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9 THE POLITICS OF HEALTH IN THE EIGHTEENTH CENTURY

First of all, two preliminary remarks:

(1) No doubt it is scarcely fruitful to look for a relation of anteriority or dependence between the two terms of a private, 'liberal' medicine subject to the mechanisms of individual initiative and laws of the market, and a medical politics drawing support from structures of power and concerning itself with the health of a collectivity. It is somewhat mythical to suppose that Western medicine originated as a collective practice, endowed by magico-religious institutions with its social character and gradually dismantled through the subsequent organisation of private clienteles.[1] But it is equally inadequate to posit the existence at the historical threshold of modern medicine of a singular, private, individual medical relation, 'clinical' in its economic functioning and epistemological form, and to imagine that a series of corrections, adjustments and constraints gradually came to socialise this relation, causing it to be to some degree taken charge of by the collectivity.

What the eighteenth century shows, in any case, is a double-sided process. The development of a medical market in the form of private clienteles, the extension of a network of personnel offering qualified medical attention, the growth of individual and family demand for health care, the emergence of a clinical medicine strongly centred on individual examination, diagnosis and therapy, the explicitly moral and scientific—and secretly economic—exaltation of 'private consultation', in short the progressive emplacement of what was to become the great medical edifice of the nineteenth century, cannot be divorced from the concurrent organisation of a politics of health, the consideration of disease as a political and economic problem for social collectivities which they must seek to resolve as a matter of overall policy. 'Private' and 'socialised' medicine, in their reciprocal support and opposition, both derive from a

common global strategy. No doubt there is no society which does not practice some kind of 'noso-politics': the eighteenth century didn't invent this. But it prescribed new rules, and above all transposed the practice on to an explicit, concerted level of analysis such as had been previously unknown. At this point the age is entered not so much of social medicine as of a considered noso-politics.

(2) The centre of initiative, organisation and control for this politics should not be located only in the apparatuses of the State. In fact there were a number of distinct health policies, and various different methods for taking charge of medical problems: those of religious groups (the considerable importance, for example, of the Quakers and the various dissenting movements in England); those of charitable and benevolent associations, ranging from the parish *bureaux* to the philanthropic societies, which operated somewhat like organs of the surveillance of one class over those others which, precisely because they are less able to defend themselves, are sources of collective danger; those of the learned societies, the eighteenth-century Academies and the early nineteenth-century statistics societies which endeavour to organise a global, quantifiable knowledge of morbid phenomena. Health and sickness, as characteristics of a group, a population, are problematised in the eighteenth century through the initiatives of multiple social instances, in relation to which the State itself plays various different roles. On occasion, it intervenes directly: a policy of free distributions of medicines is pursued in France on a varying scale from Louis XIV to Louis XVI. From time to time it also establishes bodies for purposes of consultation and information (the Prussian Sanitary Collegium dates from 1685; the Royal Society of Medicine is founded in France in 1776). Sometimes the State's projects for authoritarian medical organisation are thwarted: the Code of Health elaborated by Mai and accepted by the Elector Palatine in 1800 was never put into effect. Occasionally the State is also the object of solicitations which it resists.

Thus the eighteenth-century problematisation of noso-politics does not correlate with a uniform trend of State intervention in the practice of medicine, but rather with the emergence at a multitude of sites in the social body of health

and disease as problems requiring some form or other of collective control measures. Rather than being the product of a vertical initiative coming from above, noso-politics in the eighteenth century figures as a problem with a number of different origins and orientations, being the problem of the health of all as a priority for all, the state of health of a population as a general objective of policy.

