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RETHINKING REPRESENTATIONS OF HEALTH AND DISEASE:
FOUCAULT, CANGUILHEM, AND THE U.S. CENTER FOR DISEASE CONTROL
REPORTS ON AIDS

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RETHINKING REPRESENTATIONS OF HEALTH AND DISEASE:
FOUCAULT, CANGUILHEM, AND THE U.S. CENTER FOR DISEASE CONTROL
REPORTS ON AIDS

by

Jacob Peter Neal

A Thesis

Submitted in Partial Fulfillment of the

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Major: Philosophy

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ABSTRACT

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This project explores the representation and conceptualization of health and disease through the historical analyses of Michel Foucault and Georges Canguilhem. By tracing the historical emergence and formation of certain concepts of disease and health from the eighteenth and nineteenth centuries, their thought provides the groundwork for an investigation of our contemporary representations of a distinctly modern disease—acquired immunodeficiency syndrome (AIDS). The first two chapters extract from this philosophical and historical work the theoretical basis for an analysis of the language and representation of AIDS. The final chapter then analyzes the U.S. Center for Disease Control (CDC) publications on AIDS in the late twentieth century in these theoretical terms. The thesis argues that the contemporary theoretical basis for CDC representations of AIDS should be understood in terms of their relation to past theories of disease.

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LIST OF ABBREVIATIONS

References

Georges Canguilhem

NP *The Normal and the Pathological* (Urzone, 1991)

Center for Disease Control (CDC)

MMWR *Morbidity and Mortality Weekly Report*

Michel Foucault

A *Abnormal* (Picador, 1999)

BC *The Birth of the Clinic* (Vintage, 1994)

HM *History of Madness* (Routledge, 2006)

HS *The History of Sexuality, Vol. 1* (Vintage, 1990)

Medical Terminology

AIDS acquired immunodeficiency syndrome

HIV human immunodeficiency virus

KS Kaposi's Sarcoma

OI opportunistic infection

PCP *Pneumocystis carinii* pneumonia

INTRODUCTION

The concept of disease is neither concrete nor stable. It emerges within a particular epoch, structures recognition and knowledge for a time, and then morphs into something new or disappears entirely. When a new theory of disease comes to dominance, it alters our subjective experience and awareness of both disease and health. It even modifies our perception, changing what manifests as disease before the medical gaze. What was once classified as disease slowly evolves or suddenly vanishes, and novel configurations and manifestations of disease appear before the gaze. Indeed, the very landscape of health and disease transforms alongside our theories.

For those committed to the rationalist and realist projects of modern science, turning around to retrace the history of medical concepts may seem an unnecessary detour. Shifting our focus from the future before us to the past behind may seem to stall the progress of modern science and medicine and hinder the development of novel treatments and therapeutic interventions. If the theoretical advances of science have nothing to do with the social and political milieu from which they emerge and if the development of medical and scientific theories necessarily converges with the truth of the world, then a return to history would be both a superfluous and frivolous enterprise, one fit for historians and perhaps philosophers, but not for scientists and physicians. However, if we take seriously the insights of Nietzsche's perspectivism, then our world opens up onto a new range of perspectives and possibilities. We live in an age where our past informs our present, truth is not to be discovered within the fabric of the world, and the most productive projects are ones not of discovery but of redescription. In this post-

Nietzschean world, historicist thinkers destabilize our own systems of thought and encourage us to consider alternate ways to make sense of our world.

This project is about the configuration of disease and the language of our theories of disease and health. It is an analysis of some historical concepts of disease deployed by the sciences of medicine and pathology from the eighteenth, nineteenth, and twentieth centuries. In this work, I turn my attention to the thought and analyses of two historical thinkers, Michel Foucault and Georges Canguilhem. These two thinkers develop both historical and critical analyses of the systems of thought that undergird and maintain the shifting perspectives and theories of health and disease invoked by medicine in the past three centuries. By extracting and developing some key concepts from within their works, I aim to provide the tools to understand and reconsider the language and configuration of a distinctly modern disease—acquired immunodeficiency syndrome (AIDS). The current project discovers within Foucault’s and Canguilhem’s critical and descriptive works on health and disease a set of potential tools to help us make sense of the historical formation and emergence of the medical theory that underlies the contemporary discourse surrounding AIDS and the human immunodeficiency virus (HIV).

A caveat on method: the current project is largely a historically conceptual, or genealogical, one. Through consideration of the work of Foucault and Canguilhem, I seek not to locate transhistorical concepts of disease that must pertain to the contemporary phenomenon of HIV and AIDS, but, rather, I seek historical concepts in order to both understand and problematize our current configuration of this disease. That is, I have no *a priori* knowledge that the historical concepts that seem to me to hold the most potential for this project, which I develop in the first two chapters of this work, will have any

fruitful points of overlap with the contemporary medical and scientific discourses on HIV and AIDS. I have neither the time nor the space within this work to fully develop all the connections and draw out all the resemblances and similarities between the historical concepts presented by Foucault and Canguilhem and the modern medical and scientific discourse surrounding HIV and AIDS. Despite this methodological lack of assurance, I believe both points of congruence and divergence between historical theories of disease and the modern configuration of HIV and AIDS will prove interesting and fruitful.

This work does not address the tremendous body of secondary literature developed in and around the concept and theories of AIDS and HIV arising in the last quarter of the twentieth century. Nor does it enter into the methodological debates surrounding the work of these two historical thinkers, particularly Foucault's work with historical systems of thought. Rather, I focus exclusively on the work of Foucault and Canguilhem regarding the historical development of medicine and science. By devoting the majority of my theoretical attention to a close reading of their work, I provide the foundation for the further development of thought on this contemporary disease from the perspective of these two thinkers.

For the remainder of this introduction I briefly sketch out the structure of this work. In Chapter 1, I begin with a focused consideration of some concepts arising from Canguilhem's text *The Normal and the Pathological*. These include an assessment of three theories of disease (the ontological, functional, and positivist theories) a characterization of the point of view adopted by these theories, and a consideration of the historical development and deployment of the concepts of the biological and physiological norm by nineteenth-century positivists. In Chapter 2, I turn to the work of

Foucault. In the first section, through an analysis of *The Birth of the Clinic*, I recount the transition and epistemic rupture that reorganized medical knowledge at the close of the eighteenth century. I then turn to Foucault's discussion of the concept of the condition. For this section, I consider his analysis of the concept of the condition formulated by forensic psychiatry in the latter half of the nineteenth century in *Abnormal*, along with Foucault's analysis of two specific conditions: (1) the historical figure of the madman in *History of Madness* and (2) the historical emergence of the homosexual in *The History of Sexuality*. Then, in the third section, I extract Foucault's description of the dangerous individual from *Abnormal*.

In the final chapter, Chapter 3, I shift my focus to the medical and scientific discourse that emerged in the last quarter of the twentieth century surrounding HIV and AIDS. Since the contemporary literature on these phenomena is virtually boundless, I restrict my analysis to the discourse arising from the U.S. Center for Disease Control (CDC). Throughout what has come to be called the AIDS epidemic of the late twentieth century, the CDC has published the most up-to-date epidemiological and pathological information about the virus and the disease in its weekly publication, *Morbidity and Mortality Weekly Report (MMWR)*. In the United States, the CDC assimilated and disseminated the clinical findings of physicians across the country and the results of cutting-edge research on the virus and the syndrome. This agency also took charge in the implementation of surveillance and disease prevention programs. In addition to developing the case definition and the standard practices for HIV and AIDS reporting and surveillance, the CDC produced the first documents offering guidelines for the treatment of AIDS and the corresponding opportunistic infections (OI). Because of its critical role

at the intersection of both public health and therapeutic intervention and its mediating function between the physician and the research scientist, the CDC in its weekly publication offers a unique site of analysis. Although other discourses emerged from other outlets, the CDC's *MMWR* presents a cross-section of the dominant discourses on HIV and AIDS within both the scientific and medical communities.

Through this examination of historical concepts of health and disease and their application to our modern conceptions, this project aims to shed new light on the contemporary phenomena of HIV and AIDS. By unearthing the origins of our contemporary theories of disease, this work hopes to afford a glimpse of our own structure of knowledge as one that emerged historically and will one day more than likely be supplanted by a new structure yet to come. Following Foucault, this work ultimately aims to demonstrate that the theoretical configuration of HIV and AIDS that emerges from the CDC discourse at the turn of the last century is “only one way” to conceptualize disease and “in all likelihood neither the first, nor the most fundamental.”¹

¹ Michel Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception*, trans. A. M. Sheridan Smith (New York: Vintage, 1994), 3 (hereafter cited in text as *BC*).

CHAPTER 1

CANGUILHEM: THE EXPOSITION OF CERTAIN CONCEPTS

1.1 Three Theories of Disease

In Part I of his 1943 *Essay*, Canguilhem introduces three theories of disease that have influenced medical thought and practice from the time of Hippocrates until the nineteenth century: the functional, ontological, and positivist.¹ Two of these—the functional and ontological theories—share the vision of disease as a polemical situation, a struggle between opposing forces. On the one hand, functional theories totalize the phenomenon of disease and establish it at the level of the total organism. Under this conception, neither an organ nor a tissue can become sick; rather, the organism experiences sickness in its entirety. Disease is therefore a sign of hope, since it signals the restoration of the balance of the body via its own natural, internal mechanisms of healing. Ontological theories, on the other hand, do not situate sickness at the level of the total organism. Instead, sickness lodges itself *somewhere* within the body, and it remains the task of medicine to first locate and then expel it. Under this conception, the possibility of medicine and therapeutic intervention rests on the ability of the physician to localize the disease in order to direct her efforts. In this way, ontological theories disavow nature and put their faith in therapeutic and technological intervention. Despite their striking differences, both of these theories maintain health and disease as separate entities. The lived experience of both health and disease confirms the qualitative difference between the two. Whereas these two representations of disease have existed and competed since

¹ Georges Canguilhem, *The Normal and the Pathological*, trans. Carolyn R. Fawcett (New York: Urzone Inc., 1991), (hereafter cited in text as *NP*).

antiquity, the eighteenth century saw the formulation of a new theory: the positivist conception of disease. Like the ontological theory before it, the positivist conception seeks rational and effective medical intervention. To this end, it recasts health and disease not as antipodal forces, but as quantifiable variations in one and the same normal physiological process. From the perspective of medicine, the pathological and normal become homogeneous, the former reduces to the latter. Although it seems qualitatively different from health, the lived experience is nothing but illusion. In reality, the positivist theory asserts, disease and health stand to one another as a relation of identity. This section expounds and clarifies these three theories of disease presented by Canguilhem so that we may recognize the fragments of these theories as they are deployed in contemporary scientific and medical practices.

1.1.1 The Functional and Ontological Theories

The Greek tradition, founded upon the writings and teachings of Hippocrates, represents disease as a dynamic phenomenon of disequilibrium and imbalance. According to this conception, the healthy body is one that is in harmony with both itself and nature. Four humors with opposite qualities of wet/dry and hot/cold maintain this fluid equilibrium through regular fluctuations, with each counteracting and stabilizing the changes in its opposite. The term ‘disease’ describes “the disturbance of this harmony, of this equilibrium” (*NP*, 40). Represented in this way, disease is not localized to a particular part of the body. Just as the dissonance produced by an out-of-tune instrument destroys the entire melody, disease destroys the harmony of the total body. However, as Canguilhem notes, in the Greek tradition disease is “not simply disequilibrium or

discordance,” but more importantly, it is nature’s attempt to recreate harmony and establish a new equilibrium in the body. A body becomes sick, not in virtue of some external cause, but rather because its internal equilibrium has been lost. In this sense, disease is the mechanism of renewal and restoration; it is the “generalized reaction” of the total body aimed to restore the body to its proper balance, that is, “to bring about a cure” (*NP*, 41).

This functional, totalizing theory of disease greatly affects the goal of medicine. If disease is nature’s own therapy, then any therapeutic intervention that counteracts it will be a hindrance to the reestablishment of equilibrium and health. Human medicine, therefore, must imitate the action of nature, by augmenting and extending the natural tendencies and movements. German poet Heinrich Heine expresses this relationship between disease and cure in his account of God’s reason for creation:

Illness was no doubt the final cause
of the whole urge to create.
By creating, I could recover;
by creating, I became healthy.

(Heine, *Neue Gedichte*, “Schöpfungslieder VII”)

For Heine’s God, his disease carries within itself the impetus toward the creation that is also its cure. God knows not to subvert but to follow the “urge” brought on by disease to reestablish equilibrium and recover his health. Like Heine’s God, the doctor does not interfere with the progression of the disease but, instead, helps it along its course. The optimism in this conception of disease lies in a faith in nature. Disease is not to be feared, for it, in itself, is the cure.

By contrast, ontological theories of disease, prevalent at least since the golden age of ancient Egypt, attempt to localize the pathological phenomenon in order to act against

it. An ontological conception of disease must pinpoint the site and source of the problem in order to direct the medical intervention. While also optimistic, these theories place faith not in nature but instead in medical and technical means. As an ontological fact opposed to the healthy state, disease must enter the body “as through a door” (*NP*, 39). This metaphor again casts disease in a reassuring and hopeful light but for a different reason than did Greek medicine: “what man has lost can be restored to him, and what has entered him can also leave” (*NP*, 39). Whatever disease takes possession of the body, once effectively localized and circumscribed, it can be potentially cast out. Under this conception, diseases can be ranked “based on the extent to which symptoms can—or cannot—be readily localized”; hence, the more localizable the symptoms, the more real the disease (*NP*, 39).

According to Canguilhem, the prevalence of these localizing, ontological conceptions of disease leading up to the nineteenth century accelerated the reception of Pasteur’s germ theory of contagion, since his theory “embodies an ontological representation of sickness” (*NP*, 40). With the aid of diagnostic technologies, a microbe or virus can be seen and distinguished from the human body. Unlike the Greek humors and the miasmas thought to contribute to disease, the germ has its own separate existence and being. Because it reinforces the connection between visibility, with its corresponding localizability, and therapeutic intervention, Pasteur’s germ theory supports and enables action: “To see an entity is already to foresee an action” (*NP*, 40). The germ theory of contagion shares the motivating impulse Canguilhem locates behind all ontological theories of disease—an optimism and faith in medical and technical intervention.

These two opposing theories of disease have alternately dominated medical representations of the pathological from the time of Hippocrates through the eighteenth century. Both the totalizing conception founded upon Greek thought and the localizing one reinforced by the work of Pasteur afford a certain optimism to the scientific discipline of pathology. This optimism lends medical thought a “good reason” for utilizing “one or the other attitude,” that is, either the totalizing or localizing theory, in the explanation of new diseases (*NP*, 41). Of course, medical thought identifies a tendency toward one theory or the other within the diseases themselves: “Deficiency diseases and all infectious or parasitic diseases favor the ontological theory, while endocrine disturbances and all disease beginning with *dys*- support the dynamic or functional theory” (*NP*, 41). Despite their differences, however, both theories understand disease as “a polemical situation” (*NP*, 41). Disease is a struggle, a contest, between a pathogen or foreign substance and an organism or among internal opposing forces within a body. For both theories, the relation between the normal and the pathological phenomenon is qualitative. That is, in both configurations of disease, the pathological state is radically distinct from the normal physiological state. The normal and the diseased state are heterogeneous, defined by the presence or absence of a pathogen or toxin in the case of the localizing, ontological conception or by the modification of the entire organism in the case of the functional, totalizing representation. Whether the theory leads humans to place their faith and hope in nature or medical intervention, as originally formulated, both the localizing and totalizing theories of disease maintain a stark qualitative divide between the normal and the pathological, and this simple fact grants

them a certain affinity toward each other over and against the positivist conception of disease.

1.1.2 The Positivist Theory

Developed in the eighteenth century, the positivist conception of disease arose from an attempt to ground pathological phenomena within the normal physiology. Like the localizing, ontological theory of disease, the positivist conception has an eye toward technical and therapeutic intervention. In order to build a science of the pathological upon a firm, rational foundation, proponents of this theory of disease characterized the difference between the pathological and the normal as a matter of degree. According to Auguste Comte and Claude Bernard, the two “standardbearers” of this theory in nineteenth-century France, disease and health are linked together on a quantitative scale (*NP*, 46).

Although Canguilhem forcefully argues against this conception of disease, he finds within the concurrent ideas a motivating impulse behind this theory.² The normalizing desire to “compel nature and bend it” away from the pathological back toward the normal requires a clear linkage between these two seemingly different

² Canguilhem, a careful philosopher of science, offers a note on his method:

The thesis whose meaning and importance we are trying to define [i.e., the positivist theory of disease] has not been invented for the sake of the cause. The history of ideas cannot be superimposed perforce on the history of science. But as scientists lead their lives as men in an environment and social setting that is not exclusively scientific, the history of science cannot neglect the history of ideas. (*NP*, 46)

From this methodological caveat, we cannot understand Canguilhem to be forcing the history of science into the framework established by the ideas of the time. He assumes no direct causality between the history of ideas and the history of science. Instead, he finds it useful—and even necessary—to trace out the influences and overlap between the science of a historical epoch and its ideas, beliefs, and motivations.

phenomena (*NP*, 41). Thus, if the physician is to have any hope of helping the sick person, she must understand the relationship that ties the pathological to the normal state. Effective intervention demands the elucidation of this relationship. This theoretical need, necessary for the establishment of a purely scientific pathology, led researchers to link pathology to physiology. Canguilhem traces this evolution in thought through Morgagni, who discovered that certain physiological and anatomical lesions corresponded to stable, visible symptoms, leading him to conclude that disease has its basis in physiology. Through the work of Morgagni, “nosographical classification found a substratum in anatomical analysis” (*NP*, 42). Defects in normal anatomy (i.e., pathological anatomy) result in disease, just as health discloses the underlying normal anatomy. From the work of Morgagni and other eighteenth-century scientists, “pathology became a natural extension of physiology” (*NP*, 42). With the link between physiology and pathology secured, pathology required only one further step in order to become completely rationalized. According to Canguilhem, this final step culminated in the positivist theory of disease,

a theory of the relations between the normal and the pathological, according to which the pathological phenomena found in living organisms are nothing more than quantitative variations, greater or lesser according to the corresponding physiological phenomena. (*NP*, 42)

Through this evolution in medical thought, a positivist conception of disease came to prominence in pathology in the nineteenth century.

As expounded by Comte and Bernard, this new conception of the pathological distances itself from both the totalizing (functional) and localizing (ontological)

representations of disease.³ Whereas both previous theories envisaged disease as a battle between “qualitatively opposed” forces, the positivist conception considers disease as one end of a continuum that connects the normal and the pathological (*NP*, 42). Disease is not antithetical to health; it is a mere quantitative modification of it. As Canguilhem notes, this quantitative relation between the normal and the pathological essentially collapses the distinction back upon itself. The positivist theory, which interprets pathological phenomena as nothing but an excess or deficiency in relation to the normal state, attempts to “annul the pathological” (*NP*, 43). In this account, the lived experience of disease has no place, and the qualitative difference in experience between sickness and health is not reality but a mere appearance. More than existing together on a continuum, according to Bernard, the normal and the pathological exist in a relation of identity: “health and disease are not two essentially different modes.”⁴ Any supposed qualitative difference is relegated to the level of appearance since at the level of reality there exists an essential sameness between the normal and pathological phenomena. Despite its affinities to the ontological theory of disease in its goal of medical intervention, the positivist account denies any real difference between sickness and health and reduces pathological phenomena to the normal physiological state.

Although these three theories of disease are distinct representations of the phenomenon of sickness and are developed as independent theories, their points of convergence and divergence allow some to be deployed as correctives to others. For

³ In this section, I will only briefly sketch the main tenets and ramifications of the positivist conception of disease in order to distinguish it from the previous two theories. In section 1.2 “Point of View,” I will address this theory in more detail.

⁴ Claude Bernard, *Leçons sur la chaleur animale* (Paris: J.-B. Baillière, 1877), 391, quoted at *NP*, 71.

instance, Canguilhem argues against the positivist conception of disease in favor of a qualitative distinction between the normal and the pathological. Referring back to the 1943 *Essay* at the end of *The Normal and the Pathological*, Canguilhem summarizes his earlier work as a comparison of “the ontological conception of disease ... with the positivist conception” (NP, 275). In this dichotomy, Canguilhem obviously sides with the ontological conception. However, while forwarding his claims, he continually deploys totalizing representations and metaphors from the functional theory of disease to correct what he views are the localizing tendencies within the ontological conception. To a certain extent, he retrospectively classifies both the functional and ontological theories as “ontological” to emphasize their opposition to the quantitative reduction of the pathological to the normal in the positivist conception. Although this is merely one example, it illustrates the crucial point that these three theories of disease can be regrouped, reconfigured, and redeployed to describe new phenomena of pathogenesis.

1.2 Point of View

Canguilhem’s analysis of the ontological and positivist theories of disease invokes a slew of dualisms—qualitative–quantitative, value–fact, appearance–reality, subjective–objective—all of which emphasize the perspectival aspect of the theoretical concepts, both normal and pathological. The ontological and positivist theories adopt a point of view either of the subjective experience of the sick person or of the objective determinations of theoretical pathology. The positivist conception of disease, which receives the brunt of Canguilhem’s criticism, adopts the latter stance. By reducing disease to a quantitative variation of normal physiology, it maintains the qualitatively different

experiences of sickness and health in the living body are mere appearances masking the underlying reality—the homogeneity of the normal and the pathological. For Broussais, Comte, Bernard, and Leriche the subjective point of view inherent in the ontological theories has no place within an analysis of disease; the positivist conception to which they adhere aims to excise all traces of subjectivity. However, as Canguilhem’s analysis demonstrates, this attempt to develop a purely objective pathology fails. According to Canguilhem, the very nature of the phenomenon of disease, and of life in general, resists formalization and objectification. At the foundation of the positivist theory of disease remains an ineradicable core of the subjective experience of the living organism.

1.2.1 The Objective Point of View: Broussais, Comte, Bernard, and Leriche

The desire for the rationalization and mathematization of knowledge in the eighteenth and nineteenth centuries led pathologists to formulate a purely objective conception of disease. By linking the pathological to the normal physiology and denying any qualitative difference between the two, these thinkers attempted to develop a concept of disease that excluded all subjectivity. In fact, however, they succeeded in developing a theory that only purported to be purely objective by stubbornly overlooking the role of the subjective in theoretical conceptions of disease.

The positivist conception of disease as developed in the nineteenth century by Comte and Bernard strove for pure objectivity. Maintaining the “real identity” of the pathological and corresponding physiological phenomena, this theory invokes the subjective–objective distinction in order to reify the latter and discount the former (*NP*,

47).⁵ Although at odds with the human experience of disease, this conception establishes a parallel between the subjective–objective points of view and the philosophical appearance–reality distinction. The scientific perspective thus grasps the true reality of the phenomenon of disease, whereas the patient’s limited point of view cannot pierce through the appearance (e.g., the experience of pain or eroding function) to perceive the underlying reality. Despite the apparent difference and “opposing values” accorded to the normal and the pathological by the living being on this account, these phenomena are essentially identical, differing in degree but not in kind (*NP*, 43). The truth of disease is to be found in the principle developed by Broussais and adopted by Comte in which diseases “are only symptoms,” the expression of underlying lesions in the organs and tissues (*NP*, 47). Since diseases are merely superficial symptoms or epiphenomena, the subjective experience of disease does not grasp the physiological reality. In reality all diseases, according to Broussais, are therefore nothing more than an “excitation in various tissues above or below the degree established as the norm” (*NP*, 47-48). The disease or “symptoms” experienced by the patient are epiphenomena that point to the “simple changes in intensity” of the corresponding physiological phenomena (*NP*, 48). Through recourse to Broussais’ principle, the positivist conception of disease attempts to reduce the subjective perspective of the patient to the objective perspective of the physician.

⁵ Canguilhem culls this discussion of the real or essential identity of the pathological and physiological phenomena directly from Bernard’s formulation of the positivist theory. According to Canguilhem, it is an attempt on the part of the positivist thinkers to annul the subjective experience of disease. The qualitative difference experienced by the sick organism is nothing but appearance. This theory claims to move beyond this appearance to the level of reality, which reveals the essential relation to be one of identity. However, as I will note later, even this theory itself was unable to consistently deny any and all qualitative distinctions between health and disease.

Although it excludes subjective, qualitative differences from consideration, this theory, which aims to establish the essential identity of the pathological and the underlying physiology, permits, or rather demands, a quantitative differentiation between health and disease. The necessity for a quantitative scale of physiological functions arises from the disavowal of any real qualitative distinction. According to Canguilhem, the quantification and development of a continuum of phenomena is a logical necessity if the positivist theory is to retain the concept of the pathological, even if it only admits of pathological phenomena on the level of appearance. He affirms, “Logically speaking, it is quite correct that an identification of phenomena, whose qualitative differences are considered illusory, takes the form of a quantification” (*NP*, 61). This “assertion of identity” and denial of any real “qualitative difference” between the pathological and physiological phenomena “must lead” to the assertion of “a homogeneity capable of expression in quantitative terms” (*NP*, 53).⁶

Although Comte never quite made this final step, Bernard was fully aware of this logical demand. In his work on diabetes, he elaborates the positivist theory and its ramifications for the understanding of disease. Following Broussais and Comte, he affirms the identity of the pathological and the corresponding physiological phenomena: “Physiology and pathology are intermingled and are essentially one and the same thing.”⁷ He continues, “Every disease has a corresponding normal function of which it is only the

⁶ As the following section will address, Canguilhem argues this attempt to reduce the pathological to the normal is destined for failure. Nevertheless, he recognizes the logical conditions that must be met if one were to attempt to maintain this assertion of identity between the pathological and physiological phenomena, and still have a role for pathology.

