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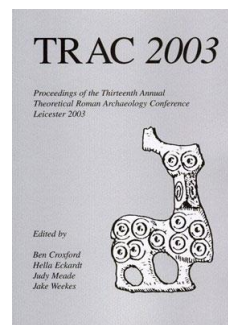
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The social identity of health in late Roman Britain

Rebecca Gowland

Introduction

The manifestation of health stress and disease within a society results from the complex interplay between its specific social and physical environment. As a result, cultural practice has a considerable influence on the type of illnesses prevalent within a society and dictates the social response to them. This dialectic between health and culture has yet to be fully explored in Roman studies, in part because elucidating the relationship between health and social identity in the past is far from straightforward. The response to health stress within a society can be subtle and varied and the social impact of disease for those afflicted will more often than not leave no archaeologically discernible trace. Skeletal remains are the most direct source of evidence for past disease. The skeletal pathology of Romano-British populations has received little attention and yet has much to offer when used in conjunction with cultural evidence from the funerary context. This study utilizes cemetery evidence as a means of examining health as an aspect of social identity in Roman Britain and it focuses more specifically on individuals excavated from the late fourth century cemetery of Lankhills, Winchester. As a means of contextualising this study, it is first necessary to critically assess the role that human skeletal analysis has played in the study of Roman social identity.

Funerary Archaeology and Human Bones

A number of years ago Richard Reece (1982) predicted that some of the most important developments within Roman funerary archaeology would come from human bone analysis. This prediction has yet to be realised and to date skeletal evidence has played a rather limited role in attempts to understand Romano-British society. This is hardly surprising when we see that funerary remains *per se* have been one of the least exploited forms of archaeological evidence for the Roman period. Esmonde Cleary (1993: 59) has described burial evidence as something of a 'blind spot' for Romano-British studies. Pearce (2000: 1) argues that this is partly because the funerary context appears poor and undifferentiated compared to the displays of hierarchy and power seen in settlements.

Those studies that *have* examined Roman funerary evidence have tended to focus on variables such as grave construction or grave goods, often with the aim of identifying aspects of Romanisation and religion (e.g. Clarke 1979; Thomas 1981; Jones 1983, 1984; Watts 1989, 1991; Toynbee 1996; Cooke 1998). Almost no attention has been paid in these studies to the skeletal remains themselves. The funerary context also receives scant attention in the recent publication by James and Millett (2001) discussing future archaeological agendas. It is clear from the literature that most researchers are actually unaware of the potentials and limitations of osteological evidence for contributing to debates concerning aspects of social organisation and identity. While there is at present a greater appreciation of the type of information that can be recovered from skeletal remains, osteological reports continue to be marginalized. In

cemetery reports skeletal information is often reduced to a series of summary tables of demographic and palaeopathological statistics. Often, linking this information to individual skeletons can be difficult and the data tends to be presented in a format incompatible with those from other cemeteries. Although this situation has improved over recent years and cemetery reports such as that of the Eastern Cemetery in London (Barber and Bowsher 2000) have produced a more integrative format, it is clear that many studies using funerary data are still failing to fully realise the potential of osteological evidence.

An examination of most cemetery studies demonstrates a very clear dichotomy in our conceptual approach towards the two main categories of evidence: the skeleton and the burial context. Human skeletal remains are examined by osteologists in a decontextualised environment and often the bones will become objectified because of this disengagement from the cultural context. Very few excavators provide the osteologist with, for example, contextual or stratigraphic information, although this can prove invaluable for interpretation. Skeletal analysis within archaeology has been categorised as a scientific undertaking, with all the trappings and trimmings associated with scientific endeavour. Subsequently, osteological methods are conceptualised as objective and the results of skeletal analysis immutable. By contrast, social interpretations of the burial context (while using the skeletal data as a series of biological variables) tend to be more ephemeral in the sense that they emphasize the historically and culturally *specific* condition of human identity. Social interpretations of funerary ritual are, therefore, viewed as subjective and fluid, because they are based upon the symbolic action of a particular social group and the particular preconceptions and views of the researchers. What becomes apparent is our contrasting conceptual treatment of the physical remains and their interpretation within the social sphere. This approach ultimately suggests that information retrieved from the skeleton is biologically universal, whilst that from the burial context is culturally specific. As a result, the social significance of the skeleton has been diminished.

