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Szasz and His Interlocutors: Reconsidering Thomas Szasz's "Myth of Mental Illness" Thesis

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INTRODUCTION

For over forty years Thomas S. Szasz, a Hungarian-born, U.S. based psychiatrist has systematically attacked the philosophical bases of the "mental illness" concept. He is famed for the style as well as the content of his countless articles and books,[1] a style at once polemical and aphoristic. He has doubtless made more than his fair share of enemies (see Schaler, 2004, pp. xviii–xxv; Leifer, 1997).

The stimulus for this paper is located in Szasz's earliest works[2]—from his papers on "psychosomatic disorders" of the late 1940s and 1950s (e.g., with Alexander, 1952); his debut book *Pain and Pleasure* (1957); through a series of interventions in the 1960s: *The Myth of Mental Illness* (1961), *Law, Liberty and Psychiatry* (1963) and the essays collected as *Ideology and Insanity* (1970). This corpus evinces wide erudition and a trenchant mind. Though often situated within a generally "anti-psychiatric" tradition of philosophical and sociological theorizing (e.g., Foucault, 2006; Goffman, 1968; Ingleby (Ed.), 1981; Laing, 1990; Scheff, 1966; see also Sedgwick, 1982), Szasz demonstrates a more thorough-going analytical approach than many of his contemporaries. In his attempted demolition of the "mental illness" concept he addresses epistemological and ethical questions of great import and their inter-relations with medicine and psychiatry.

The paper recapitulates Szasz's basic perspective and canvasses critiques (e.g., Kendell, 1993; Radden, 1985) especially those *recently* emanating from medically oriented interlocutors (Bentall, 2004; Fulford, 2004; Kendell, 2004). The subsequent discussion mounts a defense of Szasz, productively engaging his core thesis with that of the French philosopher of medical thought, Georges Canguilhem (1980, 1991, 2000). This engagement is finally deployed in exposing lacunae in the conceptions of Szasz's critical interlocutors.

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THE THESIS OF THE "MYTH OF MENTAL ILLNESS"

Szasz's seminal work, *The Myth of Mental Illness*, subtitled *Foundations of a Theory of Personal Conduct*, appeared in 1961.[3] Though lauded in some quarters, it met with a hostile reception from within the psychiatric establishment (Schaler, 2004, pp. xviii–xxv; Leifer, 1997). Much subsequent criticism was poorly motivated (e.g., Bigelow, 1962) with the result that Szasz has been frequently misrepresented. For that reason a depiction of his basic perspective remains a necessary precursor to analysis of his work.

Szasz holds that psychiatry has "stumbled into a great confusion" (1987, p. 18). It has done so by conflating the respective objects and methods of the natural and social sciences. The natural "home" of the illness concept is, for Szasz, the medical enterprise with its twin commitments to *physicalism* and *natural-scientific* methods of study. Rejecting the efficacy of the physicalist framework when applied to human conduct, Szasz asserts that explanations predicated upon the concepts of mind and behavior must be sought along radically different lines. Their correct provenance is that of the social sciences—semiotics, anthropology, psychology and sociology. He thus upholds a venerable cleavage between the *natural* and the *social* sciences (see Weber, 1949; Giddens, 1971). Why?

Szasz maintains that human conduct is not a natural event and that in the social sciences "the language of physicalism is patently false" (1974, p. 187). Moreover, such physicalism applied to conduct inevitably leads to *mechanomorphism*, an insidious process whereby "modern man 'thingifies' persons" (ibid., p. 195), paradigmatically by conceiving them according to the venerable model of a *machine* (e.g., La Mettrie, 1912). Szasz asks bluntly, "Is this the proper way to study man? The history of the dialogue between the yea-sayers and the nay sayers . . . constitutes the history of social science" (ibid., p. 196).

By situating himself four-square in the "nay-sayers" camp, Szasz constructs a *dualism*—of a kind to be specified—between the "physical" and the "mental" realms. This leads him to conclude that the great logical and epistemological error of psychiatry lies in its attempt to straddle this dualism. If physical illness is to be regarded as a deviation from a clearly defined norm—"the structural and functional integrity of the human body . . . stated in anatomical and physiological terms" (1968, p. 14)—then psychiatry's "great confusion" is to smuggle such notions into the mental arena. This is illegitimate, even mendacious, for Szasz; for we are never mere machines but "sign-using, rule-following, and game playing" persons, characterized, above all, by free will (1974, p. 199). Szasz's conception of "personhood" conforms to what Daniel Dennett calls the "intentional stance" (1997); that is to say, he considers the human being on the model of a "rational actor" (see Elster, 1989) the rationality of whose conduct we must simply presume. As "rational actor", the human being is envisaged as radically free and indefeasibly responsible for her actions—two attributes of persons which underpin Szasz's particular espousal of "humanism". Contrariwise, mechanomorphism, which

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effects its "thingification" of persons by locating conduct's explanandum in the biological order—what Dennett calls the "physical" and "design stances"—is the antithesis of that humanism Szasz sets himself up to champion.

Psychiatry's alleged mendacity is the legacy of its "founding fathers", Emile Kraepelin (1907), Eugene Bleuler (1950) and Sigmund Freud (1993), who Szasz, in a typically polemical flourish, characterizes collectively as "the conquistadors and colonizers of the mind of man" (1979, p. 22). Unable to discover any underlying organic disturbance in their charges, which would parallel the "crooked spirochete" of general paresis, the "founding fathers" conjured up, instead, an epistemological "trick": "what they did was subtly to redefine the criterion of disease, from *histopathology* to *psychopathology*—that is to say, from *abnormal bodily structure* to *abnormal personal behavior*" (ibid., p. 12, emphases added). For Szasz this constituted, "the great epistemologic transformation of our medical age: from *histopathology* to *psychopathology*" (ibid., emphasis added). Though the criterion of disease had altered—after the smoke and mirrors—still "the remedy is sought in terms of medical measures" (1968, p. 14). Szasz concludes, "The definition of the disorder and the terms in which its remedy are sought are therefore at odds with one another" (ibid.).

It is in this sense that "mental illness" is revealed as a "myth". But this does not mean, as Szasz is at pains to point out, that those symptoms now rendered as "psychopathology" do not exist, for, as Gilbert Ryle famously declared,

> A myth is, of course, not a fairy story. It is the presentation of facts belonging in one category in the idioms appropriate to another. To explode a myth is accordingly not to deny the facts but to re-allocate them (1963, p. 10).

