A Short / Plain Translation of Foucault, *The Birth of the Clinic: The Archaeology of Medical Perception*

This book is an important work from a French linguist and philosopher, Michel Foucault (pronounced "Foo - Coe"). He lived from 1926 to 1984, and this book was first published (in French) in 1963 while he was a philosophy professor near Paris. It uses the experience of the Paris teaching hospitals in the late 1700s as a window onto how medical knowledge was generated and passed on, and so *Birth of the Clinic* was both a local history and case study within some of his larger explorations. Many of his writings, as this one does, explore the relationship between power and knowledge, and between ideas/concepts and the words we use to express them those concepts (a scholarly field known as semiotics). Foucault is also interested in the science and history of epistemology ("how we know what we know"). He is known for being wordy and difficult to read, and at times it may seem like he is taking a long time to get to the point, but his ideas have been foundational to medical history and have deeply influenced medical/clinical education and so they are necessary for us to grapple with in this class. I would be doing you a disservice if I did NOT introduce you to Foucault's ideas about medicine and society.

Here I aim to provide a short paragraph-by-paragraph "re-translation" of the portions I've given you to read (Preface and Chapter 7 "Seeing and Knowing") into short summaries. By the way, this is a good reading strategy you could use in the future for any difficult text in a college-level course: outline the reading paragraph by paragraph, summarizing each one in your own words. Hopefully these notes will serve as a guide as you read; this is simply my perspective on it, and there is undoubtedly a lot more that a careful reader can find.

Preface

Page	**The Paragraph Begins…**	**My Summary**
ix	This book is about space, about language…	A list of the topics he will discuss in this book
ix	Towards the middle of the 18th century…	An example of what he will be talking about; here a doctor named Pomme took medical notes (in a style that might now seem bizarre) on a patient in severe pain in the mid-1700s. What did Pomme "see" as important about this patient and her illness?
ix	Less than 100 years later, this is how…	In contrast, "modern" 20th century medical description looks quite different, here's a very detailed example from a doctor named Bayle.
x	Between Pomme, who carried the old…	What accounts for the difference in the two styles? We might at first conclude that Bayle was "observing" while Pomme was "inventing," is the most obvious difference. BUT – how do we know Bayle was "right" and Pomme was "delusional"?
x	What occurred was not a 'pyschoanalysis'	Part of what happened in the time span between Pomme and Bayle is that doctors began to understand symptoms as a category of objects (i.e. things that can be seen, measured, etc). In other words, the system of knowledge in medical training had changed

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xi	From what moment, from what semantic	Both doctors used words, but we (now) understand Bayle's description to be "rational" and Pomme's to be "irrational" – why is that? Is it simply because Bayle uses language we consider to be objective and descriptive? What Foucault is doing here is trying to disrupt our sense of what medical rationality is, by calling attention to how medical language is CONSTRUCTED. This is a very basic point of all of Foucault's work: knowledge does not just "exist," it is BUILT, and how it is built tells us a lot about places, times, and people.
xi	In order to determine the moment…	What Foucault is actually most interested in, is WHEN this language/knowledge shift took place. How would a historian go about finding this? Only by studying the language that *doctors** use to SAY what they SEE, and how that language has changed over time. *here and throughout the book, I'm sure, he also means other medical practitioners besides doctors, but remember he's writing in the 1960s when most doctors were men
xii	Modern medicine has fixed its own date…	We can start with the timetable of medicine itself claims: that it was in the late 1700s medicine became "empirical," that is, scientific and based upon observation and classification because they could now "see" things using instruments (like for example heartbeats, using a stethoscope) that had been previously invisible. This forged "a new alliance between words and things."
xii	In 1764, J. F. Meckel set out to study…	Using brain pathology as an example: understanding brain disease begins with, and even to some extent is *located in* the brain. The important thing is what we choose to observe or measure about the brain, which tells us not so much what is wrong with a diseased brain, but (in a larger sense) what doctors think they can even learn about brains by looking at them.
xiii	For Descartes and Malebranche	Here Foucault is going back to several important people who helped construct the scientific method as it was based on observable nature, which in turn was based on the qualities of light passing over or through objects to be studied (prisms, for example). According to that method , we understand things by seeing them; thus to some extent only things that can be seen, can be understood.
xiv	The task lay with this language of things…	This new understanding, which involved reorienting the relationship between "words and things," meant that people could now structure a "rational language" around human bodies based on what they could observe about those bodies. It was a new way of seeing.
xiv	Our contemporaries see in this accession	Most medical practitioners take for granted that clinical experience begins with "encountering" a patient and subjecting him or her to (trained) observation, in much the same way that an astronomer "observes" the distant stars. This is "scientific."

