Lars Sætre:

Epistemology, Semiology, Rhetoric

On Michel Foucault's *The Birth of the Clinic.* *An Archaeology of Medical Perception* [1]

I

Michel Foucault's study *The Birth of the Clinic* (*BCl*) opens its Preface with a statement indicating the principal themes that will be under critical consideration on the pages to follow. His book, says Foucault, "is about space, about language, and about death; it is about the act of seeing, the gaze" (ix). At this point, let it suffice to bear in mind that his project, on a fundamental level, is conceived as a critical investigation of the epistemological conditions underlying one of the central sciences in our culture, the "clinic". His book is concerned with a span of roughly seventy crucial years, in which that science, in Foucault's perspective, undergoes the major inversions and develops through the most important stages that brings it into that field of practice and perception that we, in the 20th century, understand as constitutive of its general terms.

Foucault takes us from around 1760 and the age of *classificatory medicine*, across the most important rupture in Western thought into the paradigm of the *clinic proper*, and finally through another inversion into the last stage that his study is concerned with, that of *clinical pathological anatomy*, a span that thus ends around 1830.

Several considerations have motivated his project. However, among the most central has been Foucault's conviction that the "clinic", having gone through the stages leading up to and having reached its "modern" level, has, in its epistemological dimensions, in fact become akin in main constitutive traits also to many of our present-day so-called human sciences and philosophy. Nietzsche and Freud are among those mentioned as epistemological parallels in connection with Foucault's last stage of clinical medicine. Even in modern literature does Foucault find parallels to elements in the final medical paradigm: in the lyric on the trajectory from Hölderlin to Rilke. This also means, on a second look, that Foucault in some respects finds that medical experience has been a kind of forerunner to, at the least helped shape at a surprisingly earlier stage than has been usual to believe, insights and experiences that have normally been accredited the human sciences of the second half of the 19th century.

Although medicine, in our every-day experience, is normally associated with an object of study, practices, techniques, and attitudes that seem far removed from those of, say, the study of literary and philosophical texts, this may be just apparently so. For, granted that we follow Foucault in his choice of an angle of incision, with a focus on the already

---

[1] Translated from the French by A.M. Sheridan Smith, New York: Vintage, 1975. Originally published in France as *Naissance de la Clinique*, Paris: Presses Universitaires de France, 1963.

mentioned themes of "space", "language", and "gaze", all of them eventually being linked up with, imbued with, and commanded by that of "death", then we discern certain parallels to the instances involved in a researcher's (phenomenological) investigation of any object, also strictly and narrowly defined "textual" ones. It is also of interest here that what Foucault studies in his "archaeology" of the "clinic", is precisely texts: written traces from the discourses of central documents from the historical periods that he wants to launch his own construction of.

Taken *per se*, these epistemological instances are, first, that of objectal "space" - the field constituting the *object* of knowledge, the study and interpretation of which the scholar endeavours to make yield a scientific "truth".

Second, there is, in Foucault's term, the "gaze" of the investigator-*subject*, that element of consciousness (or ignorance), visibility (or invisibility) that is constituted partly for, and partly by the subjectal side of the learning and truth-seeking process.

Third - and because of the fundamental distance and rupture existing between subject and object proper by linguistic structures (mediating or creating distortions between subject and object) - there is to be taken into account the element or grid of language. Direct or metaphorical, concrete or abstract language, theoretical and methodological "codes": they filter what the subject perceives, and help establish what there is to be seen. But they also filter what may be said and what there is to say. In Foucault's perspective, elements of language and all that pertains to them, constitute what he terms discourses or discursive structures; perhaps the most important of the three instances, since they help shape both subject and object of study. Foucault is therefore concerned with an immense discourse analysis in his book.

These three factors and their highly complex interrelations are, in fact, on a general level, conditions of possibility for any science, history, or critical investigation, according to Foucault. And we might add: that in itself makes a reading of Foucault's reading of the historical discourses of clinical medicine a matter of interest and relevance also to the field of literary criticism. After Kant - who, in spite of his extremely important introduction of the critical awareness of (subjective) categories prior to any understanding, still held that there is Knowledge - Foucault, in the wake of Freud, Nietzsche and structural linguistics, holds that a critique of knowledge and Knowledge itself are fundamentally linked to the fact that *language* exists.

The factors, mentioned above, of critical understanding within any scholarly field, reside precisely in this: Until the ideological idea of the possibility of direct access from subject to object has been discarded, as well as the idealistic notion that the investigating subject may remain instrumentally outside the object that he investigates, without thinking himself as a (linguistically mediated) integral part of it, being subject and object at the same

time, - until then, clinical medicine, as well as any activity within the so-called human sciences, remain outside the full scope of modernity. In *BCl*, that stage within clinical medicine is reached with the anatomo-clinical method. Only there do the science and its gaze avoid being reductive any more, there do they manage to establish the individual in his irreducible quality (xiv).

For, according to Foucault, it is only with the entry of human experience into the full scope of modernity that the fourth major theme of his study comes into its own: the experience and acceptance of "death" and the conjoining Law of Finality. To put it very crudely at this point, we might say that without the acceptance of death and the finality of life - and also death as an integral, or rather: disintegrating part of a life unbendingly moving on its trajectory towards finality - no research, neither in clinical medicine nor, for that matter, in literary or text-oriented scholarship (of which Foucualt's discourse-analytical books are instances), will ever be able to evade or rid itself of even the most general traces of a highly ideological epistemological *idealism* and a just as problematic epistemological *realism*. These can be of no avail in dealing with that which the human predicament has to accept as areas that there is "nothing" idealistically and generally lasting, nor concretely and manifestly fixed, tangibly "real" or "essential" to know about.

What we are dealing with in the history of sciences and philosophy, are configurations and constructions; and so-called development within and between them is not continuous, but occurs in leaps and inversions. The two previous configurations in the shaping of the modern "clinic", the way Foucault sees them, are more or less removed from the one we are still presently living within, and which he takes to be the hitherto optimal state: That epistemological configuration which is possible only under the auspices of death, where space, language, and gaze are understood to be constituted by *relational differences*, without transcendence, in a sense all of them being organized according to linguistic categories widely understood. Not as ideal charts, instituted by Divinity, that help us recognize phenomena according to an eternal plan of the universe that we think we know (this corresponds roughly to Foucault's outline of classificatory medicine). Nor as concrete entitites to be realistically found out, named, understood, handled and operated on immediately (cf. the practices of the intermediary clinic proper). But as relational structures, whose laws humans *may* learn about and only thereby acquire the necessarily limited knowledge to "handle" according, so far, to the best possible benefit of mankind. And in so doing, taking man's final truth: death as the point of orientation in the effort to "grasp" also the relative and relational "truths" of his diseases (like in Foucault's final stage: anatomo-clinical medicine). Or again, for that matter: in the effort to "grasp" the "truth" of man's history or his texts.

In this connection, it is interesting to meditate on the fact that Foucault has chosen the

"clinic" as his area of investigation in this book. For, having just introduced the theme of what man, according to Foucault, *may* "learn" about, of that which structures his knowledge of the world: relational differences, we may go on to ask what the term "clinic", this strangely sounding word in English, brings into play but precisely elements of teaching and learning? Certainly, the *clinique* Foucault is concerned about is partly the treatment of sick persons at their bedsides. But just as central in that notion, and in Foucault's study, are the elements of examination, investigation, research and learning into unknown areas, and not the least: the simultaneous teaching of medical subjects by specialists to personnel under training, as well as to the specialists themselves.

That dual sense: clinical medicine, and teaching (and learning) hospital, brought into play by the "clinic", is certainly apt as a designation of an exemplary area, and an "emblem" of the investigation into that fundamental field that Foucault basically wants to bring out: the epistemological filters, the conditions of possibility for knowledge, teaching and learning in general. His study of clinical medicine is one of several accesses of his into that field.

In discerning and differentiating between the three major paradigms - classificatory (of species), clinical, and anatomo-clinical medicine - Foucault expressly states that he is not writing against or in favour of any of the kinds of medicine that he deals with. His study 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. (xix)

Having so far introduced some general themes of *BCl*, it is of obvious importance to us already now, when reading in this quotation Foucault's comments on his approach and points of primary focalization, to indicate that it will also be necessary, later, for us to discuss critically ~~Foucault's own "systematization" of his thoughts of and what he "sees" in his field.~~ What kind of semiology is his own book's discourse built up around? Does his own discourse subscribe to the epistemological tenets of the last, and according to Foucault, still lasting clinical paradigm that he describes (clinical anatomy)?

First, however, it is necessary to render a somewhat more detailed, though at the same time naturally a simplified reading of what his book "is about". It is my hope, in so doing, that some of Foucault's often unusual and complicated concepts, as well as his complex "stratified archaeology" may be brought out with some degree of lucidity.

II

To indicate the trajectory of modern medical perception, from its earliest stages in the second half of the 18th century to the hitherto final stage which I have chosen to call that of

modernity proper, and which became established during the first decades of the 19th century, *BCl* opens with a juxtaposition of two medical discourses. The middle stage (that of the clinic proper) left out for the time being, the two discourses exemplify medical attitudes at the beginning and at the end of the time span that Foucault investigates. Let us briefly look into them.

At the middle of the 18th century, says Foucault, Pomme treated a hysteric by making her take baths half of the day for ten months, and Pomme observes in writing in 1769 how

> membranous tissues like pieces of damp parchment (...) peel away with some slight discomfort, (...) passed daily with the urine; the right ureter also peeled away and came out whole in the same way. (...) (The intestines) 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 (...). (ix)

In 1825, Bayle, in the language of a completely different experience, gave this description of an anatomical lesion of the brain and its enveloping membranes:

> 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. (ix f.)

There are, to be sure, important differences between these two utterances. Pomme has no perception as to what goes on inside the body, and interprets his observations in a language of exteriority, as "parchments", "tunics", even whole organs being "peeled off" from the surface of something else in a living body. Bayle, on the other hand, whose language testifies to the possession of massive experience of cases and the repeated observation and perception of the internal body (mainly through autopsies on dead bodies), is able to describe what meets his gaze with what seems to us more precise designations. He is able to perceive, and describe, differences in the similitude of what he observes, and he likewise possesses the ability to describe structural relations (differences and contiguities) within the brain that he observes - a brain that at a more primitive stage of medical perception would be thought to be one organ.

Certainly, also Bayle expresses himself in metaphorical langauge. Still, his "spider's web" and "skins of eggs" serve in the function of a quite different designating precision (that of similarities of structural relations) than Pomme's, in our eyes, helpless "peeling parchments and tunics". In Foucault's assessment, "each of Bayle's words, with its qualitative precision,

directs our gaze into a world of constant visibility, while Pomme, lacking any perceptual basis, speaks to us in the language of fantasy" (x).

Bayle's description of structural relations (similarities, differences, contiguities) also keeps his language and his perception on the far side of the middle stage in clinical medicine, that of the clinic proper. The clinic proper lacked the necessary abstraction of the later pathological anatomy, and was concerned first and foremost with the individual Case. The clinic described it in its immediate presence, bringing a name to what was perceived to be concrete organs, lesions, and diseases. But it was not sufficiently aware that the believed-in proximity between examining gaze and language on the one hand, and sick individual body on the other, prevented the perception of the configuration of a bodily space applicable to all structural variants of individual human illness and human beings. Here, the medical gaze was so close to the thing "itself" that it prevented the simultaneously necessary abstractional distance. (However, the statistical and mathematical methods of this middle clinic proper were to become a way into the necessary abstractions and out of medical naming, a nominalism, that the contemporary medical consciousness of the middle stage held to be "realism" itself.)