⁷ Claude Bernard, *Leçons sur le diabète et la glycogénèse animale* (Paris: J.-B. Baillière, 1877), 56, quoted at *NP*, 67.

disturbed, exaggerated, diminished or obliterated expression.”⁸ Thus, for Bernard, disease is nothing new to the organism; it is not “an extra-physiological entity” (*NP*, 68). At this point Bernard surpasses Comte in his analysis, for in addition to asserting the identity of the pathological and the physiological, he demonstrates the possibility of quantitative differentiation between the normal and the pathological. Although the pathological is “essentially” identical to the normal physiology, they can be measured and ordered by the “intensity which varies in the normal state and in the diseased state.”⁹ Bernard’s formulation thus permits the retention of the distinction between the normal and the pathological while creating a continuum of normal and pathological phenomena, which purportedly ensures an entirely objective criterion for disease.

To bolster his assertion of continuity, Bernard portrays this continuum between the normal and the pathological as an offshoot of his mechanistic commitment to the continuity of life and death. The relation between life and death or organic and inorganic is analogous to the relation between health and disease. According to Bernard, “health and disease are not two essentially different modes,” and neither are the organic and the inorganic.¹⁰ Both conceptual pairs are not different in kind but, rather, differ solely in degree. Canguilhem finds support for this interpretation of Bernard’s thought in Bernard’s response to two Italian physiologists who attempted to establish a qualitative distinction between life and death. These physiologists disputed Bernard’s findings that the heat generated upon the severing of a vital nerve was a mere variation in the normal physiological heat. On the contrary, they held that the heat produced was “morbid” and

⁸ *Ibid.*, quoted in *NP*, 68.

⁹ Bernard, *Leçons sur le diabète et la glycogénèse animale*, 65-66, quoted at *NP*, 68.

¹⁰ Bernard, *Leçons sur la chaleur animale*, 391, quoted at *NP*, 71.

“different in every respect from physiological heat,” since it originated in a different kind of combustion (*NP*, 72). Bernard chastises the Italians for failing to recognize the

“universal applicability” of the determinist laws of nature (*NP*, 73):

In reality, physico-chemical manifestations do not change in nature, whether they take place inside or outside the organism, in a healthy or diseased state. There is only one kind of calorific agent; whether it is produced in a furnace or in an organism it is none the less the same. There cannot be physical heat and animal heat, still less, morbid heat and physiological heat. Morbid animal heat and physiological heat differ only in degree, not in their nature.¹¹

In this response, Bernard argues by analogy to support his assertion of the continuity of the normal and the pathological. The heat produced from a normal and a pathological process follow the same mechanistic laws, just as normal and pathological phenomena in the living being follow the same laws of physiology.

According to Canguilhem, this argument lacks force since it neglects to consider the two different points of view at stake: the point of view of the living being and that of the function under consideration. Utilizing Bernard’s example of glycosuria (excretion of sugar in the urine) in the diabetic patient, Canguilhem extracts these two points of view. On the one hand, if one considers the function or mechanism “in itself,” then glycosuria can be expressed as a difference from the normal physiological glycemia as a simple excess, a difference in quantity which surpasses a certain threshold (*NP*, 78). When considered in this light, Bernard’s claim is perfectly accurate. The physical and chemical laws governing this particular function do not admit discontinuities or variations. On the other hand, if one considers glycosuria as the living being’s “principle symptom” of diabetes, then the pathological state is not an extension of the physiological state, but rather “a new quality” entirely (*NP*, 78). This failure to account for both the objective and

¹¹ *Ibid.*, 394, quoted at *NP*, 72.

subjective points of view renders Bernard's theory "inadequate and incomplete" (*NP*, 82). As Canguilhem's analysis reveals "we have a pathological phenomenon which can be defined in terms of quality or quantity depending on one's point of view" (*NP*, 79). By overlooking the subjective point of view, the positivist conception of disease as developed by Bernard offers no solution to this ambiguity. For the positive conception of disease, the question of how to adjudicate between the two points of view never even arises, since it does not recognize any real distinction between the two.

Despite the development of the positivist conception of disease from Broussais' principle through Comte to its logical culmination in Bernard, Canguilhem argues, this theory fails to establish a purely objective pathology. According to Canguilhem, Bernard's formulation does not meet even the strictly logical demands of the theory. He objects to the claim that the continuity of the physiological and pathological phenomena ensures their homogeneity. On the contrary, Canguilhem asserts, "The continuity of the middle stages does not rule out the diversity of the extremes" (*NP*, 56). In other words, it may be possible to measure pathological and physiological states according to intensity and situate them on the same quantitative continuum while nevertheless maintaining a real qualitative difference between the two. In support of his criticism, Canguilhem points to the inability of the proponents of the positivist theory to sustain the language of identity and homogeneity throughout their works. Even the standardbearers of the theory sometimes slip into language suggestive of a qualitative distinction between physiological and pathological phenomena. For example, Broussais writes of diseases, "[they] increase, decrease, interrupt, [and] corrupt," slipping from the quantitative language of intensities—*increase, decrease, interrupt*—to the value-laden, qualitative

notion of corruption.¹² Canguilhem points out similar instances in both Comte and Bernard, highlighting their inability to categorically exclude qualitative distinctions between the pathological and the physiological.¹³ Furthermore, Canguilhem exposes the futility of the positivist attempt to render the study of the pathological purely objective without a means to objectively define the normal. This insight brings to light a “serious gap” in Comte (and also Bernard) since his account of disease “provides no criterion which would allow us to know what a normal phenomenon is” (*NP*, 53). To uphold their purportedly objective conceptions of disease, these thinkers need to prove both that a purely objective definition of the normal is possible and that “all the differences between the normal state and the pathological state could be expressed in quantitative terms” (*NP*, 57). According to Canguilhem’s analysis, the positive conception of disease fails on both counts and thus falls short of pure objectivity.

The positivist theory of disease advanced by Broussais, Comte, and Bernard is not simply a chapter from an obsolete history of nosology. The reverberations of this early nineteenth-century theory were still felt when Canguilhem published his *Essay* in 1943. In fact, René Leriche, who occupied Bernard’s chair of medicine at the Collège de France at that time, maintained committed to further developing the positivist conception of a purely objective pathology, according to Canguilhem. Even though he at first defines disease as “what irritates men” and “what makes them suffer,” Leriche offers an account of disease that, in the same vein as his predecessors, invalidates the point of view of the

¹² François-Joseph-Victor Broussais, *Traité de physiologie appliquée à la pathologie* (Paris: Mlle. Delauney, 1822-23), 114, quoted at *NP*, 56.

¹³ See *NP*, 56 and *NP*, 76 for examples of this slippage from quantitative to qualitative language in Comte and Bernard, respectively.

living organism.¹⁴ Unlike the nineteenth-century pathologists, Leriche does indeed recognize both the subjective and objective perspectives under which disease makes its appearance, yet, according to Canguilhem, he immediately hierarchizes them, privileging the objective, “for this definition of disease is that of the sick man, not that of the doctor; and valuable though it is from the point of view of awareness, it is not the point of view of science” (*NP*, 92). The critical problem with endorsing a subjective point of view in an analysis of disease for Leriche is the prodigality and superfluity of the human body: the body contains more kidneys than necessary for the secretion of urine, more liver than required for the purification of the blood, more lungs than needed for respiration, etc. This overabundance of organs and tissues performing the same functions creates a temporal delay in the conscious awareness of a disturbance in the body. Thus, for the sake of an objective pathology, according to Leriche, disease “must be dehumanized.”¹⁵ This conclusion leads Leriche back to the objective perspective adopted by Broussais, Comte, and Bernard in which the conscious experience of disease by the organism is merely an epiphenomenon or symptom of an underlying “anatomical alteration or physiological disturbance” (*NP*, 92). On this account, the appearance of the disease in consciousness is a bona fide sign of the reality of disease on the physiological level, but it is not a necessary and sufficient condition. As Canguilhem notes, Leriche’s dehumanized definition of disease does not require any conscious awareness. Since the reality of disease resides at the level of tissues, it is completely plausible to have disease without a sick person. By eschewing the perspective of the sick person, Leriche’s theory, in its

¹⁴ René Leriche, “Introduction générale”; “De la santé à la maladie”; “La douleur dans les maladies”; “Où va la médecine?” *Encyclopédie française* vol. 6, 1936, 22-23, quoted at *NP*, 91.

¹⁵ *Ibid.*, quoted at *NP*, 92.

attempt to rationalize medicine and therapeutic techniques, ironically creates diseases where there were previously none: “The disease which never existed in the man’s consciousness begins to exist in the physician’s science” (*NP*, 92). For Leriche as for his predecessors, the objective perspective of the scientist and physician has the exclusive dominion over the reality of disease and thus necessarily overrides any consideration of the subjective perspective, which fails to move beyond the appearance to the fundamental reality of disease.

1.2.2 The Subjective Point of View: Canguilhem

In his critique of positivist pathology, Canguilhem attempts to counter the pervasive trend in that discipline which discounts the point of view of the living organism. Siding with the subjective perspective of disease, he argues that the positivist dream of a purely objective pathology is impossible. Disease, according to Canguilhem, is a totalizing phenomenon, which occurs only at the level of consciousness. Although the theoretical pathology of Broussais, Comte, Bernard, and Leriche aims to dehumanize disease, Canguilhem claims the subjective, human perspective forms an ineradicable core upon which any science of disease must be founded. The positivist conception of disease tries to distance itself from clinical practice, but, as Canguilhem demonstrates, even this objective pathology requires the subjective experience to differentiate the normal from the pathological.

Responding to the question of point of view raised but unanswered by Bernard’s analysis, Canguilhem argues that the subjective point of view is primary within this conception of disease. He supports this conclusion through his reassessment of glycosuria

in diabetics. The pathological phenomenon of glycosuria permits both a quantitative and a qualitative description. Depending upon the point of view (i.e., that of the patient or physician) and level of the observation (i.e., that of the total organism or tissues), this pathological phenomenon presents itself in two different guises; it *appears* completely differently. In order to adjudicate between these two points of view, can we not follow the nineteenth-century pathologists and fall back upon the appearance–reality distinction? By invoking this perennial philosophical distinction, the physician and pathologist could insouciantly disregard the point of view of the patient, since their obligation is to a rigorous, objective pathology. “Is it not obvious,” Canguilhem writes, “that if we want to work out a scientific pathology we must consider *real* causes and not *apparent* effects, functional mechanisms and not their symptomatic expressions?” (*NP*, 79; emphasis added). On this account, the object of the science of pathology is not the total organism but rather the scientific laws and quantitative relations of chemical equilibria, governing the chemical reactions and movements of dissolved molecules. This mechanistic reduction of the living organism to a system of physio-chemical deterministic laws would solve the problem of point of view *if it were possible*.

However, according to Canguilhem, the living being resists such description: biological thresholds are not “barriers,” and the internal regulations of the living being are not “safety valves, servo-brakes or thermostats” (*NP*, 79). In the case of the biological regulation of glycosuria, two diabetics—with all other things being equal—can exhibit vastly different amounts of glucose passed in the urine. This variance certainly depends upon the individual norms of the organisms, but fluctuations within the same organism indicate that renal thresholds are “essentially mobile” and that renal “behavior” is not

fixed and quantifiable by mechanistic laws.¹⁶ Canguilhem interprets these twentieth-century scientific findings as proof that the biological regulation of blood glucose “cannot be entirely translated into analytical and quantitative terms” (*NP*, 80). The change from normal urinary excretion to glycosuria is better described as a qualitative transformation of the kidneys rather than a mere quantitative movement along a continuum: “To become a diabetic is to change kidneys” (*NP*, 80). Canguilhem’s redescription of this pathological phenomenon in light of twentieth-century scientific findings exposes the shortcomings in the positivist dream of a purely objective pathology. The living being and its biological “behavior” thwart the pathologist’s attempt at a complete reduction to physical laws and quantifiable relations, thus demanding that pathology take into account the subjective point of view of the living being.

This subjective perspective of disease, which resists reduction to a quantifiable extension of the normal physiology, necessarily exists at the level of the total organism. If health is “life lived in the silence of the organs,” as Leriche claims and Canguilhem affirms, then disease occurs when that silence is broken and the organism experiences suffering and pain.¹⁷ The phenomenon of disease from the subjective point of view thus presents itself as an “event involving the living organism taken as a whole” (*NP*, 80). By contrast, from the objective point of view disease appears as localized in a particular organ or tissue, for instance, in the kidneys and urine in glycosuria or in the basal ganglia

¹⁶ H. Chabanier and C. Lobo-Onell, *Précis du diabète* (Paris: Masson, 1931), 16, quoted at *NP*, 79.

¹⁷ Leriche, “Introduction générale”; “De la santé à la maladie”; “La douleur dans les maladies”; “Où va la médecine?” quoted at *NP*, 91. For Canguilhem’s affirmation of Leriche’s claim see *NP*, 118.

in Parkinson's disease.¹⁸ In this way, the subjective and objective perspectives align themselves with the totalizing ontological conception and the localizing positivist theories of disease respectively, adding to the laundry list of dualisms that arise within a consideration of point of view.

Although Canguilhem argues for this subjective perspective of disease at the level of the total organism, he does not aim to radically annul the objective point of view cultivated by the positivist conception of disease. Instead, his analysis merely aims to reopen pathology to make room for the subjective point of view. The restrictions positivist pathology places on itself in its quest for pure objectivity unnecessarily impoverish it to the detriment of the living beings who seek to benefit from it. Therefore, Canguilhem aims to resuscitate the subjective perspective of the sick being, not via the extirpation of the objective perspective, but rather by altering the hierarchy between these two points of view. On Canguilhem's theory of disease, the localized focus on a particular physiological site remains "privileged," but it is no longer "absolute" (*NP*, 81). That is to say, the pathologist or physician must still take into account the function that deviates from the so-called physiological norm, but she must be able to account for this on the level of the total organism. Without expanding this traditionally myopic view, positivist pathology risks labeling symptoms as disease with potentially disastrous results for the patient. For example, if pathology rests content with the localized diagnosis of a hyperactive pituitary gland, it will fail to grasp the interrelation of this symptom to "a pituitary tumor or a general endocrinal readjustment" on the level of the total organism (*NP*, 81). In his zeal to reestablish the subjective point of view of the sick being and the

¹⁸ The objective point of view always attempts to localize the pathological phenomenon. Even for diseases that seem to have amorphous origins and ambiguous locations, the objective point of view strives to pinpoint the precise location in the body.

qualitative distinction between sickness and health, Canguilhem slips into the language of the appearance–reality distinction. He claims, in the study of disease, “what appears to be partial augmentation or diminution is in fact an alteration in the whole” (*NP*, 81). Despite this regression to the philosophically tired appearance–reality distinction, Canguilhem’s point is well taken; namely, the meaning and human reality of disease is not at the level of partial function but at the level of the total organism.

The phenomenon of pain supports this shift in emphasis in pathology from the localizing to the totalizing perspective. According to Canguilhem, pain, for Leriche, is neither “a physiological sensation” nor “an expression of a normal activity” (*NP*, 96). As outside the natural laws of a species, pain presents not as a symptom of disease, but as disease itself. It is an “accident” which violates the “laws of normal sensation,” “a monstrous individual phenomenon.”¹⁹ This representation of pain as an accident and a violation of the normal physiology distances Leriche from his positivist predecessors. As Canguilhem notes, when Leriche divorces pain from the continuum of physiological function, it becomes an “authentically abnormal state” (*NP*, 96). Crucially for Canguilhem, this concept of pain-disease can only occur at the level of the total individual: “It seems quite important to us that a doctor recognize in pain a phenomenon of total reaction which makes sense, which is a sensation only at the level of concrete human individuality” (*NP*, 97). In addition, this description of pain reinforces the subjective perspective of disease. Pain as disease presents itself at the level of a biological value judgment; it does not appear as a choice, yet arises as a response of life

¹⁹ Leriche, *La chirurgie de la douleur* (Paris: Masson, 1940), 490, quoted at *NP*, 96.

to its milieu.²⁰ Of course, as a *fact*, it can be disputed and reduced to nerve impulses by the physiologist just as the physicist reduces the sight of color to a function of light wavelengths, but as a *value* expressed by the life of the being, pain and disease are irreducible. Leriche's concept of pain-disease halts any attempt to situate disease within a localized function or partial aspect of the organism. In the experience of pain, "we obtain the total coincidence of disease and the diseased person" (*NP*, 98).²¹

These shifts in emphasis advocated by Canguilhem—from partial function to total organism, from objective pathology to the subjective awareness of disease—at first blush might appear to be nothing but a reactionary humanist response to the 'progress' of rational pathology. Despite the impressive collection of evidence Canguilhem marshals to support his arguments, the realignment of pathology with the experience of the sick person away from quantifiable analysis seems to be a regression. How can we overlook the time lag between the so-called onset of disease and the awareness of the organism pointed out by Leriche? What would happen to modern medicine if we waited for the testimony of the patient's pain or her awareness of a decrease in function rather than diagnosing breast cancer via x-ray technology and HIV infection via Western blot analysis? Canguilhem is not unaware of these concerns. Unlike the objective point of view which seeks to eradicate any subjective contribution to the study of disease, Canguilhem does not advocate a renunciation of medical technologies and quantitative analysis. Rather than arguing for the overthrow of rationality and mathematization in

²⁰ The unique qualities Canguilhem attributes to life are discussed in section 1.3.1 "Life as Normative."

²¹ Canguilhem's theory of disease upholds the subjective point of view. That is, he insists that disease occurs at the level of consciousness and that recognition of the disease depends upon the sick being itself. Thus, to a large extent, Canguilhem's formulation is only relevant for human diseases.

pathology, he merely aims to demonstrate that the project of positivist pathology cannot even get off the ground without the account of disease offered by the sick person. The concept of disease itself is not “a concept of objective reality accessible to quantitative scientific knowledge” (*NP*, 76). Instead, Canguilhem argues this concept must be supplied by the living organism. Today’s medicine has laboratory techniques and diagnostic tests “which allow [it] to see ‘patients’ in people who do not feel that way” only because it rests on the testimony and experiences of yesterday’s patients (*NP*, 93).

According to Canguilhem,

[i]f, today, the physician’s knowledge of disease can anticipate the sick man’s experience of it, it is because at one time this experience gave rise to, summed up, that knowledge. Hence medicine always exists *de jure*, if not *de facto*, because there are men who feel sick, not because there are doctors to tell men of their illnesses. (*NP*, 93)

It is only the subjective experience of disease in the past that allows physicians to objectively anticipate disease in the future. Therefore, the subjective experience of disease as a distinctively different state of being for the organism cannot be shrugged off, explained away, or labeled as illusory by the pathologist, since it serves as the necessary foundation for the science of pathology itself. Although contemporary diagnostic medicine masks its relation to past subjective experiences in a veil of objectivity, what Canguilhem exposes is the “permanent relationship of the sick man and disease” (*NP*, 93).

According to Canguilhem, the motivation for the positivist denial of ontological theories of disease resides in a “deeper refusal to confirm evil” (*NP*, 104). However, he claims this outcome is not a necessary result of adopting a subjective theory of disease. The recognition of disease as an ontologically distinct state of being does not require the

confirmation of disease as evil. Of course, the positivist account does effectively avoid this result, since if the pathological is reducible to an extension of the normal, then it has no ontological substance of its own and cannot be an instantiation of evil. But this is not the only way to avoid the coupling of disease and evil. As Canguilhem notes, it is possible to “deny that disease is a kind of violation of the organism ... without denying” the novelty of disease (*NP*, 87). Thus, we can interpret disease, not as a step on the road toward death, but rather as inaugurating a new way of life for the living being. The positivist point of view attempts to reduce the normal and the pathological to a “common measure,” but in so doing it strips both concepts of their meaning (*NP*, 110). Therefore, if we are to retain the qualitative experience of disease—an experience which, according to Canguilhem, can be denied but not suppressed—then we must accept the validity of the sick being’s point of view as crucial to the understanding of both the meaning and the treatment of disease.

1.3 The Norm and the Normal

For Canguilhem’s analysis, the norm and the normal are two absolutely fundamental concepts. Since his understanding and development of these concepts is complex and nuanced, this section will necessarily be an incomplete exposition. Rather than attempt to encapsulate all their many features on these few pages, I have elected to discuss three distinct aspects of these concepts or ramifications that following from defining these concepts as Canguilhem does. The focus of the first section is Canguilhem’s discussion of life as a normative process. However, for Canguilhem, the term normative has a very specific meaning, different from its typical English usage. A

living being is normative according to Canguilhem insofar as it is “capable of establishing new, even organic norms” (*NP*, 139). Also pertinent to this discussion is Canguilhem’s description of life. For him, life is not an indifferent phenomenon. That is, unlike physics or chemistry, biological life, in itself, strives for continued existence and prefers certain conditions over others. This striving is not at the level of the conscious individual, but at the level of life itself. Thus, life reveals itself as “polarized reactivity,” or an “unconscious position of value” (*NP*, 126). In other words, life is not indifferent to its conditions, either the external or internal environment, but instead, always takes up a position of value and orients itself toward a positive or more favorable condition away from a negative one.²² In the middle section, I turn to Canguilhem’s discussion of the variability of individual norms while the third section addresses one of the ramifications of Canguilhem’s concept of normatively, what I term the relativism of norms. Here, I follow Canguilhem’s explication to show that despite the fact that norms govern both the normal and the pathological, there is still a way to establish a hierarchy of norms, thus avoiding a radical relativism.

1.3.1 Life as Normative

For Canguilhem, the norm and the normal are two of the most fundamental concepts within the study of disease. Indeed, medicine, in order to operate, constantly invokes norms. Its primary goal, according to Canguilhem, is the reestablishment of biological and physiological norms and the restoration of the organism’s normal state. Simultaneously functioning as both a fact and a value, the concept of the normal state

²² For a discussion of the anthropomorphism imbedded within the concept of life, see note 23.

claims to define the habitual function of the organs and also purports to establish itself as the ideal state. Any deviation from this “habitual ideal” justifies therapeutic intervention into the life of the living being (*NP*, 126). It is in relation to the normal, ideal state and the habitual norms of the organs that all illnesses present themselves. Thus, according to Canguilhem, the concept of the normal state with its corresponding norms holds the power to determine both sickness and health. Bringing to light the fundamental role of biological norms and the normal state within diagnostic medicine and therapeutic intervention, Canguilhem questions the foundation of these norms.

At first Canguilhem considers two possibilities: either medicine or the living being sets the biological normal. In the former case, the normal would achieve its status as the normal because it is the end goal of therapeutic intervention. That is, the normal is normal since medicine deems it “a good goal to obtain” (*NP*, 126). The latter case inverts this relation of causality: the living organism sets the norm and calls upon medicine to restore that ordinary level of function. According to Canguilhem, this latter description, where the living being sets its own functional and habitual norms, accurately grasps the relation between medicine and the normal state. Similar to his stance against positivist medicine, this assertion once again displays Canguilhem’s insistence that clinical medicine is beholden to the subjective point of view. However, in this instance, Canguilhem claims that the life of the living being and not its subjective consciousness establishes its normal state. To invoke Canguilhem’s terminology, life itself is normative; that is, life functions by establishing its own norms. The feature of the living being that affords it this normative power is not at the level of conscious awareness but rather at the level of life itself. Although the sick human may have awareness of her pain or sickness,

according to Canguilhem, it is life itself that ascribes a positive or negative value judgment to health or disease. Life itself is “an unconscious position of value,” and as such it is the demands of life that compel the conscious living being to “call certain dreaded states or behaviors pathological” (*NP*, 126). Thus, according to Canguilhem, life itself—not objective pathology—constitutes and determines the biological norms for the living being.

In this way, life is a normative activity that constantly evaluates certain biological facts against a norm. By providing its own norms, life sets its own optimal mode of existence. Unlike chemistry or physics, biology can go awry. That is to say, of these three sciences, only biology admits of pathology. There is no pathological physics or chemistry, since these sciences obey invariant natural laws. While the direction of a chemical reaction may change depending upon the concentrations of the reactants and products (i.e., whether the reaction goes in the forward or reverse direction, from reactants to products or vice versa), the laws of chemistry governing the reaction remain constant. If the reaction proceeds in the reverse direction due to a high concentration of products, chemists do not label this an abnormal or pathological reaction. The laws of chemistry are not normative; they do not establish norms. Therefore, no violations and no deviations can occur in chemistry. Rather, the laws of chemistry are indifferent to the direction in which a reaction proceeds. Likewise, in physics, a science built upon the principle of inertia, there can be no “distinction between natural and violent movements,” since “inertia is precisely an indifference with respect to directions and variations in movement” (*NP*, 128). All motions described by mechanics and all reactions

characterized by chemistry are equal. Neither of these sciences adopt a norm which could separate the normal from the abnormal, the normal from the pathological.

In contrast, biology is not indifferent to its conditions. Not all biological actions and reactions are normal and equally favored by life. When an organism fails to excrete wastes and toxins build up within the organs, the poisoning of the organism certainly occurs according to the laws of chemistry and physics—these laws are not violated. However, while this process follows certain inviolable laws, according to Canguilhem, “none of this follows the norm” (*NP*, 129). He continues, “there is no biological indifference” (*NP*, 129). The vital therapeutic response of the living organism provides evidence of this unique attribute of life. Canguilhem points to the self-restorative and self-healing behaviors of animals, even animals low on the phylogenetic evolutionary tree.²³ These behaviors express the unconscious position of value established at the level of the total organism. According to Canguilhem,

[w]e ... think that the fact that a living man reacts to a lesion, infection, functional anarchy by means of a disease, expresses the fundamental fact that life is not indifferent to the conditions in which it is possible, that life is polarity and thereby even an unconscious position of value. (*NP*, 126)

This assertion reflects his understanding of life as polarized reactivity. That is, for Canguilhem, life always evaluates its milieu, separating the various conditions into preferred and nonpreferred, striving toward the former and away from the latter. This reactivity of life is also reflected in the actions of the living being: “The living human being, in a more or less lucid way, extends a spontaneous effort, peculiar to life, to

²³ Wary of a “tendency to fall into anthropomorphism” in his description of life, Canguilhem offers this example as a corrective (*NP*, 127). Even “lower living organisms” exhibit these behaviors aimed at healing and restoration, thus revealing the therapeutic need as a vital need, essential to life (*NP*, 127). However, I believe Canguilhem is still open to this objection. In *The Normal and the Pathological*, Canguilhem frequently employs the term life in his explanations and interpretations, yet he neglects to adequately define this term.

struggle against that which obstructs its preservation and development taken as norms” (*NP*, 126). However, this polarized reactivity exists not only at the level of animal awareness, but also at the level of life itself. For example, the ability of blood to clot and tissues to form scars indicates the life of the living being is not indifferent to puncture wounds and torn tissues. If it were, these natural biological responses would be unnecessary. But this is not the case. Life, in fact, reacts to these unfavorable conditions in an attempt to reestablish the norms necessary for its own survival. As an unconscious judgment of value, life itself establishes certain states as the normal and others as pathological. The response of life itself—its dynamic reactivity—exists between the opposite poles of the negatively- and positively-valued conditions, and biological and environmental facts are positive and negative only insofar as life deems them to be beneficial or harmful. Establishing its own norms, life identifies all that is judged to be of negative vital value and exerts a “spontaneous effort of defense against [it]” (*NP*, 131). Thus, Canguilhem claims, the concept of the normal, instrumental for all therapeutic intervention, is not imposed upon the living being by the science of medicine nor does it come directly from the level of subjective consciousness, but rather represents the judgment of life itself.

