

Religion and Public Health: Learning from the [Ancient] Past

Susan R. Holman^[1]

Editors' Note: In addition to interviews with senior scholars and other features, the PHRS Bulletin includes personal essays written by field leaders and other key contributors. Here, Dr. Susan Holman describes her background as a historian of religion, providing numerous resources, tips and reflections on how religious history can contribute to the growing field of religion/spirituality and public health.

I grew up in a Protestant, working-class family that considered it a privilege to be able to live in one of Boston's wealthier suburbs. This "privilege" encompassed what we now call the social determinants of health: excellent public schools, easy public transportation, safe housing, clean water, good neighbors, and nearby medical facilities of world-class excellence. My parents' relative poverty, employment limits on "sick time," and daunting health insurance deductibles severely limited affordable health care access—with no dental insurance at all—but we got by. My parents' concern to see their children "succeed" meant that I felt pushed from an early age to study the sciences, even though I much preferred reading and creative writing—especially historical stories—from the time I could hold a pencil and open a book. Following undergraduate studies in nutrition and psychology with a biology minor, I was accepted into a rigorous dietetic internship/Master's program that included clinical, health communication, and public health rotations, at Tufts' Friedman School of Nutrition Science and Policy. My first job out of graduate school was in an urban community health center, non-stop counseling low-income families on maternal-child health, while writing my first serious book, a nutrition text for nursing students. Although I cared about health inequities and the human face of poverty, I was quickly bored—and soon burnt out—by the perpetual process of telling people what to eat. My escape reading on evenings and weekends was in religious history, soon diving into little-known texts about religious responses to poverty, illness, and hunger in Late Antiquity. Eventually I quit clinical work, took a

part-time hospital job in medical writing and editing to pay the bills, and went back to graduate school to follow what was, I then knew, my real vocational passion, for scholarship and writing in religious history. Further graduate studies at Harvard Divinity School and my doctoral work at Brown focused on fourth-century Greek Christian sermons on poverty, hunger, and disease. The texts were largely unknown because theology scholars cared little for their focus on everyday social details, and health science readers ignored religious texts entirely, especially those in a foreign language.

From the start, my interest in these narratives invited broader questions. For instance: How might these voices'

obvious commonalities between past and present social injustices relate to faith-based responses to health and welfare in today's world? Where did this ancient history continue to influence health beliefs and service practices into the present—for better and for worse? While modern medicine may all too often frown at or scorn any mention of religion in the health sciences, how might the study of such religious history contribute *positively* to modern public and "global" health concerns? And how do we respect the "voices" of ancient texts and cultures in a way that avoids



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uncritical, anachronistic, or purely instrumental “use” or “application”? Narratives that were written in the distant past but are still read today, that is, never offer a neat ethical Bandaid but are rather a complex and even dynamic construct of intersecting relationships. This is especially true of ancient narratives rooted in faith traditions that continue to apply such belief structures to modern health care responses within family and global or community services. Providers need to be aware of such histories and influences. Goethe reportedly wrote that whoever “cannot draw from 3000 years is living hand to mouth” (as quoted in Gaarder, 1994, v, p. 161). And as I continued for more than twenty years after graduate school to work directly with health care providers, it seemed clear that most were not able to draw from the rich well of history that Goethe described as essential. Despite their admirable value for addressing “resource-poor” settings in medicine and public health, that is, most health efforts (with rare exceptions) seemed chronically time-crunched, fixated on the latest new and cutting-edge evidence-based data, while perhaps oblivious to the many underlying impacts of religion and history on the very same cultures and social practices that effective health care delivery often sought to “improve.”

Happily this disciplinary blindness has lifted, at least in part, over the past decade. Both medicine and public health today tend to more openly recognize the need to reckon, seriously, with issues of religion and spirituality (R/S). This new awareness now shapes efforts, for instance, not just in traditional bioethics and psychiatry, but also in global health, narrative medicine, clinical subdisciplines such as oncology care, in the role of health care in human flourishing, and in the medical humanities. But those who understand why R/S matters for health and medicine today are often still puzzled or skeptical about the relevance of religious history.

While my work focuses most on history shaped across the Christian tradition, there is much overlap between early Christian, Rabbinic, and early Muslim texts (where we have them) on

medicine, social welfare, and health care services in Late Antiquity. Indeed, a virtual subfield has emerged of scholars who examine religion, medicine, disabilities, and health in the ancient world, and many of these scholars deliberately engage past with present. What follows in this essay is a select summary of common thematic connections that enhance our understanding and practice of public and global health today. I then highlight three common “missteps” in the use of ancient sources in public health scholarship, and offer a few concluding thoughts.