It will have been seen that Foucault's three paradigms of clinical medicine have been structurally based on the linguistic grid of three different semiologies, on three different conceptions of the relation between the "space of *configuration* of the disease and the space of *localization* of the illness" (3). As Foucault points out, the "exact superposition of the 'body' of the disease and the body of the sick man is no more than a historical, temporary datum", effective "for only a relatively short period of time - the period that coincides with nineteenth-century medicine and the privileges accorded to pathological anatomy" (3 f.).

These three semiologies, which I designate as "idealistic", "realistic" (but based on an unproblematized nominalism), and "differential-relational (structural)", Foucault in his book shows to find their conditions of possibility on the basis of ruptures, inversions and interchanges within a register of terms and instances that so to speak produce the (medical) discourses of the periods in question. This is why Foucault has to analyse, in an "archaeology", the grid constitutive of discourses, and not proceed directly to the utterances of each clinician by taking them at face value.

In Foucault's perception, the terms constitutive of discourses can be studied at three differentiated, yet closely interlaced strata that shape, synchronically and diachronically, what he calls spatializations. The elements inherent in each spatialization are variously grouped and operative (dominant or subdued) in the grid constitutive of each of the three semiologies (and each stage of medical experience).

The *primary spatialization* concerns, to a particular degree, classificatory medicine, the medicine of species, where ideal concepts or portraits of diseases and the homologies

between them determined the doctor's conception (gaze) of, as well as his description (the sayable) of the sick person's illness. The determination was reproduced according to a "map" laid out by medicine in advance, for the doctor to use as a basis for "recognition" of an illness when facing the sick person. Within this "idealistic" stratum the individual has no positive status.

The *secondary spatialization* in Foucault's system concerns precisely the individual, and is, to a particular degree, operative in the formation of the clinic proper (however, only in its early variants, before the status of the individual gave way to a dominant of serial cases). It

> required an acute perception of the individual, freed from collective medical structures, free from 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 patient by all the silent, irreplaceable qualities that, in him, betray - that is, reveal and conceal - the clearly ordered forms of the disease. (15 f.)

The *tertiary spatialization* that partakes in constituting the doctor's object of study (as well as constituting the doctor-subject's consciousness: his gaze, what is visible to him, but also what he is structurally able to say), may be designated as a social space. In Foucault's words:

> 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, (revealing how) a group, in order to protect itself, practices exclusions, establishes the forms of assistance, and reacts to poverty and to the fear of death. (This stratum shows) time lags, political struggles, demands and utopias, economic constraints, social confrontations. (16)

As a matter of fact, according to Foucault, this locus "is the point of origin of the most radical questionings" (16).

In Foucault's archaeology, the social stratum turns out to be just as important as the other two, since - along the rupture edges between nosological, classificatory medicine, and the clinical practice - it was on the basis of this social space "that the whole of medical experience was overturned and defined for its most concrete perceptions, new dimensions, a new foundation" (16).

What Foucault aims at concretely here, is the complex socio-political turmoil, also with heavy effects on the practice of medicine, that took place in France in the years before, during, and following the Revolution. There were crises in the care for the sick, a wavering central control with practitioners, debates on local family or central hospital treatment, on the investment of public funds, on the training of the medical profession, on the closing and reopening of universities, on the extradiction of hospital patients for the reception of injured soldiers, etc. With all the calamities in that socio-political space, finds Foucault, it was primarily there that the whole stratified discursive system came into sufficient sway to open

for an inversion of its terms.

Over a series of very important years, this fundamental shaking of the conditions producing "truth", opened up new areas of visibility to the human consciousness and gaze; after some more years of social and medical "unrest", this socio-political space also produced the conditions necessary for saying: formulating, those laws, directives, and regulations that ensured the establishment of the medical clinic proper out of the hospitals and special practices already introduced in them.

To Foucault, then, this tertiary spatialization is no derivative of the other two, it is no less central, in fact it combines the other two into a giant space. However, in describing the inversion from nosology to the clinic proper, it is to a particular degree this social space that Foucault is preoccupied with. In the description of (preceding) nosology and (ensuing) pathological anatomy, the social space is close to absent from his perspective.

In my reading, though, that is understandable, given two factors: on the one hand, the necessarily far-reaching effects and consequences of a major revolution like the French, and on the other, Foucault's conviction that of the two ruptures or inversions which he describes between the three paradigms, this first one is undoubtedly the more fundamental.

Let us now attempt to get a closer look at the paradigms of medical perception, their spatialized strata, and the ruptures occuring between them. In this attempt - and with the awareness that Foucault's archaeology is a very complex text - hopefully, two reading strategies would be discernible that are, in principle, irreconcilable - in my reading, as well as, I think, in Foucault's book. This requires a brief self-reflexive commentary:

Foucault's text has, in my opinion, as one of its main rhetorical devices a moving as close as possible to its textual objects of study, weaving its discourse into and out of those discourses that Foucault himself writes about. One of Foucault's objectives seems to be to supply the reader with an effect of the complexity of the seemingly disorganized *in eventu* aspects of the proliferating historical discourses that he investigates. Another would be to "demonstrate" the effects of his own epistemological stance: the fact that historical discourses never immediately yield to their archaeologist their complex structural and functional truths at face value but demand a certain analytical labour. To signal these effects of Foucault's book, I have adopted a reading strategy that to an extent endeavours, in similar manner, to stay close to Foucault's text.

On the other hand, my reading will also summarize and comment critically on major tenets of *BCl* (particularly the semiological aspects of the paradigms of medical perception in Foucault's construction), and will, in that capacity, come up against the impasses of any (critical) reading. It will be an allegorical interpretation of Foucault's interpretation, a necessary recession from the signification of Foucault's book, at odds with the vain hope of doing it justice.

But there is no other way. And in the light of the (so far latest) semiological paradigm of modernity in Foucault's structuring: pathological anatomy, endlessly operating with signs whose paradoxical constitution is the dialectics of invisible visibilty under the inescapable power of death and language - who knows, perhaps the approach is even justifiable.

III

In classificatory medicine, the configuration of the disease functioned, ideally, independently of the space of localization of the illness on the body, since the rule of classifying it dominated both the theory and the practice of medicine. Most central in the handling of illness was to give it "an organization, hierarchized into families, genera, and species" (4). The independent configuration of illness was in fact the prerequisite for this medicine to operate. The figure of diseases thus created, was neither a chart of cause and effect, nor a sketch of its localizable spaces or events of further attack in the body. Localization was secondary; primary was the fundamental system of relations, kinships, analogies, and differences between illnesses. This configurated space existed prior to any perception of the bodily illness; only on the basis of this picture, or portrait, did classificatory medicine let the disease become "embodied" in the organism.

The gaze seeing the bodily illness, a gaze constituted and made possible on the basis of the nosological chart, thus necessarily had to be an external gaze, an abstract, ideal or idealistic conception, there to function as the basis for the (self-)recognition of the chart in the body, which functioned in a certain mimetic relationship to the idea, without primary perception of the body. No wonder that the doctor-subject was determined to seek recourse in the language of fantasy.

Cause and effect, a symptom as the basis for a possibly different development in the body than that offered by the portrait: such elements were always already discarded in this kind of practice. This also means that the notion of time had a widely different value than it has for us; "classificatory medicine is the flat structure of perpetual simultaneity" (6). Moreover, analogies within the ideal picture, when recognized on the body in this primary spatialization, functioned as definitions of bodily essences; in other words, essences were defined on the basis of formal criteria alone. Even more strange to us, perhaps, essences so defined were held to be the general order of nature. Over and above manifestation in the world of disease, the botanical *model* paid service here on the level of ontology. Strangely enough, the understanding of the species of illness in this conception was on the order of both the natural and the ideal.

In this configuration, the role of the patient was less important. The illness was abstracted from him, was of interest only in relation to the believed-in ontology of the ideal chart, and all other relevant information about the patient, his environment and his habits,

was disregarded. The fixed and dominating laws of nosology also abstracted the doctor's individual activity and intervention. There was room for no treatment based only on the here and now act of the perception of the concrete body. What classificatory medicine believed to be ideal nature, had to be first recognized, and then permitted to fulfill its course in the patient's suffering body according to its "essential", "true" nature.

When the essence of a disease was structured as a flat picture, it was, only in the second instance, "articulated upon the thick, dense volume of the organism and (became) *embodied* within it" (10). However, this, in time, raised considerable problems for the practice of medicine, problems that were solved only by the structural leap that the science undertook into establishing the clinic proper during the last decades of the 18th century. For how could

> a 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. (10)

Furthermore, and in our perspective, the relationship of the structure of abstract configuration to the (devalued) space of the concrete body was bound to run into severe problems also because developments in the corporal space that were unknown in the space of the ideal chart, constantly threatened to make the two spaces diverge from one another. For in the body, where "it circulates freely, disease undergoes metastases and metamorphoses. Nothing confines it to a particular course" (10 f.).

So when, in classificatory medicine, the organizing principle of the ideal configuration was one of kinships and sympathies, the free circulation of disease in the concrete anatomical body (free, that is, of the believed-in botanical kinships of the ideal chart), then suddenly relations between diseases might occur that were not relations of kinship, but, say, of causality. For that phenomenon classificatory medicine had no model of understanding in advance, no predisposed idealistic gaze. However, it was developed as an internal contradiction in terms, as "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" (12).

In keeping with its abstraction of the individual, but as another signal that scientific contradictions did occur, classificatory medicine based itself on what Foucault calls a qualitative gaze. To make the bodily space tally with the nosological draft, i.e. to grasp the disease, the doctor could not measure individual physical or mathematical particularities, since they might take him astray from the ideal configuration. On the contrary, the physician's sense for qualities, "a perception of the difference between one case and another, a delicate perception of variants - a whole hermeneutics of the pathological fact, based on

modulated, coloured experience, is required; (...) variations, balances, excesses, and defects" (14). But this attentiveness for qualities made the medical gaze also focus on particular histories which were qualitative variations of the essential qualities of disease. However, this multiplication in the interest for variations, on the other hand, now made the individual indispensable and unique at the same time as he, as a space of localization, was impossible to classificatory medicine.

With internal contradictions as these, medical science was getting close to a discursive inversion in the spatialized strata constituting it as classificatory of species. It "becomes engaged in a renewed attention to the individual (...), ever less able to tolerate the general forms of perception and the hasty inspection of essences" (15). The historical process of understanding the individual was about to commence, at which "point, one is brought back to the theme of the portrait referred to above, but this time treated in reverse" (15). Now the "patient is the rediscovered portrait of the disease" (15), not any more the other way round. Here, a shift occurs between strata of historical formations: the primary spatialization of the medicine of species takes a devalued position to the secondary spatialization: the perception of the individual.

In this shift, the tertiary spatialization: socio-political space, also plays a very important role. In classificatory medicine, disease was considered as a natural phenomenon, whose simple and necessary forms were in accordance with the ideal chart. At the same time, simple illnesses were to be found among farmers and workers, whereas, however, the difficult disease developments, new and unknown cases, cross-breeds an the like, were increasingly to be found in the steadily more complex spaces of civilization. Illness was becoming "artificial"; so was the civilized space of the hospital, which, again, led to the occurrence of new and mixed diseases that more and more lost their correlation with the nosological schemata of kinships.

