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THE BIRTH OF THE CLINIC

An Archaeology of Medical Perception

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Preface

This book is about space, about language, and about death; it is about the act of seeing, the gaze. Towards the middle of the eighteenth century, Pomme treated and cured a hysteric by making her take ‘baths, ten or twelve hours a day, for ten whole months’. At the end of this treatment for the desiccation of the nervous system and the heat that sustained it, Pomme saw ‘membranous tissues like pieces of damp parchment ...peel away with some slight discomfort, and these were passed daily with the urine; the right ureter also peeled away and came out whole in the same way’. The same thing occurred with the intestines, which at another stage, ‘peeled off their internal tunics, which we saw emerge from the rectum. The oesophagus, the arterial trachea, and the tongue also peeled in due course; and the patient had rejected different pieces either by vomiting or by expectoration’ [1].

Less than a hundred years later, this is how a doctor observed an anatomical lesion of the brain and its enveloping membranes, the so-called ‘false membranes’ frequently found on patients suffering from ‘chronic meningitis:’

Their outer surface, which is next to the arachnoid layer of the dura mater, adheres to this layer, sometimes very lightly, when they can be separated easily, sometimes very firmly and tightly, in which case it can be very difficult to detach them. Their internal surface is only contiguous with the arachnoid, and is in no way joined to it.... The false membranes are often transparent,

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especially when they are very thin; but usually they are white, grey, or red in colour, and occasionally, yellow, brown, or black. This matter often displays different shades in different parts of the same membrane. The thickness of these accidental productions varies greatly; sometimes they are so tenuous that they might be compared to a spider’s web.... The organization of the false membranes also displays a great many differences: the thin ones are buffy, like the albuminous skins of eggs, and have no distinctive structure of their own. Others, on one of their sides, often display traces of blood vessels crossing over one another in different directions and injected. They can often be reduced to layers placed one upon another, between which discoloured blood clots are frequently interposed [2].

Between Pomme, who carried the old myths of nervous pathology to their ultimate form, and Bayle, who described the encephalic lesions of general paralysis for an era from which we have not yet emerged, the difference is both tiny and total. For us, it is total, because each of Bayle’s words, with its qualitative precision, directs our gaze into a world of constant visibility, while Pomme, lacking any perceptual base, speaks to us in the language of fantasy. But by what fundamental experience can we establish such an obvious difference below the level of our certainties, in that region from which they emerge? How can we be sure that an eighteenth-century doctor did not see what he saw, but that it needed several decades before the fantastic figures were dissipated to reveal, in the space they vacated, the shapes of things as they really are?

What occurred was not a ‘psychoanalysis’ of medical knowledge, nor any more or less spontaneous break with imaginary investments; ‘positive’ medicine is not a medicine that has made an ‘objectal’ choice in favour of objectivity itself. Not all the powers of a visionary space through which doctors and patients, physiologists and practitioners communicated (stretched and twisted nerves, burning dryness, hardened or burnt organs, the new birth of the body in the beneficent element of cool waters) have disappeared; it is, rather, as if they had been displaced, enclosed within the singularity of the patient, in that region of ‘subjective symptoms’ that—for the doctor—defines not the mode of knowledge, but the world of objects to be known. Far from being broken, the fantasy link between knowledge and pain is reinforced by a more complex means than the mere permeability of the imagination;

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the presence of disease in the body, with its tensions and its burnings, the silent world of the entrails, the whole dark underside of the body lined with endless unseeing dreams, are challenged as to their objectivity

by the reductive discourse of the doctor, as well as established as multiple objects meeting his positive gaze. The figures of pain are not conjured away by means of a body of neutralized knowledge; they have been redistributed in the space in which bodies and eyes meet. What has changed is the silent configuration in which language finds support: the relation of situation and attitude to what is speaking and what is spoken about.

From what moment, from what semantic or syntactical change, can one recognize that language has turned into rational discourse? What sharp line divides a description that depicts membranes as being like 'damp parchment' from that other equally qualitative, equally metaphorical description of them laid out over the tunic of the brain, like a film of egg whites? Do Bayle's 'white' and 'red' membranes possess greater value, solidity, and objectivity—in terms of scientific discourse—than the horny scales described by the doctors of the eighteenth century? A rather more meticulous gaze, a more measured verbal tread with a more secure footing upon things, a more delicate, though sometimes rather confused choice of adjective—are these not merely the proliferation, in medical language, of a style which, since the days of galenic medicine, has extended whole regions of description around the greyness of things and their shapes?

In order to determine the moment at which the mutation in discourse took place, we must look beyond its thematic content or its logical modalities to the region where 'things' and 'words' have not yet been separated, and where—at the most fundamental level of language—seeing and saying are still one. We must re-examine the original distribution of the visible and invisible insofar as it is linked with the division between what is stated and what remains unsaid: thus the articulation of medical language and its object will appear as a single figure. But if one poses no retrospective question, there can be no priority; only the spoken structure of the perceived—that *full* space in the *hollow* of which language assumes volume and size—may be brought up into the indifferent light of day. We must place ourselves, and remain once and for all, at the level of the fundamental *spatialization* and *verbalization* of the pathological, where the loquacious gaze with which the doctor

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observes the poisonous heart of things is born and communes with itself.

Modern medicine has fixed its own date of birth as being in the last years of the eighteenth century. Reflecting on its situation, it identifies the origin of its positivity with a return—over and above all theory—to the modest but effecting level of the perceived. In fact, this supposed empiricism is not based on a rediscovery of the absolute values of the visible, nor on the predetermined rejection of systems and all their chimeras, but on a reorganization of that manifest and secret space that opened up when a millennial gaze paused over men's sufferings. Nonetheless the rejuvenation of medical perception, the way colours and things came to life under the illuminating gaze of the first clinicians is no mere myth. At the beginning of the nineteenth century, doctors described what for centuries had remained below the threshold of the visible and the expressible, but this did not mean that, after over-indulging in speculation, they had begun to perceive once again, or that they listened to reason rather than to imagination; it meant that the relation between the visible and invisible—which is necessary to all concrete knowledge—changed its structure, revealing through gaze and language what had previously been below and beyond their domain. A new alliance was forged between words and things, enabling one *to see* and *to say*. Sometimes, indeed, the discourse was so completely 'naive' that it seems to belong to a more archaic level of rationality, as if it involved a return to the clear, innocent gaze of some earlier, golden age.

In 1764, J.F.Meckel set out to study the alterations brought about in the brain by certain disorders (apoplexy, mania, phthisis); he used the rational method of weighing equal volumes and comparing them to determine which parts of the brain had been de-hydrated, which parts had been swollen, and by which diseases. Modern medicine has made hardly any use of this research. Brain pathology achieved its 'positive' form when Bichat, and above all Récamier and Lallemand, used the celebrated 'hammer, with a broad, thin end. If one proceeds with light taps, no concussion liable to cause disorders can result as the skull is full. It is better to begin from the rear, because, when only the occipital has to be broken, it is often

so mobile that one misses one's aim... In the case of very young children, the bones are too supple to be broken

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and too thin to be sawn; they have to be cut with strong scissors' [3]. The fruit is then opened up. From under the meticulously parted shell, a soft, greyish mass appears, wrapped in viscous, veined skins: a delicate, dingy-looking pulp within which—freed at last and exposed at last to the light of day—shines the seat of knowledge. The artisanal skill of the brain-breaker has replaced the scientific precision of the scales, and yet our science since Bichat identifies with the former; the precise, but immeasurable gesture that opens up the plenitude of concrete things, combined with the delicate network of their properties to the gaze, has produced a more scientific objectivity for us than instrumental arbitrations of quantity. Medical rationality plunges into the marvelous density of perception, offering the grain of things as the first face of truth, with their colours, their spots, their hardness, their adherence. The breadth of the experiment seems to be identified with the domain of the careful gaze, and of an empirical vigilance receptive only to the evidence of visible contents. The eye becomes the depositary and source of clarity; it has the power to bring a truth to light that it receives only to the extent that it has brought it to light; as it opens, the eye first opens the truth: a flexion that marks the transition from the world of classical clarity—from the 'enlightenment'—to the nineteenth century.