There is a clear disciplinary divide operating in both cemetery studies and archaeology in general that has resulted in a lack of communication and contrasting conceptual approaches. This division stems from the way in which we construct archaeological knowledge through the academic division of labour; between social theory on the one hand and scientific methodology on the other. This in turn relates to the nature-culture dichotomy that structures the social sciences. More recently there has been a concern within the social sciences to bridge disciplinary divisions and this has been most clearly seen within the field of anthropology, where the divide between social and biological anthropology is being increasingly challenged. As Descola and Pálsson (1996: 18) state: 'the person and the environment embrace an irreducible system; the person is part of the environment and, likewise, the environment is part of the person'.

'The Body' and the Funerary Context

Theoretical developments over the last 20 years have seen a rise in the importance of the 'body' as an integral part of social identity (Shilling 1997: 65). During this time there has been a move away from the idea that aspects of identity such as gender, ethnicity, and age are biological givens; instead they are seen as subject to culturally specific interpretation. Social constructionism has been extremely important for our understanding of past societies primarily

because it has helped us get away from many of the modern preconceptions that archaeologists have had over the years concerning, for example, gender roles. However, much of the work of social constructionism in funerary archaeology, far from bridging disciplinary divisions has, actually compounded this science–social theory, body–mind divide. Because factors such as gender are no longer seen as biological constants the knock-on effect appears to have been that skeletal information is perceived as even less relevant.

Many social constructionists view the body as only a mediator of social relations; it becomes simply a means through which identity can be negotiated by its adornment with material symbols (Shilling 1993). While there is considerable discussion about ‘embodiment’, this approach tends to deny the actual physicality of the body, and the role that it plays in social relations (Shilling 1993, 1997). An inevitable consequence of this work has been that the role of the skeleton in funerary archaeology is essentially reduced to that of a clothes-horse for cultural symbolism. Ultimately human skeletal evidence has become increasingly marginalized because the flesh, blood and bones of people become an irrelevance– the body itself becomes invisible.

This disregard for the skeleton within Roman archaeology can therefore be understood in terms of a combination of the general neglect of the Romano-British funerary context and current academic trends that have characterised the skeleton as a fixed biological entity. Clearly we should view information from the skeleton as more than a series of biological facts and instead as the product of an individual interacting within a social as well as physical environment in a dynamic way. In terms of health, the prevalence of particular aspects of disease and disability can vary enormously both within and between populations. As a result, skeletal information can provide a unique means by which to access cultural information about the lifeways of individuals and groups. In the USA this relationship has long been appreciated and exploited in what has been termed the biocultural approach. Using this approach factors such as disease prevalence within and between skeletal populations have been examined in relation to changing socio-economic circumstances through time (e.g. Bush and Zvelebel 1991). The biocultural approach has contributed greatly to a social understanding of past populations and it is unfortunate that it has not been utilized in the UK to the same extent. There is considerable scope for looking at different patterns of disease in skeletons from Romano-British cemeteries, comparisons need to be made between, for example, rural and urban sites, different regions, and over times of rapid social transition. However, such studies must also have a full appreciation of the nuances of social context, for example, the shifting nature of terms such as ‘urban’ throughout the past.

The biocultural approach is very clearly a population based approach and this is possibly one of the reasons for it being eschewed in the UK. Population studies are reminiscent of processualism, whilst our theoretical emphasis over more recent years has been placed firmly on the individual. While a population level biocultural analysis is necessary to provide an appropriate context, I would argue that it should then be possible to ‘zoom in’ and examine individuals within that population. Because disease is culturally contingent, individuals *within* any one society may also be differentially exposed to health risks and treatment. Aspects of social identity such as gender, status and age impact upon the physical environment of an individual. For example, they may lead to differential access to adequate nutrition, thus affecting immune status and susceptibility to health stress. Occupations and social roles are also dictated by social identity and often result in differential risks of exposure to physical trauma or pathogens. In turn, aspects of identity and religion will often determine the health treatment provided (see Baker and Carr 2002).

Possibly the clearest example of how identity can influence pathology is with respect to gender. The gendering of labour roles is documented in many societies and has been shown to lead to markedly different patterns and prevalence of disease between the sexes. For example, an extensive study of degenerative joint changes amongst the Inuit by Merbs (1983) revealed distinctive sex specific patterns that were related to ethnographically observed gendered behaviour. For example, the adult female skeletons exhibited a high prevalence of temporomandibular (where the jaw articulates with the skull) joint degeneration as a result of chewing animal hides to soften them. The Inuit males exhibited a different pattern of joint disease, primarily around the shoulder area that is associated with kayak paddling (Merbs 1983). Sofaer-Deverenski (2000) also discusses how the skeleton can be likened to material culture in that it is modified and gendered by particular cultural activities. Sofaer-Deverenski (2000) examined spinal degeneration in the Isle of Ensay skeletal population and noted the higher degree of joint disease in females in the region of the upper vertebrae. This pathology was associated with the historically documented activity of women from the Isle carrying heavy loads on their heads.