Parallel to these changes, a conflict arose as to the most relevant place for disease. The spontaneous, loving and curing care of the family had been the place for the kind of natural diseases that fitted the classificatory portraits. The hospitals, though, mostly met with the distorted, changed illnesses of civilized society, and created more disease, that could not be handled by idealistic medicine. In this structure, a related dispute arose over (old) expectant, or (new) active medicine. During the years leading up to the French Revolution, economists and classificatory doctors agreed that the family, with home care, and decentralized financial support from the state (to compensate for the lack of income of the sick person), would be the best solution. The illness would be able to run its natural course and could be handled by the existing medical profession, whose quality the state would inspect and help guarantee. Further hospital disease would be reduced; the double financial burden of keeping in hospital a person who was incapable of working, at the same time as it

would be necessary to support his family, would be avoided - a single governmental contribution would suffice.

However, according to Foucault, in the tertiary spatialization, it is at precisely this point that the whole structure is inverted. For 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 it pays to the individual, a generalized vigilance that by extension applies to the group as a whole? (19)

Medicine based on "natural", localized assistance, but through the policy and funding of the state, would get bound up with the "civilized" state in its turn. In this way, says Foucault, "medicine becomes a task for the nation" (19):

> 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 (sic.) disappears. (20)

Foucault also sheds light upon another theme - belonging in fact to all three kinds of spatialization - to highlight the problems and impasses involved in the processes leading up to the shift from classificatory to clinical medicine: that of epidemics. The study of epidemics could not be handled by charts of species, since epidemics are based on conditions of time and place; they require a historical and geographical consciousness that classificatory medicine could not provide. Besides, perceiving them involves quantitative approaches, not the previous understanding of qualitative essences, since they are never identical, but vary according to circumstances. The specific diseases that the medicine of species could "understand", are in a sense diseases of repetition, whereas the epidemic is never repeated. Handling an epidemic, which has, then, a historical and geographical individuality, requires a multiple gaze, several view-points, that join in describing its special, accidental, and unexpected traits.

At the end of the 18th century, that kind of collective activity was getting institutionalized in France through the establishment of co-operative chains between various levels of public offices. But also on the preventive side, we can here witness how medical experience does get bound to the state, as was indicated in the discussion of local, family assistance above. A medicine of epidemics depended on a police authority to supervise, to advocate cremation instead of burial, to control the sale of alimentary articles, and so forth. The medicine of epidemics, then, stood in a contradictory relationship to that of classes,

> just as the collective perception of a phenomenon that is widespread but unique and unrepeatable may be opposed to the individual perception of the identity of an essence as constantly revealed in the multiplicity of phenomena. The analysis of a series in the one case, the decipherment of a type in the other; the integration of time in the case of epidemics, the determination of hierarchical place in the case of the species (...) (26).

What the now waning classificatory medicine was in need of, though, thereby making it more bendable towards the measures that prepared the way for the coming clinical paradigm as opposed to the earlier rigorous idealistic principles of species, was precisely that which also the medicine of epidemics required: In the tertiary space, they needed "the definition of a political status for medicine and the constitution, at state level, of a medical consciousness whose constant task would be to provide information, supervision, and constraint" (26).

A political status certainly came about. From 1776 on, with its concrete starting point in a dispute over an epidemic, the state instituted a government agency to introduce measures to counteract disease. A conflict that arose between this agency and the universities was temporarily won by the government. A collective consciousness of pathological phenomena was established, with elements of severe totalization. A clinical recording started, preoccupied with the collection of infinite, variable series of events, containing information on history, geography, and state. Also in this way the medical field changed from one of species into one understood as the interplay of series of factors. The understanding went from disease as essences, to one of causal connections between diseases and between nosological classes and environmental factors - two series thus constituting, at their points of intersection, the individual medical fact. In Foucault's phrasing:

> The locus in which knowledge is formed is no longer the pathological garden where God distributed the species, but a generalized medical consciousness, diffused in space and time, open and mobile, linked to each individual existence, as well as to the collective life of the nation, ever alert to the endless domain in which illness betrays, in its various aspects, its great, solid form. (31)

The proliferation - just before and just after the Revolution - of the myth of a strong nationalized medical profession, with the powers to politically provide, control, and dictate men's bodily health, and the intoxicated myth of a final abolishment of disease in the new society, had the function, before they died out, of "linking medicine with the destinies of the state" (34) in an additional manner. Such ideas strengthened the notion of the healthy, non-sick person as a model, a norm to live up to. Incidentally, this helped shape one of the main medical conceptions of the 19th century: that of normality as opposed to the pathological, whereas 18th century medicine generally had been much more concerned with the notion of health than with that of positive norms.

IV

The state having become involved, the collection of material having begun to establish the series of the nation's conditions of health, and the belief having been rooted, in politics as in medicine, that truth can be attained by controllable measures to ensure wished-for free communication in social and medical spaces, where parts harmonize with the whole: These were so many parallel and common elements that joined political ideology and medical

technology from the very beginning of the Revolution in 1789. There was a widespread belief in the possibility of an unhindered gaze reaching the truth of any field - socio-political or medical - provided all obstacles were removed: hospitals, doctors' associations, and the too theoretical, socially privileging medical university faculties. Medicine wished to establish a free field of medical experiment, where its gaze could have direct access to liberal truth. A new semiology, different from the idealistic type in classificatory medicine, seems to be underway.

This field tried to get established through various stages. The dual structure of "natural" family treatment and centralized gaze, that we looked into above, first produced plans to maintain the family as the place for illness to run its (still classificatory) natural course, but at the same time plans to establish common funds at state level as a means of assistance. Those funds would be diverted hospital funds, after a closing of those institutions.

This plan failed; instead the idea of decentralization was attempted held alive by the setting up of communal assistance, to make use of a geographically specific consciousness. However, in such a regional arrangement, the hospitals would still be needed: to provide for those without family, for cases of contagion, and for the difficult cases. According to this plan, the hospitals, needed for protection, would duplicate the family space, in the sense of reproducing, in the hospital, the earlier "natural" pathological state. Disease, then, "is thus caught in a double system of observation: there is a gaze that does not distinguish it from, but re-absorbs it into, all the other social ills to be eliminated; and a gaze that isolates it, with a view to circumscribing its natural truth" (42 f.).

The various plans under discussion helped shape the consciousness of the medical field, but the first concrete outcome was in fact to abolish hospitals as general treatment institutions. Hospital funds were then nationalized, and spent in the establishment and running of so-called houses of health only for those without the help from a family home. The effectuated model became, then, family treatment and treatment in houses of health.

Another problem for the Revolution was the proliferation of quacks and charlatans, as well as the bad quality of teaching given at the medical university faculties. The Revolution needed to limit the right to practice as a doctor, and to organize better the university teaching. However, both these needs clashed with the revolutionary reform movement, which eventually abolished medical guilds, the master/apprentice system, as well as the universities themselves: they were closed. Instead, practical experience and teaching were valued; but paradoxically, in spite of the movements towards reform and social control, practical training was left to free initiative; the state interfered only in theoretical teaching.

With medical assistance left to individual initiative, hospitals were reserved only for the difficult, isolated, privileged cases (out of the hospitals thus understood, the new clinical medicine proper was to emerge). Teaching, now primarily practical, got a new place in the

structure, by inversion: It had been public and belonged to the theory teaching universities, but now became private and practical.

The structural reasons that Foucault sees underlying this, reveal aspects of strength in his archaeological approach: The level of the technological structures of knowledge (the hospital now in the function of the desired free place for medical experiment on complex cases), and the level of perception (medicine still "classificatorily" understood as practical, bedside handling of disease in the natural place, the family, for the illness to run its natural course) "were not yet capable of being superimposed: the way in which one directed one's gaze and the way in which it was trained did not overlap" (48).

Under the conditions of the practicing doctor, home practice was a potentially open and free field, but, paradoxically, also a closed space of old truths about species. To the trainee's field at this stage, the truth of species and essences was enclosed and outdated, but he also had, though for him not yet as a formulated possibility, through the new special function of hospitals also a free domain (that of free experiment), where truth, in the clinic proper, was to speak "of itself" (48). In addition, the role of the hospital now became dual in this sense: "for the doctor's gaze it was the locus of systematic truths; for the knowledge formulated by the teacher it was the locus of free experiment" (48).

What was lacking during the whole revolutionary period, says Foucault, again showing the strength in his approach as to what it may bring out, was

> a structure that might have given unity to a form of experience already defined by individual observation, the examination of cases, the everyday practice of diseases, and a form of teaching that everyone knew ought really to be given in the hospital (...) and (...) the concrete world of disease. What one did not know was how to express in words what one knew to be given only to the gaze. The *Visible* was neither *Dicible* nor *Discible*. (51)

For it was still, at this stage of medical knowledge, a combination of individual perceptions on the basis of nosology and species, and a quantitative medicine of time and place that dominated. Medicine needed "a new, coherent, unitary model for the formation of medical objects, perceptions, and concepts" (51). That model's realization was to become the clinic (growing out of the new special use made of hospitals).

But the reform movements of the Revolution in fact delayed that paradigmatic change which the discursive structures of the times implied. For the reforms in the treatment of illnesses (family care, houses of health, and the early special isolation of the "non-classificatory" in hospitals), as we have seen, for the greater part came about with a considerable time lag. They were generally based on the constitutive elements of a conservative, outdated semiology and by now pretty ruffled and unstabilized discourses, those of the classificatory medicine of species.

The myth of the doctor's free gaze, which in liberty would see disease formulate itself

and its own truth on the basis of a new realism (but helped to that realism by the doctor's nonproblematized nominalism, a naming of what he believed to have direct access to), was to become constitutive of the new clinical paradigm. However, the fact that this free gaze during the Revolution was linked to the idea (a liberal myth) that the free gaze would, not only discover all truths about illness - by bringing findings into the light of Enlightenment - but thereby as well destroy and eradicate what was "found" in the light cast by the doctor's eye: disease, also contributed to the delay of the overturning of medical perception during these years. For the realist-nominalist semiology of the clinic then to come, mythical though it may have been in its own way when we today look retrospectively at it, would not be able to sustain the ideological belief in the final, once and for all dissipation of that which was precisely to constitute it: the space of *endless* objects of disease, the names of disease, and the gaze of the consciousness of disease.

V

In coming to the analysis of the second paradigm in his construction, the clinic proper, Foucault, as a basis for the understanding of the clinical experience, first gives a short historical survey of its *institutions*. Till the end of the 18th century, they had not been numerous. Still, from de la Boe's Leyden clinical school, erected in 1658, there had been other forerunners in Padua, Edinburgh, London, Oxford, Cambridge, Dublin, Vienna, Göttingen, Brest, and Copenhagen.

One of the main characteristics of these early institutions was to manifest a complete circle of diseases, in the sense of forming a structural nosological field; therefore the clinics could not be fully open to everybody, nor in any sense specialized, as they were to become in the 19th century. Furthermore, it was not the patient as a human subject that was present in these clinics, but rather illness as examples. Still under the spell of the medicine of species, these early institutional variants had no gaze convinced of reaching truth (like after the French Revolution), but operated instead as spaces of deciphering established knowledge by adding names, language to disease from outside. It was still not a matter of discovering, but of demonstrating illness by showing it.

This aspect, though, did add a certain new dimension to the old clinic, since the showing of illness, for instance by teacher to student, sometimes was a chance game involving risk, where the teaching professor could be proven wrong. It was as a contest between "a language of nature", and the doctor's designating discourse applied from outside. When the two did not cover each other, already the early clinic was apt to undertake adjustments.

