The Owl of Athena

CONTRATYRANNOS

The Natural Law Theory of Human Progress Website

EXCURSUS #13

One of a series of monographs that expands
the discussion of important topics examined in
The Natural State of Medical Practice.[1]

CONSEQUENCES AND IMPLICATIONS FOR MEDICINE OF THE MARGINALIZATION OF UNPRIVILEGED MEN AND WOMEN IN ANCIENT CIVILIZATIONS

Summary: An important question regarding the disappearance from five ancient civilizations of early attempts at developing a rational medical profession is why, once they disappeared, there was no further attempt to initiate another. The delayed commencement of modern medicine is a story of enormous consequence, and, after a brief review of the ancient losses, causes of the delay are considered. Two reasons seem most likely, both attributable to an all-powerful political hierarchy: canonization of venerable medical knowledge resistant to change and marginalization of the common citizenry from whom the original rational medical knowledge arose.

Introduction

In *The Natural State of Medical Practice* it was shown that, within the great ancient civilizations of Mesopotamia, Egypt, India, China and Greece, early successful efforts at rational/scientific medicine deteriorated as political power centralized.[2] In sympathy with the adage of not seeing the forest for the trees (see opening verse of Excursus 12), root causes are re-examined herein so that we might identify causes for the *permanency* of that deterioration.

This inquiry may also have other ramifications, for historians and philosophers often view the history of civilizations as predictable based on cyclic, linear, economic and other models, some concluding that successive civilizations are in fact gradually progressing over time because of lessons learned from preceding ones. In contrast, *The Natural State of Medical Practice* and the Natural Law Theory of Human Progress it describes provide evidence that human progress, as gauged by medical progress, does not improve in such a fashion. Indeed, with loss of freedom postulated to have existed for the early urban populations of the primary city-states of

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[1] Volume, chapter and page number of otherwise unreferenced statements in this monograph refer to the version of the four volumes as published by Liberty Hill Press:

Vol. 1 – *The Natural State of Medical Practice: An Isagorial Theory of Human Progress*
Vol. 2 – *The Natural State of Medical Practice: Hippocratic Evidence*
Vol. 3 - *The Natural State of Medical Practice: Escape from Egalitarianism*
Vol. 4 – *The Natural State of Medical Practice: Implications*

[2] See volume 1 of *The Natural State of Medical Practice*, Book I, chapters 2-6, and Book III, chapters 1-2.

Mesopotamia, Egypt, India, China and Greece, medical progress *permanently* ceased despite the sequence of prominent and powerful secondary civilizations that followed. It was also observed that following centralization of political power canonization of medicine often seemed to serve as a tool of the political class.[3] Could this persistent inability to progress, which extended over many centuries, even millennia, be explained solely on the loss of freedom?

The role of freedom

A prominent modern thinker on freedom was the psychologist, Dr. Mortimer Adler, who postulated three types of freedom of the individual:[4]

1. Social (circumstantial) freedom
2. Psychological freedom (free will)
3. Moral freedom

Now (2) and (3) reflect intrinsic freedoms effected by individual action. But the medical profession affects and is affected by many people and events. Furthermore, medical progress itself was shown, in *The Natural State of Medical Practice*, to be a group function requiring a composite of individual efforts. Many external pressures come to bear on medicine. So present focus is on Adler's social, or circumstantial, freedom, *i.e.*, freedom that varies according to prevailing circumstance.

Issues of social freedom can be even more precisely defined if the focus is on the restriction of choices rather than freedom of the individual to choose from a great variety of available choices. The effect of external constraints on choice is important to determine because it suggests that human progress can be blocked even if civil liberties of the individual are maintained. In other words, even in Western nations that have prospered so upon protection of individual civil liberties (based on natural rights), it would be possible to lose all and, for Western civilization, or any civilization, to cease or roll back medical progress with freedoms seemingly intact (also see graph, *The Natural State of Medical Practice*, volume 1, p. 580).

Historical assessment

What characterized the role played by the ancient governments of Mesopotamia, Egypt, India, China and Greece that led to loss of true medical practitioners and was it actively or passively pursued for centuries? To summarize, two features characterized the role by which institutionalized political power affected the practice of rational medicine in the long term:

1. Mesopotamian monarchical governments placed punitive controls on early Sumerian community practitioners, thus discouraging new entrants into the profession. Akkadian

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[3] What followed centralization of political power as primary city-states were engulfed within the evolving civilizations of Mesopotamia, Egypt, India and China might be considered either (1) a sequence of authoritarian civilizations or (2) one prolonged civilization with its ups and downs, but medical progress in either case remained at baseline empiricism. This suggests that the entire concept of cycling or other predictable sequences of civilizations may be a phantom of no particular value.