The skeleton, therefore, becomes gendered beyond the traditional morphologies of sexual dimorphism through lived actions connected to differing gender roles. Although one must be cautious when linking particular activities to skeletal changes in any specific way, this approach provides a useful perspective. It highlights the fact that people do not exist within a vacuum: bodies are affected by social action— the skeleton will be modified by particular activities, but in turn the bodies of individuals will then influence self and social identity, exerting an effect upon behaviour. For example, gendered social practices operate material forces that help to shape and form women's and men's bodies or skeletons in particular ways, but these may then in turn reinforce or contribute to particular images of femininity and masculinity within society (Shilling 1993: 107).

In the same way, a particular disease will not only affect an individual physically, but can have a profound affect on their social identity. Kus (1992) argues that a rich archaeology needs to incorporate 'sensual human experience'. Pain is a sensual human experience (albeit an unpleasant one) that directly impacts upon the life of the sufferer physically and, because the body is active in social discourse, any overtly apparent or debilitating signs of illness may also have important social repercussions. The most obvious example of this is leprosy where sufferers were (and still are) socially marginalized and associated with particular items of material culture (e.g. clappers or bells to indicate their presence). In today's western society where we obsess over bodily perfection we frequently classify people socially according to their physical 'ableness'. The 'stigma' associated with a particular disease or trauma is culturally contingent: as Goffman (1990: 163–164) states 'the normal and the stigmatised are not persons, rather perspectives'. The relationship between social exclusion and pathological conditions in many societies, both past and present, occurs because the physical manifestations of a disease are frequently perceived to be an outward reflection of an individual's moral decrepitude. Stigma can have a considerable impact on the social and physical experiences of the afflicted and the threat of becoming stigmatised often leads to attempts to mask the presence of diseases or 'deformities'. This is significant in terms of the health of the sufferer, because the cultural reaction to a particular disease can actually have important physical repercussions. Medical anthropology has shown that different perceptions of the same disease processes across cultures are profound and lead to markedly different outcomes. For example, Hsu (2002) has discussed how particular bodily conditions (e.g. heart palpitations) can become reinforced and worsened if they are believed within a particular culture to be indicative of a

more serious condition. We therefore need to appreciate that the body *simultaneously* has social and biological meaning (Shilling 1993; Tyrrell 2000).

This section has demonstrated the importance of disease as a social indicator between populations and between social groups *within* populations. Once this context has been established, it should then be possible to examine a single burial within a cemetery and use the skeletal and material variables to build a social picture of an individual life experience. This type of approach has been adopted before, most notably by Robb (2002), who refers to 'osteobiographies', whereby cultural information concerning the biography of an individual is obtained from their skeletal remains. Robb (2002) applies this approach to a female skeleton dating to the Neolithic in Italy and is able to relate particular pathologies to stages in her life history. For example, the female had experienced the removal of several front teeth, a procedure used to signify and bring about a rite of passage into adulthood. A similar concept is discussed by Boyd (2002) who uses the term 'body histories' and asks how individual life histories may be carried forward into death (although the application in this instance is lacking). It should be emphasized that while an 'osteobiography' may focus on a single individual, such an analysis must also include a study of the entire cemetery population. Only then can the idiosyncrasies or similarities of the osteological and cultural features of a specific burial be identified and their significance properly interpreted. Patterns of pathology in relation to group identities may also emerge from this type of analysis and shed new light on the lives and possibly also the deaths of those buried. This study briefly examines the implications of the above for aspects of health and social identity in late Roman Britain. By attempting to create an 'osteobiography' for a single individual it asks whether it is possible to link burials with particular pathologies to factors such as gender, age or status as indicated by funerary variables.