Towards the very end of the 18th century, however, a shift occurred in these institutions. In conjunction with upheavals in the triple spaces and strata that we have looked

into earlier, the old institutional clinics terminated the practice of extending their knowledge merely by saying, giving names, deciphering. They came into the atmosphere of discovery, where knowledge was born and established on its own for the first time, and the clinic was identified with the whole of medical experience.

VI

Just after the turn of the century, the conditions of possibility had been structured also for *formulating* the already present insight into the necessity to conduct individual observation and examination of cases, and to establish medical teaching *in the hospitals*. The missing unity mentioned above, for the formation of medical objects, perceptions, and concepts, was finally formulated by Vicq d'Azyr in 1805.[2] With that solution, teaching and saying terminated their functions as mere deciphering of already established knowledge. Teaching and saying in the clinic proper changed into being a way of learning and seeing: discovering scientific truths by joining, actively welding together conceptual names to that which was literally seen for the first time.

Partly as a reaction to malpractice and the high number of quacks, and to various forms of medical training (even in some of the closed faculties) in spite of the state intervention, the question of method in the teaching and practice of medicine became urgent. A new experience was formed, where ignorance was seen as something to be actively dispelled. In the new structure, the object of study was held to have an unknown truth that could

> offer itself to the gaze of both the experienced observer and the naïve apprentice; for both there is only one language: the hospital, in which the series of patients examined is itself a school. (68)

Outside the old hospital and the university with their dogmatic language, an immediate form of communication of teaching, faced with the concrete medical experience, was made possible. The new language was initially without words, it had to be formed, and it would not contain the idealistic truths of earlier established, outdated speech, but be committed to immediate speech applied to what rendered itself to immediate observation, to the gaze alone. These were the basics of the semiology of the new paradigm: the new medical clinic.

In the university field, new schools of medicine were now opened, and these introduced again, but in conjunction with the empirical clinics, theoretical teaching, and now one of a broader kind; it comprised knowledge as well of nature as of man in society. The reintroduction of medical societies and professional associations helped organize the new methodical teaching, in which the clinic as the main space for obtaining medical competence

---

[2] "(...) Do we teach in our hospitals the art of observing and treating diseases? Have we set up any chairs of clinical medicine in our hospitals?" Quoted by Foucault, p. 64.

was given priority. New regulations demanding a clinical test of future practitioners linked, for the first time, the need for theoretical knowlegde to the demands for practice obtained in hospitals. The medical profession received a closed character based on competence, and - in devaluing the old distinction between physicians and surgeons - two new levels were given. Officers of health dealt with usual illnesses, and the knowledge they needed (what to do after having seen) was on the order of controlled empiricism. Doctors, on the other hand, combined in their training theoretical knowledge with clinical experience. It was to them that the clinical gaze into truth, freed from all idealistic prior examples, applied.

The new organization of the clinic coincided with a reorganization of the hospitals, which now became municipal. At the same time, the nationalization of hospital funds was suspended, and the state freed itself from the obligation to assist. Poverty and illness became matters for the communes to deal with alone. At the end of the Revolution, then, hospitals treated the poor, and a closer contact was established between hospitals at large, and the clinic training doctors. Through this contact, the subject needing help (in the hospital), frequently became the object of the clinical gaze and its experiments. With the new financing structure of the hospitals, the sick poor depended upon the rich for treatment. What started as hospital benevolence towards the poor, was, during the course of an illness, often changed into clinical knowledge eventually applicable to the rich.

VII

What I have termed the semiology of the clinic proper, is, no less than that of classificatory medicine, certainly a matter to be looked into; Foucault devotes a whole chapter to its "Signs and Cases". The clinic stood under the sovereignty of the gaze, the gaze of a doctor who now commanded the powers to decide and to intervene on the basis of what he literally would be able to see on the sick body. He was now free to take action against unusual variants, anomalies, and deviants. He was supported by the clinical institution in his work, which was still bound to classify illness into families and species according to the botanical model, but which now also included the necessary tasks of calculation, of the risks and chances that medical experiment entailed.

Thus, the relationship between the object of knowledge and the doctor-subject became different; disease and gaze were now bound together by what Foucault calls (different) "codes of knowledge": On the one hand, the linguistic structure of the sign; on the other, the aleatory structure of the case.

In this semiology, a distinction is introduced between the symptom and the sign of the disease, but only to be immediately effaced again, and to be postulated as a unity of the signifier (sign and symptom). This signifier, moreover, is taken to be utterly "transparent for the signified, which would appear, without concealment or residue, in its most pristine

reality, (...) the essence of the signified - the heart of the disease - would be entirely exhausted in the intelligible syntax of the signifier" (91).

In this understanding, the symptom continued to function as that about the disease which is immediate to the gaze; it is "the form in which the disease is presented" (90), its immediately visible aspects. The symptom shows the invariable forms of illness. But combined with the symptom, an understanding of the sign gets operative - which, taken *per se*, in fact already belongs to modernity proper.

The sign "announces: the prognostic sign, what will happen; the anamnestic sign, what has happened; the diagnostic sign, what is now taking place", says Foucault. "Between it and the disease is a distance that it cannot cross without accentuating it, for it often appears obliquely and unexpectedly" (90). Therefore, the sign speaks about, not the visible and immediate, but of the hidden and invisible:

> (...) the sign indicates that which is further away, below, later. It concerns the outcome, life and death, time, not that immobile truth, that given, hidden truth that the symptoms restore to their transparency as phenomena. (91)

According to this concept, the sign is "prognostic" and "anamnestic" - or in different words: both proleptic and analeptic. It is always already bound to operate in a distance of temporality to that which it is supposed to reach, making it impossible for consciousness and phenomena to be conjoined in a state of presence and immediacy. This concept certainly reminds one of the "rhetoric of temporality", or the "différance" of the sign's spatialized temporality that we nowadays find in the writings of Paul de Man and Jacques Derrida.

However, in the semiology of the clinic proper, this concept of the sign was "used" in a different, and for us more problematic function. In that code of knowledge, doctors could "use" the sign as an instrumental means to bring out into the open that which they already then *did* understand to be "hidden" (but not, as in the sense of modernity and the later anatomo-clinical method, unreachable). The sign, in their understanding, could make the invisible visible.

Rudiments, already, of a semiology of modernity, then, were here, in their combination with still operative remnants of a classificatory idealism of symptoms, so to speak turned back upon themselves. There *was* introduced a difference between symptom and sign in the clinic (symptom of the visible, sign of the invisible to be made visible), a difference, though, that was immediately effaced by making both symptoms and signs operate as (to us highly problematic) transparent signifiers of the body to be signified. What made the symptom into a sign in the clinic, or what effaced the difference between them, was the gaze and thereby consciousness, which saw differences in the observed phenomena but tried to understand them, reach them as phenomena of being. Yet, by a paradigmatic leap, the semiology of the clinic was structurally different from the earlier, idealistic, "divine"

semiology of nosological configuration (where time, let us remember, played no role at all).

In the clinic, there was a realist attitude; disease, known and unknown, visible and invisible, could be made present to the commanding gaze through the strategies described above. Illness could be dealt with and treated actively in an atmosphere of scientific discovery - by creating and bringing, for the first time, a name to the symptom/sign-signifier that the body itself was believed to emit, in a kind of clinical nominalism: "(...) in the clinic, (...) the armature of the real is designed on the model of language" (96).

The epistemology of the clinic thus consists of seeing an isomorphism between bodily disease and verbal structure; disease corresponds, in transparency, with the syntax of the clinician's descriptive language. Furthermore, the descriptive act functions at this stage as a (phenomenological) seizure of being, where, through what is possible to see, language speaks things, as Foucault formulates it. This correspondence in the totality of being between signifier and signified, says Foucault, is the same for the clinician as for the philosopher, since for both, "the world is (...) the analogue of language" (96).

As we saw earlier, classificatory medicine could not measure individual physical or mathematical particularities, since they might lead astray from the ideal configuration. In the clinic proper, however, where uncertainty was handled in a much more positive manner, "dark" areas became objects of calculation on the basis of recorded events. This, in its turn, provided rudiments for probabilistic thinking, which endeavoured to isolate certainties in events as elements in aleatory series: the second major code of knowledge in the clinic.

The clinic became an "open domain"; by way of probabilistic thought, the perception of the domain was changed: "the space in which the doctor's attention had to operate became an unlimited space, made up of isolatable events whose form of solidarity was of the order of the series" (98 f.). Here was the basis for the clinic's preoccupation with *cases*: Uncertainties in diseases, in nature, could be done away with when medical perception saw its space as infinite and open, but to be invested and structured, little by little, by series of cases. Through a combinatorics of disease elements from one case to the other, analogies were revealed and established from the known to the unknown. But this, again, required precisely the close study of the multiplicity of individual cases. In this way, variations and abnormalities, earlier so hard to handle, were now not set aside, since the clinic was a domain of events, and not one of species.

Such a coded grid as the basis for the clinic's epistemology was characterized by extended calculations of the degrees of certainty. Mathematics functioned in the service of an instrument to define implications in a total system of illness.

The combination in clinical pathology, then, of semiological-grammatical and probabilistic structures, defined conditions of possibility (today again outdated) for a medicine which believed every aspect of disease to be fully open, or possible to open, to the

gaze. Oriented towards case studies, these structures did away with the aporias in the ideas of essences and symptoms, of species and individuals.

But as Foucault indicates, inherent in this epistemology is a fundamental contradiction: The mathematical model formulates, from outside, principles of coherence for "internal entities" that by a grammar of transparency are taken for "real" in their singularity. But they are in effect, as we have indicated, signifiers "standing for something", and are precisely thereby removed from the supposed entities, that can never be reached as such and never be reached as internal coherence.

The later semiology of the anatomo-clinical paradigm problematized this contradiction. There, medical signs were to be seen only in those differential relations (not as immediate entities in coherence with each other) that we still today understand as our conditions of possibility.

But as long as the mathematical model of externally added coherence was felt to overlap the grammatical model supposed
to yield immediate truth about singular entities, the gaze that commanded them "seemed, for a time, a happy gaze" (105).

VIII

The clinical gaze, committed to the immediate as well as to mathematical-logical principles - how was its practical perception structured? In Foucault's phrasing, it was a "silent" gaze, that in perceiving a spectacle, "heard" the language of the body. In its perception this gaze is analytic, in the sense that it immediately reproduces that which was given to it in the perceptual act, in the movement that at the same time "composes", structures what it sees. At the same time, it is convinced that what it perceives and analyzes, comes to it, without intervention, through the language "spoken by things themselves in an original silence" (109). Thus observer and observed object "communicate", in immediacy.

The locus of this communication was now the united hospital and teaching domain. It was a neutral area, in the sense that natural or family environments no longer were needed, since knowledge was based on the frequency of disease occurance: A room for comparison was needed; no selection nor exclusions belonged here. Therefore, the medical subject turned collective; so did the hospital in its structure. It did not consist of knowing and not knowing personnel; both categories received the language of the disease at the same time. As an "open field", the clinic, with the questions asked in language, and the examinations performed by the gaze, introduced the possibility of endlessness, an infinite area of investigation.

