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TRANSLATION

The politics of health in the eighteenth century¹

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A private, “liberal” medicine, sought out by individual initiative and subject to the mechanisms of supply and demand—and to its side, or perhaps facing it, a medical management determined by the authorities, supported by an administrative apparatus, framed by strict legislative structures, and addressing itself to the entire collectivity. Is it productive to demarcate a clear opposition and to determine which of these two types of medicine was the first, from which the other was derived? Is it necessary to suppose, at the origin of Western medicine, a collective practice from which the forms of individual relationships would have slowly disassociated? Or must we imagine that modern medicine first developed in singular relations (relationships with clients and clinical relations) before a series of corrections and adjustments would have integrated it into a politics and a management of the group?

Posing the problem in this way supposes a somewhat fictional separation. In every society, illness—the manner in which the sick person demonstrates and expresses it, that which for the sick person and for others distinguishes it from health, the signs by which it is recognized, the behaviors that it induces—makes reference to collective systems. Better: the doctor's intervention—the form of his action, right down to the secret of his remedies and their

¹ Translator: This essay was first published in *Les Machines à guérir. Aux origines de l'hôpital moderne* (Brussels: Pierre Mardaga, 1979), 7-18, and is translated from *Dits et Ecrits*, © Gallimard 1994 (no. 257, vol. III, pp. 725-742). It appears in English for the first time here, with the permission of Éditions Gallimard. The article is translated for *Foucault Studies* by Richard A. Lynch (DePauw University, USA). The translation of this text was supported by a grant from the University of San Francisco; my thanks also to Jeffrey Paris and Eduardo Mendieta.

This is the second of two texts that Michel Foucault published under the title “The politics of health in the eighteenth century;” the first (DE168) was published in 1976. Making matters more complicated, the two texts appeared in volumes also bearing the same title, *Les Machines à guérir* [Curing Machines]. (The 1976 volume was published in Paris by the Institut de l'environnement.) Nevertheless, these two texts are not identical. They are approximately the same length, and the second halves of the two essays are virtually identical (one paragraph from the 1976 version is omitted in 1979); the essays' first halves, however, differ in significant ways. The (current) second essay also includes a long list of “bibliographical suggestions,” which were not included in 1976.

The earlier 1976 essay was translated into English by Colin Gordon. It first appeared in 1980 in *Power/Knowledge*, and has since been anthologized in *The Foucault Reader*, *Power*, and *The Essential Foucault*. I benefited from consulting that translation as I completed this one.

effectiveness—constitutes, at least in part, a group response to this event of illness, which is always more than an individual's misfortune or pain. "Private" medicine is a collective mode of reaction to illness.

The question is thus not one of precedence; what is important is rather the specific manner in which, at a given moment and in a specified society, the individual interaction between the doctor and the sick person is articulated upon the collective intervention with respect to illness in general or to this sick person in particular. The history of the medical "profession," or more precisely, of the different forms of "professionalization" of the doctor, has proved to be, for analysis of these contributions, a good angle of attack.

In this history, the eighteenth century marks an important moment. Quantitatively, it saw the multiplication of doctors, the foundation of new hospitals, the opening of free health clinics, and, in a general fashion, an increased consumption of treatment in every class of society. Qualitatively, the education of doctors was more standardized; the relationship between doctors' practices and the development of medical knowledge was a little bit better defined; a little bit greater confidence was accorded to doctors' knowledge and effectiveness; thus there was also a diminution in the value that one attributes to traditional "cures." The doctor separated himself a little more clearly from other caregivers, and he began to occupy a more extensive and more valorized place within the social body.

These were slow processes, in which nothing was decisive nor absolutely new. But perhaps what characterized the years 1720-1800 is that the professionalization of the doctor occurred upon the basis of a "politics of health." Among the other collective reactions, more or less organized, that disease gave rise to—as for example the struggle against epidemics—a "politics of health" distinguished itself in several ways. It supposed:

1. A certain displacement, or at least an expansion of the objective: it was no longer solely a question of suppressing the illness where it appears, but of preventing it; better, of preventing, insofar as possible, every illness of any sort whatsoever.

