (see above, p.55 n.87); and in this instance some corruption in translation between the ideas 'see' and 'know [of]' must be possible. Nevertheless Behr's dismissal of Galen's claim as 'worth little' on the grounds that 'there is no evidence that he knew Aristides personally' (1968:162) is perhaps too confident. Circumstantial evidence suggests that they could conceivably have met: Galen was learning medicine while Aristides was at the Pergamene Asclepieion, and his teacher Satyrus was one of Aristides' doctors; both were also acquaintances of Rufinus (cos. 142), the builder of the great Asclepieion. See also Israelowich 2012:63-4.

⁷⁷⁵ Philostr. VS.2.9, Ol.581. Philostratus says nothing about Aristides' devotion to Asclepius, though he mentions incubation stays and other forms of supplication for divine healing by other sophists whose biographies he wrote (Downie 2013:18-19).

⁷⁷⁶ Harrison 2015:8; cf. Harris 2009:227 ('a marked change of attitude' towards dreams from approximately AD 100). Dodds's explanation of this surge of enthusiasm in the supernatural as the product of an 'age of anxiety' (Dodds 1965) is today widely challenged, for example by Harrison (2015:232-3 and 14) and Harris (2009:227-8), the latter warning that 'the Roman Empire is always too plural and 'too variegated a place to permit explanations of cultural changes as amorphous as the ones we have been examining'.

If gods exist not, neither does prophecy exist, it being ‘the science which observes and interprets the signs given by gods to men’; nor yet inspiration and astrology, nor divination, nor prediction by means of dreams. But it is absurd to abolish such a multitude of things which are already believed in by all men. Therefore, gods exist.⁷⁷⁷

Against this cultural backdrop, and in light of the general appetite for public performance and rhetorical display that further characterises the period, Aristides’ dream accounts should, I suggest, be read as conscious acts of self-presentation rather than channels into his unconscious: not as accurate reports of unconscious experiences, in other words, but as a literary representation of an asserted reality that speaks to contemporary cultural expectations and preoccupations.⁷⁷⁸ Aristides is an orator in an age of display, presenting his dreams to a society in which dreams are invested with special significance. As instruments of self-fashioning, the dream accounts work on several levels. They provide the author with material for fine-tuning his rhetoric.⁷⁷⁹ They showcase his literary skill, with their clever, realistic writing that skilfully conveys the illogicality and spatial and temporal dislocation of dreams.⁷⁸⁰ They illustrate his moral worth by advertising his intimacy with the god,⁷⁸¹ and they package that relationship in accessible form for the

⁷⁷⁷ S.E.M.9 (= *Adv.Phys.*1).132, tr. Bury, Loeb III.71. The codices all have λογική; Bury follows Fabricius in preferring θυτική. Mutschmann (Teubner, 1914) retained λογική, as does Bett (*ad loc.* 2012:29 n.94) though he suspects textual error, commenting, ‘one would expect something more specifically concerned with cultivation of the gods, like all the surrounding topics’.

⁷⁷⁸ On the impossibility of finding out what was ‘really’ dreamt, and the temptation to fakery when describing them to an audience that believes they reveal hidden truths, see Harris (2009:5); Perkins makes a similar point, and observes: ‘Aristides’ hermeneutic reveals more of his thought than his dreams can’ (1995:178). See also Harris 2009:8 on 1970s and 80s Freudians’ admission that ‘they were interested in the manifest content of dreams for its own sake and not simply as a means of gaining access to their supposed latent content’.

⁷⁷⁹ As Philostratus comments, τὰ δὲ βιβλία ταῦτα ἐφημερίδων ἐπέχει τινὰ αὐτῷ λόγον, αἱ δὲ ἐφημερίδες ἀγαθαὶ διδασκαλοὶ τοῦ περὶ παντὸς εὖ διαλέγεσθαι (‘These discourses [the *Hieroi Logoi*] served him in some sort as a diary, and such diaries are excellent teachers of the art of speaking well on any subject’. Philostr.VS.1.9, Ol.581, tr. Wright 1921:215).

⁷⁸⁰ See Or.47.17 and 48.18 for two good examples; cf. Harris 2009:121. Downie talks of ‘shifting identities and locations, and temporal disjuncture’ (2013:68, part of a wider discussion on pp.66-71).

⁷⁸¹ See Philostr.VA.1.12 for the observation that τοὺς ... σπουδαίους οἱ θεοὶ καὶ ἄνευ τῶν προξενούντων ἀσπάζονται (‘the gods welcome virtuous men without any go-betweens’, tr. Jones, Loeb I.54-5). Harris (2009:65) reckons that about 10% of the 160-odd dreams that Aristides describes can be considered ‘epiphanic’ (i.e. featuring a message from an authority figure) involving Asclepius; of the rest, 50 contain orders from Asclepius without featuring the god in person, and others include anonymous orders which Aristides almost certainly considered divine. (There are also occasional accounts of other people’s

edification of his public. They also, I suggest, provide a public platform on which to inhabit his illness and negotiate the private space in which his own instincts and medical advice collide and compete.

Aristides' contact with Asclepius is characterised by what Alexia Petsalis-Diomidis has called 'a complex relationship of dependence and control',⁷⁸² and this is evident from the very beginning of the *Hieroi Logoi* when he announces his decision to place his trust in the god: ἐγνώκειν παρέχειν ὡς ἀληθῶς ὥσπερ ἰατρῷ τῷ θεῷ σιγῇ ποιεῖν ὅ τι βούλεται.⁷⁸³ The formula with which he characterises this crucial relationship, παρέχειν τῷ ἰατρῷ, is used by Plato in *Gorgias* to evoke dialectic participation, when Socrates urges Polus: γενναίως τῷ λόγῳ ὥσπερ ἰατρῷ παρέχων ἀποκρίνῃ, καὶ ἢ φάθῃ ἢ μὴ ἂ ἐρωτῷ ('be a man, give yourself up to the argument as if to a doctor and reply yes or no to my question').⁷⁸⁴ Aristides' articulation of his decision to put his medical care in divine hands, couched in unmistakably similar yet crucially altered terms, thus contains a striking intertextual echo, so that an image employed by Socrates to convey outspoken engagement in discussion transmutes into a metaphor for silent obedience.⁷⁸⁵ Thus Aristides frames in terms of submission what is actually a decision to assume control: unquestioning obedience voluntarily undertaken as an act of self-determination.

epiphany dreams, e.g. *Or.*48.9) On the difference between 'epiphanic' and 'episodic' dreams, see Harris 2009:23, with n.1; cf. Downie 2013:57. Most ancient epiphany dreams feature Asclepius (Harris 2009:31). Behr puts the total number of dreams lower, at 130 (1968:171); on the difficulties inherent in trying to quantify and classify Aristides' dreams, see Harris 2009:41 and 65, and Harrisson 2015:67-68.