Therefore, certain borders had to be introduced in order to determine and limit clinical pathology. For one thing, observation was organized as an alternation between speech and perception; the patient answered questions asked, the doctor described what he saw,

alongside the ongoing perceptual observation. Further, verbal analysis and visual perception were attempted correlated into a structure that could be both visible and legible; thus there were attempts at creating "pictures" of the disease (but in a quite different sense than the portraits of classificatory medicine). A further measure was to encourage the ideal of exhaustive descriptions, to organize the infinite into a total, determinable, and coherent structure. In these efforts to relate everything visible to an encompassing structure of the expressible, the work of descriptive language transformed - as we have indicated earlier - the symptom into a sign, the patient into disease, the individual into concepts.

In our view, it is possible to discern the mythical aspects of these measures; the methods and norms of the clinic were bound to "the great myth of a pure Gaze that would be pure Language: a speaking eye" (114). Knowledge was established by saying what one sees. The problematic realist-nominalist attitude in this epistemology can be seen in this basic premiss of the clinic proper: "that all that is visible is expressible, and that it is wholly visible because it is wholly expressible" (115). The rudiments, that we looked into above, of the strange logics, belonging to modernity, of the receding signifier and the unbridgeable gap between signifier and signified, seem to have been pushed under the carpet. For the myth of the transparence between the visible and the expressible left "opaque the status of the language that must be its foundation" (117).

One of these mythical problems in the clinical perception was that disease became "merely a name"; the clinical gaze entailed a nominalist reduction of the materiality of the disease. That materiality, hard though it always will be "to read", at this stage more and more came to be experienced as impenetrable, obscure, belonging to darkness (and not to the clinic proper's myth of light).

This engaged the clinic in moving from attempts at establishing a two-dimensional picture (where the visible and the expressible-legible were thought to coincide), to a perception of the body's secrets in *spatial figures*, basing its classifications on *forms of relations*. These are elements of the pathological anatomy to come. But in the clinic proper, the spontaneous reading of disease in order to restore it as it is, was "not as adequate to itself as might be supposed: its truth is given in a decomposition which is much more than a reading since it involves the freeing of an implicit structure" (120).

Strange though it may sound, the whole apparatus of clinical medicine - the hospital with a teaching domain, the probabilistic and the linguistic codes of knowledge that for the clinic established the real - was subordinated under the myth of the immediate, the epistemology of the presence of being. As such, its gaze was linked to the art of immediate sensibility, first and foremost to those faculties that, incidentally, Jacques Derrida holds to be most "responsible" for Western metaphysics: hearing and speech.

In the upheavals from the paradigm of the clinic to that of clinical anatomy,

pathological medicine and its perception move away from the grid of transparent language, from hearing and speech. In the continued effort to "reach" the materiality of disease, which in pathological anatomy was understood as an area of obscure darkness, taction and tactility gained priority in the sense register pertaining to the observing subject's consciousness. This was *one* of the inversions in the rupture across to the third paradigm in Foucault's construction.

To be sure, there, in the anatomo-clinical method, the doctor was still trying to "reach" the material disease, and at that, he - but only initially - introduced epistemological themes that we now know as belonging to scientific positivism, like that of cause and effect, the access to essences, and the like. All the same, Foucault elicits how that positivism, already during the first decades of the 19th century, included elements of what I would call a hermeneutics of "suspicion" - a hermeneutics introduced in the human sciences, as we are used to thinking of them, only by and after Nietzsche, Marx and Freud. For pathological anatomy, in its tactile strength, did not let itself be misled by the immediate forms of the sensible; it learned to know how to traverse the immediate, and to demystify it.

Moreover, it learned how to handle obliqueness in body and disease: as spatial figures, and how to look upon illness as relational differences. One is tempted to think of certain parallels in the philosophy of language and in literary theory of a much more recent date, as in the "new rhetorical" theories of tropes, where differential, figural deviations are of primary interest, and the immediacy of presence is held to be metaphysical.

In this paradigmatic leap, Foucault sees a change in medical perception that motivates a change in the terminology he uses to designate the perceiving consciousness. *The gaze* (of immediacy) gives way to *the glance* (of structural depth and loci) - although Foucault himself continues to speak of "gaze" even after he has made the difference explicit. This is how he differentiates:

> (...) the gaze implies an open field, and its essential activity is of the successive order of reading; it records and totalizes; it gradually resconstitutes immanent organizations; it spreads out over a world that is already the world of language, and that is why it is spontaneously related to hearing and speech; it forms, as it were, the privileged articulation of two fundamental aspects of *saying* (what is said and what one says). The glance (...) does not scan a field: it strikes at one point, which is central and decisive; the gaze is endlessly modulated, the glance goes straight to its object. The glance chooses a line that instantly distinguishes the essential; it therefore goes beyond what it sees; it is not misled by the immediate forms of the sensible, for it knows how to traverse them; it is essentially demystifying. (...) It is not burdened with all the abuses of language. The glance is silent, like a finger pointing, denouncing. There is no statement in this denunciation. The glance is of the non-verbal order of *contact*, (...) a more *striking* contact, since it traverses more easily, and goes further beneath things. (121 f.)

In trying to understand this complex passage, I suggest a reading which links it up with the themes of life and death, two major semantic clusters that in fact underlie the whole

of Foucault's book. In the anatomo-clinical method, the body does not comfort the observer any longer by communicating its messages to him in a reciprocal friendliness, convincing the observer of his immediate contact with and control of the inside, the source and the principles of life.

For in clinical anatomy, a fundamental distance has been recognized, which is non-verbal in the sense that there is no communicable message, no statement to transmit and mediate either way between a body of life and the perceiving subject. The effects of this distance come into play as the body now becomes merely (but positively) tangible, and simultaneously opaque; it contains secrets, invisible damages, and - it endlessly hides the mystery of origins. For the distance is absolute, finite - it is the distance of death.

The acceptance of the premiss of death was to aquire a special and primary function in pathological anatomy. It was to make the individual come into and stand on his own. Death was to contribute to finally establishing him, irreparably, in his primary and inescapable mode.

IX

In pathological anatomy, the study of dead bodies came to an unprecedented high. It has often been believed that dissection, autopsies, the opening up of corpses had been prevented till well into the 19th century by moral standards, religious bans, superstition, and other cultural norms. In Foucault's perspective, this is utterly misleading. Throughout the 18th century, medicine commanded ample supplies of corpses for investigation, and to an extent also did work on them. When autopsy literature was scarce, this was rather due to a repression to be found in the conditions of possibility within the archaeology of clinical medicine itself. The "neutral" gaze of the clinic proper, linking live, manifest symptoms with language, prevented the investigation of dead, mute bodies.

When these conditions had changed, as we saw indicated above, and the opening up of corpses became more usual, the object of study was restructured. It was understood as a new fundamental space defined by something that only the corpse and its dark, spatial depth gave sufficient access to: the thinness of tissue. Tissue and its characteristics were found to be of an order totally new to medicine. It is distributed throughout the whole of the organism, it traverses the organs, it constitutes several and differential systems of bodily unity - it forms, in the invisible body, spatial figures. Without being itself of the order of an "essence of organs", it turned out to be a system of textures.

The processes taking place within the various tissual textures could be described as effects, in a specific, non-phenomenological sense as "tissual communication" (130) throughout the depth of the organism. The study of tissues of the same texture made it possible - again, but on a different basis than in the medicine of species - to see resemblances

between diseases, and to establish the order of classifications. Anatomical analysis freed itself from the language of presence, and became concerned with "the spatial divisibility of things rather than the verbal syntax of events and phenomena" (131). This method is removed from the nominalism of the clinical method, where nothing could be analyzed that could not be perceived as a segment or entity of being, and transcribed into the presence of language. Now, the analyzed elements are "real", but only in the sense of being necessarily isolated by abstraction. Two of the examples given by Foucault, might clarify what is at stake here.

Anatomical analysis revealed the structure of the pericardium: the double membraneous "sac" which encloses the heart. How? By abstraction from the "presence" of the heart. The same kind of analysis revealed the arachnoid: the cobweb-like tissue of the brain - again by abstraction from the "presence" of the brain. Both of these structures are constituted by something which is very hard to describe in language. Are they grids? Nets? Knots? A relationship of members? Lines that intersect? Is not anatomy here dealing with something that "consists" merely of differential relations? As opposed to essences of presence?

This kind of analysis would have been impossible without a notion of spatial divisibility and spatial figures, where elements stand in figural relations to one another. These simple anatomical elements are "real" but, precisely, abstracted: For one thing, they are abstracted from the perceivable entity, organ, or phenomenon: from the believed-in presence of the "body" that they are invested in. Second, the elements forming the tissual texture are abstracted from each other: they are never present together in the same locus at the same time, but form a structural grid that traverses that which is perceived as present. Again, in our present-day knowledge of rhetoric, one is tempted to associate to textual elements of figural language: tropes, "traversely operative" in what is believed to be the presence of the homogeneous "body" of content in an utterance. On this score, pathological anatomy was entering, at a surprisingly early stage, the era of modernity.

That the question of temporal distance became of the utmost importance to pathological anatomy - a question which had to be solved by accepting a non-present relationship between the visible and the absent but effective invisible in the dark area of the body - can be discerned from Foucault's formulations on the problems that this question gave rise to, at a stage in anatomy when it still gave highest priority to the visible symptoms as a basis for forming classes. That was exactly what was done at the earliest stages of this third paradigm:

> By never relating anything other than the visible, and in the simple, final, abstract form of its spatial coexistence, anatomy cannot say that which is connection, process, and legible text in the order of time. A clinic of symptoms seeks the living body of the disease; anatomy provides it only with the corpse. (134)

Two sets of questions had be to solved in pathological anatomy before it reached the

stage of modernity that I just indicated above:

> the first concerns the connection between a temporal set of symptoms and a spatial coexistence of tissues; the second concerns death and the strict definition of its relation to life and disease. (134)

In depth and darkness, the medical gaze had to "see" in a new dimension: "vertically from the symptomatic surface to the tissual surface; in depth, plunging from the manifest to the hidden; and in both directions" (135). The anatomo-clinical gaze had to become three-dimensional:

> the medical eye must see the illness spread before it, horizontally and vertically in graded depth, as it penetrates into the body (...) as it circumvents or lifts its masses, as it descends into its depths. Disease is no longer (...) characters (...) over the surface of the body (...) statistically observable; it is a set of forms and deformations, figures, and accidents and of displaced, destroyed, or modified elements bound together in sequence according to a geography that can be followed step by step. It is no longer a pathological species inserting itself into the body wherever possible; it is the body itself that has become ill. (136)

Some of the new rules in the new epistemological grid: The anatomo-clinical method brings in "a chequered or stratified analysis" (138). Further, it has to start its analysis from a fixed point of localization on the body, and from there follow the illness in a spatio-temporal "reading" of the attack throughout the organism. This localization of "seat", or "site", also called "origin", has nothing to do with a description of the "cause" of the illness: "to localize was to fix only a spatial and temporal starting point" - for the illness and for the gaze's "reading" of it. The idea of the figural seat of the illness had now replaced the notion of class. Thus was the solution to the question of temporality (of symptoms) and spatiality (of tissues).

The work on the question of death's relation to life and disease also gave radically new perspectives now. Prior to pathological anatomy, death had been taken to be the absolute line beyond which there was neither life nor disease any more. So, death was identified with neither of them. With anatomy, however, it was seen that death's processes could be linked to disturbances in organic phenomena. It became a point of view on the pathological.

