

POWER, SUBJECT AND SYPHILIS
TOWARDS A SOCIOLOGY OF VENEREAL DISEASE IN
THE UNITED STATES, 1900-1950

by

Klara Hribkova
M.A., Bowling Green State University 1996
M.A., Charles University 1994

THESIS SUBMITTED IN PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF

DOCTOR OF PHILOSOPHY

In the
Department
of
Sociology and Anthropology

© Klara Hribkova 2004

SIMON FRASER UNIVERSITY

January 2004

All rights reserved. This work may not be
reproduced in whole or in part, by photocopy
or other means, without permission of the author.

Approval

Name: Klara Hribkova
Degree: Doctor of Philosophy
Title of Thesis: Power, Subject and Syphilis: Towards a Sociology of Venereal Disease in the United States, 1900-1950

Examining Committee:

Chair: Dr. Cindy Patton

Dr. Dany Lacombe
Senior supervisor
Associate Professor of Sociology and Criminology
Simon Fraser University

Dr. Arlene McLaren
Member
Associate Professor of Sociology
Simon Fraser University

Dr Stacy Pigg
Internal/External Examiner
Associate Professor of Anthropology
Simon Fraser University

Dr. Becki Ross
External Examiner
Associate Professor of Sociology and Women's Studies
The University of British Columbia

Date Approved:

January 9, 2004

SIMON FRASER UNIVERSITY



Partial Copyright Licence

The author, whose copyright is declared on the title page of this work, has granted to Simon Fraser University the right to lend this thesis, project or extended essay to users of the Simon Fraser University Library, and to make partial or single copies only for such users or in response to a request from the library of any other university, or other educational institution, on its own behalf or for one of its users.

The author has further agreed that permission for multiple copying of this work for scholarly purposes may be granted by either the author or the Dean of Graduate Studies.

It is understood that copying or publication of this work for financial gain shall not be allowed without the author's written permission.

The original Partial Copyright Licence attesting to these terms, and signed by this author, may be found in the original bound copy of this work, retained in the Simon Fraser University Archive.

Bennett Library
Simon Fraser University
Burnaby, BC, Canada

ABSTRACT

This thesis is an exercise in medical sociology. In particular, it focuses on the social aspects of the fight against syphilis epidemic in the United States in the period 1900-1950. The aspects examined are articulated with the help of a broadly Foucauldian methodology, which emphasizes the concepts of productive, disciplinary power and the body.

Hence, the following three themes are explored: *First*, the investment of power in the architecture of the venereal disease clinic. Here I find that the development of the design of the clinic, in the period under discussion, is best seen as a formation of a particular form of a disciplinary space that was to facilitate as efficient as possible inflow and outflow of patients. *Second*, the political struggles over the effective method of syphilis treatment. The point of this exploration is to demonstrate that medical power had no center. I concentrate on conflicts between the medical profession and public health, and show that the medical profession was quite inimical to new methods of mass treatment of venereal diseases. *Third*, the construction of the venereal disease patient by means of new methods of discipline involved in treatment. Both the objective and the subjective side of the construction of the patient are presented: I show that the venereal disease patient was constructed as an object by various methods of labeling; and she was constructed as a subject when she was induced to speak during contact interviews at the clinic.

Throughout, it is argued that the Foucauldian methodology opens up neglected perspectives on the social study of venereal disease, ones that have so far concentrated largely on the repressive import of the representations of venereal diseases.

ACKNOWLEDGEMENTS

I would like to thank my advisors, Dr. Dany Lacombe and Arlene McLaren. I first came upon the topic of vd through an assignment of research assistant work for Dany. I ended up being paid for doing research I could use for my own dissertation. I am very grateful for the grant money that enabled me to complete this research, and both Dany and Arlene for their unfailing support throughout the extended period of writing this text and suggestions for improvement. I also want to thank my husband Tomas for great editorial help, and for being a patient partner in numerous discussions on the topic of vd.