2. A doubling of the notion of health: its traditional normative sense (which was opposed to illness) was doubled with a descriptive significance; health was thus the observable result of a collection of givens (the frequency of illnesses, the severity and duration of each, resistance to the factors that could produce illness).

3. The determination of variables characteristic of a group or collectivity: the mortality rate, the average life expectancy, life expectancy for each age group, the epidemic or endemic form of diseases characterizing the health of a population.

4. The development of types of intervention that are neither therapeutic nor even medical in the strict sense, because they concerned conditions and ways of life, nutrition, housing, the environment, childraising, etc.

5. Finally, an at least partial integration of medical practice with economic and political management, which aimed at the rationalization of society. Medicine was no longer simply an important technique in the lives and deaths of individuals about which the collectivities were never indifferent; it became, in the framework of group decisions, an essential element for the maintenance and development of the collectivity.

The politics of health was characterized first by the fact that medicine, as a collective obligation, began to be partially separated from techniques of welfare assistance. Schematically, one could say that the community's responsibility to care for illness was always carried out through aid for the poor. There were exceptions, of course: the regulations to be applied in times of epidemics, the measures that were taken in infected cities, the quarantines that were imposed in certain large ports constituted forms of authoritarian medicine that were not organically tied to the necessities of welfare. But beyond these limit cases, medicine understood and exercised as a "service" was never anything but one element of "relief." It was addressed to the category, very important despite the vagueness of its boundaries, of the "sick poor." Economically, this service-medicine was supported for the most part by charitable foundations. Institutionally, it was exercised within the framework of organizations (religious or secular) with multiple aims: distribution of food and clothing, support of abandoned children, shelter for the elderly and disabled, elementary education and moral proselytizing, the opening of workshops for men and women, and eventually the surveillance and punishment of "unstable" or "troubled" elements (in the cities, the hospital bureaus had jurisdiction over vagabonds and beggars; parish offices and charitable societies also took on, and very explicitly, the task of denouncing "ne'er-do-wells"). From the technical point of view, the role played by therapy in the functioning of hospitals in the classical age was limited in comparison with the rudimentary aid necessary for survival. In the figure of the "needy poor," who ought to be hospitalized, disease was only one element of an ensemble which included, moreover, infirmity, old age, the impossibility of finding work, and hunger. The illness-medical services-therapy series occupied a limited place in the politics and complex economy of "aid."

These mixed and polyvalent procedures of assistance were severely criticized in the course of the eighteenth century. Their dismantlement was demanded beginning with a general reexamination of their mode of investment: the "foundations," in effect, immobilized large sums of money, the earnings of which served not to provide work to the unemployed, but to support those who wished to be idle; charity distributed money in an arbitrary way that did not take any account of economic rationalities. Assistance shouldn't be the result of a moral necessity, of a global obligation of the rich towards the poor. It should be the object of a careful calculation—which implied a tighter surveillance of the population, as well as distinctions that were trying to be established between the different categories of misfortune which charity addressed indiscriminately. In the slow decline of traditional statuses, the "poor man" was one of the first to disappear and to give way to an entire series of functional distinctions (the good and the bad poor, the voluntarily idle and the involuntarily unemployed; those who are able to do a certain kind of work and those who cannot). An analysis of idleness, with its conditions and effects, tended to take the place of a somewhat general sacralization of the "poor man." In practice, this analysis aimed in the best case to render poverty useful by securing it to the apparatus of production, at worst to reduce as much as possible the burden that it posed for the rest of society: how could the "able" poor be put to work; how could they be transformed into a useful workforce? But also how could one guarantee that the least rich financially support their own illness and their temporary or permanent inability to work? Or again, how could the monies spent for the education of abandoned children and orphans be rendered profitable in the short and the long term? The specific problem of illness with respect

to the imperatives of work and the necessity of production began to appear within this utilitarian analysis of poverty.