1.3.2 Individual Norms

Biological norms exhibit individual relativity. What is normal for one person may be pathological for another. Although physiology and biometry measure, quantify, and catalog physiological constants and analyze their frequency within a population, these sciences and their statistics, by themselves, are helpless to establish the demarcation

between the normal and the pathological. “Statistics,” as Canguilhem reiterates, “offer no means for deciding whether a divergence is normal or abnormal” (*NP*, 155). Therefore, the individual patient from her affective point of view must supply this division to the physician and physiologist. Responding to the polarized activity of the life within her, the patient experiences the onset of disease and the return to normality unfolding in time. According to Canguilhem, the phenomenon of disease presents itself at the level of the concrete individual, thus it remains the task of the particular living organism—the patient—to determine when she has fallen ill and when therapeutic intervention has restored her to her particular normal state.

Recognizing the metaphysical underpinnings of the concept of disease, most practicing physicians avoid a careful scrutiny of the concept. Instead, Canguilhem claims, they leave the classification of disease and cure to the patient, and with good reason, for the physician only encounters disease when the individual experiences a reduction in capabilities. In other words, the patient seeks out the doctor in order “to be raised from an abyss of impotence or suffering,” and as soon as her suffering has abated and she has regained an adequate level of functioning, she defines herself as well (or well *enough*) and retracts the plea for help that originally sent her to the doctor (*NP*, 119). It is the patient, not the physician, who lives the phenomenon of sickness; she is the one who must grapple with this metaphysical concept. Of course, for the determination of biological norms, physicians do have recourse to physiology and the standards of their social milieu. These external, but not invariant, factors establish a baseline of capacities and functions considered necessary for an individual to be normal in a certain epoch and social milieu. However, this concession to external, ‘objective’ criteria of normality does

not radically undermine the critical importance of the subjective experience of disease, since normality does not have an upper limit.²⁴ So long as the patient's conception of her return to health and normal functioning is above this baseline, the physician should accept the patient's judgment of value.

This deference to the opinion and self-assessment of the patient amounts to a recognition of the temporal aspect of disease. Unlike an anomaly, disease manifests itself in "chronological succession" (*NP*, 138). For the living organism, disease is an event that "interrupts a course" (*NP*, 138). Even in the case of chronic disease, it first presents itself to the living being as a critical event, or rupture, before it becomes chronic, reorganizing life into the time before and the time after the break. Once the illness loses its critical character and stabilizes into a chronic condition, the past before the event of disease continues to exist in the memory and experience of the patient, "a past for which the patient or those around [her] remain nostalgic" (*NP*, 138). According to Canguilhem, the appearance of disease as a chronological event that occurs within the time of the individual is a fundamental feature of the experience of disease. Emphasizing the individual experience of disease as a temporal rupture, this description frames the relation between sickness and health as intrinsic to the individual. While individuals identify themselves as sick in relation to others who are healthy, crucially, for Canguilhem, "we are sick in relation not only to others but also to ourselves" (*NP*, 138). Since the patient primarily defines her sickness in relation to *her* previous state of health, she is the one best qualified to differentiate between the two states. The rupture caused by disease exists

²⁴ While there is a lower limit to normality, the lack of an upper limit attempts to lessen the criticism that for physiology "normal man [is] a mediocre man" (*NP*, 164). That is, by not establishing a maximum for normality, physiology need not categorize individuals who surpass the norm in the positive direction as abnormal.

within her conscious awareness. She experiences disease as an interruption, preventing her from continuing her past actions. Thus, the return to normality is equivalent to an overcoming of this interruption, allowing the patient to resume her previous actions.

According to Canguilhem, it is this quest for temporal continuity that forces the physician to leave the judgment of normality to the patient: “For a man whose future is almost always imagined starting from past experience, becoming normal again means taking up an interrupted activity or at least an activity deemed equivalent by individual tastes or the social values of the milieu” (*NP*, 119). For the individual to consider herself once again normal, the return to the interrupted activity need not be identical in all respects. The devastating experience of disease as rupture renders the individual more willing to classify herself as normal even if her new norms do not equal the old. Since the patient “almost died” and “had a narrow escape,” she likely will count the return to her past activity as a return to life and normality even if her capacity to perform that activity has significantly decreased (*NP*, 119). For example, Canguilhem discusses a patient who while working cut his arm upon a circular saw. After his operation, the patient is pleased to learn “there is the possibility he will recover much of the use of his limb,” allowing him to return to work (*NP*, 120). Even though the arm will never return to the previous norm or equal his uninjured arm in strength, range of motion, or flexibility, his ability to return to his previous action is sufficient to count as a return to normality. Despite his injury, he will continue to be evaluated and “appreciated according to former norms” (*NP*, 120). In both his eyes and those who knew him before, he will always be “a cartwright or driver and not a former cartwright or former driver” (*NP*, 120). Thus, in the case of disease, the patient determines when he has reestablished the continuity of action

ruptured by the event of disease; that is, the patient, and not the physician, decides when his individual norms have been restored.

Although the patient's assessment of her individual norms usually trumps any objective criterion of normality, if her opinion falls outside the view of her social milieu, then the physician will likely elect to intercede. According to Canguilhem, "it is the patients who *most often* decide ... whether they are no longer normal or whether they have returned to normal" (*NP*, 119; emphasis added). However, they do not *always* decide. For example, Gustave Flaubert's fictional physician, Bovary, and Homais, the pharmacist acting as his accomplice, convince Hippolyte, the stable boy with the clubfoot, that his deformity is "ugly," "hurts [him] terribly," and prevents him from carrying out the functions necessary to his livelihood.²⁵ In other words, they redescribe what he considers normal as pathological and in need of a cure. When Bovary botches the procedure and a renowned surgeon must be called to amputate the boy's leg, he chastises Bovary and Homais for foisting their conceptions of health and disease on the boy: "We practice medicine, we cure, and we never think about operating on someone who's perfectly healthy! Straighten a clubfoot indeed! Is it possible to straighten a clubfoot? It's like wanting to make a hunchback straight!"²⁶ The response of this famous surgeon indicates that the norms of that nineteenth-century rural French town admit a clubfoot as normal and "perfectly healthy." By subverting the boy's assessment of his condition and convincing him it is abnormal, the doctor and pharmacist overstep their bounds. Since the stable boy has always been able to perform the functions necessary for his work and

²⁵ Gustave Flaubert, *Madame Bovary*, trans. Mildred Marmur (New York: New American Library, 1964), 174.

²⁶ *Ibid.*, 180.

wellbeing, he has always been both healthy and normal with respect to himself.

Ironically, the botched surgery itself becomes the break in continuity for the boy that he must overcome in order for him to return to normality. As the one who experiences and lives through disease, the patient, according to Canguilhem, must be allowed to determine whether or not the therapeutic intervention of the physician restores him to his past state and reestablishes his previous individual norms.

1.3.3 Relativism of Norms

As judgments of vital value, biological norms are not absolute facts. According to Canguilhem, no fact is normal in itself. Rather, a fact can only be deemed normal in relation to its conditions. To call a function, a behavior, or a particular morphology normal is to express a relation between these biological facts and their environment. Likewise, an environment is normal only insofar as it is the environment in which a particular living organism “lives out its life better” or “maintains its own norm better” (*NP*, 142). Thus, the relativist aspect of the designation ‘normal’ holds for both the organism or function and the environment or conditions. Noting this relativity of norms, Canguilhem asserts that even the pathological fact—an aberration or a mutation—is not pathological in itself. The pathological is not the negation of all biological normativity. Rather, it is merely a different norm, albeit a norm less suited to its current environment, a norm “comparatively speaking, pushed aside by life” (*NP*, 144). However, for most norms, nothing precludes the possibility of the fact deemed pathological in relation to its current environment from becoming normal in relation to a different environment. The ongoing process of evolution, which alters the interplay between the living being and the

environment, indeed, often begins in a mutation or alteration which could be deemed pathological. Despite this relativity of norms and the normative character of both the normal *and* the pathological, according to Canguilhem, it is still possible to establish a hierarchy of human biological norms via reference to the “normal human ideal” (NP, 139). This section traces the relativist aspects Canguilhem highlights in his exposition of the biological concepts of norm and normal. In particular, it focuses on the development and interrelation of three features: (1) the relational aspect between the normal biological fact and its environment, (2) the normative character of the pathological fact, and (3) the ability to hierarchize the multiplicity of normal and pathological biological norms.

In his discussion of evolution, Canguilhem elucidates the relationship between the normal biological fact and the environment. He claims the normal and the pathological are not invariant facts, but rather are life’s judgment of vital value. In this sense, the normal and the pathological need have no particular frequency. That is to say, the normal is not necessarily the most prevalent and the pathological the least. Instead, the normal corresponds to a positive vital value and the pathological to a negative vital value. Neither absolute nor abstract, these value judgments of life always stand in relation to the life of a particular organism and its environment. A study of *Drosophila* with vestigial wings is a case in point. In a closed environment, the flies with normal wings outcompete those with vestigial wings. However, in an open environment, the study found *Drosophila* with the mutation to account for 60 percent of the population in just three generations, since these flies feed and mate constantly. The morphology of the *Drosophila* with vestigial wings thus makes them better suited to the open environment

whereas the so-called normal *Drosophila* thrive better in their usual, closed environment (NP, 142). Since the stability of an environment is never guaranteed, Canguilhem avoids labeling the closed environment the normal one for *Drosophila*. According to Canguilhem,

an environment is normal because a living being lives out its life better there, maintains its own norm better there. An environment can be called normal with reference to the living species using it to its advantage. It is normal only in terms of a morphological and functional norm. (NP, 142)

No so-called normal fact—for instance, functional wings in *Drosophila*—is absolutely normal but instead always depends upon the vital value accorded to it in regard to a specific set of conditions. Functional wings in an open seashore environment would not be normal, since it would confer a negative vital value upon the organism. The selective advantage of the heterozygote for sickle cell in certain parts of sub-Saharan Africa where malaria is prevalent offers an example on the human level. While the heterozygote has a decreased capacity to transport oxygen through the blood, in an environment where malaria is common, this individual has a selective advantage over the homozygote dominant (i.e., the ‘normal’), since the slight defect in hemoglobin structure confers resistance to malaria. Thus, in that particular environment, the heterozygote is an adaptation of life that allows the individual to live out its life better. In other words, this mutation in protein structure carries a positive vital value, making the individual “more fit to survive” (NP, 265). But again, the designation ‘normal’ only applies to the heterozygote in that particular environment. Since the parasite cannot complete its lifecycle in colder climes, the heterozygote gains no positive vital value in these environments. What constitutes the normal in sub-Saharan Africa is not normal in North America where the decreased capacity for oxygen transport might have a negative vital

value. As both these examples demonstrate, “there is no fact which is normal or pathological in itself” (*NP*, 144). Intrinsic to the concept normal is a relation between life and its environment.

Norms are not exclusive to the domain of the normal, but exist within the pathological as well. Whether deemed normal or pathological in relation to its environment, life is *always* governed by norms. Thus, the presence or absence of norms cannot mark the break between the normal and the pathological. This fact lends the study of biological norms and the normal an ambiguous quality. One cannot point to the mere fact of a biological norm and claim it is normal in the normative sense because life also admits of pathological norms. This normative character of life in both disease and health is of fundamental importance for Canguilhem. He claims that the normative character of the normal being is, in fact, the being’s ability to establish new norms. When confronted with an environmental change, a pathogenic agent, or an internal disturbance, the normal living being, insofar as it is normal, has the capacity to overcome this breach of its norms and institute new ones. Critically, for Canguilhem’s analysis, the new norms established by the organism are never equivalent to the old. Even if the living being perceives itself as recovering from having “almost died” and returning to normal, the normal reached after the event of sickness is fundamentally new. The omnipresence of norms and the normative character of life itself confer a relativist aspect upon the study of disease.

Under Canguilhem’s conception of disease, the biological norms before and after the onset of disease are different, whether the living being conceives herself to have been cured or to have entered a chronic state of sickness. Unlike the positivist account of

disease, Canguilhem's theory does not maintain sickness as a mere quantitative variation of the normal physiological state. Instead, he claims, "Disease is not a variation on the dimension of health; it is a new dimension of life" (*NP*, 186). Even though therapeutic intervention or the body's natural response may restore the living being to its previous function, it represents a new path to the same outcome. According to Canguilhem, disease is not a regression to a simpler state. That is, disease is neither a "loss of what one had possessed" nor is it a slippage on the sliding scale of health (*NP*, 188). Rather, according to Canguilhem, disease is both "deprivation *and* change," both negative *and* positive (*NP*, 186; emphasis added). Although the biological norms reestablished by the life of the living being may allow it to resume its interrupted function, the new norms are precisely that—*new*: "Disease is a new life, characterized by new physiological constants and new mechanisms for obtaining apparently unchanged results" (*NP*, 188). Describing disease as nothing but an absence, a loss, that is, something strictly negative, one misses the directionality of disease. If disease were merely a regression, then comparisons between the adult unable to speak as a result of a neurological disease and the prelinguistic child would be legitimate. However, according to Canguilhem, this sort of comparison is an "absurdity," since it ignores the normative direction of each individual (*NP*, 189). The normal impetus of development of the child pushes it to achieve new norms and acquire language whereas the sick adult no longer has the normative power to develop new norms and merely strives to maintain those norms of life "within which he feels almost normal, that is, in a position to use and dominate his own environment" (*NP*, 189). For the sick adult, the disease results in a loss of normativity (i.e., a loss of the possibility to establish new norms). The possible situations in which he can feel equal to

the demands of his task have constricted. Thus, the relation of the norm to possible future situation determines the degree of normativity; that is, the norm must always be evaluated in terms of the future to come.

The pathological fact is normal in relation to its specific situation, but it is pathological insofar as it does not admit the possibility of a new norm. It is not the lack of a norm that makes a being sick, but rather it is its “incapacity to be normative” (*NP*, 186). A norm is pathological for Canguilhem insofar as it does not admit the establishment of any new norms. The superfluity of norms—both pathological and normal—complicates the positivist account of disease as a change in intensity. Canguilhem’s insight is thus his recognition that norms govern *all* life, whether normal or pathological, and this fact gives the relationship between the normal and the pathological, or health and sickness, a relativist character, since the assessment of all norms turns upon their relation to the possible future situation.

Even though no fact is normal in itself and no life is without norms, Canguilhem contends it is still possible to maintain a meaningful distinction between the normal and the pathological. An absolute distinction between the normal and pathological marked by the presence or absence of norms is impossible, yet this fact does not lead to a radical relativism of norms. All biological norms are not equal. In fact, biological norms form a hierarchy according to their own normativity, that is, according to their ability to establish new norms. The “normal human ideal” sets the standard by which all other biological norms can be evaluated (*NP*, 139). This paradoxical formulation—normal ideal—signifies the state of health in which the living being can adapt to every possible

future condition. In this state, no change in either the external or internal environment would bring about the end of life to the living being. Instead, the ideally normal being would successfully adapt to the change and establish new norms, thereby enabling its continued existence. As an ideal, this formulation is little more than a fantasy, but it serves to illustrate Canguilhem's point: biological norms can be ranked based upon their flexibility to adapt to new conditions of life. While both health and disease have corresponding norms of life, the former has more flexibility, allowing it to continue through greater deviations whereas the latter has a more restricted set of possible conditions in which it can continue to thrive.

The pathological state is inferior to the normal state not because it lacks all norms, but rather because its norms of life are rigid. While the conditions remain constant, the pathological norms function adequately, allowing the living human being to see herself as equal to her situation and tasks. In fact, according to Canguilhem, this self-perception of the individual is not a false or incomplete consciousness—in those given conditions she is, indeed, normal. Only when the situation changes does she become aware of her inability to reestablish new norms. Thus, only then does she experience herself in her conscious awareness as sick or abnormal. For example, Canguilhem describes a housekeeper who finds herself normal in relation to the given conditions of her work. She is equal to the task of caring for the children and tending to the house. She becomes aware of her hypotension only when she vacations in the mountains, since the decrease in pressure at high altitudes causes her blood pressure to drop to the point where she begins to experience neurovegetative disturbances. Since the housekeeper does not live in the mountains and need not vacation there again, she remains normal in relation to her

normal situation upon her return home. However, according to Canguilhem, this example illustrates the hierarchy of norms: “Of course, no one is obliged to live at high altitudes. But one is superior if one can do it, for this can become inevitable at any time. A norm of life is superior to another norm when it includes what the latter permits and what it forbids” (*NP*, 182). The woman’s hypotension restricts the possible situations in which she could live in a normative relation to her environment. Thus, in this regard, her norm of life is inferior to someone with normal blood pressure. Nevertheless, in her current situation, she is perfectly normal. Likewise, the colorblind individual is normal, and equal to her task, until she determines she wants to become a pilot or an artist. So long as she is a copy editor or a plumber, her vision is normal, since she is equal to her tasks and her situation. The norms of life for these pathological or abnormal cases are normal for their particular situations, yet they do not admit of variation. The rigidity of pathological norms allows them to maintain their normative character only insofar as the situation remains static.

The recourse to the notion of a normal human ideal functions to mediate between the subjective and objective perspectives within Canguilhem’s account. In a sense, it affords him a middle way between the utterly objective and utterly subjective perspectives. His theory rehabilitates the sick being’s point of view but can still account for the preference for certain norms. By softening the break between the normal and the pathological (for him, it is no longer a question of presence and absence of norms, since both states are governed by norms), he grants the sick being normal life under certain conditions, but he also upholds a hierarchy of norms, allowing for an objective distinction between norms that are more and less favorable for certain kinds of life. Nevertheless, at

its foundation, Canguilhem's theory rests upon the subjective. By depicting the normal not as an absolute fact, but as a flexible norm, Canguilhem does not slip back into the positivist account of disease, which maintains a "continuity between the normal and the pathological in essence save for quantitative variations" (*NP*, 182). Instead, this borderline, although "imprecise" at the level of the population or species, is "perfectly precise" at the concrete level of the individual (*NP*, 182). From her subjective perspective, the individual arbitrates this distinction for herself. She experiences this qualitative transformation at "the very moment" when she "feels inferior to the tasks which the new situation imposes" upon her (*NP*, 182). In this way, Canguilhem establishes the fundamental role of the subjective perspective in the recognition of disease. By contrast, his hierarchy of norms highlights the objective character of disease as experienced by the living being, thus preventing the distinction between disease and health from falling into the obscurity of radical relativism. In one sense, a state of disease is normative in that it is governed by norms, but it is not, in another sense, because it is unable to establish new norms. Thus, disease ranks below health on the scale set forth by the normal human ideal. According to Canguilhem,

[d]isease is still a norm of life but it is an inferior norm in the sense that it tolerates no deviation from the conditions in which it is valid, incapable as it is of changing itself into another norm. The sick living being is normalized in well-defined conditions of existence and has lost its normative capacity, the capacity to establish other norms in other conditions. (*NP*, 183)

This conception of disease finds the middle ground between the absolutism of objectivity and the relativism of the subjective perspective. On the one hand, Canguilhem upholds both the relative character of the norm in relation to the situation of the living being and in relation to the pathological norm; he thus preserves disease as it is experienced by the

living being. On the other hand, this relativity inherent in the subjective perspective does not establish all norms as equal, a fact contrary to the concrete experience of the living being. Canguilhem understands we evaluate biological norms by their normative capacity: “Normal man is normative man, the being capable of establishing new, even organic norms” (*NP*, 139). Thus, a biological norm is more normal and more highly valued by the living being the greater its normative power, its ability to renormalize itself in any future condition imposed upon it. Oriented toward the future, biological norms receive their relative value based upon how well they can transform themselves to remain normal in future situations. A norm is more normal, healthier, and more highly regarded the more flexible it is—the more it can adapt to its horizon of possibilities. As Canguilhem notes, health ranks in value over disease and the normal over the pathological in the eyes of the living being (and by life itself), since healthy or normal norms can withstand via adapting to both the expected and the unexpected.

CHAPTER 2

FOUCAULT: THE EXPOSITION OF CERTAIN CONCEPTS

2.1 The Time and Space of Disease: Conceptions of Disease from Classificatory to Clinical Medicine

In *The Birth of the Clinic*, Foucault offers an account of the shift in the theoretical configuration of disease in the latter half of the eighteenth century. This section follows his analysis of this mutation in medical perception and experience. Traversing a span of a little over fifty years, this account begins with the eighteenth-century classificatory configuration of the ideal disease. From this classificatory ideal disease, it passes through the historical emergence of the proto-clinic, which gave rise to the formulation of the statistical disease, before terminating in the anatomo-pathological medicine marked by Bichat in the nineteenth century. Foucault's historical analysis of the rupture in medical knowledge that radically cleaves the projects of classificatory medicine from those of anatomo-physiological medicine in the span of a few short years illuminates the historical aspect of even our most cherished medical and scientific systems of knowledge. The exposition of these historical configurations of disease offer alternatives to our current medical and scientific theories of disease and, in addition, highlights the fact that our modern conceptions of disease are also historical and, therefore, transitory.

During the eighteenth century, the classificatory method provided the framework for the recognition, understanding, and treatment of disease. Classificatory medicine's *modus operandi* first required the construction of a table of diseases based upon the

interrelations between the different disease classes, or species. To construct a table of diseases, each disease requires a unique essence. From these essences, eighteenth-century nosology arranged the disease on the table via analogy and resemblance. For instance, classificatory nosologists perceived a fundamental resemblance among all diseases characterized by discharge. Thus, catarrh and dysentery belong to the same disease family, since they are linked via analogy: “what catarrh is to the throat, dysentery is to the intestines” (*BC*, 5). From these pathological essences classificatory medicine discerned an inherent orderability within diseases. The essences of disease presented themselves to the classificatory gaze which then perceived their essential resemblances. From this medical perception, eighteenth-century nosographers situated each disease in its proper place on the invariant table of hierarchal “families, genera, and species” (*BC*, 4). This table of diseases, once properly constructed, affords a “picture” that reveals to the physician the inherent connections between different diseases and the proper treatments necessary to each (*BC*, 4). That is, it serves both to organize all pathological knowledge and to provide the impetus for effective therapeutic intervention. According to Foucault, the condition of possibility for this tabular organization of knowledge in the eighteenth century is the ontological conception of the “being of disease” (*BC*, 189), that is, the positing of a pathological essence, and this conception of disease creates a multiplicity of effects in classificatory medicine’s theoretical understanding and clinical perception of disease.

First and foremost, this configuration of disease and the construction of a nosological table establish the primacy of the historical knowledge of disease. Classificatory medicine does not concern itself with the philosophical knowledge of

disease; it is not interested in the “origin, the principle, the causes of disease” for their own sake and in their own right (*BC*, 5). It only concerns itself with these philosophical concepts insofar as they are also historical, that is, insofar as they are accessible to the medical gaze. Under this configuration, the condition of possibility for knowledge of disease is the accessibility of the pathological fact—that is, the candidate for knowledge—to the medical gaze. In other words, classificatory medicine seeks the history of pathological phenomena discernable by the direct observation of the medical gaze, or what Foucault terms “historical knowledge” (*BC*, 5). What differentiates philosophical from historical knowledge of disease is the ability of the gaze to grasp the latter. Any fact of disease that exposes itself to the gaze—for instance, “a cause that can be seen, a symptom that is gradually discovered, a principle that can be deciphered from its root” (*BC*, 5)—is a candidate for pathological knowledge. This is the simplest knowledge and thus “must precede all others” as the “original form of medical experience” (*BC*, 6). This focus on the simple and perceptible facts available to the medical gaze creates as a condition for knowledge the possibility of the placement of the pathological fact on the nosological table.

Identifying and classifying species of disease, eighteenth-century pathology conceives of its task in the same vein as the work of the natural historians in biology and botany, since all of them aim to arrange the different species and classes onto a table of knowledge. In fact, the English physician Thomas Sydenham draws a direct parallel between the study of plant and animal species and disease species. According to him, the species of the plant and animal kingdoms confirm that each disease also has its own species. He claims the author of nature is bound by equally certain laws for “producing

diseases” as for “growing plants and animals.”¹ Propping the study of diseases upon the stable foundation already established by the classification of living organisms, he continues his argument from analogy:

He who observes attentively the order, the time, the hour at which the attack of quart fever begins, the phenomena of shivering, of heat, in a word all the symptoms proper to it, will have as many reasons to believe that this disease is a species as he has to believe that a plant constitutes a species because it grows, flowers, and dies always in the same way.²

From this botanical model, Sydenham seeks to establish the rational order of diseases as flowing directly from the essence of disease. Disease, as an ontologically distinct being, has a unique essence that always follows the same rational order. Just as the regular development of a plant from a seed to a sprout to a bud to a flower reveals its essential nature, so too does the progression and development of disease. The ideality of disease—its species essence—necessitates the regularity of this process and allows for no deviations. Invoking the analogy to plants, this botanical model suggests “the rationality of life is identical with the rationality of that which threatens it” (*BC*, 7). Both the processes of life and disease follow the same invariant laws of nature.