⁷⁸² Petsalis-Diomidis 2010:135.

⁷⁸³ 'I decided to submit to the god, truly as if to a doctor, to do in silence whatever he wishes.' *Or.*47. 4, 377.8-9 Keil.

⁷⁸⁴ *Pl.Grg.*475d.

⁷⁸⁵ For the sense of παρέχειν, see also *Pl.Protag.*348a, where Socrates, describing the sort of discussion that takes place between 'men of culture, who prefer to converse directly with each other and to use their own way of speech in putting one another by turns to the test', concludes κἂν μὲν βούλῃ ἔτι ἐρωτᾶν, ἔτοιμός εἰμι σοὶ παρέχειν ἀποκρινόμενος ('so if you want to ask me further questions, I am ready to put myself at your service and reply').

Interestingly, Xenophon uses the same vocabulary to depict devoted care of the physical self: τοῖς ἰατροῖς παρέχουσι μετὰ πόνων τε καὶ αλγηδόνων καὶ αποτέμνειν καὶ αποκαίειν καὶ τούτου χάριν οἶονται δεῖν αὐτοῖς καὶ μισθὸν τίνειν⁷⁸⁶ – an image in which the patient is fully in control of his own healthcare and the doctor the paid provider of an elective service.

Submission to the god is not, then, an act of self-effacement for Aristides, but a distinctly ambiguous state; and in this state he is able to use the god's authority as a way of exercising control over his doctors, who feature frequently in the narrative. One repeated motif involves Aristides receiving counter-intuitive instructions which he persists in obeying against all medical advice. A particularly striking example is given here in full:

ὁ μὲν γὰρ θεὸς προὔλεγεν ἐκ πολλοῦ δεῖν ὕδρον φυλάττεσθαι, καὶ ἄλλα τε ἔδωκεν ἀλεξιφάρμακα καὶ ὑποδήματα Αἰγύπτια, οἷσπερ οἱ ἱερεῖς χρῆσθαι νομίζουσι. καὶ δὴ καὶ ἔδοξεν αὐτῷ τὸ ρεύμα ἀπάγειν κάτω. (62) καὶ γίγνεται φῦμα ἀπ' ἀρχῆς οὐδεμιᾶς φανεραῖς τὸ μὲν πρῶτον οἶον ἂν τῷ καὶ ἄλλῳ γένοιτο, ἔπειτα προῆλθεν εἰς ὄγκον ἐξαίσιον, καὶ ὃ τε βουβῶν μεστὸς ἦν καὶ πάντα ἐξώδει, καὶ ὁδύναι παρηκολούθουν δειναὶ καὶ πυρετὸς ἔστιν ἅς ἡμέρας. ἐνταῦθα οἱ μὲν ἱατροὶ πάσας φωνὰς ἠφίεσαν, οἱ μὲν τέμνειν, οἱ δὲ ἐπικάειν φαρμάκοις, ἢ πάντως δεῖν ὑπόπυον γενόμενον διαφθαρῆναι. (63) ὁ δὲ θεὸς τὴν ἐναντίαν ἐτίθετο, ἀντέχειν καὶ τρέφειν τὸν ὄγκον· καὶ δηλαδὴ οὐχ αἵρεσις ἦν ἢ τῶν ἱατρῶν ἀκούειν, ἢ τοῦ θεοῦ. ὁ δὲ ὄγκος ἔτι ἐπὶ μᾶλλον ἤρετο καὶ ἦν ἀπορία πολλή. τῶν δὲ φίλων οἱ μὲν ἐθαύμαζον τὴν καρτερίαν, οἱ δὲ ἐνεκάλουν ὥς λίαν ἅπαντα ἐπὶ τοῖς ὀνείρασι ποιουμένῳ, τινὲς δὲ καὶ ὥς ἄτολμον ἐπητιῶντο, ἐπειδὴ οὐ παρεῖχον τέμνειν οὐδ' αὖ φαρμάκων ἠνειχόμεν. ὁ δ' αὖ θεὸς διὰ τέλους ἀντεῖχε, κελεύων φέρειν τὸ παρόν, πάντως γὰρ αὐτὸ ὑπὲρ σωτηρίας εἶναι· εἶναι γὰρ τοῦ ρεύματος τούτου τὰς πηγὰς ἄνω, τοὺς δὲ κηπουροὺς τούτους οὐκ εἰδέναι τοὺς ὀχετοὺς ἢ χρὴ τρέπειν. συνέβαινεν δὲ θαυμαστά. ... (66) τέλος δὲ ὁ Σωτὴρ σημαίνει τῆς αὐτῆς νυκτὸς ταυτὸν ἐμοί τε καὶ τῷ τροφεῖ – περιῆν γὰρ δὴ τότε ὁ Ζώσιμος – ὥστε ἐγὼ μὲν ἔπεμπον ἐκείνῳ φράσεων ἃ εἰρηκῶς εἶη ὁ θεός, ὁ δ' ἀπῆντα φράσεων αὐτός μοι ἃ ἠκηκόει τοῦ θεοῦ. ἦν δὲ τι φάρμακον οὐ τὰ μὲν καθ' ἕκαστα οὐ μέμνημαι, ἀλὼν δὲ ὅτι μετεῖχεν· ὥς δὲ ἐπεπάσαμεν, ἔρρει δὴ ταχὺ τοῦ ὄγκου τὸ πλεῖστον, καὶ ἅμα ἔφω παρῆσαν οἱ ἐπιτήδαιοι χαίροντες μετὰ ἀπιστίας. (67) ἐντεῦθεν δὲ ἤδη τῶν μὲν ἐγκλημάτων ἐπαύσαντο ἱατροὶ καὶ ἐθαύμαζον ὑπερφυῶς ἐφ' ἑκάστῳ τοῦ θεοῦ τὴν πρόνοιαν, καὶ ὥς

⁷⁸⁶ X.Mem.1.2.54. See above, p.221.

