"The Birth of Social Medicine" / Power: 134-56 / DE2: 207-28
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I. Review of previous lecture
- A. Bio-history: effect on biological level of medical intervention
- B. Medicalization of human life
- C. Economy of health: integration of health and economics

II. F's thesis: modern medicine is a social medicine based on technology of social body
- A. Capitalism establishes social medicine focused on social body as work force
- B. Social control not just through ideology, but through bodies and bio-politics

III. State Medicine (Germany)
- A. "State science" [*Staatswissenschaft*]
  1) Object is the state
  2) Methods by which the state produces and accumulates knowledge
- B. Development in Germany due to
  1) political factors (multiple small states)
  2) blockage of economic outlets for bourgeoisie (become state bureaucrats)
- C. European states were mercantilist and so concerned with population health
  1) France and England were content with numerical measures
  2) But Germany attempted to intervene and ameliorate
- D. The German "medical police"
  1) Knowledge of morbidity: statistical measures AND detailed information
  2) Normalization of medicine and of physicians
     a) France normalized its cannons and its professors
     b) Germany normalized its physicians
  3) Administrative organization of physicians
  4) Medical bureaucrats
- E. Two things to note re: German state medicine
  1) It was not focused on labor force, but on individuals forming State
  2) New science of 19th C clinical medicine was preceded by State medicine

IV. Urban Medicine (France)
- A. 18th C saw the unification of urban agglomerations in France
  1) Economics: national and international markets [coffee, sugar]
  2) Politics: production of division of rich and poor [proletarianization]
     a) Fear of urban revolts
     b) Fear of urban epidemics coming from poor
- B. The quarantine as model for urban control [cf: DP]
  1) Military model of quarantine for the plague
  2) Replacing religious model of exclusion and purification of the leper
- C. Principal objectives of urban medicine
  1) Study the sites of "refuse" [*déchets*] which might provoke illness
     a) Cemeteries
        (1) Individual treatment of corpses, coffins and tombs was not religious but politico-medical: to protect the living from the dead
        (2) Organization of burial plots

b) Slaughterhouses
2) Control of circulation of air and water
3) Organization of distribution and sequences for flows of water
a) Fountains, sewers, etc.
b) Problem of the ownership of the below-ground

D. Importance of urban medicine
1) Articulation of medical profession with physical sciences, esp. chemistry
2) Formation of a medicine not of men, but of things
a) Development of concept of ambient milieu ["environment"]
b) Medicine arrives at analysis of organism via that of milieu and its effects
3) Development of notion of "salubrity" ["healthy environment"]

E. Principle of private property prevented French urban medicine from intervention

V. Labor Force Medicine (England)

A. Prior to 19th C, why were the poor not medicalized as a labor force?
1) Insufficient numbers in urban areas ["poor" = plebes or lumpen vs proles]
2) The poor provided useful urban services: delivering mail, running errands, etc

B. Starting in mid-19th C, the urban poor became a problem
1) Political reasons: fear of revolt or at least problem of social movements
2) Establishment of public services eliminated utility of poor
3) Panics over urban epidemics

C. Response: division of urban space into rich and poor neighborhoods

D. Development of medicine directed to urban poor in England
1) Early industrialization and formation of proletariat
2) Poor Law [1834] gave powers for medical control / financial assistance
a) Created a "sanitation curtain" [*cordon sanitaire*] btw rich and poor
3) Health Service (1875) allowed for further control of the poor
a) Control of vaccinations
b) Registry of epidemics
c) Isolation and if necessary destruction of unhealthy areas

E. Popular resistance to social control via medicalization
1) Religious sects seeking freedom from medical intervention
2) Pilgrimages in Catholic countries

F. The English model succeeded; it can be seen in various forms today
1) Objectives:
a) Medical help for poor
b) Control of health of the labor force
c) General inquiry into health conditions (thus protecting rich)
2) Co-existence of three systems
a) Medicine of assistance for poor
b) Administrative medicine for general problems (vaccination, epidemics)
c) Private medicine for those able to afford it