For Descartes and Malebranche, to see was to perceive (even in the most concrete kinds of experience, such as Descartes's practice of anatomy, or Malebranche's microscopic observations); but, without stripping perception of its sensitive body, it was a matter of rendering it transparent for the exercise of the mind: light, anterior to every gaze, was the element of ideality—the unassignable place of origin where things were adequate to their essence—and the form by which things reached it through the geometry of bodies; according to them, the act of seeing, having attained perfection, was absorbed back into the unbending, unending figure of light. At the end of the eighteenth century, however, seeing consists in leaving to experience its greatest corporal opacity; the solidity, the obscurity, the density of things closed in upon themselves, have powers of truth that they owe not to light, but to the slowness of the gaze that passes over them, around them, and gradually into them, bringing them nothing more than its own light. The residence of truth in the dark centre of things is linked, paradoxically, to this sovereign power of the empirical gaze that turns their darkness into

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light. All light has passed over into the thin flame of the eye, which now flickers around solid objects and, in so doing, establishes their place and form. Rational discourse is based less on the geometry of light than on the insistent, impenetrable density of the object, for prior to all knowledge, the source, the domain, and the boundaries of experience can be found in its dark presence. The gaze is passively linked to the primary passivity that dedicates it to the endless task of absorbing experience in its entirety, and of mastering it.

The task lay with this language of things, and perhaps with it alone, to authorize a knowledge of the individual that was not simply of a historic or aesthetic order. That the definition of the individual should be an endless labour was no longer an obstacle to an experience, which, by accepting its own limits, extended its task into the infinite. By acquiring the status of object, its particular quality, its impalpable colour, its unique, transitory form took on weight and solidity. No light could now dissolve them in ideal truths; but the gaze directed upon them would, in turn, awaken them and make them stand out against a background of objectivity. The gaze is no longer reductive, it is, rather, that which establishes the individual in his irreducible quality. And thus it becomes possible to organize a rational language around it. The *object* of discourse may equally well be a *subject*, without the figures of objectivity being in any way altered. It is this *formal* reorganization, *in depth*, rather than the abandonment of theories and old systems, that made *clinical experience* possible; it lifted the old Aristotelian prohibition: one could at last hold a scientifically structured discourse about an individual.

Our contemporaries see in this accession to the individual the establishment of a 'unique dialogue', the most concentrated formulation of an old medical humanism, as old as man's compassion. The mindless phenomenologies of understanding mingle the sand of their conceptual desert with this half-baked notion;

the feebly eroticized vocabulary of Encounter' and of the 'doctor/patient relationship' (*le couple médecin-malade*) exhausts itself in trying to communicate the pale powers of matrimonial fantasies to so much non-thought Clinical experience—that opening up of the concrete individual, for the first time in Western history, to the language of rationality, that major event in the relationship of man to himself and of language to things—was soon taken as a simple, uncon-

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ceptualized confrontation of a gaze and a face, or a glance and a silent body; a son of contact prior to all discourse, free of the burdens of language, by which two living individuals are 'trapped' in a common, but non-reciprocal situation. Recently, in the interests of an open market, so-called 'liberal' medicine has revived the old rights of a clinic understood as a special contract, a tacit pact made between one man and another. This patient gaze has even been attributed with the power of assuming—with the calculated addition of reasoning (neither too much nor too little)—the general form of all scientific observation:

In order to be able to offer each of our patients a course of treatment perfectly adapted to his illness and to himself, we try to obtain a complete, objective idea of his case; we gather together in a file of his own all the information we have about him. We 'observe' him in the same way that we observe the stars or a laboratory experiment [4].

Miracles are not so easy to come by: the mutation that made it possible—and which continues to do so every day—for the patient's 'bed' to become a field of scientific investigation and discourse is not the sudden explosive mixture of an old practice and an even older logic, or that of a body of knowledge and some strange, sensorial element of 'touch', 'glance', or 'flair'. Medicine made its appearance as a clinical science in conditions which define, together with its historical possibility, the domain of its experience and the structure of its rationality. They form its concrete a priori, which it is now possible to uncover, perhaps because a new experience of disease is coming into being that will make possible a historical and critical understanding of the old experience.

A detour is necessary here if we are to lay the foundations of our discourse on the birth of the clinic. It is a strange discourse, I admit, since it will be based neither on the present consciousness of clinicians, nor even on a repetition of what they once might have said.

It may well be that we belong to an age of criticism whose lack of a primary philosophy reminds us at every moment of its reign and its fatality: an age of intelligence that keeps us irremediably at a distance from an original language. For Kant, the possibility and necessity of a critique were linked, through certain scientific contents, to the fact that there is such a thing as knowledge. In our

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time—and Nietzsche the philologist testifies to it—they are linked to the fact that language exists and that, in the innumerable words spoken by men—whether they are reasonable or senseless, demonstrative or poetic—a meaning has taken shape that hangs over us, leading us forward in our blindness, but awaiting in the darkness for us to attain awareness before emerging into the light of day and speaking. We are doomed historically to history, to the patient construction of discourses about discourses, and to the task of hearing what has already been said.

But is it inevitable that we should know of no other function for speech (*parole*) than that of commentary? *Commentary* questions discourse as to what it says and intended to say; it tries to uncover that deeper meaning of speech that enables it to achieve an identity with itself, supposedly nearer to its essential truth; in other words, in stating what has been said, one has to re-state what has never been said. In this activity known as commentary which tries to transmit an old, unyielding discourse seemingly silent to itself, into another, more prolix discourse that is both more archaic and more contemporary—is concealed a strange attitude towards language: to comment is to admit by definition an excess of the signified over the signifier; a necessary, unformulated remainder of thought that language has left in the shade—a remainder that is the very essence of that thought, driven outside its secret—but to comment also presupposes that this unspoken element slumbers within speech (*parole*), and that, by a super-abundance proper to the signifier, one may,

in questioning it, give voice to a content that was not explicitly signified. By opening up the possibility of commentary, this double plethora dooms us to an endless task that nothing can limit: there is always a certain amount of signified remaining that must be allowed to speak, while the signifier is always offered to us in an abundance that questions us, in spite of ourselves, as to what it 'means' (*veut dire*). Signifier and signified thus assume a substantial autonomy that accords the treasure of a virtual signification to each of them separately; one may even exist without the other, and begin to speak of itself: commentary resides in that supposed space. But at the same time, it invents a complex link between them, a whole tangled web that concerns the poetic values of expression: the signifier is not supposed to 'translate' without concealing, without leaving the signified with an inexhaustible reserve; the signified is revealed only in the visible, heavy world of a signifier that is itself burdened with a

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meaning that it cannot control. Commentary rests on the postulate that speech (*parole*) is an act of 'translation', that it has the dangerous privilege images have of showing while concealing, and that it can be substituted for itself indefinitely in the open series of discursive repetitions; in short, it rests on a psychologicist interpretation of language that shows the stigmata of its historical origin. This is an exegesis, which listens, through the prohibitions, the symbols, the concrete images, through the whole apparatus of Revelation, to the Word of God, ever secret, ever beyond itself. For years we have been commenting on the language of our culture from the very point where for centuries we had awaited in vain for the decision of the Word.

