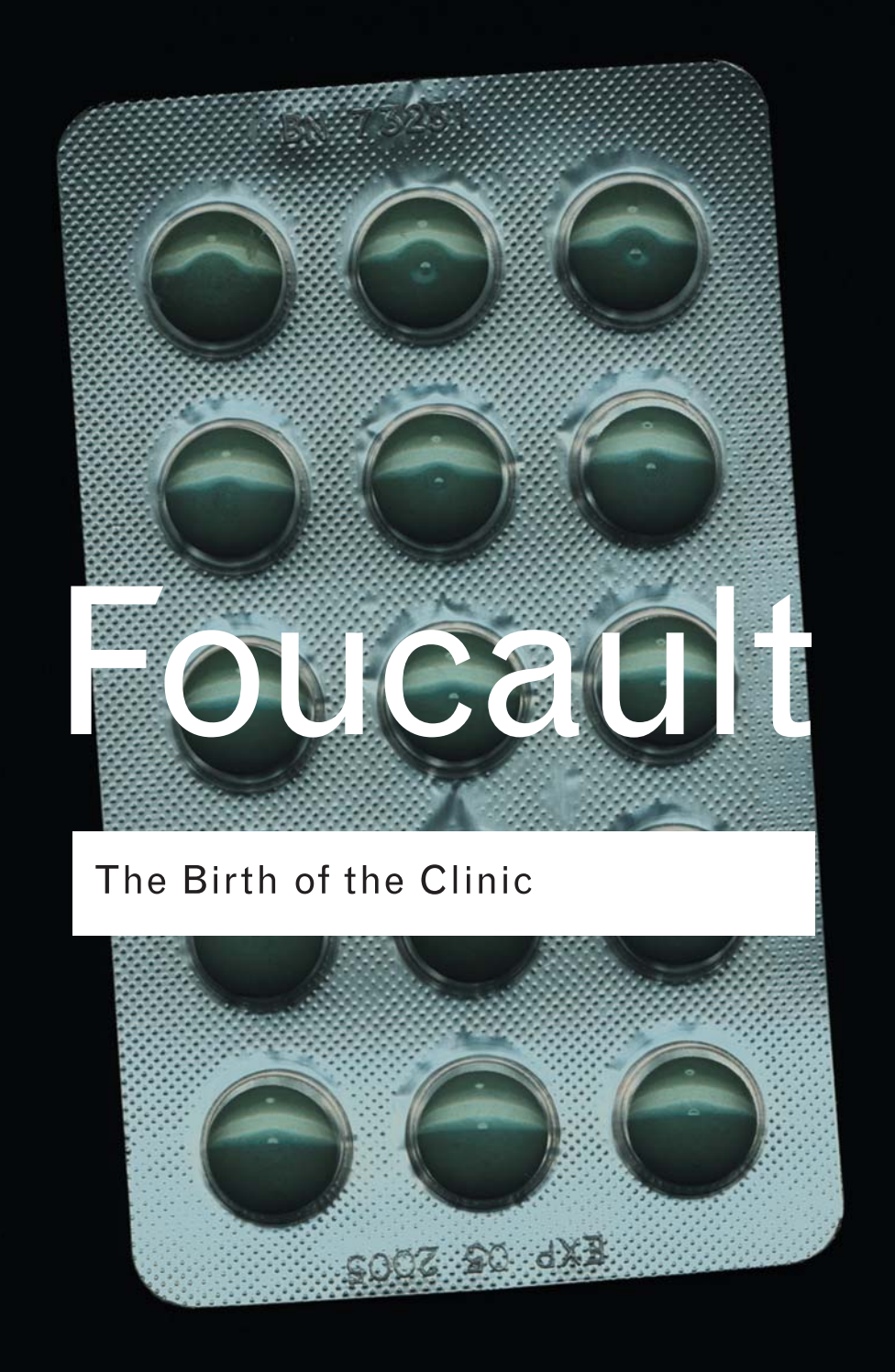
Foucault
The Birth of the Clinic

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'*The Birth of the Clinic* repeatedly allows us to glimpse the face, the personal and distinctive features of a philosopher-historian whose declared aim is nevertheless to get rid of the subject and subjectivity, to disappear in his own discourse . . . and to leave the way open for a formulation of the anonymous rules which govern human knowledge and behavior.'

New York Review of Books

'No other thinker in recent history had so dynamically influenced the fields of history, philosophy, literature and literary theory, the social sciences, even medicine.'

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The Times Literary Supplement

Michel

Foucault

The Birth of the Clinic

An archaeology of medical perception

Translated by A. M. Sheridan

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Translator's Note

One of the characteristics of Foucault's language is his repeated use of certain key words. Many of these present no difficulty to the translator. Others, however, have no normal equivalent. In such cases, it is generally preferable to use a single unusual word rather than a number of familiar ones. When Foucault speaks of *la clinique*, he is thinking of both clinical medicine and the teaching hospital. So if one wishes to retain the unity of the concept, one is obliged to use the rather odd-sounding 'clinic'. Similarly, I have used the unusual 'gaze' for the common '*regard*', except in the book's subtitle, where I have made a concession to the unprepared reader.

Introduction

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 arachnoidian 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, 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; 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 reexamine 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 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 dehydrated, 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 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 antisanal 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 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, unconceptualized confrontation of a gaze and a face, or a glance and a silent body; a sort 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 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 superabundance 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 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 psychologistic interpretation of language that shows the stigmatas 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—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 statable: 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 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).

1

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 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.

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' knowledge, 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 juxtaposition 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 logicotemporal 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 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 morbific 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