2 The clinical method of the anonymous of Paris^{*}

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1 Introduction

At the end of MS.MSL.52B held at the Library at Wellcome Collection we find an anonymous treatise concerning acute and chronic diseases, dated to the first century CE.¹ The treatise has survived also in two manuscripts in Paris and one in Vienna.² The author is commonly known as Anonymus Parisinus (henceforth AP or the Anonymous). He earned this appellation from his unknown identity and from Paris being the place to which the first manuscript, found originally on Mt. Athos, was brought and identified.³ Two of the manuscripts offer titles. The title in the London manuscript reads: διαγνωστική διάλεκτος τῶν μεγάλων ποιητῶν⁴ ἱατρῶν περὶ τῶν ὀξέων νοσημάτων, καὶ ὀξέων τὲ καὶ χρονίων (“A diagnostic discussion of the great physician authors – on the acute diseases – both acute and chronic”). The title in Parisinus suppl. gr. 636 is shorter: διάγνωσις περὶ τῶν ὀξέων (sic) καὶ χρονίων νοσημάτων (“Diagnosis concerning acute and chronic diseases”). As Ivan Garofalo notes, the treatise discusses more than diagnostics.⁵ It is divided into fifty-one sections, each setting out the causes, signs and treatments of a particular disease.

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1 Ff. 366v–403v. On this manuscript, see Bouras-Vallianatos (2015: 286–92). For the dating, see Garofalo (1997: xi); van der Eijk (1999a: 296–300, 326–9).

2 Parisinus suppl. gr. 636, Parisinus gr. 2324, Vindobonensis med. gr. 37. For an overview and comparison between the manuscripts, see Garofalo (1992) and (Garofalo, 1997: xiv–xxii).

3 On the author’s identity, see Fuchs (1903), who attributes it to Themison, the pupil of Asclepiades; Wellmann (1905) argues for the Pneumatist Herodotus, which was accepted by Liddell and Scott in their Greek-English dictionary; Garofalo (1997: xi–xiii) and van der Eijk (1999a: 300–1, 325–9) both reject these attributions and argue that the author remains anonymous.

4 Garofalo suggests that this should perhaps read παλαιῶν (“ancient”) – Garofalo (1997: 2).

5 Ibid.

First come sixteen acute diseases, followed by thirty-five chronic diseases. It is the author himself who makes this distinction: at the end of chapter sixteen he notes that he has reached the end (τέλος) of the study (πραγματεία) of the acute diseases and is moving on (μετιέναι) to the collection (συναγωγή) of the chronic diseases.⁶ None of the manuscripts contain all of the sections – Parisinus suppl. gr. 636 is the most complete, while the Wellcome manuscript, which spans thirty-seven folios, includes twenty-nine of the fifty-one sections.⁷

The treatise was first discovered in 1840. In 1894 Robert Fuchs published the text based on the Paris manuscripts, but it was only in 1997 that Garofalo published a complete edition, based on all four manuscripts, together with a translation.⁸ Scholars have engaged with this treatise mostly on account of it being an important source for the ideas of earlier physicians. Others have focused on the question of the author's identity or relation to certain medical "schools".⁹ Van der Eijk's 1999 extensive article in a volume on medical doxography and historiography in antiquity goes beyond the treatise's doxographic aspects; however, the scope and context restricted the ability to explore the treatise as a whole. Although over twenty years have passed since these publications, there is still no study of the methods and professional considerations of the author, regardless of his identity or possible affiliation with other groups or "schools".¹⁰ This is particularly unfortunate since AP is one of the few medical works which have survived from the period between the Hippocratic works (mostly fifth and fourth centuries BCE) and Galen (second century CE). The work is thus a rare direct testimony to a medical treatise from this period and the professional concerns and interests of physicians of the time; the author's ideas and methods are thus worthy of consideration on their own account, regardless of his identity, "affiliation" and sources.

This chapter is intended as a step towards such a study. It brings to light some of the main features and threads in the author's medical method and the underlying ideas they reflect. I use "method" here in the general sense of an approach or a set of procedures directing the Anonymous' clinical work with patients. My underlying assumption is that he considered his treatise comprehensive and sufficient for guiding a practising physician. It is possible that the treatise is mostly

6 Anonymus Parisinus, *On Acute and Chronic Diseases*, 16, ed. Garofalo (1997) 108.22–3. References to the Anonymus Parisinus are by chapter and page numbers (and when necessary line numbers).

7 See the table in Garofalo (1997: xviii–xix).

8 Fuchs (1894). Cf. Fuchs (1895) and Fuchs (1903). Garofalo (1997) – the English translation in that edition is Brian Fuchs' (not to be confused with the earlier editor, Robert Fuchs) translation of Garofalo's Italian translation of the text. See van der Eijk (1999a: 295–302) for a detailed overview of the editorial history of this text.

9 Fuchs (1901); Fuchs (1903); Wellmann (1901); Wellmann (1905); Wellmann (1913).

10 While focusing on the doxographical contribution of AP, van der Eijk (1999a) also attempts to identify the author's own voice and mark in the doxographical parts. For the ambiguous meaning of the concept of medical "school" (αἵρεσις) in antiquity, see Von Staden (1982) and Leith (2016) as well as Gucker (1978: 174–92) for the broader context.

Figure 2.1 Londiniensis Wellcomensis MS.MSL.52, f. 366v.

Photograph by Petros Bouras-Vallianatos.

an edited collection and compilation of information from other sources, with only very few independent or original views. But even if this is the case, I believe that his selection of content and the “clinical narrative” he relates represent his

own perception of how to practise medicine and what is required to do so properly. The author himself does not claim to be providing a systematic universal clinical method, nor does he use the Greek term μέθοδος, which Galen opposes to proceeding “by chance or spontaneously” (κατὰ τύχην καὶ αὐτομάτως).¹¹ Nevertheless, an analysis of the text reveals, as we shall see, some underlying considerations and traits which guide the Anonymous’ clinical work and approach and which allow him and physicians using his treatise to pursue their practice without relying on chance or luck. It is these considerations and traits which I call his “method”. In accordance with the author’s form of presentation, I discuss first his engagement with the causes of diseases, then signs and diagnosis and finally treatment.

2 Causes of diseases

When discussing the causes (αἰτία) of the different diseases, AP usually lists the views of four physicians from the fifth to third centuries BCE: Hippocrates, Diocles of Carystus, Praxagoras of Cos and Erasistratus of Ceos.¹² At times he lists the opinions of all four concerning the cause of the particular disease, sometimes of only some of the four, other times he groups them together under the label of “the ancients” (οἱ ἀρχαῖοι, οἱ παλαιοί) and once simply as “the four” (κατὰ τοὺς τέσσαρας).¹³ However, these doxographies are only part of the picture – the author’s voice is often heard. Occasionally he uses the first person: “we say” (φάμεν) or notes that whereas “some think” one thing, “we think...” (μέν τινες οἴονται ... ὥς δὲ ἡμεῖς).¹⁴ In many cases he describes the causes of the given disease with no reference to earlier authors (particularly in the case of chronic diseases); other times he notes an additional cause or explanation to the causes he reports for “the ancients”.¹⁵ Based on these parts in which the author expresses his own

11 Galen, *Method of Medicine*, 1.4, ed. Kühn (1825) X.31.10–12, and see van der Eijk (2008: 287–8).

12 In thirty-eight of the fifty-one chapters – see the informative list in van der Eijk (1999a: 304–7). Twelve of the thirteen cases without any reference to ancient authorities concern chronic diseases; the one acute disease is satyriasis.

13 See van der Eijk (1999a: 303–4) and van der Eijk (1999b: 144–6). There is a single mention of a different ancient authority: the philosopher Democritus regarding the cause of elephantiasis (Anonymus Parisinus, *On Acute and Chronic Diseases*, 51, ed. Garofalo (1997) 258.5).

14 Anonymus Parisinus, *On Acute and Chronic Diseases*, 11, 31, ed. Garofalo (1997) 82.1, 166.15.

15 See the tables in van der Eijk (1999a: 304–7). The anonymous reviewer of my chapter raised the important question of whether there was possibly a connection between the severity of the diseases and the reference to the authority of the ancients. I believe such a connection is possible in so far that there was, for these diseases, a stronger tradition of discourse, particularly as regards their causes. Nevertheless, the severity was probably only part of the motivation for the livelier debate; presumably, the obscurity of the causes of these diseases as well as their relation to broader ancient debates (e.g. concerning mental faculties or the bodily location of disease) also contributed much to the interest in them.

views, we can make several observations regarding his ideas concerning disease aetiology.

2.1 A range of causes

Overall the Anonymous refers (without mention of a source) to the full range of causes found in other Greco-Roman medical sources: qualitative changes related to heat, chill, wetness and dryness in the entire body, or in certain parts or substances; blockage or hindrance to the passage of substances such as blood or air; accumulation of blood, air or humours in locations they should not naturally be; physical trauma. In vertigo, for example, the liquids in the head and the pneuma are blocked (ἐνανείλησις);¹⁶ in colic it is “either inflammation of the colon or stoppage of the thick pneumata in it”;¹⁷ spasm can arise from dryness of the nerves which are thus “contracted like leather straps” and on account of “lack of tension of the pneuma” (ἀτονία πνεύματος).¹⁸

This last reference to the tension of the pneuma and to the lack thereof (ἀτονία) as a cause of disease are interesting. Most medical authors generally conceive pneuma solely as a substance which moves through channels and parts. The free flow of this pneuma ensured healthy motor, sensory, and sometimes, intellectual faculties. A disruption in the flow of this pneuma would cause dysfunction and disease. The theory of the physicians of the Pneumatist school (ἡ πνευματικὴ αἵρεσις) adopts this concept of pneuma, but their theory of disease uniquely incorporated, and indeed centred round, their conception of another pneuma, which permeates and is present in the solid parts. This pneuma is active inside the parts of the body at their most basic compositional level, and some sources refer to it as the “connate pneuma” (τὸ σύμφυτον πνεῦμα).¹⁹ According to the Pneumatist theory, changes in the body due to external and internal causes bring about a qualitative imbalance or a lack of tension of this pneuma, which in turn disrupt the pneuma’s activity; this causes various dysfunctions, depending on the part affected.²⁰

The chapter on spasm cited above is not the only place in which AP refers to the tension of the pneuma. In the case of dysenteric flux he refers to the lack of tension of the innate pneuma (ἀτονία ἐμφύτου πνεύματος).²¹ In the case of syncope, the pneuma loses its natural tension on account of

16 Anonymus Parisinus, *On Acute and Chronic Diseases*, 17, ed. Garofalo (1997) 110.6–7.

17 Anonymus Parisinus, *On Acute and Chronic Diseases*, 15, ed. Garofalo (1997) 102.5–6. Translations from AP are by Fuchs in Garofalo (1997) with slight modifications. Where an implied word needs to be made explicit for reasons of clarity, it is supplied within parentheses.