TABLE OF CONTENTS

Approval	ii
Abstract	iii
Acknowledgments	iv
Table of Contents	v
List of Abbreviations	vii
Preface	viii
Introduction	1
1. Power, Event, Body	9
1.1 Against Ideology	11
1.2 Against Medicalization	18
1.3 From Archaeology to Genealogy	33
1.4 Genealogy of the Body	42
2. Sites of Disciplination	59
2.1 Architecture of the Clinic	61
2.2 Rites of Passage: The Norm	70
2.3 Rites of Passage: Failures and Adjustments	92
3. Power Networks	107
3.1 Medical Practice and Ideology	109
3.2 The Character of Private Care	115
3.3 Medical Profession vs. Private Care	127
4. The VD Patient: Object, Subject, Resistance	155
4.1 Patient as an Object	156
4.2 Patient as a Subject	175
4.3 Ways of Resistance	190

Conclusion	200
Appendix: Current Treatment of VD	204
Bibliography	206

List of Abbreviations

AJS	<i>American Journal of Syphilis</i>
AMA	American Medical Association
APHA	American Public Health Association
ADS	<i>Archives of Dermatology and Syphilology</i>
H	<i>Hygeia</i>
JAMA	<i>Journal of the American Medical Association</i>
JAPH	<i>Journal of the American Public Health</i>
JSH	<i>Journal of Social Hygiene</i>
JVDI	<i>Journal of Venereal Disease Information</i>
ME	<i>Medical Economics</i>
MH	<i>Modern Hospital</i>
PHR	<i>Public Health Reports</i>
RMMJ	<i>Rocky Mountain Medical Journal</i>

Preface

I chose the topic of the early twentieth-century campaigns against syphilis and gonorrhea epidemic because it promised to provide me with a wealth of material for a Foucault-oriented study of bodies and power. I did not know, however, when I began the research, how *much* of the interesting material there really was! Digging up the long-forgotten texts in archives and discovering in them evidence for Foucauldian hypotheses was thrilling indeed. I will always remember how encouraged I felt by my friend Tonio Sadik who, after one of our discussions of my dissertation topic, said: “Klara, you always make vd sound so exciting.” I hope that I managed to communicate some of that excitement in the following pages—for me, at least, writing the stuff down was more painful and tiresome than research. Let me add a terminological note. Throughout this work, I am using a somewhat outdated term, *venereal diseases*, sometimes abbreviated as *vd*. I thought using the contemporary term, *sexually transmitted diseases* (usually shortened as STDs), would be anachronistic.

Introduction

Various strands of social research have shared, for some time now, the goal of promoting awareness that the way we behave today is not a universal constant, but rather a contingent and historically situated phenomenon. Our ways of doing things could have been otherwise. This, of course, does not imply that things could have *easily* been otherwise, or that they could become so transparent to us that we could manipulate them according to our designs. Our ways, our practices, become well entrenched over time; we hardly ever have a full knowledge of what we do; and our designs have effects that are not only unintended, but also beyond our control. Yet even if we do not understand our ways of behaving, we can become aware of their contingency by studying their origin. And as we learn that the ways of behaving we presumed to be natural are contingent upon specific political relations, we realize that these relations—and, hence, the behaviors themselves—could have been different. This knowledge is surely liberating, even if we do not necessarily know how to reform our ways.

The kind of strategy or methodology which I discussed in most general terms in the above paragraph is known as social constructionism. This approach is now so popular that there is hardly any phenomenon, either social or—putatively—natural, that would not be claimed by some social researcher or other to be socially constructed. Philosopher Ian Hacking opens his recent illuminating analysis of the methodological commitments of social constructionism, *The Social Construction of What?*, with a list of objects he found, through a search of library catalogues, that are alleged to have been socially constructed. These objects range from “authorship” to “Nature,” and from “Reality” to “Zulu nationalism”—all these and countless more concrete names have been substituted for the variable X in the general formula “The Social Construction of X.”

Hacking goes on to helpfully identify the social constructionist approach as a conjunction of the following three theses:

Social constructionists about *X* tend to hold that:

(1) *X* need not have existed, or need not be at all as it is. *X*, or *X* as it is at present, is not determined by the nature of things; it is not inevitable.

Very often they go further, and urge that:

(2) *X* is quite bad as it is.

(3) We would be much better off if *X* were done away with, or at least radically transformed.¹

Hacking recognizes that not every social constructionist is necessarily committed to holding all the three theses, although holding at least (1) is necessary. The most usual way of establishing (1) is by telling a story as to how a chosen *X* originated, which reveals it in all its fragile contingency. As Hacking puts it, “[c]onstruction stories are histories.”² While social constructionists operate in different academic fields—sociology, cultural anthropology, history of science, criminology, etc.—they share this basic historicist assumption.