ἕτερόν τι ἄρα ἦν μεῖζον, ὃ λάθρα ἰᾶτο, τὸ δὲ τοῦ κόλπου τίνα ἂν τρόπον κατασταίῃ διεσκοποῦντο· καὶ ἐδόκει αὐτοῖς νῦν γε δὴ πάντως δεῖν τομῆς, οὐ γὰρ εἶναι ἄλλως εἰς τὸ ἀρχαῖον καταστῆναι. κάμει τοῦτό γε ἡξίουσιν συγχωρῆσαι, πάντως δὲ ἥδη πεπρᾶχθαι τά γε τοῦ θεοῦ. (68) ὁ δ' ἄρα οὐδὲ τοῦτο ἐκείνοις παρήκεν, ἀλλ' οὔσης τῆς ἀποστάσεως θαυμαστῆς ὄσης καὶ δοκοῦντος ἅπαντος ἀπηλλοτριῶσθαι τοῦ δέρματος, ὥδ' κελεύσας ἐπιχρίειν οὕτως ἰάσατο καὶ συνήγαγεν πάντα εἰς ταὐτόν, ὥστε ὀλίγων ἡμερῶν παρελθουσῶν οὐδεις οἶός τ' ἦν εὐρεῖν ἐν ὁποτέρῳ μηρῷ τὸ φῦμα ἐκεῖνο ἐγένετο, ἀλλ' ἦσθην ἀμφοτέρῳ καθαρῶ τοῖς ἅπασιν.⁷⁸⁷

For the god predicted for a long time that I should beware of dropsy, and he gave me various drugs and Egyptian slippers, which the priests are accustomed to use. And he decided to divert the flux downwards. And a tumour grew from no apparent cause, at first as you might see in anyone else, but then it increased to an extraordinary size, and my groin was distended, and everything was swollen, and terrible pains ensued, and a fever for some days. At this point, the doctors cried out all sorts of things, some said surgery, some said cauterisation by drug, or that an infection would arise and I must surely die. But the God gave a contrary opinion, telling me to endure and foster the growth. And there was obviously no choice between listening to the doctors or to the God. But the growth increased even more, and there was much dismay. Some of my friends marvelled at my endurance, others criticised me for acting too much on account of dreams, and some even accused me of cowardice for neither permitting surgery nor allowing any cauterising drugs. But the God held quite firm, and ordered me to bear the present circumstances, He said that this was wholly for my safety, for this flux was streaming upwards, and these gardeners did not know where they ought to turn their channels. Wonderful things kept happening. ... Finally the Saviour indicated on the same night the same thing to me and to my foster father – for Zosimus was then alive – so that I sent to him to tell him what the God had said, and he came to see me to tell me what he had heard from the God. There was a certain drug, whose particulars I do not remember, save that it contained salt. When we applied this, most of the growth quickly disappeared, and at dawn my friends were present, happy and incredulous. From here on, the doctors stopped their criticism, expressing extraordinary admiration for every aspect of the God's providence and saying that it had been some other greater disease which he had secretly cured, and began to consider the state of the loose skin (left from the tumour). Now it seemed to them that there was an absolute need for surgery, on the grounds that it would not otherwise go back to normal. And they claimed this concession, the God's part being now done. But he did not even allow them this; though the lesion was of remarkable size, and all my skin seemed to have changed, he told me to smear on an egg and thus cured me. And he brought everything back together, so that after

⁷⁸⁷ Aristid.Or.47.61-68, 390-392 Keil.

a few days had passed, no one was able to find on which thigh the tumour had been, but both were completely unscarred.⁷⁸⁸

This can be read as an account of holistic versus interventionist medicine as well as medical versus divine authority. The god's prediction of dropsy (an oedematous swelling) is accurate, but no medical prognosis is mentioned. Medicine is divided in its opinions and advice, while the god is consistent and clear. The condition is severe, but Aristides rejects treatment and allows the malady to take its course, resisting all temptation to succumb to human intervention despite the length of time the problem lasts and the terrible pain he suffers. Noticeable too is the way that the doctors beg to be allowed a role in dealing with the loose skin that remains once the god has effected his cure, but are denied even this. There is no doubt about the god's superior authority, nor about the control that Aristides portrays himself exercising over the doctors through his choice of co-operation with the god. In similar vein, he swims in icy mid-winter weather to the amazement and consternation of various doctors and friends – one of whom, Heracleon, fears that curvature of the spine will result – and emerges feeling refreshed and euphoric:

ὥς δ' ἐξέβην, ὃ τε δὴ χρώς πᾶς ἦνθει καὶ τὸ σῶμα πάντα κοῦφον ἦν ...
(22) οὐ τῆς θερμῆς ἀνῆκεν οὐδέν, οὐ προσεγένετο, οὐδ' αὖ τοιοῦτον ἡ
θερμὴ ἦν, οἷον ἂν τῷ καὶ ἀπ' ἀνθρωπίνης μηχανῆς ὑπάρξειεν, ἀλλὰ τις
ἦν ἀλέα διηνεκῆς, δύναμιν φέρουσα ἴσην διὰ παντὸς τοῦ σώματός τε
καὶ τοῦ χρωτός. παραπλησίως δὲ καὶ τὰ τῆς γνώμης εἶχεν.

When I came out, all my skin was glowing and my body was comfortable everywhere ... nor did any of the warmth abate, nor was any added, nor again was the warmth such as one would have from a human contrivance, but it was a certain continuous body heat, bringing an even power throughout the whole of my body and my skin. My mental state was nearly the same.⁷⁸⁹

⁷⁸⁸ Tr.Behr 1968:219-20, adapted.

⁷⁸⁹ Aristid.Or.48.21-2, 399 Keil, tr. Behr 1968:227 (adapted). In the last quoted line, Keil (but not Behr) accepts Haury's emendation *χρωτός* for mss *χρόνου*. For the whole story, see *id.*19-23. Aristides' account resonates interestingly with one told to me by a long-term ME patient, now recovered, who during her

Other incongruous-sounding outdoor treatments cause consternation and amazement among doctors and friends and, on one occasion, hypothermia in a friend who decides to offer moral support by joining in.⁷⁹⁰

At times Aristides deliberately manipulates the tension between divine and medical advice so as to ensure a continued relationship with his doctors. In one episode he accepts the advice of his companions against his own instincts, explicitly in order to dispel any suspicion that he favours self-reliance:

ἐγκατεκεκλίμην μεταξὺ τῶν τε θυρῶν καὶ τῶν κιγκλίδων τοῦ νεῶ κατὰ δὴ τινα ὀνειράτος ὄψιν· ... (72) καὶ μικροῦ πᾶσαν ἐξέβαλον τὴν νόσον, εἰ μὴ τοῦ θεοῦ σημεῖα φαίνοντος καὶ μεταβάλλοντος ἤδη τὴν δίαιταν αὐτὸς μὲν οὕτως εἶχον ὥς ταύτη ποιήσων, ‘βουλὴ δὲ κακὴ νίκησεν ἐταίρων’,⁷⁹¹ οἱ σοφίας τε ἀντιποιοῦμενοι καὶ τινα ἔχειν περὶ ταῦτα δοκοῦντες δεινότητα ἀτοπώτερον τὰ ἐνύπνια ἐξηγοῦντο, φάσκοντες δι’ ὑπερβολῆς ἐνδείκνυσθαι τὸν θεὸν ὅτι χρή μένειν ἐπὶ τῶν αὐτῶν. κἀγὼ συνεχώρησα ἅκων μὲν καὶ ὑφορώμενος καὶ νομίζων αὐτὸς ἄμεινον γινώσκειν, ὥς δ’ ἂν μὴ δοκοίην ἐμαυτῷ τις εἶναι μόνῳ πειθόμενος· παθὼν δ’ ἔγνω καλῶς ὥς ὀρθῶς ἐγίγνωσκον. (73) ἀλλ’ ὅσα μὲν σύμβουλοι διήμαρτον χωρὶς ἔστω· καίτοι καὶ ταῦτα ἔοικε τῶν σφόδρα πρὸς τὸν θεὸν εἶναι. τὸ γὰρ τὴν αὐτὴν δίαιταν καὶ τὰ αὐτὰ πράγματα, ὁπότε μὲν ὁ θεὸς ἡγοῖτό⁷⁹² τε καὶ διαρρήδην εἶποι, σωτηρίαν ἰσχὺν κουφότητα ῥαστώνην εὐθυμίαν πάντα τὰ κάλλιστα καὶ τῷ σώματι καὶ τῇ ψυχῇ φέρειν, ἄλλου δὲ τοῦ συμβουλευσάντος καὶ μὴ στοχασαμένου τῆς γνώμης τοῦ θεοῦ πάντα τὰναντία τοῦτοις ἐπιφέρειν, πῶς οὐ μέγιστον σημεῖον τοῦ θεοῦ τῆς δυνάμεως;

I was lying between the doors and the latticed gates of the Temple, in accordance with a dream. ... [the God gives him an oracle and he takes an open-air bath, much to the spectators’ surprise]. And I almost got rid of all my disease, save that when the God gave me signs and now changed my regimen, I was ready to do as he said, but ‘the evil counsel of my comrades prevailed’, who pretending to wisdom and seeming to have a certain cleverness in these matters, explained my dreams rather unnaturally, and said that the God expressly indicated that it was

illness had derived a sense of great mental and physical wellbeing from taking icy showers under a freezing waterfall in Wales (personal conversation, 2012).

⁷⁹⁰ ὁ δὲ σπασμῷ τε εἶχετο καὶ κομισθεὶς ὑπὸ σπουδῆς εἰς βαλανεῖον μετὰ πολλῶν πραγμάτων ἐξεθερμαίνετο (Aristid.Or.48.76, 412.5-7 Keil). Other episodes cause ‘a spectacle’ (παρέσχον οὖν θέαν, 48.74, 411.24-5 Keil) and ‘wonder’ (ὁ τοίνυν οὐδενὸς ἤττον ἐθαυμάσθη τῶν εἰρημένων, 48.78, 412.11-12 Keil; οἱ δ’ ὀρῶντες οὐχ ἤττον τὸ λουτρὸν ἢ τοὺς λόγους ἐθαύμαζον· τὰ δ’ ἀμφοτέρ’ ἦν παρὰ τοῦ θεοῦ, 48.82, 413.10-12 Keil).

⁷⁹¹ Od.10.46.

⁷⁹² Cf. Od.1.125.

necessary to keep to the same regimen. And I yielded, though unwilling and suspicious and believing that I myself knew better, but in order that I might not seem to be one who trusts only in himself. And experience taught me clearly that I had been right. But let us pass over the errors my advisers made; though even these things, I think, are part of what all comes down to the God. For the fact that the same regimen and the same actions brought my body and spirit salvation, strength, comfort, ease, high spirits and every good thing, when the God led the way with explicit instructions, but all the opposite results when I was advised by some other person who did not fathom the intention of the God, is surely the greatest indication of the God's power.⁷⁹³

In another story he unashamedly hedges his bets, vacillating between medical and divine advice in a way that was doubtless characteristic of the mixed healthcare economy of the time:

οὐδ' ἐπὶ τῆς κλίνης οἴκοι εἶχον ἀνταρκεῖν. (8) καὶ ἦν δὴ ὁ ἰατρὸς Σάτυρος ἐν Περγάμῳ κατὰ τοῦτον τὸν χρόνον, σοφιστῆς, ὡς ἐλέγετο, οὐ τῶν ἀγεννῶν. οὗτος ἐμοὶ προσελθὼν κατακειμένῳ καὶ τοῦ τε θώρακος καὶ τῶν ὑποχονδρίων ἀψάμενος, ἐπειδὴ προϊόντος τοῦ λόγου τὰς καθάρσεις τοῦ αἵματος ἤκουσεν ὅσαι γεγόνασί μοι, τὸ μὲν αἷμα ἐπισχεῖν ἐκέλευε καὶ μὴ καταλύειν τὸ σῶμα· 'ἐγὼ δέ σοι, ἔφη, δώσω τι κατάπλασμα πάνυ κοῦφον καὶ ἀπλοῦν· ὃ σὺ θεῖναι ἐπὶ τοῦ στομάχου καὶ τῶν ὑποχονδρίων, καὶ εἴσει δὴ ὅπόσον τι ὀνήσει.' (9) ταῦτα συνεβούλευε, κἀγὼ τὸ μὲν τοῦ αἵματος οὐκ ἔφην εἶναι κύριος οὔτε οὕτως οὔτ' ἐκείνως ποιεῖν, ἀλλ' ἕως ἄν ὁ θεὸς προστάτῃ ἀφαιρεῖν, ὑπακούσεσθαι καὶ ἐκὼν καὶ ἄκων, μᾶλλον δὲ οὐδέποτε ἄκων· τὴν δόσιν δὲ οὐκ ἔφυγον τοῦ Σατύρου, ἀλλ' ἐφύλαττον λαβὼν· τὸ δ' ἦν ἄρα οὐκ Ἀμαλθείας κέρας. ... (10) τοῦτο μὲν ἤδη πᾶν ἐδόκει κέρδος εἶναι. ἐδεόμην δὲ συχνῆς τῆς βοηθείας, καὶ τοῖς ὕδασι μόλις τε καὶ πεφεισμένως ὠμίλουν. ἔδοξεν οὖν μοι τὸ τοῦ Σατύρου φάρμακον θεῖναι κατὰ τοῦ στομάχου τε καὶ τοῦ στήθους, ὥσπερ ὁ Σάτυρος παρηγγέλλει· πάντως δὲ οὐδὲν μέγα ἐκβαίνειν τῆς θεραπείας τῆς παρὰ τοῦ θεοῦ. (11) εὐθὺς μὲν οὖν οὐ προσεῖτό με ἡ πρώτη προσβολή, ἀλλ' ἐδόκει ψυχρότερον εἶναι· ὅμως δὲ ἔδοξέ μοι διακαρτερεῖν καὶ παρέχειν τῷ φαρμάκῳ εἰ ἄρα ἀλλὰ τῷ χρόνῳ τι ἀνύσειεν. καὶ οὕτω δὴ τό τε στήθος ψύχεται ψύξιν δεινὴν καὶ βῆξ ἐπιγίγνεται πυκνή τε καὶ ἰσχυρὰ, καὶ ἀπορία εἰχόμην, καὶ ὁ θεὸς σημαίνει φθόην εἶναι. καὶ τῆς ἐπιούσης οἱ κρόταφοι καὶ ὁ κύκλος τοῦ προσώπου ἅπας κατετείνετο, καὶ <αἰ>σιαγόνες συνεκέκλειντο, καὶ θόρυβος ἦν εἴπερ ποτέ. ... (13) ἐμοὶ δὲ τῆς αὐτῆς νυκτὸς τάδε ἐγίγνετο, ὡς κεφαλαίων ἀπομνημονεῦσαι. ἐδόκουν ἐπὶ τῆς πατρώας ἐστίας εἶναι, ἐν δὲ τῷ τοίχῳ οὐ τὰ ἔδη τῶν θεῶν ἐπιγράμματα εἶναι τοιάδε· 'οἱ δεῖνες σωθέντες ἐκ τῶν ἐσχάτων θεοῖς πᾶσι χαριστήρια'· καὶ ἐφαίνετο δὴ τῶν θυσιῶν ἵχνη. καὶ ἐμοὶ μὲν