The career of Thomas Szasz may be summarized as a sustained endeavor to re-classify "psychopathology"—in the physical and medical idiom—as "social and ethical *problems in living*" (Szasz, 1981, p. 269, emphasis added). Hence, the negative side of his project is quintessentially Rylean: to explode "the myth".

PSYCHIATRIC "MECHANOMORPHISM"

The "enemy", then, is in our sights: *psychiatric mechanomorphism*. For Szasz this constitutes psychiatry's paradigmatic presumption. Explaining the "deviancy" of human conduct in mechanomorphic terms is typically addressed by reference to the biological order whereby, for instance, "aberrant chemistry" (Bentall, 2004, pp. 308–310) or "specific genetic loci" (ibid., p. 313) variously constitute the putative referent for the taxonomic label "schizophrenia" (ibid., pp. 308–314). Szasz's strategy consists in undermining the validity of this referent, which he regards as psychiatry's originary *theoretical* assumption—one of a metaphysical, specifically *physicalist*, hue.

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The argument is this. Szasz holds that, "mental illness is not a thing or physical object" (1968, p. 11); it is a *theory* and, as such, stands in need of *empirical* support. Without this, it inevitably becomes the case that "to those who believe in them, familiar theories are likely to appear, sooner or later, as 'objective truths'" (ibid., p. 12). His views have close affinity with those of the Logical Positivists, both in the valorisation of "verification" as the paradigmatic criterion of science and the correlative dismissal of metaphysical conjecture as "meaningless" (e.g., Ayer, 1971). With consistency, therefore, Szasz is able to concede that, "We cannot be certain that some patients now labelled schizophrenic do not suffer from diseases of the brain" (1968, p. 34), though he clearly thinks that the lack of observational warrant for such claims—which we may flag up at this point as *the problem of unobservables*—provides an incisive objection against the sort of *scientific realism* canvassed by psychiatric mechanomorphism. Thus, Szasz maintains that deploying the label "schizophrenia" is a,

> psychosemantic trick to affirm that a "disease" without a demonstrable histopathological lesion . . . is nevertheless a disease . . . not only does it not identify any demonstrable disease, it does not even point to any objectively demonstrable referent (1979, p. 87).

Szasz's robust empiricism leads him to endorse the philosophical doctrine of *operationalism* and, in turn, to focus upon a *methodological* critique of psychiatry. *Operationalism*, as the philosophy of science espoused by the physicist Percy Bridgman, is usually taken to refer to a form of "pure empiricism" (Bridgman, 1992, p. 58) whereby scientific concepts are defined solely in terms of the actual operations employed to measure them. Obvious examples are time, temperature and distance. Bridgman's specific disciplinary referent is physics but Szasz pushes the doctrine in the direction of social science: first, by including amongst the candidates for observation the "measurement" of the social situation in which psychiatric practice occurs, (private practice consulting room, state asylum, or judicial proceeding); then, by seeking the relevant operational definitions in the psychological and sociological, rather than biological, orders.[4] Thus, his impatience with matters metaphysical is revealed as follows: "My thesis is that the significance of a psychiatric label depends more on the social situation in which it occurs than on the *nature* of the object labeled" (1968, p. 35, emphasis added).

Eschewing such operational sharpness, the danger is that a concept like "schizophrenia" becomes reified, purports to explain everything about myriad human behaviours, but ends up explaining nothing at all. Apropos the "problem of schizophrenia" (Szasz: "there is no such problem" [ibid., p. 34]), Szasz sums up the indicated "operationalism":

> the task is to redefine the questions by relating them to the conceptual and observational tools at our command . . . biochemical studies may throw light on disorders of brain function . . . psychological and social studies could add to our knowledge of the uses of language and symbolization . . . It is unlikely, however, that either type of research . . . would "explain"

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> schizophrenia. What seems more likely is that various behavioural processes would be better understood and that the need for the word "schizophrenia" would disappear (ibid., pp. 34/35).

In the above, Szasz would appear to advocate a methodological pluralism in psychiatric research. However, this position turns out to be strictly circumscribed. Invariably, Szasz's view is that the reduction of human conduct to the biological (e.g., "aberrant chemistry/genetic loci") order is simply wrongheaded (see also Thornton, 2004): "in behavioural science the logic of physicalism is patently false: it neglects the differences between persons and things and the effects of language on each" (1974, p. 187, emphasis added).

Szasz is, in fact, a *methodological dualist*. The problem with psychiatric mechanomorphism, for him, lies in its failure to cognize this distinction. The resulting conceptual confusion is constituted by both an epistemological error *and* a common-sense perplexity about the mind-body relation, to which that error refers. This perplexity consists of,

> interpreting communications about ourselves and the world . . . as symptoms of neurological functioning. This is an error not in observation or reasoning, but rather in the organisation and expression of knowledge . . . the error lies in making a dualism between mental and physical symptoms, a dualism which is a habit of speech and not the result of known observations (1968, pp. 12/13).

This latter point, which is a variation on Ryle's notion of "category-error", occupied Szasz greatly in his first book, *Pain and Pleasure: A Study of Bodily Feelings* (1957) wherein, summarizing a decade of research into psychosomatic disorders (e.g., 1948; 1949), he first established the methodological dualism which he never relinquished:

> The "common sense" view, which regards the matter as if there were two types of pain—one organic and another psychogenic . . . is misleading and is responsible for numerous pseudo-problems in the borderland between medicine and psychology . . . physics and psychology possess different sets of objects which constitute their respective sources of data and the methods of observing data differ similarly from one another (1957, pp. 19/24).

Note that this distinctive dualism is a *methodological* dualism solely—"physics and psychology possess different sets of objects . . . and the *methods* . . . differ similarly" (ibid., emphasis added)—and eschews, as Szasz scrupulously maintains (e.g., 2004, p. 380), a dualistic ontology of *substance*. It is by dint of *his* dualism that Szasz establishes the methodological bifurcation between natural and social science from which the "myth of mental illness" thesis follows. Specifically, it leads Szasz to a *rejection* of the following three propositions:

1. a "unity of science" perspective predicated upon the doctrine of reductive physicalism;
2. the applicability of the "illness" concept to mind and behaviour;
3. a causal-determinist rendition of human conduct.

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Point 1. serves to reinforce his dualism by refusing to envisage any future rapprochement of the natural/social science "split". Psychiatry wants to claim it is both a natural *and* a social science but Szasz objects that, "We can have two psychiatries but not a combination of both, despite the insistence in many quarters that man is a *psychosomatic unity*" (1968, p. 25, emphasis added).

