Montaigne on Medicine: Insights of a 16th-Century Skeptic

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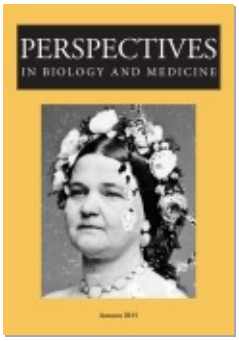

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ABSTRACT Michel de Montaigne (1533–1592) viewed the medicine of his time with a well-merited skepticism and had remarkable insight into its best resource, the placebo effect. Because less separates biomedicine from its Early Modern counterpart than commonly supposed, Montaigne still has much to tell us about the workings of this potent variable. When people improve as a result of surgery that did not take place, or for that matter sicken as a result of fumes that elude detection, they behave much like their counterparts in Montaigne's world. But doctors as well as patients are subject to errors of perception and inference. It was the goal of correcting misleading impressions by more reliable knowledge that led mid-20th-century investigators of the placebo effect to propose the sort of methodologically demanding trials through which drugs are now run before being brought to market. Montaigne's awareness of the weak foundations of claimed knowledge, prominently including medical knowledge, was central to his philosophy of the human.

False Treatments and False Inferences

Running irregularly through the *Essays* (1580–88) of the great Renaissance humanist Michel de Montaigne (1533–1592), along with comments on the close ties between mind and body, are thoughts on the perplexing agency now known as the placebo effect. An anecdote in the essay "On the Power of the

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Imagination," for example, tells of a merchant of Toulouse who receives a novel therapy for kidney stones. He lies on his side and the attendant goes through the motions of administering an enema, without injecting anything.[1]

While Montaigne's account of the episode is not the clearest, and no reason for the strange therapy is given, a few points stand out. First, the usual enema procedure consisted of a series of steps, beginning perhaps with the preparation of the liquid. Second, the merchant had frequent enemas, so that the entire sequence had become a familiar ritual. Third, all the customary steps were followed, except for the injection. It appears that the treatment, if it can be called that, was successful. The patient was billed as usual.

Today we would say that the fake enema was a placebo, and that it worked because the merchant fully expected it to, or perhaps because he was conditioned by his history with the actual procedure. In fact, Montaigne's account accords with many findings of the placebo literature, not least that the ritual of care itself serves as a conductor of the placebo effect. According to his telling, the deception failed only when the merchant's wife tried to cut costs by injecting warm water, whereupon she learned what investigators have recently confirmed: more expensive placebos tend to work better (Waber et al. 2008). Importantly, Montaigne also understood that while placebo can relieve it does not cure (Miller and Colloca 2011). The stones themselves persist. At the time, the only way to remove stones from the body was by surgery, a dangerous and by no means minor procedure. The dreadful prospect of surgery for the stone—the only form of surgery specified as off-limits in the Hippocratic Oath, perhaps because it conflicted so markedly with the principle of avoiding harm—may have made placebo treatments and palliatives all the more appealing.

While it might seem that nothing as outlandish as a pantomime enema could possibly take place in the realm of biomedicine, the fact is that fake procedures are still performed from time to time and are still capable of producing an effect. Recently, to test the value of a certain mode of knee surgery, investigators ran a trial in which one group had it while the other was treated with an elaborate charade worthy of the *Thousand and One Nights*:

> To mimic the sensations and sounds of a true arthroscopic partial meniscectomy, the surgeon asked for all instruments, manipulated the knee as if [the actual procedure] was being performed, pushed a mechanized shaver (without the blade) firmly against the patella (outside the knee), and used suction. The patient was also kept in the operating room for the amount of time required to perform an actual arthroscopic partial meniscectomy. (Sihvonen et al. 2013, 2517)

[1]All page references to Montaigne's *Essays* are from the 2003 Penguin edition, translated by M. A. Screech.

Those who underwent this mime fared as well as those who had the surgery per se.