18 Anonymus Parisinus, *On Acute and Chronic Diseases*, 7, ed. Garofalo (1997) 50.11–14.

19 Ps.-Galen *Introduction, or the Physician*, 9, ed. Petit (2009) 21.20–1 = ed. Kühn (1827) XIV.698, and see Coughlin and Lewis (forthcoming) for discussion.

20 See Coughlin and Lewis (forthcoming).

21 Anonymus Parisinus, *On Acute and Chronic Diseases*, 43, ed. Garofalo (1997) 218.3–4.

inflammation (ὑπὸ φλεγμονῆς ἐκτονιζομένου τοῦ πνεύματος).²² Importantly, in the treatment of this condition AP refers to the strengthening (ρόννυται) of the pneuma as a defined therapeutic aim.²³ This further echoes the Pneumatist theory, which considered pneuma an explicit object of medical care and its restoration to its natural state a therapeutic aim. The passages in AP are our only direct evidence for the practical clinical consideration of the quality of the pneuma (rather than its freedom of motion in vessels or nerves) with regard to disease aetiology and treatment.

2.2 *Causal relations*

The Anonymous is aware and sensitive to different stages of disease causation and pathological processes. He describes a chain of effects and processes which occur inside or on the surface of the body. Catarrh, for example, is the result of strong chilling in the head which leads to an increase in the liquid inside the head, which then flows into the nostrils or channels.²⁴ Inflammation of the kidneys can occur due to various causes, among these are cases in which morbid matter flows to the kidneys from all over the body, causing the kidneys to fill and distend and this causes the inflammation. He opposes such cases to those arising from “some external cause” (ἐξωθέν τις αἰτία).²⁵ He offers no example for such an external cause, but it is clear that he is distinguishing between morbid processes arising from internal changes and those arising from a change or event affecting the body from without. An example for such an external cause in a different context is a bite from a raging dog (κύων λυσσῶν). Such a bite can cause the disease called *hydrophobos* – a fear of water so fierce that it causes tremors, a frequent pulse, disrupted breathing and speech, howling and confused and frightened behaviour.²⁶ Through the bite the dog “poisons” (ἐξιόν) the humours in the body. In some cases humours which cause the affection can “arise inside the body” (ἐντραφέντων τῷ σώματι) without the external stimulant.²⁷ The author explains in detail the cause-and-effect process generated by these noxious

22 Anonymus Parisinus, *On Acute and Chronic Diseases*, 10, ed. Garofalo (1997) 72.7–8; his use of the verb ἐκτονίζομαι is a *hapax* and one wonders whether the Anonymous coined it or adopted it from another (now lost) source. The latter explanation seems to me more likely; this could imply that (at least some) of the aetiologies he adds to those of the ancient authorities derive from later authorities, which he does not name for some reason (perhaps it was clear to his contemporary readers?). Either way, I assume that the passages in which he “concludes” the cause from the ancients’ writings (see above p. 28) are his own original contribution.

23 Anonymus Parisinus, *On Acute and Chronic Diseases*, 10, ed. Garofalo (1997) 72.7–9, 80.11–13. The treatment of pneuma in this sense appears to be part of a Pneumatist method – see Coughlin and Lewis (forthcoming).

24 Anonymus Parisinus, *On Acute and Chronic Diseases*, 28, ed. Garofalo (1997) 154–6.

25 Anonymus Parisinus, *On Acute and Chronic Diseases*, 37, ed. Garofalo (1997) 192.

26 Anonymus Parisinus, *On Acute and Chronic Diseases*, 12, ed. Garofalo (1997) 84–6.

27 Anonymus Parisinus, *On Acute and Chronic Diseases*, 12, ed. Garofalo (1997) 84.14–17.

humours (regardless of their origin): the humours dry the body, and with it the pneuma in the oesophagus and in the entire body is dried. The dryness means that the oesophagus (στόμαχος)²⁸ and other appetitive organs (τὰ ὀρεκτικὰ ὄργανα) are either paralysed or move with much pain. The dryness in these organs, claims the author, also explains the convulsions and the aversion to the sound of water.²⁹ The author's explanation demonstrates his attempt to connect between the signs (convulsion, aversion to water, irregularities in speech and swallowing, which are connected to the throat) and the causes (dryness and effects on the oesophagus). In the final sentence of the passage he notes that motion depends on wetness (and hence dryness harms the mobility of the parts). In this remark he reveals an interest in the relation between pathological processes and physiological theory and in showing that the causes are not random. Throughout the treatise, theoretical remarks are mostly restricted to the aetiological sections³⁰ and, as in this case, they are brief, general, and do not seem to strive for completeness.³¹

2.3 *Technical causal terminology*

On a handful of occasions AP uses technical causal terminology known from other medical and philosophical sources. He mentions that haemorrhage of the bladder has “many antecedent (προκαταρκτικαί) causes” and he distinguishes between antecedent and cohesive (συνεκτικά) causes in cases of coughing up blood (haemoptysis).³² Lifting a weight, jumping, straining one's voice or an abundance of humours are possible antecedent causes which can cause, in turn, the cohesive causes of the disease such as an unnatural “opening” (ἀναστόμωσις), a rupture or corrosion (διάβρωσις) in the mouth, stomach, trachea, lung or other parts of the head or thorax.³³ Antecedent causes are usually external causes which bring about a change or process inside the body; the cohesive causes are those which actually bring about the disease (coughing blood in this case), without them there would be no disease. These causal terms originated in Stoic thought and their explanations of the cosmos and natural phenomena.

28 στόμαχος could also refer here to the cardia, the upper/cranial opening of the stomach; cf. Skoda (1988: 155).

29 Anonymus Parisinus, *On Acute and Chronic Diseases*, 12, ed. Garofalo (1997) 84.17–25.

30 Other examples include, for instance: phrenitis (the explanations of the roles of different parts according to the ancients – Anonymus Parisinus, *On Acute and Chronic Diseases*, 1, ed. Garofalo (1997) 2; satyriasis (the relation between spasm and voluntary motion and parts partaking in voluntary motion – *ibid.*, 16, ed. Garofalo (1997) 106.19–20).

31 In the cited case of *hydrophobia* it is not clear, for example, whether the author is thinking in “mechanical”, “macroscopic” terms when speaking of dryness and wetness and their effect on mobility, or rather in “chemical”, histological terms related to the qualitative, elemental mixture. The reference to the pneuma and its dryness seems to point to the latter; but see page 29.

32 Anonymus Parisinus, *On Acute and Chronic Diseases*, 26, ed. Garofalo (1997) 140.17–19; cf. *ibid.*, 38, ed. Garofalo (1997) 198.8 for antecedent causes.

33 Anonymus Parisinus, *On Acute and Chronic Diseases*, 26, ed. Garofalo (1997) 140.16–22.

According to Galen, it was the physician Athenaeus of Attaleia, the founder of the Pneumatist school, who introduced these terms and especially the concept of cohesive cause into medical theory.³⁴ Notably, AP's list of cohesive causes differs from the claim attributed to Athenaeus and the Pneumatists, according to which changes in the pneuma and in its mixture are the cohesive causes of diseases.³⁵ AP uses less common terms too, such as “stimulating causes” (συγκινητικά αίτια) found in later sources³⁶ and “productive causes” (ποιητικά αίτια), a term which Galen mentions as used by some authors and which Galen himself uses but not with respect to disease;³⁷ we find it in a pathological context in Pseudo-Galen *Medical Definitions*.³⁸ AP also distinguishes once between “apparent” (προφανής) and “unseen” (ἄδηλος) causes.³⁹ Since AP refers to all these technical terms only rarely, he may have simply “inherited” them from the sources he was using for describing these diseases, without actively adopting these concepts and terms into his theory. While he was clearly interested in noting the causes of disease, he does not seem to be particularly interested in the debates on causal terminology and classification.

The Anonymous also uses once the term “first-affection” (πρωτοπάθεια) – a rare term associated with Pneumatist physicians;⁴⁰ on several occasions he uses its opposite: “co-affection” (συνπάθεια).⁴¹ Inflammation of the kidney can arise, he says, on account of a “first-affection” (πρωτοπάθεια);

34 Coughlin and Lewis (forthcoming). See Hankinson (1987), Hankinson (1998), and Frede (1980) on ancient Greek causal theories and terminology. Galen wrote books on both kinds of causes, interestingly, neither is extant in Greek: *Cohesive Causes* survives only in the medieval Arabic translation (ed. Lyons, 1969) and *Antecedent Causes* only in a fourteenth-century Latin translation (ed. Hankinson, 1998).