The crux for Szasz is that, in the privileged terms presented by modern science, which Karl Popper referred to as "the great tradition of materialism" (1993, p. 47), "unity" postures euphemistically for "reductive physicalism" only, and this Szasz sees as inapposite for the study of human conduct:

> Whereas primitive man personifies things, modern man "thingifies" persons. We call this *mechanomorphism* . . . modern man tries to understand man as if "it" were a machine . . . Where do psychiatrists . . . stand on this issue? . . . they are mechanomorphists of the first rank: they view man, especially mentally ill man, as a defective machine (1974, pp. 195/196, emphasis added).

We should note, though, that Szasz does view *physical* illness on the model of the defective machine, and this is legitimate to him:

> The concept of illness . . . implies deviation from a clearly defined norm. In the case of physical illness the norm is the structural and functional integrity of the human body . . . what health is can be stated in anatomical and physiological terms (1968, p. 14).

However, this analogy—the faulty machine—breaks down when applied to the "mental symptom":

> the notion of mental symptom is . . . inextricably tied to the social and particularly the ethical context in which it is made . . . What is the norm deviation from which is regarded as mental illness? . . . it must be stated in terms of psychosocial, ethical and legal concepts (ibid., pp. 13/14).

Psychiatry, on this view, involves a conceptual "sleight of hand", Ryle's celebrated "category-error": the conflation of "three classes of concepts—brain, mind and behaviour" (ibid., p. 25) results in the bundling of all three together fallaciously within the context of the biological order. To employ a computational analogy, this is to confuse "software" (mind, behaviour) with "hardware" (brain); or, as Szasz wittily remarks:

> bodily illness stands in the same relation to mental illness as a defective television receiver stands to an objectionable television programme . . . It's as if a television viewer were to send for a TV repairman because he disapproves of the programme he is watching. (1981, p. 11).

Finally, Szasz rejects the causal-determinist account of human conduct implicated in psychiatric mechanomorphism. His objection turns upon the distinction between, on the one hand, *happenings* and *causes*, and on the other, *actions* and

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reasons. Apropos the contention that mental illness stands in relation to the brain as dermatitis to the skin, Szasz observes,

> This position is at least clear: mind is like skin. Things happen to each. Some of these happenings we call "diseases" . . . There is no such thing as action to obtain a goal—only behaviour determined by causes. Herein lies the fundamental error of the medical and mechanomorphic approach to human behaviour and psychiatric classification (1974, p. 192).

Szasz contrasts such a view with his own "humanist" conception; that is to say, as the Szaszian "manifesto" announces, "human behaviour has reasons, not causes".[5]

SZASZ'S INTERLOCUTORS

Such is the thesis of the "myth of mental illness", as extracted not only from the celebrated book of that name but from the early-Szaszian corpus. Though there are certainly those who would consider the thesis intellectually passé today[6]—chiefly on account of "enormous advances in the neurosciences" (Bentall, 2004, p. 307) in subsequent years—Szasz has nevertheless maintained a serious, if critical, secondary literature. Moreover, this has been recently augmented by the publication in 2004 of the Jeffrey A. Schaler edited *Szasz Under Fire*, subtitled *The Psychiatric Abolitionist Faces His Critics*. This intervention, which takes the form of a series of dialogues in which Szasz directly responds to his erstwhile interlocutors, affords an opportunity to reconsider the thesis in light of both sustained and recent critiques.

Taking these critiques "in the round", Szasz's interlocutors posit the following *anti*-theses:

1. an argument from psychosomatic holism;
2. an argument from scientific realism.

As we shall see, these anti-theses are tightly entwined.

1. The Argument from Psychosomatic Holism

By the concept *holism* I am referring to the notion that the properties of elements within a "system" are determined by both their interrelationships *and* the properties of the system taken *as a whole*, rather than being reducible to their individual parts. On this view, *psychosomatic holism* can be taken to refer to the unified system of the individual person comprising both mental and physical aspects, such that those features of personhood which might be characterised as belonging to the "intentional stance" are brought into a relationship of whole-system unity with

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the biological order. Such a perspective is potentially non-reductive and presupposes the existence of "emergent" properties of the system not deducible from an analysis of constituent parts.

Such a view is at once anathema to Szaszian dualism, for it combines what he strives to divide: studies of the body and "conduct" ("physics and psychology possess different sets of objects" etc. (1957, p. 24). At this point his interlocutors intercede. Jennifer Radden (1985, Ch. 2), for instance, has taken Szasz to task on this count. In her view, there need be no discrepancy, as Szasz maintains, between an illness model which stresses mechanomorphism and a social science of "conduct" predicated upon the "intentional stance" (ibid.). For Szasz, a *sufficient* criterion for illness ascription is the presence of an underlying physical disease process ("what health is can be stated in anatomical and physiological terms" [1968, p. 14]). Radden accepts this as a *necessary* but not *sufficient* condition; for the presence of *human suffering* is important also in her conception and this presupposes the holistic notion of illness-sufferer-as-whole person: "Only by appeal to social norms can the idea of organic malfunction be explained. The organic view need not preclude the importance of non-organic features, which are emphasised in the holistic account" (1985, p. 14).

This view is echoed canonically in the critique of that doyen of British psychiatry, R.E. Kendell: "Neither minds, nor brains nor bodies become ill in isolation. Only people, or in a wider context organisms, become ill or develop diseases. The most characteristic feature of so-called bodily illness is pain, a purely subjective or mental phenomenon" (1993, p. 5). Further, in his prominent contribution to *Szasz Under Fire*, Kendell reinforces the "illness-sufferer-as-whole person" thrust: "Suffering and disability are fundamental characteristics of disease, and it would be difficult to question the suffering and disability associated with most mental disorders" (2004, p. 33).

Not surprisingly psychiatric practitioners influenced by this perspective claim to adopt an eclectic approach to aetiology and treatment combining physical, psychological and social factors and therapies (e.g., Clare, 1980, p. 71), an approach bound to be considered "confused" by Szasz. Notwithstanding that view, the "argument from holism" is substantial—especially when combined with the second anti-thesis.