This ideality of disease captured by the table of knowledge does not admit a temporality of disease independent from its ideal nature or essence. According to eighteenth-century nosology, the temporal aspect of disease progression available to the medical gaze is an epiphenomenon of the ontological ordering of the disease, a mere replication or “‘carbon copy’ of the world of life” (*BC*, 7). The medical gaze collects and catalogs these pathological phenomena that seem to occur in time, not to elucidate the

¹ Thomas Sydenham, quoted by F. Boissier de Sauvages, *Nosologie methodique*, vol. 2 (Lyons, 1772), 124-25, quoted at *BC*, 7.

² *Ibid.*

philosophical question of cause and effect, but rather to “communicate with the ontological order” of the disease (BC, 7). According to Foucault, the gaze that scans the body does not differentiate *temporally* between cause and effect: “an effect has the same status as its cause, the antecedent coincides with what follows it” (BC, 6). In this way, the classificatory table abolishes time in its “flat surface of perpetual simultaneity” (BC, 6). What seems to unfold in time is, in fact, always already included within the nosological table, within the essence of the disease. The inflammation from a muscle sprain or the mucosal secretions from catarrh are not perceived causally. Indeed, they are not fundamentally *in time*. The apparent progression of disease derives solely from the ontological order of the ideal disease. On the nosological table of knowledge, the respiratory inflammation and mucosal secretions of catarrh occur not at the level of cause and effect but at the more fundamental level of the ontological order of disease. At this level, the level of all nosological knowledge, the ideal, ontological order “organizes from the inside, prior to all manifestation” (BC, 7). The ideality of disease, arranged in a table of analogies and resemblances, supersedes any chronological or temporal progression of disease. According to Foucault, eighteenth-century pathology tracked the time of disease, but only because it revealed “part of the essential structure of disease” (BC, 12). By itself, time never introduces its own events or deviations in the course of disease. The ideal and essential nature of the disease already contains time. It is not a variable, which when introduced modifies the course of the disease:

There is no process of evolution in which duration introduces new events of itself and at its own insistence; time is integrated as a nosological constant, not as an organic variable. The time of the body does not affect, and still less determines, the time of the disease. (BC, 12)

In fact, the time of disease is pre-established in Leibnizian fashion by the ‘author of nature’. Just as he established the laws of physics, God “fixed the course of most diseases through immutable laws” (*BC*, 14). Thus, the progression of disease is predetermined and invariant. The unfolding of the disease in time is merely the completion of its essence, leading the disease to its necessary and immutable fulfillment as set out in the nosological table.

This primary configuration of disease into classes, or species, in the eighteenth century structures diseases as both ideal and natural. Although classificatory medicine’s nosological table captures the ideality of disease, the medical gaze never encounters this pure form of disease in nature. Nevertheless, diseases are natural because they “state their essential truths” (*BC*, 8). As it appears in nature, the essential, ideal character of disease is never “unchanged and undisturbed” (*BC*, 8). That is, the essence of disease can never reveal itself in its purity because it always manifests within the patient’s body, which partially veils the essence from the medical gaze (*BC*, 8). In Aristotelian fashion, the body acts as an accidental cause. It is never included within the pure essence of the disease. For the doctor attempting to identify and classify the disease species, the patient’s body obscures the essential nature of the disease. All the extraneous characteristics of the patient—“his predispositions, his age, his way of life”—are accidents added to the “essential nucleus” of the disease (*BC*, 8). The individual patient is a “negative element, the accident of the disease” (*BC*, 14). Thus, in order for the medical gaze to perceive the unadulterated essence of the disease, it must excise everything nonessential. In other words, to reach the pure form of the ideal disease, the physician must subtract the contribution of the dispositions and proclivities of patient’s body from

the constellation of symptoms. By bracketing the patient in this manner, the physician can discern the essential symptoms and the ideal form of the disease. Since both life and disease follow the laws of nature and develop according to their essences, disease is not the antithesis of life, but rather the patient is the antithesis of disease: “It is not the pathological that functions, in relation to life, as *counter-nature*, but the patient in relation to the disease itself” (BC, 8). In itself, the disease is both natural and ideal, the perfect instantiation and fulfillment of its essence.

If the mere addition of the patient’s body can alter the appearance of the disease to the medical gaze, the imprudent actions of the physician can obscure the pure form of disease beyond recognition. The ideality of the disease ensures that it will progress in the manner natural to its essence if left to itself. Disease progression is predetermined by the essence and slowly but surely reveals itself to the medical gaze. However, any intervention of the doctor not aligned with the “ideal ordering of nosology” constitutes an “act of violence” against the disease (BC, 8). Since the disease is not contrary to life, this violence serves no beneficial or therapeutic purpose. In fact, it is deleterious to the aims of medicine because it renders the goal of classificatory medicine, i.e., the designation of disease, impossible. A “remedy administered too early” thwarts the natural progress of the disease and “prevents the disease from acceding to its true nature,” thereby making the disease unnatural and untreatable (BC, 8). To avoid modifying the essential nature of disease into something bastard and incurable, the physician “must hold his breath” and wait for the disease to “reveal its class, its genus, and its species.”³ She should content herself with lessening the pain of the patient and observing the natural, ideal progression

³ T. Guindant, *La nature opprimée par la médecine modene* (Paris, 1768), 10-11, quoted at BC, 8.

of the disease.⁴ Rather than blocking or diverting the progress of disease, the physician must first observe in order to classify and then assist the disease in reaching its natural, preordained telos.

In the classificatory medicine of the eighteenth century, the ideality of disease insists disease itself is the rightful commander of its fate. It is equipped with an essential nature that impels it forward toward its necessary end. Neither the patient nor the doctor should stand in its way, since the progression of disease belongs to the natural and rational order of things. Under this conception, the ultimate goal of medicine is its own self-effacement. Because of the “disturbance” introduced by the patient and the doctor “can hardly be avoided,” medicine settles for the next best thing: the minimization and neutralization of these effects (*BC*, 9). Thus, it attempts to abstract both the effects of the patient and the doctor from the effects of the disease. By heightening the differences between the true effects of the disease and the mere artifacts of the patient and doctor, classificatory medicine hopes to discern the “ideal configuration of the disease” in the “concrete, free form, totalized at last in a motionless, simultaneous picture” (*BC*, 9). Medicine built upon this nosological table must not interfere with the progress of disease, but rather must stand back as the essence of disease reveals itself in its ideal spatiality.

While the complications of the patient and the doctor are unavoidable and thus tolerated by classificatory medicine, the hospital, with its medical apparatuses and therapeutic interventions, is a flagrant violation of the essence of disease. In the hospital

⁴ Convinced by the feminist critique of the power of language and the exclusion of the feminine from the domain of the symbolic, I have purposefully utilized anachronistic feminine pronouns to refer to eighteenth- and nineteenth-century physicians, judges, and other authority figures throughout this work. Simulating an act of textual violence, this rhetorical technique is meant to be jarring and discomfiting to both the writer and reader, bringing to the fore past disparities of opportunity and present inequalities within the grammatical structure of language itself.

environment, no disease could exist with its essence intact. Everything about the hospital is artificial, and, according to eighteenth-century classificatory medicine, it stands opposed to the natural essence of disease in every way. The recognition of disease species by the doctor becomes nearly impossible in the hospital because the “transplanted disease runs the risk of losing its essential identity” (*BC*, 17). In this “unkempt garden” of disease, species crossbreed, thus altering the “natural course of the disease” and making it “more difficult to decipher” (*BC*, 17). With the proliferating effects of the hospital denigrating the natural essence of disease, it is no wonder classificatory medicine labeled these cesspools of disease “temples of death” (*BC*, 17).

Since the eighteenth century configured disease as both natural and ideal, an essential phenomenon with invariant laws, the natural place of disease was in the family. The logic of this assertion is apparent. Because life and disease follow the same laws of nature, what is natural for life is likewise natural for disease. The natural setting for life is within the context of the family; therefore, the proper place for disease is also within the family. In this setting, the disease has free reign to develop according to its predetermined course. For both the patient and her disease, the loving family provides the ideal backdrop since she avoids the despair of entering a “temple of death” and her illness is afforded the space and freedom “to attain its own truth” without interference (*BC*, 17). For the poor and those without families, the hospital was a necessary evil, but in general situating illness within the natural environs of the family, free of “artificial complications,” was the proper course of action (*BC*, 39). According to this logic, “disease would everywhere find its natural, or almost natural, locale where it would be free to follow its own course” (*BC*, 40). When granted the freedom to accede to its ideal

essence, the disease would naturally run its course and “abolish itself in its truth,” thus allowing the patient to return to health (*BC*, 40).

On the cusp of the nineteenth century, an epistemic break marked the end of classificatory medicine and the reorganization of all medical knowledge. The simultaneous table of disease lost its authority and the medical gaze shifted from the nosological gaze, perceptive of essences, to an anatomo-clinical gaze that sought the foundations of disease, not in pathological essences, but rather in the living being gone awry. Foucault finds evidence for the emergence of the age of the clinic in what he calls the proto-clinics of the end of the eighteenth century. Existing in the liminal position between classificatory and clinical medicine, the proto-clinic overcame many of the shortcomings of classificatory medicine but nevertheless retained the conception of an ideal disease.

The primary goal of the clinic was the instruction and training of aspiring physicians and surgeons. However, the focus on learning from practical experience was not a new idea, for there was already in the eighteenth century “very wide recognition of the need for teaching through practice itself” (*BC*, 58). For Foucault, what accords these clinics an integral place within the history of medicine is not the fact *that* they aimed to teach via a practice but *how* they did so. As the eighteenth century saw, the hospital was a breeding ground for disease, an artificial complication in the natural progression of ideal diseases. How could the proto-clinic not fall prey to this same criticism? According to Foucault, the arrangement of the clinic and the selection of “cases” allow the disease to maintain its ideality within the clinic. Patients, or, more properly, cases, were admitted to the clinic for a particular purpose. The clinic could neither accept everyone nor be overly

specialized, since the ensemble of cases gathered there had a quite specific aim—“to manifest the complete circle of diseases” (*BC*, 59). In order for it to overcome the problems of the hospital, the clinic must accept cases on the basis of pedagogic utility. It must create a “didactic totality of an ideal experience” representative of all diseases (*BC*, 59). Thus, even before a doctor met with a patient, the proto-clinic was a carefully “structured nosological field” (*BC*, 59).

Although the ideal conception of disease was little altered by this restructuring of the nosological field, the level of knowledge and truth shifted. Prior to the formation of these proto-clinics, in the hospitals and in the homes of the ill, the doctor sought the knowledge of disease at the level of the individual before her. She was summoned by the family when one of its members “happen[ed] to be suffering from one disease or another,” and her task was to sort through the symptoms, separate the effects of the pure disease from those of the patient, and classify the species (*BC*, 59). She had to look for the truth of disease “buried in the patient, concealed within him like a cryptogram” (*BC*, 59). By contrast, the proto-clinic established itself as a repository of ideal cases or examples of disease. Here, the doctor does not encounter an individual who happens to be suffering, but rather a disease “that happen[s] to be afflicting this or that patient” (*BC*, 59). Truth in the proto-clinic was thus gleaned at the level of the totality in its “synthetic form” (*BC*, 59). The physician or students attended the patient’s bedside with the chief task of naming the disease from its visible manifestations. Like the ideal disease of the eighteenth century, the ontological order of disease in the proto-clinic existed “already completed” and the perceptible symptoms were “no more than its consequences” (*BC*, 59). Thus, an *a priori* relation between the essence of the ideal disease and its visible

manifestation provides the framework for the clinical gaze. What needs to be discerned are these *a priori* “relations set up between the phenomena observed” and the “antecedents ascertained,” or in other words the “ideal key” that would fully elucidate the disease (*BC*, 60). However, the chief difference between the task of the hospital doctor or family physician and the clinical student is the assurance the latter has that what she sees is an uncorrupted, ideal type. By selecting only ideal cases that complete the “circle of diseases,” the shift in knowledge of disease to a higher synthetic plane negates the disturbance caused by the patient’s body (*BC*, 59). Whereas the hospital doctor encounters disease in its bastard form, often altered beyond hope of identification, the clinician deals only with ideal “examples” of disease (*BC*, 59).

As before, the ideal structure of disease already incorporates time, but now, within the proto-clinic, time takes on a pedagogic role. Disease in its pure form in the proto-clinic invariably follows its fixed course, since there is nothing to disrupt it. However, in this setting, time provides the ultimate confirmation or disconfirmation of the designation of the disease. If, through her observations, the clinical student has failed to grasp the ideal key and reach the proper designation of the disease, the inexorable movement of time will reveal this failing. Time is the medium through which the truth of disease speaks to the medical gaze. Since it is structured around diseases in their pure form, the clinic allows for this test of time. This temporal test would have been impossible in the unkempt garden of the hospital, since in that setting there are no guarantees that the essence of disease will show itself through the disturbances caused by both the body of the patient and the investigation of doctor. By contrast, the ideal setting of the clinic allows nature to speak in the silence while the doctor and students observe.

The reorganization of medicine around the clinic and the anatomico-clinical gaze brought together two divergent themes of eighteenth-century medicine: the dramatic time of disease and its invariant, ideal nature. For classificatory medicine, these two aspects of disease, the dynamic and the atemporal, formed a “double reality” (*BC*, 91). These two aspects mapped directly onto the eighteenth century’s conception of signs and symptoms. On the one hand, the symptom, as the “form in which the disease is presented,” has ontological priority. It communes most closely with the essential nature of the disease: “it is the first transcription of the inaccessible nature of the disease” (*BC*, 90). Although the constellations of symptoms never reveal the disease itself to the gaze, since it is accessible only to reason, they nevertheless comprise the “essential symptom” and “make it possible to designate a pathological state” (*BC*, 90). The sign, on the other hand, deals with the dramatic time of the disease. It announces, points to, and indicates “what will happen” or “what has happened” (*BC*, 90). Offering up no hidden truth, no essence of disease, the sign adds nothing to the knowledge of disease but instead “provides a basis for recognition” (*BC*, 90). Inscribed in the temporal progression of disease, the sign addresses itself to the outcome of disease and not its “immobile truth” (*BC*, 91). According to Foucault, the doublets of ‘dramatic time–sign’ and ‘essential truth–symptom’ existed in eighteenth-century medicine as two separate and distinct systems. Through the reorganization of medical knowledge in the age of clinic, the nineteenth century dissolved the absolute distinction between the two and annulled their opposition.

This move to efface the radical distinction between the sign and the symptom—the dramatic time and the ideal nature of disease—by nineteenth-century clinical medicine was bound up with a greater change in the very language of disease. In the

eighteenth century, signs and symptoms related to disease as signifier to signified. The former indicated the latter without exhausting it. As Foucault points out in the preface, this relation is identical to that between commentary and speech in which “to comment is to admit by definition an excess of the signified over the signifier.”⁵ The signs and symptoms can point to, indicate, and signal the disease as much and as often as they can, but they still fail to reveal the disease in its essence. A surplus of the essence always remains left over, as if hidden behind a veil, inaccessible to the signifier. Thus, the true form of disease was never entirely accessible to the nosological gaze of classificatory medicine. According to Foucault, nineteenth-century clinical medicine did away with this signifier-signified structure of disease, and in so doing, it also did away with the essence of disease. Thus, in the nineteenth century, the medical gaze achieved direct access to the truth: finally, “truth” was “wholly given to the gaze” (*BC*, 91). By abolishing the essence of disease, this restructuring of the conditions of medical knowledge exposed the disease to the full light of day in utter transparency. Under this configuration of disease, the signs and symptoms lose their distinctive character, for “signs and symptoms are and say the same thing” (*BC*, 93), and together they cease to merely signify the disease, but rather they become the disease: “the disease is simply a collection of symptoms” (*BC*, 92). Thus, clinical medicine dissolves the tension between the dramatic time and the ideal nature of disease:

The opposition between nature and time, between what is manifested and what announces, has disappeared; the distinction between the essence of disease, its symptoms and its signs, has also disappeared. . . . The medical field was no longer to know these silent species; it was to open on to something which always speaks a language that is at one in its existence and meaning with the gaze that deciphers it—a language inseparably read and reading. (*BC*, 96)

⁵ Foucault, preface to *BC*, xvi.

In this manner, the chronological time of disease progression and the ideality of disease, which always includes this time in advance, come together before the nineteenth-century gaze. For clinical medicine, the language of disease ceases to differentiate between the gaze that reads the text of disease and the nature that both writes and speaks it—the world and language are exactly superimposed.

In the eighteenth century, medicine recognized itself as an uncertain knowledge. This admission of uncertainty, despite medicine's recourse to an ideal and invariant configuration of disease, indicated both the complexity of its object (i.e., the human being) and the imprecision of medicine itself, caused principally by the disconnect between the signifier-signified structure, which forever prevented the medical gaze from obtaining the essential nature of disease. However, with the dawning of the age of the clinic in the nineteenth century and its reduction of the gap between the signifier and the signified to the point of complete overlap, this uncertainty was transformed into a type of statistical probability that converged upon certainty. Clinical medicine no longer looked upon each patient as a sick person with a corrupted essential disease, completely distinct from all others. Instead, it saw in the sick individual “an endlessly reproducible pathological fact to be found in all patients suffering in a similar way” (*BC*, 97). In this manner, the multiplicity of observations of each patient represented a part of the whole. When combined, the observation of a theoretically infinite number of patients formed a convergent series. For nineteenth-century medicine, the physician did not need an ideal key of disease by which to recognize and distinguish the essential disease from its artificial complications. Rather, clinical medicine constructed the series of all the partial facts, and the resulting synthesis gave the ideal disease. In other words, “the general laws

of nature” are to be discovered through “studying” and analyzing “the most frequent phenomena.”⁶ Whereas for the recognition of the pure form of disease in classificatory medicine “it was first necessary to possess it,” and from this pure essence to subtract out the accidental features of actual experience, in the nineteenth century the accidental features of disease “separate of their own accord ... because they are integrated into the domain of probability” (*BC*, 102). That is, the statistical frequencies of the individual pathological facts gathered from each patient combined to “cancel each other out in the general configuration” (*BC*, 102). This alteration in the configuration of medical knowledge also had a rehabilitating effect on the institution of the hospital. Once nineteenth-century medicine developed a method to obtain the ideal disease from the statistical frequency, the practice of medicine no longer required that disease remain in a natural environment:

As soon as medical knowledge is defined in terms of frequency, one no longer needs a natural environment; what one now needs is a neutral domain, one that is homogeneous in all its parts and in which comparison is possible and open to any form of pathological event, with no principle of selection or exclusion. (*BC*, 109)

So long as there is no extraneous selection or variables, whatever the effects of the hospital on disease, they will be “rigorously annulled,” since the hospital will be a constant across all the patients (*BC*, 109). In this manner, the clinical medicine of the nineteenth century established a probabilistic knowledge, which no longer required *a priori* access to an ideal key, since the ideal disease could be empirically derived from the observed frequency of symptoms.

Through the work of Bichat, nineteenth-century medicine’s clinical gaze redirected its attention from the disease within life to the corpse in the repose of death.

⁶ F. J. Double, *Séméiologie générale*, vol. 1 (Paris, 1811), 33, quoted at *BC*, 102.

According to Foucault, this rediscovering of pathological anatomy by Bichat and his followers reveals a fundamental reconfiguration of the movement of time within disease. Foucault contends that pathological anatomy would never have been readmitted into the clinic at the beginning of the nineteenth century unless the progression of disease were inextricably linked to the progression of knowledge. While the knowledge of the living disease was obscure and unintelligible, death brought clarity to this confusion. The transparency and “white visibility of the dead” served as the necessary lens to elucidate the complex living disease (*BC*, 126). In this way, the development of medical knowledge directly mirrors the progression of disease as captured in the anatomical gaze. As disease tends toward death, the medical gaze ascends closer and closer to the truth of disease, and in death, it finally reaches this ultimate goal. For Bichat, this linkage between the forward movement of knowledge and disease is no accident. In fact, according to him the coupled development arises from the very nature of disease itself. That is, the essence of disease is analytic; it breaks down and separates the complex into the simple. Thus, the analysis by the physician is merely a “repetition in the doctor’s consciousness of the decomposition raging in the patient’s body” (*BC*, 130). For example, the pia mater and arachnoid, two of the membranes covering the brain and spinal cord, are easily confused in life. However, the alteration caused by inflammation easily separates and clarifies these two tissues, since the former “reddens” and “then becomes harder and dryer” while the latter “becomes whiter” (*BC*, 130). More than providing a model for objective analysis, this analytic progress of disease is, for Bichat, “an essential stage in the pathological process” (*BC*, 131). In this way, the disease speaks its own truth to the anatomical gaze in death. For nineteenth-century pathological

anatomy, the essential nature of disease constantly propels it towards further simplification and clarification to ultimately culminate in the illuminating white light of death.

This new focus on pathological anatomy supplanted the chronological appearance of symptoms with the localized lesion as the definitive sign of disease. Prior to the nineteenth century, the nosological gaze was able to designate the disease from its impure appearance in the patient because it already held the ideal key. At the cusp of the clinical period, the physician no longer required this key in advance, since patients were reconceived as part of a convergent series that cancelled out all anomalies to reveal the pure form of the ideal disease. Of course, this configuration of the disease first required the symptoms of many patients in order to recognize the disease in any given patient. With the shift to pathological anatomy, this focus on cataloging and combining the plurality of symptoms from all the different patients was no longer necessary. Under this reconfiguration of disease, the anatomical gaze discovered a constant phenomenon. All the visible symptoms with which it had previously concerned itself turned out to be imprecise and uncertain. The convergent series now only seemed to capture a generic disease, not the ideal disease. For instance, the observable symptoms of pulmonary phthisis—that is, “coughing, difficulty in breathing, marasmus, hectic fever”—were not the “necessary and sufficient condition[s] for the presence of phthisis” (*BC*, 138). One could encounter a patient lacking any (or all) of these symptoms who nevertheless had phthisis, just as one could discover a patient with all these visible symptoms who was later discovered not to have had this disease. For pathological anatomy, none of the visible manifestations of a disease “is absolutely indispensable” (*BC*, 138). Rather, the

“one constant phenomenon” indicative of phthisis was the localizable lesion (*BC*, 138). Without this lesion of the pulmonary parenchyma, discoverable only through autopsy, there could be no phthisis.

From Bichat onwards, the gaze of pathological anatomy reigned supreme within medicine. The presence or absence of a lesion—the “localization of [this] fixed point”—determined the presence or absence of disease (*BC*, 138). The frequency of visible symptoms apparent to the clinical gaze and the construction of the convergent series were now only useful insofar as they pointed to the underlying site of disease. These symptoms in the “chronological series” became “secondary phenomena” hovering over the fixed point, the privileged site of disease (*BC*, 139). Henceforth, “the succession of forms and symptoms ... appears simply as the chronological image of a more complex network: a spatio-temporal proliferation spreading from an original attack throughout the organism” (*BC*, 139). Under this configuration, the observations of the clinical gaze could be potentially useful since they could afford an indication of the disease in life. However, they were not certain signs of disease, since they could “slip and disappear” (*BC*, 138). Only the gaze of pathological anatomy, with its privileged access to the corpse, could once and for all discover the site of disease.

With this turn to pathological anatomy, medicine established new rules governing disease progression. Whereas the eighteenth century conceived of the dramatic time of disease as already contained in its essence, the nineteenth-century anatomical gaze situated disease progression at the level of the local lesion. That is to say, through its reconfiguration of the disease and its symptoms, the nineteenth century reversed the relation, describing the origin and movement of disease from the fixed point in the

pathological anatomy. The progression of disease was no longer determined at the level of the visible symptoms of the ideal disease and then played out in the body, but rather it began at the fixed point of disease and continued by following the anatomical law of tissual communication. According to Bichat, “a pathological phenomenon follows in the organism the privileged way prescribed by tissual identity” (*BC*, 149). That is, the localized disease traverses along the tissues, “follow[ing] a tissue horizontally, without penetrating vertically into others” (*BC*, 150). Thus, the anatomy of the body, with its layers of distinct tissues, predetermined the course of disease; the body itself proscribed the only lines of continuity that the disease could follow. Just as “organic vegetation” develops in the soil proper to it, so too the disease: it thrives only in the appropriate tissue and flourishes and spreads throughout that tissue following law-like patterns of growth (*BC*, 152). By situating disease within the life of the living being, nineteenth-century pathological anatomy inscribes within the body the progression of disease: “the pathological course now has its obligatory ways” (*BC*, 150).

This inscription of disease within the body inserts death into life and establishes disease for the first time not as negative and a metaphysical evil, but rather as something with positive content. According to Foucault, disease becomes the link between life and death in the nineteenth century. In one sense, death opposes life, but in another the two are “profoundly bound up” together (*BC*, 155). The concepts of degeneration and wear illustrate this profound linkage between life and death for the anatomical gaze. The degeneration of the living body is completely natural, governed by the same reversible laws that led to its creation. In other words, this degeneration is neither random nor a simple decline, since “nature is constrained by constant laws in the destruction as in the

construction of beings.”⁷ Disease and death, in this manner, are neither counter-nature nor an accident of life, but rather they are essential to it. Although it ultimately ends in death, the processes of degeneration are not counter to life: “Degeneration lies at the very principle of life, the necessity of death that is indissociably bound up with life, and the most general possibility of disease” (*BC*, 158). As an essential temporal dimension of organic activity, wear effects the gradual destruction of the tissue, organ, or body in the very action that constitutes its life. For instance, the continual pumping of the heart muscle is both a sign of life and of the death to come. Wear, that precursor to death, creeps in and resides within the contractions of the heart that establish its life. Nineteenth-century medicine, by crafting the trinity of life-disease-death, does away with the conception of disease as a metaphysical, ideal presence hovering over the life of the living being. The gaze of nineteenth-century pathological anatomy opens up onto the death already inscribed in life.

