History, Philosophy and Medicine

Phytotherapy in Context

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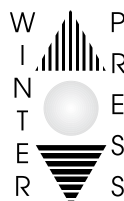

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ABOUT THIS PUBLICATION

Winter Press has produced this book with financial support from the University of East London's School of Health and Bioscience. This support has helped us to make this valuable book available to anyone with an interest in how philosophy and beliefs have interacted with the historical evolution of medicine.

Julian Barker, who has taught Clinical Phytotherapy for many years, opens the flower of intelligent questioning and brings to fruition a text rooted in his wealth of knowledge and experience.

For Winter Press, as publisher, an important factor in our enthusiasm for this book lies in the challenge it poses to all of us — to explore and be aware of the basis of our assumptions and beliefs. Here lies a route to health, one that we hope will be of value to you and many others.

OTHER BOOKS BY THE AUTHOR
The Medicinal Flora of Britain and Northwestern Europe
624pp, £28, Winter Press, 2001

ACKNOWLEDGMENTS

Good medicine is difficult to practice without thinking and looking. If the tendency to be thoughtful and curious is the first requirement for any practitioner of medicine, let us acknowledge that capacity in us all. Perhaps temperament (see Avicenna later) plays a part, but also one's early exposure: I have always been grateful to have been born in a decaying industrial seaside town and then brought up in open countryside. Though not an unusual circumstance, I think it to be an advantageous one for the practice of herbal medicine because it gives the growing mind access to a wide range of habitats and to the dual experience of crowds and open silence in which to think. The relative proximity of the Botanic Gardens at Kew, and having to learn Latin at an early age, were bonuses.

If this book is to encourage thinking and looking in the student of natural medicine, I must fully acknowledge that the thinkers who crowd into the Bibliography have generously nourished me for years: we are all the mouthpieces for others who have spoken better.

I must also take this opportunity again to thank particularly Hein Zeylstra and Simon Mills who enabled the enormous expansion of herbal medicine in Britain during the 1980's and 90's and which continues unabated. That is not to say that they acted unaided: a profession is only as good as its practitioners. Michael McIntyre and Andrew Chevallier deserve especial thanks as pioneers in the political and educational spheres. Had these not been developed, the reader the reader would have had fewer options for studying this kind of medicine. This book is an attempt to place a special type of medicine within the fullest possible context of "the general", both past and present.

For my own grasp of clinical sciences I must thank other herbalists, but also my teachers Simon Mills, Dr Robin Royston, Dr Jalal Sharif and Dr Jean–Claude Lapraz.

I am most grateful to my publishers Susan Curtis and Colin Winter for their enthusiasm in bringing this work to a wider public. As with The Medicinal Flora, they have made the editorial and design experience a pleasure and not a burden.

FOREWORD

This text is primarily designed for students of herbal medicine and is intended as a platform for discussion as well as a guide to sources in the comparative studies of human thought. While the historical sections are arranged in the usual linear fashion, the text is deliberately broken up to provide a mosaic rather than a single line of argument. The intention of any work on philosophy should be to disabuse the enquirer of the notion that a single line of argument can ever describe life. This text hopes to avoid the tendencies of essays on herbal medicine which leap from pre–history to Dioscorides with a nod to the Hippocratic Oath thus omitting the intricacies and subtleties of human therapeutic Thought and Practice; to redress this rather impoverished perspective is one of the aims of this text.

A second aim is for a practising herbalist to write a short account of medical history which neither marginalises nor idealises herbal medicine. The author takes the view that, if herbal medicine is not to be marginalised, if we are to flourish in the world and not in a self–made ghetto, we need not a ***separate*** historical essay of our own but one which is integrated as an unbroken thread in the human tapestry. The third aim is to remind the world that a phytotherapist is neither a retailer of plants, nor a mere administrator of a herbal materia medica but a physician in the full sense of the word. Accordingly, we must look at the whole field.