[4] M. Adler, *Idea of Freedom*, New York, 1958, pp. xxvii, 689, and Adler and M. Weismann, *How to Think about the Great Ideas: From the Great Books of Western Civilization*, Chicago, 2001, chapter 18.

conquerors, in their commercial unification of the Sumerian city-states, appeared to devalue the significance of those practitioners by favoring the palace favorites, exorcists. Despite this, Sumerian medical knowledge, as with Sumerian knowledge in other technical areas, was canonized as superior, and, except for addition of mystical components and chants during subsequent empires, remained little changed even to the 7th C BC. In addition, the role of enforced work, required by the State and elite classes, was widespread and included much more than overt slavery. Monarchical states took over the temples and allocated land and servile populations to select elites, working hand-in-hand with their development. Options for commerce and specialization open to the average citizen, seen during the initial urbanization periods of the city-states, were not present under subsequent totalitarian leadership. The possibility of a resurgent and autonomous collegial association of practitioners capable of furthering medical progress would have been remote.[5]

2. In Egypt early community practitioners were integrated into palace hierarchy as priests and made part of its conservative bureaucracy. Two things happened. First, the original medical observations and writings later identified in the *Papyrus Ebers* were canonized. This veneration made them resistant to change. Second, the far greater part of the population worked in specified crafts and trades, usually familial, or were peasants tied to the land. The economy, a system of redistribution, and even wages were determined by the State, and social mobility was difficult. Even though the Egyptian citizenry was, unlike its slaves, free (*e.g.*, the legal autonomy of women was similar to that of men), its predetermined and rigidly regulated economy precluded the option of a spontaneous collegial association of professional practitioners, especially if they might be competition for the priest-physicians.
3. In India there were also two events that prevented medical progress. First, the early Brahminic institutions of Hinduism collected and amended the medical knowledge of an earlier civilization, retaining the original but editing it as the *Charaka Samhita*, thus making their specialized knowledge resistant to change and consistent with the Laws of Manu. Second, over the centuries in a disunited subcontinent, medical guilds appeared in large cities, but these, like Renaissance guilds, were monopolistic institutions protected by the local monarch in return for favors. A competitive medical association capable of progress would not have been permitted. Wandering solitary mendicant practitioners would have been unable to form collegial associations to improve their product.
4. In Chinese dynastic governments select medical practitioners were integrated into an elite medical bureaucracy. There were two consequences in medicine. First, collected original medical observations of a much earlier age were codified in the *Huang Ti Nei Ching Su Wen* and canonized by that medical bureaucracy, thus becoming resistant to change. Second, with the far greater part of the population being poor and servile, options for forming an autonomous medical profession were nonexistent. Wandering individual medical practitioners, the "bell-ringers," could not form medical associations to collegially share and improve their knowledge, instead being at times even competitive with each other, their knowledge unrecorded.

[5] The clever ways by which monarch and oligarch were able to organize and control land and workforce is considered in detail by: Tenney, J. S., *Babylonian Populations, Servility and Cuneiform Records*, in *Journal of the Economic and Social History of the Orient*, 60:715-787, 2017.

5. In contrast to the preceding civilizations, the Greco-Roman civilization did not canonize Hippocratic medicine, and the option of forming an autonomous collegial profession was not closed to the people. But there still were the same two consequences. First, social disruption caused by wars and conquests discouraged investment in medical careers by the average citizen, and Hippocratic medicine gradually disappeared, only to be rediscovered and canonized during the Dark Ages and Medieval Period and thus resistant to change even into the 18th C. Secondly, local political hierarchies in a feudal Europe assigned the far greater part of the population to serfdom with few options for self-betterment.

In the five civilizations under discussion there were two important consequences of governmental misappropriation of existing medical knowledge. One was canonization of the original knowledge, thus making it resistant to improvement. This was not purposely done. Essentially, that original knowledge was canonized as it became venerable over time in great part because there was nothing else with which to replace it. Thus, the primary issue in this excursus does not revolve around the original medical practitioners or their knowledge, although the role of canonization will be more closely examined in a future excursus. The primary issue remains: why was there no replacement.

The second consequence was unanticipated. In four of the five civilizations centralized political governance and a rigidly controlled economy led to marginalization of the general population. Because a medical "profession" had been integrated into the bureaucracies of ancient Sumer, Egypt and China a parallel medical profession arising among the common citizenry was remote. But more importantly, as elite classes increased their regional control, most of the population were relegated to little more than serfdom. The options for self-betterment were limited or nonexistent, collegial associations of medical practitioners did not develop, and medical progress did not occur. In ancient India the situation was different: following the decline of the Indus River Valley city-states no sizeable cities would appear for over a thousand years and individual practitioners were peripatetic, presumably because demographic requirements for a nascent medical profession did not exist. In Greece, Hippocratic medicine vanished because its practitioners were not renewed as ancient Greco-Roman civilization ended. It was feudalism that then enchained the bulk of the European population for more than a thousand years.

Conclusion

As more completely described in *The Natural State of Medical Practice* (volume 3), it is postulated that the importance of the unprivileged, or common citizenry, in developing rational medical practices in five great civilizations predominated at their founding. In a sense, at that early state of urbanization everyone was relatively "unprivileged." They were the source of practitioners, the source of medical ingenuity, and the source of autonomous associations that produced desired specializations, including a nascent rational medical profession.