Much thanks to the work of Bichat, the old understanding of a contiguity from life over disease to death, was replaced by a new conceptual trinity with death as the pinnacle, "ruling" over life as well as disease. It was understood that death could reveal and elucidate the space of the organism, and the time of disease: "It is from the height of death that one can see and analyse organic dependences and pathological sequences" (144):

> Analysis, the philosophy of elements and their laws, meets its death in what it had vainly sought in mathematics, chemistry, and even language: an unsupersedable model, prescribed by nature; it is on this great example that the medical gaze will now rest. It is no longer that of a living eye, but the gaze of an eye that has seen death - a great white eye that unties the knot of life. (144).

What Bichat did, was to relativize the concept of death; he placed it in life "in the form of separate, partial, progressive deaths" (144). Death becomes that to which life is opposed and

exposed: a "living *opposition*, and therefore *life*". Death also becomes the origin of knowledge now, since death is that to which life is "analytically *exposed*, and therefore *true*" (145). The gaze of medical perception turned completely around, and received its "account" of life and disease from death. According to Foucault, this, in the first decade of the 19th century, was when Western medicine, and man, came to their own: when "clinical experience became the anatomo-clinical gaze" (146).

X

The principles underlying this kind of perception of life by way of its absence in the dead body, were, for one thing, tissual "communication", in the sense that pathological phenomena occur in the organism on the basis of tissual relations, contact, or "identity". The pathological gets inscribed into the analogy of a structure. Further, a morbid process is found to follow the tissue horizontally, without penetrating vertically into other tissual strata (penetration may, by lasting disease, occur into subjacent and neighbouring tissues). Moreover, this perception of the body as constituted of structurally related strata, paradoxical though it may have seemed at the beginning, now made it possible for medicine to "see" that *different* morbid disorders could be *linked*.

Disease was no longer, as in the 18th century, so to speak imported, embodied, from outside; it became a deviation of a life, within that life itself, under the irremovable conditions of death. In clinical nominalism, disease had its truth as symptoms and translucid signifiers of visible life-threatening essences; in clinical anatomy, disease was seen merely as pathological life, as morbid life; and life became perceptible only as that which is *beyond* disease.

This, according to Foucault, is no less than a shift in the ontological basis of perception, linked to death. Death becomes the absolute point of view over life and its truth; and it becomes that against which life comes up, in its daily existence. Such a shift also made the understanding of degeneration different. It is given a positive determination henceforth, since it is possible to understand it as a deviation "of the order of life, but of a life that moves towards death" (156), as a life in self-destruction, like any other form of life.

Death as the point of view on life and disease: the gaze of death could, in retrospect, see life and disease as a unity; but this also meant that that gaze had to invest death in itself, thus this death also made possible the truth of life and disease by anticipation:

> For thousands of years, medicine had sought a mode of articulation that might define the relations between disease and life. Only the intervention of a third term was able to give to their encounter, to their coexistence, to their interferences, a form based both on conceptual possibility and on perceived plenitude; this third term is death. On the basis of death, disease is embodied in a space that coincides with that of the organism; it follows its lines and dissects it; it is organized in accordance with its general geometry; it is also inflected towards its singularities. From the moment death

> was introduced into a technical and conceptual organon, disease was able to be both spatialized and individualized. Space and individual, two associated structures deriving necessarily from a death-bearing perception. (158 f.)

The problems of configuration and embodiment, of place and seat, as we remember them already from the medicine of species, then through the clinic proper (with their different semiologies and their different solutions as to making the two overlap): These problems of what Foucault calls secondary spatialization, find a new solution in clinical anatomy, where configuration and body eventually are found to coincide in a perception that basically has not changed up to our own days.

But this overlapping, let me add, is not, and neither could be, the condition of possibility of the final "truth" to be attained within medicine, nor, *mutatis mutandis*, in any other science. It is not the telos of a "history" that Foucault "believes" more in than those stages he has described before. Nor does he hold this overlapping to be more scientifically "correct" than the other instances of secondary spatialization that he has described. Such a view would run counter to Foucault's own project, which - as we recall - is not so much concerned with what men may have thought behind what they have said, as with "that which systematizes (the things said by men) from the outset, thus making them thereafter endlessly accessible to new discourses and open to the task of transforming them" (xix). Also the anatomo-clinical perception may change. Even Foucault's own archaeological construction.

And also the anatomo-clinical perception has, as one of its conditions of possibility, a semiology. Foucault problematizes also that semiology, and in so doing, discusses the relationship between the visible and the invisible. With disease bound to the obscurity of tissual reactions, what now with the visible signs and symptoms of the body? With illness now "enclosed" in a dark body, does pathological anatomy necessarily reduce the importance of symptoms and that which is visible, and value the "truth" of the absence within the dead body? So it seems to Foucault; truth now emerges from the "inaccessible reserve", from "the inert", from "forms in which living signification withdraws in favour of a massive geometry" (159). In this semiology, we are dealing with a "new reversal of the relations between signs and symptoms" (159).

In the clinic proper, symptoms became signs: lucid signifiers. In the anatomo-clinical perception, the symptom may remain silent, it has nothing to express, its nucleus of believed-in signified proves to be non-existent. Now the sign is a circumscription only: "it is not an expressive symptom, but one which is substituted for the fundamental absence of expression in the symptom" (160). This sign is able to "traverse, diagonally as it were, the visible body of the disease". It is not based on statistical series any more, and is not taken to form a part of a whole, as an element in the production of a convergent series of certainty. Now

> the sign speaks alone, and what it declares is apodictic: coughing, chronic fever, weakness, expectoration, and haemoptysis make phthisis more and more probable,

> but, in the last resort, never quite certain; pectoriloquy alone designates it without any possibility of error. (...) the clinical sign referred to disease itself, the anatomo-clinical sign to the lesion; and although certain tissue alterations are common to several diseases, the sign that reveals them can say nothing about the nature of the disorder: one may observe hepatization of the lung, but the sign that indicates it will not say what disease is responsible for that condition (...). The sign, then, can refer only to a lesional occurrence, never to a pathological essence. (160 f.)

Medicine is no longer "a science analogous with that of the Supreme Being, conforming to the laws of natural movements, but of the formulation of a certain number of perceptions of signals" (161). It is only the investigation, and the questions asked in the examination of the sick organism, that now give status to the sign. The sign appears as artificial, it is produced by medicine, laid out as mappings: "the dotted outline of the future autopsy" (161).

Medicine, then, was in effect no longer a question of a "reading" (the term we used above), but of the development of techniques able to constitute a projective pathological anatomy. In the clinic proper, series were analysed; now the gaze had to "*map a volume*; it deals with the complexity of spatial data which for the first time in medicine are three-dimensional" (163). The clinic's approach by way of the visible and the readable now gave way to what Foucault calls a "sensorial triangulation"; therefore also other senses, like touch, had to be given value.

Again, it seems to me that the semiology of pathological anatomy comes close to theories of the sign and of language, that we have become accustomed to linking with developments within the philosophy of language, say from the mid 1960's on. The total loss of presence of being in the sign; the sign's lack of expressibility; its character of substitute; and of traversing that which is visible in a "diagonal" manner, thereby operating according to an ungraspable distribution which necessarily entails temporal delays and spatial recessions; its opposition to "readings" of contents or essences; its artificiality, being fabricated in the conjunction of that which is "real" and at the same time abstracted; and its ontological basis in the tomb of death: These are so many indices of a semiology which is a "rhetoric", of the kind that e.g. Jacques Derrida has launched in his theories of the sign as mark, as trace, signifying nothing, filling the space of silence in the economy of death.[3] There are certainly parallels here, as in Derrida, to an understanding of signs as figural, as parts of structures of tropes.

With the sign as artificial, pathological anatomy developed techniques to circumscribe illness, presicely by "mute marks", with the help of several sensorial faculties:

> The sight/touch/hearing trinity defines a perceptual configuration in which the inaccessible illness is tracked down by markers, gauged in depth, drawn to the

---

[3] Cf. e.g. Jacques Derrida, "Différance", in *Margins of Philosophy*, Chicago: Univ. of Chicago Press, 1982, p. 4.

> surface, and projected virtually on the dispersed organs of the corpse. The 'glance' has become a complex organization with a view to a spatial assignation of the invisible. (164)

However, in its practical work, and in spite of the switch to a semiology of a kind just indicated, pathological anatomy in its perception did continue to give at least a potentially dominant position to the gaze and the visible. This was so, since doctors of that time, when treating illness, "knew" that truth, in the sense of a luminous presence of the visible, would be possible to attain at the autopsy.

This is part of the background of what Foucault refers to as the duplicated gaze. There is on the one hand a local "gaze" of the sense organs of the doctor, which has to start with the visible surfaces. On the other, there is an "absolutely integrating gaze that dominates and founds all perceptual experiences" (165). This is the systematizing, conjectural gaze, that has to "see" also that which is invisible. Thus, the duplicated gaze of the anotomo-clinical method became a structure, both perceptually and epistemologically, of a dialectics of "invisible visibility" (165).

This structure does away with all vain notions of freedom, and of enlightenment and the sciences developing into a space liberating the human being from the night of the terror of ignorance. For the discursive structures during the decades analyzed in *BCl* thematize a philosophy of another terror, of power, death, and a human suppression that are found as analyzed parallels also in other of Foucault's archaeologies (e.g. *Madness and Civilization, Discipline and Punish*), where Foucault states that man came into his own as an individual only at the expense of his freedom. In *BCl*, we have reached this stage in connection with the anatomo-clinical gaze. There,

> the absolute eye of knowledge has already confiscated, and re-absorbed into its geometry of lines, surfaces, and volumes, raucous or shrill voices, whistlings, palpitations, rough, tender skin, cries - a suzerainty of the visible, and one all the more imperious in that it associates with it *power and death*. That which hides and envelops, the curtain of night over truth, is, paradoxically, life; and death, on the contrary, opens up to the light of day the black coffer of the body: obscure life, limpid death, the oldest imaginary values of the Western world are crossed here in a strange misconstruction that is the very meaning of pathological anatomy (which) was haunted by that absolute eye that cadaverizes life and rediscovers in the corpse the frail, broken nervure of life. (166, my ital.)

With such a gaze, reminiscent of the gaze of power of the "Panopticon" in *Discipline and Punish*, absolute and authoritarian, it would seem that the individual would be annihilated. But it is Foucault's point here, that only such a gaze made a discourse on the individual possible. Looking back on the clinic proper, we recall that its science was one of cases, of seriality, in order to establish what was believed to be essentials; therefore individualities were reduced. In the anatomic method, individual perception becomes the most differentiated structure, and the one most open to modulations, the accidental,

deviations:

> In anatomical perception, the disease is given only with a certain 'blurring'; it has, from the outset, a latitude of insertion, direction, intensity, and acceleration that forms its individual figure. This figure is not a deviation added to pathological deviation; the disease is itself a perpetual deviation within its essentially deviant nature. Only individual illnesses exist: not because the individual reacts upon his own illness, but because the action of the illness rightly unfolds in the form of individuality. (168 f.)

Thus medical language is no longer a question of making the visible legible in a universal, codified language. It becomes the difficult, sometimes impossible task of "opening words to a certain qualitative, ever more concrete, more individualized, more modelled refinement".