35 Galen, *Cohesive Causes*, 2.4, ed. Lyons (1969) 54.23–5, and see Coughlin and Lewis (forthcoming).

36 Anonymus Parisinus, *On Acute and Chronic Diseases*, 5, ed. Garofalo (1997) 38.13. He refers also to a cause “recalling” (ὑπομνηστική) the affection. This is not a cause of the disease as such but something which might cause a relapse by reminding the patient of the affection (ibid. 37, ed. Garofalo (1997) 196.26–198.1); nevertheless, it is noteworthy that the Empiricist doctors referred to ‘recalling signs’ in their diagnostic method (e.g. Ps.-Galen, *Medical Definitions*, 176, ed. Kühn (1830) XIX.396.12). I am grateful to Philip van der Eijk for drawing my attention to this term.

37 Anonymus Parisinus, *On Acute and Chronic Diseases*, 19, ed. Garofalo (1997) 120.2; cf. Galen, *On Abundance*, ed. Kühn (1824) VII.524.

38 Ps.-Galen, *Medical Definitions*, 64, ed. Kühn (1830) XIX.363.12, cf. Aristotle, *Poetics*, ed. Bekker (1831) 1448b4.

39 Anonymus Parisinus, *On Acute and Chronic Diseases*, 30, ed. Garofalo (1997) 164.17–18; cf. Hankinson (1987: 336), (1998: 40–3).

40 Ps.-Galen, *Introduction, or the Physician*, 9, ed. Petit (2009) 22.17 = ed. Kühn (1827) XIV.699 and see Gärtner (2015: 543–4, n. ad 260.17–20). Galen criticises this term and argues for ἰδιοπάθεια (“own-affection”): *On Identifying the Affected Parts*, 1.3.2, 1.6.1, ed. Gärtner (2015) 260.18, 282.5 = ed. Kühn (1824) VIII.31, VIII.48.

41 For sympathetic affection (συνπάθεια, συμπάθεω) in AP, see: Anonymus Parisinus, *On Acute and Chronic Diseases*, 7, ed. Garofalo (1997) 54.27 (spasm), ibid., 32, ed. Garofalo (1997) 172.5 (inflammation of liver), ibid., 37, ed. Garofalo (1997) 194.1 (nephritis), ibid., 50, ed. Garofalo (1997) 246.19 (sciatica); this is a key concept in Galen's theory, e.g. *On Identifying the Affected Parts*, 1.3.2, 1.6.1–7 ed. Gärtner (2015) 260, 282–8 = ed. Kühn (1824) VIII.301, VIII.48–53 and the note and references in Gärtner (2015: 543–4, n. ad 260, 17–20).

in other words, the kidney is “primarily” affected, or is the “first to be affected”. He does not suggest what could cause such an inflammation, but the point seems to be that some unnatural internal change or process began locally in the kidney and caused the inflammation inside it. Alternatively, it can arise, as we saw earlier, from morbid fluids flowing to the kidneys from another part and which cause the inflammation. This latter would be affection by “sympathy”, although he does not use the term in this case.

3 Signs

The sections on the signs (σημεῖα) accompanying each disease are between a paragraph and one-page long in the modern edition. We find here the range of signs and diagnostic methods familiar to us from Greco-Roman diagnostic treatises and patient case histories.⁴² The Anonymous lists signs physicians themselves can observe by means of their senses while examining patients; and signs which require physicians to rely on the patient’s descriptions of their subjective sensations and feelings.⁴³ The former include signs such as: pulse, respiration, swellings, complexion and changes in the face, temperature changes, odours, bowel movements, secretions, coughing, sleep patterns, speech and the patient’s attitude and manner. AP refers to the size, frequency and strength of the pulse, using terms known from Hellenistic and Roman pulse theories.⁴⁴ Concerning the face he notes, for instance, its bulging appearance, redness or it becoming “more ugly”.⁴⁵ In addition to “acute fever” he describes the fever’s pattern, for example: increases at night; “continuous” (συνεχής); “intermittent”

42 See García-Ballester (1994: 1652–9) on Galen, Jouanna (1999: 291–307) on Hippocrates, Thumiger (2017: 71–173) on cases of mental illness and (2018: 270–1) more broadly.

43 On this distinction, see Jouanna (1999: 291–307) and García-Ballester (1994: 1652–62).

44 He uses terms referring to size (“small”, μικρός and “large”, μέγας – e.g. Anonymus Parisinus, *On Acute and Chronic Diseases*, 2, 18, ed. Garofalo (1997) 12.3, 114.12), speed (“fast”, ταχύς and “slow”, βραδύνων rather than the more common βραδύς – e.g. *ibid.*, 3, 6, ed. Garofalo (1997) 20.11, 40.17), frequency (only “frequent”, πικνός, but not its opposite ἀραιός, “sparse” – e.g. *ibid.*, 6, 18, ed. Garofalo (1997) 40.16, 114.12.) and strength (“strong”, σφοδρός and “weak”, ἀσθενής – e.g. *ibid.*, 9, 19, ed. Garofalo (1997) 66.2, 118.7). He uses also rare terms such as διηρημένος (literally “divided” – perhaps for “sparse”) in the case of lethargy (*ibid.*, 2, ed. Garofalo (1997) 12.3) and δεδιωγμένος (“running”, “rapid”) in the case of phrenitis (*ibid.*, 1, ed. Garofalo (1997) 3.24–4.1; cf. Ps.-Rufus, *Synopsis on Pulse*, 6, ed. Dar-emberg and Ruelle (1879) 228.2).

45 For the face and eyes, see for example: Anonymus Parisinus, *On Acute and Chronic Diseases*, 31, ed. Garofalo (1997) 166.24–168.1 (bulging, red); *ibid.*, 6, ed. Garofalo (1997) 40.7, 40.12–13 (eyes hollow, face livid and black); *ibid.*, 21, ed. Garofalo (1997) 124.18 (“leaden and sunken” μολυβδόωδης καὶ κατενηνεγμένη); *ibid.*, 27, ed. Garofalo (1997) 150.6–8 (face uglier, eyes dirty and whitish).

(διαλείπων).⁴⁶ He refers to sounds emitted from patients' bodies, for example rumbling from the bowels⁴⁷ and to information gained from haptic examination, for example the sound arising from tapping the body⁴⁸ or how pressing a particular part affects the patient's sensation of pain.⁴⁹ In the case of affections in the kidneys or bladder the author refers not only to disrupted urinating patters (e.g. blocked, in drops) but also to the appearance and quality of the urine itself.⁵⁰

Among the signs about which physicians must learn from the patients we find diverse sensations and perceptions. Most common of these is pain, which is described with reference to its location, intensity and quality. Some descriptions of pain are very detailed, describing how the pain spreads to different parts and the sensations which accompany it, such as "heaviness" (βάρος).⁵¹ In pleurisy, for instance, there is

severe pain in the pleura reaching the flank and collarbone, sometimes even the shoulders and arm. Patients have the feeling of being pierced by something pointed. In the aforementioned places there are "currents".

συνεδρεύει πόνος πλευρᾶς ὑπερβάλλων διήκων μέχρι λαγόνος καὶ κλειδός, ἐνίοτε δὲ καὶ ὤμου καὶ βραχίονος. δοκοῦσι δὲ οἱ ἐν τῷ πάθει [ἐν] ἀκμῇ τινι διαπείρεσθαι. διαδρομαὶ δὲ ἐν τοῖς προειρημένοις τόποις γίνονται.⁵²

The reference to what patients "think" (δοκεῖν) or "imagine" (φαντασίαν ἔχειν) they are sensing occurs in many passages and is followed at times by vivid descriptions of such sensations or perceptions. In colic, the pain and

46 Anonymus Parisinus, *On Acute and Chronic Diseases*, 9, ed. Garofalo (1997) 64.23 (acute, increases at night); *ibid.*, 37, ed. Garofalo (1997) 194.1 (acute). συνεχής (*ibid.*, 1, 2, ed. Garofalo (1997) 2.23, 12.2) and διαλείπων (*ibid.*, 32, ed. Garofalo (1997) 172.5) are technical terms for describing fever, but we do not find in AP other common terms, such as τριταῖος (tertian).

47 Anonymus Parisinus, *On Acute and Chronic Diseases*, 15, ed. Garofalo (1997) 102.10, 102.19–20 (colic).

48 Anonymus Parisinus, *On Acute and Chronic Diseases*, 45, ed. Garofalo (1997) 226.12–13 (dropsy).

49 Anonymus Parisinus, *On Acute and Chronic Diseases*, 49, ed. Garofalo (1997) 246.15–16 (sciatica).

50 For example: Anonymus Parisinus, *On Acute and Chronic Diseases*, 37, ed. Garofalo (1997) 196.19–20 (nephritis) "like a spider web" (οἷα ἀράχνια) or "like that of beasts of burden" (ὅμοια τοῖς ὑποζυγίοις); *ibid.*, 33, ed. Garofalo (1997) 180.13 (jaundice): bilious and yellow; *ibid.*, 40, ed. Garofalo (1997) 206.14–15 (paralysis of the bladder): stoppage or drops.

51 Some examples of pain descriptions: Anonymus Parisinus, *On Acute and Chronic Diseases*, 14, ed. Garofalo (1997) 94.16–20 (ileus); *ibid.*, 32, ed. Garofalo (1997) 170.25–172.3 (inflammation of liver); *ibid.*, 37, ed. Garofalo (1997) 192.24–194.1 (inflammation of kidneys). A sensation of heaviness: *ibid.*, 9, ed. Garofalo (1997) 64.24–5 (*peripneumonia*); *ibid.*, 10, ed. Garofalo (1997) 72.20–1 (syncope); *ibid.*, 26, ed. Garofalo (1997) 142.7 (haemoptysis); *ibid.*, 31, ed. Garofalo (1997) 166.22 (asthma); *ibid.*, 40, ed. Garofalo (1997) 206.15–16 (paralysis of the bladder).