2. The Argument from Scientific Realism

Szasz ridicules psychiatry's scientific claims on the grounds that there is no "demonstrable histopathological lesion . . . not even . . . any objectively demonstrable referent" (1979, p. 87). To both Radden and Kendell, however, this is to misconstrue the medical enterprise and its relation to the doctrine of *scientific realism*. Hitting this point home they need not emphasise that those "enormous advances in the neurosciences" (Bentall, 2004, p. 307) and correlative medical

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technologies have mitigated the "problem of 'unobservables'" (e.g., CT/MRI scanning *in vivo*), though they surely have. Rather, they point out that to qualify as "realist", medicine must posit *real* entities beneath a presenting symptom picture. Radden remarks that, in this respect, psychiatry is often no worse off than general medicine, where the organic malfunctions underlying physical disease states are not always observable (1985, p. 14).

What medicine has to commit to is the thesis that there *are* real underlying disease states which can be inferred from clinical semiology. Such states are neither theoretical constructs employed to aid theory construction, nor mere heuristic devices. They are posited as *real* entities, often observable in practice, but always so in principle. This claim can be made apropos psychiatry because, as Kendell opines, "all mental events are accompanied by and dependant on events in the brain" (1993, p. 3). He proceeds to imbricate this claim with the "argument from holism" (above), refusing to concede that scientific realism in psychiatry commits it to a "crude somaticism" (ibid.) only. Thus, he invokes psychosomatic holism to argue for a scientific realism fully cognisant of the role of social and psychological factors.

This *imbrication* of holism/realism is further developed in *Szasz Under Fire*. In particular, Kendell (again) and K.W.M. Fulford finesse it in complementary directions both of which seek to undermine Szaszian dualism. First, Kendell recognizes a logical corollary of imbrication: that it need *not* causally privilege biological (e.g., "aberrant chemistry") mechanomorphism. On the contrary, what is located on the "whole person" side of the dualism, such as certain "psychogenic states" associated with the "intentional stance", may decisively contribute to what is best considered a *multi-level* causation of conduct.[7] Indeed, "multi-level causation" not only makes trouble for Szasz's hard-and-fast dualism ("We can have two psychiatries but not a combination of both" [Szasz, 1968, p. 25]) but simultaneously troubles the cognate distinction between "physical" and "mental" symptoms upon which the "myth of mental illness" thesis rests. As Kendell argues,

> The mechanisms underlying hysterical amnesia . . . are very different from those underlying the amnesia of dementia . . . and are commonly described as "psychogenic". But a myocardial infarction precipitated by fear or anger is equally "psychogenic" and in both cases there are good grounds for assuming that the *emotional predicament* generates neuronal or endocrine changes which play a critical role in producing the loss of access to memories . . . In reality, *the differences between mental and physical illnesses are quantitative rather than qualitative* (Kendell, 2004, pp. 41–42, emphases added).

With this latter statement, Fulford fully agrees: "Mental and physical illnesses are of course on a *continuum* rather than being categorically different" (2004, p. 76n, emphasis added). But whereas the mental/physical illness continuum for Kendell is of a *biological* order—the *emotion* underlying hysteria and evinced by the "whole person" may be reduced to the *same* order as the "aberrant chemistry" which

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proximally causes memory loss, both being presumably susceptible to a *quantitative* rendition—the continuum in question for Fulford is one of *human value*.

Drawing upon the resources of *philosophical value theory* (e.g., Fulford, 1989; Hare, 1952), Fulford provides an account of the difference—in the order of *value*—between physical and mental illness, a difference he locates precisely in the extent to which they are *differentially* valued:

> Philosophical value theory generates a model which . . . suggests that the negative value judgements by which experiences . . . are . . . marked out as . . . illness, are the origin of the negative value judgements by which, in turn, the underlying bodily causes of those experiences . . . are marked out as *pathological*, and, hence, as *diseases* (2004, p. 75n, emphases added).

The account is subtle insofar as it eludes Szasz's hard-and-fast dualism in preference for a view which regards the originary experience of illness *qua* suffering as *antedating* knowledge of the biological order ("aberrant chemistry" etc.). In other words, the mechanomorphic perspective of scientific realism is always already present, as it were, *in statu nascendi*, "in" the experience of the suffering "whole person". From this follows the necessary imbrication of human value and mechanomorphism of the biological order—between holism and realism.

Fulford's "value model" undermines Szaszian dualism insofar as it posits no *a priori* reason why the "negative value judgements" of holism need not obtain for mental as much as for physical symptoms and, hence, no *a priori* reason why the former, as much as the latter, may not find its "realist" expression in the biological order. Yet the model is subtle to the extent that it *does* maintain a distinction between mental and physical symptoms: *both* may be negatively valued, but according to a continuum which holds that,

> There is no . . . category error in taking a mental condition to be an illness in the same sense that physical illnesses are illnesses. The term "illness" in both contexts expresses . . . a negative value judgement. Mental illnesses are, in general, more overtly value-laden than physical illnesses only because the value judgements expressed by "illness" in respect of mental conditions tend to be open and contested, while the corresponding value judgements expressed by the use of the term "illness" in respect of bodily conditions tend to be widely settled and agreed upon (ibid., p. 75).

Kendell and Fulford, therefore, contest Szaszian dualism via the imbrication of holism/realism. Both posit a continuum-concept with which to effect the rapprochement of the mental and the physical which Szasz cast asunder. For Kendell, this continuum finds its common currency in quantitative fluctuations of the biological order; without eliminating the suffering of the whole person *qua* suffering—hence the gesture towards "eclectic" interventions—he nevertheless upholds the applicability of a mechanomorphic research programme of human conduct for both mental and physical illness. Whatever "aberrant chemistry" or "specific genetic loci" subsist within the biological order will do so equally for physical

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and mental symptoms. Fulford, by contrast, posits a continuum of values which are yet (again) subject to quantitative fluctuations. On this reading, the distinction to be drawn between physical and mental illnesses may be rendered by the quantifiers "more" and "less": mental illnesses are "*more* overtly value-laden" (ibid., emphasis added), physical illnesses *less* so.

It should be noted that there is nothing incommensurable in Kendell and Fulford's contrasting perspectives; this is the *force* of the imbrication of holism/realism. It is perfectly reasonable to combine the view that mental and physical illnesses are differentially valued—indeed, Szasz must presumably concur—with the view that both may (one day) be susceptible to a biological explanandum, one which will nevertheless fail to vitiate the "argument from holism". And if, as I suggested above, *that* argument alone is substantial, then its imbrication with realism *à la* Kendell/Fulford only fortifies the effect. It will play a central role in the "Discussion" to come.