The text, then, does not idealise phytotherapy as uniquely Good Medicine. Rather, it tries to place it in context along with other contemporary forms of medical practice from the perspective of a common ancestry: if we are a part of the whole, we must first examine the whole to find our place in it. To be truly holistic, we must strive for the most comprehensive and impartial view so that our commitment to good practice is imbued with just the right level of confidence. We need to avoid status anxiety on the one hand and too great a certitude in all things herbal on the other. However, given the extraordinary biological congruence between plants and mammals, we hope that the student can eventually be assured that firm confidence in plant–based medicine is entirely well placed, especially when coupled with a good understanding of our limitations and boundaries.

There are two main assumptions in this book:

- That belief is intrinsic to all human activities and it is therefore proper to study the history of what people have believed (or said they have believed) to understand the conceptual basis of their medicine and its bearing upon contemporary practice
- That medical interaction involves a relationship between practitioner and patient and that the quality of concordance between the beliefs and expectations of the two parties influences the quality of the outcome

It should be added that the mediating instrument of healing influences the quality and character of that interaction. So, in herbal medicine, beliefs and conceptions about plants are likely to colour the relationship between practitioner and patient in an important way.

The text has attempted to process similar information in parallel texts and so cycles the same ideas more than once: this is an attempt to blur the necessary or convenient illusion that history is linear whereas in fact the historical flow of ideas could be said more to resemble a network.

While the author makes a number of assertions that are drawn from reflection upon his own clinical experience, the work hopes to be accepted as philosophical in the sense that no answers are provided, but has the hope that the student will be drawn to ask good questions. Meditating upon the themes of one's profession is one of the mental habits that should be well developed in studenthood but should not lapse during medical practice. On the contrary, such reflection on themes of purpose is as important to good clinical judgement as are revising and refining the knowledge–base of your art.

This text is designed to stand alone as a source of information. The evidence for the assertions contained within it is derived from texts in the fields of history (of science, medicine, philosophy, literature and culture), philosophy, anthropology and comparative religion, psychology, literature and literary criticism. If the sources of many of the facts, opinions and contentions had been given, each sentence of this text would necessarily have been littered with references and would thus have interfered with the flow of reading these multi–faceted subjects. To remedy this lack of specific attribution, a list of the works consulted in the preparation of this work are given in the *Acknowledgement Of Sources* that follow the Appendices.

In an age of specialism, this text can justifiably be criticised for spanning too many disciplines, which a single author could never hope to master. However, as I hope to argue in the discussion sections (4 & 6), Phytotherapists need to be generalists in the best sense of having the widest regard for the needs and beliefs of their patients. We are obliged to span not only disciplines, but also both the human and the plant worlds. In this spirit I hope this short book may be forgiven its generalisations and assumptions and redeemed by the critical debates of its reader, the Phytotherapist of the future.

1 OVERVIEW OF PHILOSOPHY

Everyone wonders, at some time in their lives about the why, and the how of life and the world.

This very uncritical sentence just would not do for the technical investigative discipline known as philosophy in which absolutely nothing is taken for granted: it would demand evidence of such a generalisation: how do we know that literally "everyone" wonders and what is the meaning of "wonders" and, for that matter, what is the meaning of "meaning"? As the philosopher and mathematician Bertrand Russell lamented of his enterprise: "one never knows what one is talking about and one never knows whether what one is saying is true".

However, between the common–sense assumption of universality with which we opened and the scrupulous academic philosophy there is a middle way: the more historical and descriptive discourse that records and evaluates philosophical questions especially with respect to an important branch of human activity. Thus, we have the philosophy of science, of history, of economics and, of course, the philosophy of medicine. In effect, the history of philosophy is the history of ideas: philosophy, while it may try to uncover universal truths, cannot help but articulate the world–view of its time.

Such studies are concerned with meaning as well as with method. They make the assumption made in our first sentence: it *is* human to wonder who we are and how best to live. Any answers put forward must be subjected to rigorous scrutiny but, unlike "pure" philosophy, they will more overtly be coloured by the assumptions made by the history of the society in question and by the position held within that society by those posing the question. In other words, the search for human universals is conducted through the very relative constraints of politics and history.