Common Connections

Western religious traditions from Late Antiquity—roughly the period between 100 and 800 C.E. in ancient Graeco-Roman, Persian, and early Islamic cultures across Europe, the Middle East, and northern Africa—inform how we got where we are today. These traditions, preserved and perpetuated in “folk” beliefs, theological statements, and religious practices continue to shape individual and community choices that directly impact both the social determinants of health and the social determinants of public health responses. While we tend to think of medicine and public health as two distinct areas of study, medical historians (e.g., Ferngren, 2014; van der Eijk, 2005) make it clear that ancient writers viewed environment, society, and population dynamics as key factors in what went on (and went wrong) in individual bodies. Thus the history of medicine in the ancient world inevitably overlaps with a history of public health. Health science students and scholars interested in how the ancient past shapes the present must pay as much attention to ancient *medicine* as to standard *public health* topics such as population health, environment, climate, social crises, health equity, and epidemiology. Within the public health literature itself, Nancy Krieger (2011, pp. 42-57) offers an accessible starting point for understanding some of the basic terms and ideas relevant to religion in public health history.

Disciplinary periodicals in public health may also include a nod to the past. The *American Journal of*

Public Health, for instance, invites history essays or short “Voices from the Past” for one such History section.^[2] While not focused explicitly on R/S themes, this section represents a good-faith effort at meaningfully engaging history to inform modern practice. In health equity dialogue and action, themes of liberation theology and the history of human rights (including but not limited to controversial topics such as sexual and reproductive rights), further shape health narratives (e.g., Farmer & Gutiérrez, 2013; Holman 2015, pp. 83-122; Reed, 2007; Yamin, 2015, 2020).

Beyond disciplinary publications in health science, scholarly resources from across the arts and humanities connect a broad range of issues directly pertinent to modern public health. These include, to name just a few: the role of environment, epidemiology, religious culture, politics, and climate change in the ancient Graeco-Roman world (e.g. Green, 2017; Harper, 2018; Stathakopoulos, 2004), therapeutic rhetoric pertinent to infectious disease and “contagion” (Buell 2014; Holman, 1999; Mayer, 2015a, 2015b, 2018; Miller and Nesbitt, 2014), mental health related to the religious “voice” (Cook, 2019), the emergence and development of hospitals and health care systems in the Western world (Anderson, 2012; Crislip, 2005; Henderson, Horden & Pastore 2007; Horden, 2005, forthcoming; Marx-Wolf, 2018; Miller & Nesbitt, 2014; Nutton, 1977, 2013), Rabbinic and Islamic health care (Balberg, 2014, 2015; Ragab, 2015, 2018; Shinnar 2019); nutrition and the body (Penniman, 2017), disability and medicine (Laes, 2019; Watts-Belser, 2017), philanthropy and human flourishing (Rhee, 2018), and “folk” or popular medicine (de Bruyn, 2017; Harris, 2016; Mercier, 1997).

Interpretive Challenges

One serious challenge to reading across disciplines, however, is that of interpreting sources fairly and responsibly. This is a particular challenge in connecting past and present texts and “evidence” on health. To help scholars begin to

understand and address this challenge, Heidi Marx, a specialist in ancient religious philosophies and the history of medicine, and Kristi Upson-Saia, who team-teaches a course on the bioethics, economics, and history of medicine, as well as public health epidemiology, published an essay on “The State of the Question: Religion, Medicine, Disability, and Health in Late Antiquity” (Marx-Wolf and Upson-Saia, 2015). The authors are co-founders of the international working group on Religion, Medicine, Disability, and Health in Late Antiquity^[3] and co-authors of a forthcoming sourcebook on ancient medicine to include sources useful in public health education (Upson-Saia, Marx-Wolf, & Secord, forthcoming). While “The State of the Question” speaks most directly to scholars in the study of Late Antiquity, its discussion on three potential “methodological missteps” is relevant to health science readers as well. These three “missteps,” described below, present interpretive challenges that commonly plague anyone who wishes to responsibly connect contemporary issues with health and religion across history.