The appearance of a politics of health must also be related to a much more general process: that which made the “well-being” of society one of the essential objectives of political power. “Common sense teaches us [...] that governments are not established for the advantage, the profit, the pleasure or the glory of the one or ones who govern, but for the good and the happiness of the entire society... A legitimate king is one whose aim is the public good.”² Certainly this is a traditional idea, but in the seventeenth and eighteenth centuries it took on a much denser and much more precise meaning than it had in the past. One no longer thought only of that idea of happiness, tranquility and justice which will dawn in human history following the elimination of war, chaos, the iniquity of laws and judges, famines and exactions. The “public good” refers, in a positive way, to a complex material field that encompasses natural resources, manufactured goods, their distribution, the extent of commerce, but also the development of cities and roads, living conditions (housing, nourishment, etc.), the number of inhabitants, their longevity, their health, and their aptitude for work. And this public good must not be expected from a government that would only be “wise,” limiting itself to respect for the law and tradition; it could not be obtained without interventions (or without a subtle game of interventions and liberties) that must be calculated according to a specific expertise [savoir]. It required a whole set of management techniques, applied to particular domains—not just one politics, but multiple politics.

The ensemble of means that had to be put into play in order to assure this “public good,” beyond tranquility and good order, was, in general, what in Germany and in France was called the “police:” “the ensemble of laws and regulations that concern the interior of a State, which serve to consolidate and augment its power, and to make good use of its forces and to procure the happiness of its subjects.”³ Thus understood, the police extends its domain far beyond surveillance and the maintenance of order. It must see to (according to a list that, despite several variations by author and country, remains quite constant) the abundance of the population, always defined as the first source of riches and power; the elementary necessities of life and its preservation (the quantity, price, and quality of food, the healthiness of cities

² Algernon Sidney, *Discourses concerning government* (London: J. Darby, 1698). French translation: *Discours sur le gouvernement*, trad. P. A. Samson (Paris: Josse), Year II [1793 or 1794], vol. I, p. 197.

[Translator: The quotation above is translated back into English from the French cited in Foucault's text. Here is the original English passage without Foucault's ellipses; I have italicized the quoted sections:

“...common sense teaches, and all good men acknowledge, that governments are not set up for the advantage, profit, pleasure or glory of one or a few men, but for the good of the society. For this reason, Plato and Aristotle find no more certain way of distinguishing between a lawful king and a tyrant, than that *the first seeks to procure the common good, and the other his own pleasure or profit;...*” Algernon Sidney (ed. Thomas G. West), *Discourses concerning government*, revised edition (Indianapolis: Liberty Fund, 1996), 91. This text was originally published posthumously in 1698, fifteen years after Sidney's death; this passage is in chapter two, section three.]

³ Johann Heinrich Gottlob von Justi, *Grundsätze der policeywissenschaft in einen vernünftigen, auf den Endzweck der Policey gegründeten* (Göttingen: A. Van den Hoecks, 1756 [sic: 1754?]). French translation: *Éléments généraux de police démontrés par des raisonnements fondés sur l'objet et la fin qu'elle se propose*, trad. M. Einous (Paris: Rozet, 1769), introduction, §2, p. 18.

and houses, the prevention or termination of epidemics); individuals' activities (overseeing the idle poor and beggars, contributing to the fair distribution of assistance, insuring that trade regulations are upheld); the movement of goods and people (whether it is a question of rights to tax the traded products, of exercising surveillance over the men who are traveling, or of the upkeep and orderliness of different roads).

We see that the police constituted a complete administration of the social "body." This term "body" must not be understood in a simply metaphorical fashion, because it is a question of a complex and multiple materiality that includes, apart from the "body" of individuals, the ensemble of material elements that insure their life, constitute the framework and results of their activity, and allow for transportation and exchange. The police, as an institutional ensemble and as a calculated modality of intervention, was responsible for the "physical" element of the social body: the materiality, in some sense, of this civil society, about which in the same period, moreover, it was attempted to conceive the juridical status and forms.