To speak about the thought of others, to try to say what they have said has, by tradition, been to analyse the signified. But must the things said, elsewhere and by others, be treated exclusively in accordance with the play of signifier and signified, as a series of themes present more or less implicitly to one another? Is it not possible to make a structural analysis of discourses that would evade the fate of commentary by supposing no remainder, nothing in excess of what has been said, but only the fact of its historical appearance? The facts of discourse would then have to be treated not as autonomous nuclei of multiple significations, but as events and functional segments gradually coming together to form a system. The meaning of a statement would be defined not by the treasure of intentions that it might contain, revealing and concealing it at the same time, but by the difference that articulates it upon the other real or possible statements, which are contemporary to it or to which it is opposed in the linear series of time. A systematic history of discourses would then become possible.

Until recently, the history of ideas was only aware of two methods: the first, aesthetic method involved analogy, with diffusion charted in time (geneses, filiations, kinships, influences) or on the surface of a given historical space (the spirit of a period, its *Weltanschauung*, its fundamental categories, the organization of its sociocultural world). The second, which was a psychological method, involved a denial of contents (this or that century was not as rationalistic, or irrationalistic as was said or believed), from which there has since developed a sort of 'psychoanalysis' of thought, the results of which can quite legitimately be reversed—the nucleus of the nucleus being always its opposite.

I should like to attempt here the analysis of a type of discourse—

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that of medical experience—at a period when, before the great discoveries of the nineteenth century, it had changed its materials more than its systematic form. The clinic is both a new 'carving up' of things and the principle of their verbalization in a form which we have been accustomed to recognizing as the language of a 'positive science'.

To anyone wishing to draw up an inventory of its themes, the idea of the clinic would undoubtedly seem to be imbued with rather vague values; insipid figures would probably take shape, such as the strange effect of disease on the patient, the diversity of individual temperaments, the probability of pathological evolution, the need for sharp perception (the need to be constantly alert to the slightest visible modalities), the empirical form—cumulative, and endlessly open to medical knowledge—old, threadbare notions that had been medicine's basic tools as far back as the Greeks. Nothing in this ancient arsenal can designate clearly

what took place at that turning point in the eighteenth century, when the calling into question of the old clinical theme ‘produced’—if we are to believe first appearances—an essential mutation in medical knowledge. Nonetheless, considered on an over-all basis, the clinic appears—in terms of the doctor’s experience—as a new outline of the perceptible and storable: a new distribution of the discrete elements of corporal space (for example, the isolation of *tissue*—a functional, two-dimensional area—in contrast with the functioning mass of the organ, constituting the paradox of an ‘internal surface’) a reorganization of the elements that make up the pathological phenomenon (a grammar of signs has replaced a botany of symptoms), a definition of the linear series of morbid events (as opposed to the table of nosological species), a welding of the disease onto the organism (the disappearance of the general morbid entities that grouped symptoms together in a single logical figure, and their replacement by a local status that situates the being of the disease with its causes and effects in a three-dimensional space). The appearance of the clinic as a historical fact must be identified with the system of these reorganizations. This new structure is indicated—but not, of course, exhausted—by the minute but decisive change, whereby the question: ‘What is the matter with you?’, with which the eighteenth-century dialogue between doctor and patient began (a dialogue possessing its own grammar and style), was replaced by that other question: ‘Where does it hurt?’, in which we recognize the operation of the clinic and the principle of its entire discourse. From

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then on, the whole relationship of signifier to signified, at every level of medical experience, is redistributed: between the symptoms that signify and the disease that is signified, between the description and what is described, between the event and what it prognosticates, between the lesion and the pain that it indicates, etc. The clinic—constantly praised for its empiricism, the modesty of its attention, and the care with which it silently lets things surface to the observing gaze without disturbing them with discourse—owes its real importance to the fact that it is a reorganization in depth, not only of medical discourse, but of the very possibility of a discourse about disease. The *restraint* of clinical discourse (its rejection of theory, its abandonment of systems, its lack of a philosophy; all so proudly proclaimed by doctors) reflects the non-verbal conditions on the basis of which it can speak: the common structure that carves up and articulates what is seen and what is said.

The research that I am undertaking here therefore involves a project that is deliberately both historical and critical, in that it is concerned—outside all prescriptive intent—with determining the conditions of possibility of medical experience in modern times.

I should like to make it plain once and for all that this book has not been written in favour of one kind of medicine as against another kind of medicine, or against medicine and in favour of an absence of medicine. It is a structural study that sets out to disentangle the conditions of its history from the density of discourse, as do others of my works.

What counts in the things said by men is not so much what they may have thought or the extent to which these things represent their thoughts, as that which systematizes them from the outset, thus making them thereafter endlessly accessible to new discourses and open to the task of transforming them.

NOTES

[1] Pomme, *Traité des affections vaporeuses des deux sexes* (4th edn., Lyons, 1769, vol. I, pp. 60–5).

[2] A.L.J. Bayle, *Nouvelle doctrine des maladies mentales* (Paris, 1825, pp. 23–4).

[3] F. Lallemand, *Recherches anatomo-pathologiques sur l’encéphale* (Paris, 1820, introduction, p. vii, n.).

[4] J. -Ch. Sournia, *Logique et morale du diagnostic* (Paris, 1962, p. 19).

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Spaces and Classes

For us, the human body defines, by natural right, the space of origin and of distribution of disease: a space whose lines, volumes, surfaces, and routes are laid down, in accordance with a now familiar geometry, by the anatomical atlas. But this order of the solid, visible body is only one way—in all likelihood neither the first, nor the most fundamental—in which one spatializes disease. There have been, and will be, other distributions of illness.

When will we be able to define the structures that determine, in the secret volume of the body, the course of allergic reactions? Has anyone ever drawn up the specific geometry of a virus diffusion in the thin layer of a segment of tissue? Is the law governing the spatialization of these phenomena to be found in a Euclidean anatomy? After all, one only has to remember that the old theory of sympathies spoke a vocabulary of correspondences, vicinities, and homologies, terms for which the perceived space of anatomy hardly offers a coherent lexicon. Every great thought in the field of pathology lays down a configuration for disease whose spatial requisites are not necessarily those of classical geometry.

The exact superposition of the 'body' of the disease and the body of the sick man is no more than a historical, temporary datum. Their encounter is self-evident only for us, or, rather, we are only just beginning to detach ourselves from it. The space of *configuration* of the disease and the space of *localization* of the illness in the body have been superimposed, in medical experience, for only a relatively short period of time—the period that coincides with

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nineteenth-century medicine and the privileges accorded to pathological anatomy. This is the period that marks the suzerainty of the gaze, since in the same perceptual field, following the same continuities or the same breaks, experience reads at a glance the visible lesions of the organism and the coherence of pathological forms; the illness is articulated exactly on the body, and its logical distribution is carried out at once in terms of anatomical masses. The 'glance' has simply to exercise its right of origin over truth.