> It is not any more the hope of making the perceived semantic,
>
> but of bending language back entirely towards that region in which the perceived, in its singularity, runs the risk of eluding the form of the word and of becoming finally imperceptible because incapable of being said. (Discovering is) to push a little farther back the foamy line of language (...) - to introduce language into that penumbra where the gaze is bereft of words. (169)

The living individuality makes the visible invisible. But it is also this invisible that the patient but hopeless task of language endeavours to make visible to everybody. This becomes the structure, when death, and with it language, form the basis for knowledge about man. This is the paradox that he has to live with henceforth:

> To know life is given only to that derisory, reductive, and already infernal knowledge that only wishes it dead. The Gaze that envelops, caresses, details, atomizes the most individual flesh and enumerates its secret bites is that fixed, attentive, rather dilated gaze which, from the height of death, has already condemned life. (171)

This is also the paradox that underlies the scientific debate on fevers, where, with Broussais' inversion of Bichat's view, the paradox of death's epistemological command over life was fastened with another turn of the screw: It is not because (thus Bichat:) disease is perceptible in living visibility that we can localize it. Instead it is because disease always already is local and only exists in an invisible, "dead" space absent from the presence of being, that it can be brought out in front of sight (thus Broussais) - into that visibility that we deceptively think of *as* the presence of being. This was, according to Foucault, Broussais' great discovery in 1816.

At that, Broussais also avoided the previous, unsolvable attempts made at defining the cause of diseases. Now, the local space of the illness became its "cause". "Disease is now no more than a certain complex movement of tissues in reaction to an irritating cause: it is in this that the whole essence of the pathological lies, for there are no longer either essential diseases or essences of diseases" (189).

Here began the medicine of pathological reactions, taking us right up into the 20th century, with its gaze directed upon a space filled with the numerous *forms* of composing organs and "unities" in the body. Hence, the space of disease will be the space of the organism. Since Broussais, "the doctor's eye has been able to confront a sick organism. The

historical and concrete a priori of the modern medical gaze was finally constituted" (192).

The power of death did it.

XI

That inescapable condition of possibility, for modern medicine, and by extension for the human sciences, and for us as individuals even in the 20th century, gives me an opportunity to return to the beginning of my reading of *BCl*, where I raised the question of Foucault's own "semiology" in his archaeology of medical percpetion.

What kind of "semiology" is his own book's discourse built up around? Does it subscribe to the epistemological tenets of the last, and according to him, still lasting clinical paradigm that he describes (clinical anatomy), and that he holds to have such far-reaching effects for modern man? At this point, a critical reading of some of Foucault's comments in the Preface and in the Conclusion, as well as a general side view to other works of his, would be of great interest.

Foucault, in an attempt to lay the self-reflexive foundations of his discourse on the birth of the clinic, concedes that 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" (xv). Certainly, we should take into account that *BCl* was written before Foucault's nuancing redefinition of his epistemological position, as a reaction to a controversy with critics, in which he denounced that his work is structuralist or an instance of structuralism.[4]

Still, regarding *BCl per se*, we may point to the fact that in this work, Foucault expressly states that it "is a structural study that sets out to disentangle the conditions of (medicine's) history from the density of discourse, as do others of my works" (xix). In my view, *BCl* is more than that; it comes closer to a post-structuralist practice, particularly in the way it handles, in connection with each of the paradigms of medicine, the relationship between their signifiers and their signifieds. Foucault undoubtedly treats this relationship as a play with internal contradictions and impasses, which, under "optimal" conditions in a whole discursive system, makes possible a rupture that redistributes the signifying elements of discourses into a new general paradigm, giving a new and qualitative different play, but still a play, of significatory elements.

Before discussing further the details of *BCl*, it is of relevance here to offer a side view of how Foucault in his greater production has developed the problem of the relationship that I (and

---

[4] The debate is summed up by Foucault in his book *The Archaeology of Knowledge*, New York: Pantheon, 1972, pp. 199-211; originally published in France as *L'Archéologie du Savoir*, 1969.

he himself in *BCl*) have referred to as that of signifier to signified. Gilles Deleuze speaks of this in his admirable book from 1986.[5] Foucault does operate with the opposition between signifier and signified, but develops it, in his special vocabulary, as an opposition between articulable (expressions) and visible (contents), or as statements and visibilities.[6]

To Foucault, knowledge is the combination of statements and visibilities. There is nothing hidden in the articulable and the visible in any historical age; everything that can be said and be seen in each age is positively there. Statements are there in the mode of spontaneity (of language). Visibilities are there in the mode of receptivity (of light). Still, statements and visibilities are not the concrete words and propositions, objects and things that persons say and see.

Therefore, statements have to be extracted from the concretely said; and visibilities have to be extracted from that concretely seen. Although nothing is hidden, words and things have to be opened up in Foucault's archaeology; they are not directly readable or visible.

This is so, because language does not "begin" with persons ("I speak"), nor with the referential signifier of structuralism ("it speaks"), nor with the phenomenological experience ("the world speaks"). Instead, there is in history the "anonymous murmur" of "one speaks", the fact that there is language, the being of language.

And it is so, because visibility does not "begin" with what subjects see (they are themselves a place of visibility); it is neither the act of seeing, nor visual "meaning". Instead, there is in history the "there is" of light, the being of light.

Now, it is Foucault's opinion that each age or historical formation puts language and light together in specific manners. Language can be representational; or non-unifying. Light can shape visibilities that are fantasies; that are (multi)sensorial; or that are even "of darkness", or unseen. The elements of light and the visible, let us bear in mind, are metaphors to indicate forms of receptivity, and are by no means necessarily connected to the sense organ of vision.

In his earliest works (including the first version of *BCl*), Foucault held that knowledge was constituted as much by the visible as the articulable. This can be seen also from the subtitle of *BCl*: An Archaeology of Medical Perception (or Gaze). Foucault later realized that the visible cannot be reduced to a perceptible thing or quality, and that the being

---

[5] English version: Gilles Deleuze, *Foucault*, Minneapolis: Univ. of Minnesota Press, 1988. Cf.in particular pp. 47-69.

[6] Deleuze maintains that these are not to be confused with signifiers and signifieds in the sense of structural linguistics, since both the visible and the articulable have both a form and a substance, and since there is neither causality nor symbolization between the two. - That would be a view that new rhetorics, post-structuralism, or deconstruction could subscribe to.

of light cannot be reduced to a physical environment. His view here is partly also a reaction against phenomenology, and from *The Archaeology of Knowledge* on (orig. 1969), he holds that the system of statements have primacy over the different ways of seeing and perceiving (when he revised *BCl* in 1972, he removed the subtitle; still, the 'absolute gaze' from *BCl* was a notion he kept).

From 1969, then, he holds that the statement has primacy, a determining role, over the visible; visibilities being forms of that which is determinable (but not of determination by the statement). In Deleuze's phrasing:

> The statement has primacy by virtue of the spontaneity of its conditions (language) which give it a determining form, while the visible element, by virtue of the receptivity of its conditions (light), merely has the form of the determinable. Therefore, we can assume that determination always comes from the statement, although the two forms differ in nature. (67)

Be that as it may; the important thing for us in discussing Foucault's "semiology" in *BCl*, is that in spite of mutual presupposition between statement and visibility, and in spite of the primacy of the statement, there is no isomorphism, conformity, or overlapping between them. There may be ideological notions of conformity in variuos periods, as we have seen in the clinic proper, or fictional dreams of overlapping, as in idealistic philosophy or literature.

Still, "word" and "thing" in principle never coalesce. This has concequences for the notion of truth in Foucault, which, according to Deleuze,

> is defined neither by conformity or common form, nor by a correspondence between the two forms. There is a disjunction between speaking and seeing, between the visibile and the articulable: 'what we see never lies in what we say', and vice versa. The conjunction is impossible for two reasons: the statement has its own correlative object and is not a proposition designating a state of things or a visible object, as logic would have it; but neither is the visible a mute meaning, a signified of power to be realized in language, as phenomenology would have it. The archive, the audiovisual is disjunctive. (64)

This dissemination, the heterogeneity of the two forms is, to my mind, very close to what a "deconstructionist" like Paul de Man speaks about, when - in discussing the main types of tropes in figural language: allegory and irony - he focusses on the unbridgeable gap between signifier and signified, or (his language of new rhetoric provocatively using the vocabulary of phenomenology:) between consciousness and Nature.

What sometimes confuses in the critical discussion of Foucault, is the massive rejection of any link between his work and the terms signifier and signified (though not always by Foucault himself: in *BCl* he uses them even when discussing his own approach). Instead, we are led through demanding discussions of Foucault's very complex metaphorical notions of statements and visibilities. Deleuze also rejects signifier and signified from use in connection with Foucault, but at least he indicates what terms he is referring to when doing so: those of (high) structuralism. When I in my understanding still think that (post-

structuralist) signifier and signified are terms that may correspond to Foucault's notions of the articulable and the visible, statement and visibility, it is based on certain parallels in the structures of their respective constituents (as I have already indicated above).

In particular I am thinking of the parallel figure of distance or rupture, occurring both between statements and visibilities, and between signifier and signified, when the latter are understood as post-structuralist or new-rhetorical terms: As such, the signifier is never, as in structuralism, a way "of making language begin" (Deleuze: 55). Nor is the signified a (visible) "meaning" that the signifier connects to; it is not a meaning set by a thetic consciousness at all. That is another parallel.

A further one is that there is no symbolization between signifier and signified, either (that would indicate precisely a consciousness and a "beginning" of language).

The doubleness of signifier and signified - in the sense that both have a form as well as a substance, and in the sense that, in complex, graded constructions, the form of one can be linked to the substance of the other, and the signified in one instance can become the signifier in the next - this doubleness is also something that theory after structuralism (even structuralism "itself") is well acquainted with.[7] And, as we have seen, a similar doubleness is found in Foucault's terms of the visible and the articulable.

Even the primacy of the signifier over the signified, as a parallell to that of statement over visibility, which we have seen that Foucault gradually assumes, is something post-structuralist and deconstructionist thinking has been preoccupied with in the study of the (spontaneous) play of the signifier.

Statements, which have to be archaeologically extracted from words, phrases, and propositions, could in my view be understood, then, as signifiers of a higher degree. Likewise, visibilities, which have to be extracted from objects, things, and perceptible qualities, could be designated as complex signifieds of higher order.

An awareness of such parallels, then, between the *post*-structuralist notions of signifier and signified, and Foucault's terms of statements and visibilities (which are certainly often hard to grasp), might help us to a clearer view of what fundamental insights about dissemination as a condition of possibility for knowledge that are at stake in Foucault. Knowledge is the combination, at various strata of the historical formation, of signifiers and signifieds that never conform, but still are linked, disjointed, and relinked over an irrational break or crack, as Deleuze says. This is how he summarizes:

> (...) the visible and the statement form a stratum, one that is none the less continually crossed and constituted by a central archaeological fissure (...). As long as we stick to things and words we can believe that we are speaking of what we see, that we see

---

[7] Cf. e.g. Miroslav Červenka, *Der Bedeutungsaufbau des literarischen Werks*, München: Fink, 1978, esp. pp. 93-115.

> what we are speaking of, and that the two are linked: in this way we remain on the level of an empirical exercise. But as soon as we open up words and things, as soon as we discover statements and visibilities, words and sight are raised to a higher exercise that is *a priori*, so that each reaches its own unique limit which separates it from the other, a visible element that can only be seen, an articulable element that can only be spoken. And yet the unique limit that separates each one is also the common limit that links one to the other, a limit with two irregular faces, a blind word and a mute vision. Foucault is uniquely akin to contemporary film. (65)

The two forms of possibility constantly grapple with each other, even spill over into one another in a heterogeneous battle.