DISCUSSION

That discussion proceeds in the following way. First, I *reinforce* the imbrication holism/realism as a doctrine which girds the medical enterprise. In doing so, I engage the thought of the French philosopher and historian of science Georges Canguilhem, whose work on medical and psychological discourse (1980, 1991, 2000) addresses and in certain respects surpasses *both* that of Szasz and his interlocutors. The import of Canguilhem's work is to focus upon the *technological* features of psychiatry and medicine (e.g., diagnosis and treatment) in addition to their epistemological and ethical aspects. The upshot of this engagement, I argue, is extremely conducive to Szasz vis-à-vis his interlocutors. So, whilst I reinforce the *imbrication* of holism/realism, as per Szasz's interlocutors, I yet defend the enduring applicability of Szaszian dualism *in the case of psychiatry*. Moreover, notwithstanding the force of holism/realism, it is possible to snipe at his interlocutors by exposing how, behind their eclectic prudence lurk confusions, which Szasz, in the act of "facing his critics" in *Szasz Under Fire*, clinically dissects. The strategy, then, is dual—defending dualism (by way of Canguilhem) sniping at Szasz's interlocutors—constituting my defence of Szasz *in the case of psychiatry*.

Methodological Dualism and the Singularity of Psychiatry

Now, it is not only possible to concede the force of Kendell et al's brand of holism/realism; it is *necessary* to do so. Indeed, I not only concede the case, I would *reinforce* it. Szasz's interlocutors are, in fact, parasitic upon a venerable tradition of medical thought, one which likewise adopts the holistic perspective as its point of departure (e.g., Canguilhem, 1991; Goldstein, 1939; Leriche, 1939). Georges Canguilhem,

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for instance, as long ago as 1943, persuasively argued that medicine is a "*technique* . . . at the crossroads of several sciences, rather than . . . strictly speaking . . . one *science*" (1991, p. 34, emphases added). Neither anti-scientific, nor anti-realist in temper (see Rabinow, 2000, p. 13), Canguilhem nonetheless insists that medicine, *qua* "technique", exists because human subjects "feel sick not because there are doctors to tell them of their illness" (1991, p. 93). He was fond of invoking the mantra: "[t]he doctor is called by the patient" (ibid., p. 226)—from which it follows that it is the "subjectivity" of the patient's suffering which, for Canguilhem, as for Kendell/Fulford et al., *precedes* the "objectivity" of medical science. This is why the subjectivity of the suffering subject, holistically conceived, contains epistemological *and* ethical content.

None of this means that there are no *sciences* of the biological order; or that they are not susceptible to a "realist" rendition. Indeed, Louis Althusser said of Canguilhem, as may be said also of Szasz, that he possessed a "scrupulous respect for the *reality* of *real* science" (in Rabinow, 2000, p. 13, emphases added). Canguilhem is clear that "[t]here is a science of biological . . . conditions *called* normal. That science is physiology" (ibid., p. 228, original emphasis); yet, this science is in itself an *a posteriori* formation, brought to light only *after* the presentation of suffering subjects. Hence, a surprising and profound dénouement, which finds no equivalence in Szasz's interlocutors: Canguilhem's definition of "health" as "life lived in the *silence* of the organs"[8] (ibid., pp. 91–101, emphasis added). For it is only when the organs "speak" through the intermediary of the suffering subject, that the doctor "treats", the scientist "discovers" and we speak of "medical science".

It will be conceded, perhaps, that this reinforcement of the imbrication holism/realism is especially germane for the *general* medical case—in just those cases where Canguilhem's invocation ("the doctor is called by the patient") paradigmatically applies. I take this to be close to Szasz's position also ("in the general medical case"). But the contrast with Szasz is instructive also in the psychiatric case where Canguilhem, in advance of Szasz, harboured an equally jaundiced conception of its *scientific* pretensions.

These misgivings appeared in a lecture from 1956 (see Canguilhem, 1980, p. 50) five years *before* the publication of *Myth.* In that lecture Canguilhem castigated "psychology"—beneath which he subsumed "psychopathology as a medical discipline" (ibid., p. 40)—for failing to constitute its "object" *scientifically*; that is to say, whilst eschewing philosophical discourses of the "soul", psychology had nevertheless failed to attain the level of scientificity associated with the physical sciences. The argument may be rendered in two directions, which respectively respond to, first, the "realist" and, second, the "holist" sides of our imbrication. So, in the first sense, psychology is indicted as "medicine without control" (Canguilhem, 1980, p. 37) insofar as the "source" of its "observations and hypotheses", which just is "mental illness" (ibid.), is, of all "illnesses" the "most unintelligible and the least curable" (ibid.); whilst, in the second sense, a science

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of "holistic" conduct could hardly help but impose upon its "subjects" a measure of social *coercion*. Hence, for Canguilhem, an "instrumentalism" taints the psychologist's "techniques" (ibid., pp. 46–49), which,

> necessarily gives to his quantifications an *evaluative* aspect . . . The end result is that the behaviour of the psychologist inevitably carries with it a belief in his own superiority, a good authoritarian conscience and a managerial attitude towards human relations (ibid., p. 48, emphasis added).

It is this "evaluative aspect" which has been echoed so often in the discourses of "anti" and "critical" psychiatry (e.g., Ingleby (Ed.), 1981; Laing, 1990), the sociology of "deviance" (e.g., Goffman, 1968; Scheff, 1966) and, latterly, those social movements promoting the patient's "voice" (e.g., Read & Reynolds (Eds.), 1996; see Crossley & Crossley, 2001). Moreover, it was this aspect of Canguilhem's thought which was specified further by Nikolas Rose who, in modifying the aforementioned definition of "health" for the psychiatric case, announced it, not as "health . . . in the silence of the *organs*", but, with equal profundity, as *mental* health "in the silence of the *authorities*" (1985, p. 231).

The "silence of the authorities"—the phrase is worth pondering. In its invocation of a *social* and *power-laden*, rather than a *biological* and *scientific* "norm" against which to "evaluate" conduct, it clearly evinces an exquisitely Szaszian ring. Moreover, what it constitutes is the nodal point around which coalesce the myriad "paths of anti-psychiatry" (see Kotowicz, 1997): social coercion constituting, for all such "paths", psychiatry's institutional raison d'être. And this is why there subsists such a gritty kernel to Szaszian dualism. Szasz is always at his best railing against just those "techniques" which find little equivalence in the general medical case: the lawful incarceration of individuals and treatment without the patient's consent (see Szasz, 1965, 1977). Such coercive phenomena, accompanied by even the finest "authoritarian conscience" (Canguilhem, 1980, p. 48), occupy a singular ethical realm. With this in mind, it does seem possible to reinforce the imbrication of holism/realism whilst yet defending Szaszian dualism *in the case of psychiatry*. Support for such a perspective turns upon analysis of the *differential contingencies* obtaining for, on the one hand the psychiatric, and, on the other, the general medical case.