But how did this supposedly natural, immemorial right come about? How was this locus, in which disease indicated its presence, able to determine in so sovereign a way the figure that groups its elements together? Paradoxically, never was the space of configuration of disease more free, more independent of its space of localization than in classificatory medicine, that is to say, in that form of medical thought that, historically, just preceded the anatomo-clinical method, and made it structurally possible.

'Never treat a disease without first being sure of its species,' said Gilibert [\[1\]](#). From the *Nosologie* of Sauvages (1761) to the *Nosographie* of Pinel (1798), the classificatory rule dominates medical theory and practice: it appears as the immanent logic of morbid forms, the principle of their decipherment, and the semantic rule of their definition: 'Pay no heed to those envious men who would cast the shadow of contempt over the writings of the celebrated Sauvages... Remember that of all the doctors who have ever lived he is perhaps the only one to have subjected all our dogmas to the infallible rules of healthy logic. Observe with what care he defines his words, with what scrupulousness he circumscribes the definitions of each malady.' Before it is removed from the density of the body, disease is given an organization, hierarchized into families, genera, and species. Apparently, this is no more than a 'picture' that helps us to

learn and to remember the proliferating domain of the diseases. But at a deeper level than this spatial 'metaphor', and in order to make it possible, classificatory medicine presupposes a certain 'configuration' of disease: it has never been formulated for itself, but one can define its essential requisites after the event. Just as the genealogical tree, at a lower level than the comparison that it involves and all its imaginary themes, presupposes a space in which kinship is formalizable, the nosological picture involves a figure of the diseases that is neither the chain of causes and effects nor the chronological series of events nor its visible trajectory in the human body.

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This organization treats localization in the organism as a subsidiary problem, but defines a fundamental system of relations involving envelopments, subordinations, divisions, resemblances. This space involves: a 'vertical', in which the implications are drawn up—fever, 'a successive struggle between cold and heat', may occur in a single episode, or in several; these may follow without interruption or after an interval; this respite may not exceed twelve hours, attain a whole day, last two whole days, or have a poorly defined rhythm [2]; and a 'horizontal', in which the homologies are transferred—in the two great subdivisions of the spasms are to be found, in perfect symmetry, the 'partial tonics', the 'general tonics', the 'partial clonics', and the 'general clonics' [3]; or again, in the order of the discharges, what catarrh is to the throat, dysentery is to the intestines [4]; a deep space, anterior to all perceptions, and governing them from afar; it is on the basis of this space, the lines that it intersects, the masses that it distributes or hierarchizes, that disease, emerging beneath our gaze, becomes embodied in a living organism.

What are the principles of this primary configuration of disease?

1. The doctors of the eighteenth century identified it with 'historical', as opposed to philosophical, 'knowledge'. Knowledge is historical that circumscribes pleurisy by its four phenomena: fever, difficulty in breathing, coughing, and pains in the side. Knowledge would be philosophical that called into question the origin, the principle, the causes of the disease: cold, serous discharge, inflammation of the pleura. The distinction between the historical and the philosophical is not the distinction between cause and effect: Cullen based his classificatory system on the attribution of related causes [5]; nor is the distinction between principle and consequences, since Sydenham thought he was engaged in historical research when studying 'the way in which nature produces and sustains the different forms of diseases' [6]; nor even is it exactly the difference between the visible and the hidden or conjectural, for one sometimes has to track down a 'history' that is enclosed upon itself and develops invisibly, like hectic fever in certain phthisics: 'reefs caught under water' [7]. The historical embraces whatever, *de facto* or *de jure*, sooner or later, directly or indirectly, may be offered to the gaze. A cause that can be seen, a symptom that is gradually discovered, a principle that can be deciphered from its root do not belong to the order of 'philosophical' knowl-

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edge, but to a 'very simple' knowledge, which 'must precede all others', and which situates the original form of medical experience. It is a question of defining a sort of fundamental area in which perspectives are levelled off, and in which shifts of level are aligned: an effect has the same status as its cause, the antecedent coincides with what follows it. In this homogeneous space series are broken and time abolished: a local inflammation is merely the ideal juxta-position of its historical elements (redness, tumour, heat, pain) without their network of reciprocal determinations or their temporal intersection being involved.

Disease is perceived fundamentally in a space of projection without depth, of coincidence without development. There is only one plane and one moment. The form in which truth is originally shown is the surface in which relief is both manifested and abolished—the portrait: 'He who writes the history of diseases must...observe attentively the clear and natural phenomena of diseases, however uninteresting they may seem. In this he must imitate the painters who when they paint a portrait are careful to mark the smallest signs and natural things that are to be found on the face of the person they are painting' [8]. The first structure provided by classificatory medicine is the flat surface of perpetual simultaneity. Table and picture.

2. It is a space in which analogies define essences. The pictures resemble things, but they also resemble one another. The *distance* that separates one disease from another can be measured only by the *degree* of their *resemblance*, without reference to the logico-temporal divergence of genealogy. The disappearance of voluntary movements and reduced activity in the internal or external sense organs form the general outline that emerges beneath such particular forms as apoplexy, syncope, or paralysis. Within this great kinship, minor divergences are established: apoplexy robs one of the use of all the senses, and of all voluntary motility, but it spares the breathing and the functioning of the heart; paralysis affects only a locally assignable sector of the nervous system and motility; like apoplexy, syncope has a general effect, but it also interrupts respiratory movements [9]. The perspective distribution, which enables us to see in paralysis a symptom, in syncope an episode, and in apoplexy an organic and functional attack, does not exist for the classificatory gaze, which is sensitive only to surface divisions, in which vicinity is not defined by measurable distances but

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by formal similarities. When they become dense enough, these similarities cross the threshold of mere kinship and accede to unity of essence. There is no fundamental difference between an apoplexy that suddenly suspends motility, and the chronic, evolutive forms that gradually invade the whole motor system: in that simultaneous space in which forms distributed by time come together and are superimposed, kinship folds back into identity. In a flat, homogeneous, non-measurable world, there is essential disease where there is a plethora of similarities.

3. The form of the similarity uncovers the rational order of the diseases. When one perceives a resemblance, one does not simply lay down a system of convenient, relative 'mappings'; one begins to read off the intelligible ordering of the diseases. The veil is lifted from the principle of their creation; this is the general order of nature. As in the case of plants or animals, the action of disease is fundamentally specific: 'The supreme Being is not subjected to less certain laws in producing diseases or in maturing morbid humours, than in growing plants and animals... He who observes attentively the order, the time, the hour at which the attack of quart fever begins, the phenomena of shivering, of heat, in a word all the symptoms proper to it, will have as many reasons to believe that this disease is a species as he has to believe that a plant constitutes a species because it grows, flowers, and dies always in the same way' [10].

This botanical model has a double importance for medical thought. First, it made it possible to turn the principle of the analogy of forms into the law of the production of essences; and, secondly, it allowed the perceptual attention of the doctor—which, here and there, discovers and relates—to communicate with the ontological order—which organizes from the inside, prior to all manifestation—the world of disease. The order of disease is simply a 'carbon copy' of the world of life; the same structures govern each, the same forms of division, the same ordering. The rationality of life is identical with the rationality of that which threatens it. Their relationship is not one of nature and counter-nature; but, in a natural order common to both, they fit into one another, one superimposed upon the other. In disease, one *recognizes (reconnait t)* life because it is on the law of life that *knowledge (connaissance)* of the disease is also based.

4. We are dealing with species that are both natural and ideal.

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Natural, because it is in them that diseases state their essential truths; ideal insofar as they are never experienced unchanged and undisturbed.