The most striking trait of this noso-politics, concern with which extends throughout French, and indeed European society in the eighteenth century, no doubt consists in the displacement of health problems relative to problems of assistance. Schematically, one can say that up to the end of the seventeenth century institutions for assistance to the poor serve as the collective means of dealing with disease. Certainly there are exceptions to this: the regulations for times of epidemic, measures taken in plague-towns, and the quarantines enforced in certain large ports all constituted forms of authoritarian medicalisation not organically linked to techniques of assistance. But outside these limit-cases, medicine understood and practiced as a 'service' operated simply as one of the components of 'assistance'. It was addressed to the category, so important despite the vagueness of its boundaries, of the 'sick poor'. In economic terms, this medical service was provided mainly thanks to charitable foundations. Institutionally it was exercised within the framework of lay and religious organisations devoted to a number of ends: distribution of food and clothing, care of abandoned children, projects of elementary education and moral proselytism, provision of workshops and workrooms, and in some cases the surveillance of 'unstable' or 'troublesome' elements (in the cities, the hospital *bureaux* had a jurisdiction over vagabonds and beggars, and the parish *bureaux* and charitable societies also very explicitly adopted the role of denouncing 'bad subjects'). From a technical point of view, the role of therapeutics in the working of the hospitals in the Classical age was limited in extent in comparison with the scale of provision of material assistance, and with the administrative structure. Sickness is only one among a range of factors, including infirmity, old age, inability to find work and destitution, which compose the

figure of the 'necessitous pauper' who deserves hospitalisation.

The first phenomenon during the eighteenth century which should be noted is the progressive dislocation of these mixed and polyvalent procedures of assistance. This dismantling is carried out, or rather is called for (since it only begins to become effective late in the century) as the upshot of a general re-examination of modes of investment and capitalisation. The system of 'foundations', which immobilise substantial sums of money and whose revenues serve to support the idle and thus allow them to remain outside the circuits of production, is criticised by economists and administrators. The process of dismemberment is also carried out as a result of a finer grid of observation of the population and the distinctions which this observation aims to draw between the different categories of unfortunates to which charity confusedly addresses itself. In this process of the gradual attenuation of traditional social statuses, the 'pauper' is one of the first to be effaced, giving way to a whole series of functional discriminations (the good poor and the bad poor, the wilfully idle and the involuntarily unemployed, those who can do some kind of work and those who cannot). An analysis of idleness—and its conditions and effects—tends to replace the somewhat global charitable sacralisation of 'the poor'. This analysis has as its practical objective at best to make poverty useful by fixing it to the apparatus of production, at worst to lighten as much as possible the burden it imposes on the rest of society. The problem is to set the 'able-bodied' poor to work and transform them into a useful labour force, but it is also to assure the self-financing by the poor themselves of the cost of their sickness and temporary or permanent incapacitation, and further to render profitable in the short or long term the educating of orphans and foundlings. Thus, a complete utilitarian decomposition of poverty is marked out and the specific problem of the sickness of the poor begins to figure in the relationship of the imperatives of labour to the needs of production.

But one must also note another process which is more general than the first, and more than its simple elaboration. This is the emergence of the health and physical well-being

of the population in general as one of the essential objectives of political power. Here it is not a matter of offering support to a particularly fragile, troubled and troublesome margin of the population, but of how to raise the level of health of the social body as a whole. Different power apparatuses are called upon to take charge of 'bodies', not simply so as to exact blood service from them or levy dues, but to help and if necessary constrain them to ensure their own good health. The imperative of health: at once the duty of each and the objective of all.

Taking a longer perspective, one could say that from the heart of the Middle Ages power traditionally exercised two great functions: that of war and peace, which it exercised through the hard-won monopoly of arms, and that of the arbitration of lawsuits and punishments of crimes, which it ensured through its control of judicial functions. *Pax et justitia*. To these functions were added—from the end of the Middle Ages—those of the maintenance of order and the organisation of enrichment. Now in the eighteenth century we find a further function emerging, that of the disposition of society as a milieu of physical well-being, health and optimum longevity. The exercise of these three latter functions—order, enrichment and health—is assured less through a single apparatus than by an ensemble of multiple regulations and institutions which in the eighteenth century take the generic name of 'police'. Down to the end of the *ancien régime*, the term 'police' does not signify, at least not exclusively, the institution of police in the modern sense; 'police' is the ensemble of mechanisms serving to ensure order, the properly channelled growth of wealth and the conditions of preservation of health 'in general'. Delamare's *Treatise* on police, the great charter of police functions in the Classical period, is significant in this respect. The eleven headings under which it classifies police activities can readily be distinguished in terms of three main sets of aims: economic regulation (the circulation of commodities, manufacturing processes, the obligations of tradespeople both to one another and to their clientele), measures of public order (surveillance of dangerous individuals, expulsion of vagabonds and, if necessary, beggars and the pursuit of criminals) and general rules of hygiene

(checks on the quality of foodstuffs sold, the water supply and the cleanliness of streets).

