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The Bioethics of Diagnosis: A Biocultural Critique of Certainty

In comparison with the complexity of discussions of biopower, the tenets of bioethics are relatively simple. These are simple in the sense that the foundational notions of bioethics read like the list of virtues—autonomy, beneficence, and justice, with the later addition of non-maleficence—that have remained the central theoretical foundations of bioethics ever since its coming into being in the United States with the Belmont report in the 1970s. That report was further elaborated in the book *The Principles of Medical Bioethics* (1979) by Beauchamp and Childress. This core set of values was a product of a certain time and place, although they have remained with us as we enter the second decade of the twenty-first century. We may see this list as a product of post-sixties' attitudes toward the body and its relationship to the medical establishment, when the power of physicians was seen as antagonistic to the freedoms of the patient. Generated by anti-psychiatrists, feminists, and other medically focused activists these libratory notions about patients' rights, informed consent, and so on were seen as a radical step forward. However, it is also possible to see these as essentially positivist credos echoing enlightenment concerns about the nature of the individual and his/her relationship to society. In this sense, bioethics stands in opposition to other theories of power and the body, most notably those of Michel Foucault, which sees

biopower as a function of discursivity and enlightenment ideas about the nature of identity and citizenship.

So notions of medical bioethics are highly susceptible to an anti-enlightenment critique, concerned as they are on notions of individuality, freedom, rationality, categorization, and so on. It would be difficult to imagine the current notion of bioethics in the context of a Foucauldian critique of medicine and psychiatry. Most notably, the notion of power expressed by Foucault is often very different from the one implied in bioethics. There are many ways that this is true, but I want to focus in this essay on one subset of the bioethics paradigm—the relatively unproblematic notion of diagnosis. The assumption has been that non-malfeasance and beneficence will predict a scenario in which a patient receives a good and proper diagnosis from a responsible practitioner who will then assign, based on the diagnosis, an effective treatment. But if practitioner and patient are interwoven in a discursive web of power, it is harder to see this relatively unproblematic unfolding of responsibilities and capabilities laid out by bioethics as anything other than obfuscatory, however well-meaning.

In this essay I want to concentrate less on general medicine and more on psychiatry, where I think the problem of diagnosis is particularly vexed. One could argue that in the scenario of a patient with a broken leg or with cholera, there would be no special interest in the social-cultural surround of the patient. The diagnosis would be unproblematic and the treatment obvious. Of course, no diagnosis is actually unproblematic or freed from social and cultural issues. Anne Fausto-Sterling (2001) has shown us that even bone density diagnosis is dependent on social and cultural factors. So when we discuss psychiatric diagnoses, we have to be especially careful to pay attention

to such factors. In the case of psychiatric disorders, particularly affective disorders, there is a complex cultural and historical scenario, I will argue, that has in effect formed and pre-selected the categories available for diagnosis, positioned the diagnostician and the patient within a power relation, and raised basic problems around the activity of diagnosis itself. As treatment is dependent on these diagnoses and on the production of both disease and cure, how ethical can an approach to “bio” be? In addition, we raise the question of how there can be an ethics of a disease entity whose existence is far from certain.¹

In pursuing this point, I want to focus particularly on Obsessive-Compulsive Disorder (OCD). If one begins with the *Diagnostic and Statistical Manual of Mental Disorders* (known as the *DSM IV TR*) diagnosis of OCD we will be able to interrogate notions of being “mentally ill” implied in a bioethical approach.² The *DSM IV TR* is the book used by practitioners to arrive a numerical code for diagnostic and insurance reimbursement purposes (for example, the code for OCD is 300.3). The manual appears to be definitive and is written in a style that indicates authority and lack of doubt—this despite the fact that there is considerable play within and between diagnoses (made less of a problem by the inclusion of the idea of “co-morbidity”—which emphasizes that many other symptoms might be present beyond those grouped into the diagnosis).³

¹ Cultural and social factors are important in any diagnosis and within medical practice there are fads and trends in all areas. Recently I gave a version of this talk to fourth-year medical students at Albert Einstein College of Medicine in New York. -One student pointed out to me that such factors impinged on something as simple as infantile digestion, with a huge increase recently in giving infants medication for reflux. -The student maintained that about one-third of all babies now in the institution [where](#) she worked were on such medication.