Foucault’s discussion in *The Birth of the Clinic* brings to light the mutation in epistemic experience that led to this profound transformation in the knowledge available to the medical gaze. Focusing on the rupture at the turn of the eighteenth century, he highlights the reorganization of knowledge necessary for the profound reconfiguration of disease—from the metaphysical and ideal pure disease of the eighteenth century to the nineteenth-century conception of disease as a localized point fixed in anatomy. The historical conceptions of disease he unearths serve to disturb the complacency with which many think the modern medical and scientific practices and discourses of disease have attained the light of truth to perceive the totality of the signified disease without the distortion and limitation of the signifier. Like the relation between speech and

⁷ R. Laënnec, *Traité inédit d’anatomie*, 52, quoted at *BC*, 157.

commentary, his work suggests the concept of disease has not been exhausted but rather points to a future open to new ways of thinking and rethinking.

2.2 From Condition to *Being*: The Formation of Recognizable *Types of Being*

According to Foucault's account in *Abnormal*, at the end of the nineteenth century psychiatry discovered a concept which would allow the discipline to retain its newfound authority without passing through the domain of medical illness—the condition. No longer would psychiatry need to inscribe an individual's actions or behavior within a pathological process in order to form the individual into possible object of study for psychiatry. Through the configuration and deployment of the concept of the abnormal condition, psychiatry bypasses organic medicine and its focus on sick individuals. Instead, the discipline constitutes abnormal individuals who become the exclusive objects of psychiatric knowledge. This concept takes the constellation of disparate and amorphous signs and symptoms and transforms them into a stable *type of being* that can then be measured against the opposing norm.

The following discussion of the condition begins with an exploration of the historical formation and emergence of this concept and an analysis of its function within psychiatry as presented by Foucault in *Abnormal*. It then turns to a consideration of two *types of being*—the madman and the homosexual—both of which fit the general characteristics of the abnormal condition. This section distills the crucial aspects of these two conditions from Foucault's *History of Madness* and *History of Sexuality*, respectively. Even though the configuration of madness in the eighteenth century

predates the historical formation and elucidation of the condition, it nevertheless bears a striking resemblance to the key features of the condition.

While the relevance of the historical emergence of the *being* of the homosexual likely is obvious for this analysis of the contemporary emergence of AIDS and HIV, the discussion of the madman may seem tangential. However, even on the surface, parallels between the manifestation and recognition of the madman in the classical age and the individual with AIDS at the turn of the century abound. For instance, each condition presents primarily as a lack, despite the plenitude of signs and symptoms. In the eighteenth-century configuration of madness, it is the lack of reason; in AIDS, it is the lack of health or the generalized absence of the proper immune response. In addition, the recognition of both madness in the classical age and AIDS in our own precedes any theoretical knowledge. According to Foucault, the classical gaze recognized madness in an immediate sense perception without detouring into the realm of theoretical knowledge. Likewise, the condition of AIDS was perceptible to the trained medical gaze long before any knowledge of the virus, HIV, was available. The many superficial linkages such as these between the appearance and recognition of both the madman and the individual with AIDS warrant a closer look at Foucault's account of the historical emergence and development of madness.

2.2.1 The Condition

The theory of the condition emerged within psychiatric discourses in the latter half of the nineteenth century as the discipline attempted to universalize its medical power and expand the domain of the psychiatric gaze. While this transformation in

psychiatry had diverse motivations and ramifications for the discipline, it also had a profound effect on the configuration and perception of illness. Eschewing traditional medicine's emphasis on precise chains of causality, this new psychiatry, organized around the grand theory of the condition, sought to establish an indefinite yet stable backdrop as the foundation of disease.⁸ Passed down through complex heredities and often marking the physical body, the condition signified a new *type of being*. That is to say, the theoretical development of the condition within psychiatric discourse caused permanent, stable beings to appear before the gaze from within the amorphous constellation of behaviors and actions of the individual.

Prior to the historical formation of these grand theories, psychiatry sought to validate its medical authority through recourse to organic illness. An individual became a possible object of psychiatry only if her behavior and actions could be inserted into a pathological process. Thus, psychiatry searched for discontinuities in behavior that could constitute the rupture between the normal state and the pathological. According to Foucault, this "medicine of mental alienation," exemplified by the work of Esquirol, modeled itself on traditional medicine.⁹ In order to legitimately exercise medical power, it first had to establish the objective relation between medicine and illness. For psychiatry to function at the beginning of the nineteenth century, it was obliged to constitute the

⁸ Here, I am attempting to draw a distinction between the precise chains of causality that operate within organic medicine (e.g., an etiologic agent causes infection, which causes an immune response, which in turn causes swelling, etc.) and the background, generalized causality established by the condition. The causality operating from this background condition is neither linear nor fixed (i.e., the condition can act as a cause for a complex network of effects, but the presence of the condition need not have any particular effect).

⁹ Michel Foucault, *Abnormal: Lectures at the Collège de France, 1974-1975*, trans. Graham Burchell (New York: Picador, 2003), 309 (hereafter cited in text as A).

individual as “ill for a knowledge that will then authorize [the psychiatrist] to function as medical power” (A, 309).

Foucault cites the 1826 Henriette Cornier case as the example *par excellence* of this deployment of psychiatry.¹⁰ In this case, Cornier, a young woman who was abandoned by her husband and abandoned her children in turn, found work as a domestic servant in Paris. She was given to bouts of sadness and often threatened to commit suicide. One day she offered to care for her neighbor’s infant. Upon securing the neighbor’s assent, Cornier took the child to her room and cleaved the child’s head from its body with a large knife she had placed in her room in advance. When questioned why she had committed the act, she replied, “Why? An idea.”¹¹ Incomprehensible to doctors, the case was handed over to the psychiatric authority. According to Foucault, the absence of motive in this case “function[s] as the cornerstone for psychiatric intervention” (A, 113). In order for early nineteenth-century psychiatry to attribute the act to madness or mental illness, it had to demonstrate a rupture in Cornier’s behavior and to situate this rupture as the onset of the pathological process. In other words, the psychiatrists who examined Cornier needed to establish the discontinuity in her behavior in order to consider her mentally ill:

One tried to inscribe Henriette Cornier’s decapitation of a child within an illness that was naturally very difficult to see but whose signs a practiced eye at least could detect. And this was how, not without difficulty and much subtlety, one came to refer all this back to a change of mood that affected Henriette Cornier at a certain time of her life and marked the insidious invasion of this illness that remained practically without symptom except the crime, but which was already signaled by this little crack in her mood. (A, 297)

¹⁰ See A, 112.

¹¹ H. Cornier in Ch. H. Marc, *De la folie*, vol. 2, 84 and 114, quoted at A, 112.

The transformation in her mood marks the break between her and her childhood. In fact, according to Foucault, Cornier was “radically separated from childhood in two ways”: first, the morose adult she had become bore no resemblance to her carefree childhood, and second, she had no link whatsoever to the child she decapitated (A, 303). This focus on discontinuity reveals early nineteenth-century psychiatry’s dependence upon the traditional pathological model. That is, it followed traditional medicine’s emphasis on the chronological process of disease and the event of illness itself. The psychiatrists in the case considered the change in Cornier to be “monstrous, sick, and pathological in itself,” something that “nothing can justify except, precisely, a pathological basis” (A, 297).

With the shift in psychiatry in the second half of the nineteenth century, the theories of the condition supplanted the appeals to the pathological model. Instead of inserting the offense in question into a chronological pathological process, psychiatry situated it “within a schema of permanent and stable stigmata” (A, 298). The mental illness no longer presented in time like any other, but rather it pervaded the entire being. That is to say, where previously psychiatry saw a person afflicted with mental illness, by the end of the nineteenth century the psychiatric gaze met with individuals fixed within a “*condition of abnormality*” (A, 307). The reification of amorphous signs and symptoms into these stable conditions of abnormality led to the constitution of new *types of being*, which then appeared before the psychiatric gaze. There was a complete coincidence between the mental illness and the individual; the illness, be it homosexuality, exhibitionism, or kleptomania, was no longer a disease with an identifiable onset, fixed progression, and recognizable symptomatology. Instead, the behaviors and actions that constituted these conditions coalesced around the individual to produce new *types of*

being: the homosexual, the exhibitionist, and the kleptomaniac. In this way, the fixed condition had the effect of ontologizing and codifying various “eccentricities into well-specified, autonomous, and recognizable syndromes” (A, 310).¹²

The theoretical framework of the condition reconfigured the entire domain of psychiatry and the people who were considered its valid objects. With the development of these theories, psychiatry was no longer beholden to the pathological model of illness. According to Foucault, from roughly 1865-1870 this transformation of psychiatry caused the abnormal individual to “emerge in psychiatry ... and populate it until the end of the nineteenth century” (A, 310). Behaviors that deviated from the norm were characterized and reified into *types* of abnormal individuals. Henceforth, the behaviors and actions of these individuals ceased to be simply actions and instead became constitutive of *being*.

Whereas the Henriette Cornier case exemplified the psychiatry of the first half of the century, Foucault points to the case of Charles Jouy to illustrate this new psychiatry of conditions that emerged in the latter half. The facts of the case are quite banal: Charles Jouy, an agricultural worker in the Nancy region, persuades a little girl to masturbate him in return for treats or money.¹³ Born an illegitimate child and orphaned quite young, Jouy worked and lived his entire life at the margins of society. He was “poorly educated, a bit

¹² In his account in *Abnormal*, Foucault draws a slight distinction between the syndrome and the condition (See A, 310-312). For Foucault, although he lists each as a concurrent development in this new psychiatry at the end of the nineteenth century, the condition is the “fundamental” term (A, 311). Despite this concurrence, the syndrome appears primarily as a precursor to the condition. However, the distinction between the two is difficult to extract since Foucault only touches upon the theoretical conceptualization of the syndrome while he expounds at length the precise function of the condition. For the level of exposition in the present work, this distinction is too fine to be pertinent.

¹³ I thank Mary Beth Mader for bringing to my attention the contemporary critical debates surrounding Foucault’s treatment of the Jouy case. Foucault reduces the interaction between Jouy and the child to a matter of persuasion: “Charles Jouy got her to masturbate him in the fields” (A, 292). By contrast, contemporary feminists have characterized the interaction as a transaction, promising the girl money or sweets in return for the sexual favor.

drunk, solitary and badly paid,” or as Foucault summarizes, “the village idiot” (A, 292). The incident between this forty year old man and the little girl was anything but extraordinary. In fact, according to Foucault, a similar incident “a few years earlier would doubtless have seemed perfectly commonplace and anodyne,” but in this instance, the mayor, the girl’s family, and the entire village appealed to the psychiatric authority for professional intervention (A, 296). However, rather than look for the decisive break between Jouy’s childhood and the sexual incident, the psychiatrists find in Jouy a proper object of psychiatry precisely because there is no break. According to the psychiatric evaluation, the crime was not a result of some radical change in his personality that occurred at the initiation of the pathological process, as was the case with Cornier. Instead, Jouy’s action is situated within “a permanent, constitutive, congenital condition” (A, 298). He is not separated from his action by any discontinuity. In fact, his entire being typifies his crime, and this fact “allows the act to be psychiatrized” (A, 299). The psychiatrists point to the physical signs of his abnormal condition:

The face and cranium do not present the standard symmetry that one should normally find. There is a lack of proportion between trunk and limbs. The cranium is faultily developed; the forehead recedes, which, with posterior flattening, makes the head into a sugarloaf; the lateral sides are also flattened, which raises the parietal bones more than is usual.¹⁴

These physical signs along with his behavior implicate an underlying condition, the “permanent causal background,” which serves as the foundation for all his abnormal actions (A, 312). The psychiatric evaluation finds the physical and mental signs “typical of imbecility,” and this label confers upon Jouy a distinctive *type of being*, the being of an imbecile (A, 298). The attribution of this fixed condition, from the constellation of polymorphous symptoms and signs, no longer seeks to constitute the individual as ill, but

¹⁴ H. Bonnet and J. Bulard, *Rapport médico-légal*, 6, quoted in A, 297-98.

rather as abnormal, for psychiatry in the second half of the nineteenth century has broken its ties to pathology and no longer derives its power from traditional medicine. Indeed, the deployment of the condition, which results in the constitution of a new *type of being*, is precisely the point at which psychiatry establishes its authority independent from medical authority.

The psychiatry of the latter half of the nineteenth century thus becomes a science of the normal and abnormal. Not concerned with illness, it refocuses its attention on deviations from the norm. In itself, each of the characteristics that point to the underlying condition (e.g., the shape of Jouy's skull) is not a pathological fact. Rather, it is a deviation from the norm, a sign of abnormality, but again, each deviation in itself is not sufficient to constitute a new *type of being*. Only when it "appear[s] within the constellation in which it figures" does it become constitutive of an abnormal individual (A, 307). If they occur, illnesses are necessarily secondary, derivative phenomena "with regard to this condition that is fundamentally a condition of abnormality" (A, 307). Opposing the condition of abnormality to the normal individual, this reconfiguration of psychiatry focuses on the "reality of lack" and the "visible consequence of this primary and fundamental lack" (A, 300). That is, the condition, structured as a deviation from the norm, is fundamentally negative, an absence of normality. It is the lack of inhibitions, a deficiency in development, which link the condition to the aberrant behavior. Thus, the abnormal individuals that populate the domain of psychiatry toward the end of the nineteenth century appear fundamentally and primarily as a visible absence, a lack of normality.

Although it dispenses with the positive manifestations of illness and the precise causal chain of pathological chronology, this new psychiatry founded upon permanent and stable conditions of abnormality did not do away with causality entirely. In fact, the nosography of conditions developed in the latter half of the nineteenth century demanded a causal explanation for the condition. Whence did all “these little people[s] of abnormal individuals” suddenly appearing before the psychiatric gaze come (A, 310)? For psychiatry to maintain its newfound authority it must account for this strange phenomenon: “the condition must be set within a sequence that can produce it and confirm it” (A, 313). However, since it just distanced itself from pathological chronology and replaced the concept of illness with that of abnormality, psychiatry was not about to reinscribe the condition into a pathological series within an individual. Instead, it looked to the domain of heredity. According to Foucault, this turn to heredity positioned the abnormal individual—“the victim, subject, and bearer” of the abnormal condition—within a family lineage (A, 313). Only the “body of heredity” seemed sufficiently diverse yet powerful enough to “definitely mark the whole of an individual’s body” (A, 313).

Explaining and confirming the presence of the condition of abnormality via recourse to heredity has the great advantage of offering to the psychiatrist a huge pool of individuals—parents, siblings, and ancestors—from which to find the causal link. In addition, the study of heredity, according to Foucault, admits “an indefinite causal permissiveness” (A, 314). Thus, to explain the presence of tuberculosis or delinquent behavior in an individual, the psychiatrist need not find a parent or relation who was also tubercular or delinquent to confirm the presence of the condition. Rather, the demands of heredity are not nearly so stringent. Any mental illness, or even a simply a vice such as

drunkenness, could be identified as the causal agent. For the psychiatrist, this “ultraliberal functioning of heredity” established the fact that “anything can be the cause of anything else” (A, 314).

The introduction of the body of heredity thus undergirds the condition of abnormality and provides the causal nexus for the transmission of the condition, both explaining and confirming the diagnosed condition. Moreover, this recourse to heredity further establishes the abnormal individual as a particular *type of being*. The formation and development of the theoretical concept of the condition, with its foundation in heredity, within late nineteenth-century psychiatry allowed for the emergence of abnormal individuals bearing the permanent stigmata of the condition. Through the development and deployment of this concept, psychiatry took diverse sets of behaviors and symptoms and molded them into concrete, stable forms, thus creating fundamentally *new types of abnormal beings*.

2.2.2 The Madman

As presented by Foucault in *History of Madness*, the historical formation and emergence of the madman as a recognizable *type of being* resembles the development of the grand theory of the condition in psychiatry in the latter half of the nineteenth century. Once again, a stable being—the madman—appears and crystallizes against the backdrop of an amorphous constellation of signs and symptoms. Like the condition of the abnormal individual, the madman in the eighteenth century is apprehended by the gaze as a fundamental absence, a lack of reason. However, according to Foucault, a unique feature of this perceptual apprehension of the madman is its disavowal of knowledge—the

madman is immediately recognizable. That is to say, the madman, as a *type of being*, appears in utter transparency before the gaze without first passing through the domain of knowledge. In fact, for the eighteenth century, knowledge of madness as such was hopelessly obscure and only fit for the idle speculations of nosographers. Nevertheless, by virtue of her sanity and normal reasoning, any person could clearly recognize madness insofar as it was instantiated within a particular individual. While the theoretical concept of madness remained opaque, the peculiar *being* of the madman was obvious.

Since the dawning of the classical age, the historical figure of madness has appeared before the objective gaze in an immediate perception. Apprehended by an “enunciatory consciousness,” madness was always simply and immediately perceived as present or absent.¹⁵ According to Foucault, the structure of this consciousness of madness never appeals to any theoretical knowledge, but instead immediately recognizes the madman as a specific *type of being*. The enunciatory consciousness of madness

allows for immediate pronouncements, without any detours through the world of knowledge: ‘that man is mad’. Here there is no question of qualifying or disqualifying madness, but only of pointing at it as a kind of substantive existence: there before us, the object of our gaze, is someone who is undeniably, indisputably mad.... This consciousness is not concerned with values, peril or risk, but is on the level of being. It is nothing more than a monosyllabic nod that categorizes at a glance,.... a simple perceptive apprehension. (*HM*, 166)

Madness thus appears to the gaze in the *being* of the madman. He is a peculiar type of man, devoid of reason all the while imitating it, yet the perceptual consciousness of madness does not become mired in the multiplicity of possible manifestations of the madman’s madness. It does not dwell on the vacant stare, the incoherent mumblings, the incessant and meaningless gesturing. It does not catalog the signs and symptoms to arrive

¹⁵ Michel Foucault, *History of Madness*, trans. Jonathan Murphy and Jean Khalfa (New York: Routledge, 2006), 166, (hereafter cited in text as *HM*).

at the conclusion: 'that man is mad'. All that is unnecessary. Instead, it completely bypasses the domain of knowledge and holds no pretensions that it knows what madness is. For the enunciatory consciousness, madness simply appears as the *type of being* of the madman. This eighteenth-century structure of madness "recognized the madman, while simultaneously admitting its incapacity to define madness itself" (*HM*, 180). Whereas "madness has a confused, distant, almost imperceptible outline," according to Foucault, "the madman has an immediately precise, obvious, concrete character" (*HM*, 180).

This immediate perception of the madman as a peculiar *type of being* occurs despite a lack of positive symptoms and a definitive sign. By the beginning of the eighteenth century, madness had lost its distinctive character. Unlike in the Renaissance, when madness "had made its presence manifest through innumerable signs, threatening reason with immediate contradiction," the madness of the classical age was much more subtle (*HM*, 178). Indeed, according to Foucault, by the turn of the century, "madness [had] grown sufficiently subtle to have lost all visible, assignable form" (*HM*, 176). Madness had shed "its real plenitude," and instead of presenting itself with positive phenomena, it became characterized by a lack (*HM*, 176). Thus, the critical problems posed by madness itself to the theoretical and discursive understanding of madness in the classical age were questions of identity: "How could the madman be recognized...? How could he be singled out without error?" (*HM*, 175) The attempt to respond to these pressing questions of identity was further confounded by madness' affinity to reason, since "there is in madness an essential aptitude for mimicking reason" (*HM*, 176-77). For the classical age, madness was to be found everywhere, even lurking within reason itself. Even an individual's arrival at wisdom could not guarantee an absence of madness, since

madness, as an aspect of nature, operates at an instinctual level to “ensure that, man, despite himself is the instrument of wisdom” (*HM*, 177). In this way, madness and unreason were the handmaidens of reason. They offered shortcuts to wisdom, bypassing the difficult terrain and “arduous paths” of reason (*HM*, 177). By the eighteenth century,

madness had become a more diffuse presence, devoid of obvious signs, exterior to the world of the senses, in the secret reign of a universal reason. It was at once plenitude and total absence: inhabiting all regions of the world, it spared no wisdom, no order, and escaped destruction by the senses. It was present everywhere, but never in that which made it what it is. (*HM*, 178)

This diffusion and proliferation of madness and its elusive nature, hiding just below the surface of reason, made it difficult to identify and pin down with any theoretical accuracy. The problem of madness thus seemed irresolvable for the classical age. Indeed, this problem was irresolvable, perhaps, but not unavoidable.

The configuration of madness in the classical age rendered it structurally invisible to the gaze. Within this configuration, a fundamental gap existed between the presence and manifestation of madness. No definitive sign nor positive manifestation gave madness away, yet madness, for the classical age, was an indisputable fact. This gap between its presence and visible manifestation rendered madness structurally impossible to locate in itself. By positing the figure of the madman as consubstantial with madness, the invisibility of madness ceases to be a problem, since the visibility and positive presence of the madman fills in the visible space left vacant by the lack of positive manifestation of madness itself. Thus, although madness itself remained invisible to the classical gaze, the being of the madman appeared as a pure, positive presence in the place of madness. By circumscribing madness within the confines of being, the classical age overcame this “essential gap” between the “presence and ... manifestation” of madness”

(*HM*, 179). Madness was not permitted to recede from the “world of evidence to an inaccessible domain,” but rather was captured within the being of the madman (*HM*, 179). The exact coincidence of the madman with his madness ensured the truth of madness would not be lost or hidden. Although it exhibited no definitive signs nor a “positive presence,” madness appeared to the gaze “with a sort of calm immediacy, on the surface of the world, with no possible distance for doubt,” *in the figure of the madman* (*HM*, 179). That is to say, it presented itself in this utterly lucid manner not as madness *per se*, “but rather as a recognizable type, as the madman” (*HM*, 179). Thus, the constitution of the *being of madness*, instantiated in the madman himself, became the condition of possibility for the appearance of the state of madness before the classical gaze. In other words, to become visible, madness, like the psychiatric conditions of the nineteenth century, must first have an ontologizing function—it must make its bearer into a recognizable type, a *peculiar sort of being*, the madman.

Like the psychiatric discourses surrounding the formation of the abnormal individual toward the end of nineteenth century, the structure of madness in the classical age presents its object as pure negativity. Beginning in the latter part of the nineteenth century, psychiatry ceased to invoke illness and instead located the condition within a nexus of abnormality. That is, the condition itself is cast as “intrinsically abnormal” (A, 310). Reason opposes madness as pure presence to lack. Thus, the condition for the immediate perception of madness turns upon the visibility of reason. Madness presents itself to the gaze not as a positive presence but as the lack of reason, or unreason itself. According to Foucault,

there is no perception of madness other than by reference to an order of reason, and to the consciousness that we have when confronted with a man of reason,

which can assure us of the coherence, the logic and the continuity that underlies his speech. (*HM*, 180)

It is through recourse to reason that the classical age perceives unreason. In its essential nature, “madness ... was negativity” (*HM*, 251). However, this negativity “offered itself in a plenitude of phenomena, part of the well-ordered riches in the garden of species” (*HM*, 251). In front of the permanent backdrop of madness, the signs and symptoms of the “great figures of madness” were able to reify into particular *types of being* (*HM*, 251). That is, the visible manifestations of the lack, which *is* madness, “took on a particular cohesiveness” to reveal “the *negativity* of madness in a *positive* manner” (*HM*, 251). Foucault cites the conception of dementia in the classical age as support for this claim. As one of these great figures of madness, dementia presented with “no clear symptomatology” (*HM*, 257). Between the level of causes and the level of effects of dementia there is a rupture. The multiplicity of divergent events imbued with causal efficacy never match up with the chain of visible effects. The list of partial causes drawn up by eighteenth-century theorists of madness is virtually endless. Nevertheless, these causes fail to give dementia a positive form, since they all refer back to a fundamental lack—a lack of reason. For the eighteenth century, dementia remains the “most general and negative empirical form of unreason all at once” (*HM*, 257). At best, these postulated causes point out dementia but only via a “negative result” (*HM*, 257). In other words, they express the fundamental negativity of dementia as “a rupture between the mind and the outside world and truth” (*HM*, 257). Dementia, like all forms of madness, remains fundamentally and primarily an absence of reason within classical discourse.

Characterized by this fundamental lack and an evasion of any sort of theoretical knowledge, madness, in the classical age, could only be reached through the *being* of the

madman. Since madness had neither a definitive sign nor stable symptoms itself, it had to be instantiated within the figure of the madman. By reifying the amorphous and pervasive nature of madness into the concrete being of the madman, the classical gaze, despite its inability to comprehend madness, was ultimately able to apprehend madness in the transparency of direct and immediate perception.

2.2.3 The Homosexual

In the *History of Sexuality*, Foucault returns to the homosexual, one of the “little people[s] of abnormal individuals” that emerge in the late nineteenth century, during the consolidation of psychiatric power via the deployment of the grand theory of the condition (A, 310). According to Foucault, the homosexual first appears as a peculiar *type of being* in Westphal’s 1870 article on the classification of sexual perversions.¹⁶ Up to that moment, although the actions and behaviors of the sodomite were well known and regulated by the law, the acts defined as sodomy did not fundamentally alter the *being* of the subject who committed them. However, with the elucidation and codification of homosexuality in the late nineteenth century, the set of acts and behaviors characterized as sodomy suddenly imbued the *being* of the perpetrators with new meaning. What had previously been simply a forbidden act, a breach of religious or civil law, now inhered in the *being* of the homosexual and held the secret to his essential truth. Thus, the abnormal condition of homosexuality and that strange *being*, the homosexual, were born.