Focusing on diseases of the body and physical or pharmacological treatments, scientific medicine does not concern itself with the mind's possible influence on the body. While we might have expected it to drive the placebo effect out of existence (thereby antiquating everything Montaigne had to say about the latter), upon reflection it's clear that biomedicine provides fertile soil for the placebo effect because it commands belief—and the placebo thrives on belief. Particularly belief-inspiring is surgery. In the case at hand, the fake partial meniscectomy was performed to determine whether the actual procedure—the most common orthopedic procedure in the United States at the time—was superior to placebo. It was not: the "true" procedure proved to be placebo itself. It's in part because the placebo effect continues to haunt medicine that Montaigne's insights into it, attained at a time when medicine had little better to offer, apply even in an age of decoded DNA and high-tech imaging. As in the case of a popular operation that turns out to have no value beyond giving the impression of treatment, the power of the placebo can mislead clinicians as well as beguile patients. Hence Montaigne's larger theme, the frailty of human judgment, applies as well.

The influence of the placebo effect extends beyond this or that procedure, permeating medicine and often escaping notice for that reason. In an elegant study on 200 subjects representing the half of his patient population with no specific diagnosable problem, K. B. Thomas (1978), a British GP, found that randomly assigned subjects either given a diagnosis and a medication or told they needed no treatment at all had identical outcomes. He concluded: "The doctor himself is a powerful therapeutic agent. In ancient times he was almost the only effective treatment. . . . This study supports the belief that the patient who is made better with no treatment will also be made better with treatment. The danger is that the doctor may ascribe recovery to his treatment and go on to see this as a confirmation of his diagnosis" (1328). That is, the doctor may fall into the trap of believing that the patient improved as a result of correct diagnosis and treatment, while in reality he or she was helped by nothing other than the encounter with a "therapeutic agent." Of course, we don't know how many of those "made better with no treatment" would have improved had they never seen the doctor; their ailments were minor enough, after all, for him to experiment with not treating them. According to Montaigne, "medicine claims the right to take credit for every improvement or cure brought about by Fortune" (868). The doctor who boasts of recoveries that are the work of Fortune and the doctor who reads recovery as a confirmation of diagnosis, when the patient might have improved with no diagnosis, no treatment, and possibly even no visit, belong to the same family tree though separated by centuries. The fallacy of post hoc, ergo propter hoc operates across the centuries and remains seductive.

Emphasizing that the GP sees much amorphous illness as opposed to definite disease, Thomas (1994) later described diagnosis as "a personal interpretation of

an ill-defined and unstable situation" (1066). That is a fair description of a Montaignean essay, with the unstable situation being human life.

Context, Paradox, Surprise

Montaigne's understanding of medicine as a human transaction gave him prescient insight into the placebo effect as well as its contrary. Among the principles of the placebo literature as we know it that were foretold by Montaigne are the following:

1. Both patients and doctors tend to attribute to medications properties they don't possess.
2. We can be relieved by imaginary remedies and sickened by imaginary causes.
3. The efficacy of a treatment seems to depend on our confidence in it.
4. The context in which a treatment is given contributes to the treatment.
5. Mind and body communicate.
6. When we improve following treatment, we tend to attribute the improvement to the treatment even if we might have improved with no intervention at all. (More than a fallacy of logic, this error illustrates a Montaignean theme: our bias in favor of events that command attention—in this case, medical interventions—to the neglect of those that lie outside the field or below the line of perception—in this case, spontaneous improvement.)

Under the influence of these principles among others, people in Montaigne's pages flock to spas where the scenery is probably more medicinal than the waters. Their hopes are so heightened by reports of a wonder-working healer that they convince their ailing bodies to feel better for a while after consulting him. A nobleman in fear of impotence is saved by a certain gold medallion inscribed with astrological symbols, lent by Montaigne himself. Doctors enlist the patient's imagination in order to compensate for the worthlessness of their remedies—and yet if imagination helps today, it will torment tomorrow. "How many men have been made ill by the sheer force of imagination?" Montaigne asks (547). In brief, for better or worse everyone in Montaigne's world, including himself, stands exposed to the promptings of suggestion, as do all of us today.