² I put the words “mentally ill” in scare quotes because there is a fundamental question, not answerable in this essay, about the ontological nature of psychic distress. - Is it a disease, a condition, an philosophical problem, etc? -The history of psychiatry leads us to an understanding of why mental conditions were considered “diseases” or “illnesses” but a large body of work and many new organizations now question the disease categorization.

³ Co-morbidity is a [wriggle-room](#) concept, like the cosmological constant that Einstein added to his general theory of relativity to try to keep a stationary model of the universe. -Co-morbidity allows for a diagnosis in

Many people have written about the problems inherent in the *DSM*, and I can't go into those in this essay. But I want to pinpoint that, by its own admission, the *DSM* was designed to "improve communication" among practitioners (xxiii). Thus it is less of a bible and more of a playbook. What appears in it is more tentative than might first appear to be the case. The epistemological and ontological category of a particular diagnosis rests on its derivation from the *DSM*, but the *DSM* cannot itself provide anything resembling certainty, although it aspires to certainty.⁴

One might want to begin by saying that the clinical entity of OCD is far from an established and naturally occurring phenomenon. It may be true that humans have always counted, ordered, checked, washed, collected and so on. And it may be true that the human mind can have a tendency to return repeatedly and continually to some thought or mental activity. However, when we group a set of mental or physical behaviors into a disease entity, we take a step that is constitutive but also imaginary and symbolic.⁵ Having then created this category that makes "sense" of random or seemingly linked behaviors, we then can assign people and their behaviors to those categories.

Diagnosis is a complex process in which a person's behaviors and thoughts, capable of being seen in many registers, are transmuted into the specific register of symptoms. That transmutation is part of a continuous process in which the observer

the presence of extraneous symptoms. -Much more needs to be analyzed in this area, but the brevity of this essay won't allow further discussion.

⁴ Robert Burton (2008) has written about the difficulty of arriving at certainty as a physician. He notes that "we aren't reliable assessors" and that "an attempt to base our opinions on as thorough a scientific understanding as possible, while simultaneously reminding ourselves and our patients that our information will necessarily have been filtered through our own personal biases, affecting our selection of evidence and even which articles trigger a sense of correctness. Once we've made this admission, we have stepped off the pedestal of certainty and into the more realistic world of likelihoods and probabilities." (172-73).

⁵ Even the *DSM*'s recommendation that obsessive thinking might have a different kind of treatment from checking and ordering behaviors is a tacit admission that two different kinds of activities have been agglutinated into one disease entity.

places the subject into a category of what might be called the “pre-diagnosed” or “diagnosable.” Of course we are all potentially pre-diagnosed, but in reality we only slide into that category when, in some liminal moment, one moves or is moved from person to patient. Likewise, the observer must shift in that register from fellow human, co-conversationalist, to diagnostician. A diagnostician is no longer engaging in a “natural” and equal exchange with the interlocutor. Rather, the diagnostician must move from personal, moral, and social judgments made in the course of the haphazard but explicable space of conversation to the seemingly more stratified, scientific and regulated kind of description that is found in the *DSM*. From one perspective we may say that this shift is one that defamiliarizes one modality of being by making another estranged form of interacting seem more natural. Apparently normal conversation, then, becomes in fact an occasion for symptom-gathering on the part of the practitioner, and normal thinking becomes transformed into clinical analysis.

How strange this is might be illustrated by an amusing “report” from the satiric newspaper *The Onion* from March 23, 2009. In a story with the headline, “98% of Babies Manic Depressive,” the paper goes on to report:

A new study published in *The Journal Of Pediatric Medicine* found that a shocking 98 percent of all infants suffer from bipolar disorder. “The majority of our subjects, regardless of size, sex, or race, exhibited extreme mood swings, often crying one minute and then giggling playfully the next,” the study’s author Dr. Steven Gregory told reporters. “Additionally we found that most babies had trouble concentrating during the day, often struggled to sleep at night, and could not be counted on to take care of themselves—all classic symptoms of manic

depression.” Gregory added that nearly 100 percent of infants appear to suffer from the poor motor skills and impaired speech associated with Parkinson’s disease. (http://www.theonion.com/content/news_briefs/98_of_babies_manic)