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xv	Miracles are not so easy to come by…	However, that situation did not just magically arise: it developed in a particular historical period, which limited the possibilities as much as it opened them.
xv	It may well be that we belong to an age…	This is because we can only ever "know" what we can manage to express in language. That which is inexpressible is also, by definition, unknowable. Does this mean we are trapped by language?
xvi	But is it inevitable that we should know…	Well, not entirely trapped. It turns out there is a special kind of discourse/dialogue (Foucault here calls it "*commentary*") that lets us get at things that are not yet known or knowable. This paragraph explores the complex relation between the signifier (ie a sign = a word), and the signified (the thing the word refers to); he's setting up some semiotic definitions in order to make a larger argument about what KIND of history he's doing.
xvii	To speak about the thought of others…	Foucault asks: What if we take the study of history up to an entirely different level, and instead of talking about words & concepts (signifiers and signified), we talk about discourses (SYSTEMS of language)? What if we took as the object of study not just the WORDS themselves but something bigger - the LANGUAGE and MEANING within larger systems of knowledge? Then, this would be a new development: to make discourses themselves the object of historical study (i.e. to "historicize" discourse, to make discourse into a THING that historians can study).
xvii	Until recently, the history of ideas was…	There are two "old" methods of studying the history of ideas: 1) analogy, categories of ideas, and 2) something similar to psychoanalysis of the "collective" human mind
xvii	I should like to attempt here to analysis…	What this book will study is the history of medical discourse (medical language, explanation, knowledge expressed in language) during the historical moment when people began to be treated not in their homes but in a special medical setting which Foucault generalizes as "the clinic." (He means any medicalized place, including hospitals)
xviii	To anyone wishing to draw up…	The "invention" of the clinic in the late 1700s changed medical knowledge forever. It reorganized the way doctors thought about space, about the body, and about time. All of these things were transformed together, at the same time. For example, we can see this change most clearly in the shift from doctors asking not "What is the matter with you?" but rather "Where does it hurt?"
xix	The research that I am undertaking…	Basically, this project seeks to explore not how things SHOULD BE, but how they WERE
xix	I should like to make it plain…	Foucault insists he's not judging one kind of medical knowledge as better or worse than any other kind – just exploring why they are different.
xix	What counts in the things said by men…	Foucault actually isn't even interested in whether old-time doctors were "right" or not, he's just interested in what we can learn about them from the evidence they've left us.

Chapter 7 “Seeing and Knowing”