At the point when the mixed procedures of police are being broken down into these elements and the problem of sickness among the poor is identified in its economic specificity, the health and physical well-being of populations comes to figure as a political objective which the 'police' of the social body must ensure along with those of economic regulation and the needs of order. The sudden importance assumed by medicine in the eighteenth century originates at the point of intersection of a new, 'analytical' economy of assistance with the emergence of a general 'police' of health. The new noso-politics inscribes the specific question of the sickness of the poor within the general problem of the health of populations, and makes the shift from the narrow context of charitable aid to the more general form of a 'medical police', imposing its constraints and dispensing its services. The texts of Th. Rau (the *Medizinische Polizei ordnung* of 1764), and above all the great work of J. P. Frank, *System einer medizinische Polizei*, give this transformation its most coherent expression.

What is the basis for this transformation? Broadly one can say that it has to do with the preservation, upkeep and conservation of the 'labour force'. But no doubt the problem is a wider one. It arguably concerns the economico-political effects of the accumulation of men. The great eighteenth-century demographic upswing in Western Europe, the necessity for co-ordinating and integrating it into the apparatus of production and the urgency of controlling it with finer and more adequate power mechanisms cause 'population', with its numerical variables of space and chronology, longevity and health, to emerge not only as a problem but as an object of surveillance, analysis, intervention, modification etc. The project of a technology of population begins to be sketched: demographic estimates, the calculation of the pyramid of ages, different life expectations and levels of mortality, studies of the reciprocal relations of growth of wealth and growth of population, various measures of incitement to marriage and procreation, the development of forms of education and professional

training. Within this set of problems, the 'body'—the body of individuals and the body of populations—appears as the bearer of new variables, not merely as between the scarce and the numerous, the submissive and the restive, rich and poor, healthy and sick, strong and weak, but also as between the more or less utilisable, more or less amenable to profitable investment, those with greater or lesser prospects of survival, death and illness, and with more or less capacity for being usefully trained. The biological traits of a population become relevant factors for economic management, and it becomes necessary to organise around them an apparatus which will ensure not only their subjection but the constant increase of their utility.

This enables us to understand the main characteristics of eighteenth-century noso-politics as follows:

(1) *The privilege of the child and the medicalisation of the family*. The problem of 'children' (that is, of their number at birth and the relation of births to mortalities) is now joined by the problem of 'childhood' (that is, of survival to adulthood, the physical and economic conditions for this survival, the necessary and sufficient amount of investment for the period of child development to become useful, in brief the organisation of this 'phase' perceived as being both specific and finalised). It is no longer just a matter of producing an optimum number of children, but one of the correct management of this age of life.

New and highly detailed rules serve to codify relations between adults and children. The relations of filial submission and the system of signs that these entail certainly persist, with few changes. But they are to be henceforth invested by a whole series of obligations imposed on parents and children alike: obligations of a physical kind (care, contact, hygiene, cleanliness, attentive proximity), suckling of children by their mothers, clean clothing, physical exercise to ensure the proper development of the organism: the permanent and exacting corporal relation between adults and their children. The family is no longer to be just a system of relations inscribed in a social status, a kinship system, a mechanism for the transmission of property. It is to become a dense, saturated, permanent, continuous physical environment which envelops, maintains and