The humor of this piece is dependent on the fact that we don’t generally use the diagnostic register to talk about the behavior of very young infants (although there are feeding and eating disorders listed in the DSM for infants). But why should we use that register at all? Clearly there are reasons to think diagnostically in categorical ways, but what are the foundations for such thinking about thinking diagnostically? Is diagnosis the only way of knowing, shaping, and collecting these behaviors into putatively clear and distinct entities? Does the “correct” diagnosis then produce a specific and beneficial cure?⁶

The *DSM* is itself an enlightenment project of the first order. Its goal is to categorize unmistakably and “know” the discrete entities of mental illness that it tautologically predicts will exist. The process by which these categories arise has been very haphazard and arbitrary: literally the result of committee work done by small groups or practitioners, influenced by social and economic forces, and the result of voting and consensus. The fact that the disorders change over time and that new symptoms and grouping arise in each edition of the *DSM* only emphasizes the contingent nature of the diagnosis. Tellingly, in the seven years between the last and current editions of the *DSM* the number of categories and subcategories increased from 297 to 374, amounting to almost 25 per cent, or about ten new disorders or diseases per year.

⁶ One study indicated that diagnosis of mental disorders co-ordinated only very slightly with treatment outcomes.

The implication of the word “diagnosis” is that we can know a disease apart from other diseases or apart from anything. *Dia* means both “through” or “thoroughly.” Those rather different meanings point to a profound ambivalence in the concept of diagnosis. If you gain knowledge “through” something, is the knowledge gained *of* the subject or the object? If the object is the means through which you know, then is the knowledge of the subject or the object? What makes the knowledge “thorough” in that case? *Gnosis*, as knowledge, implies the certainty of religious knowledge, and its adjective, *Gnostic*, is opposed to the doubtful—that is to say, full of doubt—knowledge of the agnostic. The heyday of the use of *gnosis* and of “diagnosis” in the English language is the second half of the nineteenth century and coincides with the rise of evangelical Christianity as well as the professionalization of medicine. Without making too much of that point, could we not see the physician as displacing the divine as the source for certain knowledge? Diagnosis in this scenario would be the medical equivalent for the theological certainty offered by a knowing—in this case a knowing of the body if not the soul.

Understanding diagnosis as a new kind of certain knowing

Knowing someone diagnostically may seem to present the most certain kind of knowing among a variety of knowings, but I would argue in fact it represents a serious type of misrecognition. We might explore this misrecognition by starting with the first stage of diagnosis—the symptom. This stage begins with a presentation of a symptom or group of symptoms to the practitioner. But even this beginning has a pre-history, since

the patient has to know that he or she “has” a symptom.⁷ To “know” one “has” a symptom initiates the cascading effect of misrecognition or what we might consider the earliest phase of the diagnostic mirror phase. First, you must sense something within the self, fit it into a taxonomy, use a pre-existing language of description, and communicate that “something” to a practitioner. Each one of those steps will therefore involve intuitions, conformity to norms and standards, rendering the physical or psychic intelligible through the deformations of language, and shaping that response to the listening practitioner. In this sense there are no “natural” or “inherent” symptoms apart from those communal and social ways of knowing the body and categorizing what is sensed or not sensed as symptoms. For example, to sense a symptom can be particularly complex when the symptom itself involves not a presence but an absence of feeling or wellbeing. Anhedonia, for example, is the state of not feeling pleasure. Hypoactive Sexual Desire Disorder (HSDD) concerns a lack or absence of sexual fantasies and desire for sexual activity for some period. Even stranger, Situational HSDD is lack of desire for one’s current partner. Such a non-feeling will only become apparent in a group that stresses the importance of feeling pleasure or the discursive requirements of sexuality in particular relationships and settings. It would seem that something like pain would be less dependent on the social and situational. However, David Morris (1991) points out the very biocultural aspect of pain, which seems at face value to be a natural and immanent sensation unmediated by culture or language. Morris notes that pain “is decisively shaped or modified by individual human minds and specific human cultures” (1991, 1). And, of course, psychic pain is even more dependent on discursive knowledges.

⁷ In English one “has” a symptom. Why does one *have* it? Is it an object to have? More properly it might be said that the symptom has the person, transforming them into a patient by that having.

Sensing a symptom, then, is to become involved in a matrix of significations whose meanings are more or less purely social. What happens when we move from sensing to presenting? Indeed, presenting symptoms is a phenomenal part of sociability, as we routinely ask each other upon seeing one another, “How are you?” We are hailed into the language of medicine in a neo-medicalized Gramscian sense each time we meet another and engage in phatic conversation. We are required to report on our mental and physical wellbeing or absence of wellbeing. Symptom presentation is part of the performance of everyday life, the collective understanding of bodies, and thus the advice given by the other is part of that sociability. But what happens when the other is a professional diagnostician?