But an element appeared at the center of this materiality, an element whose importance unceasingly asserted itself and grew in the seventeenth and eighteenth centuries: it was the *population*, understood in the already traditional sense of the number of inhabitants in proportion to the habitable area, but equally in the sense of an ensemble of individuals having between them relations of coexistence and constituting therefore a specific reality. The "population" has a growth rate; it has its mortality and morbidity; it has its conditions of existence, whether a question of the necessary elements for its survival or of those which permit its development and improvement. In appearance, it is a question of nothing but the sum of individual phenomena; nevertheless, one observes there constants and variables which are proper to the population; and if one wishes to modify them, specific interventions are necessary.

The politics of health emerged in the course of the eighteenth century, at the intersection of a new economy of assistance and a management of the social body in its materiality including the biological phenomena proper to a "population." Most likely, these two processes were part of the same ensemble: the control of assistance and the useful distribution of its benefits was one of the problems of the "police," and the latter had among its major objectives the adjustment of a population to an economic apparatus of production and exchange.

But it is useful to maintain their specificity for reasons of analysis: in effect, the first separated the problem of illness from charitable assistance, in such a way that the problem was posed in a differential fashion according to wealth, age, capacity and willingness to work. The second, on the other hand, integrated the problems of illness with those of the general conditions of life, integrated the sick with the ensemble of the population, medicine with the economic and political management of society. In one case, it went from the vague mass of those needing assistance to the specification of the ill. In the other, the specific reaction to disease was integrated into the control of forms of existence and coexistence. Assistance was bent toward a medicalization that legitimated it by claiming simultaneously to render it rational and efficient. Medicine, however, was able to take a place, according to the various degrees of subordination or coordination, in an administrative system that set the well-being and the health of a population as its explicit goal.

Such are the two motifs and the two axes of this "politics of health" which was articulated in the eighteenth century: the constitution of an apparatus which could take responsibil-

ity for the ill as such (it is with respect to this system [dispositif] that health has the sense of a state to be restored and a goal to be attained); and the arrangement of a system which permitted the perpetual observation, measuring, and improvement of a “state of health” of the population, in which illness is only one dependent variable in a long series of factors.

1. *The privileging of childhood and the medicalization of the family.* To the problem of “children” (that is, the number of births and the relationship between natality and mortality) is added the problem of “childhood” (that is, survival to adulthood, the physical and economic conditions for this survival, the necessary and sufficient investments in order that the developmental period can become useful; in brief, the organization of this “phase” which is perceived as simultaneously specific and determined. It is no longer a question only of producing an optimal number of children, but of appropriately managing this period of life.

The relations between parents and children were thus codified according to new—and very precise—rules. Certainly, the relations of submission and the system of signs that it required continued with little alteration. But it had to be invested henceforth by an entire ensemble of obligations which were imposed at the same time on both parents and children: obligations of a physical order (care, contact, hygiene, cleanliness, attentive closeness); breastfeeding of children by mothers; concern for healthy dress; physical exercise to assure the good development of the organism—a permanent struggle that constrained adults as well as children. The family could no longer be only a network of relations enrolled by virtue of this fact in a social status, in a kinship system, a mechanism of inheritance. It had to become a dense, saturated, permanent and continuous physical environment that surrounded, maintained, and promoted the child's body. It thus took a material figure, projecting itself along a narrower range; it became organized as the immediate circle of the child; it tended to become for the child an intimate setting for survival and development. This entailed a tightening effect, or at least an intensification of the elements and relations that constitute the nuclear family (the parent-child group). This also entailed a certain reversal of axes: the conjugal bond no longer served only (or perhaps even in the first place) to establish a connection between two lineages, but to organize what will serve as the matrix for the adult individual. Of course, it still served to unite two lineages, and thus to produce descendents, but it served also to produce in the best possible conditions a human being that will attain maturity. The new “conjuality” is rather the conjunction of parents and children. The family—a narrow apparatus with a localized function—became solidified at the interior of the great and traditional marriage-union. And at the same time, health—most importantly, the health of children—became one of the most constraining objectives of the family. The parent-child relationship had to become a sort of stable-state of health. In any case, since the end of the eighteenth century, the healthy, clean, and fit body, the purified, cleaned and ventilated space, the medically optimal distribution of individuals, places, beds and utensils, the game of “care-giver” and “cared-for” have constituted several of the essential moral laws of the family. And since this epoch, the family has become the most constant agent of medicalization. From the second half of the eighteenth century, it became the target of a great enterprise of medical acculturation. The first wave addressed care-giving for children, and especially breastfeeding: Andry, *L'Orthopédie* [Orthopædia] (1741); Vandermonde, *Essai sur la manière de perfectionner l'espèce humaine* [Essay on how to perfect the human species] (1756); Cadogan, *An Essay upon nursing and the management*