The reason for studying the philosophy of medicine is that most of us require a meaning and a sense of purpose for the career upon which we have embarked. As our studies progress we also wish to know why one course of action is preferable to another; we need to know the basis upon which we form our judgements.

Humans are historical beings: we remember our childhood and what was taught us. Even to challenge an orthodoxy (literally, from the Greek,

'straight teaching') means remembering what it teaches; asking why it should be challenged is the philosophical bit. The practise of medicine seeks to improve people's lives with respect to their health, so although medical students need a good knowledge–base from which to offer their advice and treatments, they need also to reflect as they acquire this knowledge so as to know how to act in the best interest of their patients.

Although we like to question, history (as well as psychology and anthropology) suggests that we also like to believe, for therein lies a certain security and it is difficult to act in the best interest of your patients if you don't believe in what you are doing or cannot understand the basis for what you are advocating. The history of medicine is both inspired and bedevilled by belief and counter belief and doctors have a history of vexatious disputation. Two sorts of question underlay these disputes:

1) Is the medical procedure ***correct***? (according to the greatest authority)?
2) but does it ***work***?

An examination of the history of medicine will demonstrate that these are polarised questions that point up fundamental divergences in approach between:

the theoretical and the empirical

and can usually be analysed as how closely attached the enquiry is towards the particular as against the general. If a remedy is used for a certain complaint can it be used for other similar complaints? If so, what are the qualities shared by the complaints? Supposing that the remedy is not to hand, would another remedy do just as well? If it would, what are the qualities shared by the remedies? You can see that very quickly a so–called empirical approach to a particular problem calls for a general understanding of the human condition and so leads, however loosely defined, to theory. The purpose of any medical theory is to find causal laws that determine health and disease. The whole question of ***Universals*** was opened up in the most detailed way by Plato whose place in history we shall come across in Section 5. Much of the philosophy of the 20th Century argued that the debate is founded in a confusion inherent in language, but the matter is far from settled[1].

1 Philosophy as the study of reality has tended to polarise, since ancient times, between mathematical concepts of the world and concepts which try to examine the proofs offered by our senses. Philosophers of the 20th Century, notably Russell and Wittgenstein, have tried to make a synthesis between the two streams.

You may, after years of practice, come to decide that the difference between the empirical and the theoretical approaches is really a function of how closely you look at a particular medical problem, and that it is possible (even desirable) to oscillate between the two and perhaps this is actually how most physicians operate. Pure theoreticians of any time and persuasion might howl at this kind of fudge, but you are likely to come across this kind of paradox sooner than you may think. [Don't make your mind up too soon.]

Let us contrast the approaches in a contemporary setting: practitioners of orthodox medicine with their purely empirical approach treat the complaint of a particular individual as a general phenomenon rather than a particular one: while it will be acknowledged that certain patients may present idiosyncrasies, these features contribute more to the understanding of the condition in general than to that of the individual patient. This may lead to a shorthand characterised by ***synecdoche***—a figure which uses the part for the whole, as in: "the gall–bladder in bed 3 is waiting for the doctor". By contrast, the avowed intention of contemporary herbalists is to work in a ***holistic*** way, which means treating each patient as an individual particular case. Taken to its logical conclusion, this approach could not permit saying, for example, that ***Allium ursinum*** is a specific remedy for Crohn's disease because each manifestation of inflammatory bowel disease is as unique as the individual who suffers and therefore requires a unique prescription.

A moment's thought will show the strengths of both approaches: on the one hand the power of generalisation permits the treatment of a large number of people quickly and simplifies the therapeutic approach; on the other, the experience of the patient—which research has shown to be highly significant for recovery—is likely to be richer [though here it would depend more crucially upon the qualities of the practitioner while, in conventional medicine, the qualities of the treatment itself could be said to be predominant].