The conversation ends then and clinic hours begin. The shift from sociability to medical interaction changes the agency involved. One’s “having” a symptom is now made less active. One becomes a function of one’s symptom, and the symptom becomes a sign in a text to be deciphered (and deciphered quickly, given the pressures of time and money in today’s medical practice). Any notion of agency on the part of the symptom presenter is transformed to docility, in Foucault’s sense, and the agency is transferred, seemingly, to the diagnostician whose job is now a kind of detective work. But even the diagnostician’s agency is only apparent, given that the list of possible interpretations are predetermined by the *DSM* in this case or professional guidelines in general.⁸ Thus we might speculate that the diagnostician becomes less of a bricoleur, cobbling things together from a range of possibilities, and more of a factory worker sorting nuts and bolts

⁸ While we might want to accept the idea that professional guidelines serve to insure that the patient is getting the best of the bioethical virtues from the practitioner, it is also the case that these guidelines [that](#) present a synthesis of bench science, epidemiological evidence, and clinical trials are very particularly of a given moment and tend to present that moment as if it were devoid of uncertainty.

into their proper boxes. Of course, each instance will have its own parameters, and no doubt there are excellent detectives out there as well as competent sorters.

Seeing the diagnostician as someone engaged in deciphering a riddle raises the cultural specter of Oedipus before the Sphinx. In that story, a pile of bones lay in a crevasse below the Sphinx, remains of those unsuccessful in answering the question “What walks on four legs in the morning, two at midday, and three at night.” The question is in fact a medical question, one that traces the ability of the body to ambulate or not at various points in one’s physical development. In some sense, the Sphinx is asking of the human race, “How are you?” Oedipus, whose name itself relates to the ability to walk properly—“swollen foot”—is a symptom-bearer for the human race, and he evidently must walk with some degree of limp in order to bear his name. In answering the Sphinx, he is able to diagnose the physical problem because he himself perhaps knows something about the complexity of ambulating.⁹ His actions of killing his father and marrying his mother then cause the state to fall ill with the symptom of infertility. This time Oedipus will diagnose and cure the city, but his own lack of knowing will prevent him from finding the correct diagnosis until he realizes that he is the *pharmakon*—both cause and cure, according to Derrida—and must be driven out in order to make the city well again.

In this Oedipal version of diagnosis, the practitioner attempts to answer the riddle presented by the patient’s symptom. The bodies in the pile are those who have been misdiagnosed, who have asked themselves the wrong question or presented the wrong symptoms. The diagnostician never falls into the crevasse, but the risk is to the reporting

⁹ Indeed, his problem stems from his having walked from Sparta to Thebes, where on the road he meets his father and kills him. -His father is on a chariot, not walking, and that murder leads to Oedipus’ encounter with the Sphinx and his marrying of his mother.

subject. Yet, we could also see the diagnostician as answering the riddle only when he or she misrecognizes the complicity within himself or herself. As with Oedipus, it is the lack of gnosis within the diagnostic that triggers the cascade of tragic events. The diagnostician knows “through” the patient, but in knowing through he or she leaves out the knowing of the categorical ontogeny of the knowing. In the biocultural scenario I am presenting, the lack of knowing of one’s history, the history of not only the symptom but of the disease entity, as with Oedipus, can produce the outcome of a successful diagnosis which fails to cure because it is successful in one sense of knowing only.

To know and diagnose in our current world is to know and select something from a list of many other things. As mentioned, it is a decipherment through sorting rather than analysis. To diagnose is to attempt to emphasize difference. The act of setting OCD apart from other anxiety disorders, for example, will always be difficult if not impossible since the setting apart denies the clinal nature of experience and sensation. To set behaviors and mental actions apart in diagnosis (as opposed to “analysis,” which looks at a totality and breaks it apart) is in effect done in an imaginary space only, since if there is a real space—in this biocultural sense I am proposing—it will always be a clinal one. The paradox is that the definitive act of diagnosis of mental disorders will almost always produce co-morbid states because no anxiety disorder exists alone. The idea of co-morbidity is, in effect, a tacit admission that diagnostics are always imprecise, overlapping other disease states, blurred at the borders. The clinal, in which there is an infinite range of change within a continuum, should be opposed to the diagnostic in which the correct outcome can only be one (or more) fixed location. However, the cline’s incline, according to the derivation of the word from the Greek for “slope,” may provide

more certainty than the level-headed fixed point of diagnosis, which—by denying the askew nature of gnosis—becomes a slippery slope itself.