Montaigne was attuned to the placebo effect not just because it accounted for people's belief in medicine despite the poverty of "the Art" itself, and not just because its affinity with its contrary (the nocebo effect) spoke to his feeling for paradox, but because its situational nature agreed with his circumstantial view of human life. Being situational, the placebo effect acts in a variable manner, thus complicating the scientific search for regularity. (Despite its representation as a constant in the seminal paper of the placebo literature [Beecher 1955], the author himself recognized that it behaved differently on the battlefield than in civilian life, and in the laboratory than on the surgical ward.) Dependent on suggestive

messages and cues—think of the carefully managed "sensations and sounds" of simulated knee surgery—the placebo effect, like the nocebo effect, reflects the context it which it occurs, and context itself varies by definition. While some cavil at calling it nonspecific, the placebo effect certainly is nonspecific if it is fired by something as inclusive and difficult to itemize as a context.

Montaigne had a keen sense of context. In discussing spas, for example, he judged the natural surroundings and the assembled company more important than the waters themselves. Mineral water without the amenities of the human and natural context isn't much; mineral water enriched with fellowship and a beautiful setting is something else again. As to ways of taking the waters, these too he set in context, pointing out that the Germans, the Italians, and the French had entirely different healing rituals. Montaigne's understanding of these matters and many others distinctly presages current understanding of the placebo effect as, in fact, a context effect. If a treatment has no inherent active component, from where should its efficacy or semblance of efficacy arise, if not from the cues and lore surrounding it?

As this may suggest, context encompasses not only the circumstances surrounding a treatment but the messages that frame and explain it (Benedetti 2002). The drama of knee surgery would lack meaning were it not supported by a plausible, even intuitive medical rationale: to relieve symptoms by removing torn tissue. While automatic associations may account for some part of the placebo effect, it is also a cognitive operation driven by expectations; but expectations in turn draw strength from our understanding of treatments. Antidepressants relieve depression because they correct the chemical imbalance responsible for depression: so it's said. The medicine of Montaigne's time (in which treatment was framed on the principle of opposition, the same principle that gives us the term "antidepressant") could not offer effective remedies but did have at its disposal a system of explanations based on seemingly intuitive notions like the balance of humors. As part of his general interrogation of knowledge, Montaigne questioned that explanatory construct—a system that solicited and, it seems, often won the confidence of patients.

In addition to his feeling for the context, including the verbal context, surrounding medical treatments, Montaigne understood the mind and body in the context of one another. Montaigne differed from René Descartes—born four years after his death—not only in adorning his essays with the sort of classical quotations the other declared worthless, not only in writing in a nonlinear fashion that stands in high contrast with the other's emphasis on method, but in habitually thinking and speaking of mind and body in concert. Recently a doctor wrote that the mind-body dualism inherited from Descartes "has made the placebo effect difficult for us to understand" (Newman 2008, 146). (This helps explain why many findings of mid-20th-century investigations of the placebo effect lay fallow until they were rediscovered decades later. They simply didn't sink in, quite as if

comprehension were blocked.) The nocebo effect, for its part, not only challenges understanding but attracts little notice in the medical literature (Häuser, Hansen, and Enck 2012). Montaigne would have found it difficult *not* to notice these pervasive if elusive phenomena. His reiterated belief that therapies in his time depended entirely on the patient's faith in them has led some, even in our own day, to accuse him of depriving medicine of its best resource (Nutton 1981, 25)—a paradoxical concession that he was right. Rather similarly, some reproach Irving Kirsch (2010) for bringing to light the poor record of SSRI's in unpublished trials and exposing the drugs themselves as glorified placebos (Begley 2010).