Page	The Paragraph Begins…	My Summary
107	Hippocrates applied himself only…	Doctors are taught to emulate Hippocrates and diagnose from their own observation as if that “seeing” was a pure, untaught practice. But what doctors “see” when they look at / examine a patient comes with an entire system of knowledge. In other words they are not “just seeing” but they are bringing that entire system with them. This particular kind of seeing entangled with specialized knowledge, will be the subject of this chapter.
107	The observing gaze refrains from…	Observation is not doing, it is “silent and gestureless,” and by definition it involves (only) what is visible and real. Doctors are not supposed to let “theory” or presupposition cloud their observation. Only after noticing the visible signs of an illness, is a clinician THEN supposed to make a judgment, not the other way around. “The clinical gaze has the paradoxical ability to hear a language as soon as it perceives a spectacle.” Observation is not always literally silent, since it involves asking the right kinds of questions using a scientific method to deduce the illness (“experimentation”), but ideally clinicians mentally “silence” their theories and conclusions until after conducting their observations of the patient. They then “give voice” to those theories when they decide & speak the diagnosis.
108	This gaze, then, which refrains from…	Part of what makes this “seeing” or “gaze” so powerful is that clinicians refrain from acting (they show restraint) until after they have analyzed the situation. There is both a logic and an art to clinical observation.
109	One can, therefore, as an initial…	Foucault now defines “the gaze” initially as “a perceptual act sustained by a logic of operations” – something one DOES, but according to certain shared RULES.
109	Clinical observation involves two…	Foucault separates clinical observation into two categories: hospital and teaching
109	The hospital domain is that in which…	People bring their sickness to a hospital when their home-based understanding of care becomes overwhelmed. Their sickness becomes an “event” that is out-of-the-ordinary at home, but routine-and-manageable at the hospital. Hospitals are places where things that are unusual become usual, because of the frequency of related cases.
109	The old objection that hospital causes…	Because of this, it is (only) within hospitals that the “truth” of a disease/sickness can be uncovered. The disease has not changed, only the setting when the patient enters the hospital, but the setting makes all the difference because the disease becomes (in theory) understandable now that is in the context of other diseases, other sick people, other doctors and nurses.

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110	By means of the endless play of…	The patient, in entering the hospital, in some ways stops being a single, unique individual and becomes part of a population, an aggregate, of "sick people," subject to further sorting and categorization according to the symptoms he or she "presents" at the door. Because hospitals are where this process happens over and over again, the patient's uniqueness gets "cancelled out" and the *shared* characteristics of the disease get emphasized instead. In part, this is how diseases get "created" – a process of continually and cumulatively objectifying patient experiences.
110	The *collective* structure of medical…	When a patient "presents" at the hospital, ANYTHING could be wrong ("the infinite domain of events") and so clinicians must "carve up" that infinite field by asking certain questions, so to arrive, by process of elimination at the ONE THING that is wrong. In one Scotland clinic, doctors focused only on ASKING: they were trained to take a patient history, inquire about symptoms, "the origin and developments" of the sickness, and any prior history. At another clinic, doctors focused on EXAMINATION, especially changes in body function. Foucault is here explaining the method by which various famous late-18th century French doctors "invented" the process of clinical diagnosis.
111	The alternation of spoken stages…	1) Philippe Pinel (a pioneer in the treatment of the mentally ill) improved upon these, he taught doctors to alternate looking / examination with asking questions. During treatment, too, clinicians keep track of the patient's progress, noting "evolution of symptoms, possible appearance of new phenomena, state of secretions, and effect of medications." (Possibly this is still pretty much the case in your own clinical settings?) Lastly, doctors "pronounce" or "prescribe" what should happen to help recovery. If the patient dies, an autopsy is the final act of "seeing" to understand what the disease was. So: observation & examination should be complemented by inquiry & listening to the patient.
112	The effort to define a statutory form…	Fordyce (I don't know who this is) correlated observable symptoms with information obtained from patient history by literally graphing them on an x-y axis chart. This might be helpful, but the chart only REPRESENTS something larger, which is the medical understanding that such things can be correlated, graphed, and understood. The chart does not teach knowledge, it just helps someone "in the know" recognize that knowledge.
113	The ideal of an exhaustive description…	Pinel emphasized the importance of a good description: precise, inclusive, and without irrelevant details. Such descriptions have come to use formulaic / shared vocabulary.
114	It is in this exhaustive and complete…	Language does the "work" of translating symptoms into signs and transforming the person who "presents" with a unique experience, into a patient with a specific named condition. Generating a description / diagnosis is "the supreme art in medicine."