Wittgenstein (1991) notes the problem inherent in any diagnostic act of certainty: “I know there is a sick man lying here? Nonsense! I am sitting at his bedside. I am looking attentively into his face—So I don’t know there is a sick man lying here? Neither the question nor the assertion makes sense” (1991, 3). Neither statement makes sense because the act of being certain is itself a kind of language game. Wittgenstein explores the idea of certainty and notes: “Certainty is *as it were* a tone of voice in which one declares how things are, but one does not infer from the tone of voice that one is justified” (1991, 6e). The *DSM* aids clinicians in achieving this tone of voice—what might be called authority—by providing categorical imperatives (not in the Kantian sense).

How discrete is the object?

I have argued in *Obsession: A History* (2008) that OCD is not a discrete clinical entity. I make that point in several ways. First, I provide a genealogy of obsession to show that it has a taproot in culture, society, and history. I trace the development of a growing interest in obsession from the eighteenth through the nineteenth centuries in the UK, the US, and the Continent. What becomes obvious in that genealogy is that certain groups of symptoms, which we now assemble into OCD, were assembled differently in the past. The gradual grouping of those symptoms into entities like monomania and *idée fixe* coincided with a larger cultural interest in obsessive behavior, thought, and with obsession as a regnant cultural paradigm. On the one hand, obsession becomes a kind of

cultural goal focused in the idea of increasing human productivity through the single-minded application of the self to the environment; on the other hand it becomes pathological. In the former category we find the rise of the professions and of the modern university, in which specialization, continuous work, and obsessive focus become hallmark traits. Interestingly, the rise of psychiatry and neurology was also conditioned on the obsessive study of obsessives and hysterics. Linked to this is the cult of the genius who is defined as a person whose intellectual or artistic abilities come yoked to the ills or harms of the single-minded pursuit of a practice. The nervous breakdown then becomes an expected and understandable event in the autobiography or narrative portrayal of the genius—and the cause of the breakdown is always working too hard, doing one thing too much. Thus the cause and the symptom are the same.

Meanwhile, the pathological side is seen, in addition to the nervous breakdown, in the rise of disease entities like neurasthenia, the disease of modernity that is influenced by excessive work and concentration. Indeed, the rise of psychology, psychiatry, and neurology is based to a great degree on the studying of people with such monomanias. Books like Krafft Von Ebing's *Psychopathia Sexualis* (1899) is nothing but an obsessive compendium of hundreds of sexual obsessions. The hand-in-glove relationship between diagnosis and disease is seen clearly in books such as this, that assemble random sexual behaviors into disease entities, which then proliferate such diseases through the agency of diagnosis and publication. Pathology then becomes a function of diagnosis, which itself is a function of pathology. We might call this the diagnostic circle, a tautological process that produces a reductive inevitability. To diagnose is to define; to define is to diagnose. Definitions produce diagnoses, which in turn produce definitions.

Without going into great detail, it is possible to say that the *DSM* diagnosis of OCD is conditioned on creating a firewall between the larger cultural practices and the appearance in an individual of some of those practices. The enlightenment subject lives and breathes in the psychiatric or therapeutic patient because frequently only the simplest notions of identity are permitted. Any suggestion that there is a co-dependency between person and culture goes against the idea that the truly well person must be independent, just as the disabled person who needs a personal assistant is seen as a failure of personhood as defined by the same notions. It is certainly true that the work of Stephen Mitchell, Lewis Aron, and Neil Altman and other relational psychoanalysts emphasize “a balance between internal and external relationships, real and imagined, the intrapsychic and the interpersonal, the intrasubjective, the individual and the social” (Aron 1996, ix; See also Altman 2004).