52 Anonymus Parisinus, *On Acute and Chronic Diseases*, 8, ed. Garofalo (1997) 58.18–21.

sensation of “distention” (διάτασις) is so great that the patients “think their flanks are breaking and imagine that their vertebrae are separating”.⁵³ In vertigo the patients “think they see circles”.⁵⁴ It seems that the exact quality of the pain or sensation was recorded in order to assist physicians in identifying the disease from which their patient was suffering and distinguishing it from similar diseases.⁵⁵ These descriptions reflect the accounts of patients attempting to explain to their physicians subjective sensations otherwise inaccessible to the physician. Much of this information was probably gained from direct questions the physician addressed to the patient, which was a common part of the physician’s examination.⁵⁶ The universal nature of the treatise means that there are no case histories or information on particular patients. However, the particularity and peculiarity of some of the signs and sensations most likely derive from individual (at times perhaps unique) cases, which were then compiled into a general comprehensive list.⁵⁷ AP or his sources might have changed some of the patients’ original formulations, but the particularities of the sensations imply that they reflect the patients’ original perception of the experience and the language they used to express it.⁵⁸ The physicians could not know that a patient is seeing circles, feeling heaviness, a piercing sensation or his/her parts separating without verbal input from the patients. The physicians’ addition of verbs such as “think” or “imagine” further delimitates between the patient’s and physician’s perspectives and experiences. These were probably not (all) AP’s own patients and part of the information probably originates from works of other authors and from other diagnostic and therapeutic handbooks. It is hard to imagine that he encountered all the kinds of diseases and their diverse manifestation he describes; and the doxographic parts of his work clearly indicate that he was using other sources.

53 Anonymus Parisinus, *On Acute and Chronic Diseases*, 15, ed. Garofalo (1997) 102.12–15; cf. in ileus, the patient’s belief that their hip joints and ribs are “releasing” (λύεσθαι) – *ibid.*, 14, ed. Garofalo (1997) 94.24–6.

54 Anonymus Parisinus, *On Acute and Chronic Diseases*, 17, ed. Garofalo (1997) 110.13–15.

55 The presence or severity of pain (rather than the particular quality of the pain) also had a therapeutic significance, namely in indicating the recommended course of treatment. We find many sentences such “if pains persist ...” followed by a recommended treatment (for instance: Anonymus Parisinus, *On Acute and Chronic Diseases*, 6, ed. Garofalo (1997) 44.6; *ibid.*, 5, ed. Garofalo (1997) 34.20; *ibid.*, 14, ed. Garofalo (1997) 96.27.

56 García-Ballester (1994: 1659–62), Letts (2015), Thumiger (2018: 271–3).

57 On case histories in the Hippocratic *Epidemics* see most recently Thumiger (2018); in Galen many case histories are intended to demonstrate the universal method or theoretical point and prove his professional superiority, see García-Ballester (1994: 1648–51) and Nutton (1991: 9–14); see also Mattern (2008) for a detailed discussion of Galen’s case histories and Lloyd (2009) for a comparison.

58 On the language of expressing pain and the patient’s role, see Roselli (2015), Roby (2015), and King (2018).

3.1 *The progress of disease*

The diagnostic sections in AP are not just “flat” or random lists of signs, but describe the diversity in cases and manifestations of each disease. The narrative usually begins from the external apparent signs, or most obvious ones, moving on to behaviour or subjective sensations. In other cases the narrative follows the different manifestations of the disease and its signs, and especially the intensification or remission of certain signs. The signs change as the disease progresses and the patient’s condition worsens or improves. AP sometimes marks the passage of time and the progress of the disease by noting the time of day or the number of days which have elapsed.⁵⁹ In other cases, he marks the progress by referring to general stages (“at the beginning ... later”, “if they get worse”)⁶⁰ or key changes (such as the burst of an abscess) which entail or lead to a new or slightly changed set of signs: for example, new pains or secretions appear, the pulse or fever change and so forth.⁶¹ In some diseases AP distinguishes two different kinds. One kind of angina entails swelling and pain, the other does not.⁶² In some affections (such as *mania* and epilepsy) patients might be either agitated and active, or lethargic and passive – each kind with its particular symptoms.⁶³ As we shall see, the distinction of different stages, sets of symptoms or manifestations of the disease was essential for the treatment, for each requires a different intervention, remedy or course of action.

3.2 *Localising disease*

The author often mentions the body part(s) in which the signs occur. Such information was important for identifying the disease and determining the course of treatment, especially in the case of applying external remedies. In some cases, the language and remarks of AP in this respect point to

59 For example: Anonymus Parisinus, *On Acute and Chronic Diseases*, 2, ed. Garofalo (1997) 12.2–3 (lethargy: “fever intensifies at nighttime”); *ibid.*, 4, ed. Garofalo (1997) 26.13–14 (apoplexy: “some succumb on the first, second or third day”; *ibid.*, 8, ed. Garofalo (1997) 60.6–7 (pleurisy: “all things worsen around the fourth day”).

60 “If they get worse” (χειρόν ἀπαλλάττοντες), for instance: Anonymus Parisinus, *On Acute and Chronic Diseases*, 7, 21 ed. Garofalo (1997) 50.20, 124.16; “when the bursting (of the abscess) is near” (πλησίον οὐσης ἀναρρήξεως), “when the abscess breaks” (ῥαγέντος τοῦ ἀποστήματος): *ibid.*, 27, ed. Garofalo (1997) 160.5–10; “at the beginning ... later” (κατ’ ἀρχάς ... ὕστερον): *ibid.*, 27, ed. Garofalo (1997) 160.1–2.

61 For example: symptoms get inverted in *melancholia* – Anonymus Parisinus, *On Acute and Chronic Diseases*, 19, ed. Garofalo (1997) 118.5–6; the fever pattern changes during abscesses and shivers begin (*ibid.*, 27, ed. Garofalo (1997) 160.1–3); pains increase in ileus (*ibid.*, 14, ed. Garofalo (1997) 94.24).

62 Anonymus Parisinus, *On Acute and Chronic Diseases*, 6, ed. Garofalo (1997) 40.

63 Anonymus Parisinus, *On Acute and Chronic Diseases*, 3, ed. Garofalo (1997) 20; *ibid.*, 18, ed. Garofalo (1997) 114.

the diagnostic idea of “the affected part” (ὁ πεπονθὼς τόπος, τὸ πεπονθὸς μέρος), which emerged in post-classical medicine. Classical sources often note the bodily location of a disease or the signs accompanying it,⁶⁴ but in later sources the question of identifying the affected part becomes a distinct diagnostic aim and matter of debate. Extensive anatomical research together with a need to overcome practical diagnostic challenges and the intense professional rivalry in the Hellenistic and Early-Roman periods all contributed to the emergence of this question.⁶⁵ There is still much to investigate concerning the history of this idea, but what can be said with certainty is that by the first century CE the idea and question were sufficiently articulated so as to lead the Rome-based physician, Archigenes of Apamea, to write a three-book treatise entitled “On the Affected Parts” (Περὶ τῶν πεπονθότων τόπων). The work is now lost, but fragments which have reached us through later sources demonstrate his attempt to identify the connection between particular physical signs (e.g. distinct types of pain) and particular body parts.⁶⁶ Less than a century later, Galen adopted and adapted Archigenes’ title in his own work “On Identifying the Affected Parts” (Περὶ διαγνώσεως τόπων πεπονθότων) – further stressing the diagnostic nature and importance of this idea.⁶⁷ The aim of Galen’s six-book work is to teach the physician how to identify the disease and affected part based on the signs which patients show. Galen’s treatise and the fragments from Archigenes’ work reflect the challenge which physicians faced when attempting to identify the exact internal anatomical source and location of a patient’s distress in a period in which there were no means for looking deep inside the body without harming it. The identification of the affected part had clinical implications as regards treatment: as Galen demonstrates in an often-cited case history, treating impaired mobility of the fingers by applying remedies to those parts is completely useless if the impairment is caused, in fact, by a problem in the spine and spinal cord.⁶⁸

64 For example, in the Hippocratic nosological works (*Affections, Internal Affections, Diseases 1–3*) listing different diseases and their signs and treatments; on this group of works see Craik (2015: sections 3, 22, 30–33) and Roselli (2018); see also Gundert (1992) for a more general discussion of body parts in the Hippocratic Corpus.

65 Gelpke (1987); van der Eijk (1998: 349–51); McDonald (2012).

66 On Archigenes theory regarding pain and its diagnostic relevance, see, in particular, Galen, *On Identifying the Affected Parts*, 2.6.1, 2.8.1–3, 2.9.1, ed. Gärtner (2015) 326.1–14, 328.25–330.24, 352.16–24 = ed. Kühn (1824) VIII.86–7, VIII.90–2, VIII.110; for discussion, see Roselli (2015), Roby (2015), Gärtner (2015: 606–7), and King (2018: 83–6).

67 On the form of Galen’s title, see Gärtner (2015: 450–1).

68 Galen, *On Identifying the Affected Parts*, 1.6, ed. Gärtner (2015) 290–4 = ed. Kühn (1824) VIII.56–9.

It has been shown that many of the aetiological sections in AP reflect his interest in the question of the location of disease.⁶⁹ We find important evidence in other sections of AP as well. He uses the term “affected part” twice in full and several times with the noun implied by the participle.⁷⁰ He is, in fact, the earliest extant source in which this combination appears, although the loss of most of our Hellenistic medical sources means that he was not necessarily the first to use it; and we do not know the chronological relation between him and Archigenes. Most of the relevant references in AP occur in the therapeutic context. However, two occasions in the diagnostic sections are noteworthy. In the case of ulceration of the bladder, half of the (short) diagnostic section concerns the location of the ulcer:

if the upper parts are in pain, the ulcer is around the “bottom” (of the bladder),⁷¹ but if the groin and perineum are in pain, the fleshy part (of the bladder) is affected. When the (painful) sensation is near the penis itself, the ulceration is around that part (μέρος).⁷²

τῶν μὲν οὖν ἀνωτέρω μερῶν ἀλγουντων περὶ πυθμένα τὸ ἕλκος· εἰ δὲ βουβῶνες εἶεν καὶ περίνεον ἐν ὀδύνῃ, τὰ σαρκώδη πέπονθεν· ὅτε δὲ πρὸς αὐτῷ τῷ καυλῷ ἢ αἰσθησίς, περὶ τοῦτο τὸ μέρος ἢ ἑλκωσίς ἐστιν.