⁷⁹³ Aristid.Or.48.71-3, 410-11 Keil, tr. Behr 1968:238 (adapted).

γε ἡ ὄψις αὕτη τῆς συνεχείας τῶν θυσιῶν ἤρξεν, οὐ μᾶλλον τι πρὸς τὸ ὄναρ ἀφορῶντι ... ἐκ δ' οὖν τῆς Λεβέδου μετ' εὐθυμίας ἀνεχωρήσαμεν, ἡνίκα ἐδόκει τῷ θεῷ, καὶ ῥαστώνης ἀπέλαυσα λόγου ἀξίας. (14) ὁ δ' εἶπεν περὶ τῆς φθόγης, ἐπεσημύνατο ὕστερον πρὸς τὸν νεωκόρον ὁ θεὸς, ὡς αὐτὸς ἐμοὶ διηγεῖτο <ὁ> Ἀσκληπιακός, οὐδὲν παρ' ἐμοῦ προακηκοώς· ἔφη γὰρ ἀκοῦσαι τοῦ θεοῦ λέγοντος ὡς ἄρα φθόγην μὲν καὶ κατάρρουν περιηρηκώς εἶη μου, τὸν δὲ στόμαχον ἰᾶτο.⁷⁹⁴

This story begins with Aristides ‘so weak that I could not even endure in bed at home’ (7). A doctor, Satyrus, ‘a sophist of no mean rank’, attends his bedside and, having examined him, orders him to stop purging himself and to use instead ‘a very light and simple ointment, which you should put on your stomach and abdomen, and you will see how much it will help’ (8). Aristides flatly refuses: ‘I said I had no authority to choose between doing this or doing that, but that while the God commanded the letting of my blood I would obey whether willing or not, and moreover never unwillingly’. Even so, he takes Satyrus’s ointment and keeps it (9). His condition deteriorates and, by now ready to try anything (10), he applies Satyrus’s ointment, reasoning that ‘I was not departing much from the cure which came from the God’ (10). This turns out to have been a bad decision: ‘straightway the first application did not please me, but it seemed to be too cold. Nevertheless I decided to persevere and to submit to the drug, in case in time it might accomplish something’; but the ointment proves ineffective: ‘I developed a terrible chest cold, and a constant and strong cough ensued, and I was in difficulty’ (11). At this point the god appears and gives him a diagnosis of consumption. Aristides’ symptoms continue to deteriorate (11); finally, he dreams an instruction to offer sacrifices in return for a cure – and he recovers (13). His account is subsequently corroborated by a temple warden

⁷⁹⁴ Aristid.Or.48.7-14, 415-17 Keil.

who, having heard nothing of this story, dreams of Asclepius announcing that he has cured Aristides of consumption, catarrh and stomach problems (14).⁷⁹⁵

Equivocation of this kind – declarations of unchangeable loyalty to one treatment regime interspersed with periodic engagements with other methods– is very characteristic of chronically ill people today, who, in desperation for relief from their symptoms, are often prepared to ‘try anything’ even if it involves compromising some previously held principle. Sometimes this leads to genuine co-operation, such as we see in another of Aristides’ stories:

... γενομένης γε κάμοι παρὰ τοῦ θεοῦ βοηθείας πολλῆς καὶ συνεχοῦς καὶ παράδοξα ἐχούσης. ... (73) καὶ δὴ καὶ κλύσματι χρήσασθαι ἐπετάχθην, ὥσθ’ ὁ μὲν ἰατρὸς οὐκ ἐθάρρει προσφέρειν, ὁρῶν τὴν λεπτότητα τοῦ σώματος καὶ τὴν ἀδυναμίαν, ἀλλ’ ἠγεῖτο ὥσπερ αὐτόχειρ ἔσεσθαι μου· ἐγὼ δ’ ἔπεισα μόλις καὶ παραχρῆμα ἀνήνεγκα. τροφήν δὲ ἔδωκε λάχανα ἄγρια, ἃ καὶ πέψιν καὶ δύναμιν παρέσχε μοι τινά.⁷⁹⁶

... The God also helped me much, continuously and strangely. ... And I was enjoined to take enemas, so that the doctor, when he saw the thinness and weakness of my body, did not have the courage to apply them but believed that he would, as it were, be my murderer. I persuaded him with difficulty, and immediately recovered. And he gave me green vegetables as nourishment, which provided me with some means of digestion and strength.

Here the doctor offers useful dietary guidance rather than taking offence at having been proved wrong by Aristides on the god’s advice; the reference to the god makes it safe for Aristides to follow his own instincts while simultaneously allowing the doctor to avoid losing face.

⁷⁹⁵ Tr. Behr 1968:242-44, adapted.

⁷⁹⁶ Aristid.Or.47.72-3, 393 Keil, tr. Behr 1968:221 (adapted).