Apropos the "technical" aspects of "case-management", it is the doctor who *diagnoses*. That is a truism. But, if we are to take the imbrication of holism/realism seriously, we are forced to concede that diagnosis constitutes only the end-game, the specific naming of a malaise, knowledge of which arose initially *in statu nascendi*—"in" the patient's subjectivity. Of course, there exists no *a priori* reason why this contingency should not obtain for the psychiatric consultation also (*if* the doctor *is* indeed *called* by the patient), a fact which, *pace* Szasz's interlocutors, it is wise to acknowledge. Not all psychiatric "technique" is coercive and Szasz has been at pains to promote help-soliciting, help-providing behaviours insofar as they can be reconciled with "other consensual, cooperative . . . practices" (Szasz, 2004:

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53; 1965; see also Engelhardt Jnr., 2004). However, in just those sectors of psychiatry which arouse Szasz's invective—incarceration/forced treatment—the force of holism/realism undergoes an erasure. In such cases the contingency invoked by Canguilhem's mantra fails to obtain. The doctor is neither "called" by the patient—she may be bodily presented by "third parties" (relatives, the police etc.)—nor does she give voice to a prior malaise—there may be no "pain" to speak of, there may be even an extant *euphoria*.

It is precisely *this* contingency which Szasz mobilises against Kendell, in response to the latter's rendition of the holistic perspective ("it would be difficult to question the suffering . . . associated with most mental disorders" (2004, p. 33)), with the following rejoinder:

> It is *easy* to question it ["the suffering" etc.] . . . most people who psychiatrists characterise as "seriously mentally ill" do not suffer: they make others suffer . . . If such persons were suffering it would not be necessary to incarcerate them and treat them against their will (2004, p. 51).

Note here how, for Szasz, the question of "suffering" (who is suffering?) together with its ethical accretions, is first and foremost connected to the technological question of psychiatric treatment (incarceration/forced treatment) with all *its* ethical accretions (e.g., "consent"). In the quotation above the epistemological question of the *scientific* status of psychiatry is held in abeyance, though to fill in the blank we know from the aforementioned that for neither Szasz nor Canguilhem is that status regarded as high.

These observations permit the clarification of a potential confusion. For the thesis of the "myth of mental illness" is *not* a thesis which contraposes just a *power-laden*, *values-pervaded* psychiatry to a *power-neutral*, *fact-eliciting* medicine. In Szasz's early work this was never the case *simpliciter*. Neither is it a case of positing a dichotomy of epistemology and ethics for the sake of which epistemology "speaks" on the side of medicine whilst ethics "speaks" on the side of psychiatry. For Szasz, like Canguilhem, evinces a tripartite distinction within *both* medicine *and* psychiatry *between* their ethical, epistemological and, *pace* Canguilhem, "technological" aspects. And with these distinctions established the full import of the "myth of mental illness" thesis swings into view. It may be stated in the following way.

In the general medical case, a harmony obtains between the ethical, epistemological and technological aspects of medical practice insofar as the doctor *is* "called by the patient", from which impetus a range of technological interventions arise (diagnosis, treatment etc.) the epistemological foundations of which, it may be historically demonstrated, are rooted soundly in the soil of science (see Bernard, 1957). Szasz summed up the paradigmatic medical case succinctly:

> the practices of modern Western medicine rests upon the *scientific* premise that the physicians task is to diagnose and treat disorders of the human body, and on the *ethical* premise that he can carry out these services only with the consent of his patient (1981, p. 10, original emphases).

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a view with which Canguilhem would have doubtless concurred, having nuanced it eighteen years earlier in the following way:

> [t]he fact is that the physiologist's scientific activity, however separate . . . he may conceive it in his laboratory, maintains [an] . . . unquestionable relationship with medical activity. It is life's setbacks which draw . . . attention to it. Knowledge always has its source in reflection on a setback to life (1991, p. 222).

But *the psychiatric case* is a cacophony juxtaposed to such harmony—and this in two senses, the second of which is the far more discordant. In the first sense, in which case *likewise* "the doctor is called by the patient", the dissonance resides, not in the ethics/technology relation—for, as Szasz always maintained, there can be no objection to "consensual . . . practices" (2004: 53) predicated upon explicit consent—but, rather, in the technology/epistemology relation, psychiatry being rooted only *precariously* in the soil of science. This is an embarrassment only if one holds that psychiatry, *à la* medicine, *needs* to be rooted in a scientific realism of the biological order and an accompanying mechanomorphic research programme.

But it is the second sense that is more than embarrassing and justifies both Szasz's polemic and Canguilhem's critique. For, in this second sense, the dissonance resides in *both* the ethics/technology relation *and* the epistemology/technology relation: the doctor is *neither* "called by the patient" (ethics) *nor* are the "interventions" (technology) resulting (incarceration, forced treatment etc.) scientifically sound (epistemology). And it is this failure *on all counts* of the harmonious functioning of the tripartite distinctions *within psychiatry* (ethics/technology/epistemology)—which distinctions function harmoniously *within medicine*—which justifies Szaszian dualism *in the case of psychiatry*.

The Lacunae of Szasz's Interlocutors

Faced with such an analysis, there is a "heroic" line of objection open to Szasz's interlocutors—which, in *Szasz Under Fire, none of them take.* The "heroic" line is this: assert, before anything else, that the epistemology/technology relation in the case of psychiatry *is* rooted soundly in the soil of science. In *Szasz Under Fire* the prospects for pursuing the "heroic line" are carefully canvassed by Richard Bentall (2004).