Now some social constructionists decide to move beyond (1), perhaps up to (2), and others even as far as (3). There are different grades of social constructionism, or attitudes to *X*. Hacking distinguishes as many as six such grades or attitudes: historical, ironic, reformist, unmasking, rebellious, and revolutionary.³ The least demanding grade of constructionism is called *historical*, since its proponents do nothing more than write a history of *X*, in which they show how this *X* resulted from particular social forces and processes. The next grade of social constructionism assumes an *ironic* attitude to *X*, because it claims that although this *X* is a product of social forces, somehow we cannot presently do without it. The third grade of social constructionism moves towards (2) by

¹ Ian Hacking, *The Social Construction of What?* (Cambridge, Mass. and London, Eng.: Harvard University Press, 1999), 6.

² *Ibid.*, 37.

³ See *ibid.*, 19-20.

maintaining that *X* is bad and, while we might not know how to replace it completely, we can at least modify some of its aspects—hence the label *reformist* for this type of constructionism. Next, the *unmasking* social constructionism is committed not only to (2)—i.e., that *X* is a bad thing—but also to (3)—i.e., that we would be better off without it. Unmasking, however, is primarily an intellectual project. Once a social constructionist actively maintains (1), (2) and (3) about *X*, she is *rebellious* about it. If she becomes an activist and tries to change the world with respect to *X*, she is *revolutionary*.

My topic—my *X*, that is—is the *treatment* of venereal disease, as well as the venereal disease *patient*. Where do I fit in Hacking's useful scheme of varieties of social constructionism? My social constructionist story will be a history: a history of the emergence, by means of particular disciplinary strategies and practices of treatment, of the modern venereal disease patient in the United States during the early decades of twentieth century. This history will hopefully show that things could have been otherwise, so that I am certainly committed to the first of the three Hacking theses, or what he calls a *historical* social constructivism. However, I am willing to go further, at least as far as a partial endorsement of (2). I do not want to say that the disciplinary techniques that shaped up the modern venereal disease patient are necessarily bad, because I do not believe—for reasons that will become clearer later—that we either have a ready alternative, or that such an alternative would be implementable. I prefer to say that disciplinary techniques—those that I will analyze here or any other, for that matter—are dangerous. Thus I might appear committed to an *ironic* attitude to these practices and their products; I am suspicious of them, but I think they are not easily revisable—in part because our conscious attitudes are shaped by the practices in which we participate, rather than *vice versa*.

I would locate my thesis within the field of historical sociology. In particular, I am trying to contribute to the brand of historical sociology that has developed under the

main influence of Michel Foucault. Other authors have maintained that understanding the medical practice is a key to understanding the present age; indeed, there is a growing body of sociological and historical literature that investigates the social significance of vd for modernity.⁴ Much of this literature is social constructionist, ranging from historical to revolutionary social constructionism. However, although the authors of many works on the interconnections between vd and modernity acknowledge the influence of Foucault, their methodological attitude is rather that of social historians. That is, they tend to emphasize global phenomena such as class struggle, state power and relations of production. Foucault's approach is different. Firstly, he suggests that we should turn our attention away from the central institutions to the marginal practices—or, perhaps better, if we wish to understand the center, we have to start from the margin. The margin is crucial to the very definition of the center, because the former draws the boundary around the latter. Foucault's lifetime work can be seen as an exploration of several such margins of modernity: insanity at the periphery of reason,