7.3. Interpretation

Aristides may be no hypochondriac, but this does not mean that his accounts of his illnesses are to be understood as artless or even necessarily accurate narrative.⁷⁹⁷ The *Hieroi Logoi* are, as already noted, the product of a culture of self-display and competitive oratory, a culture in which the educated elite are enormously interested in matters of health, in which temple medicine is flourishing, and dream reports are indisputably significant. They come, too, from an age in which medicine is claiming greater knowledge and authority for itself and yet paradoxically remains as ineffectual as it has ever been.⁷⁹⁸ Aristides' complaints of medicine's inability to help him are manifold. His experience at the end of a journey from Rome is typical:

Ἐπειδὴ γὰρ ἐκομίσθην ἀπὸ τῆς Ἰταλίας, πολλὰ καὶ παντοῖα συνειλοχῶς τῷ σώματι ἀπὸ τῶν συνεχῶν καμάτων τε καὶ χειμώνων, οἷς ἐχρησάμην ἀπιὼν διὰ Θράκης καὶ Μακεδονίας, ἔτι κάμνων ἐξελθὼν οἴκοθεν, ἦν τοῖς ἰατροῖς ἀπορία πολλὴ μὴ ὅτι ὠφελεῖν οὐκ ἔχουσιν, ἀλλ' οὐδὲ γνωρίσαι ὃ τι εἴη τὸ σύμπαν.

When I was brought from Italy, I had contracted by ill luck many varied ailments from constant sickness and the stormy weather which I experienced while travelling through Thrace and Macedonia, for I left home while I was still sick. The doctors were wholly at a loss not only as to how to help, but even to recognise what the whole thing was.⁷⁹⁹

Or again, on another occasion:

καὶ συνῆλθον οἱ τε ἰατροὶ καὶ γυμνασταὶ, καὶ οὔτε βοηθεῖν εἶχον οὔτε ἐγνώριζον τὴν ποικιλίαν τῆς νόσου. τοσοῦτον δ' οὖν συνέδοξεν, εἰς τὰς πηγὰς τὰς θερμὰς κομίσαι, ἐπειδὴ καὶ τὸν ἐν τῇ πόλει ἀέρα φέρειν οὐχ οἷός τε ἦν.

⁷⁹⁷ Cf. Petsalis-Diomidis 2010:122, on the distorting effect of attempts to read the *Hieroi Logoi* over-realistically. She criticises the interpretations of Behr (unique access to Aristides' inner life), Brown (illness as an expression of thwarted political ambition), Festugiere (development of a Christian-style 'personal religion'); Dodds (Asclepius the focus of Aristides' search for a father figure); Gourevitch (Aristides an hysteric); Michenaud and Dierkens (Aristides an hypochondriac, hysteric and unconscious homosexual); Andersson and Roos (the *Hieroi Logoi* a manifestation of narcissism) – all of which she regards as 'excessively simplistic' and based on retrospective physical and/or psychological diagnoses 'with little reference either to 2nd century medical understanding or to the literary function of descriptions of Aristides' symptoms'.

⁷⁹⁸ Harris comments on the weakness of doctors' authority compared to modern society (2009:185).

⁷⁹⁹ Aristid.Or.48.5, 395-96 Keil, tr. Behr 1968:224.

Doctors and gymnastic trainers assembled. They could neither help nor grasp the complexity of my disease. The only thing on which they agreed was that I be brought to the warm springs, since I was not even able to bear the climate in the city.⁸⁰⁰

And in a particularly vivid example:

καὶ μετ' οὐ πολὺ τὰ σπλάγχνα ὥδήκει καὶ τὰ νεῦρα κατέψυκτο καὶ φρίκη διέθει διὰ παντὸς τοῦ σώματος καὶ τὸ πνεῦμα ἀπεκέκλειτο. (63) καὶ οἱ ἱατροὶ καθάρσεις προσῆγον καὶ πίων ἐλατήριον εἰς δύο ἡμέρας ἐκαθαίρομην, ἕως εἰς αἷμα ἀπέσκηπεν. καὶ πυρετοὶ κατέλαβον καὶ πάντ' ἦν ἄπορα ἤδη καὶ σωτηρίας οὐδ' ἠτισοῦν ἐλπίς. καὶ τέλος οἱ ἱατροὶ κατέτεμνον ἐκ τοῦ στήθους ἀρξάμενοι πάντα ἐξῆς ἄχρι πρὸς τὴν κύστιν κάτω· καὶ ὡς ἀνθήσαντο αἱ σικύαι, παντάπασι τὸ πνεῦμα ἀπελήφθη, καὶ διῆλθεν ὁδύνη ναρκώδης καὶ ἄπορος φέρειν, καὶ πάντα αἷματι ἐπέφυρτο καὶ γίγνομαι ὑπέρινος, καὶ τῶν σπλάγχνων ἡσθανόμην οἶον ψυχρῶν τε καὶ ἐκκρεμαμένων, καὶ τὸ τῆς ἀμνηχανίας τῆς περὶ τὴν ἀναπνοὴν ἐπετάθη. (64) καὶ τί χρὴ ποιεῖν οὐκ ἦν· καὶ γὰρ σίτον αἰρουμένῳ καὶ διαλεγομένῳ μεταξὺ προσίστατο καὶ ἔδει πεπνίχθαι δοκεῖν. καὶ ἡ ἄλλη τοῦ σώματος ἀσθένεια κατὰ λόγον τούτων ἦν. φάρμακα δὲ θήρειά τε καὶ ἄλλα παντοῖα τηγάλλως ἐδίδοτο.

And shortly thereafter my intestines swelled, I trembled with cold, shivering ran through all my body, and my breath was impeded. And the doctors produced purges, and I was purged for two days, by drinking squirting cucumber, until finally there was a bloody discharge. And fevers attacked me, and now everything was despaired of, and there was not any hope even for my survival. And finally the doctors made an incision, beginning from my chest all the way down to the bladder. And when the cupping instruments were applied, my breathing was completely stopped, and a pain, numbing and impossible to bear, passed through me and everything was smeared with blood, and I was excessively purged. And I felt as if my intestine were cold and hanging out, and the difficulty in my respiration was intensified. And I did not know what to do, for in the midst of food and of talking, there was an attack, and I thought that I must choke. And my other physical debilities were in proportion to these things. Antidotes and various other things were given in vain.⁸⁰¹

Petsalis-Diomidis regards Aristides as exhibiting a marked distrust of the ‘medical profession’, and suggests that his appropriation of their language can be read as a polemical act.⁸⁰² But it appears more complex than that. Despite characterising doctors

⁸⁰⁰ Aristid.Or.48.69, 410 Keil, tr. Behr 1968:237-8 (adapted).

⁸⁰¹ Aristid.Or.48.62-4, 409 Keil.