In this passage, the locations of the pain which the patients report serve as an indication for the location of the ulcer in each patient. It is interesting that the aetiological and therapeutic sections do not pick up this issue of localisation, although is distinctively emphasised in the diagnostic section. The aetiological section, which is not doxographic, refers to different causes (e.g. drugs and inflammation), but not to different parts. The long therapeutic section lists diverse remedies, distinguishes the treatment of women and even gives

69 van der Eijk (1998: 350–1), (1999a: 321–3); McDonald (2012: 76–8). In this context it was related also to debates concerning the soul and its relation to particular parts of the body, see Mansfeld (1989) and Mansfeld (1990); McDonald (2012: 79–82); Lewis (2017: 287–92); Lewis (2018: 167–74).

70 Anonymus Parisinus, *On Acute and Chronic Diseases*, 26, ed. Garofalo (1997) 142.26–144.1 (τὰ πεπονθότα μέρη) – in the therapeutic section; *ibid.*, 49, ed. Garofalo (1997) 246.9–10 (οἱ πεπονθότες τόποι) – in the aetiological section. With participle alone and noun implied: *ibid.*, 27, 48, 50, ed. Garofalo (1997) 148.9, 242.11, 252.21 – all in therapeutic sections.

71 πυθμὴν literally means “foundation” or “bottom” (Fuchs translates it simply as “the bottom”, presumably referring to the bottom part of the bladder) – cf. Galen, *On the Anatomy of the Uterus*, 1.2, 3.1, ed. Nickel (1971) 34.10, 38.1 = ed. Kühn (1821) II.888, II.890. The terminology is converse to what we would expect: the “bottom of the bladder” is its cranial (“upper”) part, as is the case for the “bottom” (πυθμὴν) of the uterus – *ibid.* 2.2, 9.1, ed. Nickel (1971) 36.11–12, 48.5–6 = Kühn (1821–33) II.889, II.899 (compare the modern name “fundus” for these parts of the bladder and uterus – named so since they are at the opposite end of the “mouths” of the organs). See Fürst von Lieven and Humar (2017: 99–102, 104) for the converse directions in ancient terminology.

72 Anonymus Parisinus, *On Acute and Chronic Diseases*, 38, ed. Garofalo (1997) 202.6–9.

particular instructions for cases of “dirty ulcers” (ῥυπαρὰ ἔλκη), which are mentioned in the diagnostic section.⁷³ He does not prescribe, however, different treatments according to the affected part. He recommends applying external remedies to the “lower abdomen” (τὸ ἥτρον) and “loin” (ὀσφύς), but this appears to be a universal recommendation regardless of the ulcer’s exact location.⁷⁴ A few lines later he refers to soothing “the places” (οἱ τόποι) with fomentations, but it is unclear whether he is referring only to the abdomen and loin just mentioned, or to other parts too.⁷⁵ Perhaps experienced readers were expected to understand that such treatments are to be applied to the affected part identified from the location of the pain (on the Anonymous’ expectations from his readers, see below, section 4.2).

In the second reference to the particular location of the affection we find a close connection between the diagnostic localisation and the aetiological section. This is the chapter on haemoptysis – the coughing up of blood. After listing different antecedent and cohesive causes for the disease (see above, pp. 31–2), AP adds:

It also differs according to location. For it (sc. the blood) is carried either from the head, or the mouth, or the oesophagus, or the stomach, or the bronchus, or the windpipe, or the lung, or the thorax.⁷⁶

διαφέρει δὲ καὶ κατὰ τόπους, ἢ γὰρ ἀπὸ κεφαλῆς φέρεται, ἢ στόματος, ἢ στομάχου, ἢ κοιλίας, ἢ βρόγχου, ἢ τραχείας ἀρτηρίας, ἢ πνεύμονος, ἢ θώρακος.

The diagnostic section is dedicated entirely to explaining the manner in which one can diagnose the anatomical origin of the blood, that is, the location of the affection. The section is structured as a list of parts mentioned in the aetiological section – windpipe, head, lung, thorax, oesophagus and stomach (the mouth and bronchi are not mentioned). For each part there follows a description of the blood in terms of colour and other qualities (e.g. clotted, frothy, ill-smelling) as well as of other signs (e.g. cough or pain).⁷⁷ The

73 On dirty ulcers: Anonymus Parisinus, *On Acute and Chronic Diseases*, 39, ed. Garofalo (1997) 202.5, and for their treatment: *ibid.*, 39, ed. Garofalo (1997) 204.19–24. On the treatment of women, see pp. 47–8.

74 Anonymus Parisinus, *On Acute and Chronic Diseases*, 39, ed. Garofalo (1997) 202.24–204.1.

75 Anonymus Parisinus, *On Acute and Chronic Diseases*, 39, ed. Garofalo (1997) 204.3.

76 Anonymus Parisinus, *On Acute and Chronic Diseases*, 26, ed. Garofalo (1997) 140.19–22.

77 Anonymus Parisinus, *On Acute and Chronic Diseases*, 26, ed. Garofalo (1997) 140–2. This reminds one somewhat of Galen’s examples, right at the outset of his work on affected parts, for identifying the affected part from the substance expelled from inner parts of the body (Galen, *On Identifying the Affected Parts*, 1.1.2–10, Gärtner (2015) 226–32 = ed. Kühn (1824) VIII.2–6). Among these examples he mentions the difficulty of identifying whether matter coughed up originates from the bronchi or lung, which could point to the location of the affection. Identifying the anatomical origin of coughed blood still challenges modern physicians.

treatment recommended by AP is partially “common” (κοινῶς) for all patients, and partially adapted to the individual patient, according to the severity of the case and the patient’s endurance or preferences.⁷⁸ AP notes once that certain external remedies (sponges with diluted vinegar) “should be applied to the affected parts” (ἐπιρριπτέον τοῖς πεπονθόσι μέρεσι) – presumably following the identification of these parts by means of the detailed diagnostic list.

4 Treatment

The therapeutic sections are the longest and most detailed parts of the work. They are at least a page long in the modern edition and often extend to two or three pages, sometimes even to four or five pages (e.g. on angina and dropsy – chapters 6, 45). There is a clear logical narrative in the prescriptions, depicting an organised but flexible method. The sections often begin with instructions as to where and how to lay the patients, with regard to both the actual room (cellar, no light, near a fire, etc.),⁷⁹ the type of mattress or bedding (light, soft, etc.),⁸⁰ and the posture of the patient (e.g. on an elevated pillow).⁸¹ This sets the spatial location in which the treatment and patient–doctor encounters will take place.⁸² In many cases, however, the author jumps straight to the therapeutic prescriptions.⁸³ On a few occasions he begins with a general note on the chances of successful treatment (e.g. phthisis)

78 Anonymus Parisinus, *On Acute and Chronic Diseases*, 26, ed. Garofalo (1997) 142–4; κοινῶς, *ibid.*, 26, ed. Garofalo (1997) 142.17. For other adaptations, e.g. *ibid.* 26, ed. Garofalo (1997) 142.24–6, 144.7–11, 144.16.

79 For example: Anonymus Parisinus, *On Acute and Chronic Diseases*, 10, ed. Garofalo (1997) 74.6–8 (syncope); *ibid.*, 11, ed. Garofalo (1997) 82.17 (ravenous appetite); *ibid.*, 31, ed. Garofalo (1997) 168.6–7 (asthma).

80 For example: Anonymus Parisinus, *On Acute and Chronic Diseases*, 10, ed. Garofalo (1997) 74.8–9, *ibid.*, 11, ed. Garofalo (1997) 82.18–19 (ravenous appetite); *ibid.*, 26, ed. Garofalo (1997) 142.20 (haemoptysis).

81 For example: Anonymus Parisinus, *On Acute and Chronic Diseases*, 7, ed. Garofalo (1997) 52.6–9 (spasm); *ibid.*, 26, ed. Garofalo (1997) 142.18–19 (haemoptysis).

82 AP usually relates the instructions to the practitioner in the impersonal adverbial form with -έον endings, for example: κατακλιτέον – “one must lay (the patient)”, e.g. Anonymus Parisinus, *On Acute and Chronic Diseases*, 1, 18, ed. Garofalo (1997) 4.18, 114.18; χρηστέον – “one must use”, e.g. *ibid.*, 2, ed. Garofalo (1997) 16.8; ἐμφυσητέον – “one must blow (vinegar into their nostrils)”, *ibid.*, 3, ed. Garofalo (1997) 24.1 and so forth. He often uses also the third-person imperatives, for example: ἐμβρεχέσθω “the patients are to be embrocated”, *ibid.*, 23, ed. Garofalo (1997) 134.19; προσαγέσθω “(phlebotomy) should be applied”, *ibid.*, 26, ed. Garofalo (1997) 142.26 and so forth. In some cases, he uses the first-person plural, for instance: ἐπιρρίψομεν, “we apply...” – *ibid.*, 23, ed. Garofalo (1997) 134.24.