⁴ There is a number of feminist, post-colonial and quasi-Marxist studies on vd in modern times that concentrate on the victimization of female prostitutes, people of color, or members of "inferior" classes. Judith Walkowitz's *Prostitution and Victorian Society: Women, Class, and the State* (Cambridge: Cambridge University Press, 1982) is a classic. Other works in this category include Mary Spongberg, *Feminizing Venereal Disease: The Body of the Prostitute in Nineteenth-Century Medical Discourse* (Washington Square, N.Y.: New York University Press, 1997); Annet Mooij, *Out of Otherness: Characters and Narrators in the Dutch Venereal Disease Debates 1850-1990* (Atlanta, GA: Rodopi, 1998); Robert T. Eberwein, *Sex Ed: Film, Video, and the Framework of Desire* (New Brunswick, N.J.: Rutgers University Press, 1999); Roger Davidson, *Dangerous Liaisons: A Social History of Venereal Disease in Twentieth-Century Scotland* (Atlanta, GA: Rodopi, 2000); Katherine E. Bliss, *Compromised Positions: Prostitution, Public Health, and Gender Politics in Revolutionary Mexico City* (University Park: Pennsylvania State University Press, 2001); Philippa Levine, *Prostitution, Race, and Politics: Policing Venereal Disease in the British Empire* (New York: Routledge, 2003). There are several studies of the famous "Tuskegee Case," in which African American men were used by the US government as guinea pigs in a syphilis research, and not properly treated. See esp. James H. Jones, *Bad Blood: The Tuskegee Syphilis Experiment* (New York: Maxwell McMillan International, 1993), and Susan M. Reverby (ed.) and *Tuskegee's Truths: Rethinking the Tuskegee Syphilis Study* (Chapel Hill, NC: University of North Carolina Press, 2000). Most of this literature shares basic methodological orientation with the classic work in the social study of vd, Allan Brandt's *No Magic Bullet: A Social History of Venereal Disease in the United States since 1880* (New York and Oxford: Oxford University Press, 1987). While I am not challenging the value of either Brandt's work or that of his followers, I will argue later other, equally interesting perspectives open up when one adopts the framework of Foucault's theory.

sickness beyond the boundary of health, and criminality outside the sphere of legality. Using these studies as a model, I intend to show how dealing with venereal disease helped constitute normalcy. Secondly, connected with the flight from the central to the peripheral is Foucault's insistence that any simple directions of determination in the social realm must be avoided. For example, he opposes the Marxist model of the determination of the political by the economic. Accordingly, I shall try to demonstrate the irreducibility of the political conflicts surrounding the treatment of vd to any simple scheme of determination. Thirdly, unlike many others, Foucault does not construe modern health care practices as repressive or constraining, but rather as productive and enabling. As will become clear in the pages to follow, I shall make use of this idea mainly by arguing that the modern practices of vd treatment helped constitute the self-disciplined patient of today, and, *a fortiori*, the modern self-disciplined subject as such. I have used as my sources any period professional literature on vd that I could find, any that could shed light on the themes above, even if—or, rather, because—they appear rather insignificant or peripheral. Accordingly, I discuss the debates about the most efficient spatial organization of the vd clinic, skirmishes between the medical profession and public health, and methods of interrogating the vd patients.

As for my data, I dug most of them out of the medical journals published during the period under investigation here, i.e., 1910-1950. I tried to look at nearly every article or report that concerned vd, though concentrating on materials that dealt with the social aspects of the issue, rather than the technicalities of treatment. Let me briefly describe the journals that I used most in my research, and characterize the type of material that is to be found in them. *The Journal of the American Medical Association*, established in 1883, was, and still is, an official journal of the AMA. During the period I covered, each member of the AMA received its *Journal*, so it was a very important channel for spreading the political views of the AMA. I was interested especially in the editorials or

the first articles, which usually dealt with the political aspects of medicine (the rest of the articles in each issue concerned the theoretical aspects of medicine). *Hygeia* (1923-1950) is another publication of the AMA. It began its circulation in response to the complaints from public health officials, reformers and the general public that the AMA ignored the education of the public about medicine. Accordingly, *Hygeia* was established to publish popularizing and educational articles, which, however, had to fit the AMA's notions about these issues. *Journal of Social Hygiene*, published between 1914 and 1954, was the official journal of the American Social Hygiene Association. It published especially articles about the results of surveys conducted in cooperation with the American Public Health Service. Most materials related to social hygiene rather than medical treatment. *Modern Hospital*, published between 1913 and 1974 by the American Hospital Association, bears this heading: "A Monthly Journal Devoted to the Building, Equipment and Administration of Hospitals, Sanatoriums and Allied Institutions, and to Their Medical, Surgical and Nursing Services." The pages of this journal contain hundreds of advertisements for the latest medical equipment, pictures of new hospitals and clinics, and papers about the latest advances in hospital management. *The Journal of Venereal Disease Information* (1923-1951) was issued by the US Public Health Service in cooperation with State Health Departments. It published both technical articles on treatment and research, as well as on public health aspects of vd. The US Public Health Service also established *Public Health Reports*, a periodical started in 1885 and still in circulation. It publishes weekly statistics about diseases, and its interwar issues are one of the rare sources about the extent of the vd epidemic. *Medical Economics* (established in 1923), "The Business Magazine of the Medical Profession" is interesting for publishing views bitterly opposed by the AMA. While the AMA presented the medical profession as elevated above petty financial concerns, *Medical Economics* had an openly businesslike attitude to medicine. In addition to the journals, I found

important primary sources in the 1937 collection *American Medicine*, which provides a survey of the opinions of hundreds of American physicians, both seasoned practitioners and recent graduates. It provides evidence of the split between the older generation of general practitioners and the younger generation of specialists.