Though fully *au fait* with those "enormous advances in the neurosciences" since Szasz wrote *Myth*, Bentall concludes that cumulative inquiries into "aberrant chemistry" (ibid., pp. 308–310) or "specific genetic loci" (ibid., p. 313), have failed to uncover any "clear causal connections" (2004, p. 312) between "behaviours . . . subsumed by . . . diagnosis" and physical pathology (ibid., p. 304). Unlike Szasz and Canguilhem, however, Bentall fails to surmise that relations obtaining between ethics, technology and epistemology are thereby fractured. Notwithstanding the lack of a sound scientific basis for "treatment" he nevertheless insists

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that "there can be no doubt that anti-psychotic medication . . . produces in . . . the majority of patients a reduction in hallucinations and delusions" (ibid., p. 309) and that the main issue confronting psychiatry therefore consists in the development of "more ethical psychiatric services" (ibid., p. 315), the status of psychiatry's epistemology/technology relation being relegated to that of a "sideshow" (ibid., pp. 314–316). "Such [ethical psychiatric] services", Bentall continues, "should meet the moral requirements of any medical system" (ibid.), but he fails to detect that the wished-for identification with "any medical system" is not apt here; for *neither* is the epistemology/technology relation identical—medicine being rooted soundly in the soil of science—*nor* is the ethics/technology relation identical—medical interventions being generally conducted only with the patient's consent.

The precariousness of psychiatry's epistemology/technology relation in particular leads some of Szasz's interlocutors into surprising lacunae. Kendell, for instance, wants to simultaneously assert that the "evidence that genetic factors play a major role [in mental illness causation] is almost universally accepted" (2004, pp. 30–31) whilst yet *inflating* Szasz's "myth of mental illness" thesis to subsume *in toto* the field of physical health, *viz.*:

> the concept of physical . . . illness is equally meaningless, equally mythical and equally dangerous (ibid., p. 42).

This is a somewhat surprising concession to *relativism*—apparently we cannot now canvass *any* scientific concept of "illness" in general—from a *physician* so prominent. Yet it is repeated virtually term-for-term by Fulford in *Szasz Under Fire*:

> [t]here is no such thing as mental illness . . . if physical illness is defined by exclusively scientific norms . . . But this in turn . . . is because there is no such thing as physical illness, so defined (2004, p. 87).

A feature of *Szasz Under Fire* is Szasz's robust response to such relativism, re-asserting (against Bentall) his long-rehearsed claim that the "scientific status . . . for a disease . . . is physical pathology (2004, pp. 321–22), which can be therefore no "sideshow"; whilst maintaining the circumscribed provenance of the "myth of mental illness" thesis contra Kendell (and Fulford's) inflation:

> Kendell agrees that mental illness is a myth and seeks to blunt the force of his observation by asserting that physical illness is also a myth . . . I disagree. The "concept of physical illness" demarcates a category . . . (2004, p. 54).

To be precise, what the "concept of physical illness" demarcates is a *scientific* category which, following Szasz and Canguilhem, may be seen as engaged *in relation to*—in a certain sense *a posteriori* to—the fields of technology and medical ethics. These relations are neither reductive nor relativist. But vis-à-vis his

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interlocutor's lacunae, Szasz saves his toughest polemic for Fulford who, in contraposing an "evidence-based" to a "values-based" medicine argues that we may thereby avoid the,

> risk of slipping from the traditional abuses of "doctor knows best" . . . to the abuses of an equal and opposite extreme of "patient knows best" (2004, p. 81).

Szasz responds tartly:

> [f]rom a medical point of view—assuming that the doctor is a well-trained physician and the patient a lay person—the doctor always knows best about what ails the patient and about how best to treat him (2004, p. 111).

As will by now be familiar, Szasz is referring here to *the general medical case*.

How do such lacunae arise? They arise because Szasz's interlocutors, cognizing both that: i) the ethics/technology relations of medicine and psychiatry are not on a par; and ii) the epistemology/technology relations of medicine and psychiatry are not on a par, are caught on the horns of invidious dilemmas. Either, vis-à-vis i), they have to stand fast for Bentall's "ethical psychiatric services", observant of the "moral requirements of any medical system", which would presumably require *either* that they fall in behind Szasz and his repeated insistence upon "consensual . . . practices" only (2004, p. 3), forswearing the treatment of patients without their consent; *or* they have to subsume within such "moral requirements" such ethically dubious practices. That the choice is invidious is demonstrated in *Szasz Under Fire* by Bentall's and Kendell's silence upon the issue of consent and Fulford's somewhat disingenuous acceptance (see 2004, p. 70) of coercion, for which Szasz effectively takes him to task (2004, pp. 100–101).

But it is the invidious status of ii), the epistemology/technology relation, which accounts for Fulford and Kendell's descent into relativism. Not confident of the "heroic line", they somewhat astoundingly concede the "mythical" status of physical illness also, as the above quotations imply. To explain this shared error requires a return to the imbrication of holism/realism canvassed above, which I have been at some pains to endorse. The problem, however, is that there is a right and a wrong way to endorse it.

All Szasz's interlocutors, but Fulford and Kendell especially, posit the imbrication of holism/realism *dichotomously*; in other words, they posit a realm of *values*, which is described in terms of "pain", "subjectivity", "suffering" etc., and this they contrapose to a realm of *science*, alternatively described in terms of "specific genetic loci", "aberrant chemistry" etc. The question then becomes whether (and how) to unite the two realms. The dichotomy is most starkly posited in Fulford's contraposition between an "evidence-based" (epistemology) and a "values-based" (ethics) medicine. In different ways, but evincing the same logical form, Fulford and Kendell posit a *continuum-concept* with which to unite the two realms.

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The continuum-concept works like this. First, *à la* Fulford, between physical and mental illness one posits a continuum of *values*, not *qualitatively* but *quantitatively* differentiated, in respect of the fact that physical illness is *less* contested in value terms and mental illness *more* so. Next, *à la* Kendell, one posits a continuum of the biological order, again, not *qualitatively* but *quantitatively* differentiated, in respect of the fact that the "psychogenic" factors located on the "holistic" side of the holism/realism divide generate, as Kendell argues, "neuronal or endocrine changes" relevant equally to, say, "hysterical amnesia" or the "amnesia of dementia" (Kendell, 2004, pp. 41–42).

Without wishing to impute a biological reductionism to what clearly possesses a holistic intent, it has to be said that what unites the continuums posited is their *quantitative* character. This permits the elision of any *qualitative* differences obtaining between the physical and mental symptom, which is to say, between medicine and psychiatry, viz.:

> [i]n reality, the differences between mental and physical illnesses are quantitative rather than qualitative (Kendell, 2004, pp. 41–42);

> [m]ental and physical illnesses are of course on a continuum rather than being categorically different (Fulford, 2004, p. 76n).