develops the child's body. Hence it assumes a material figure defined within a narrower compass; it organises itself as the child's immediate environment, tending increasingly to become its basic framework for survival and growth. This leads to an effect of tightening, or at least intensification, of the elements and relations constituting the restricted family (the group of parents and children). It also leads to a certain inversion of axes: the conjugal bond no longer serves only, nor even perhaps primarily, to establish the junction of two lines of descent, but to organise the matrix of the new adult individual. No doubt it still serves to give rise to two lineages and hence produce a descent, but it serves also to produce—under the best possible conditions—a human being who will live to the state of adulthood. The new 'conjugality' lies rather in the link between parents and children. The family, seen as a narrow, localised pedagogical apparatus, consolidates itself within the interior of the great traditional family-as-alliance. And at the same time health, and principally the health of children, becomes one of the family's most demanding objectives. The rectangle of parents and children must become a sort of homeostasis of health. At all events, from the eighteenth century onwards the healthy, clean, fit body, a purified, cleansed aerated domestic space, the medically optimal siting of individuals, places, beds and utensils, and the interplay of the 'caring' and the 'cared for' figure among the family's essential laws. And from this period the family becomes the most constant agent of medicalisation. From the second half of the eighteenth century, the family is the target for a great enterprise of medical acculturation. The first wave of this offensive bears on care of children, especially babies. Among the principal texts are Audrey's *L'orthopédie* (1749), Vandermonde's *Essai sur la manière de perfectionner l'espèce humaine* (1756), Cadogan's *An essay upon nursing, and the management of children, from their birth to three years of age* (1748; French translation, 1752), des Essartz's *Traité de l'éducation corporelle en bas age* (1760), Ballexsert's *Dissertation sur l'Éducation physique des enfants* (1762), Raulin's *De la conservation des enfants* (1768), Nicolas' *Le cri de la nature en faveur des enfants nouveaux-nés* (1775), Daignan's *Tableau des sociétés de la vie humaine*

(1786), Saucerotte's *De la conservation des enfants* (year IV), W. Buchan's *Advice to mothers on the subject of their own health; and on the means of promoting the health, strength and beauty of their offspring* (1803; French translation, 1804), J. A. Millot's *Le Nestor francais* (1807), Laplace Chanvre's *Dissertation sur quelques points de l'éducation physique et morale des enfants* (1813), Leretz's *Hygiène des enfants* (1814) and Prévost Leygonie's *Essai sur l'éducation physique des enfants* (1813). This literature gains even further in extension in the nineteenth century with the appearance of a whole series of journals which address themselves directly to the lower classes.

The long campaign of inoculation and vaccination has its place in this movement to organise around the child a system of medical care for which the family is to bear the moral responsibility and at least part of the economic cost. Via different routes, the policy for orphans follows an analogous strategy. Special institutions are opened: the Foundling Hospital, the Enfants Trouvés in Paris; but there is also a system organised for placing children with nurses or in families where they can make themselves useful by taking at least a minimal part in domestic life, and where, moreover, they will find a more favourable milieu of development at less cost than in a hospital where they would be barracked until adolescence.

The medical politics outlined in the eighteenth century in all European countries has as its first effect the organisation of the family, or rather the family–children complex, as the first and most important instance for the medicalisation of individuals.The family is assigned a linking role between general objectives regarding the good health of the social body and individuals' desire or need for care. This enables a 'private' ethic of good health as the reciprocal duty of parents and children to be articulated on to a collective system of hygiene and scientific technique of cure made available to individual and family demand by a professional corps of doctors qualified and, as it were, recommended by the State. The rights and duties of individuals respecting their health and that of others, the market where supply and demand for medical care meet, authoritarian interventions of power in the order of hygiene and illness accompanied at

the same time by the institutionalising and protection of the private doctor–patient relation, all these features in their multiplicity and coherence characterise the global functioning of the politics of health in the nineteenth century, yet they cannot be properly understood if one abstracts them from this central element formed in the eighteenth century, the medicalised and medicalising family.

(2) *The privilege of hygiene and the function of medicine as an instance of social control.* The old notion of the régime, understood at once as a rule of life and a form of preventive medicine, tends to become enlarged into that of the collective 'régime' of a population in general, with the disappearance of the great epidemic tempests, the reduction of the death-rate and the extension of the average life-span and life-expectation for every age group as its triple objective. This programme of hygiene as a régime of health for populations entails a certain number of authoritarian medical interventions and controls.