Diagnosis is always synchronic. It always takes place in a clinical present moment of certainty. It has to willfully suppress the diachronicity of its own coming into being, because such history might reveal contingency, chance, convention, and so on. By definition, the diagnostic criteria of the moment are always right, and previous criteria are almost always wrong. In that sense, according to the synchronic perspective, the history of medicine is a history, largely, of error. Through trial and error, so the argument goes, what was wrong in the past is discovered and discarded. The new criteria are based on corrections of the old mistakes. Thus the current diagnostic criteria are always the last step, the utopian moment, the final correction of a history of error. In this sense, the diagnostic process is amnesiac, and is constitutionally incapable of being uncertain about its certainty. The only thing the amnesiac knows for certain is that he or she is here in the

moment. The next phase of the amnesia will come when the current criteria are updated or discarded. Then it will be impossible to remember the former correctness of that last stage of diagnosis and that discarded diagnostic category will fall into the crevasse of error. As with the Oedipal nature of diagnosis, the pile of bodies below the Sphinx are the bones of discarded diagnostic entities.

In suggesting, as I have, that OCD has a history, then, I presume to indicate the genealogy of the category of OCD, connect the current diagnosis with cultural, historical, and political practice, and show how simply producing this diagnosis now is somewhat problematic. I am suggesting that the past is not the pile of bones, no longer vital, but the story told, the archeology of, the narrative of how those bones met their fate. In the case of OCD, if we can see the transformations, disjunctions, and paradigms that have changed over time, we can better see the contingent, aleatory, and liminal nature of the contemporary diagnosis. If that is the case, then the simple rules that govern a bioethical approach must be put into doubt.

One might want to suggest that the encounter between patient and practitioner is one dependent on history and yet at the same time a singular encounter. To be ethical in the broadest sense of the term the encounter must constitute a dialectic between those conditions, must be based on mutually involved subjects interacting with each other in a time–space continuum. As Lewis Aron notes, “When I say that psychoanalysis is a mutual endeavor, I mean, more precisely, that the patient and the analyst create a unique system in which ... there is a reciprocal influence and mutual regulation ...” (1996, 149). The validity of the moment of that interaction must take into account the “nowness” of the moment, the uniqueness of the encounter through the uniqueness of both patient and

practitioner. The patient brings experience and the practitioner brings knowledge of the diagnostic criteria and treatment options. But with psychiatric encounters, particularly, this asymmetrical mutuality is often subsumed to the demands of time, institutional requirements, and professional practices. Yet the encounter must take place in the consciousness of time, but time in the sense of the *longue durée*. Indeed, the historical continuum is suppressed in the interests of making the diagnostic criteria less contingent and in some major sense developmental. Thus the diagnostic criteria can only become inscribed as a kind of law or writ if they are presented as having no ontological basis. No one claims a law is invalid because of the existence of previous laws; however, current diagnoses might have less sovereignty if the existence of previous diagnostic criteria were more apparent. One might ask the question, why is hysteria a less valid diagnosis than mania? Why have we largely abandoned one and kept the other? For more on hysteria see Showalter (1985) and Mitchell (2001), among others.

In effect, the diagnostician has to balance the singular moment of encounter with the customary nomenclature and categories provided by the profession. His or her diagnosis will amount to a decision or judgment based on the current moment and the criteria. But the criteria will be simultaneously ahistorical in their claim to universality but deeply historical in their coming into being. Diagnosis will require a repression of that coming into being in favor of the moment of judgment. Thus there will be a suppressed conflict between custom and justice.

Such a conflict takes us back to the tragic theme in diagnosis, now requiring that we turn from Oedipus to his daughter Antigone. If Oedipus is the diagnostician, Antigone is the patient. A long critical tradition has tried to diagnose her and her motives. Why

does she willingly give up her life to bury her brother? Who is guilty? Creon or Antigone? Sophocles' play is one that continually cries out for defining diagnostics. Kant, Hegel, Lacan and Žižek, among others, have seen the main character as representing some fundamental ethical position. Antigone's conflict between *dike*, or justice, and *nomos*, or the customary laws is highlighted in the play by Creon's insistence on the priority of state law while Antigone appeals to the authority of custom in the proper burial of her brother. This is, in fact, the conflict facing the diagnostician. Is a diagnostician involved in a just decision or a customary one? Is the decision an ethical one or a political one? Is there a gap between those binaries? Lacan argues that Antigone's act represents a pure act because it defies the Symbolic order and is contrary to the pleasure principle in its rush toward death. Žižek (2005) goes further and sees Antigone as the focus of the ethico-political debate because her act is both in defiance of the Symbolic order but also at the same time dependent on it. In either case, Antigone is seen as an exemplary figure and, from the point of view of diagnosis, her state of indeterminacy demands a judgment from the viewers of this play who need to give her a label, name her condition. That requirement inevitably falls into whether we consider the dictate of Creon, a singular act of his own diagnostic criteria, a law unto itself, or whether her reference to custom and history have greater sway. In terms of the problematic of diagnosis we have been considering, we might ask whether the cumulative history of psychiatry, ignored and upheld in the singular act of diagnosing a patient, is more important than the individual relation between the patient and the practitioner.