This dichotomy is artificial: while the experience of each of us is unique, patients like to know whether a physician has seen and treated their condition before (and with what success); in other words, they are conceding to the act of generalisation. Indeed, some generalisation is inherent in thought and language and is necessary to classification; classification is necessary to survival: friend or foe, close or distant, food or poison. In traditional medicine, it may be that the degree of gener-

alisation differs from that in modern medicine: it is a question of scale: how much detail do you include, and upon what criteria do you exclude other facts? In herbal medicine, where we always make a therapeutic classification of plants—this herb is for that condition, this should help that—are we making a simultaneous generalisation about people and disease? As I hope it will become clear from your studies on plant taxonomy, classification needs to be preceded by typification[2]. The uncomfortable realisation may come upon you that herbal medicine is often very close to the empiricism of modern medicine. We will meet this discussion again in Sections 4 and 6, and again in Section 7.

We need to study the history of medicine to make these philosophical dichotomies more concrete, but there is one more polarity that has become part of the folklore of the educated:

folk medicine ***versus*** that of the educated élite

which not only permeates history but has recently been invoked by some herbalists in Britain as the reason for the profession (sic) to resist state registration—that such an accommodation betrays the nature of folk medicine which has been given to us in trust, by the folk, presumably. It is a false dichotomy: it is patronising to assume that empirical hunter/gatherers did not reflect upon their practice; it was not written down and codified but that does not mean that oral traditions failed to systematise their medical approaches. There is good evidence that popular knowledge and scholarly formulations constantly cross–fertilised one another. The medicinal text of the Ebers papyrus (c.1500BCE) declares that the knowledge it describes is based upon much older sources. Similarly, the clay tablets from Nineveh (probably the world's first botanical work) acknowledge a much more ancient tradition. We are all inheritors of the human past and none of it remains parcelled up too tightly for too long. It is an insult to the unity of human intelligence to make principled oppositions such as the caricature of lofty pedants who can't tell their **** from their elbow as against the shrewd, observant artisan who is not afraid to get dirt beneath his fingernails.

Actually, the history of medicine is full of such insults, Galen for one being notable in his contempt for those who were neither philosophical

2 Likewise, Typology of Humans is very much involved in making a diagnosis in some kinds of naturopathic medicine and, at the level of tissues, characterised the approach of the physiomedicalists and also 19th Century heterodox medical movements, many of which were herbal.

enough nor sound in their practice. But as for the origins of medicine, we have no record of what was said and thought so we shall proceed in the following section on the basis of inference.

2 PREHISTORY AND THE ROOTS OF MEDICINE

Philosophy is an enquiry, not a dogma. However, for pedagogic purposes, let us hold the following "truths to be self–evident" to quote Euclid and a more recent famous source:

Humans are:

1 social animals with absolute requirements for preening which includes verbal communication and a requirement for symbolic representation
2 Technological creatures which means the ability to make a tool and to use a tool to make another tool
3 The understanding of sequence of events in the above (you have to do one task in order to be able to carry out a later task) is structurally connected and almost certainly co–evolved with the rules of sequence in language itself; the human consciousness of time and mortality lead to the universal requirement of linguistic narrative
4 possessed of a memory which matches in detail the observations made in time of the natural world, recording and expanding the span of human experience

If you would accept these propositions, they match respectively the following prehistoric and historical facts:

1 all societies have practised healing which involves touch and speech
2 all societies have practised surgery and first–aid
3 all societies have symbolic narratives about the world and their place in it and tell stories to one another; the sick are usually asked for their story
4 all societies have practised medication using objects and substances from the natural world in which plants have played usually the predominant role; certainly no people has been without herbal medicine

Anthropological studies and archaeological records appear to support the view that in hunter/gatherer societies there was very little division of labour even though specialisms in medicine and surgery were invested in individuals. But in semi–nomadic pastoralist and primitive agriculturist societies, the shaman was often given a life apart, a life at the margins. The physician in our societies, too, occupy a liminal position. Whether this position is accorded high or low status fluctuates as social and political power shifts between different groups, and probably as a function of the nature of pressures on health within a society. Death is the ultimate liminal state and illness, likewise, removes the patient from participation in normal activity; both sickness and death belong to the great transitions which also include birth and puberty. Those who attend these transitions enjoy (or suffer) liminality in the eye of their fellow humans.