Let me now give an overview of the text ahead. It is organized largely along the three features of Foucault's methodology listed two paragraphs above. In Chapter 1, "Power, Event, Body," I lay out the theoretical foundations of my research. Here are explained Foucault's key concepts of the body and power, and differentiate his approach from other, competing, approaches. This survey of Foucault's theory is geared to the purposes of the chapters that lie ahead. Here are some of the questions I mean to answer in the theory chapter: How is Foucault's notion of power different from the one used in broadly Marxist ideology critique? How is the latter implicitly endorsed by Allan Brandt, in his renowned work on the social history of VD in the US? Why is Foucault's notion of power preferable to the Marxist one? How does Foucault's work on the emergence of medical power differ from various theories of "medicalization"? What are the relative strengths of Foucault's two methodologies, archaeology and genealogy, respectively? In what sense is the body and the subject a social construct? In Chapter 2, "Sites of Discipline," I attempt a genealogical analysis of various disciplinary practices that were developed to perfect the treatment of venereal disease in the early decades of the twentieth century. Some of the issues I tackle are as follows: Can the early twentieth-century VD clinic be viewed as an example of Panoptic architecture, which Foucault considered the model of modern disciplinary power? What ideal of the clinic can be glimpsed from the debates during this period? To what extent was that ideal realized? More importantly, to what degree can we interpret the untidy attempt to improve the early VD clinic as the lowly origins of the present efficient clinical practice? Next, in Chapter 3, "Contesting Power," I describe various kinds of conflicts that

characterized the efforts to eradicate the vd epidemic. Is Allan Brandt's hypothesis concerning the ideological influence of the social hygiene movement over the medical profession valid? What were the implications of the differences between the vd treatment at the clinics and at private office? And what was the nature of the political struggles between the medical profession—as represented by the American Medical Association—and public health? Finally, in Chapter 4, "The VD Patient: Object, Subject, Resistance," I concentrate on the ways of constructing the modern patient. The issues are suggested by questions such as: How is the vd patient constructed as a kind of object of medical treatment? Specifically, what is the role of medical labels and descriptions in positing such an object? How is the patient constructed as a subject? Specifically, how are the confessional techniques, whose salience was pointed out by Foucault, utilized in constructing the patient as a subject? Finally, is the grip of power over the vd patient completely tight, or is there a space for resistance? Or should we rather rethink the idea of resistance, so that the complete dominance by power and resistance are not mutually incompatible notions?

Chapter 1: Power, Event, Body

People know what they do; they frequently know why they do what they do; but what they don't know is what they do does.

—Michel Foucault, personal communication
to Dreyfus and Rabinow (1982)

Anything worth calling a construction was or is constructed in quite definite stages, where the later stages are built upon, or out of, the product of earlier stages. Anything worth calling a construction has a history. But not just any history. It has to be a history of building.

—Ian Hacking, *The Social Construction of What?* (1999)

The present study adopts a social constructionist approach that aims to be, at the same time, resolutely materialist. This may strike some readers as inconsistent. Until relatively recently, social constructionism has been viewed as a methodology that does not recognize, if consistently applied, any domain of supposedly natural phenomena—i.e., such that would not turn out to be, upon examination, a result of social or political intervention. In the eyes of social constructionists, materialism appears a suspicious doctrine precisely because it seems to posit an unconstructed substrate—the immutable matter of bodies on which social forces can do their constructive work. Materialism has come under attack by some feminist critics, who argued that the dichotomy between the supposedly natural—i.e., biological and pre-social—sex, on the one hand, and the socially constructed gender, on the other, is untenable. These authors—most notably, Judith Butler—drew inspiration from Michel Foucault's histories of sexuality and criminology that purport to show how the bodies become sexed or penalized as a result of particular disciplinary practices. In Butler's work, however, the materiality of bodies almost seemed to be replaced by the textuality of a discourse. More recently, however, Butler and other radical constructionists have conceded that there is not necessarily any

contradiction between their unmasking strategies and materialism, as long as bodies are not understood as irreducible substrates, but rather as effects of certain practices that are themselves very corporeal in their character. I will examine the contemporary discussion on materialism and social constructionism in Section 1.3 below. A particular, broadly Foucauldian notion of the body that results from it will be important throughout the rest of my thesis; it will be especially crucial for the analysis in Chapter 4.