Skeletal Indicators of Health Stress in the Past

Before looking at the skeletal evidence it is first necessary to emphasize the interpretational limitations of palaeopathological studies. One of the most fundamental points is that only a small minority of diseases affect the skeleton: these tend to be long term (chronic) diseases and often the bones only become involved during the later stages of the disease. For example, venereal syphilis is a disease that (if left untreated) progresses over many years and it is only during the tertiary stages that the skeleton exhibits the characteristic lesions (Ortner 2003: 278). Further interpretational problems stem from the fact that bone has only a limited response to a wide variety of pathological conditions. This complicates diagnosis, particularly when skeletons are poorly preserved and poor skeletal preservation also means that pathologies of all types are likely to be under-represented. Finally, it is the paradoxical nature of palaeopathology that individuals exhibiting signs of infection may in fact be the healthier ones in a society. This is because pathological skeletal changes demonstrate that an individual had a sufficiently strong immune status to withstand a disease process long enough for the bones to become affected. Individuals showing no evidence of pathology may have died before the disease was able to manifest itself skeletally (Wood *et al.* 1992). This is a somewhat confusing, yet important, point to note when interpreting skeletal pathology in terms of the health of past populations.

Clearly there are some rather fundamental limitations when interpreting the social significance of skeletal pathology and this is compounded by the interpretational difficulties one encounters when attempting to relate this information to cultural variables from the funerary context. Research has shown that the social meaning imbued by funerary variables such as grave goods may be far from straightforward. The funerary treatment accorded to individuals reflects conscious decisions by the burying society to display the deceased in a particular manner. These choices will not necessarily reflect the social identity of the deceased in an objective way, but are likely to draw upon an idealized representation of social identity (Pader 1982; Brush 1993: 28). The extent to which individuals conform to broader conventions will also serve to confuse interpretation in terms of social organization. It is clear that there are a number of possible pitfalls with this type of study on several different analytical levels. However, although not always explicitly detailed, much archaeological research faces comparable difficulties concerning the incomplete nature of the material record and the uncertainties of deciphering past intentions and behaviour. With these caveats firmly in place, it is now time to examine the evidence.

'Health Stress' and Social Identity at Lankhills

This study is based on an assessment of the skeletal pathology from the late Roman cemetery of Lankhills, Winchester. The Lankhills cemetery report was published by Clarke (1979) and was groundbreaking at that time with respect to the analysis and presentation of the cemetery data. However, only the sex and approximate ages of the skeletons were published and this has meant that a reanalysis of the entire skeletal collection has been undertaken for the first time. For the purposes of this study an *assessment* only was made of the pathology, therefore terms such as *prevalence* will not be used and the information presented here should not be used as the basis of comparisons with other cemeteries. A more detailed and thorough analysis of the skeletal material (which will be conducted over the next few years) would be required for such a study. The level of skeletal recording is however sufficient to use as a preliminary examination of the occurrence of particular pathologies with individuals of different ages and sexes and relating these to patterns of grave goods.

A total of 451 graves were excavated from Lankhills: this study is going to focus on only one of these, that of skeleton 283. Of course, as discussed above, to make the analysis of this grave meaningful it will also be related to skeletal and funerary evidence from the cemetery as a whole. Skeleton 283 is that of a male aged 35–49 years of age, buried supine in the grave with what are believed to be planks placed over the body rather than a proper coffin. The grave cut was too short for the skeleton and Clarke (1979: 61) speculates that it may have been unfinished. Seven objects were buried with the deceased (although of course additional organic objects may have perished), including: a knife, a whetstone, a bronze buckle, a bone knife handle, two coins and a buckle loop. Clarke (1979: 391) argued that this individual was 'intrusive' because of the number of grave goods, the unusual presence of broken objects within the grave and the use of planking rather than a coffin.

Skeleton 283 exhibited a series of pathological changes including infection, joint disease, and trauma. Pathological information is important because, as stated previously, the very presence of trauma and 'health stress' on the skeleton can yield evidence concerning lifestyle. This study examines these pathologies in relation to the age, sex, and 'status' of not only this

individual, but also of other skeletons from the rest of the cemetery. The aim of this study is to try to integrate this data with all aspects of the burial so that we might access more specific information concerning the life of the individual interred: to go beyond a 'shopping list' of skeletal and cultural traits and instead use this data towards a reanimation of aspects of the individual's life experience.

a) Infection

Skeleton 283 is one of only three individuals (two males and one of unknown sex) at the cemetery to exhibit osteomyelitis which is a severe form of infection involving the marrow cavity of bone. Skeleton 283 shows evidence of osteomyelitis in the right shoulder joint: the bone has an enlarged appearance and small cloacae (sinuses) are visible. New bone has formed on the joint surface, which may be part of the bone's response to the infection itself, or the enlarged condition of the shoulder blade may have resulted in secondary joint degeneration. Osteomyelitic infection usually occurs due to the presence of pyogenic bacteria, but may also be the result of infection secondary to trauma, although in skeleton 283 there is no evidence for this (Ortner 2003). The infection produces a build-up of pus in the marrow cavity, which eventually escapes through to the surface of the bone via the cloaca. There is also evidence for a second focus of infection due to the presence of a possible cloaca close to the elbow joint on the ulna (bone of the forearm). When the infection reaches such a stage, a weeping, ulcerated lesion may be visible at the surface of the skin. Osteomyelitis is more frequent in the lower limbs and infection in the upper limbs is relatively rare. Needless to say, this type of infection would have caused severe discomfort and would have been debilitating.