83 For example: Anonymus Parisinus, *On Acute and Chronic Diseases*, 8, ed. Garofalo (1997) 60.11 (pleurisy); *ibid.*, 23, ed. Garofalo (1997) 134.16 (cynic spasm).

or the consideration of the causes of the disease (atrophy, jaundice).⁸⁴ Regardless of the manner in which they begin, all the therapeutic sections follow a diachronic narrative. In some cases, time is mentioned explicitly by reference to the number of days.⁸⁵ More often, however, the passage of time is noted with reference to the course of the disease rather than by exact days. The section lists possible signs and changes occurring to the patient and what one must do in each case. This is usually marked with conditional clauses, with the therapeutic measure in the apodosis: “if inflammations of the bladder also occur, evacuate with...”,⁸⁶ “if the loss of blood is not checked, inject...”,⁸⁷ “if he does not awaken, we shall blow...”,⁸⁸ “if the vomiting persists ... apply also cupping glasses ... if the extremities become cold and the pulse diminishes, anoint them...”.⁸⁹ The examples are numerous and occur throughout. Such references to the number of days or changing signs point to the expectation or assumption that often the physician will be treating and visiting the patient over a prolonged period, extending to weeks and even months.⁹⁰ We see, then, that changes in the course of the disease and in the patient’s condition and the effects of the treatment on the patient are crucial for determining the appropriate therapeutic measure(s) – each requires a different intervention, remedy, or course of action. We will discuss shortly some of the considerations which determine the choice at each juncture.

As for the treatments themselves, AP’s instructions include the whole range of therapeutic measures known from Greco-Roman medical sources: phlebotomy, also by means of leeches;⁹¹ medicines and substances taken through the mouth or other cavities (e.g. as clysters), or applied externally (e.g. embrocation and pitch-plaster) – occasionally exact recipes are noted;⁹² cupping; scarification; amulets; massage; dietary and other regimen instructions; exercises – passive and active movements. On several occasions, he notes that the external remedy should be applied to the

84 Anonymus Parisinus, *On Acute and Chronic Diseases*, 27, ed. Garofalo (1997) 150.14–16 (phthisis); *ibid.*, 30, ed. Garofalo (1997) 164.17–18; (atrophy); *ibid.*, 33, ed. Garofalo (1997) 180.22–182.1 (jaundice) (cf. *ibid.* 182.19, 184.12).

85 For example: Anonymus Parisinus, *On Acute and Chronic Diseases*, 2, ed. Garofalo (1997) 18.6 (lethargy); *ibid.*, 21, ed. Garofalo (1997) 128.2, 128.14–15 (paralysis).

86 Anonymus Parisinus, *On Acute and Chronic Diseases*, 39, ed. Garofalo (1997) 204.14–15.

87 Anonymus Parisinus, *On Acute and Chronic Diseases*, 38, ed. Garofalo (1997) 200.10.

88 Anonymus Parisinus, *On Acute and Chronic Diseases*, 2, ed. Garofalo (1997) 16.21.

89 Anonymus Parisinus, *On Acute and Chronic Diseases*, 13, ed. Garofalo (1997) 92.7–11.

90 On the duration of physicians’ involvement and care, see Thumiger (2018: 267–8) on Hippocratic authors, and Mattern (2008: 65) on Galen.

91 For leeches, see, for example: Anonymus Parisinus, *On Acute and Chronic Diseases*, 2, ed. Garofalo (1997) 16.10–13 in persistent cases of lethargy; *ibid.*, 16, ed. Garofalo (1997) 108.12–13, 108.16–17 (satyriasis).

92 Examples include: medicinal drinks for asthma (Anonymus Parisinus, *On Acute and Chronic Diseases*, 31, ed. Garofalo (1997) 168.12–19); a clyster injected for bleeding from the bladder (*ibid.*, 39, ed. Garofalo (1997) 200.10–13).

“affected part”.⁹³ However, in some cases in which his discussions of the causes or signs stress the question of the affected part, the therapeutic prescriptions do not reflect the complexity at all (e.g. in phrenitis) or only in passing (in haemoptysis).⁹⁴ He also refers to proven experience and tested measures: “I know (οἶδα) that many have confirmed from experience (προσμαρτυροῦντες)” (for ileus); “drugs which are for melancholics through experience (διὰ πείρας)”.⁹⁵ Surgery is rarely mentioned: for cases of a “bursting” of an abscess between the peritoneum and intestines and as a last resort in the case of bladder bleeding and paralysis.⁹⁶ In some cases, physical measures to restrain the patient are sanctioned, but a distinction is made between slaves and freemen regarding the measures which may be used.⁹⁷ Some measures are more “psychological”, such as encouraging the patient, or instilling hope; in such cases “words” or “reason” (λόγοι, λόγος) are therapeutic “tools” which the physician applies in attempting to cure the patient.⁹⁸ These are not forms of “emotional” or “philosophical” therapy, which centred on ethical improvement and philosophical discourse between patient and “therapist”, rather, the measures recommended by AP are means to address specific distressed feelings or behaviour which occur on account of a particular pathology.⁹⁹

93 Anonymus Parisinus, *On Acute and Chronic Diseases*, 26, ed. Garofalo (1997) 142.26–148.9 (sponging and then meal flower or incense powder in cases of haemoptysis); *ibid.*, 47, ed. Garofalo (1997) 242.11–12 (pitch-plaster in the case of gonorrhoea); *ibid.*, 50, ed. Garofalo (1997) 252.20 (rubbing in the case of gout).

94 See above, pp. 39–40 on haemoptysis and van der Eijk (1999a: 308) on phrenitis.

95 Anonymus Parisinus, *On Acute and Chronic Diseases*, 14, ed. Garofalo (1997) 98.17–18; *ibid.*, 19, ed. Garofalo (1997) 118.24–5; cf. *ibid.*, 50, ed. Garofalo (1997) 256.20–1 for gout. Cf. Bouras-Vallianatos (2014) on the ways in which Alexander of Tralles (sixth century CE) relates and emphasises his practical experience.

96 Anonymus Parisinus, *On Acute and Chronic Diseases*, 33, ed. Garofalo (1997) 178.10–12; *ibid.*, 38, ed. Garofalo (1997) 200.17–20; *ibid.*, 40, ed. Garofalo (1997) 208.17–19. These appear as cases in which fluids accumulate in hollows of the body which cannot be accessed through other “routes” (e.g. urethra, mouth, anus) since they lie between passages leading to the surface of the body.

97 Slaves suffering from certain effects of phrenitis should be bound, whereas freemen should not; the reason given is that “this measure excites anger and can increase it” (Anonymus Parisinus, *On Acute and Chronic Diseases*, 1, ed. Garofalo (1997) 10.3–7).

98 For example, in the cases of phrenitis, syncope, *melancholia*, and neurosis (Anonymus Parisinus, *On Acute and Chronic Diseases*, 1, 10, 19–20 ed. Garofalo (1997) 6.16–24, 74.16–17, 118.27–120.9, 122.9–11, 122.14–15). For λόγος, see for instance: *ibid.*, 1, ed. Garofalo (1997) 6.16: τῇ ἀπὸ λόγου βοήθειά παρηγορήσομεν (“we will encourage with the help from reason”) – cf. *ibid.*, 19, ed. Garofalo (1997) 118.27: ἡ διὰ τοῦ λόγου βοήθεια (“through the help of reason”); *ibid.*, 20, ed. Garofalo (1997) 122.9: τῇ διὰ τῶν λόγων νουθεσίᾳ (“using warning through words”). See Gill (2018: 366, nn. 3–5) for some parallels. See Porter (2015) for similar methods in Soranus; see Thumiger (2016) and Thumiger (2017: 345–76) on the emotional signs in bodily pathologies in the Hippocratic writers and these physicians’ efforts to disperse patients’ fears regarding their chances of surviving the disease.

99 See Gill (2018) for a recent discussion of “philosophical therapy of emotions” and its place in medical writings; see van der Eijk (2013) on the treatment and curability of mental diseases in Greco-Roman philosophical and medical thought.

4.1 A distinction between curative and restorative stages

In many cases, the therapeutic sections end with a transition to the “restorative” (ἀναληπτικός, ἀνάληψις) stage, which aims to help the patient regain his or her strength and recover fully. In one case AP opposes this restorative treatment (ἀναληπτικῶς) to the treatment aimed at eradicating (ἀποικονομεῖσθαι) the cause of the disease. AP does not always explain what this restorative stage entails and often simply states that one “can proceed to the restorative method” (ἔστι ἐπὶ τὸν ἀναληπτικὸν χωρεῖν τρόπον) or “should adopt” (ἀναλαμβάνεσθω) it.¹⁰⁰ Those using the treatise are expected to know what to do. Other passages offer some details: wine and baths are often mentioned (and in the case of pleurisy are said to be the first stage),¹⁰¹ easily-digested, appetising and laxative food and drink,¹⁰² riding,¹⁰³ passive exercises or walks, and at times vocal exercises and the retention of breath as well as massages.¹⁰⁴ The idea seems to be to apply measures and regimens which are not too demanding or taxing, but which cannot be performed before the patient regains some of his or her strength nor before their impaired faculties (e.g. digestive, motor) are somewhat restored.

4.2 An expectation for informed readers

Despite the length and detail of the therapeutic instructions, crucial information is “missing”. Drugs and external remedies are often mentioned only generally: “sprinkle ... (drugs) which are capable of condensing and strengthening (ῥωννῦναι καὶ συστρέφειν δυναμένοις)”;¹⁰⁵ “we apply also (drugs) with attractive faculties (αἱ ἐπισπαστικαὶ δυνάμεις)...”.¹⁰⁶ This is the case with other aspects of the treatment as well. For example, in the case of ileus, “if the general condition is changing” the physician must encourage “an accurate (ἀκριβής) restorative treatment”.¹⁰⁷ And for those suffering from *mania*, “one must choose the air appropriate (κατάλληλον) to them”.¹⁰⁸ Similar examples can be found in almost every chapter. Which

100 For example: Anonymus Parisinus, *On Acute and Chronic Diseases*, 1, 6, 26, 33, ed. Garofalo (1997) 10.12–13, 48.22–4, 146.17–18, 182.13. In liver inflammation he refers to “the common restorative method” (ὁ κοινὸς τῆς ἀναλήψεως τρόπος, *ibid.*, 32, ed. Garofalo (1997) 178.11–12), but it is not clear whether this is common only to all possible cases described for this disease, or more generally for different diseases.