Before I turn to the concept of the body, however, I wish to treat two other issues, namely ideology and power. As for the concept of ideology, I open Section 1.1 with a review of the methodological assumptions of the foundational study in the social studies of venereal disease, Allan Brandt's *No Magic Bullet*. Brandt is also a self-professed social constructionist, so it seems apt to sum up his project in order to better distinguish it from mine. I do not suggest that Brandt's project is unsuccessful, nor that it does not bring results; the point I want to make by contrasting the two projects rather is that the methodology I am about to use opens up certain topics not accessible with Brandt's approach.⁵ I identify his strategy as a variety of ideology critique—a remote descendant of the approach originally introduced by Marx. This leads me to introduce some Foucauldian reasons for rejecting this kind of strategy. Another issue concerns power: In Section 1.2, I review the work of a group of (predominantly British) scholars who attempt to develop a new approach to the sociology of medicine strongly inspired by Foucault. My aim is a further clarification of methodology, since I claim that the work of sociologists such as David Armstrong or Deborah Lupton betrays a particular

⁵ The Brandtian approach has many direct or indirect followers in the growing literature on the social significance of vd in the modern era. See, e.g., Mary Spongberg, *Feminizing Venereal Disease: The Body of the Prostitute in Nineteenth-Century Medical Discourse* (Washington Square, N.Y.: New York University Press, 1997); Annet Mooij, *Out of Otherness: Characters and Narrators in the Dutch Venereal Disease Debates 1850-1990* (Atlanta, GA: Rodopi, 1998); Roger Davidson, *Dangerous Liaisons: A Social History of Venereal Disease in Twentieth-Century Scotland* (Atlanta, GA: Rodopi, 2000); Katherine E. Bliss, *Compromised Positions: Prostitution, Public Health, and Gender Politics in Revolutionary Mexico City* (University Park: Pennsylvania State University Press, 2001); Philippa Levine, *Prostitution, Race, and Politics: Policing Venereal Disease in the British Empire* (New York: Routledge, 2003).

misinterpretation of Foucault's concept of power. The British seem to understand power as a relentless force that eliminates all agency, whereas Foucault, I believe, rather stresses the relational character of power, thus making room for struggles whose results are not predetermined at any point. This relational definition of power will be important in Chapter 3, where I examine a contest between medical professionals and public health officials in the 1930s. I proceed, in Section 1.3, to explain Foucault's methodology by reviewing his notion of genealogy, which contrasts with conventional history by emphasizing the role of the marginal and the lowly. One of the shifts of focus urged by genealogy is from ideology to the body. Accordingly, I devote the last section—Section 1.4—of this chapter to a discussion of Foucault's concept of the body as socially constructed. I compare Foucault's approach with the Marxist idea of materiality and the phenomenological concept of embodiment, and show how Foucault tries to steer clear off the Scylla of an excessively naturalistic, biological concept of body, on the one hand, and the Charybdis of a textualistic and relativistic construal, on the other. I argue that Foucault urges the same kind of approach to the concept of disease, venereal or otherwise. Disease, too, cannot be easily identified with some natural condition, yet it cannot be considered a mere discursive phenomenon, either.

1.1 Against Ideology

The social study of venereal disease received its strongest impetus from Allan Brandt's *No Magic Bullet* (1987). This landmark of social history was the first to examine with any seriousness the early twentieth-century campaigns against syphilis and gonorrhea in the United States. Brandt's reading of the history of anti-*vd* campaigns is, in a nutshell, as follows: The beginning of the modern struggle with venereal disease coincides with the outset of World War I, when the medical exams of recruits demonstrated that the spread of syphilis reached epidemic proportions. This caused a

moral panic among the middle classes and a proliferation of discourses and images about “degeneracy,” “the decline of the race,” “wages of the sin,” etc. It was in terms of these representations that the enthusiasts of social hygiene waged their war against syphilis during this period. Their aim was not so much to treat people—although, ironically enough, the first efficient drug for syphilis, Salvarsan, became available in 1910—as to divert them from contact with prostitutes, stigmatizing the latter as well as their customers. These first campaigns largely died off by the end of the War, as the topic of venereal disease was a social taboo and it was nearly impossible to obtain any public funding to seriously fight it. New efforts did not begin until the 1930s, when the initiative was taken over by public health officials. However, with the approach and onset of World War II, the stigmatization of venereal disease and its victims returned with a vengeance, again effectively killing a more direct approach to treatment. Brandt’s thesis is that, had there been a will to fund the treatment of venereal disease, and had it not been wrapped up in moralistic clichés, it would have been possible to effectively get rid of syphilis and gonorrhea. This is the thesis that I wish to question.