It is of note that two out of the three individuals suffering from osteomyelitis (including skeleton 283) were amongst those that Clarke (1979) considered 'foreign' or 'intrusive' individuals based on associated grave goods. Another of these, a male over the age of 50 years (skeleton 373), was buried with a very ornate cross-bow brooch, a pot and two coins by the skull. This individual exhibits bony changes consistent with osteomyelitis in his tibia and fibula, although in the absence of visible cloaca a radiograph would need to confirm diagnosis. It may be significant or simply coincidental that two of the individuals deemed 'foreign' suffered from this condition. Grave good associations at Lankhills have been shown by Gowland (2001, 2002) to relate to the gender and age of the dead, not simply 'status' in the hierarchical definition of the term. Likewise, 'intrusive' items of material culture such as cross-bow brooches (Clarke 1979: 391) were found to be associated with age and sex and were considered more likely to be indicative of a particular status or position of power achieved during life, rather than necessarily a specific ethnic identity.

Other individuals within the cemetery exhibited less severe indications of infection known as periosteal new bone growth. This refers to the growth of new inflammatory bone, of a greyish, porous appearance, on the bone surface. At Lankhills equal numbers males and females exhibited periosteal new bone growth and these changes were primarily observed on the bones of the lower legs. However, a large number of skeletons at Lankhills were poorly preserved and bones (when present) often exhibited severe 'weathering' of the outer surface which would remove evidence of periosteal activity. While equal numbers of males and females exhibited these changes, it was noted that females tended to exhibit periosteal new bone growth in a greater variety of skeletal elements. For example, one female showed severe active lesions on the radius and ulna as well as the lower limbs and another female showed

active periosteal changes throughout the skeleton, including the pelvis. This may indicate either a different pattern of immune response to similar 'health stresses' between the sexes (Redfern 2002), or differential exposure to such stresses according to gender. Only one female and one male exhibiting periosteal new bone growth were buried with grave goods. The female was 18–24 years of age and was buried with five bracelets, a necklace, two pins and a bowl. This is the age at which a larger proportion of females were buried with similar assemblages containing numerous bracelets (Gowland 2002). Overall, there were no clear patterns regarding periostitis and particular funerary rites.

b) Joint Disease

Skeleton 283 also suffered from severe forms of osteoarthritis in both elbow joints, which exhibited eburnation (a polished appearance caused when the cartilage is destroyed and the bones grind against each other) in identical areas in both joints. The nature of these degenerative changes indicates that this individual undertook a specific activity, involving the use of both arms in a similar motion. Unfortunately it is not possible to link particular degenerative patterns to specific occupations or activities without further supporting evidence. Because of the advanced stage of the osteoarthritic changes in skeleton 283 and the debilitation that the osteomyelitis would have caused (at least for a time), we can assume that the joint disease had progressed prior to the formation of infection. Further degenerative changes were also present in the mid and lower spine of this male and again the severity of the joint changes when compared to many other males of similar age within the cemetery points to a comparatively strenuous lifestyle.

With respect to degenerative joint changes overall in the cemetery, males were more frequently afflicted than females, particularly in the spine. The more severe changes amongst the males tended to be in the lower spine. The onset of osteoarthritis was only seen in those individuals aged 35–49 years and over, indicating that age as opposed to simply activity was the over-riding factor determining osteoarthritic change. A number of males also showed resorptive lesions in the collar bones indicative of heavy lifting and, as one might expect, these were quite often associated with spinal changes. It is interesting that the majority of these individuals were not buried with grave goods. No females showed these resorptive lesions suggesting some gendered differentiation in activity during life.