of children from their birth to three years of age (1749, French translation 1752); Desessartz, *Traité de l'éducation corporelle in bas âge* [Treatise on bodily education in infancy] (1760); Ballexserd, *Dissertation sur l'éducation physique des enfants* [Dissertation on the physical education of children] (1762); Raulin, *De la conservation des enfants* [On the care of children] (1768); Nicolas, *Le Cri de la nature en faveur des enfants nouveau nés* [Nature's call for newborn children] (1775); Daignan, *Tableau des variétés de la vie humaine* [A tabulation of the varieties of human life] (1786); Saucerotte, *De la conservation des enfants* [On the care of children] (Year IV); W. Buchan, *Advice to mothers on the subject of their own health; and of the means to promoting the health, strength, and beauty of their offspring* (1803, French translation 1804); Millot, *Le Nestor français* [The French Nestor] (1807); Laplace-Chauvac] *Sur quelques points de l'éducation physique et morale des enfants* [On several points of the physical and moral education of children] (1813); Lernetz, *Hygiène des enfants* [Children's hygiene] (1814); Prevot-Leygonie, *Sur l'éducation physique des enfants* [On the physical education of children] (1813).⁴ This literature continued to grow more extensive up to the nineteenth century, when a whole series of periodicals and newspapers more directly addressed to the popular classes were published.

The long campaign regarding inoculation and vaccination took place within this movement that sought to organize medical care around the child, in which the family would have the moral responsibility and at least a part of the economic obligation. The politics in favor of orphans followed, by different paths, an analogous strategy. Institutions opened that were especially intended to receive and give particular care to them (the Foundling Hospital of London, the Enfants-Trouvés of Paris); but a system was also organized to place the orphans with nurses or in families where they would be useful in taking an even minimal part in domestic life, and where, moreover, they would find a more favorable and less economically expensive developmental environment than in a hospital where they would continue to be barracked until adolescence.

The first consequence of the medical politics that emerged throughout Europe in the eighteenth century was the organization of the family, or rather the family-child complex, as a first and immediate instance of the medicalization of individuals. It was made to serve as a hinge between the general objectives concerning the good health of the social body and the desire or need for care for individuals; it permitted the articulation of a "private" ethic of good health (a reciprocal obligation of parents and children) upon a collective control of hygiene and a scientific technique of healing, available at the request of individuals and families, by a professional corps of qualified doctors recommended by the state. Individuals' rights and obligations concerning their own health and the health of others, the market where those seeking and providing medical assistance come together, the authoritarian interventions of power within the order of hygiene and diseases, but also the institutionalization and the defense of a private relationship with one's doctor—all of this, in its multiplicity and its coherence, marked the global functioning of the politics of health in the nineteenth century; but it cannot be understood unless we abstract out this central element which was formed in the eighteenth century: the medicalized and medicalizing family.

⁴ Translator: Full bibliographical citations for these texts are included at the end of the essay, as "Works Cited."

2. *The privileging of hygiene and the functioning of medicine as an instance of social control.* The old notion of a regime understood as both a rule to live by and a form of preventative medicine tended to expand and to become the collective “regime” of a population taken as a whole, with a triple objective: eradication of great storms of epidemics, reduction of the death rate, and increase of the average lifespan.⁵ This hygiene, as a regime for the health of populations, implies on the part of medicine a certain number of authoritarian interventions and controls.