The first potential misstep, the authors suggest (p. 266), is when we impose modern interpretations on ancient understandings about illness, disease, impairment, and disability. For example, illness in antiquity represented communal and systemic ‘disharmony’ rather than the modern physiologic understanding of pathogenic “attacks.” Diseases explained by ancient authors in terms of bodily humors and qualities of air, water, and environment may at times appear to evoke similarities with modern ideas. In fact, we must always keep in mind that such explanations are based on a very different set of assumptions, expressing a rhetoric or viewpoint on the body quite unlike twenty-first century allopathic medicine and evidence-based public health. If we fail to recognize these differences, such misunderstandings “can obfuscate our access” (p. 266) to the physical impairments or illnesses described by the original authors. Further, imposing modern taxonomies of disease and embodiment risks missing the diagnostic social

variables that may have been more relevant to the ancient cultures.

A second potential misstep is the imposition of modern disciplinary boundaries. Ancient medical and health-related texts rarely separated the individual body from its social, religious/spiritual, and environmental context. Indeed, “‘professional’ medicine was, from its earliest moments...interwoven with religion and philosophy.” (p. 269). To silo such studies within our modern boundaries risks misinterpreting the sources (or missing them completely).

A third potential misstep, these authors suggest, is “overlooking lived experience,” that is, treating ancient illness narratives as merely ‘fictions’ or representations. To assume that past stories are nothing *more* than fictive constructs risks missing the “everyday lives and experiences” of the sick, disabled, dying, and healing bodies and social relationships in antiquity. Even if a distant time is no longer available for certain strictly empirical measures, recent studies in historical anthropology and bioarchaeology illustrate how the past does leave us substantial “evidence-based” data on the effect of lived experience, in bones, teeth, DNA, burial practices, and the archaeological remains of urban water and sanitation management (e.g., Gregoricka, Sheridan & Schirtzinger, 2017; Kemp, 2013; Killgrove, 2018; Koloski-Ostrow, 2017; Lewis, 2010; Lockau et al, 2019; Prowse, 2018; Robb et. al., 2019; Rohnberger and Lewis, 2017). Thus historical sources indeed bear genuinely human data that, with careful reading, sometimes identify issues from the past that merit ongoing discussion today.

Conclusions

The interconnecting fields of R/S, “ancient” history, and public health today are marked by ongoing lively thematic dialogues rather than static conclusions. This essay introduces the dialogue and highlights some key points vital for responsible interpretive consideration given the current state of scholarship at this intersection. Such interdisciplinary dialogue is possible and, I

would argue, necessary, because social determinants of health, including public health, are similar and similarly relevant across the centuries, and often shaped by religion and spiritual traditions that are rooted in the distant past. Taking time in public health to think about the history of religious texts, religious spaces (whether rhetorically constructed or literal built space), and ideas that have shaped faith and health traditions and communities—can help students, scholars, and practitioners to build and appreciate constructively critical thinking on health risks and challenges still relevant today.

When we understand and appreciate such differences between past and present, we may also open ourselves to cultural sensitivities that respect different expressions and understandings of body and illness today. The effort to see the past in this way may help train diagnostic and therapeutic skills to better engage diversities among disciplinary conversation partners, comparable, perhaps to the way art appreciation is used with medical students to improve clinical diagnostics (Miller, Grohe, Khoshbin & Katz, 2013). Yet we must always keep in mind that past and modern cultures will never exactly align, despite the temptation to conflate apparent similarities with the global cross-border dynamics of our modern world today.

Where ancient sources manifest or illustrate the “dark side” of PHRS—for example, religious discrimination, abuse, sexual and gender bias, ethnic oppression, and health-related human rights violations—critical thinking about R/S and public health across history can keep us honest, open to our own issues and implicit bias in the human journey and its everyday choices about body and society, open to ways to address such injustices, and mindful of our own health as it touches on the health of those around us. Thinking “outside the box” on R/S and public health across history may enable us to push back on religious and scientific boundaries we might encounter that otherwise perpetuate unhelpful stereotypes through ministry, health, and social service efforts. While readers in the health sciences should never uncritically “hunt

the present in the past” (Pormann and Savage-Smith, 2007, 4), we can recognize how, in health care and faith-based responses to hunger and disease around the world today, the past still haunts and shapes the present. Carefully perceiving and listening to the voices of conversation partners from another time may equip us to shape new public health choices that learn from their mistakes—and their wisdom.

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[1]^Susan R. Holman, John R. Eckrich Chair and Professor, Religion and the Healing Arts, Valparaiso University, Valparaiso, Indiana (susan.holman@valpo.edu).

[2]^Guidelines for contributor to the *AJPH* history section are available at <http://ajph.aphapublications.org/userimages/ContentEditor/1432646399120/authorinstructions.pdf>.

[3]^ ReMeDHe. <https://remedhe.com>.