The first disturbance is introduced with and by disease itself. To the pure nosological essence, which fixes and exhausts its place in the order of the species without residue, the patient adds, in the form of so many disturbances, his predispositions, his age, his way of life, and a whole series of events that, in relation to the essential nucleus, appear as accidents. In order to know the truth of the pathological fact, the doctor must abstract the patient: 'He who describes a disease must take care to distinguish the symptoms that necessarily accompany it, and which are proper to it, from those that are only accidental and fortuitous, such as those that depend on the temperament and age of the patient' [11]. Paradoxically, in relation to that which he is suffering from, the patient is only an external fact; the medical reading must take him into

account only to place him in parentheses. Of course, the doctor must know ‘the internal structure of our bodies’; but only in order to subtract it, and to free to the doctor’s gaze ‘the nature and combination of symptoms, crises, and other circumstances that accompany diseases’ [12]. It is not the pathological that functions, in relation to life, as a *counter-nature*, but the patient in relation to the disease itself.

And not only the patient; the doctor, too. His intervention is an act of violence if it is not subjected strictly to the ideal ordering of nosology: ‘The knowledge of diseases is the doctor’s compass; the success of the cure depends on an exact knowledge of the disease’; the doctor’s gaze is directed initially not towards that concrete body, that visible whole, that positive plenitude that faces him—the patient—but towards intervals in nature, lacunae, distances, in which there appear, like negatives, ‘the signs that differentiate one disease from another, the true from the false, the legitimate from the bastard, the malign from the benign’ [13]. It is a grid that catches the real patient and holds back any therapeutic indiscretion. If, for polemical reasons, the remedy is administered too early, it contradicts and blurs the essence of the disease; it prevents the disease from acceding to its true nature, and, by making it irregular, makes it unbeatable. In the period of invasion, the doctor must hold his breath, for ‘the beginnings of disease reveal its class, its genus, and its species’; when the symptoms increase and

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become more marked, it is enough ‘to diminish their violence and reduce the pains’; when the disease has settled in, one must ‘follow step by step the paths followed by nature’, strengthening it if it is too weak, diminishing it if it strives too vigorously to destroy what resists it’ [14].

In the rational space of disease, doctors and patients do not occupy a place as of right; they are tolerated as disturbances that can hardly be avoided: the paradoxical role of medicine consists, above all, in neutralizing them, in maintaining the maximum difference between them, so that, in the void that appears between them, the ideal configuration of the disease becomes a concrete, free form, totalized at last in a motionless, simultaneous picture, lacking both density and secrecy, where recognition opens of itself onto the order of essences.

Classificatory thought gives itself an essential space, which it proceeds to efface at each moment. Disease exists only in that space, since that space constitutes it as nature; and yet it always appears rather out of phase in relation to that space, because it is manifested in a real patient, beneath the observing eye of a forearmed doctor. The fine two-dimensional space of the portrait is both the origin and the final result: that which makes possible, at the outset, a rational, well-founded body of medical knowledge, and that towards which it must constantly proceed through that which conceals it. One of the tasks of medicine, therefore, is to rejoin its own condition, but by a path in which it must efface each of its steps, because it attains its aim in a gradual neutralization of itself. The condition of its truth is the necessity that blurs its outlines. Hence the strange character of the medical gaze; it is caught up in an endless reciprocity. It is directed upon that which is visible in the disease—but on the basis of the patient, who hides this visible element even as he shows it; consequently, in order to know, he must recognize, while already being in possession of the knowledge that will lend support to his recognition. And, as it moves forward, this gaze is really retreating, since it reaches the truth of the disease only by allowing it to win the struggle and to fulfill, in all its phenomena, its true nature.

Disease, which can be mapped out on the picture, becomes apparent in the body. There it meets a space with a quite different configuration: the concrete space of perception. Its laws define the

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visible forms assumed by disease in a sick organism: the way in which disease is distributed in the organism, manifests its presence there, progresses by altering solids, movements, or functions, causes lesions that become visible under autopsy, triggers off, at one point or another, the interplay of symptoms, causes reactions, and thus moves towards a fatal, and for it favourable, outcome. We are dealing here with

those complex, derived figures by means of which the essence of the disease, with its structure of a picture, is articulated upon the thick, dense volume of the organism and becomes *embodied* within it.

How can the flat, homogeneous, homological space of classes become visible in a geographical system of masses differentiated by their volume and distance? How can a disease, defined by its *place* in a family, be characterized by its *seat* in an organism? This is the problem that might be called the *secondary spatialization* of the pathological.

For classificatory medicine, presence in an organ is never absolutely necessary to define a disease: this disease may travel from one point of localization to another, reach other bodily surfaces, while remaining identical in nature. The space of the body and the space of the disease possess enough latitude to slide away from one another. The same, single spasmodic malady may move from the lower part of the abdomen, where it may cause dyspepsia, visceral congestion, interruption of the menstrual or haemorrhoidal flow, towards the chest, with breathlessness, palpitations, the feeling of a lump in the throat, coughing, and finally reach the head, causing epileptic convulsions, syncopes, or sleepiness [15]. These movements, which are accompanied by symptomatic changes, may occur in time in a single individual; they may also be found by examining a series of individuals with different link points: in its visceral form, spasm is encountered, above all, in lymphatic subjects, while in its cerebral form it is encountered more among sanguine temperaments. But in any case, the essential pathological configuration is not altered. The organs are the concrete supports of the disease; they never constitute its indispensable conditions. The system of points that defines the relation of the disease to the organism is neither constant nor necessary. They do not possess a common, previously defined space.

In this corporal space in which it circulates freely, disease undergoes metastases and metamorphoses. Nothing confines it to a par-

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ticular course. A nosebleed may become haemoptysis (spitting of blood) or cerebral haemorrhage; the only thing that must remain is the specific form of blood discharge. This is why the medicine of spaces has, throughout its history, been linked to the doctrine of sympathies—each notion being compelled to reinforce the other for the correct balance of the system. Sympathetic communication through the organism is sometimes carried out by a locally assignable relay (the diaphragm for spasms, the stomach for the discharge of humour); sometimes by a whole system of diffusion that radiates through the body (the nervous system for pains and convulsions, the vascular system for inflammations); in other cases, by means of a simple functional correspondence (a suppression of the excretions is communicated from the intestines to the kidneys, and from these to the skin); lastly, by means of an adjustment of the nervous system from one region to another (lumbar pains in the hydrocele). But the anatomical redistribution of the disease, whether through correspondence, diffusion, or relay, does not alter its essential structure; sympathy operates the interplay between the space of localization and the space of configuration; it defines their reciprocal freedom and the boundaries of that freedom.

Or, rather, threshold, not boundary. For beyond the sympathetic transference of the structural homology that it authorizes, a relation may be set up between one disease and another that is a relation of causality, but not of kinship. By virtue of its own creative force, one pathological form may engender another that is very far removed in the nosological picture. Hence the complications; hence the mixed forms; hence certain regular, or at least frequent, successions, as that between mania and paralysis. Haslam knew of delirious patients whose ‘speech is disturbed, whose mouths are twisted, whose arms and legs are deprived of voluntary movement, whose memory is weakened’, and who, generally speaking, ‘have no awareness of their position’ [16]. Overlapping of the symptoms or simultaneity of their extreme forms are not enough to constitute a single disease; the distance between verbal excitation and motor paralysis in the table of morbid kinships prevents a chronological proximity from deciding on a unity. Hence the idea of a causality that moves by virtue of a slight time-lag; sometimes the onset of mania appears first, sometimes the motor signs introduce the whole set of symptoms. The paralytic affections are a much more frequent cause of madness than is thought; and they are also

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a very common effect of mania.' No sympathetic translation can cross this gap between the species; and the solidarity of the symptoms in the organism are not enough to constitute a unity that clashes with the essences. There is, therefore, an inter-nosological causality, whose role is the contrary of sympathy: sympathy preserves the fundamental form by ranging over time and space; causality dissociates the simultaneities and intersections in order to maintain the essential purities.