And first of all, within the urban space in general—for it constituted perhaps the most dangerous milieu for the population. The location of different districts, their dampness and exposure, the ventilation of the entire city, its water and sewer systems, the location of cemeteries and slaughterhouses, the population density—all these constituted factors that play a decisive role in determining the mortality and morbidity of residents. The city, with its principle spatial variables, appeared as an object to medicalize. Whereas the medical topographies of regions analyzed climactic givens or geological facts which they could not control but could only suggest measures of protection or compensation, the topographies of cities designate, at least in outline, the general principles of a unified urbanism. In the eighteenth century, the pathogenic city provided the occasion for of a whole mythology and very real panics (the Cemetery of Innocents was, in Paris, one important such place saturated with fear); it also called forth a medical discourse on urban morbidity and a medical surveillance of a whole series of arrangements, buildings, and institutions (cf. for example, J. P. L. Morel, *Dissertation sur les causes qui contribuent le plus à rendre cachectique et rachitique la constitution d’un grand nombre d’enfants de la ville de Lille*, 1812 [A dissertation on the causes which most contribute to cachexia and rickets in a great number of children of Lille]).

In a more precise and more localized fashion, the necessities of hygiene called for an authoritarian medical intervention into what passed as the privileged entry-way for diseases: the prisons, ships, port facilities, the general hospitals where vagabonds, beggars, and the disabled were brought together, the hospitals themselves where the medical staff was usually inadequate, and where patients' illnesses became reactivated and complicated when they didn't spread pathological germs to the outside. Within the urban system were thus isolated regions of emergency medicalization that were to constitute so many points of application for the exercise of an intensified medical power.

Furthermore, doctors were to teach individuals the fundamental rules of hygiene that they should respect for their own health as well as that of others: hygiene of food handling and of housing, and an exhortation to be treated in case of illness.

Medicine as a general technique of health, much more than as treatment of illnesses and an art of cures, took a more and more important place in the administrative structures and in that machinery of power which continued to expand and to assert itself through the course of the eighteenth century. The doctor acquired a foothold in the different processes of power. The administration served as a fulcrum, and occasionally as a point of departure, for large

⁵ Translator: The sentence ends here in the original publication, but continues in the reprint in *Dits et Écrits*: « ...et de suppression de vie pour chaque âge. » (“...and [an increase] of the suppression of life for each age group.”) This makes little sense and I exclude it from the translation as a typographical error.

medical investigations on the health of populations, and, on the other hand, doctors spent more and more of their time on the general and administrative tasks which were assigned to them by the authorities. A “medico-administrative” knowledge began to be formed concerning society, its health and its diseases, its standards of living, housing conditions, and customs; this “medico-administrative” knowledge served as the original seed for the “social economy” and the sociology of the nineteenth century. Just as much, it constituted a politico-medical hold on the populations which were managed by a long series of regulations that concerned not only disease, but the general forms of existence and behavior (food and drink, sexuality and reproduction, modes of dress, the arrangement and design of housing).

The “surplus of power” which the doctor has obtained since the eighteenth century bears witness to this interpretation of politics and medicine along the bias of hygiene: doctors' presence in larger and larger numbers in the Academies and learned societies, their significant participation in encyclopedia projects, their presence as advisors to government representatives, the organization of medical associations officially charged with a number of administrative responsibilities and qualified to execute or suggest authoritarian measures, the role played by many doctors as planners of a well-regulated society (the doctor as a reformer of economics or politics is a common figure in the second half of the eighteenth century), the over-representation of doctors in the revolutionary assemblies. The doctor became the great advisor and expert, if not in the art of governing, at least in the art of observing, correcting, and improving the social “body” and in maintaining it in a continuous state of health. And it is his function as a public health official, more than his prestige as a therapist, that assured him this politically privileged position in the eighteenth century, before it would become, in the nineteenth, an economically and socially privileged one.