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114	Over all these endeavors on the part of…	According to this way of thinking, we could wish for something that would integrate the two separate processes of seeing and saying into one thing: "a speaking eye." It doesn't exist, but that would be the ideal.
115	It is understandable that, after the…	Medical language of diagnosis and treatment functions as a foreign language, much like Latin used to for doctors in old times. One must be trained and "initiated" into the medical world to understand that language.
115	A hearing gaze and a speaking gaze…	To reiterate his earlier points: to some extent only things that can be seen, can be understood, and we can only ever "know" what we can manage to express in language. So that which is inexpressible/unseen is also, by definition, unknowable. Thus the ideal of being all-knowing is impossible, although it remains the distant goal of medicine.
116	There is a simple historical reason for…	Foucault now brings up the philosophy of logic developed by 18th century French philosopher Etienne Condillac, in which you start with observation and systematically try out different hypotheses over and over until one fits.
116	This ambiguity had its effect on the…	Condillac's ideas about logic and the mind were formative in this historical transformation about medical knowledge, but sort of in reverse:
116	It redescended from the exigency of…	Medical knowledge / diagnosis is a process of narrowing down to the most likely diagnosis (a process of elimination, that also involves understanding of statistics and probabilities). Foucault is comparing METHODS among different medical philosophers (Condillac, Cabanis, and Brulley).
117	It might be thought—and all the…	These philosophers thought they had figured out the process of clinical diagnosis & knowledge.
117	But this generalized form of transparence	But what their methods left unexamined was the structure of language itself. For Foucault, language is the key to knowledge, and so these philosophers hadn't dug deep enough. In the next few paragraphs he will be critiquing these older ideas.
117	The first of these epistemological myths	1) For one thing, medical philosophers of the 18th century used the alphabet as a system to organize medical knowledge (as well as many other kinds of scholarly knowledge in those days).
118	This alphabetical structure of disease	This assumed that the universe of disease was both knowable and small (the length of the alphabet, essentially). Foucault thinks this was a misguided assumption to have made; it limited their abilities to conceive of things beyond the same framework that organized language itself.

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118	The clinical gaze effects a nominalist…	2) A disease really doesn't exist until it's given a name; the name reduces the total reality of a disease down to a single word. The word itself doesn't carry any meaning; words themselves are arbitrary; the only meaning comes from people agreeing upon what the disease entails (to use an example from our own experience, when a new disease gets added to the DSM).
119	The clinical gaze operates on pathological	3) When doctors began (in the early 19th century) to use "chemical" diagnostics in addition to visual ones, this involved a different layer of categorization borrowed from chemistry – i.e. isolating elements and compounds.
120	And, by reciprocity, the clinician's gaze	Just as fire causes chemicals to combust, so the ideal clinician's gaze separates out the relevant information from the irrelevant, distilling out the essence of a disease. It consumes the disease in the process of identifying it.
121	The clinical experience is identified with	4) Trained clinicians' sight is more "sensitive" – i.e. they notice more than the untrained observer, they distinguish more finely. It's as if their eyes had magnifiers.
121	The whole dimension of analysis is…	Despite this, we speak of the clinician's gaze as if it were related to art, involving skill and taste and discernment.
121	At this level, all structures are dissolved…	Foucault here distinguishes between the "gaze" – which is wide, and open to inquiry – and the "glance" which zooms in on one aspect with. A "glance" is more like a touch, like a finger poking someone else.
122	And by that very fact, clinical experience	This shift from analysis of symptoms to "the medicine of origins, sites, causes" was transformative in medicine; it ushered in the age of Bichat; the "clinic" had been born.* *Bichat (i.e. Marie Francoise Bichat, 1771-1802) is known as the father of histology and descriptive anatomy. He believed that the human body was made up of layers of tissues and membranes, and that disease attacked the tissue, rather than whole organs or whole people.