101 Anonymus Parisinus, *On Acute and Chronic Diseases*, 8, ed. Garofalo (1997) 64.12–13.

102 Anonymus Parisinus, *On Acute and Chronic Diseases*, 12, ed. Garofalo (1997) 88.17–20.

103 Anonymus Parisinus, *On Acute and Chronic Diseases*, 21, ed. Garofalo (1997) 130.1–2.

104 Anonymus Parisinus, *On Acute and Chronic Diseases*, 15, ed. Garofalo (1997) 106.1–3.

105 Anonymus Parisinus, *On Acute and Chronic Diseases*, 33, ed. Garofalo (1997) 184.20–1.

106 Anonymus Parisinus, *On Acute and Chronic Diseases*, 23, ed. Garofalo (1997) 134.24.

107 Anonymus Parisinus, *On Acute and Chronic Diseases*, 14, ed. Garofalo (1997) 100.25–6.

108 Anonymus Parisinus, *On Acute and Chronic Diseases*, 18, ed. Garofalo (1997) 114.19–20.

drugs are strengthening or hold attractive faculties, what is the accurate treatment or appropriate air? This is knowledge the readers must gain independently. One may argue that these vague instructions are a result of AP's method of copying snippets from other sources, which had originally explained these details. But even if this was the case, it appears the Anonymous considered his presentation acceptable and comprehensive – he expected his readers to know what he meant and to be able to complete the details we consider “missing”. Nevertheless, the ambiguity may indicate something deeper as well.

4.3 *Theory, experience and the patient*

The lack of detail concerning the “accurate” regimen or particular drugs to apply may derive from more than just the assumption that experienced physicians know what these were in each case. It may reflect the understanding that the suitable drugs or regimen may change from case to case and from patient to patient, even if a particular case seems to fit the universal pattern the physician learned about in theory or the pattern he observed in earlier cases.¹⁰⁹ AP demonstrates an acute awareness that what theory or even prior experience have taught or shown to be “useful” or “correct” cannot be taken for granted or followed blindly in practice. It is necessary, therefore, to leave the choice of the appropriate remedy or the time of its application to the judgement of the physician at hand, based not only on “textbook theory” and prior experience, but also on common sense and (an educated) assessment of the individual patient and his or her condition at a given time. A passage from the therapeutic section of syncope illustrates the point:

The best physicians should follow closely the benefits obtained from the administered (remedy); and if the patient benefits (from a certain remedy), then continue (the treatment) with the same (remedies); and if not, pass on to a different remedy.

δεῖ δὲ τὸν ἄριστον ἱατρὸν παρακολουθεῖν τοῖς ἐκ τῶν προσφερομένων βοηθήμασι καί, εἰ μὲν εὐαρεστοίτο, τοῖς αὐτοῖς ἐπιμένειν, εἰ δ' οὐκ, μεταβαίνειν ἐφ' ἕτερα.¹¹⁰

This passage is an important testimony for the manner of gaining empirical experience through trial and error. It is also a fascinating window onto medical practice and the Roman “physician at work”. It reflects the

109 This problem stands at the basis of Galen's concept of “qualified experience” (διωρισμένη πείρα), on which see van der Eijk (2005).

110 Anonymus Parisinus, *On Acute and Chronic Diseases*, 10, ed. Garofalo (1997) 76.13–15.

challenge which physicians faced (and still face) each time they examined a patient and tried to solve the particular puzzle the patient's condition posed. What should guide the physician at this moment, according to the Anonymous, is the particular case at hand. He must determine the course of treatment based on the condition of the individual patient: his/her strength, response to treatment, and their comfort, tolerance or ability to endure certain treatments.¹¹¹ This emerges as an essential part of AP's therapeutic approach and method. In many cases, AP refers explicitly to the patient's ability to endure and tolerate a certain remedy. For jaundice, boiled hellebore can be used, and in spasm, gentle massages "if the patients are vigorous (εὔτονοι)".¹¹² As AP notes elsewhere, the *dynamis*, i.e. the patient's individual capacity, "must always (ἐκ παντός) be preserved".¹¹³ In *phthisis*, food should be given "in accordance with (the patient's) *dynamis*" (κατὰ δύναμιν).¹¹⁴ In some cases of dysentery, one must bleed the patient at the beginning of the treatment, but only "if the *dynamis* permits" (τῆς δυνάμεως ἐπιτρεπούσης).¹¹⁵ Caelius Aurelianus, writing in Latin in the fourth century CE on the basis of Soranus' Greek second-century writings, often uses the phrase *permittentibus viribus* (lit: "if the capacities allow") to remind his readers to take into account the endurance of their patient when applying therapeutic measures.¹¹⁶ Scholars have noted similar concerns in other medical sources of the Roman period, such as Scribonius Largus, Celsus and Soranus. Amber J. Porter concludes that writers from the first to the second century "demonstrate a particular – if not necessarily novel – interest in how patients are treated, advocating compassion and humanity in their interactions with them".¹¹⁷

AP is an important testimony for such interest. In the passages cited above, there seems to be more at stake for him than the patient's strength

111 Galen discusses this tension between the universal and particular, between theory and practice, but unlike AP he stresses the importance of theory (pathological, physiological and pharmacological) in solving the particular case. He presents a complex classification of a set of criteria (such as gender, age, body mixture and so forth) which indicates the appropriate therapeutic course to the physician trained in this theoretical framework. See van der Eijk (2008: 287–97).

112 Anonymus Parisinus, *On Acute and Chronic Diseases*, 33, ed. Garofalo (1997) 184.9; cf. *ibid.*, 7, 27, 31, ed. Garofalo (1997) 54.1, 160.22–3, 168.7–8.

113 Anonymus Parisinus, *On Acute and Chronic Diseases*, 4, ed. Garofalo (1997) 28.20–1.

114 Anonymus Parisinus, *On Acute and Chronic Diseases*, 27, ed. Garofalo (1997) 152.17; cf. *ibid.*, 5, 6, 7, 51, ed. Garofalo (1997) 32.14–15, 40.24, 32.28, 260.12.

115 Anonymus Parisinus, *On Acute and Chronic Diseases*, 43, ed. Garofalo (1997) 220.2; cf. *ibid.*, 4, and 5, ed. Garofalo (1997) 28.15, 28.20–1, and 34.14–15.

116 Caelius Aurelianus, *Acute Diseases*, 1.10.70, ed. Bendz (1990) I.62.5 (phlebotomy); *ibid.*, 1.10.82, ed. Bendz (1990–3) I.68.1 (fasting); *ibid.*, 3.4.45, ed. Bendz (1990–3) I.318.24 (phlebotomy); Caelius Aurelianus, *Chronic Diseases*, 3.2.24, ed. Bendz (1993) II.692.21 (eating).

117 Porter (2015: 301). See also Deichgraber (1950) and Mudry (1997), as well as Ecce (2015: 329, 331–7) who also notes that such concerns are practical at times in so far as they regard the effect on the physician's fee or the utility of the treatment, rather than the patient's comfort or distress (*ibid.*: 329, 340).

in a purely “clinical” sense and the possibility that the wrong treatment would undermine the chances of recovery. Rather, the consideration seems to be the patient’s general well-being and comfort – whether out of pure compassion or practical considerations of avoiding a bad reputation among potential clients. Often the therapeutic instructions are introduced by conditional clauses such as “if they (sc. the patients) can tolerate (ἀνέχονται, ἐπιδέχονται) it” or “if they cannot bear (φέρειν) it”.¹¹⁸ Terms such as εὐαρέστησις (“relief”) and its cognates εὐάρεστον and εὐαρεστέω (“bringing relief” or “pleasing”) hint more strongly at the feeling of comfort.¹¹⁹ The frequency of changing the poultices, for example, and the “suitable measure” (αὐταρκὲς μέτρον) for applying them is determined by the “endurance” or “well-being” of the patient (ἡ τοῦ νοσοῦντος εὐφορία).¹²⁰ Such phrases are not general statements in introductory or aphoristic passages such as in Scribonius or the *Praecepta*.¹²¹ They are an essential part of particular therapeutic instructions AP expects his readers to follow in order to ensure that the treatments are not too harsh and harming. Moreover, the patient’s endurance appears in AP as a crucial consideration guiding the physician’s work in place of theoretical classifications. In one case, AP explicitly promotes this subjective criterion of the patient’s well-being or reaction to the treatment over more rigid criteria such as particular times: “the best measure (μέτρον ἄριστον) (of applying the aforementioned remedies to the head) is the relief (εὐαρέστησις) to the patient, rather than fixed times (ἢ ὁ κριθεὶς χρόνος)”.¹²² Indeed, in AP we find fairly little consideration of “given” criteria such as age group, favoured by many authors as indications for the appropriate course of treatment.

4.4 *Limited consideration of gender, age and other “given” criteria*

Our medical sources from the classical period onward commonly use external criteria such as the seasons or the time of day, as well as inherent criteria such as gender and age as a means for classifying patients, signs and

118 For example: ἐπιδέχονται: Anonymus Parisinus, *On Acute and Chronic Diseases*, 4, ed. Garofalo (1997) 28.17; φέροιεν, φέροιτο: *ibid.*, 10, 42, 39, 26 ed. Garofalo (1997) 78.10–11, 78.19, 216.18, 204.11, 144.7; ἀνέχονται: *ibid.*, 14, ed. Garofalo (1997) 98.4–5.

119 εὐαρέστησις: Anonymus Parisinus, *On Acute and Chronic Diseases*, 5, ed. Garofalo (1997) 36.2–3; εὐαρεστηθείη: *ibid.*, 5, ed. Garofalo (1997) 32.18–19; εὐάρεστον *ibid.*, 14, ed. Garofalo (1997) 98.5.

120 Anonymus Parisinus, *On Acute and Chronic Diseases*, 9, 12, ed. Garofalo (1997) 70.8–9, 88.2–3.

121 Scribonius Largus, *Medicinal Compositions*, Epistula 3, ed. Jouanna-Bouchet (2016) 2–3; [Hippocrates], *Praecepta*, Heiberg (1927) 32.5–13 = ed. Littré (1861) IX.258.6–15.