First of all, control of the urban space in general: it is this space which constitutes perhaps the most dangerous environment for the population. The disposition of various quarters, their humidity and exposure, the ventilation of the city as a whole, its sewage and drainage systems, the siting of abattoirs and cemeteries, the density of population, all these are decisive factors for the mortality and morbidity of the inhabitants. The city with its principal spatial variables appears as a medicalisable object. Whereas the medical topographies of regions analyse climatic and geological conditions which are outside human control, and can only recommend measures of correction and compensation, the urban topographies outline, in negative at least, the general principles of a concerted urban policy. During the eighteenth century the idea of the pathogenic city inspires a whole mythology and very real states of popular panic (the Charnel House of the Innocents in Paris was one of these high places of fear); it also gave rise to a medical discourse on urban morbidity and the placing under surveillance of a whole range of urban developments, constructions and institutions.[2]

In a more precise and localised fashion, the needs of hygiene demand an authoritarian medical intervention in

what are regarded as the privileged breeding-grounds of disease: prisons, ships, harbour installations, the *hôpitaux généraux* where vagabonds, beggars and invalids mingle together, the hospitals themselves, whose medical staffing is usually inadequate, and which aggravate or complicate the diseases of their patients, to say nothing of their diffusing of pathological germs into the outside world. Thus priority areas of medicalisation in the urban environment are isolated and are destined to constitute so many points for the exercise and application of an intensified medical power. Doctors will, moreover, have the task of teaching individuals the basic rules of hygiene which they must respect for the sake of their own health and that of others: hygiene of food and habitat, exhortations to seek treatment in case of illness.

Medicine, as a general technique of health even more than as a service to the sick or an art of cures, assumes an increasingly important place in the administrative system and the machinery of power, a role which is constantly widened and strengthened throughout the eighteenth century. The doctor wins a footing within the different instances of social power. The administration acts as a point of support and sometimes a point of departure for the great medical enquiries into the health of populations, and conversely doctors devote an increasing amount of their activity to tasks, both general and administrative, assigned to them by power. A 'medico-administrative' knowledge begins to develop concerning society, its health and sickness, its conditions of life, housing and habits, which serves as the basic core for the 'social economy' and sociology of the nineteenth century. And there is likewise constituted a politico-medical hold on a population hedged in by a whole series of prescriptions relating not only to disease but to general forms of existence and behaviour (food and drink, sexuality and fecundity, clothing and the layout of living space).

A number of phenomena dating from the eighteenth century testify to this hygienist interpretation of political and medical questions and the 'surplus of power' which it bestows on the doctor: the increasing presence of doctors in the Academies and learned societies, the very substantial

medical participation in the production of the Encyclopedias, their presence as counsellors to representatives of power, the organisation of medical societies officially charged with a certain number of administrative responsibilities and qualified to adopt or recommend authoritarian measures, the frequent role of doctors as programmers of a well-ordered society (the doctor as social or political reformer is a frequent figure in the second half of the eighteenth century), and the super-abundance of doctors in the Revolutionary Assemblies. The doctor becomes the great advisor and expert, if not in the art of governing, at least in that of observing, correcting and improving the social 'body' and maintaining it in a permanent state of health. And it is the doctor's function as hygienist rather than his prestige as a therapist that assures him this politically privileged position in the eighteenth century, prior to his accumulation of economic and social privileges in the nineteenth century.

The challenge to the hospital institution in the eighteenth century can be understood on the basis of these three major phenomena: the emergence of 'population' with its bio-medical variables of longevity and health, the organisation of the narrowly parental family as a relay in a process of medicalisation for which it acts both as the permanent source and the ultimate instrument, and the interlacing of medical and administrative instances in organising the control of collective hygiene.