In this pathology, time plays a limited role. It is admitted that a disease may last, and that its various episodes may appear in turn; ever since Hippocrates doctors have calculated the critical days of a disease, and known the significant values of the arterial pulsations: 'When the rebounding pulse appears at each thirtieth pulsation, or thereabouts, the haemorrhage occurs four days later, more or less; when it occurs at every sixteenth pulsation, the haemorrhage will occur in three days' time... Lastly, when it recurs every fourth, third, second pulsation, or when it is continual, one must expect the haemorrhage within twenty-four hours' [17]. But this numerically fixed duration is part of the essential structure of disease, just as chronic catarrh becomes, after a period of time, phthisic fever. There is no process of evolution in which duration introduces new events of itself and at its own insistence; time is integrated as a nosological constant, not as an organic variable. The time of the body does not affect, and still less determines, the time of the disease.

What communicates the essential 'body' of the disease to the real body of the patient are not, therefore, the points of localization, nor the effects of duration, but, rather, the quality. In one of the experiments described before the Prussian Royal Academy in 1764, Meckel explains how he observed the alteration in the brain during different diseases. When he carried out an autopsy, he removed from the brain small cubes of equal volume ('6 lines in each direction') in different places in the cerebral mass: he compared these extractions with each other, and with similar cubes taken from other corpses. The instrument used for this comparison were weighing scales; in phthisis, a disease involving exhaustion, the specific weight of the brain was found to be relatively lower than in the case of apoplexy, a disease involving discharge (1 dr $3\frac{3}{4}$ gr as against 1 dr 6 or 7 gr); whereas in the case of a normal subject who had died naturally the average weight was 1 dr 5 gr. These

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weights may vary according to the part of the brain from which the samples have been extracted: in phthisis it is, above all, the cerebellum that is light; in apoplexy the central areas are heavy [18]. Between the disease and the organism, then, there are connexion points that are situated according to a regional principle; but these are only sectors in which the disease secretes or transposes its specific qualities: the brains of maniacs are light, dry, and friable because mania is a lively, hot, explosive disease; those of phthisics are exhausted and languishing, inert, anaemic, because phthisis belongs to the general class of the haemorrhages. The set of qualities characterizing a disease is laid down in an organ, which then serves as a support for the symptoms. The disease and the body communicate only through the non-spatial element of quality.

It is understandable, then, that medicine should turn away from what Sauvages called a 'mathematical' form of knowledge: 'Knowing quantities and being able to measure them, being able, for example, to determine the force and speed of the pulse, the degree of heat, the intensity of pain, the violence of the cough, and other such symptoms' [19]. Meckel measured, not to obtain knowledge of mathematical form, but to gauge the intensity of the pathological quality that constituted the disease. No measurable mechanics of the body can, in its physical or mathematical particularities, account for a pathological phenomenon; convulsions may be due to a dehydration and contraction of the nervous system—and this is certainly a phenomenon of a mechanical order; but it is a mechanics of interlinked qualities, articulated movements, upheavals that are triggered off in series, not a mechanics of quantifiable segments. It may involve a mechanism, but it cannot belong to the order of Mechanics as such. 'Physicians must confine themselves to knowing the forces of medicines and diseases by means of their operations; they must observe them with care and strive to know their laws, and be tireless in the search for physical causes' [20]. A true mathematization of disease would imply a common, homogeneous space, with organic figures and a nosological ordering.

On the contrary, their shift implies a qualitative gaze; in order to grasp the disease, one must look at those parts where there is dryness, ardour, excitation, and where there is humidity, discharge, debility. How can

one distinguish, beneath the same fever, the same coughing, the same tiredness, pleurisy of the phthisis, if one does not recognize here a dry inflammation of the lungs, and there a

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serous discharge? How can one distinguish, if not by their quality, the convulsions of an epileptic suffering from cerebral inflammation, and those of a hypochondriac suffering from congestion of the viscera? A subtle perception of qualities, a perception of the differences between one case and another, a delicate perception of variants—a whole hermeneutics of the pathological fact, based on modulated, coloured experience, is required; one should measure variations, balances, excesses, and defects.

The human body is made up of vessels and fluids;..when the vessels and fibres have neither too much nor too little tone, when the fluids have just the right consistency, when they have neither too much nor too little movement, man is in a state of health; if the movement..is too strong, the solids harden and the fluids thicken; if it is too weak, the fibre slackens and the blood becomes thinner [\[21\]](#).

And the medical gaze, open to these fine qualities, necessarily becomes attentive to all their modulations; the decipherment of disease in its specific characteristics is based on a subtle form of perception that must take account of each particular equilibrium. But in what does this particularity consist? It is not that of an organism in which pathological process and reactions are linked together in a unique way to form a 'case'. We are dealing, rather, with qualitative varieties of the illness, to which are added the varieties that may be presented by the temperaments, thus modulating the qualitative varieties in the second stage. What classificatory medicine calls particular histories' are the effects of multiplication caused by the qualitative variations (owing to the temperaments) of the essential qualities that characterize illnesses. The individual patient finds himself at the point at which the result of this multiplication appears.

Hence his paradoxical position. If one wishes to know the illness from which he is suffering, one must subtract the individual, with his particular qualities: 'The author of nature,' said Zimmermann, 'has fixed the course of most diseases through immutable laws that one soon discovers if the course of the disease is not interrupted or disturbed by the patient' [\[22\]](#); at this level the individual was merely a negative element, the accident of the disease, which, for it and in it, is most alien to its essence. But the individual now reappears as the positive, ineffaceable support of all these qualitative phenomena, which articulate upon the organism the fundamental ordering of the disease; it is the local, sensible presence of this order—a segment

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of enigmatic space that unites the nosological plane of kinships to the anatomic volume of vicinities. The patient is a geometrically impossible spatial synthesis, but for that very reason unique, central, and irreplaceable: an order that has become density in a set of qualifying modulations. And the same Zimmermann, who recognized in the patient only the negative of the disease, is 'sometimes tempted', contrary to Sydenham's general descriptions, 'to admit only of particular histories. However simple nature may be as a whole, it is nevertheless varied in its parts; consequently, we must try to know it both as a whole and in its parts' [\[23\]](#). The medicine of species becomes engaged in a renewed attention to the individual—an ever-more impatient attention, ever less able to tolerate the general forms of perception and the hasty inspection of essences.

'Every morning a certain Aesculapius has fifty or sixty patients in his waiting room; he listens to the complaints of each, arranges them into four lines, prescribes a bleeding for the first, a purge for the second, a clyster for the third, and a change of air for the fourth [\[24\]](#). This is not medicine; the same is true of hospital practice, which kills the capacity for observation and stifles the talents of the observer by the sheer number of things to observe. Medical perception must be directed neither to series nor to groups; it must be structured as a look through 'a magnifying glass, which, when applied to different parts of an object, makes one notice other parts that one would not otherwise perceive' [\[25\]](#), thus initiating the endless task of understanding the individual. At this point, one is brought back to the theme of the portrait referred to above, but this time treated in reverse. The patient is the rediscovered portrait of the disease; he is the disease itself, with shadow and relief, modulations, nuances, depth; and when describing the disease the

doctor must strive to restore this living density: ‘One must render the patient’s own infirmities, his own pains, his own gestures, his own posture, his own terms, and his own complaints’ [26].