⁸⁰² Petsalis-Diomidis 2010:105-106. Israelowich takes a different view, arguing that Aristides’ readiness to ‘entrust himself to their hands and knives serves as powerful evidence in support of the reliable reputation of the title “physician”(ἱατρός)’ (2012:88).

as people who fail to understand his illnesses, he is careful, as we have seen, not to alienate them completely. It is a conflicted relationship that conveys strong senses of both frustration and need. This is not, perhaps, surprising. The combination of the growing awareness of the body's complexity, as the site of invisible physical qualities and powers acting in its hidden interior and comprehensible only by physicians and philosophers, together with the inescapable fact of medicine's inability to deal with serious illness, must have been deeply discomfiting for anyone suffering recurring symptoms such as those described by Aristides. The body had become something that doctors knew about – yet their knowledge was self-evidently limited. Chronically ill people tend to want the support of a doctor but they also tend to have strong instincts about what they need to do to feel better, even if they do not know the biomedical processes involved. Aristides' declaration of voluntary submission⁸⁰³ is as much a passionate articulation of desire to put his trust in doctors as much as it is an expression of reluctance to do so and determination to control what happens to his own body. He embraces the idea of obedience to the doctor while transferring that obedience to the god he encounters in his dreams, thus blurring the boundaries between his instinctual response to his illness and the support of a doctor, defining obedience in his own terms and remaining in ultimate control.

7.4. Conclusion

As Downie has said, the *Hieroi Logoi* invite interpretation on many different levels, and the route to understanding them lies in collaboration.⁸⁰⁴ In recent years their richness and multi-dimensionality have invited several new analyses: Downie focuses on Aristides'

⁸⁰³ See above, pp.263-264.

⁸⁰⁴ Downie 2013:33.

use of the rhetoric of religion, illness and healing to ‘shape his self-portrait as an orator’; Petsalis-Diomidis concentrates on his use of the divine to construct a self-portrait of a new kind of elite persona, the θεῖος ἄνθρωπος; Israelowich regards the *Hieroi Logoi* as an account of salvation and faith;⁸⁰⁵ Cox-Miller interprets them as an articulation of male identity crisis verging on asceticism,⁸⁰⁶ Perkins as a narrative of pain,⁸⁰⁷ and King as an account of living with chronic illness.⁸⁰⁸ My argument in this chapter has been that they can be read as a source of insight into personal experiences of illness, showing a chronically ill person negotiating his relationship with healers in a way that enabled him to maintain relations with them without compromising his own autonomy. In particular, I have allowed Aristides to illustrate the shortcomings of the doctor-patient relationship in 2nd century Asia Minor, shortcomings to which, I have claimed in this thesis, Rufus’s insistence on questioning was in part a reaction. I have argued that there is no reason to regard Aristides as having been anything other than genuinely ill, and that there are in fact elements of his response to his condition that noticeably resemble the ways in which people cope with living with chronic illness today. Though his interactions with doctors are characterised by frustration, he does not sever relations with them, but instead creates an idealised relationship with a doctor substitute whose key characteristic is that he gives instructions which Aristides is content to obey. The *Hieroi Logoi* thus reflect both the failure of ancient doctors to listen to their patients and the strong desire of at least one ancient patient that this should not be the case.

⁸⁰⁵ Israelowich 2012:29-34.

⁸⁰⁶ Cox Miller 1994:184-204.

⁸⁰⁷ Perkins 1995:173-189.

⁸⁰⁸ King 1998:126-31.

Part V: Conclusion

This thesis set out to argue that *QM* should be understood as part of an enduring diachronic debate about the weight that should be attached to the patient's narrative in medicine. Specifically, I proposed at the outset that it articulates the idea that the aim of medicine cannot be achieved through medical knowledge alone; that in it Rufus constructs the patient as an essential partner in diagnosis and decisions about treatment; and that he thereby implies a sharing of authority between doctor and patient that contrasts noticeably with other authors' emphasis on obedience and highlights the extent of Galen's subsequent claims to hierarchical medical authority. The theoretical and conceptual framework within which these propositions have been explored posited that health and illness and the idea of 'the patient' are constructs that mean different things in different circumstances and eras, that medical authority is not a foregone conclusion of expert knowledge, and that, when expert and experiential knowledge co-operate, the scope and effectiveness of medical authority are significantly extended. Central to my approach has been the claim that *QM* is not, as has generally been assumed, an instruction manual on how to ask questions, but rather an ardent plea for doctors to recognise the limits of their own knowledge and the consequent indispensability of questioning the patient. I have argued that Rufus is unusual in the clarity with which he perceives the limits of medical knowledge, in his conceptualisation of questioning as a discursive rather than a formulaic activity, in his explicit insistence that it must be addressed to the patient himself rather than any intermediary, in his psychological concept of habits, and in his recommendation of questioning as a strategy for resolving the tension between universal theory and individual experience. All these features, I have contended, stem from and exemplify Rufus's unusually well developed sense of the patient as a psychologically

complex entity, which I have further illustrated by reference to his famous work *On Melancholy*.

With his authoritative discourse Galen stakes medicine's claim for control of patients' bodies. Scepticism about the value of the patient's narrative was not new, of course;⁸⁰⁹ but the attitude that Galen reveals transcends mere scepticism. We have seen that he presents questioning patients as a principally semiotic rather than exploratory activity, a concept that tightly circumscribes the hermeneutic relevance of what the patient says and that is heavily conditioned by an explicit desire to gain control of the patient and secure compliance, and that he takes every opportunity to amaze and impress, explicitly discouraging anything that might betray weakness, such as asking questions to which one does not already know the answer or questioning them about causation. We have seen his claims to omniscience⁸¹⁰ and the constant power struggle in which he is engaged with his patients, which Mattern has characterised as 'reducing them to servile passivity in their own homes' like a pater familias. Though various Hippocratic authors articulate similar concerns about obedience and control of patients, Galen takes that concern to new heights. His practice, I suggest, constitutes a change in the terms of the relationship, or perhaps at the very least some kind of fulcrum in the way doctors thought about patients' narratives; and *QM* plays an important part in enabling us to recognise this, for it is Rufus who provides the clearest, most focused pre-Galenic picture of attitudes to the respective roles of doctor and patient in understanding and treating illness. His passionate insistence on questioning patients as a matter of principle makes it obvious that the issue was a live one in his professional and cultural milieu, and by drawing our attention to this Rufus

⁸⁰⁹ See above, pp.159-160.

⁸¹⁰ Gourevitch 1998:135. Galen, she says, presents himself as being at the peak of medical knowledge and as having read and understood everything.

trains an inescapable spotlight on the transactional aspects of Galen's legacy. Obviously it is impossible to quantify the scale of Galen's impact on the doctor-patient relation, but seen against the backdrop of Rufus's articulation of a shared authority paradigm, Galen's hierarchical approach stands out all the more clearly – particularly given the chronological and cultural proximity of one to the other.