122 Anonymus Parisinus, *On Acute and Chronic Diseases*, 5, ed. Garofalo (1997) 36.2–3.

diseases and for determining the appropriate therapeutic measures.¹²³ Not all physicians accepted this theoretical framework and its practical implications, however. The Methodist school, for one, argued for a much simpler classification: diseases were either flux-related, or constriction-related, or a combination of both. Accordingly, treatments focused on either stopping the flux or releasing the constriction. Age, seasons and so forth, were of limited, if any, relevance.¹²⁴

The Anonymous, for his part, rarely prescribes different treatments on account of seasons, age or gender differences. He refers to age differences only twice, both in the case of ileus. First, he instructs one to “bleed youth and those in their prime without delay, and old people too, if they can tolerate it, otherwise apply cupping-glasses...”;¹²⁵ shortly later, he adds that in the case of pains “boys coming of age” (οἱ τελεώτεροι παῖδες) should be treated with an enema and cupping with scarification “if they tolerate it”, whereas “older ones” (μειζονες) should be treated with drugs applied externally.¹²⁶ The distinction seems to reflect a general notion that younger, stronger people can better endure (their *dynamis* allows, so to speak) strong and invasive treatments. The treatment of women is distinguished five times. Three of these references are in cases of bladder problems (ulceration and haemorrhage): once he notes that “one must treat women with the uttermost care, for in them haemorrhage is very hard to stop” and twice he notes that women are “more suitable for injections” of particular drugs.¹²⁷ It is possible that the apparent anatomical differences in the case of the urine system called for different measures.¹²⁸ The genitalia are mentioned in the case of spasm, where it is noted that “with female (patients) in addition to the aforementioned (measures) we will also pay attention to the feminine parts (τὰ γυναικεῖα)”.¹²⁹ The meaning of this statement is ambiguous – it may refer to ensuring that the womb does not get infected (as AP notes regarding the

123 The Hippocratic work *On Airs, Waters, and Places* is the most well-known example for promoting these kinds of classifications, but these ideas were widely discussed in our sources. We find in Galen the most systematic consideration of these criteria in the clinical context; although he acknowledges that a single theory and generalisation cannot apply for all cases, he argues nonetheless that when dealing with a single case one must determine the appropriate cause of treatment based on a complex system of classifications (“division” – διαίρεσις) and “qualifications” (διορισμοί), which include age, gender, climate and so forth – for discussion see van der Eijk (2008: 288–97).

124 See Frede (1987: 268) and the references there.

125 Anonymus Parisinus, *On Acute and Chronic Diseases*, 14, ed. Garofalo (1997) 96.12–14.

126 Anonymus Parisinus, *On Acute and Chronic Diseases*, 14, ed. Garofalo (1997) 98.8–12.

127 Anonymus Parisinus, *On Acute and Chronic Diseases*, 38, ed. Garofalo (1997) 198.24–5 (haemorrhage); *ibid.*, 39, ed. Garofalo (1997) 204.6 and 204.12–13 (ulcer).

128 In the section on the signs of bladder ulceration, the penis is mentioned, but not women: “when the (painful) sensation is near the penis itself, the ulcer is around this part” – Anonymus Parisinus, *On Acute and Chronic Diseases*, 39, ed. Garofalo (1997) 202.8–9.

129 Anonymus Parisinus, *On Acute and Chronic Diseases*, 7, ed. Garofalo (1997) 56.20–1.

bladder shortly before); but it is perhaps a reference to observing patients' menstruation or dealing with menstrual bleeding in a state in which they were unable to do so themselves. Finally, in women suffering from epilepsy, cupping-glasses should be applied also to the lower abdomen and the groin, in addition to the back, loins, chest and upper abdomen – the reason remains unexplained.¹³⁰ References to the seasons are just as sporadic, and they mostly refer to the need to adapt the clothing or surroundings of the patient to the temperature.¹³¹ The one exception is the reference to a different number of meals in the winter in the case of dropsy.¹³²

All in all, these criteria do not constitute a central consideration guiding the physician through the complex, multifaceted conditions he encounters. These references are very “practical” in nature, rather than theoretical. They do not reflect an underlying theoretical classification and conceptualisation of these groups in qualitative terms (such as their relative wetness or natural abundance of bile which then indicatively determines the kind of treatment suitable for them).¹³³ The considerations are more general and “intuitive”, aimed at ensuring, for instance, that the patient is strong enough or dressed appropriately for the climate.

5 The anonymous and the medical schools

In the course of this chapter I have noted some cases of similarity between the ideas or approach of the Anonymous and those of certain medical groups or schools. The limited clinical relevance he assigns seasons, age and gender, resemble the ideas of the Methodists. His reference to cohesive causes of disease, his use of the term “affected part”, and his consideration of the quality and tension of pneuma as a cause of disease and an object of treatment – all point to an acquaintance with writings and theories of Pneumatist physicians (who were themselves “Rational” physicians in many aspects).¹³⁴ He refers often to humours, pneuma, and other “theoretical”,

130 Anonymus Parisinus, *On Acute and Chronic Diseases*, 3, ed. Garofalo (1997) 22.16.

131 Anonymus Parisinus, *On Acute and Chronic Diseases*, 45, ed. Garofalo (1997) 228.28–30, with regard to the need of clothes and staying warm; cf. *ibid.*, 45, ed. Garofalo (1997) 228.21–4 – kind of pillows and posture to use in winter and the converse case of preventing the patient suffering from the heat in warm seasons (*ibid.*, 10, 45 ed. Garofalo (1997) 80.14–16, 228.12–15). In the latter passage (concerning dropsy), AP notes that “chilling and inactivity” (ψύξις καὶ ἀργία) are harmful to the patients.

132 Anonymus Parisinus, *On Acute and Chronic Diseases*, 45, ed. Garofalo (1997) 230.18–19.

133 AP refers once to patients’ “mixture” (σύγκρασις): he notes that patients suffering from dropsy who are “of a more delicate mixture” (οἱ τρυφερωτέρας συγκράσεως ὄντες) faint on account of thirst (Anonymus Parisinus, *On Acute and Chronic Diseases*, 45, ed. Garofalo (1997) 230.11–12).

134 See also his remark that καχεξία (“bad state”) concerns “the solids, liquids, and pneumata” (Anonymus Parisinus, *On Acute and Chronic Diseases*, 44, ed. Garofalo (1997) 222.6–7); for the possible Pneumatist connection of this triad, see Coughlin and Lewis (forthcoming).

non-empirical concepts and the only physicians he mentions by name are ones associated with the Rational school. At the same time, he offers little in the form of theoretical thought and discussion: his diagnostic and therapeutic sections are mostly practical instructions which follow the diverse “empirical” realities physicians have and might experience, with little or no reference to theoretical explanations or considerations.

This brief summary suffices to demonstrate the difficulty and futility of trying to identify the Anonymous’ affiliation. The author himself does not mention any physician known as Pneumatist, Methodist or Empiricist, nor does he refer to himself as belonging to any of these groups. Indeed, he does not mention any medical “school” – not even the “Rational” school with which the ancient sources traditionally associate the physicians he mentions. This may mean he was not at all interested in affiliating himself with any school or medical method or theory, whether since the question was irrelevant to him and his audience, or since the answer was obvious to them from his writing. Be the reason as it may, the lack of any statement on the Anonymous’ behalf and the circumstantial evidence connecting him with the different groups, mean that labelling him as a physician of a particular school is circular and redundant – it will not contribute to our historical understanding of that school and its opinions, beyond what we know already, that is, beyond what has led us to make the connection with the Anonymous in the first place.¹³⁵ Nor will it allow us to better understand the Anonymous himself. The importance of the Anonymous does not lie in labelling him as a physician of a certain school in order to learn about that group, but rather in his treatise being a rare example for medical concerns and a clinical approach at the turn of the first millennium and important evidence for the challenges physicians faced in this period. It testifies, moreover, to the fact that the medical schools and the rivalry between them were only part of the medical scene and activity in Rome. One could practise and write about medicine without branding oneself as a follower of a certain group or arguing for their theory and method, or against those of other groups.

6 Conclusion

This work on diseases seems to be intended as a practical work for those practising medicine, a “handbook”, so to speak; it does not aspire to instruct in medical theory or argue for overarching ideas concerning disease or the body, or concerning drugs and other treatments. The author demonstrates an acquaintance with technical causal, anatomical and diagnostic terminology known from later periods. He has a doxographic interest which sets four much earlier physicians at the centre of aetiological debates. The

135 On this methodological point see Coughlin and Lewis (forthcoming).

author clearly thinks this is knowledge one should have, although he rarely explains its relevance to the practical diagnosis and treatment. The sections concerning diagnosis and treatment are those most relevant to the physician's practical work and they are the richest sections. What lends authority to the information and guidelines they relate is not the name of an esteemed physician, but the minute details, which follow closely the phenomena physicians will encounter. These detailed descriptions are what would have made this work so useful: they allowed physicians to navigate the multitude of phenomena and disease manifestations they encountered in their many patients and to identify the appropriate course of action. While presenting his readers with a rich arsenal of practical knowledge and experience, the Anonymous places the responsibility for choosing the appropriate method in the hands of the individual physician facing the individual case. This latitude or ambiguity is neither loose nor incoherent, but anchored in a perception which allows the physician to continuously check himself, namely ensuring that the patient is comfortable and reacting well to the treatment. This will not prevent mistakes, but might prevent the physician from continuing blindly with a certain treatment simply because it was prescribed by an earlier authority or was useful on another patient.

The above analysis is by no means exhaustive. It has brought to light some important aspects in the Anonymous' method, but there is still much to be done, as regards, for instance, the rich therapeutic and diagnostic information the treatise contains, the wide use of *materia medica* it describes and a comparison in style and content to other authors from the period.

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