One of the main points of Foucault's argument here is that the form of diagnosis and treatment in the "modern" clinic is not what it claims to be. It claims to be an objective, scientific observation of truth, far advanced than previous kinds of medical treatment. Foucault argues, instead, that the clinic (i.e. teaching hospitals of the late 18th century) are artifacts of the prevailing theory of scientific knowledge in that time period. What makes a clinician "authoritative" is her/his relationship to whatever is the current way of organizing knowledge, instead of her/his relationship to objective reality. This is actually Foucault's way of saying that objective reality does not exist, which makes him a post-modernist theorist. Back

to his opening example: an early 18th century doctor like Pomme could observe an organ with exactly the same disease as a 20th century doctor like Bayle, with both doctors coming to vastly different conclusions about what caused the disease and how to treat it. Despite this difference, both accounts would be 'true', since they were both spoken within the mental and conceptual world of their own times that considered such statements to be true.

You might see numerous examples throughout your workday of these modern assumptions about "the gaze" and medical knowledge and power evident in the way that you and your colleagues interact with patients. For me, one of the clearest examples is a scene from the 1993 film *The Fugitive* starring Harrison Ford (great film, by the way, if you've never seen it). Ford plays a doctor wrongly convicted of murdering his wife who has escaped from prison and is hiding under the noses of federal agents in his home city of Chicago while he tries to solve the crime on his own. He disguises himself as a janitor in the hospital. No one there recognizes him as a doctor, but of course, he cannot just "undo" his medical training. One day he is standing around in the busy, overcrowded ER when a child is brought in, and he immediately knows – just by looking at the kid on the stretcher – what is wrong with him, but he cannot act because, in his disguise, he lacks the external signs of his medical authority (white coat, stethoscope, ID tag, etc). When someone asks him to deliver the child to the OR in the elevator, he springs into action out of sight of everyone else, correctly re-diagnosing the child and correcting his chart, thus saving his life. This scene exemplifies the ideal clinician in Foucault's sense: someone who is unable to stop himself from acting in the patient's best interest, who cannot "unsee" the patient's symptoms, whose "gaze" compels him to diagnosis and treatment – who possesses the power, because he has the knowledge, and who exercises that knowledge/power primarily through the act of seeing.

Discussion Questions

For Wednesday, we are not meeting in person. Please write a journal entry reflecting on Foucault's ideas by considering the questions below (in about 500 words total). I already know this is hard to read, so don't use the journal to complain about its difficulty; rather, see what you CAN gain and learn from it.

> How does your own hospital/clinical settings differ from the late 18th century "clinics" Foucault studied and the 19th century medical care that Rutkow describes?
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> At what point in your own medical/nursing training did you learn "the gaze" as Foucault describes it? This was probably an entirely unconscious process, and perhaps you have never had a chance to reflect on it. But think back: somewhere along the way, you learned to separate a patient from his/her disease and to establish, through trained observation (what Foucault calls "the medical gaze"), your authority over that disease by learning to recognize and name it.

In your own clinical settings, it's your job to generate an explanation (verbal, or written in a chart using the SOAP formula) to communicate your findings 1) to other medical professionals and 2) also to the patient. How do those explanations and descriptions (what Foucault calls "discourses") differ? How easy do you find it to "switch" between discourses?

I'm curious: do you think electronic medical records (which of course Foucalt had no experience with) are an entirely new system of medical explanation, or are they just a digital version of the modern explanatory systems we already have?

On that same note, do you find that today's technological interface that comes between you and the patient (electronic monitors, thermometers, even gloves) helps or hinders your trained ability to "discover" the disease? What are some ways that 21st century clinical technologies are an advantage and/or a disadvantage in diagnosing and treating patients? In other words, how has technology altered "the gaze" (and therefore, medical thought/discourse itself)?