The point is that in relation to these new problems the hospital appears in many respects as an obsolete structure. A fragment of space closed in on itself, a place of internment of men and diseases, its ceremonious but inept architecture multiplying the ills in its interior without preventing their outward diffusion, the hospital is more the seat of death for the cities where it is sited than a therapeutic agent for the population as a whole. Not only the difficulty of admission and the stringent conditions imposed on those seeking to enter, but also the incessant disorder of comings and goings, inefficient medical surveillance and the difficulty of effective treatment cause the hospital to be regarded, from the moment the population in general is specified as the object of medicalisation and the overall improvement in

its level of health as the objective, as an inadequate instrument. The hospital is perceived as an area of darkness within the urban space that medicine is called upon to purify. And it acts as a deadweight on the economy since it provides a mode of assistance that can never make possible the diminution of poverty, but at best the survival of certain paupers—and hence their increase in number, the prolongation of their sicknesses, the consolidation of their ill-health with all the consequent effects of contagion.

Hence there is the idea, which spreads during the eighteenth century, of a replacement of the hospital by three principal mechanisms. The first of these is the organisation of a domestic form of 'hospitalisation'. No doubt this has its risks where epidemics are concerned, but it has economic advantages in that the cost to society of the patient's upkeep is far less as he is fed and cared for at home in the normal manner. The cost to the social body is hardly more than the loss represented by his forced idleness, and then only where he had actually been working. The method also offers medical advantages, in that the family—given a little advice—can attend to the patient's needs in a constant and adjustable manner that would be impossible under hospital administration: each family will be enabled to function as a small, temporary, individual and inexpensive hospital. But such a procedure requires the replacement of the hospital to be backed by a medical corps dispersed throughout the social body and able to offer treatment either free or as cheaply as possible. A medical staffing of the population, provided it is permanent, flexible and easy to make use of, should render unnecessary a good many of the traditional hospitals. Lastly, it is possible to envisage the care, consultation, and distribution of medicaments already offered by certain hospitals to out-patients being extended to a general basis, without the need to hold or intern the patients: this is the method of the dispensaries which aim to retain the technical advantages of hospitalisation without its medical and economic drawbacks.

These three methods gave rise, especially in the latter half of the eighteenth century, to a whole series of projects and programmes. They inspired a number of experiments. In 1769 the Red Lion Square dispensary for poor children was

opened in London. Thirty years later almost every district of the city had its dispensary and the annual number of those receiving free treatment there was estimated at nearly 50,000. In France it seems that the main effort was towards the improvement, extension and more-or-less homogeneous distribution of medical personnel in town and country. The reform of medical and surgical studies (in 1772 and 1784), the requirement of doctors to practice in boroughs and small towns before being admitted to certain of the large cities, the work of investigation and coordination performed by the Royal Society of Medicine, the increasing part occupied by control of health and hygiene in the responsibilities of the Intendants, the development of free distribution of medicaments under the authority of doctors designated by the administration, all these measures are related to a health policy resting on the extensive presence of medical personnel in the social body. At the extreme point of these criticisms of the hospital and this project for its replacement, one finds under the Revolution a marked tendency towards 'dehospitalisation'; this tendency is already perceptible in the reports of the *Comité de mendicité*, with the project to establish a doctor or surgeon in each rural district to care for the indigent, supervise children under assistance and practice inoculation. It becomes more clearly formulated under the Convention, with the proposal for three doctors in each district to provide the main health care for the whole population. However, the disappearance of the hospital was never more than the vanishing point of a utopian perspective. The real work lay in the effort to elaborate a complex system of functions in which the hospital comes to have a specialised role relative to the family (now considered as the primary instance of health), to the extensive and continuous network of medical personnel, and to the administrative control of the population. It is within this complex framework of policies that the reform of the hospitals is attempted.