I do not accuse Galen of not having questioned his patients. Obviously, he did.⁸¹¹ To suggest otherwise would be absurd, as well as patently untrue, and an unhelpfully crude response to a subtle and complex issue. Galen, as Susan Mattern makes clear in her two books on his life and work, gathered many facts from patients. What is at issue here is not whether doctors question their patients but in what spirit they do so, and what use they imagine themselves making of the information thus gained; in other words, how they construct 'the patient' as they conduct their discussions. Rufus is not the only ancient medical author to have admitted the shortcomings of medical knowledge, but the way he develops the implications of that admission, using it as the basis of an argument for always questioning the patient, about all aspects of the illness, is unparalleled. For him, the patient is a key informant, a crucial partner in the project of understanding and ameliorating illness. For Galen, patients are unreliable witnesses who are likely to lie and disobey and who must be impressed by prestidigitatory feats of prognosis, given strict instructions, and watched closely for acts of non-compliance. We can understand the full implications of these two different constructions in light of the distinction drawn by Mark Sullivan between 'the epistemological dualism implicit within clinico-pathological medicine where physician is knower and patient is known' and 'a fully developed negotiation model [in which] despite their relative differences in knowledge and power,

⁸¹¹ Cf. Katz 2002:3-4.

two knowers [are] recognised in the physician-patient encounter'. In this latter model, 'both physician and patient have the capacity for interpretation; each can be cognitively and therapeutically active toward the malady at hand'.⁸¹²

When we 21st century readers find Rufus maintaining that doctors' knowledge is inherently limited and inadequate unless they question their patients on a wide range of topics, we do not find this a surprising statement, because it conforms to our own cultural norm. Similarly, when earlier generations read Galen's expressions of hierarchical authority they were perhaps unsurprised, because such attitudes reflected contemporary expectations of doctors' conduct in relation to patients. This is not, however, a story of simple linear (or circular) evolution, from a shared authority paradigm to a hierarchical model (and eventually back again). Lineaments of both discourses of authority – the hierarchical and the shared concept – can be discerned in different Hippocratic texts; Plato, in the *Laws*, describes elite Athenians enjoying a highly participative style of consultation; Taddeo Alderotti presents the tension between the two models as a topic for medieval scholastic debate; evidence there has not been room to discuss in this thesis, by authors such as Roy and Dorothy Porter and Norman Jewson, suggests that pre-modern patients were relatively powerful compared to those of the eras of hospital and laboratory medicine, and Foucault identifies the 'clinical gaze' as a key signifier of the ascendancy of biomedicine.⁸¹³ The pendulum has swung in different directions at different times, in other words. What Galen does with his assertive modelling of the hierarchical paradigm is to trigger one of those periodic shifts in the prevailing discourse.

⁸¹² Sullivan 1986:348.

⁸¹³ Porter and Porter 1989:54-69; Jewson 1976; Foucault 2003.

I have drawn attention to Rufus's apparent lack of concern with securing patients' obedience. In the absence of any positive statement of his opinion on the subject, all we can do is speculate as to what that omission might signify, and I have cited modern research that provides us with a context within which to do that. The expert/lay person tension is inescapable. Special knowledge has marked out the doctor since the Homeric poems, where Machaon is ἰητρὸς ... ἀνὴρ πολλῶν ἀντάξιος ἄλλων / ἰοῦς τ' ἐκτάμνειν ἐπὶ τ' ἥπια φάρμακα πάσσειν.⁸¹⁴ And of course the development of specialist knowledge presupposes the development of experts. But the social construction of expert and lay person varies, and this depends on, among other things, the stories a cultural group chooses to tell itself about the knowledge set and the expert. A very powerful story in Western medicine has been that the body is a thing that doctors understand. In this story, doctors and patients are defined against one another in terms of the possession or lack of specialist knowledge. Another powerful story in Western medicine has been that this special medical knowledge is what is required for healing. The same kind of oppositional definition then tends to occur, so that by extension patients' knowledge is not required or is even actively dismissed. Thus the possession of special knowledge becomes both a symbol of the medical profession's power and justification for its claim. Both of these stories were told by Galen. In 1951 Talcott Parsons identified doctors as the gatekeepers of what he called the 'sick role'; what he meant by this was that once a doctor confirmed a person was ill, making the person a patient, doctor and patient then assumed a set of mutual expectations about each other's role, governed by certain rights and duties, with the ideal patient represented as 'passive and compliant in deferring to the expertise of the doctor'.⁸¹⁵ McDonnell *et al* have paraphrased the Parsonian model as consisting

⁸¹⁴ *Il.*11.514-15.

⁸¹⁵ Parsons 1951:430.

particularly in the idea that ‘power imbalance between the doctor and the patient is inevitable by virtue of the doctor’s technical expertise and the vulnerability of patients’, and this describes the Galenic paradigm very well.⁸¹⁶ Yet Rufus was an expert too, one who had no qualms about asserting that the doctor does not know enough by himself without asking questions. He is a witness to a type of expertise that does not pretend to omniscience, the kind of expertise that can co-exist harmoniously and productively with the knowledgeable sort of self-care practised by the *pepaideumenoí* we meet in Plutarch’s *Advice About Keeping Well*.

Though this thesis has *QM* at its centre, Galen has featured heavily throughout, functioning both as foil to Rufus and as a source of information about contemporary medical ideas and practices. This was inevitable because so much of what we know of Greco-Roman medicine reaches us through the words of that intriguing, infuriating, prolix, relentlessly self-referential and overwhelmingly self-satisfied physician.⁸¹⁷ Nutton has talked of Galen’s ‘suffocating embrace’ (more suffocation than embrace, in truth). The idea that Rufus articulated so passionately – that the aim of medicine cannot be achieved by medical knowledge alone – was, not much later, crushed by Galen – not deliberately, I suggest, but heedlessly, as Catullus’s passing ploughman, his eyes trained on a different goal, left a flower unnoticed at the edge of the meadow.⁸¹⁸ I have tried to show that *QM* is a work of considerable significance, not just because of the way it enriches the study of ancient medicine but also because recognising the existence of a shared authority paradigm in the practice of a doctor who is chronologically, geographically and culturally so closely related to the hierarchical Galen highlights the

⁸¹⁶ McDonnell et al 2009:27-28.

⁸¹⁷ As Nutton emphasises, there were a very large number of doctors and other healers at work in the period, of most of whose practices we are entirely ignorant (2000:943-4, 965).

⁸¹⁸ Catullus 11.

impact that Galen had on the transactional as well as the scientific aspects of medicine. Thus what began as an enquiry into an under-studied treatise has turned out to have the ability not just to shed light on a neglected area of the study of ancient medicine but also to throw into relief the practice and principles of the man who had so profound an influence on how western medicine developed. We are left wondering whether Rufus's model of shared authority is likely to have engendered more co-operation and thereby fostered more successful outcomes than the autocratic paradigm that Galen promoted so tirelessly and which was met with so much disobedience. That, perhaps, is the next question.

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