The subsequent appropriation of medical practitioners by early governments as described above was important. But what the present historical assessment brings to attention is the mechanism by which policies of large government can be so destructive for so long. A mere temporary lapse of a credible medical presence for perhaps one or a few generations following integration of practitioners into the political bureaucracy might have been replenished by a

subsequent generation of practitioners arising from the general population. Instead, the political hierarchy poisoned the well from which the original medical advances were drawn, namely the unprivileged general citizenry. By control over the entire social environment to pursue objectives of the State, the option of a collegial association of persons with similar goals of self-betterment was closed to the general population. Occupations became familial, servile, and devoid of choice.

This was not done by direct command, and it was not done for the purpose of abolishing the goal of health improvement. No laws were passed, and nothing was directly taken from the general population for the purpose of depriving them of a competent medical profession. Instead, the mere presence of a social environment resulting from a rigid political hierarchy was to blame.

Seeing that circumstances other than clear-cut legal and targeted transgression of individual freedom were involved in this social calamity, it is appropriate to re-examine freedom of choice, Adler's "social freedom" and its limitation by "circumstances." He does not pursue the consequences of circumstantial limitations on the range of choices. But it is clear they can be monstrous, for it was the limitation on social "circumstances" rather than edicts that prevented a spontaneous reappearance of collegial affiliations of medical practitioners. In the ancient civilizations described herein restrictions by authoritarian governance spanned society. The general population may have retained "freedom of choice" in many daily activities, but the choices of work were profoundly limited. In the hands of technically ignorant authoritarian governments, severe consequences would descend on the general populations of the five civilizations over the next two thousand years. [6] Does this have relevance to modern medicine?

Four out of five great civilizations assessed for their history of medical practice displayed a similar pattern, and our present course seems to be running parallel with them. (India's Indus River Valley civilization had no replacement.) Arising from the 16th C Reformation and appearing in the general population of the 18th C, medical progress in the West has been remarkable as proven by a global increase in human longevity. But in the last century there has been an inexorable increase in the role of government in the practice of medicine in the United States and a concurrent decrease in individual physicians in private practice. The presence of the federal government is felt, directly or indirectly, in many areas, and intrusions into the relation between physician and patient are ubiquitous.

It is unseemly that governments of Western "democratic" nations would purposely take back the power of the people. And they are not taking that power back. But they are more than willing to accept it when offered, and many people in Western democracies are ceding personal decisions and responsibility to their central governments to manage on their behalf and over which they have little control. At the same time, (1) political power is increasingly concentrated in fewer and fewer persons, and (2) inevitably as government grows there is a simultaneous concentration of incompetence, for the fount of competence lies with the unprivileged citizens. The importance of centralized incompetence cannot be overestimated as a fundamental flaw of centralized governance. It is not lessened by inclusion in government of select consultants with a point of

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[6] There is powerful philosophical justification for this position. Dr. Adler (see reference 4) noted that "Freedom consists in a man acting as he pleases, being able to do what he wishes, being able to execute, carry out his desire. A man can have this freedom even if his wishes or his desires were themselves determined." He appends the thinking of the eminent 18th C American theologian and philosopher, Jonathan Edwards: "a man is free if he can do as he wishes, even if he cannot wish as he wishes, meaning that I may not be able to determine my own wishes, but if whatever I wish I am able to execute and carry out, then in so far forth, I am free." For Dr. Edwards, a strong proponent of Calvinist predetermination, it is God who determines what one may wish. Thus, government, by limiting options for the general population of society and thereby interfering in what could be wished by the marginalized (and generally impoverished) population, is acting as God.

view. There is already a shift in focus in America from the well-being of the individual patient to the well-being of the subjects of the State such as now exists in China, an anathema to the Hippocratic Oath.

What to do? Some suggestions will be offered in Excursus 17. But, in general, medical practice needs to be solely in the hands of the medical practitioner. We should remember that the purpose of organizing in medicine is to get better, not bigger. The more medicine comes under the aegis of the political class, the more restricted is the physician's approach to the individual patient, fewer are the options in diagnosis and therapy for the patient, and more limited is the opportunity for a new observation, idea or innovation to be validated.[7] There is canonization of medicine reminiscent of the ancient civilizations, although it is more subtle. These are today's issues.

Thus, a big issue for the future of medicine is **choice** rather than **freedom of choice**. It is about the range of options. The more control central government has over society and its industries, professions, and institutions, the fewer will be the choices of those outside of government. As has always happened, it is the proponents and progeny of the "privileged class" who will have the greater options of a career choice. In medicine this will moderate the effect on society for a while. Government regulations on the profession will prefer those applicants deemed politically correct. But for the rest of the citizenry choice be limited. Gradually, progress will be suppressed, despite claims to the contrary. The solution, of course, is to defeat the specter of big government, for greater will be the variety of solutions emerging and the more likely there will be successful ones.

[7] At the end of Excursus 17 is appended the contents of the medical journal *Lancet* from early July, 1962, and early July, 2022. In the former there 22 articles and letters to the editor that specifically involved clinical care; in the latter there was 1. For the *New England Journal of Medicine* from the same dates the difference is less stark but limited to "articles:" 5 from the 1962 date and 2 from the 2022 date, with a third being a report of the first genetically modified porcine-to-human cardiac transplantation, the patient dying a month later.