The historical emergence of the homosexual, along with a multitude of other sexual perverts, coincides with the ascension of the Victorian regime. Although

¹⁶ See Michel Foucault, *The History of Sexuality: An Introduction, Vol. 1*, trans. Robert Hurley (New York: Vintage, 1990), 43 (hereafter cited in text as *HS*).

commonly characterized by the “image of the imperial prude,” supposedly constraining and silencing all but the most necessary forms of sexuality, according to Foucault, the Victorian age did not mark the beginning of the great repression of sexuality but rather the “incitement to discourse” (*HS*, 3). Debunking this myth of repression, Foucault points to the endless proliferation of discourses in the nineteenth century: the sexuality of children and perverts was called to account for itself and put under constant surveillance, the sexualized space of the family was studied and scrutinized, and the sexualized power relations between teachers and pupils were analyzed and considered in the construction of schools and dormitories. According to Foucault, “The nineteenth century and our own have been rather the age of multiplication: a dispersion of sexualities, a strengthening of their disparate forms, a multiple implantation of ‘perversions.’ Our epoch has initiated sexual heterogeneities” (*HS*, 37). Although the aim of the admonishments against perverse sexualities may have been the preservation of “a sexuality that is economically useful and politically conservative,” Foucault claims this aim was not achieved via reduction (*HS*, 37). Under the supposed repression of sexuality during the Victorian age, the discourses of sexuality blossomed, flourished, and spread into new domains. Rather than inaugurating an uneasy silence, the Victorian age witnessed the emergence of a cacophony of disparate voices engaging in discourses of sexuality, and it is from within this milieu that the homosexual first appears and gains the status of *being*.

Prior to the nineteenth century, the focus of the most intense scrutiny and the target of all sexual prescriptions was the relation of marriage. Other possible sexual relations were neither codified nor prescribed in the same manner. In fact, they were hardly addressed at all. At that time all other sexual relations, such as sodomy, had an

“uncertain status” in the eyes of both morality and the law (*HS*, 37). What would come to be known as sexual perversions in the late nineteenth century were not yet permanent and stable conditions of *being*.

The being of the homosexual emerges toward the end of the nineteenth century when the set of behaviors and actions defined as sodomy coalesce around the individual perpetrator and solidify into a permanent *type of being*. The act of characterization, which identifies the peculiar features and distinctive behaviors of the homosexual, is also the act of constitution. From this moment onward, “homosexuality appear[s] as one of the forms of sexuality” (*HS*, 43). Whereas the ancient concept of sodomy exists on the level of acts, this modern discourse of homosexuality exists on the level of being:

As defined by the ancient civil or canonical codes, sodomy was a category of forbidden acts; their perpetrator was nothing more than the juridical subject of them. The nineteenth-century homosexual became a personage, a past, a case history, and a childhood. (*HS*, 43)

This ontological transformation forged, from a diverse set of actions, “a type of life, a life form, and a morphology,” or in other words, an entirely new *type of being* (*HS*, 43).

Rather than repress or hide the sexual perversions of the homosexual, the medical and theoretical texts from the end of the nineteenth century sought to “draw out” and expose “these polymorphous conducts” in order to fix them into a stable condition (*HS*, 48).

As with all other conditions, homosexuality serves as a permanent backdrop. In itself, it is not a sufficient cause, but any causal explanation must pass through and acknowledge this abnormal condition. Within the homosexual, homosexuality “was everywhere present,” and it could give rise to any number of other abnormal behaviors since it was positioned “at the root of all his actions” (*HS*, 43). Just as madness appeared to the classical gaze in complete coincidence with the madman, so too does

homosexuality in the late nineteenth century. According to Foucault, the homosexual's homosexuality is "consubstantial with him" (*HS*, 43). He is not an individual who happens to be afflicted with this abnormal condition, but rather he *is* this condition—homosexuality *is* his "singular nature" (*HS*, 43). Through this incorporation of perversions, the homosexual's being absorbs his homosexuality and is transformed by it:

Homosexuality appeared as one of the forms of sexuality when it was transposed from the practice of sodomy onto a kind of interior androgyny, a hermaphroditism of the soul. The sodomite had been a temporary aberration; the homosexual was now a species. (*HS*, 43)

Through the action of the medical and technical discourses of sexuality, homosexuality comes to present itself as an "alien strain," and the homosexual himself as a peculiar *type of being* (*HS*, 44). The consolidation of divergent behaviors thus forms the permanent condition "imbedded in [the] bod[y]" that both signifies homosexuality and transforms the human being into the being of the homosexual (*HS*, 44).

Emerging from psychiatry in the late nineteenth century, the concept of homosexuality, as a permanent condition of abnormality, appeals not to the pathological model of illness but rather refers back to normal sexuality. Like the configuration of madness in the eighteenth century, the discourses proliferating around sexuality were also normative, setting the deviant behaviors apart from the normal. The marital relation, which dominated all discussion and analysis of sexual relations prior to the explosion of discourse at the end of the nineteenth century, reappeared within the proliferation and incorporation of perversions. However, now it was granted a modicum of discretion, and instead of receiving the brunt of attention, it began to "function as a norm" (*HS*, 38). According to Foucault, "the legitimate couple, with its regular sexuality" served as the ideal point of reference from which to pick out the sexual deviants (*HS*, 38). The

establishment of this normal sexuality contrasted with the abnormal characteristics of the sexual perversions, casting them as developmental deficiencies that fell short of the norm. Against a backdrop of normal sexuality and sexual development, the deviant sexual behaviors stood out as black on white. By situating homosexuality within this normative discourse, late nineteenth-century psychiatry described it in purely negative terms: homosexuality and the other sexual perversions were a set of “‘incomplete’ sexual practices,” characterized as deficiencies, “instinctual ‘disturbances,’” or interrupted development (*HS*, 41). Despite the multitude of positive manifestations detailed in the extensive studies of these “minor perverts” of the nineteenth century, the primary characteristic of the homosexual was a lack—a lack of normality (*HS*, 43).

Following the model of the abnormal condition, homosexuality, in many ways, is just like any other psychiatric condition: it creates a new *type of being* from a farraginous system of behaviors, actions, and features, and it deploys the concept of normality rather than pathology. However, homosexuality has a distinctive feature—its structure as “a secret that always [gives] itself away” (*HS*, 43). This key structure serves to distinguish homosexuality from the classical consciousness of madness. One might object that madness, too, was an inaccessible secret, hidden from the classical gaze. Indeed, madness itself was elusive, evading the quest for knowledge, but this secret knowledge of madness remained a secret. What presented itself to the enunciatory consciousness of the eighteenth century was never madness in itself, but only the madman. By contrast, Foucault claims a special status for sexuality in general and homosexuality in particular. The condition of homosexuality presents with a host of signs and symptoms “written immodestly on [the] face and the body” of the homosexual (*HS*, 43). It is a unique

“morphology” (*HS*, 43). Nevertheless, it is ontologically structured as a secret.

Regardless of how many times it speaks its name, either voluntarily or involuntarily, how many morphological observations signify its presence, or how many psychiatric evaluations conclude it is so, the *being* of the homosexual, despite these disclosures, remains constitutionally a secret. This injection of secrecy between *being* and knowledge, in this case, does not mean the psychiatrist can obtain no knowledge of homosexuality; the studies, evaluations, and discourses proliferating at the end of the nineteenth century do, in fact, achieve the level of theoretical knowledge of homosexuality, precisely because the secret of homosexuality always gives itself away.

Unlike the classical configuration of madness, the appearance of the abnormal condition of the homosexual toward the end of the nineteenth century reveals its essential nature. Forged within the raging fires of discourse during the Victorian age, the homosexual emerges as a *new type of being*, a codification and solidification of diverse behaviors and traits into a stable configuration.

2.3 The Dangerous Individual and Social Protection

According to Foucault’s account in *Abnormal*, the historical formation of the concept of the dangerous individual coincides with the constitution of psychiatry as a medical specialization in the nineteenth century. It emerges from the discourses deployed by the expert psychiatric opinion in order to secure its position and authority mediating between the scientific production of truth and the judicial practices of justice. In fact, according to Foucault, it is precisely this placement of the expert psychiatric opinion in the liminal space between truth and justice that serves as the condition of possibility for

the dangerous individual to appear before the psychiatric gaze. Linking together judicial and medical power, psychiatric expert opinion engages in discourses that ultimately have the power of life and death, yet these discourses, which obtain the status of truth in the courtroom, are neither properly judicial nor properly scientific. That is, the psychiatric discourses of expert testimony, from which the dangerous individual emerges, do not meet the epistemological standards for truth in either discipline. These discourses constitute the dangerous individual as a particular *type of being* with recognizable traits as their exclusive object of knowledge. This individual belongs exclusively to psychiatry and not organic medicine, for instance, because psychiatry claims that only it can recognize the individual's origins, thus only it can perceive the dangerous individual. Only the psychiatric gaze can see what is not yet visible—the crime yet to be committed. On the basis of this concept, psychiatric expert opinion presents itself as a science of prediction, offering foreknowledge of danger to come, thereby establishing itself as an invaluable institution for the protection of society. This heterogeneous concept of the dangerous individual thus appears before the psychiatric gaze on a plane bounded on one side by the twin poles of danger-protection and on the other by the medical-judicial.

Forensic psychiatry, this strange amalgam of the medical and judicial, in which the dangerous individual begins to take shape, attempts to conjoin these two heterogeneous types of power. Operating as the “switch-point” between the medical and judicial institutions, the expert opinion functions by “stitching together the judicial and the medical,” but it neither follows the rules of the judicial system nor the “internal norms of medical knowledge” (A, 41). According to Foucault, it is “infrapathological” and “paralegal” or “parapathological” and “infralegal” (A, 18). In this flagrant violation

of both domains, the power of the psychiatric opinion assumes a “grotesque” aspect (A, 11). Foucault does not employ this term as “an insulting epithet” (A, 11). Rather, for him, it is a concept with a precise function:

I am calling ‘grotesque’ the fact that, by virtue of their status, a discourse or an individual can have effects of power that their intrinsic qualities should disqualify them from having.... I think that there is a precise category, or, in any case, that we should define a precise category of historico-political analysis, that would be the category of the grotesque or Ubu-esque. Ubu-esque terror, grotesque sovereignty, or, in starker terms, the maximization of power on the basis of the disqualification of the one who produces them. (A, 11-12)¹⁷

The power of the psychiatric expert opinion fits this description, since it produces a discourse wielding tremendous power over life and death only by adopting “a childish discourse that disqualifies [the psychiatrist] as a scientist at the very moment [she] is appealed to as a scientist” (A, 36). That is, the expert opinion obtains access to judicial power and effects even though she lacks the qualification to wield that power. She is appealed to by the judge precisely for her epistemic position as an expert, a psychiatrist, and yet her characterization as a psychiatrist and not a member of the judiciary, precludes her from actually obtaining the judicial qualities and characterization that should be necessary to exercise judicial power. The court calls upon the psychiatrist precisely for her characterization as a psychiatrist, but as such she does not have the qualities of the judiciary. Despite not having the qualities of a member of the judiciary, the Ubu-esque function of power recasts her childish pronouncements and puerile analyses—e.g., “He played with wooden weapons.” “He cut off the heads of cabbages.” “He was a trial to his parents.” (A, 36)—as “true discourses with considerable judicial effects” (A, 11). Thus,

¹⁷ According to the editors of Foucault’s *Abnormal* lectures, the term Ubu-esque originates from the ridiculous figure of the King Ubu in Alfred Jarry’s 1896 play, *Ubu roi*. They cite a 1985 French dictionary definition of Ubuesque: “Someone resembling the figure of King Ubu (in his comically and extravagantly cruel, cynical, or cowardly character” (*Le Grand Robert* in A, 28n20).

even though the grotesque, “Ubu-science” of psychiatry is not properly qualified to exercise judicial power, the concept of the dangerous individual to which it gives birth achieves the status of medical and judicial truth.

To constitute the dangerous individual, psychiatry first creates a double of the individual to be psychiatrized and then shifts “the level of reality of the offense” from the actual act in question to the double (A, 16). This doubling of the individual offense converts it into a character trait. In other words, psychiatry shifts the focus from the actual criminal offense to the abnormal condition of the individual, that is, the double. In this way, the expert opinion “delegalize[s] the offense,” since in the same move, it both obscures the person who committed the act and brings to light a psychologico-moral double that, in fact, never committed a crime (A, 16). This shift then allows psychiatry a foothold into the purely judicial realm of the courtroom. Without this dual process of doubling and replacement, psychiatry could have no legitimate claim to power, since its concepts, diagnoses, and tools are not judicial: “There is no law against being affectively unbalanced or having emotional disturbances. There is no law against having perverted pride, and there are no legal measures against Herostratism” (A, 16). The psychiatric double, which transfers the discourse from the level of the act to the level of being, recasts the offense at the level of the permanent condition, the *being*, of the offender. In this way, the *state of being* of the dangerous individual—her emotional disturbances, her nastiness, or her stubbornness—becomes construed as her criminal act. In this way, psychiatry brings the dangerous individual and not the criminal offender before the court. According to Foucault, the expert opinion constructs a double through which one can “pass from the action to conduct, from an offense to a way of being” (A, 16). In effect,

the formation of the psychologico-moral double supplants the original offender. This shift in “the level of reality of the offense” is particularly evident in the practices of special courts for children (A, 16). In these courts, children never appear before the judge alone. Instead, they are always accompanied by the psychiatrist’s evaluation of their “psychological, social, and medical” background, information which pertains not to the offense in question but to the child’s “existence, life, and discipline” (A, 40). On the basis of this information, the judge will issue her decision. The offense itself will not be the site of judicial intervention. Rather, the *being* of the child will be punished. Likewise, it is the character of the dangerous individual, presented by the psychiatric testimony, and not the actual individual whom the judge will find guilty. Thanks to psychiatric expert opinion, the judge can no longer convict the individual on the basis of crime in question even if the individual is, in fact, guilty, since the individual never appears in court without the double. About this result, Foucault writes: “even if the subject in question is guilty, what the judge is able to condemn in him on the basis of expert psychiatric opinion is no longer the crime or offense exactly” (A, 17). Instead, the judge will punish the roots of the crime, “the irregular forms of conduct that were put forward as the crime’s cause and point of origin,” or in other words, the psychologico-moral double (A, 17).

The expert opinion effects this transposition from original offense to psychiatric double by demonstrating that the dangerous individual always already resembles her crime. Psychiatry investigates and analyzes the condition of the individual before the crime, cataloging the “faults that are not illegal” in order to reveal the continuity between the individual before and after the crime (A, 19). For instance, it notes that in her childhood, the individual on trial for murder killed a bird or tortured a cat. In these

juvenile acts of disobedience, the psychiatrist can see “a kind of reconstruction of the crime itself, in scaled-down version” (A, 20). Tracing a series of childhood “misdeeds,” the expert opinion links these acts to the current crime through the “repetitive use of the adverb *already*”: as a young girl, she *already* showed signs of domination or delinquency, or she *already* exhibited a tendency towards violence (A, 19). These “biographical elements,” according to Foucault, have no bearing on the offense in question—they “do not in any way explain the action in questions”—but rather “are kinds of miniature warning signs, little scenes from childhood...that are presented as already analogous to the crime” (A, 33). Nevertheless, the shift in the reality of the offense from the level of the act itself to the level of being (i.e., the psychologico-moral double) allows these ‘insights’ to obtain legal standing, since the double, which the psychiatrist describes, now constitutes the offense. From this analysis, the expert can then conclude it was simply a matter of time before the dangerous individual revealed her abnormal or “criminal desire” in a violent crime, since all along she already *was* her crime (A, 20).

By pulling together the medical and the judicial and securing the seam between them, the psychiatric expert opinion creates of these disparate institutions a medico-judicial continuum. Prior to the nineteenth century, psychiatry was called before the court to pass judgment on the mental state of the accused. If she were mentally ill, then the court would turn her over to the doctors for a cure, since “madness wipes out the crime” (A, 32-33). Only if she were sane would her actions merit punishment. All that changed with the historico-political emergence of the psychiatric expert opinion in the nineteenth century. The insertion of the expert opinion between the law and medicine obliterates

these as separate discourses and replaces the historical institutional alternative of “either prison or hospital” with a new “protective continuum” (A, 33). According to Foucault, an institutionalized disciplinary regime formed around and sustained by the expert opinion operates along a continuum with the punitive and the therapeutic responses as opposing poles. Judge and doctor, crime and illness, and punishment and cure were no longer different in kind, but rather merely differed in degree. As Foucault notes, this line of graduated disciplinary responses, anchored on the judicial side in the punitive and on the medical side in the therapeutic, cannot be a response to either illness or crime. Neither illness nor crime in their pure form would require a continuum of responses spanning from one institution to the other. An illness would necessitate a therapeutic response and a crime a judicial response. According to Foucault, this continuum is in response to something entirely new: “This continuum with its therapeutic and judicial poles, this institutional mixture, is actually a response to danger” (A, 34).

Since the concept of danger and its embodiment in the dangerous individual emerge from within the discourse of the medico-legal expert opinion of the psychiatrist, psychiatry lays claim to these concepts and institutes itself as a science of the recognition and prediction of danger. In fact, within the medico-judicial continuum, psychiatry assumes epistemic privilege over both danger and the dangerous individual. After this transformation in medical and judicial power in the nineteenth century, the judge no longer calls upon the psychiatrist simply to assess the sanity of the accused. Instead, the judge poses a new question for the psychiatrist to answer: “Is the individual dangerous?” (A, 25). It is a question both of probability and of recognition. The psychiatrist must testify about “whether the subject analyzed has traits or forms of conduct that, in terms of

criminality, make it probable that there will be a breach of the law” (A, 22). However, not all projections into the future and not all tabulations of probabilities are equal. While the psychiatrist may not be the only one who can ferret out danger, she is the only one capable of detecting the *possibility* of danger. Whereas for someone else, the “detection of possible danger” may be a matter of tallying probabilities, this is not so for the psychiatrist (A, 120). She has no need for probabilities and does not predict in the proper sense because she actually *perceives* potential danger:

To justify itself as a scientific and authoritative intervention in society, as the power and science of public hygiene and social protection, mental medicine must demonstrate that it can detect a certain danger, even when it is not yet visible to anyone else. (A, 120)

For this reason, according to Foucault, psychiatry took such a great interest in motiveless crimes in the nineteenth century. When the standard medical and judicial authorities could not make sense of these motiveless crimes, psychiatry came forward and claimed it could “recognize them when they occur” and could “even predict them, or enable them to be predicted, by diagnosing in time the strange illness that consists in committing them” (A, 121). Through recourse to the puerile language of the parent-child relation and the constitution of the psychologico-moral double, psychiatry claims to have developed a “technique that consists in singling out dangerous individuals” (A, 25). Prior to the nineteenth century, the childhood signs of nastiness, stubbornness, perverted pride, etc. foreshadowed crime or pointed to mental illness to come, but “they signified nothing in themselves” (A, 149). After psychiatry inserted itself and conjoined the medical to the judicial, “these elements themselves apart from any reference to either a major dementia or a major crime” constituted danger and were a sufficient reason for internment. In these

elements, which are below the threshold of crime and madness, the psychiatrist recognizes the dangerous individual.

By constituting the dangerous individual as the object of its specialized knowledge, psychiatry explicitly instituted itself as the science of social protection and control. Since it, alone of all disciplines, could recognize the signs of danger that have “never been recognized” before, it took charge of these curious beings—the dangerous individuals (A, 122). Displacing the subject who actually commits an act with the *type of being* who commits criminal acts, nineteenth-century psychiatry caused the dangerous individual to present herself to the psychiatric gaze before she could be detected by medicine in an act of madness or law in an act of crime. With the deployment of the concept of the dangerous individual, psychiatry thus guaranteed its authority and ensured its role as the institution of “generalized social defense” (A, 316).

CHAPTER 3

THE EMERGENCE OF AIDS

3.1 The Theoretical Configuration of AIDS

This section brings Canguilhem's discussion of the different representations of disease (from 1.1 and 1.2) to bear on the contemporary medical and scientific discourse surrounding AIDS and HIV. Utilizing his elucidation of ontological and positivist and totalizing and localizing theories of disease, it aims to analyze the contemporary representation of AIDS and HIV. An analysis of the language of the CDC's *MMWR* reveals a diversity of representations and configurations of both AIDS and HIV; however, the CDC never *explicitly* acknowledges the use of *any* theory of disease. The work of Canguilhem thus helps us to parse through the layers of discourse and meanings to extract the implicit theories of disease that lie beneath these representations.

The emergence of AIDS in the late twentieth century brought together three theories of disease: both the localizing and totalizing ontological theories and the positivist theory. At the level of effects, the localizing ontological and positivist theories served to confirm and reinforce one another while they, for the most part, exclude the totalizing ontological, or subjective, experience of disease. According to Canguilhem, the positivist theory of disease constitutes disease and health as the same in kind, differing only in degree of intensity. This theory denies the totalizing, subjective consciousness of disease by the sick being, labeling the experience of sickness as a mere appearance which masks the underlying reality. The localizing ontological theory likewise places little importance in the totalizing, subjective experience. It situates disease at the level of

tissues and organs or within a particular physiological function, but not at the level of the total organism. Even though an infected cut may rise to the organismic level through the experience of pain or pressure, the localizing theory maintains that this subjective experience is merely an epiphenomenon. The real disease is localized in the interaction between the microbe and the body's immune system at the site of the cut. With the contemporary emergence of AIDS and HIV, all three of these conceptions of disease run together throughout the medical and scientific discourses of the CDC, although the passage of time and the production and modification of knowledge lead to the gradual effacement of the totalizing, subjective experience of disease by the other two representations.

3.1.1 Totalizing, Subjective, Ontological Representations

From the earliest cases reported in the 1980s, AIDS met all the conditions to fit Canguilhem's description of a totalizing, subjective, ontological disease.¹ Even though its initial manifestation as *Pneumocystis carinii* pneumonia (PCP) and Kaposi's Sarcoma (KS) lesions were localizable by modern medicine to the lungs and skin, respectively, they presented themselves directly to the subjective consciousness of the total individual. The previously healthy young men, suddenly afflicted with these diseases, recognized

¹ Since the documents analyzed for this section, the *MMWR*, are part of a (purportedly) objective scientific and medical discourse surrounding AIDS and HIV, the perspective of the sick individual is categorically omitted from the account. Nevertheless, I present this section as a brief sketch, describing the subjective foundation for objectivity, following both Canguilhem's account and memoirs from the time (esp., Guibert's *To the Friend Who Did Not Save My Life*, Monette's *Borrowed Time: An AIDS Memoir*, White's *The Farewell Symphony*, and Wojnarowicz's *Close to the Knives: A Memoir of Disintegration*). The inclusion of this section provides a more complete picture of the transformation in the representation of AIDS. In particular, it brings to light the movement by the scientific and medical discourse (and consequently by the sick being himself) away from primarily subjective and totalizing configurations of AIDS to a predominance of localizing and positivist representations.

themselves as sick. Indeed, these men sought out their doctors precisely because they perceived their radical change in state from the normal to the pathological. With the onset of these symptoms, they saw themselves as no longer normal and no longer equal to their situations.

From the perspective of the physicians, these men were indeed sick. The physicians recognized that these previously healthy young men had entered a qualitatively distinct state. In the *MMWR*, the repeated descriptor “previously healthy” man or man “well until” he presented with these symptoms signifies this change of state from one of health to one of sickness.² After they sought the assistance of the physician, most of these men underwent a battery of tests to confirm their totalizing, subjective experience of disease, or rather, to reproduce their illnesses in the form of localized representations (i.e., bacterial cultures, viral evidence, serum titers, etc.). In other words, these diagnostic tests double the subjective disease of the patient as the localized disease of the physician. Nevertheless, the first presentation of the disease was as a subjective, totalizing disease, and it was on the basis of the consciousness of the sick being that the physicians ordered these laboratory tests and cultures.

During these early years before the development of diagnostic tests for HIV, the totalizing, subjective configuration of AIDS (or what would soon be named AIDS) dominated the representations. AIDS presented itself to the individual as an entirely novel state. The person afflicted with the disease recognized a rupture, a clear

² CDC, “Pneumocystis Pneumonia—Los Angeles,” *MMWR* 30, no. 21 (1981), 1-3. The June 5, 1981 *MMWR* designated after the fact as the first report of AIDS in the US describes the cases as “a previously healthy 33-year-old man,” “a previously healthy 30-year-old man,” “a previously healthy 36-year-old man,” and “a 30-year-old man well until January 1981” (ibid.) This locution signifies a change in state (i.e., from health to disease), not initially discerned by a diagnostic test, but rather by the sick being himself.

demarcation between the before and after of the event of AIDS (i.e., the presentation of symptoms). At this time, before the collection of statistically significant amounts of data from a sufficiently large pool of patients, the entire discourse arising from the CDC rests upon the sick being's conscious awareness of itself as sick. The body of knowledge produced by the CDC and disseminated in the form of case definitions and treatment guidelines beginning in the mid-1980s is historical knowledge of disease, founded upon the testimony of these individuals who first experienced AIDS at the level of their total organism.

3.1.2 Localizing Ontological Representations

The localizing ontological configuration of AIDS shares with the totalizing ontological configuration the assertion of a qualitative difference between health and disease. For both configurations, the pathological state is something novel with a positive presence; it is a new mode of life.³ However, for the localizing theories, this qualitative change is not reflected at the level of sick being's consciousness of itself as sick, but rather at the level of the virus, HIV, and the lymphocyte. That is, the ontological focus shifts from the *being* of the sick organism to the *being* of the virus.

Despite the initial presentation of AIDS as a disease of the total organism, the CDC discourse immediately reconfigures AIDS in local terms. While the discourse recognizes the novelty of this pathological phenomenon, qualitatively distinct from the

³ For the patient who experiences his sickness, it is a new state, divorced from his previous state of health. Likewise, for the CDC discourse, the individual with AIDS is a new type of being, a being capable of transmitting HIV to others.

previous state of health, it attempts to *locate* the source of the underlying disease.⁴ Of course, PCP and KS were not novel, but their appearance in previously healthy young men represented a sufficient deviation from the normal clinical presentation to constitute something qualitatively different, something entirely new. The explanation of these novel symptoms of disease demonstrates the modern medical tendency to localize disease. Almost immediately and without any direct evidence, this emergent pathological phenomenon was attributed to a previously unknown etiologic agent.⁵ From the very start, scientific and medical thought invoked a localized ontological representation of the disease.