The first problem concerns the spatial adaptation of the hospital, and in particular its adaptation to the urban space in which it is located. A series of discussions and conflicts arise between different schemes of implantation, respectively advocating massive hospitals capable of accommodating a

sizeable population, uniting and thus rendering more coherent the various forms of treatment, or alternatively smaller hospitals where patients will receive better attention and the risks of contagion will be less grave. There was another, connected problem: should hospitals be sited outside the cities where ventilation is better and there is no risk of hospital miasmas being diffused among the population—a solution which in general is linked to the planning of large architectural installations; or should a multiplicity of small hospitals be built at scattered points where they can most easily be reached by the population which is to use them, a solution which often involves the coupling of hospital and dispensary? In either case, the hospital is intended to become a functional element in an urban space where its effects must be subject to measurement and control.

It is also necessary to organise the internal space of the hospital so as to make it medically efficacious, a place no longer of assistance but of therapeutic action. The hospital must function as a 'curing machine'. First, in a negative manner, all the factors which make the hospital dangerous for its occupants must be suppressed, solving the problem of the circulation of air which must be constantly renewed without its miasmas or mephitic qualities being carried from one patient to another, solving as well the problem of the changing, transport and laundering of bed-linen. Secondly, in a positive manner, the space of the hospital must be organised according to a concerted therapeutic strategy, through the uninterrupted presence and hierarchical prerogatives of doctors, through systems of observation, notation and record-taking which make it possible to fix the knowledge of different cases, to follow their particular evolution, and also to globalise the data which bear on the long-term life of a whole population, and finally through substituting better-adapted medical and pharmaceutical cures for the somewhat indiscriminate curative régimes which formed the essential part of traditional nursing. The hospital tends towards becoming an essential element in medical technology, not simply as a place for curing, but as an instrument which, for a certain number of serious cases, makes curing possible.

Consequently it becomes necessary in the hospital to

articulate medical knowledge with therapeutic efficiency. In the eighteenth century there emerge specialised hospitals. If there existed certain establishments previously reserved for madmen or venereal patients, this was less for the sake of any specialised treatment than as a measure of exclusion or out of fear. The new 'unifunctional' hospital on the other hand comes to be organised only from the moment when hospitalisation becomes the basis, and sometimes the condition, for a more-or-less complex therapeutic approach. The Middlesex Hospital, intended for the treatment of smallpox and the practice of vaccination, was opened in London in 1745, The London Fever Hospital dates from 1802, and the Royal Ophthalmic Hospital from 1804. The first Maternity Hospital was opened in London in 1749. In Paris, the Enfants Malades was founded in 1802. One sees the gradual constitution of a hospital system whose therapeutic function is strongly emphasised, designed on the one hand to cover with sufficient continuity the urban or rural space whose population it has charge of, and on the other to articulate itself with medical knowledge and its classifications and techniques.

Lastly, the hospital must serve as the supporting structure for the permanent staffing of the population by medical personnel. Both for economic and medical reasons, it must be possible to make the passage from treatment at home to a hospital régime. By their visiting rounds, country and city doctors must lighten the burden of the hospitals and prevent their overcrowding, and in return the hospital must be accessible to patients on the advice and at the request of their doctors. Moreover, the hospital as a place of accumulation and development of knowledge must provide for the training of doctors for private practice. Clinical teaching in the hospital, the first rudiments of which appear in Holland with Sylvius and then Boerhaave, at Vienna with Van Swieten, and at Edinburgh through the linking of the School of Medicine with the Edinburgh Infirmary, becomes at the end of the eighteenth century the general principle around which the reorganisation of medical studies is undertaken. The hospital, a therapeutic instrument for the patients who occupy it, contributes at the same time, through its clinical teaching and the quality of the medical

knowledge acquired there, to the improvement of the population's health as a whole.

The return of the hospitals, and more particularly the projects for their architectural, institutional and technical reorganisation, owed its importance in the eighteenth century to this set of problems relating to the urban space, the mass of the population with its biological characteristics, the close-knit family cell and the bodies of individuals. It is in the history of these materialities, which are at once political and economic, that the 'physical' process of transformation of the hospitals is inscribed.

Notes

1 Cf. G. Rosen, *A History of Public Health*, New York 1958.
2 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* (A dissertation on the causes which most contribute to rendering the constitution of a great number of children in the city of Lille cachectic and rachitic), 1812.