Here, with another quotation from Deleuze, we can see how also he "spills over" into a language which precisely formulates the dilemma that has informed so much theory in deconstruction and post-structuralism, *since* structuralism:

> If determination is infinite how would the determinable element not be inexhaustible, since it would have a different form to that of determination? How would the visible not slip away, as something eternally determinable, when statements can determine it *ad infinitum*? How can we stop the object from escaping? (68)

Like Nietzsche, Freud, Derrida, Barthes, Lacan, Kristeva, de Man: Foucault needs to take into consideration a vantage point in order to understand, and to relate the two forms: signifier and signified, or statement and visibility, to each other.

He needs to operate with, and in, a dimension that can throw new light on the endless flowing of language, into a void where things cannot be reached. The factor that he gradually encircles, had not been paid close enough attention to by the metaphysical tradition of presence in the human sciences - it necessarily had to be a dimension of absence:

> (...) Foucault needs a third agency to coadapt the determinable and determination, the visible and the articulable, the receptivity of light and the spontaneity of language, operating either beyond or this side of the two forms. It is for this reason that Foucault said that the grappling implies a *distance* across which the adversaries 'exchange their threats and words', and that the place of confrontation implies a 'non-place' which bears witness to the fact that the opponents do not belong to the same space or rely on the same form. (The) visible figures and the signs of writing combine, but in a different dimension to that of their respective forms. (68 f.)

That dimension, to be found in Foucault's thought from the early 1970's on, but also discernible earlier (as in *BCl*), is Power, and associated with it: Death. The power of mortal forces, as the top of the triangle, imbuing and threatening the two constituent forms of knowledge, the visibilities to be described and the statements to be articulated, finally makes it clear to Foucault why the two (the signified and the signifier) never coalesce.

These forces are (as in Nietzsche) relational forces, and are as such non-places, distanced from that said and that seen, but still forming the needed *finality* of the condition of possibility which underlies the struggle, between statement and visibility, to overlap or to disseminate. With the awareness of the Power of Death, all vain hope of a "meaningful" life, where signifier covers a signified in plenitude, vanishes.

The play or the struggle, then, is, as I have argued, possible to read as one of signification, between significatory elements. Returning now to details of method in *BCl*, we can see that Foucault, in his self-reflexive comments on his method, is even utterly aware of the consequences that the never-ending play of signifier and signified, impossible to halt in an overlapping of signified plenitude, of presence, would have for his own historical and critical approach to his "object" of study.

Starting this meditation with a reference to Nietzsche (who has testified that the possibility and the necessity of a critique are linked to the fact that language exists, and that 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" (xvi)), Foucault goes on to reflect on the inescapable paradoxes of the critical *commentary*. Here his thinking is not only post-structuralist, it has much in common with deconstructionist understanding.

Commentary, questioning "discourse as to what it says and intended to say", tries to reach a deeper meaning of speech, which, paradoxically, entails that "in stating what has been said, one has to re-state what has never been said". Trying to grasp something "more archaic" by making it "more contemporary", is "to admit by definition an excess of the signified over the signifier; a necessary, unformulated remainder of thought (its essence) that language has left in the shade". And again, paradoxically, "to comment (...) presupposes that this unspoken element slumbers within speech", at the same time as the signifier may "give voice to a content that was not explicitly signified" (xvi).

In this strange way,

> 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' (...). Signifier and signified thus assume a substantial autonomy that accords the treasure of a virtual signification to each of them separately (...). (xvi)

In the commentary, "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" (xvi f.). This translation "can be substituted for itself indefinitely in the open series of discursive repetitions" (xvii).

The awareness of this paradoxical status of the commentary is, again, something that Foucault's book has in common with the somewhat later writings of Paul de Man, who has chosen the term allegory for the endless repetitions and substitutions in reading as commentary, in the readings of the endlessly receding signifieds "behind" signifiers without control. Foucault thinks of this as a century-long waiting in our culture, in vain, for the revelation, the decision of the Word (of God).

However, in spite of this insight, and in trying to found his own archaeology of the *BCI*, Foucault tries to evade the play of signifier and signified. In my reading, he here turns counter to his own just stated awareness:

> 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. (xvii)

Not the revealed and concealed intentions would then define the meaning of a statement, says Foucault, "but (...) 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". In this way, Foucault wants to establish a "systematic history of discourses" (xvii).

It would be safe enough to leave Foucault's play on the repeated argument of intentions for what it is (he has already adequately shown that a historical and critical reading *de facto* never can be concerned with intentions). Still, his argument that, in discourse analysis, meaning would be defined by a statement's difference to other contemporary statements or statements removed linearly in time, adequate though it is in itself, seems to come short of the insight shown in Foucault's earlier reflexions on commentary. For here, it seems to me, Foucault suddenly abandons his self-reflexivity, and, for a few paragraphs, even steps outside the main lines of his other *oevre*.

The statements, opposed to other real or possible statements, that he here talks about, all of a sudden belong, unproblematized, to the "object of study". For one thing, relegating now the problem of the relationship of signifier to signified to a historical "object" to be structured in its *in eventu* historical differences, does not in itself make the already discussed paradox of signification less obtrusive.

More problematic seems to be that Foucault here sees a possibility of finding in his reading of historical discourses, not heterogeneous but homogeneous overlappings of signifiers and signifieds - beyond intentions and what men have thought in connection with what they have said, and in believing that he does not in any sense repeat what men have said - without any longer reflecting on his own subjective activity in stating, and to be sure: repeating, that conjuncture.

At least *he* is removed by unbridgeable temporal and spatial distances from that conjuncture of signification that he thinks it possible to make come to light, "supposing no remainder". The distance between the perceiving subject and statements as well as visibilities, is something that his book is otherwise quite aware of. This awareness is also signalled in his self-reflexive comment that getting hold of what systematizes things said and thought, makes "them thereafter endlessly accessible to new discourses and open to the task of transforming them" (xix) - *mutatis mutandis*: including that which he himself says and

thinks, *and* that which systematizes it.

The problems of commentary, that Foucault discards in the passage in question, seem not as irrelevant to his own project as might be supposed. In apparently basing himself on the idea of looking beyond to a "region where 'things' and 'words' have not yet been separated", to "the spoken structure of the perceived" (xi), Foucault *says* he does one thing, but paradoxically, brings to the light of visibility something quite different.

Let me finally give a couple of examples from his book that his expressly stated "semiology", and that of his own practice, do not overlap. - Supposing it possible that Foucault in his major paradigms would find things and words, signifieds and signifiers, more or less completely covering each other, then one would expect the three stratified discursive structures of medical perception to be homogeneous, forming structural wholes without residue. Certainly, to an extent, and if we are not too strict in our demands of signifying elements to overlap each other, this is also the case in Foucault's study.

However, in its analyses of the three stages, one of the main concerns of the book is to show the contradictions, inherent in each historical formation, between various strata in the discursive structures, and between elements of signification and that signified by them. In a sense (and this I have referred to as one of the strenghts in Foucault's method), the study, in its practice, is out to show precisely how signifier and supposed signified do *not* overlap at the three stages in question, and instead consist of irreconcilable contradictions.

In the medicine of species, and before the rupture leading into the clinic proper has taken place, one of the fundamental contradictions is, as we have seen, that the ideal portrait of natural disease occuring in the natural surroundings of the family, sufficed for the treatment of ordinary ailments among ordinary people. But it did not at all suffice for, and came in contradictory opposition to, the requirements of configuration that "civilization", the society at large, the state, the hospital institutions, the prisons, etc. posed. All of them demanded active medicine, experiments, and an open field, since what needed to be signified did not coalesce with the extant signifier. We also remember Foucault's book showing how, for a number of years, the visibility of making the hospital into a teaching space was disjuncted from the necessary articulation of it. The structure of classificatory medicine, when we count all strata, is not stable enough to support the allegation that what signified and what was signified within it overlapped.

A similar point can be made about the clinic proper, which, as we recall, operated according to two major codes of knowledge: that of the linguistic structure of the sign, and that of the aleatory series of the case. It will also be remembered that the linguistic code yielded what was thought to be immediacy and presence of the morbid phenomena, but without internal coherence in the body. On the other hand, however, by a profound contradiction inherent in the clinic, that coherence was imported from outside: by way of

mathematical and probabilistic thinking. What is signified and what signifies it are also here dimensions that are shown to diverge.

Even in the anatomo-clinical method, contradictions inherent in the discursive structure are highlighted by Foucault's study. Let me here only mention two. There is an in principle unbridgeable opposition between positivist thinking in terms of cause and effect on the one hand, and, on the other, its contradiction in seeing the cause of an illness as the space of the illness. Another contradiction in anatomy was the opposition between holding localization of disease dependent upon concrete visibility, as opposed to the inverted structure, which occurred within pathological anatomy itself, of giving localization in space priority over visibility.

My own perspective on Foucault's epistemology in *BCl*, and here I return to my opening question in this chapter, is to answer that question positively. To my mind, Foucault's archaeology is built up around a "semiology" of modernity, to be found in its earliest rudiments also in the medicine of clinical anatomy at the very beginning of the 19th century. It operates with spatial figures and differential relations as important axioms, breaking with structuralism's believed-in centricity of sign and structure. Foucault's "semiology", then, becomes in effect a "rhetoric" which, at least in some aspects concerning the understanding of the sign that I have dwelt somewhat by above, puts him on a par with thinkers like Derrida and de Man (although he himself would not necessarily have granted the comparison).

It is one of Michel Foucault's merits, by way of a complex discourse analysis that in its practical aspects has a lot to yield, to have shown that modernity (in the epistemological sense that I have used that word in this paper), in effect comes into its own "self-consciousness" close to a hundred years earlier than it has been usual to assume.

In Foucault's construction, positivism, which is introduced with the anatomo-clinical method through the new awareness of death and "the Law, the harsh law of limit" (198), gets a radically new assessment. Foucault is aware that the changes in the early 19th century in human experience that he has depicted, "go well beyond what might be made out from a cursory reading of positivism" (199). But through a vertical reading of positivism, which is precisely what Foucault does in his analysis of various discursive strata, then elements in positivism become visible that we thought belonged to science and the human sciences of a much later stage, and which have even functioned as elements in the critique of positivism. Then

> one sees the emergence of a whole series of figures - hidden by (positivism), but also indispensable to its birth - that will be released later, and, paradoxically, used against it. In particular, that with which phenomenology was to oppose it so tenaciously was already present in its underlying structures: the original powers of the perceived and its correlation with language in the original forms of experience, the organization of

> objectivity on the basis of sign values, the secretly linguistic structure of the datum, the constitutive character of corporal spatiality, the importance of finitude in the relation of man with truth, and in the foundation of this relation, all this was involved in the genesis of positivism. (199)

Certainly, there are aspects of this positivism that are epistemologically problematic, and that Foucault does not touch upon in his study - I am thinking of the series of instrumental techniques, the problematic status of objectivity and the independent research subject, and the way positivist research has been thought of as contributing to the mythically endless project of enlightenment and modernization. However, Foucault is concerned with bringing out those aspects of nascent positivism that have been drowned in the myth, but that all the same have functioned as constituting elements of our modern experience.

I think Foucault is right in holding that that experience could never have been shaped without the stronghold of Death and the Law of finality facing man. Not that man has become more "free" from the shift in assessment and experience of limit that occurred almost two centuries ago. But as that "truth" has dawned upon him (and Foucault shows how that process has been underway for a long time), man has, perhaps, in the structuring of his knowledge, become better equipped to fight the authoritarian bondage he is held in by those discourses that say he is.