We might then see the problem of diagnosis to be a problem in some sense between ethics and politics. Simon Critchley says of Derrida's ideas:

On the one hand ethics is left defined as the infinite responsibility of unconditional hospitality. Whilst, on the other hand the political can be defined as the taking of a decision without any determinate transcendental guarantees. Thus the hiatus in Levinas allows Derrida both to affirm the primacy of an ethics of hospitality, whilst leaving open the sphere of the political as a realm of risk and danger. (1999, 275)

To this point, Žižek comments, in the context of his discussion of Antigone, “the ethical is thus the (back)ground of undecidability, while the political is the domain of decision(s) ...” (2005, 316). We can then say that diagnosis hesitates before the undecidability between *nomos* and *dike*, between custom and justice. In that sense, it contains within in it the Aristotelian definition of tragedy—involving the choice the protagonist must make between two impossible courses based on a kind of knowledge which is itself a kind of blindness involving both awareness and lack of awareness.

At the same time there is an undecidable opposition between a concept of hospitality, which implies a guest–host relationship that is easily reversible so that host can become guest and vice versa, and the political decision, in which the sovereign can never change places with the governed except through the most violent of means. Is the physician a fellow interlocutor or a Grand Inquisitor? In the world of bioethics, as it stands, the patient has rights, but never has the right to be the physician. Thus, the rule of hospitality is barred, and the state of exception rules. One of the means by which the sovereignty of the practitioner holds sway is through the metaphors and metonymics of diagnostic representation. Hospitality requires an undecidability, but diagnosis in its political sense requires decision. Like all sovereign decisions, it requires the certainty that

comes from the amnesia of past and the dissolution of commensurability between subject and object. In that moment we have described, the ethics of bioethics become useless, and the biopower of the instant becomes the law of the realm. Through a thorough understanding of the diagnostic moment, we can become aware of the tragedy of certainty.

I began with the notion that bioethics key concepts might not map so easily onto a framework that includes biopower and biocultural imperatives, including a profound sense of historicity and of social construction. We can see now that concepts like autonomy, beneficence, and non-maleficence require a dully positivist mentality to work or be considered sufficient. And justice, as it is considered in bioethics, needs to be put into dialogue with custom, as it is in Greek tragedy. In the case of psychiatric disorders, how would a biocultural model of diagnosis work? Greek tragedy offers us a medical model of sorts. Aristotle's notion of catharsis is taken directly from Greek medical notions. A cathartic is a powerful purgative administered to clear the bowels. Aristotle's notion is that the audience's pity and fear, in reaction to the fate of the protagonist, would purge them of their emotions and leave them feeling cleansed and emptied. In other words, for Aristotle, the cure offered to characters within the play, the cure administered by fate and by the gods, as well as by the narrative process, would be heuristic and salutary. We might then say that something in the diagnostic process might in fact provide a curative modality. If that were the case, what would that curative modality look like? As we said, the diagnosis would have to be attained in a condition of mutuality; one that took the history of not only the patient and the practitioner, but also the profession itself, into consideration. Pity and fear might be the motivating factors in that mutuality:

each side of the diagnostic equation would both fear for the outcome and pity the other. In the permutations involved in that complex process, the practitioner would be conscious of the self-otherness of the patient, placing himself or herself in the futurity of diagnostic process (for who will be immune from being diagnosed?) and, at the same time, fear both the incorrect diagnosis and probably for the correct one as well. So when Tiresias says to Oedipus, “You do not know who you are!” that caution must apply to both the patient and the practitioner. As the theater of Greek tragedy provided a location to explore that question, the space of diagnosis must also be aware of its theatricality and provide a place to pose, if not answer, that central question. Bioethics, too, must expand its work to be a chorus to that central drama, and can only do so if it understands fully the implications of a more profound complexity than it has heretofore allowed itself to engage.

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