With side effects including sexual dysfunction, insomnia, and gastrointestinal distress, SSRIs fall into the class of remedies Montaigne specially disliked, those that give us "two ills for the price of one" (Montaigne, 1233). Recalling Montaigne's judgment that people generally interpret the unpleasantness of a medication as a sign of its power and that "the bitter taste and the hardship [of drugs] are attributes which make them work" (Montaigne, 226), Kirsch (2010) argues that the side effects of SSRIs serve to convince those who get them in clinical trials that they are, in fact, on a medication and not a placebo—thereby undoing the blind and inflating the ratings of the drugs' efficacy. An imagination that reads bodily disturbances as encouraging signs behaves much like the capricious faculty portrayed by Montaigne. In the world of Montaigne's *Essays,* the imagination can both induce and relieve impotence. By analogy, it has been shown that simply informing men of the low risk of sexual dysfunction associated with a beta-blocker can increase the incidence of that adverse effect dramatically, and that the resulting dysfunction can be successfully reversed with placebo (Silvestri et al. 2003).

Both the placebo effect and its opposite compel us to admit surprising, at times disturbing possibilities without surrendering critical judgment, and reading Montaigne is an education in the same sense. Manifestations of the placebo and nocebo effects that the Cartesian in us finds hard to process seem less foreign to the reader of Montaigne. In some studies the same procedure yields either a placebo or nocebo outcome depending only on the message given to the subjects (Benedetti et al. 2007). In Montaigne, the institution of medicine constitutes a kind of mixed message in itself, playing on the placebo effect even as it courts its opposite. Anticipating the critique of "disease-mongering" today, Montaigne comments sardonically in the *Apology for Raymond Sebond* that when we lack for genuine illnesses, "Learning will lend us some of her own" (547). "Learning" in this case can only refer to medicine. Colluding with our erratic imagination to inflict debility and distress, the healing art becomes an agent of the nocebo effect.

While some of Montaigne's examples seem like curiosities, even a curiosity can have far-reaching implications, and so it is that a Montaignean illustration of our vulnerability to false impressions acquires new meaning in the light of recent research into our sensitivity to medical cues. According to Montaigne, a master of medicine was candid enough to disclose the trade secret that "there are men for

whom it is enough to look at a medicine for it to prove effective" (117). Intended by Montaigne as a reflection on the vanity of medicine, this observation turns out to be more robust than he supposed. Not only do we react to the sight of a medication or presumed medication, but, conversely, if given one without knowing it and without visual cues—intravenously by means of a computerized infusion pump—we tend to receive less effect. Studies have shown that a drug presumed active may prove totally ineffective if administered in a manner hidden from the subject (Benedetti 2009). Even morphine may lose some of its power if you don't know you're getting it. But the evidence suggests that anyone, not just credulous folk, can benefit by the administration of a treatment with full medical ritual. The profound value of practices so ordinary that we take them for granted—in this instance the rite of medical care—constitutes a rich Montaignean topic in itself, just as the variation in a drug's power in different settings comports with Montaigne's circumstantial vision.

"WHAT DO I KNOW?"

While doctors in the mid-20th century used placebos at their own discretion, reformers like the anesthesiologist and placebo researcher Henry Beecher reminded them that they somehow forgot to correct for the placebo effect in assessing the worth of prescribed drugs. It's as if they fooled not only patients but themselves, all too much like the errant doctors of Montaigne's *Essays*. It was to tame the risks to clinical judgment posed by this subtle confounder that investigators in the 1950s undertook systematic study of the placebo effect. Campaigning for careful trials in order to replace impressionistic reports with solid evidence, these researchers, prominently including Beecher, prepared the way for the system through which drugs are now run before coming to market.

Beecher became interested in the placebo effect as a result of his encounter in World War II with wounded men who did not request or require morphine, even though most civilians in a comparable state certainly would. For them the wound was a ticket to safety; hence the "euphoria" it induced in some (Beecher 1956, 110). Illustrating Montaigne's dictum that "the taste of good and evil things depends in large part on the opinion we have of them" (52), the paradox of the painless wound is the sort of riddle we meet often in the *Essays*—arresting, challenging to reason, but within the realm of the possible. Believing as he did in "the power of the soul over sense impressions" (Frame 1955, 107), Montaigne would probably have been open to the idea of self-anesthesia. In Rome he was struck by the sight of flagellants who seemed not to feel their own wounds. Where placebo researchers today speak of the "top-down control of sensory input" (Benedetti et al. 2007, 260), Montaigne cites "an old Greek saying that men are tormented not by things themselves but by what they think about them" (52). The principle that thoughts can beget suffering comes to life in the experience of patients who

inflame ordinary ills by attributing them to serious causes and dwelling on them inordinately (Ferrari 2000).