Canguilhem's account of the various representations of disease indicates this early move by CDC doctors and scientists to both localize and ontologize AIDS was not unique to the characterization of AIDS but rather representative of twentieth-century medicine. He claims that effective intervention requires localization: "To act, it is necessary, at least to localize" (*NP*, 39). In other words, it is the desire to intervene in the progression of disease and to aid the sick body that motivates the localized, ontological theory of disease. In order to act against disease in the body and the epidemic in society,

⁴ In addition to creating an individual qualitatively distinct from his previously healthy self, HIV infection creates a new population of individuals—those with HIV and AIDS. For epidemiologists, this new population is qualitatively different from those not infected and also *quantifiable*, demanding clear standards of reporting and techniques of surveillance.

⁵ Of course, this assertion is difficult to prove definitively. At best, I can point to the fact that the CDC reports invoke an etiologic agent even before the critical moment of scientific verification and visualization of the virus. Although the CDC hints at a possible etiologic agent for AIDS, namely, a virus, in 1981 through explicit comparisons to transmission rates of sexually transmitted viruses (e.g. Hepatitis B and Herpes), the first explicit postulation I uncovered occurred in the December 10, 1982 publication about AIDS in hemophiliacs ("if the platelet transfusion contained an etiologic agent for AIDS"). This explicit reference to an etiologic agent for AIDS appears five months before the scientific visualization of the virus. CDC, "Update on Acquired Immune Deficiency Syndrome (AIDS) among Patients with Hemophilia A," *MMWR* 31, no. 48 (1982), 644-46, 652.

the physician and the epidemiologist must first recognize the disease and locate it within the body and within the population. Just as the virus targets a particular, localized site within the body (i.e., the “primary target of HIV is the T-helper lymphocyte”⁶), effective treatment must target a site localized to a specific viral protein. Indeed, under this configuration of disease, effective treatment is only possible if the disease is localized or at least potentially localizable. A parallel mechanism occurs at the level of epidemiology. For the CDC to prevent new infections it must localize its action and “target risk-reduction in high risk groups.”⁷ To be able to localize the virus, one must first be able to see it. In other words, the etiologic agent must become visible to the scientist or doctor, either directly through magnification or indirectly through diagnostic tests. By establishing both the *being* of the virus and localizing it during infection and transmission, the CDC forms the virus into an ontological being and locates it as the practical site for therapeutic intervention.⁸

Structured by this relation between visibility and knowledge, the phenomenon of AIDS emerges at the end of the twentieth century within the scientific and medical discourses of the CDC as a localizable and ontological disease. The condition of

⁶ CDC, “Current Trends Estimates of HIV Prevalence and Projected AIDS Cases: Summary of a Workshop, October 31-November 1, 1989,” *MMWR* 39, no. 7 (1990), 110-12, 117-19.

⁷ CDC, “Current Trends Partner Notification for Preventing Human Immunodeficiency Virus (HIV) Infection—Colorado, Idaho, South Carolina, Virginia,” *MMWR* 37, no. 25 (1988), 393-6, 401-2.

⁸ By invoking the language of ‘forming’ or ‘making’ over the typical scientific notion of discovery, I am trying to emphasize the connection between visualization and scientific knowledge. Only the visible virus, isolated and localized by various scientific techniques, could have the ontological status of *being*. Before this moment of visualization, the hypothesized etiologic agent does not exist—in an ontologically rigorous sense—for scientific knowledge. For this reason, the language of forming a *being* or conferring being upon the virus seems applicable in this case.

possibility for scientific and medical knowledge is a certain transparency before the gaze, and AIDS first breaches the visible, phenomenal field in the five men from Los Angeles who develop PCP, a rare pneumonia in 1981.⁹ According to the natural history of PCP, acquired through the documentation of previous cases, this disease only occurs in severely immunocompromised patients. Confident in this knowledge of PCP, the physicians and epidemiologists at the CDC posit some “underlying cause for immune deficiency.”¹⁰ Some *thing*, some microscopic cause, some “transmissible agent” must have weakened the immune system of these five individuals, opening the doors for the pneumonia to establish residency within their bronchi.¹¹ In this way, the PCP, which, in Canguilhem’s terms, is the subjective totalizing disease (i.e., the disease that the living being perceives as interrupting its course and making the being feel no longer normal), becomes for the scientific and medical discourse merely a symptom of the underlying disease, which is imperceptible to consciousness. The medical and scientific discourse inserts the real cause of disease as some (potentially) visible and localizable microbe. Thus, this ontological, localizable disease replaces the subjective disease of the total organism within the discourses of the CDC.

This move on the part of scientists and doctors to posit an underlying etiologic agent of immunosuppression fits within the available theories of disease at the end of the twentieth century. According to Canguilhem, even before Pasteur, but especially after his development of the germ theory, the ontological, localizing representation of disease

⁹ CDC, “Pneumocystis Pneumonia—Los Angeles,” *MMWR* 30, no. 21 (1981), 1-3.

¹⁰ CDC, “Current Trends Prevention of Acquired Immune Deficiency Syndrome (AIDS): Report of Inter-Agency Recommendations,” *MMWR* 32, no. 8 (1983), 101-3.

¹¹ *Ibid.*

became the dominant representation of disease deployed to understand transmissible diseases. In other words, infectious and parasitic diseases strongly “favor the ontological theory,” and this fact helps explain the willingness of the CDC to hypothesize an underlying cause without any direct evidence (*NP*, 41). Although the etiologic agent, the retrovirus HIV, would not make its first appearance in the visible realm in French and American laboratories until the middle of 1983, the CDC explicitly hypothesized a transmissible agent as the possible cause of AIDS by 1982. In this way, the CDC implicitly invoked the ontological and localizing theory of disease and posited an unseen “etiologic agent” in order to ‘see’ within the visible manifestation of PCP the indication of a still-unknown and -unseen causative agent.¹²

The deployment of this theory of disease must be understood in the public health context in which it emerges. The CDC is an agency of action. Its mission is to ensure the public health, halt the transmission of disease, and avert catastrophe.¹³ However, in order to act, according to Canguilhem, action requires the ability to see and localize. Thus, in hypothesizing an underlying cause of immunosuppression, the CDC opens up the possibility of intervention. “To see an entity is already to foresee an action” (*NP*, 40). By ‘seeing’ the initial unexplained cases of PCP or the later cases of KS as signs of a hidden cause, the CDC positions itself to respond to the threat of this new disease. While it effaces the subjective experience of disease, this conferral of ontological status of *being* to this as-yet-unseen cause is tantamount to recognition of the foe to be conquered.

¹² CDC, “Epidemiologic Notes and Reports Possible Transfusion-Associated Acquired Immune Deficiency Syndrome (AIDS)—California,” *MMWR* 31, no. 48 (1982), 652-54.

¹³ The official mission statement of the CDC’s Office of Infectious Diseases is currently listed as “to lead, promote, and facilitate science, programs, and policies to reduce the burden of infectious diseases in the United States and globally” (<http://www.cdc.gov/maso/pdf/OIDfs.pdf>).

The localizing, ontological representation of disease, deployed by the CDC even before it had ‘seen’ the causal agent, received support by the twentieth-century scientific technologies of visualization. The discovery of HIV, the etiologic agent of AIDS, in 1983 by Gallo and Barré-Sinoussi, was interpreted as confirmation and ratification of the CDC’s hypothesis.¹⁴ Henceforth, no one within these scientific and medical discourses would question the ontological status and reality of the *being* of HIV, since it was now visible before the gaze. The electron micrographs of the virus budding on the cell surface of human lymphocytes reproduced in the May 20, 1983 issue of *Science* were sufficient to quell any lingering doubts.¹⁵ The medical and scientific discourse surrounding AIDS construed this new evidence as confirmation of the configuration of AIDS as a localizable ontological disease. Propelled by this new evidence, the discourse replaced the ontological disease that presented itself to the patient’s consciousness in the early 1980s to the scientifically localizable *being* of the virus.

According to Canguilhem, one of the key distinguishing features of ontological configurations of disease is their representation of the disease as something fundamentally new. He highlights this feature in order to contrast it to the positivist representation. Under the positivist representation, disease is not radically separated from what came before, but instead is only different in degree. Disease takes on a purely

¹⁴ Between the viral identification in 1983 until 1986, the virus had various names. For the sake of consistency, all references to the virus in this text have been modified to HIV to reflect the name settled upon by the international community in 1986.

¹⁵ For electron micrograph, see the French article: F. Barre-Sinoussi et al., “Isolation of a T-lymphotropic retrovirus from a patient at risk for acquired immune deficiency syndrome (AIDS),” *Science* 220 (1983), 868-71. For the concurrently published American article, see R.C. Gallo, et al., “Isolation of human T-cell leukemia virus in acquired immune deficiency syndrome (AIDS),” *Science* 220 (1983), 865-67.

negative form, characterized by absence and lack. Both the localizing and totalizing ontological theories represent the state of disease as something new. That is, this representation of disease as a positive manifestation of a novel mode of life is common to both the totalizing and localizing ontological theories. For the former, the total organism recognizes the change in her relation to her environment and tasks. She experiences disease at a conscious level as a new mode of life, completely divorced from her previous state of health. For the latter, it is the doctor or the scientist who perceives the change. Sickness, under the localizing, ontological conception, lodges within the body in the organs and the tissues. It occurs below the level of consciousness and hence never appears as a subjective disease.¹⁶ Thus, only the doctor or scientist can isolate and see the positive presence of a fundamental new state.

The localizing, ontological representation of the disease, confirmed by the recognition and identification of the etiologic agent of AIDS in May 1983, creates a definite qualitative difference between the normal and the pathological. Under this conception, there is a decisive rupture between health and disease, evidenced by the event of infection. Interpreted in light of the event of infection, disease becomes characterized as a “polemical situation” (*NP*, 41); it is now characterized as struggle between the virus and the immune system localized on the surface of one specific type of lymphocyte.

According to Canguilhem, the assertion of a qualitative difference between health and disease corresponds to ontological representations of disease. With a totalizing, ontological representation of disease, one does not experience sickness as essentially the same in kind as the normal state, a mere quantitative variation, but rather, one perceives

¹⁶ Although symptoms can appear at the level of consciousness in the sick being, the disease itself remains below at the level of the localizable virion.

sickness to be something fundamentally new. The event of disease effects a radical break in the continuity of life and inaugurates a fundamentally new mode of being. In relation to both its previous state and to its environment, the sick being recognizes itself to have been radically cleaved from its former healthy state. Life, after the event of sickness, takes on an entirely new meaning for the living being. This description, however, does not accurately describe the event of infection with HIV. In this *localizing*, ontological representation, HIV enters the body. In other words, something fundamentally new joins the body, so this representation resists the positivist account of disease. There is no way to account for the sudden presence of HIV as an excess or deficiency in some normal physiological process. However, the event of infection with HIV, in general, has no affect upon consciousness. The living being does not recognize itself in a changed state, and its previous course of action has not been interrupted. Thus, while the ontological nature of this representation indicates a fundamental change in state has occurred, the localizing aspect ensures there is no subjective experience of disease.

Based upon a localizing, ontological representation of the emergent disease, the scientific and medical discourses of HIV and AIDS arising from the CDC in the 1980s attributed a positive presence to the *being* of the disease. The ability to localize the virus and ‘see’ it accounts for its ontological status as a *being*. After the scientific elucidation of the etiologic agent, the human immunodeficiency virus, scientists worked to isolate the virus in individual patients and to further localize its presence within the body. By 1985, the CDC reports HIV “has been isolated from blood, semen, saliva, tears, breast milk, and urine and is likely to be isolated from some other body fluids, secretions, and excretions, but epidemiologic evidence has implicated only blood and semen in

transmission.”¹⁷ This ability to identify, isolate, and render visible the etiologic agent, either directly via microscopy or indirectly via antibody testing or other means, establishes the indisputable positive reality of the disease. With this evidence in hand, no one could attempt to classify HIV as a positivist disease, arising from a mere change in intensity in the normal physiology. According to Canguilhem, within ontological representations of disease, “a vulgar hierarchy of diseases” exists in which a disease is more fully a disease the more localizable it is (*NP*, 39). This scientific quest to pinpoint the precise location of the virus in the body can thus be understood as an attempt to confer maximal reality onto it. By elucidating its precise location and revealing the virus in its positive presence, these scientific practices aimed to enable more potent therapeutic intervention.

This development in scientific knowledge of HIV and AIDS translated into developments in clinical and diagnostic knowledge as well. New diagnostic tests were devised to quickly and accurately identify the presence of the virus from a patient’s blood sample. From this new diagnostic tool, the qualitative difference between health and disease became apparent. Of course, this qualitative difference did not occur at the level of the total organism, but instead occurred well below the level of consciousness. Nevertheless, the deployment of localizing, ontological representations of the disease detects illness before there is a patient.¹⁸ In the words of Canguilhem, by utilizing this conception of disease, “the disease which never existed in the man’s consciousness

¹⁷ CDC, “Recommendations for Preventing Transmission of Infection with Human-T Lymphotropic Virus Type III/ Lymphadenopathy-Associated Virus in the Workplace,” *MMWR* 34, no. 45 (1985), 682-86, 691-95.

¹⁸ Or, in Canguilhem’s opinion, it *creates* the disease that never existed in consciousness (See *NP*, 92).

begins to exist in the physician's science" (NP, 92). Without evidence of the virus, the generalized immune suppression of AIDS might appear as a decline or degradation, a mere slippage on the sliding scale of health.¹⁹ If ever there were a continuum connecting the normal and the pathological, this diagnostic test demonstrated that it had no explanatory power when it came to understanding the phenomenon of AIDS. The HIV antibody test arbitrates between two fundamentally different states. It is a question of either/or: either the test reveals the positive presence of the virus or it reveals its absence. The hiatus separating these two manifestations cannot be crossed. From this localizing, ontological perspective, health and disease correspond to the mutually exclusive test results, negative and positive, respectively.

Although a necessary result of any serologic antibody test, the designation of the diseased state as positive does, in fact, emphasize the recognition by modern science that the disease is something new, a positive manifestation, rather than simply an absence of health. In other words, the positive test result signifies the positive reality of the invisible virus. When a diagnostic test returns a positive result, it describes an addition. However, this addition is not to be interpreted as a mere increase or augmentation of what was already there beyond a certain threshold, but instead, it highlights the addition of something entirely new. For Canguilhem's analysis of ontological representations of disease, this point is absolutely crucial. Under these configurations, disease appears as something entirely new. For the totalizing, subjective, ontological representations, disease is not an absence of health or a lack of norms, but rather it is a novel mode of being, a new way of life. With the localizing ontological representations, such as the ones

¹⁹ In fact, this is *exactly* how the positivist representation accounts for AIDS, as I will discuss in section 3.1.3.

deployed to explain AIDS and HIV, disease still signifies something entirely new. However, this novelty does not occur at the level of the living being. That is to say, the living being with a disease under the localizing ontological representation will not experience a novel mode of being or a new way of life. In fact, it is questionable whether it is even proper to speak of a *living being with this sort of disease*. Since the localizing, ontological disease exists at the level of the organ, the tissue, or the cell, this disease does not properly belong to the living being as a total organism. This disease belongs either to the scientist, who ‘sees’ it, or, perhaps, to the organ, tissue, or cell, but *not* to the total organism. Perhaps, in the case of HIV, the disease belongs to the lymphocytes.²⁰ Despite this lack of novelty at the level of the living being, in the eyes of medicine the positive result of the diagnostic test for HIV reveals something new that was not there before when the test returned a negative result. “Conversion from a negative result on a previous serologic test to a positive result in a subsequent test is considered indicative of *new* infection.”²¹ From the perspective of the medical and scientific discourse that deploys this localizing, ontological representation, the positive test result is a positive signifier of the rupture from the previous state of health of the patient, despite the patient’s lack of any firsthand subjective awareness of this rupture.

The description of the event of HIV infection employed by the CDC confirms its configuration of the disease as a state qualitatively distinct from health. When the CDC discourse considers the event of infection, it recognizes the rupture caused by the sudden

²⁰ Following Canguilhem, it would be possible to claim the lymphocyte has the disease if we consider the lymphocyte to be the organismic unit. The lymphocyte has a certain ‘awareness’ of the virion attached to its membrane and develops fundamentally new norms, creating a rupture from its previous state of normal activity.

²¹ CDC, “Human Immunodeficiency Virus Infection in the United States: A Review of Current Knowledge,” *MMWR* 36, no. SU06 (1987), 1-20; emphasis added.

presence of virus in the body. Focusing on the absence or presence of the virus, these documents stress the radical alteration which signifies the transition between these two states. The language of “transmission” and “acquisition” deployed within the CDC documents to describe this phenomenon highlight the addition of something entirely new to the infected body.²² This language reinforces the ontological status of the virus: it is the “causative agent” of disease, a mobile *being* which circulates within and between bodies.²³ Crucially, however, in acquiring this agent of disease, visible only to the scientist or doctor, the individual, by the action of this discourse, becomes a new sort of being—a sick being—despite the fact that the disease has not yet reached the level of consciousness and thus does not properly belong to total organism. The language of the CDC ‘sees’ a qualitatively new state of being for the individual with a positive result, but the individual does not experience this qualitative transformation firsthand. By emphasizing the moment of viral transmission, the CDC discourse calls attention to the novelty in the transformation, since it is through this transmission that the presence of the virus replaces its previous absence in the body.

In their interpretation of the event of infection, these CDC documents describe this transformation as a process of “conversion.”²⁴ Thus, the movement within a body

²² CDC, “Recommendations for Preventing Transmission of Infection with Human-T Lymphotropic Virus Type III/ Lymphadenopathy-Associated Virus in the Workplace,” *MMWR* 34, no. 45 (1985), 682-86, 691-95, and CDC, “Current Trends Update: Acquired Immunodeficiency Syndrome (AIDS)—United States,” *MMWR* 32, no. 35 (1983), 465-67.

²³ CDC, “Current Trends Classification System for Human Immunodeficiency Virus (HIV) Infection in Children Under 13 Years of Age,” *MMWR* 36, no. 15 (1987), 225-30, 235-36.

²⁴ CDC, “Human Immunodeficiency Virus Infection in the United States: A Review of Current Knowledge,” *MMWR* 36, no. SU06 (1987), 1-20. After the development of accurate serologic assays in the mid 1980s, the terms ‘conversion’ and ‘seroconversion’ appear regularly throughout the CDC publications. By 1993, the accessibility and prevalence of serologic testing

from seronegativity to seropositivity defies any notion of a linear progression. This cannot be simply a movement along a continuum, a quantitative increase or decrease in intensity. Rather, the insertion of the virus engenders within the newly-infected being a conversion, causing a radical break between the past and future *from the point of view of the objective scientific discourse*. Similar to any conscious act of conversion in which one's previous beliefs and behaviors lose all meaning, the event of seroconversion in the newly-infected being is understood by the CDC discourse as an instantaneous break, a rupture, or a mutation, rather than the slow progress of a potentially predictable or inevitable evolution. The sudden appearance of serologic evidence for HIV infection marks the advent of a radically altered state *according to the CDC discourse*. To reiterate, this radical transformation *does not* occur at the level of the total organism. The localizing, ontological representations of disease do not even address the level of the total organism. Instead, this qualitative change in state occurs *only* within the scientific discourse and not within the consciousness of the patient.

The presence of serologic evidence of the virus, which constitutes a radical, qualitative transformation from health to disease *for the scientific discourse*, may in turn be taken up by the consciousness of the living being. That is to say, the effects of the medical and scientific discourse more than likely will encourage the living being to experience the knowledge of seroconversion as the event of disease. However, any effect at the level of consciousness is simply a mirroring of the rupture in health created by the discourse. Since the event of seroconversion occurs at a level below consciousness, it cannot constitute a subjective disease in the strict sense maintained by Canguilhem. The

in the US had increased sufficiently for the CDC to update its AIDS classification to require a positive serologic diagnosis.

medical and scientific discourse constitutes this test result as a rupture, a dividing line between health and disease, and this medical classification might produce a corresponding rupture in conscious state—the infected individual may ‘experience’ himself to have moved from a healthy to diseased state. Nevertheless, this effect on consciousness is secondary and does not obtain the real level of subjective disease according to Canguilhem’s formulation.

From the point of view of the scientific discourse, not only does the insertion of the virus into the body transport the individual from a state of health to one of sickness, it also crystallizes into a specific type of *being*: the “seroconverter.”²⁵ Infection with HIV thus effects an ontological transformation *at the discursive level*, creating a new type of *being*. Whether for expediency’s sake or some other reason, the grammatical shift from the adjectival “man who seroconverted” or “those who seroconverted” to the nominal “seroconverter” or “seroconverters” reifies this transformation in HIV status—the change from absence to presence—as a fixed state of being from the point of view of the medical and scientific discourse of the CDC.²⁶ From the perspective of the individual, by contrast, there is no direct experience of a transformation in being at the level of subjective consciousness, since this process of conversion does not constitute a disease of the total being. Nevertheless, the discourse of the CDC construes this serologic evidence of the presence of the virus in the body not as a lack, a slippage away from health toward death, but rather as a positive sign inaugurating an entirely new mode of *being*.

²⁵ CDC, “Current Trends Update: Acquired Immunodeficiency Syndrome (AIDS) in the San Francisco Cohort Study, 1978-1985,” *MMWR* 34, no. 38 (1985), 573-75.

²⁶ *Ibid.* Whatever the reason for its origin, “seroconverter” is a lasting term within the CDC reports, occurring in over ten documents between this 1985 reference and 2009.

When the medical and scientific discourses arising from the CDC publications focus on the event of infection and the causative agent, they interpret HIV and AIDS through the rubric of a localizing, ontological disease. This fact, however, should come as no surprise, since Canguilhem, in his characterization of the different theories of disease, indicates infectious diseases lend themselves to this conceptualization. With infectious diseases, one can localize, identify, and render visible the cause of infection, thus granting the etiologic agent the status of *being*. By conferring *being* onto the etiologic agent of disease, these theories inevitably cast sickness as ontologically distinct from health, even though, *at the level of the total organism*, there is no perceived rupture or consciousness of sickness at all. The discourse arising from the CDC completely eschews any reference to the subjective disease. Instead, the localizing, ontological configuration dominates the discourse, creating sickness in total organisms that, according to Canguilhem's conception, are not ill, since they have no firsthand subjective experience of the disease. As this analysis demonstrates, when the CDC considers the event of disease or the infectious agent, the manifestation of disease in the infected individual is the visible sign constituting sickness and inaugurating a novel state of *being*, *according to the objective conceptualization by the CDC*, even though the living being experiences absolutely no change in state.

3.1.3 The Positivist Representation

This tidy depiction of the CDC discourses as unified in their deployment of a localizing, ontological model of disease to make sense of AIDS and HIV in the late twentieth century hides a fundamental theoretical paradox. While the above analysis of

the CDC language accurately represents the CDC's interpretation of the event of infection and the transmission via etiologic agent, these facets of the discourse only present one side of the discussion. By contrast, the documents produced by the CDC dealing with the classification and surveillance of the incidence of HIV infection and AIDS offer a somewhat contradictory picture. Although the localizing, ontological representation of disease seems most fitting for an infectious disease, within its classificatory project, the CDC's discourse aligns itself with the positivist conception of disease, as explicated by Canguilhem.

Under the positivist conception of disease as it emerged from the work of Broussais, Comte, and Bernard in the nineteenth century, disease was understood as a mere quantitative deviation from health. These men were motivated by a desire to construct pathology as a well-ordered science. To this end, they attempted to forge a link between pathology and physiology by asserting the reducibility of pathology to physiology. In other words, the theories of these influential pathologists maintain that pathological phenomena are simply changes in intensity of the normal physiology. Health and disease are no longer ontologically distinct states, but are instead conceived as points along the same continuum. Unable to negate the subjective experience of disease, these theories invoke the appearance/reality distinction. Thus, what appears to consciousness and is experienced by the sick individual as a qualitatively distinct mode of being refers back to the same underlying reality, the reality of physiology. Although these thinkers have difficulty maintaining the language of homogeneity and continuity, they

nevertheless forward the key positivist tenet that physiology and pathology are “essentially one and the same thing.”²⁷

The positivist and ontological theories thus offer radically different manifestations of disease to the medical and scientific gaze. The ontological configuration of disease, on the one hand, populates the field before the gaze with diseases that are both qualitatively distinct from health and manifest themselves as innovative, positive phenomena. On the other hand, application of the positivist theory produces diseases that are mere quantitative deviations from health, with no essential differences. These diseases present themselves to the gaze not through their positivity, but rather through their negativity. That is, because of their reducibility to normal physiology, these diseases present, in relation to the normal, as absence, lack, and pure negativity.

The introduction of HIV into the body would seem to preclude the use of the positivist model, since the virus does not originate within the normal physiology. Nevertheless, the medical and scientific discourse arising from the CDC’s classification system manages to conceptualize AIDS as a disease remarkably similar to the positivist ideal. That is to say, these CDC documents, by focusing on the immune system itself, depict AIDS as classifiable on a quantitative scale, without any reference to the qualitative distinction between health and disease. Attempting to develop a wholly objective description of the disease, they fail to recognize AIDS as a positive presentation of a novel pathological phenomenon, but instead identify AIDS as a lack of health and an absence of normal immune function. According to this conception, the presence of HIV or AIDS is not conceived as radically distinct from health. Thus, the staging of HIV and AIDS progression remains directly comparable to the normal physiology. By and large,

²⁷ Bernard, *Leçons sur le diabète et la glycogénèse animale*, 56, quoted at NP, 67.

the CDC is able to present HIV infection and AIDS on the quantitative, sliding scale of health because it overlooks the event of infection and the virus itself to focus instead on the manifestation of the disease. Through this shift in focus, the discourse arising from the CDC documents can encompass two conflicting theories of disease. AIDS, through this discursive shift, can thus appear as an ontological disease at one moment and as a positivist manifestation the next.