Through the play of primary spatialization, the medicine of species situated the disease in an area of homologies in which the individual could receive no positive status; in secondary spatialization, on the other hand, it required an acute perception of the individual, freed from collective medical structures, free of any group gaze and of hospital experience itself. Doctor and patient are caught up in an ever-greater proximity, bound together, the doctor by an ever-more attentive, more insistent, more penetrating gaze, the

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patient by all the silent, irreplaceable qualities that, in him, betray—that is, reveal and conceal—the clearly ordered forms of the disease. Between the nosological characters and terminal features to be read on the patient’s face, the qualities have roamed freely over the body. The medical gaze need hardly dwell on this body for long, at least in its densities and functioning.

Let us call tertiary spatialization all the gestures by which, in a given society, a disease is circumscribed, medically invested, isolated, divided up into closed, privileged regions, or distributed throughout cure centres, arranged in the most favorable way. Tertiary is not intended to imply a derivative, less essential structure than the preceding ones; it brings into play a system of options that reveals the way in which a group, in order to protect itself, practises exclusions, establishes the forms of assistance, and reacts to poverty and to the fear of death. But to a greater extent than the other forms of spatialization, it is the locus of various dialectics: heterogeneous figures, time lags, political struggles, demands and utopias, economic constraints, social confrontations. In it, a whole corpus of medical practices and institutions confronts the primary and secondary spatializations with forms of a social space whose genesis, structure, and laws are of a different nature. And yet, or, rather, for this very reason, it is the point of origin of the most radical questionings. It so happened that it was on the basis of this tertiary spatialization that the whole of medical experience was overturned and defined for its most concrete perceptions, new dimensions, and a new foundation.

In the medicine of species, disease has, as a birthright, forms and seasons that are alien to the space of societies. There is a ‘savage’ nature of disease that is both its true nature and its most obedient course: alone, free of intervention, without medical artifice, it reveals the ordered, almost vegetal nervure of its essence. But the more complex the social space in which it is situated becomes, the more *denatured* it becomes. Before the advent of civilization, people had only the simplest, most necessary diseases. Peasants and workers still remain close to the basic nosological table; the simplicity of their lives allows it to show through in its reasonable order: they have none of those variable, complex, intermingled nervous ills, but down-to-earth apoplexies, or uncomplicated attacks of mania [27]. As one improves one’s conditions of life, and as the social network tightens its grip around individuals, ‘health seems to

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diminish by degrees’; diseases become diversified, and combine with one another; ‘their number is already great in the superior order of the bourgeois;.. it is as great as possible in people of quality’ [28].

Like civilization, the hospital is an artificial locus in which the transplanted disease runs the risk of losing its essential identity. It comes up against a form of complication that doctors call prison or hospital fever: muscular asthenia, dry or coated tongue, livid face, sticky skin, diarrhoea, pale urine, difficulty in breathing, death on the eighth or eleventh day, or on the thirteenth at the latest [29]. More generally, contact with other diseases, in this unkempt garden where the species cross-breed, alters the proper nature of the disease and makes it more difficult to decipher; and how in this necessary proximity can one ‘correct the malign effluvium that exudes from the bodies of the sick, from gangrenous limbs, decayed bones, contagious ulcers, and putrid fevers’? [30] And, in any case, can one efface the unfortunate impression that the sight of these places, which for many are nothing more than ‘temples of death’, will have on a sick man or woman, removed from the familiar surroundings of his home and family? This loneliness in a crowd, this despair disturb, with the healthy reactions of the organism, the natural course of the disease; it would require a very skilful hospital doctor ‘to avoid the danger of the false experience that seems to result from

the artificial diseases to which he devotes himself in the hospitals. In fact, no hospital disease is a pure disease' [31].

The natural locus of disease is the natural locus of life—the family: gentle, spontaneous care, expressive of love and a common desire for a cure, assists nature in its struggle against the illness, and allows the illness itself to attain its own truth. The hospital doctor sees only distorted, altered diseases, a whole teratology of the pathological; the family doctor 'soon acquires true experience based on the natural phenomena of all species of disease' [32]. This family medicine must necessarily be respectful: 'Observe the sick, assist nature without violating it, and wait, admitting in all modesty that much knowledge is still lacking' [33]. Thus, on the subject of the pathology of species, there is a revival of the old dispute between active medicine and expectant medicine [34]. The nosologists of necessity favoured the latter, and one of these, Vitet, in a classification containing over two thousand species, and bearing the title *Médecine expectante*, invariably prescribes quina to help nature follow its natural course [35].

The medicine of species implies, therefore, a free spatialization

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for the disease, with no privileged region, no constraint imposed by hospital conditions—a sort of spontaneous division in the setting of its birth and development that must function as the paradoxical and natural locus of its own abolition. At the place in which it appears, it is obliged, by the same movement, to disappear. It must not be fixed in a medically prepared domain, but be allowed, in the positive sense of the term, to 'vegetate' in its original soil: the family, a social space conceived in its most natural, most primitive, most morally secure form, both enclosed upon itself and entirely transparent, where the illness is left to itself. Now, this structure coincides exactly with the way in which, in political thought, the problem of assistance is reflected.

The criticism levelled at hospital foundations was a common-place of eighteenth-century economic analysis. The funds on which they are based are, of course, inalienable: they are the perpetual due of the poor. But poverty is not perpetual; needs change, and assistance must be given to those provinces and towns that need it. To do so would not be to contravene the wishes of the donors, but on the contrary to give them back their true form; their 'principal aim was to serve the public, to relieve the State; without departing from the intention of the founders, and even in conformity with their views, one must regard as a common mass all the funds donated to the hospitals' [36]. The single, sacrosanct foundation must be dissolved in favor of a generalized system of assistance, of which society is both the sole administrator and the undifferentiated beneficiary. Moreover, it is an error in economics to base assistance on an immobilization of capital—that is to say, on an impoverishment of the nation, which, in turn, brings with it the need for new foundations; hence, at worst, a stifling of activity. Assistance should be related neither to productive wealth (capital), nor to the wealth produced (profits, which are always capitalizable), but to the very principle that produces wealth: work. It is by giving the poor work that one will help the poor without impoverishing the nation [37].

The sick man is no doubt incapable of working, but if he is placed in a hospital he becomes a double burden for society: the assistance that he is given relates only to himself, and his family is, in turn, left exposed to poverty and disease. The hospital, which creates disease by means of the enclosed, pestilential domain that it constitutes, creates further disease in the social space in which it is placed. This separation, intended to protect, communicates disease and multiplies

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it to infinity. Inversely, if it is left in the free field of its birth and development, it will never be more than itself—as it appeared, so will it be extinguished—and the assistance that is given in the home will make up for the poverty that the disease has caused. The care spontaneously given by family and friends will cost nobody anything; and the financial assistance given to the sick man will be to the advantage of the family: 'someone will have to eat the meat from which his broth is made; and in heating his tisane, it costs no more to warm his children as well' [38]. The chain of one disease engendering another, and that of the perpetual impoverishment of poverty, is thus broken when one gives up trying to create for the sick a differentiated,

distinct space, which results, in an ambiguous but clumsy way, in both the protection and the preservation of disease.