Beecher came to realize that the same placebo power that manifested itself so impressively on the battlefield could play havoc with clinical judgment. With Montaigne, too, an awareness of the power of the placebo went hand in hand with a concern with the grounds of judgment. A skeptic whose motto was "What do I know?" Montaigne was keenly aware of the weakness of much received in his time as evidence, medical evidence in particular. His world was awash in a "vast and troubled sea of medical error" (626). Medical inferences of whatever school were questionable, he thought, simply because almost all signs of illness are attended with "great uncertainty, variability and obscurity" (Montaigne, 1243), regardless of the shows of knowledge put on by the masters of the medical art. (In at least one case, he himself was brought in to arbitrate a dispute between two doctors with competing theories, a proceeding that gave him a private laugh.) Montaigne's philosophical modesty alone put him in opposition to physicians who claimed the authority of revelation for their theories and doctrines—physicians like Girolamo Cardano, who imagined himself "a magus, in touch with higher astral forces and gifted with powers of divination" (Siraisi 1990, 18). While Cardano was one of a kind, Montaigne was struck by the contradiction between the haughty bearing and the little knowledge of many doctors, and he was on to something. In point of fact, Renaissance medicine "hardly helped physicians to cure diseases. But it gave the medical profession an elevated sense of its proper dignity" (Porter 1997, 197). Throughout the *Essays,* doctors are portrayed just so, as figures puffed up with pretended knowledge who act like the lords of health and illness.

What medicine could and did do was offer believable explanations of symptoms, the workings of treatments, and the rest; and belief per se can be potent. In the *Essays,* belief acts sometimes like a monarch, sometimes like a trickster, sometimes like both or neither. If people in the *Essays* believe that a spell harms or a medication helps, they do so not abstractly or propositionally but in a way that engages the body. (For that matter, when Montaigne himself was told by a certain nobleman that dew is especially dangerous before sunset, "he made such an impression on me that I almost not so much believed it as felt it" [1231].) While we no longer worry about witchcraft, people today may be convinced that a toxic dump in their midst is making them sick even if it doesn't exist (Maugh 1982), just as they may believe a surgical procedure helped them even if it never took place. If patients with experience of mild head injury display cognitive deficits upon prompting, it's because they believe the injury causes such deficits (Suhr and Gunstad 2002). Ills attributed to a cause can become more compelling for the affected person even if the causal link happens to be fictitious.

As unusual as such cases may be, they bear out Montaigne's opinion of our genius for error and, in particular, his estimate of the power of the imagination. Imagination as Montaigne understands it is no playful faculty but an error-prone

organ that produces beliefs strong enough to communicate themselves to the body, often for the worse. Friedrich Nietzsche, an admirer of Montaigne, uses the term in the essayist's sense when he says, "To calm the imagination of the invalid, so that at least he should not . . . have to suffer *more* from thinking about his illness than from the illness itself—that, I think, would be something!" (Nietzsche 1881, 34). Montaigne's imagination was a strong one by his own admission, and the *Essays* suggest that he learned to live with his kidney stones in good part by learning how to think about them.