c) Trauma

Skeleton 283 also exhibited a healed fracture to the right fibula (lower leg bone). Fourteen individuals in total exhibited healed fractures and only two of these were females. Clearly the risk of fracture must be related to gender and this must in turn be linked to gendered roles. Interestingly, eleven out of the fourteen fractured bones were of the tibia and fibula. Although the lack of prevalence rates here makes comparisons with other cemeteries difficult, the majority of populations show a greater proportion of fractures amongst the bones of the upper limbs (Larsen 1997). The skeletal population at the late Roman site of Queensford farm also exhibits lower leg fractures, but there is a much higher proportion of upper limb fractures than at Lankhills (Harman *et al.* 1979; Chambers 1987). The late Roman cemetery of Poundbury, however, is similar to Lankhills in that the individuals buried there also show a higher proportion of lower leg fractures. Molleson (1993) suggests that these injuries may have been sustained during agricultural work, when feet are caught in plough furrows. Five of the males

with fractures at Lankhills were buried with grave goods, usually just a vessel. They were all individuals aged 35–49 years or older, however, the fractures were well-healed and it is impossible to determine at what age the injuries were actually sustained. The fractures tend to be well-aligned indicating some form of treatment (e.g. splinting), and this appears to be a general characteristic of healed fractures in the Roman period (Larsen 1997).

Summary and Discussion

Skeleton 283 is an unusual burial in terms of the unfinished nature of the grave, the apparent lack of coffin, the number and type of grave goods and the story of physical suffering revealed by the skeleton. This man was one of only seven individuals to be buried with a knife and one of only two to be buried with a whetstone. The lack of a coffin is particularly striking when at least 80% of males aged 35–49 years were buried within a coffin. Clarke (1979) also hints at a degree of carelessness with which this man was buried within his ‘too short’ grave. While buried with a higher than usual number of grave goods for an adult male at Lankhills, the general impression is not that of a ‘high status’ burial.

The perspective of the ‘osteobiography’ has provided useful additional information concerning the life of this man. We have observed that he was engaged in a repetitive and probably strenuous task involving both arms, which led to severe joint disease in both elbows and some degeneration of both shoulders. All of these joints would have been painful and probably would have shown periods of inflammation, thereby restricting or reducing movement. In addition the severe degeneration of the middle and lower vertebrae indicates that he would have experienced some stiffness and pain in these regions of his back. He, along with a number of other individuals buried in the cemetery, had also fractured his fibula at some point in his life, probably during adulthood as healed childhood fractures are difficult to identify in adult skeletons. The bone has healed with no visible complications and may well have been treated. This man also suffered from an infection to the bones of his right shoulder and forearm. The cause of this infection is uncertain, but both areas would have been painful, inflamed and are likely to have caused periods of debilitation. The infection would have been visible on the skin surface, although the areas were likely to have been covered by clothes. The effect that these pathologies would have had on social discourse is therefore difficult to ascertain.

There are a number of problems one encounters when attempting to construct an osteobiography. We do not actually know when his healed fracture was sustained, or how long it has taken for the joint disease, or infectious processes to progress to the stages reached at death. Although it is probable that the infection occurred after the joint disease had progressed, we cannot definitely state a pathological sequence since there are too many variables at play. This is problematic because social variables change over an individual’s life course: status may fluctuate in accordance with age or over time and this may impact on exposure to disease processes. For example, could the pathologies relate to a more or less impoverished period of an individual’s life? Finally, while we may hazard a guess, we do not really know just how much these pathologies would have affected his day to day life and movements (Dettwyler 1991; Hawkey 1998). That said, we have gleaned important additional information concerning the life of this man.

Conclusion

Although some sex and age specific patterns in particular pathologies were present at Lankhills, it was difficult to relate these to any specific grave good patterns, with the exception of the osteomyelitis. When using grave good evidence we need to be aware of how these are related to the age and gender of an individual, not just status, and we have to be careful not to oversimplify social identity and relations. The inter-action of individuals with their environment is incredibly complex and intricate. Multiple and inter-related causes of diseases frustrate diagnostic attempts and limit our ability to interpret the meaning and cultural relevance of particular disease processes. Understanding the relationship between health and social identity in the past is far from straightforward. The response to health stress within a society can be subtle and varied and the social impact of disease for those afflicted will more often than not leave no archaeologically discernible trace. Such interpretive difficulties are further exacerbated by the limitations of palaeopathological evidence. Nevertheless, the skeletal pathology of past populations has much to offer when used in conjunction with cultural evidence from the funerary context. Its value lies primarily in the comparison of health between different populations, but must proceed from a more nuanced understanding of social context than has hitherto been conducted. By doing so we may attempt to go some way towards understanding the dialectic between health and social identity in Roman Britain.

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