The invention of leisure is commonly attributed to the invention of agriculture (shortly before 10,000BCE); while the cultivation of crops and barns certainly provided a surplus of food (and so could be said to have invented the crime of theft), the "free time" was unevenly distributed. With the increased sophistication of metallurgy and the coming of civilisation (which literally means urbanisation), division of labour became the norm with most of the spare–time reserved for the thinking class. As groups in urban societies became more specialised with patches to protect, they also became more layered: hierarchy originally meant 'rule by priests.' The priest needed an understanding of the natural world derived from "folk" knowledge and also needed the time to study the heavens for patterns of the night sky and the weather so better to interpret portents for the survival of the agricultural enterprise upon which the city depended. In relating the macrocosm to the microcosm of the city, the re–interpretation of the group narrative fell to the priests and so dictated the proper behaviour of groups and individuals. So, after the invention of writing (in Sumeria after 4000BCE), the Babylonian and Egyptian priests and, later, the Brahmins not only directed law and ethics, but had the time to formulate the scientific discoveries of astronomy and mathematics which were not at first "pure" exercises but were stimulated by the technology required for farming as well as architectural and military planning. The survival of the more complex city–state depended upon a different kind of understanding of a greater number of natural phenomena.

By the Biblical time of King David and his son Solomon (960–925 BCE), iron–working had spread from Greece and the Near East to include what is now Italy and part of Southern France. This improved technology (which bypassed the decaying Egyptian civilisation) made the colonisation of the Western Mediterranean easier and more worthwhile for the Greeks (and Phoenicians). While they later lost their

territorial gains, Greek intellectual influence remained far–reaching even till Roman times: the loose–knit nature of their changing political allegiances appears to have fostered the free–thinking nature of Hellenic culture which gave rise to the flowering of the humanistic scientific venture that allowed medicine to be separated from magic and religion.

3 OVERVIEW OF THE HISTORY OF MEDICINE

Medicine is integral to human experience and has been since our earliest times. While plants belong with us in a co-evolutionary and pan-cultural sense whether prehistoric medicine was ever exclusively from plants, is impossible to tell, but is unlikely from the evidence. Besides, medicine is more than just medication, just as putting on a plaster is more than first aid: the ***care*** and ***intention*** of the helper/healer is a crucial part of the process.

If philosophy is halfway between religion and science, the early history is more of the former while the latter is, well, later.

There are palaeolithic remains of diet and medicine from various sites in the world, but the most ancient tradition for which we have hard evidence (as hard as sunbaked clay tablets) is that of the Mesopotamian cultures, followed closely by that of Egypt. The slightly later Indus Valley ('Vedic') civilisation and that of Persia (Zoroastrian) are rich sources of medical practice to this day. An equally rich system of medicine was formulated and codified when the Chinese empire achieved political cohesion in the 3rd Century BCE. China has not only absorbed much from other parts of Asia but has maintained a remarkable thread of continuity until modern times. The medicine of the New World with its hospitals and herb gardens probably developed independently. Its destruction by the Christian colonisers is one of the great tragic losses of human history. Every other culture has had medicine and the evidence is good that their relationship with plants has always had a strong therapeutic connection. But these cultures have not written down their materia medica, and so what we know of their practice is either lost or kept alive by oral tradition (rare) or can be studied in the many ethnographies of the world.

MEDICINE IN THE MEDITERRANEAN AND EUROPE

The European tradition which we are studying derived from the Ionian[3] Greeks of the pre–Classical Period. The cult of Asclepias was born from

3 A glance at a modern atlas will show the Ionian Sea to lie between Southern Italy and the Ionian islands off the Western coast of Greece but this is named after the area that the Ionians colonised. Ancient Ionia was an area North of Ephesus in what is now Western Turkey, on the Aegean coast.