Following the onset of his ailment in 1578, Montaigne found that he could bear the attacks themselves well enough if only he cleared the doctors' warnings and dictates from his head. Here, then, was the beginning of an answer to the simple yet overarching question, how to live (Wasserstein 2007). Just as he would later argue against pretending to be more than a human being, Montaigne now freed himself from those who claimed a knowledge beyond the reach of humanity. Doctors as portrayed by Montaigne badly overplay their knowledge, and in so doing abet and exploit our worries when well and our misguided attempts to combat our condition when ill. Perhaps what he most dislikes about them is their way of bullying with dark prophecies, as when they informed one of his uncles that he would certainly die unless he put himself in their care during a bout of fever. We mortals commonly purport to know more than we really do, but to Montaigne's way of thinking this was pretended knowledge at its worst. Montaigne's uncle defied the doctors and lived, as he himself did when he too was threatened with "imminent death" (1237); yet if Montaigne were practicing medicine today, he might well be one of the many reluctant to predict the death of a patient lest the prediction take hold and realize itself through what might be called, for lack of a better term, the power of the imagination (Christakis 1999).

If Montaigne had devoted an essay to good medical practice, it probably would have shown the doctor assisting the patient rather than giving orders, abstaining from prognostication, speaking in the frank spirit beloved by the author instead of putting on airs, moderating disease rather than trying to master or expel it, and refraining from the all-too-common practices of purgation and bloodletting, which Montaigne of course questioned. Judgment as Montaigne understands it is "close to the facts, patient, always ready to learn, cautious in reaching conclusions" (Frame 1955, 80)—an excellent faculty for a clinician.

Montaigne's Continuing Resonance

As if in keeping with Montaigne's essay "On Habit," in 1981, two decades after the requirement of "adequate and well-controlled investigations" was written into law, half of clinical trials were still not double-blinded (Chalmers 1981, 329). In the same year, a trenchant critic pointed out that many medical practices arose from nothing more than a "promising report"—that is, an anecdote, retailed by

the medical literature or even the press: "Dr. A, from a respected institution, may describe how he successfully treated Mrs. B, who was suffering from X, by employing Y. . . . One seldom reads of *un*successful interventions, even though their frequency may be equal to, and probably greater than, those purported to be successful" (McKinlay 1981, 379). Montaigne, who loved anecdotes up to a point, objected to claims of medical authority founded on a kind of folkloric knowledge. Talk to men of academic standing such as doctors, and "they clobber you with the authority of their experience; they have heard this; they have seen that; they have done this; you are overwhelmed with cases" (1054). Montaigne also asked how many failures lie hidden behind every boast of clinical success. "How often was the doctor able to string such chance encounters together again, so as to establish a rule?" (884).

The findings of randomized clinical trials (RCTs) are now deemed statistically significant only if they are unlikely to have resulted from chance. The rationale for RCTs, as it took shape in the 1950s, held not only that findings must be validated statistically, but that only methodical testing of drug against placebo can expose drugs little better than placebos themselves. However, in the 1950s the right to deceive in the interest of science was taken for granted. That was to change. In line with Montaigne's observation that opinions have births and deaths "every bit as much as cabbages do" (648), the right to lie in the conduct of medical research was soon a right no longer, deposed by informed consent. But when informed consent was incorporated into clinical trial protocol, it altered the behavior of the placebo, for the simple reason that subjects told that they might or might not get a drug tend to have reduced expectations. According to a meta-analysis of 182 antidepressant trials, the message that subjects had a 50/50 chance of receiving placebo reduced the placebo effect by about 7% and increased the drug-placebo difference about 5% (Papakostas and Fava 2009). A meta-analysis of 51 antidepressant trials from 1985 to 2000 found many drug-placebo differences of less than 5% (Khan et al. 2003). Thus, under conditions of informed consent a drug might well pass as superior to placebo that would have been indistinguishable from placebo in 1962, when the requirement of "adequate and well-controlled investigations" went on the books. Montaigne's insight into the variability of norms, and his inference that therapies depend on a patient's confidence in them, prove to have implications he couldn't have dreamed of. In some cases, the line between a drug and a placebo isn't hard and fast, but Montaignean.