Independently of their justifications, the thought structure of the economists and that of the classificatory doctors coincide in broad terms: the space in which disease is isolated and reaches fulfilment is an absolutely open space, without either division or a privileged, fixed figure, reduced solely to the plane of visible manifestations; a homogeneous space in which no intervention is authorized except that of a gaze which is effaced as it alights, and of assistance whose sole value is its transitory compensation—a space with no other morphology than that of the resemblances perceived from one individual to another, and of the treatment administered by private medicine to a private patient.

But, by being carried to its conclusion in this way, the structure is inverted. Is a medical experience, diluted in the free space of a society reduced to the single, nodal, and necessary figure of the family, not bound up with the very structure of society? Does it not involve, because of the special attention that it pays to the individual, a generalized vigilance that by extension applies to the group as a whole? It would be necessary to conceive of a medicine sufficiently bound up with the state for it to be able, with the co-operation of the state, to carry out a constant, general, but differentiated policy of assistance; medicine becomes a task for the nation. (Menuret in the early days of the French Revolution dreamt of a system of free medical care administered by doctors who would be paid by the government out of the income from former church property [39].) In this way a certain supervision would be exercised over the doctors themselves; abuses would be prevented and quacks forbidden to practise, and, by means of an organized, healthy, ra-

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tional medicine, home care would prevent the patient's becoming a victim of medicine and avoid exposure to contagion of the patient's family. Good medicine would be given status and legal protection by the state; and it would be the task of the state 'to make sure that a true art of curing does exist' [40]. The medicine of individual perception, of family assistance, of home care can be based only on a collectively controlled structure, or on one that is integrated into the social space in its entirety. At this point, a quite new form, virtually unknown in the eighteenth century, of institutional spatialization of disease, makes its appearance. The medicine of spaces disappears.

NOTES

[1] Gilibert, *L'anarchie médicale* (Neuchâtel, 1772, vol. I, p. 198).

[2] F. Boissier de Sauvages, *Nosologie méthodique* (Lyons, 1772, vol. II).

[3] *Ibid.*, vol. III.

[4] W. Cullen, *Institutions de médecine pratique* (Fr. trans., Paris 1785, vol. II, pp. 39–60).

[5] W. Cullen, *Institutions de médecine pratique* (Fr. trans., Paris, 1785, 2 vols.).

[6] Th. Sydenham, *Médecine pratique* (Fr. trans. Jault, Paris, 1784, p. 300).

[7] *Ibid.*

[8] Th. Sydenham, quoted by Sauvages, *op. cit.*, vol. I, p. 88.

[9] W. Cullen, *op. cit.*, vol. II, p. 86.

[10] Sydenham, quoted by Sauvages, *op. cit.*, vol. I, pp. 124–5.

[11] *Ibid.*

- [12] Clifton, *État de la médecine ancienne et moderne* (Fr. trans., Paris, 1742, p. 213).
- [13] Frier, *Guide pour la conservation de l'homme* (Grenoble, 1789, p. 113).
- [14] T.Guindant, *La nature opprimée par la médecine moderne* (Paris, 1768, pp. 10–11).
- [15] *L'Encyclopédie*, article 'Spasme'.
- [16] J.Haslam, *Observations on Madness* (London, 1798, p. 259).
- [17] Fr.Solano de Luques, *Observations nouvelles et extraordinaires sur la prédiction des crises*, enlarged by several new cases by Nihell (Fr. trans., Paris, 1748, p. 2).
- [18] Account in *Gazette salutaire*, vol. XXI, 2 August 1764.
- [19] Sauvages, *op. cit.*, vol. I, pp. 91–2.
- [20] Tissot, *Avis aux gens de lettres sur leur santé* (Lausanne, 1767, p. 28).
- [21] *Ibid.*, p. 28.
- [22] Zimmermann, *Traité de l'expérience* (Fr. trans., Paris, 1800, vol. I, p. 122).
- [23] *Ibid.*, p. 184.
- [24] *Ibid.*, p. 187.
- [25] *Ibid.*, p. 127.
- [26] *Ibid.*, p. 178.
- [27] Tissot, *Traité des nerfs et de leurs maladies* (Paris, 1778–1780, vol. II, pp. 432–44).
- [28] Tissot, *Essai sur la santé des gens du monde* (Lausanne, 1770, pp. 8–12).
- [29] Tenon, *Mémoires sur les ho• pitaux* (Paris, 1788, p. 451).
- [30] Percival, 'Lettre à M.Aikin', in J.Aikin, *Observations sur les ho• pitaux* (Fr. trans., Paris, 1777, p. 113).

- [31] Dupont de Nemours, *Idées sur les secours à donner* (Paris, 17–6, pp. 24–5).
- [32] *Ibid.*
- [33] Moscati, *De l'emploi des systèmes dans la médecine pratique* (Fr. trans., Strasbourg, Year VII, pp. 26–7).
- [34] Cf. Vicq d'Azyr, *Remarques sur la médecine agissante* (Paris, 1786).
- [35] Vitet, *La médecine expectante* (Paris, 1806, 6 vols.).
- [36] Chamousset (C.H.P.), 'Plan général pour l'administration des hôpitaux', *Vues d'un citoyen* (Paris, 1757, vol. II).
- [37] Turgot, article 'Fondation', in *L'Encyclopédie*.
- [38] Dupont de Nemours, *op. cit.*, pp. 14–30.
- [39] J. -J. Menuret, *Essai sur les moyens de former de bons médecins* (Paris, 1791).
- [40] Jadelot, *Adresse à Nos Seigneurs de l'Assemblée Nationale sur la nécessité et le moyen de perfectionner l'enseignement de la médecine* (Nancy, 1790, p. 7).

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2

A Political Consciousness

Compared with the medicine of species, the notions of constitution, endemic disease, and epidemic were of only marginal importance in the eighteenth century.

But we must return to Sydenham and to the ambiguity of what he has to teach us: in addition to being the initiator of classificatory thought, he defined what might be a historical and geographical consciousness of disease. Sydenham's 'constitution' is not an autonomous nature, but the complex—a kind of temporary node—of a set of natural events: qualities of soil, climate, seasons, rain, drought, centres of pestilence, famine; and when all these factors do not account for phenomena, there remains no clear species in the garden of disease, but an obscure nucleus, buried in the earth: 'Variae sunt semper annorum constitutiones quae neque calori neque frigori non sicco humidove ortum suum debent, sed ab occulta potius inexplicabili quadam alternatione in ipsis terrae visceribus pendent' [1]. The constitutions hardly have symptoms of their own; they define, by displacements of accent, unexpected groups of signs, phenomena of a more intense or weaker kind: fevers may be violent and dry, catarrhs and serous discharges more frequent; during a long, hot summer, visceral congestion is more common and more tenacious than usual. Of London, between July and September 1661, Sydenham says: 'Aegri paroxysmus atrocior, lingua magis nigra siccaque, extra paroxysmum aporexia obscurio, virium et appetitus prostratio major, major item ad paroxysmum proclinitas, omnia summatim accidentia immaniora, ipseque morbus quam pro more Febrium

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intermittentium funestior' [2]. The constitution is not related to a specific absolute of which it is the more or less modified manifestation: it is perceived solely in the relativity of differences—by a gaze that is in some sense diacritical.