3. *Dangers and uses of the hospital.* With respect to these new problems, the hospital appeared in many ways as an antiquated structure. A fragment of space closed upon itself, a place of internment for individuals and diseases, a solemn yet awkward architecture that multiplies the evils that it contains without preventing their spread to the outside, it was rather an entryway to death for the cities where it was located than a therapeutic agent for the population as a whole. The difficulty of finding available beds in the hospital, the exigencies posed for those who would be admitted, but also the incessant disorder of constant running about, the poor medical surveillance that was exercised there, and the difficulty to effectively care for the sick there—all this made the hospital an inadequate instrument as soon as the population in general became the object of medicalization, with the objective of an improvement in its overall level of health. In the urban space which medicine was to purify, the hospital represented a dark stain. And it was a dead weight in the economy, because it provided a kind of assistance that never permitted a reduction of poverty, but at the very best the survival of poor individuals, and thus the increase in their number and the prolongation of their diseases along with all the contagious effects that could result.

From this situation, the idea emerged in the eighteenth century to replace the hospital by three principal mechanisms. By the organization of a “hospitalization” at home: this doubtless has risks when it is a question of epidemic diseases, but it presented economic advantages insofar as the cost of maintaining a sick person is much smaller for society if he is sustained and fed at home, like he was before he became ill (the cost for the social body is

hardly more than the lost profits from his enforced idleness, and that only if he had had actual work). It also presented medical advantages, to the extent that the family—assuming they were given a little advice—could assure both constant and adaptable care, which one couldn't ask for from a hospital administration; each family could be able to function as a small provisional hospital, individual and inexpensive. But such a procedure implied that the replacement of the hospital be furthermore assured by a medical corps widely dispersed in society and capable of offering treatment, either totally free of charge or at least as inexpensively as possible. A medical management of the population, if it were continuous, flexible, and easily usable, could render a large number of traditional hospitals unnecessary. Finally, one could imagine the generalization of treatment, consultation, and distribution of medicines that certain hospitals were already offering to outpatients without admitting or confining them—the method of clinics, which sought to preserve the technical advantages of hospitalization without the medical or economic inconveniences.

These three methods gave rise, especially in the second half of the eighteenth century, to a whole series of projects and programs. They prompted several experiments. In 1769 the Dispensary for the Infant Poor was founded at Red Lion Square in London; thirty years later, almost every district of the city had a dispensary, and it is estimated that approximately 50,000 people received free treatment at them each year. In France, it seems that the improvement, extension, and a somewhat homogenous distribution of medical management in towns and in the country was the principal aim: the reform of medical and surgical studies (1772 and 1784); requirements for doctors to practices in villages and small towns before being admitted in certain large cities; the surveys and coordination projects made by the Royal Society of Medicine; the larger and larger part of provincial administrators' work devoted to the control of health and hygiene; the development of free distribution of medicines under the supervision of doctors designated by the administration—all this attests to a politics of health that was supported by the extensive presence of medical personnel in the social body. At the extreme end of these critiques of the hospital and this project of substitution could be found a distinct tendency towards “dehospitalization” in the period of the French Revolution. This was already recognizable in the reports of the Comité de Mendicité [Committee on Begging, 1790] (a plan to establish in each rural district a doctor or a surgeon who would treat indigents, watch over children on welfare, and provide inoculations), but it was clearly formulated at the time of the Convention [1792] (a plan for three doctors per district, to assure essential care of health for the whole of the population).

But the disappearance of the hospital was never more than a utopian vanishing point. In fact, the real work was done as soon as a complex function was elaborated in which the hospital would have a quite specific role in relation to the family (which had become the primary authority of health), to an extensive and continuous network of medical personnel, and to the administrative supervision of the population. It was in relation to this ensemble that hospital reforms were attempted.

It was a question, first of all, of adjusting the hospital to the space, and more precisely to the urban space, where it was located. A series of discussions and conflicts between different methods of implementation followed: massive hospitals, capable of taking in a large population and where treatments would be organized to be more coherent, easier to supervise and

less expensive; or, on the contrary, hospitals of smaller scale, where the ill would be better observed and where the risks of internal contagion would be less serious. Another problem reinforced the first: should hospitals be located outside of the city, where ventilation is better and where they wouldn't risk spreading their miasmas to the population—a solution which generally went in common with the development of large architectural ensembles? Or would it be better to construct a multiplicity of small hospitals distributed at locations where they could be most easily accessible for the population that must use them—a solution that often implied a connection between hospitals and clinics? In any case, the hospital had to become a functional element in an urban space where its effects should be measured and supervised.