As prescient as he was, Montaigne had no inkling of much of medicine as we know it. Foreign to him was the notion of specific diseases caused by particular pathogens, a model we inherit from the bacteriological discoveries of the last quarter of the 19th century. Even so, he mocked the wholesale imprecision, the complete lack of specificity, of the medicine practiced in the world around him, where one and the same remedy was taken "for some fifty illnesses" (881), and a compound with dozens of ingredients was taken for one illness. Then too, many of the complaints for which patients now see doctors are actually far from specific

(like the indefinite ailments in Thomas's 200-patient study), and the boundaries of many psychiatric disorders are porous and disputed. For that matter, nominally specific SSRIs—*selective* serotonin reuptake inhibitors—are frequently prescribed with no psychiatric diagnosis at all, the drugs being used in the manner of latter-day elixirs to treat smoking problems, nonspecific pain, premenstrual tension, and such (Mojtabai and Olfson 2011). Nor are these the only omnibus drugs. A single drug, Neurontin, has reportedly had as many as 48 off-label uses (Angell 2005). Whether or not every single egg is unique as Montaigne alleges, we may fairly question whether the millions who take over-prescribed drugs suffer from exactly the same problem, and whether the populations of clinical trials can possibly represent all who end up on such drugs.

To judge from the catchphrase "The Powerful Placebo," which does double duty as the title of the most widely cited article and the most learned and wide-ranging book on the placebo effect (Beecher 1955; Shapiro and Shapiro 1997), Montaigne's emphasis on what he called the power of the imagination was well placed. Though he did not, of course, foresee randomized trials designed to control for this power, he might have appreciated the subtlest reason for randomization itself: that it guards not only against selection biases but confounders whose nature we cannot even guess (Wessely 2007). Montaigne also deemed repeated tests necessary to confirm a result. Even if a cure takes place, he asks in one of his major essays on medicine, how can the doctor be sure it was due to the prescribed treatment and not the natural waning of symptoms or some other cause (884)? Clinical judgment must be based on more than apparent or coincidental findings. Characteristically, however, Montaigne turned the concept of repeated tests against medicine itself, concluding that it held no benefit for him because his forebears did so well without it. That his father, grandfather, and great-grandfather all abjured medicine and lived long lives suggested to Montaigne a successful test or assay of almost 200 years' duration. When he sank into melancholy upon his retirement at the age of 38, he didn't seek medical treatment; he started writing the *Essays*.

At once satiric and tolerant, bold and humble, stoic and humane, Montaigne continues to speak to us more than four centuries after his death. As Stephen Toulmin (2001) puts it:

> Better nutrition and genetic evolution now mean that we share the land with people several inches taller than our predecessors, but in other ways Montaigne's *Essais* show us how little has changed in the ways we lead our lives. Indolence, vanity, moderation, constancy, and not least cowardice . . . are no different now from what they always were. Professional academics may dismiss Montaigne as a philosopher, because he ignores the technical issues they profess to find important. For the rest of us, however, he remains the preeminent philosopher of everyday experience, the writer who succeeded in focusing on things that really matter. (192–93)

Among those things that really matter is health, the topic of Montaigne's final essay, "On Experience." Indeed, the last words of "On Experience"—the author's farewell to the world—salute the god of health. Precisely because he prizes well-being so highly, Montaigne criticizes medicine so sharply: "It is a great misfortune that the most important of all the sciences we use, the one with responsibility for our health and preservation, should be the most uncertain, the most unstable, and the one shaken by the most changes" (871).

For Montaigne, the things that really matter pertain to our humanity, and our humanity entails that we live in our body and can't deny it or fly out of it to tap transcendent sources of knowledge. He distrusts claimed revelations and theories that seem to come from outside the realm of experience, including medical notions purportedly derived from "gods and *daemons*" (870). Doctors in the *Essays* are as liable as anyone else to false presumptions and impressions, though in their field of endeavor the stakes are higher than most. Repudiating their pretenses of authority and writing in a down-to-earth style that claims no authority, Montaigne affirms that the best and most beautiful lives are "those which conform to the common measure, human and ordinate" (1269). The depth of his insights into medicine measures the richness of his concept of the human.

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