Hence, psychiatry is conceived as a branch of medicine. But against this conception, I want to question the validity of the continuum-concept and its relation to the imbrication of holism/realism. Here, Canguilhem's prior analysis is, again, most conducive to Szasz. For Canguilhem (1991, pp. 47–101) long ago identified the lacunae of such a conception.

Once identified, the problem is simple. As Canguilhem pointed out, to assert the *homogeneity* of a continuum save for its *quantitative* variations—as Fulford and Kendell both do—does not rule out the *heterogeneity* of the extremes of the continuum. Canguilhem correctly surmised that the holistic aspect of the imbrication holism/realism is precisely such an element. Who does not see that the concepts of "pain" and "suffering" are *qualitative*, with respect to the whole human subject, not quantitative and, hence, heterogeneous vis-à-vis the quantitative aspects of either the biological or the values-laden continuum? Of course, one would be right to protest that this observation holds both for the psychiatric *and* the general medical case—an observation with which both Szasz and Canguilhem would concur. But here Szasz and Canguilhem's *refusal* to deal with the imbrication holism/realism dichotomously affords them insights not readily available to Fulford, Kendell et al.

Szasz and Canguilhem, in fact, deal with the imbrication *relationally*; which is to say, they analyse the relations obtaining between the tripartite distinctions of epistemology, technology and ethics with respect to medicine and psychiatry. Their analysis is conceptual but it is also *historical*; both have contributed significantly to the histories of medicine and psychiatry and their histories are precisely the histories of these distinctions (see Canguilhem, 2000; Szasz, 1970). The question for them, then, is not how to unite two apparently heterogeneous realms but to ascertain

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the harmony of the relations obtaining between a values-laden holism, expressed in the idiom of "suffering", and the epistemologically-valorised facts, expressed in the idiom of the physical sciences. According to this relational perspective, "technology" (diagnosis, treatment etc.) plays an intermediary role; it is Janus-faced, looking towards the holistic aspect—because "the doctor is called by the patient"—and towards the scientific aspect—because "medical . . . technology prompted by the pathological state" provides the very stimulus for "physiological knowledge" (Canguilhem, 1991, p. 51).

It is in light of this analysis that medicine and psychiatry cannot be considered all of a piece—for the aforementioned reasons. As Szasz and Canguilhem clearly divined, in psychiatry the doctor is not always "called" by the patient; but even when the doctor is so "called", the very precariousness of psychiatry's technology/epistemology relation cannot qualify it as medical science. To conclude: whatever else psychiatry may be, it is not a branch of medicine.

Finally, Szsaz and Canguilhem help us understand Fulford and Kendell's descent in to *relativism*. As Szasz pointed out contra Fulford, if one is sanguine about medicine's technology/epistemology relation, one is sanguine about advancing the "heroic" line; this is precisely what Szasz means by asserting that, in the general medical case, "the doctor always knows best about what ails the patient and about how best to treat him" (2004, p. 111). Relativism rears its head in the psychiatric case precisely because the Fulford/Kendell continuum concept, whether constructed in valuational or biological terms, can only conceive of the quantitative continuity between states—it cannot conceive of their qualitative difference. As Canguilhem pointed out, the quantitative continuum concept results in a rather paradoxical effect: either, in pointing to the essential homogeneity of quantitative differences, one can say "that there is no completely normal state, no perfect health" (1991, p. 77); on the other hand, one may also perversely conclude, "that there exist only sick men" (ibid.), which Canguilhem adds, in a Szaszian vein, "is nonetheless absurd" (ibid.).

The lacunae of Szasz's interlocutors resides in the fact that, in making of the difference between the physical and the mental symptom a quantitative continuum, they have reached a conclusion which is equally "absurd". They have substituted "the myth of mental illness" thesis—a logical corollary of Szaszian dualism—with "the myth of illness" *in toto*.

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NOTES

[1] The Szasz bibliography compiled by Jeffrey A. Schaler and Antonio F. Mastroniani for the compilation *Szasz Under Fire: The Psychiatric Abolitionist Faces His Critics* (2004) runs to 27 pages spanning chronologically 1947 to 2004. Not counting new editions this includes 27 books—and Szasz, now in his eighty sixth year, has remained active (e.g., 2006). An up-to-date Szasz bibliography may be found on the web at http://www.szasz.com/publist.html (consulted, 15/10/06).

[2] Here I refer to the year of publication. Elsewhere in the text I refer to the actual edition cited.

[3] It was, in fact, a substantial extrapolation of an earlier paper, "The myth of mental illness", which had appeared in *American Psychologist* in 1960.

[4] Of course, Szasz imparts his own distinctive sociological "twist" to the doctrine of operationalism; but it has also been widely influential within mainstream psychiatry, at least since the delivery of a landmark paper "Fundamentals of Taxonomy" by the philosopher of science Carl G. Hempel to the World Conference on Field Studies in the Mental Disorders in 1959. Hempel argued that psychiatry needed to *operationalise* its classificatory system by sharply characterising diagnostic criteria in terms of intersubjectively warranted observation. For Hempel, such descriptive acuity went hand in hand with the discovery of "law-like" relations, vis-à-vis the phenomena in question, and with theory-building. Hempel's views have had an impact upon the development of the diagnostician's bible, the American Psychiatric Association's *Diagnostic & Statistic Manual of Mental Disorders*, e.g., *DSM/IV-TR*, APA, 2000. Hempel's paper is to be found in the appendix to *Philosophical Perspectives on Psychiatric Diagnostic Classification* (1994), edited by John Z. Sadler et al. A number of papers in that publication also contain useful expositions and critiques of Hempel's philosophy in its psychiatric application.

[5] Jeffrey Schaler, from the grandiloquently titled "Thomas S. Szasz Cybercenter for Liberty and Responsibility", (http://www.enabling.org/ia/szasz).

[6] In *Szasz Under Fire* Jeffrey Schaler quotes Dr. Thomas G. Gutheuil, a Professor of Psychiatry at Harvard Medical School, as opining that, "Szasz's ideas . . . have been rendered obsolete by genetic studies, imaging, cross-cultural anthropology and the like . . . Dr. Szasz is simply no longer worth it" (2004, pp. xxiii–xxiv). This paper is written against that perspective.

[7] I am indebted to a referee of this journal for provoking this line of thought.

[8] In fact, Canguilhem is quoting and endorsing the work of the French surgeon and Chair of Experimental Medicine at the Collège de France, René Leriche (see 1939).

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