The language of the CDC documents offers a predominantly negative characterization of AIDS. Out of this discourse, AIDS arises as a disease that, despite the plethora of positive symptoms, is fundamentally a disease of absence and lack. AIDS appears before the medical gaze as a “*defect* in cell-mediated immunity,”²⁸ “immune *dysfunction*,”²⁹ “*progressive impairment* of the immune response,”³⁰ a “*cellular immunodeficiency*,”³¹ and “*immune suppression*.”³² Individuals with AIDS are recognizable by their “*defective* immune systems,”³³ by the numerical “*rates of decline*”

²⁸ CDC, “Current Trends Classification System for Human T-Lymphotropic Virus Type III/ Lymphadenopathy-Associated Virus Infections,” *MMWR* 35, no. 20 (1986), 334-39; emphasis added.

²⁹ CDC, “1993 Revised Classification System for HIV Infection and Expanded Surveillance Case Definition for AIDS Among Adolescents and Adults,” *MMWR* 41, no. RR-17 (1992); emphasis added.

³⁰ *Ibid.*

³¹ CDC, “Current Trends Revision of the Case Definition of Acquired Immunodeficiency Syndrome for National Reporting—United States,” *MMWR* 34, no. 25 (1985), 373-75; emphasis added.

³² CDC, “HIV Prevalence Estimates and AIDS Case Projections for the United States: Report Based upon a Workshop,” *MMWR* 39, no. RR-16 (1990), 1-18; emphasis added.

³³ CDC, “Recommendations for Preventing Transmission of Infection with Human-T Lymphotropic Virus Type III/ Lymphadenopathy-Associated Virus in the Workplace,” *MMWR* 34, no. 45 (1985), 682-86, 691-95; emphasis added.

in their immune cells,³⁴ and by their generalized “loss” of immune function.³⁵ Piecing together the fragmented and multifarious descriptions from these documents, a picture of AIDS emerges that represents the disease as, essentially, a negation of health and normality. The discourse situates AIDS along the sliding scale of health, moving further away from the physiological norm. It is a loss of health, a defect in normal functioning. This disease appears before the medical and scientific gaze chiefly in the opening so recently vacated by health itself. Paradoxically, it is only in the absence of health or proper immune function that AIDS can appear before the gaze, since the disease seems to have no positive reality of its own with which to assert itself as a proper object of knowledge.

This negative characterization of the disease in adults recurs in the discussion of infected children. In children, AIDS manifests itself in the laboratory in “abnormal immunologic test results,” but it also presents itself to the clinician.³⁶ However, even though the 1987 classification system claims that adolescent and childhood AIDS has “a broad spectrum of clinical manifestation,” it fails to note that all these manifestations are the absence of health or normality recoded as a positive manifestation of disease.³⁷ For instance, included among the symptoms of childhood AIDS are “*loss* of developmental

³⁴ CDC, “HIV Prevalence Estimates and AIDS Case Projections for the United States: Report Based upon a Workshop,” *MMWR* 39, no. RR-16 (1990), 1-18; emphasis added.

³⁵ CDC, “1993 Revised Classification System for HIV Infection and Expanded Surveillance Case Definition for AIDS Among Adolescents and Adults,” *MMWR* 41, no. RR-17 (1992).

³⁶ CDC, “Current Trends Classification System for Human Immunodeficiency Virus (HIV) Infection in Children Under 13 Years of Age,” *MMWR* 36, no. 15 (1987), 225-30, 235-36.

³⁷ *Ibid.*

milestones,” “*impaired brain growth*,” “*motor deficits*” and “*gait disturbances*” along with nonspecific “*immunologic abnormalities*.”³⁸ None of these constitutes a positive symptom or a manifestation of disease in its own right. Instead, these appear before the medical gaze as symptoms only because they occur in front of the backdrop of the concepts of normal and healthy childhood development.

From this concurrent discourse within the CDC publications on AIDS, opposing portraits of the disease appear. Whereas Canguilhem’s conception of a totalizing, ontological representation of disease requires a clear distinction between the normal and the pathological in the subjective experience of the sick being, this positivist model does not recognize the diseased state as a fundamentally new way of life. Instead, it situates both the diseased state and the normal state on the same quantitative continuum. Established through the scientific technologies of quantification, this second image partially occludes the novelty of the pathological state that appears when AIDS is configured as a localizing, ontological disease. Identical laboratory and diagnostic measurements of cell-mediated immunologic response can track the degree of immune function in the HIV-infected individual and the healthy individual. By focusing on the immune function, which is a part of normal physiology, the CDC has developed a positivist classification system in which the loss of immune function caused by the virus is wholly quantifiable and thereby comparable to the normal physiology. In this way, the contemporary discourse structures the progression of AIDS as a steady slippage along the continuum connecting health and disease in the positivist model of disease.

³⁸ Ibid., emphasis added.

From this analysis of the CDC discourse on AIDS and HIV, the dominance of these two configurations of disease emerges. The localizing, ontological representation and the positivist conception have monopolized the CDC discourse since the beginning of the 1980s. Each functions differently within the overall characterization of AIDS and HIV. For instance, the discourse makes use of the localizing, ontological model when it attempts to explain transmission and infection, but it turns to the positivist account when it desires to track the progression of the disease within the individual. However, both exhibit one critical similarity that cannot be overlooked. Their dual deployment to explain and configure AIDS and HIV supports and reinforces each other to effectively exclude any conception of an ontological, *totalizing* disease. In other words, these two configurations—the positivist and localizing, ontological—ensure that of the many manifestations of HIV and AIDS, none will appear as a disease before the subjective consciousness of the sick being.

3.2 AIDS as Condition

This section explores the connections between Foucault's discussion of the historical concept of the condition as presented in Chapter 2 Section II and the development of the contemporary phenomenon of AIDS within the medical and scientific discourses of the CDC. Through the theoretical lens provided by Foucault's *History of Madness*, it attempts to distinguish which parts of the contemporary AIDS discourse arise simply from the deployment of the concept of the condition and which from the unique contribution of AIDS itself. Although the disease, by its very name, constitutes a syndrome, there is little explicit reference within the CDC discourse as to what exactly

this entails. The striking parallels between Foucault's account of two conditions—madness and homosexuality—and the contemporary discourse on AIDS suggest that his elucidation of the historical concept of the condition may have practical value in the interpretation of AIDS. Within his analysis, Foucault clarifies the complex relation between the recognition and knowledge of the condition and also brings to light the unique role of causality between the condition and its symptoms and other conditions or diseases. Both of these topics prove to be fruitfully applied to the contemporary phenomenon of AIDS, filling in the theoretical picture of disease only outlined within the CDC documents.

3.2.1 Recognition and Knowledge

Within the structure of the condition, the fundamental gap that exists between its presence and its manifestation creates a unique relationship between the recognition and the knowledge of the condition. Because of this gap, the mere absence of a visible manifestation, such as a definitive sign or symptom, does not rule out the possibility of the condition's presence. Describing the condition of madness, Foucault claims this is an "essential gap," built into the concept (*HM*, 179). Nevertheless, this noncoincidence between the presence and manifestation of the condition does not cause madness to disappear into the realm of the inaccessible. Instead, he claims that in the eighteenth century every sane individual could recognize the condition of madness in others through a direct perceptual awareness, or "enunciatory consciousness" (*HM*, 166). This direct perception of madness is made possible by the figure of the madman. In the eighteenth century, the madman is consubstantial with his madness. Only in him, in the figure of the

madman, does madness reveal itself to the perceptual consciousness. The condition of madness, which in itself is invisible to the gaze and imperceptible to consciousness, becomes accessible to consciousness in the *being* of the madman. The presence of the condition thus constitutes a *being*, and it is this *being* that is immediately recognizable. Through this creation of a new type of *being*, the eighteenth century bridges the fundamental gap between the presence and manifestation of the condition. Although the presence of the condition might not disclose itself in a definitive sign, its manifestation is unmistakable in the *being* of the madman.

Whereas the eighteenth century overcame the fundamental gap between the presence and manifestation of the condition through recourse to the figure of the madman, the recognition and identification of AIDS in the twentieth century still seems hindered by this gap. Nothing nearly so certain as an enunciatory consciousness operates within the discourse on AIDS which could bridge this gap entirely. An explicit awareness of the noncoincidence between the presence and manifestation of AIDS exists within the CDC discourse. Because the visible manifestation does not map directly onto the condition, the CDC claims “individuals at risk for transmitting AIDS may be difficult to identify.”³⁹ In this case, the discourse on AIDS configures this fundamental gap as temporal in nature. A time lag between the presence and visible manifestation of the condition creates a moment of uncertainty when the presence of the condition cannot be readily recognized and identified. The “latent period” between exposure and

³⁹ CDC, “Current Trends Prevention of Acquired Immune Deficiency Syndrome (AIDS): Report of Inter-Agency Recommendations,” *MMWR* 32, no. 8 (1983), 101-3.

“recognizable clinical illness” suggests that before its visible manifestation, AIDS hides within health.⁴⁰

Like the relation between reason and unreason in the eighteenth century, AIDS also masquerades as its opposite—health. According to Foucault, madness in the eighteenth century “hides [its] enigmatic truth” (*HM*, 164), “disguises most of its powers and truths” (*HM*, 167), and has “an essential aptitude for mimicking reason” (*HM*, 177). All these traits arise from the gap between the invisible condition and its visible manifestation. However, the eighteenth-century enunciatory consciousness of madness overcomes this difficulty of recognition, since it does not require a visible presence. Without recourse to a direct and immediate perception of the condition, the discourse on AIDS cannot resolve this problem. AIDS and health intertwine and offer no opening for the medical gaze to pry them apart. Not wanting to let AIDS recede into the inaccessible depths of health in this way, the CDC, paradoxically, attempts to classify health as a symptom of AIDS. The following are two excerpts from CDC publications, one from before the discovery of HIV and one after:

This case definition [of AIDS] may not include the full spectrum of AIDS *manifestations*, which may range from *absence of symptoms*...to non-specific symptoms...to specific diseases that are insufficiently predictive of cellular immunodeficiency...to malignant neoplasms.⁴¹

Persons infected with the etiologic retrovirus of acquired immunodeficiency syndrome (AIDS) may present with a variety of *manifestations* ranging from *asymptomatic infection* to severe immunodeficiency and life-threatening secondary disease or cancers.⁴²

⁴⁰ Ibid.

⁴¹ CDC, “Current Trends Update on Acquired Immune Deficiency Syndrome (AIDS)—United States,” *MMWR* 31, no. 37 (1982), 507-8, 513-14; emphasis added.

These excerpts from the *MMWR* both acknowledge the difficulty of identifying AIDS, since the presence of AIDS does not necessarily coincide with its visible manifestation. One of the *manifestations* of AIDS and HIV, according to both these documents, is the absence of symptoms. But what is this absence of symptoms? By claiming AIDS can *present by not presenting* any symptoms, these documents imply AIDS, in respect to at least one of its manifestations, is indistinguishable from health. In other words, one of the symptoms of the condition is an absence of symptoms. Although the document most likely simply means to assert that sometimes the condition of AIDS has no visible manifestation and has no recognizable presentation, this paradoxical formulation underlines the difficulty posed by the essential gap that accompanies any condition. The application of Foucault's discussion of the condition of madness to the discourse on AIDS brings this fundamental gap to the fore. The CDC glosses over the fact that AIDS and HIV sometimes have no visible manifestation, since it recasts an absence of symptoms as a positive symptom. For the CDC, it is neither an absence nor a lack but a *presentation* and a *manifestation* of the condition. Foucault's work with the historical formation of the concept of the condition sheds light on this peculiar aspect of the discourse on AIDS and HIV. The conundrum the CDC grapples with in this case is not unique to the contemporary phenomenon of AIDS, but rather it emerges from the fundamental structure of the concept of the condition.

In Foucault's account, the immediate consciousness of madness in the figure of the madman reveals an interesting disconnect between recognition and knowledge.

⁴² CDC, "Current Trends Classification System for Human T-Lymphotropic Virus Type III/ Lymphadenopathy-Associated Virus Infections," *MMWR* 35, no. 20 (1986), 334-39; emphasis added.

Whereas recognition of disease historically requires a knowledge of that disease, either in the form of an ideal key (as in the eighteenth century) or a statistical representation (as in the nineteenth), the recognition of the condition, in contrast, does not. Since recognition of the condition occurs at the level of sense perception, it avoids passing through the domain of knowledge altogether. Hence, the mere recognition of the condition does not imply any theoretical knowledge of it. Any theoretical knowledge of the condition comes *a posteriori* based upon this prior recognition. About the possibility of theoretical knowledge of the condition of madness, Foucault writes: “There can be no knowledge of madness, however much it claims to rest exclusively on scientific knowledge, that does not, despite everything, suppose the prior movement of a critical debate, where reason confronted madness” (*HM*, 167). In other words, the confrontation between the sane individual and the madman in which madness presents itself immediately to consciousness provides the foundation for the development of any knowledge of this condition. Even though the eighteenth century later built a theoretical discourse around the condition of madness, this knowledge arose from the primal recognition of madness in the being of the madman by the enunciatory consciousness.

Although the relationship between the recognition and the knowledge of AIDS in the late twentieth century operates somewhat differently than the relationship Foucault depicts between these two concepts for the condition of madness in the eighteenth century, there is, nevertheless, sufficient overlap for a fruitful comparison. The primary divergence between the account Foucault gives of the condition of madness and the account gleaned from the CDC discourse on AIDS centers upon the act of recognition. For the eighteenth century, no ideal key, no knowledge, and no previous experience of

madness were required for one to recognize madness in the madman. The act of recognition was instantaneous and completely divorced from all knowledge. In the case of AIDS, the distance between recognition and knowledge is not quite so great. Nevertheless, something similar to the enunciatory consciousness Foucault describes in the eighteenth century seems to be operating in the recognition of AIDS.

The June 5, 1981 *MMWR* offers insights into the mode of perception of AIDS. Presenting the first documented cases of an unknown immune dysfunction, this report, obviously, does not mention AIDS by name. In fact, the report, which details five cases of PCP in previously healthy homosexual men, does not have any experiential or theoretical *knowledge* of AIDS or some generalized underlying condition. At most, the authors can offer speculation about the unusual occurrence of PCP in otherwise healthy individuals. In an editorial note, they indicate that these findings may “*suggest the possibility* of a cellular-immune dysfunction.”⁴³ The cautionary language of this suggestion indicates the CDC has no *knowledge* of AIDS. At this moment in time, there exists no theoretical knowledge of AIDS, since it is an entirely unknown phenomenon. Moreover, before this report in the *MMWR*, there was also no experiential knowledge of AIDS. Yet, despite this lack of knowledge, the physicians in southern California perceived the trace, a mere glimpse, of an underlying condition. If nothing else, the physicians recognized a perceptible sameness in these five disparate cases.⁴⁴ Of course, this recognition is not as utterly isolated from knowledge as the recognition of the

⁴³ CDC, “Pneumocystis Pneumonia—Los Angeles,” *MMWR* 30, no. 21 (1981), 1-3; emphasis added.

⁴⁴ Indeed, these five cases were truly disparate with PCP and homosexuality providing the only links. The men’s ages, occupations, and other illnesses and symptoms differ in every respect.

madman in the eighteenth century. One might argue, quite plausibly, that the physicians' knowledge of PCP undergirds the recognition of sameness of some underlying condition. Even so, there seems to be a hint of some more primal consciousness that bears a resemblance to the enunciatory consciousness of the condition of madness. Because of the diversity of other symptoms and illnesses also present in these men, PCP cannot function as a definitive sign of the condition in 1981. Like madness, this new condition of immune dysfunction seems to appear to consciousness as a distinct *thing* without first passing through a "tell-tale sign" or the domain of knowledge (*HM*, 178). Only after this prior recognition of clusters of cases of this unknown condition can the medical and scientific discourse begin to found a knowledge of AIDS. In this case, the primary recognition of the condition of AIDS, while it approaches knowledge, ultimately does not seem to pass through the domain of knowledge on its route to recognition.⁴⁵

3.2.2 Causality

As it developed within psychiatry in the late nineteenth century, the concept of the condition established a unique relation to causality. Unlike a disease, the condition does not follow the linear progression of pathological processes, and it does not act in a one-to-one chain of cause and effect. Rather, according to Foucault, the condition operates as

⁴⁵ The CDC admits that the historical recognition of AIDS preceded knowledge of the virus, the cause of the condition: "AIDS was defined for national reporting before its etiology was known and has encompassed only certain secondary conditions that reliably reflect the presence of a severe immune dysfunction." (CDC, "Current Trends Revision of the Case Definition of Acquired Immunodeficiency Syndrome for National Reporting—United States," *MMWR* 34, no. 25 (1985).) This claim on the part of the CDC aligns even more closely with the account of madness given by Foucault if we recall that the virus, HIV, and not the syndrome, AIDS, has ontological priority as it is conceptualized by the medical and scientific discourse. Knowledge resides at the level of the virus and not at the level of the visible manifestations of the syndrome. In this way, the perception of the syndrome (i.e., the visible, clinical manifestations) historically precedes all knowledge of it (i.e., the underlying cause, HIV).

the stable backdrop from which any number of other conditions or diseases can emerge. It is the uncultivated yet fecund soil of the garden of perversions. Although it is not the sole cause, the condition provides the nourishment and support for the illness to take root. In this way, the causal nexus of the condition defies the strict causality of disease processes. It has “total etiological value” and must be deployed in any explanation, yet it exhibits an “indefinite causal permissiveness” (A, 312, 314). The chief characteristic of the condition is that it enables the positing of practically any causal linkages—“anything can be the cause of anything else” (A, 314). For nineteenth-century psychiatry, the expansiveness and permissiveness of the concept of the condition enables it to establish its position of authority over the abnormal. The concept of the condition, which functions similarly in modern medicine, by contrast only serves to befuddle medicine, which prefers the strict causality of the disease to this nebulous web of infinitely many causal relations of the condition.

The constantly evolving case definitions of AIDS as formulated by the CDC exhibit an attempt to reign in the causal permissiveness of the condition. That is, the scientific and medical discourse of the CDC attempts to achieve the strict causality of pathological processes despite the characterization of AIDS as a condition. In 1982, the CDC produced the first case definition of AIDS. According to that definition, AIDS was classified as the appearance of KS, PCP, or other serious opportunistic infections “in a person with no known cause for diminished resistance to that disease.”⁴⁶ With this definition, the CDC aimed to capture all the known visible manifestations that were “at

⁴⁶ CDC, “Current Trends Update on Acquired Immune Deficiency Syndrome (AIDS)—United States,” *MMWR* 31, no. 37 (1982), 507-8, 513-14.

least moderately predictive of a defect in cell-mediated immunity.”⁴⁷ Although it does not reach the level of causality, this attempt at prediction seems to signify a resistance to the causal permissiveness of the condition. In other words, the CDC does not want to remain at the level of the condition, since, according to Foucault, “a condition can produce absolutely anything, at any time, and in any order” (A, 312). Instead, the medical and scientific discourse of the CDC wants to situate AIDS within a well-ordered and well-defined pathological process, but the “nonspecific” presentation of AIDS thwarts this attempt.⁴⁸ As the CDC updates the case definition of AIDS by enumerating more and more visible manifestations (e.g., disseminated histoplasmosis, isoporiasis with chronic diarrhea, candidiasis, and non-Hodgkin’s lymphoma, added to the 1985 case definition),⁴⁹ the condition continues to evade any strict causality. Despite the efforts of the CDC, the causal permissiveness of the condition within the natural history of AIDS has not given way to a fixed course and necessary causal connections, since the notion of the condition, which the CDC deploys to explain AIDS, resists this type of causality.

While the characterization of AIDS as a condition at the etiologic level proves troublesome, the CDC discourse exploits the function of the condition at the level of risk. By invoking the language of risk, the CDC discourse mimics nineteenth-century psychiatry’s relation to the abnormal and dangerous individual. With the notion of danger, nineteenth-century psychiatry establishes its position as an institution of public hygiene and safety. It claims to perceive danger where others cannot; the “detection of

⁴⁷ Ibid.

⁴⁸ CDC, “Current Trends Classification System for Human Immunodeficiency Virus (HIV) Infection in Children Under 13 Years of Age,” *MMWR* 36, no. 15 (1987), 225-30, 235-36.

⁴⁹ CDC, “Current Trends Revision of the Case Definition of Acquired Immunodeficiency Syndrome for National Reporting—United States,” *MMWR* 34, no. 25 (1985), 373-75

possible danger” is the exclusive domain of psychiatry (A, 120). In addition, it creates the *being* of the dangerous individual prior to the constitutive act. That is, before she breaks any law or commits any crime, the dangerous individual appears before the gaze of the psychiatrist. The twentieth-century deployment of the term ‘risk groups’ in regard to potential AIDS cases functions in much the same manner. By classifying individuals by certain behaviors or characteristics and then reifying them into a certain type—the dangerous, potentially infectious individual—the CDC implicitly invokes the concept of the condition. According to Foucault, the condition acts as “a sort of permanent causal backdrop on the basis of which illness may develop” (A, 312). The concept of the risk group has precisely the same function. According to the CDC classification system, “reported AIDS cases may be separated into groups based on these risk factors”:
homosexual or bisexual males, intravenous drug users, Haitians, and persons with hemophilia A.⁵⁰ By labeling these four groups as at risk, the CDC presents them as afflicted with a condition, not the condition of AIDS, but rather the condition which entails the possibility of AIDS. That is to say, neither homosexuality nor hemophilia is the cause of AIDS, but it provides that “permanent causal backdrop” from which AIDS can emerge. Conferring the status of *being* on individuals within these groups, the CDC, like psychiatry before it, aims to perceive dangerous individuals prior to the visible manifestation of the condition of AIDS. Thus, at the level of populations and risk, the discourse on AIDS reproduces the discourses that originally emerged around the condition of the abnormal individual within psychiatry a century before.

⁵⁰ CDC, “Current Trends Update on Acquired Immune Deficiency Syndrome (AIDS)—United States,” *MMWR* 31, no. 37 (1982), 507-8, 513-14.

INCONCLUSION

Thinking about illness!—To calm the imagination of the invalid, so that at least he should not, as hitherto, have to suffer more from thinking about his illness than from the illness itself—that, I think, would be something! It would be a great deal!

—Nietzsche, *Daybreak*

Like other cultural events that are mysterious, life threatening, and indefinitely extended over space and time, the AIDS epidemic compels us to try to make sense of it—hence its enormous power to generate meanings. Yet we need to push past this commonsense conclusion and ask more precise questions about the conditions under which meanings proliferate. What are the key cultural and structural characteristics that promote the generation of meanings? What are the processes and mechanisms through which individual meanings originate? Whose discourses speak through particular understandings of the AIDS epidemic? Whose are obscured? And what are we to make of them?

—Paula Treichler, *How to Have Theory in an Epidemic: Cultural Chronicles of AIDS*

A theoretical work on health and disease and the configuration of AIDS and HIV can never be complete. At best it can offer a few points of intervention and sites of resistance against hegemonic discourses and encourage the reconsideration of the use and deployment of these purportedly objective medical and scientific concepts. By focusing on the historical emergence and formation of concepts relating to health and disease, this work hopes to have done just that. Through the careful review and analysis of the medical and scientific projects of Michel Foucault and Georges Canguilhem and a preliminary investigation of both points of overlap and of divergence between these historical concepts and the contemporary portrait of AIDS and HIV, I am optimistic that my reader now has new tools with which to reenvision the relationship between AIDS and health. Establishing a firm theoretical foundation rooted in historical analysis, this work serves

merely as a point of departure from which to interrogate the systems of knowledge that undergird the contemporary medical and scientific configuration of AIDS and HIV.

Within the theoretical conceptualization of this work, many avenues for future study remain open. For instance, Canguilhem's text with its denunciation of a positivist conception of disease might offer us a new way of thinking about AIDS and HIV. Derailing the positivist dream of a completely objective knowledge of disease, Canguilhem's analysis forces us to consider what medical practices and discourses might look like if we reinserted the subjective perspective of the sick being. How would the practice of medicine change if it acknowledged the critical role of the patient in distinguishing the normal from the pathological and health from sickness? How could the reconfiguration of AIDS as an ontological pathological phenomenon, a state qualitatively different from health, affect the sick being? Obviously, for one, asymptomatic HIV infection would no longer constitute a disease for the sick being, since by definition it has no positive presence in consciousness. Canguilhem's work leaves us with this ethical project. The question of how to meld together the subjective and objective points of view, while retaining therapeutic efficacy, is one challenge opened up by Canguilhem's analysis that remains for future studies to consider. Likewise, the work of Foucault reminds us that the modern configuration of disease, with its spatialization in the body and its temporal progression, is not a transhistorical truth of disease. New projects of redescription and perspectival analyses arising with new systems of knowledge will lead to different and perhaps better (or worse) configurations. This prevalence of ideas and fragments, leads and possible paths for future inquiry arising from this work, confirm

openness of the perceptual and theoretical horizon for those who find the same urgency as I for rethinking and redescribing disease.

Although my project focuses on medical and scientific discourses from the eighteenth to the twentieth century and ultimately turns to the specific discourse that emerged from the CDC in the late twentieth century, it does not intend to imply that the medical and scientific discourse produced and promulgated by this US governmental agency holds exclusive rights to the domain of meanings surrounding AIDS and HIV, nor that it should. That is, the selective focus of this work does not mean to efface the subjective and phenomenological experiences of people with HIV and AIDS. Indeed, if anything, this work demands further theoretical labor to understand the changing perceptions of the disease in those most affected by it. How do the dominant medical and scientific discourses alter the ways in which those infected confer meaning upon their own disease? How does the modern medical configuration of HIV and AIDS translate into subjective experience? In addition, this project illuminates the need to continue Foucault's work of exposing the relation between systems of knowledge and the deployment of power. If nothing else, the emergence of AIDS late last century revealed the urgent need to carry on Foucault's project of querying this relationship between knowledge and power into the domain of our modern conceptions of health and disease.

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