It was also necessary to manage the interior space of the hospital in such a way that it would become medically effective—it would no longer be a place of assistance, but of therapeutic action. The hospital would need to function as a “curing machine.” In a negative way, one had to put an end to all the factors that made the hospital dangerous for those who stayed there (the problem of circulation of air which ought to be constantly renewed lest the miasmas or their noxious qualities be carried from one patient to another, the problem of changing the linens, their cleaning and transport). In a positive way, the hospital had to be organized as a function of a concerted therapeutic strategy: the uninterrupted presence and hierarchical privilege of doctors; a system of observations, notations, and recordkeeping which secured a knowledge of different cases, allowed their particular evolution to be followed, and made possible an aggregation of the data for an entire population over long periods; a substitution of better adapted medical and pharmaceutical cures for poorly differentiated regimes which traditionally constituted the essence of treatment. The hospital tended to become an essential element in medical technology—not only a place where one could be cured, but an instrument which, for a certain number of serious cases, would enable a cure.

As a consequence, medical knowledge and technical efficacy had to be joined together in the hospital. If in the past certain institutions had been reserved for the mad or for venereal diseases, this had been more as a measure of exclusion or fear than for reasons of specialized treatment. The “unifunctional” hospital was not organized until the moment when hospitalization became the support and sometimes the condition for a more or less complex therapeutic action. The Middlesex Hospital of London was opened in 1745—it was destined to treat smallpox and to provide vaccinations; the London Fever Hospital dates from 1802 and the Royal Ophthalmic Hospital from 1804. The first maternity hospital in London was opened in 1749.⁶ In Paris, the Enfants-Malades was founded in 1802. We can see the slow constitution of a hospital network whose therapeutic function was clearly indicated; on the one hand, it had to provide rather continuous coverage for the urban or rural space for whose population it was responsible, on the other, it had to be articulated upon medical knowledge, classifications, and techniques.

Finally, the hospital had to serve as a support structure for the continuous supervision of the population by the medical personnel. It had to be possible to transfer a patient from home-based care to a hospital regime, for simultaneously economic and medical reasons. Doctors, whether urban or rural, were expected with their rounds to ease the demand on hospitals

⁶ Translator: This was the British Lying-in Hospital.

and prevent their overcrowding; in return, the hospital had to be accessible upon the recommendation and request of doctors. Furthermore, the hospital as a place of the accumulation and development of knowledge had to support the education of doctors who would practice in the accepted way with a private clientele. Clinical education in a hospital environment—the first rudiments of which appeared in Holland with Franciscus Sylvius, and later Herman Boerhaave; in Vienna with Gerard Van Swieten; and in Edinburgh (by the joining of the School of Medicine and the Edinburgh Infirmary)—became at the end of the century the general principle around which a reorganization of medical studies was attempted. The hospital, a therapeutic instrument for those who stayed there, contributed, through clinical education and the good quality of medical knowledge, to an elevation of the population's level of health.

The reform of hospitals and more particularly the projects of their architectural, institutional, and technical reorganization owed their importance, in the eighteenth century, to this ensemble of problems which put into play the urban space, the mass of the population with its biological characteristics, the dense familial cell and the bodies of individuals. It is in the history of these materialities, at once political and economic, that the “physical” transformation of hospitals is inscribed—a transformation that will be more carefully examined in this volume.⁷

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⁷ Translator: This essay served as the first, introductory, essay in a volume on the history of the hospital (*Les Machines à Guérir*); hence the reference here.

⁸ Translator: Foucault included this list at the end of the article, and works are listed in chronological order. If an English translation (or a more recent, more easily accessible edition) is available, I have listed it under the original entry.

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