Before turning to an analysis of historical material in the next chapter, however, I would like to show how Brandt is led to his findings by relying on a certain methodology which he does not necessarily formulate explicitly. Articulating Brandt’s methodological principles will actually serve a double purpose: for one thing, it will enable us to see more clearly the contours of my alternative methodology; secondly, we shall see how this alternative methodology might open up research topics unavailable from Brandt’s perspective.

Above I stated my allegiance to social constructionism. Now, Brandt also indicates that he is a social constructionist of sorts. What sort of constructionism does characterize his approach? It appears that in his view, social constructionism is an epistemological thesis, according to which natural phenomena—such as diseases—are

always mediated by various symbolizations in public discourse that reflect the interests of the different social groups involved. As Brandt puts it,

[f]undamental to the notion that disease is socially constructed is the premise that it is profoundly shaped by both biological and cultural variables. Attitudes and values concerning disease affect the perception of its pattern or transmission, its epidemiological nature. Only if we understand the way disease is influenced by social and cultural forces—issues of class, race, ethnicity, and gender—can we effectively address its biological dimension. A “social construction” reveals tacit values, it becomes a symbol for ordering and explaining aspects of the human experience. In this light, medicine is not just affected by social, economic, and political variables—it is embedded in them.⁶

“Attitudes” and “values” that according to Brandt shaped the perception of venereal disease during the early decades of the twentieth century were bourgeois views of sexual propriety, cleanliness, orderliness and self-restraint. It was the allegiance of the social hygienists of the 1910s and the public health officials of the 1930s—recruited as they all were from the middle classes—to such values, that explains, in Brandt’s view, the failure to stamp out venereal disease during this period. By stigmatizing syphilis and gonorrhea as “wages of sin,” symbols of moral as much as physical uncleanness and unruliness, social hygienists and, later, public health officials attempted to hide information about venereal diseases and to obstruct access to free treatment for those who lost moral credentials for it.

Brandt’s version of social constructionism assumes that beneath various social symbolizations and representations of disease there is a genuine reality of disease, presumably authentically described by the scientific language of medicine. In other words, Brandt seems to suggest that “values” and “attitudes” characteristic for the practices concerning venereal disease in the period he studies function as some kind of ideological sham hiding the true “biological dimension” of disease. If so, Brandt is

⁶ Brandt, *No Magic Bullet*, 5.

committed to a fairly traditional form of *Ideologiekritik*, which is precisely the view that a veil of illusions, consisting of socially determined values, beliefs and attitudes, hides from subjects a true reality. Ideology critique, as a kind of methodological stance, advises us to identify ideological illusions and strip them off reality, so that it could be seen for what it is. The most notorious representative of this kind of methodology is, of course, Marxism. According to Marxists, social reality under a class system such as capitalism is obscured by ideology generated by a dominant bourgeoisie that helps legitimize and stabilize its rule. Brandt seems to adopt this perspective when he claims that in the period of ca. 1910-1940s, the representatives of the US middle classes—from whom social hygienists, doctors, and public health officials were generally recruited—obscured, presumably in the interest of keeping “order” in the face of “chaos,” the reality of disease by spreading middle class perceptions and representations of venereal disease, and thus prevented, in effect, a more efficient treatment. Admittedly, though, the class analysis is much less pronounced in Brandt’s study than in orthodox Marxism, so that we should consider his project a liberal-humanist variety of ideology critique.

In the context of the sociology of health and illness, ideology critique has become more popular in the form of the so-called medicalization critique. Some of the proponents of this approach are Marxists, others are liberals (like Brandt), but they all share an underlying assumption: they see modern medicine, as it has developed since the 19th century, as a major tool of dominance. I shall examine the commitments of the proponents of medicalization critique in more detail in Section 1.2. Before I come to that, however, I would like to discuss the concept of ideology some more, especially in the light of Foucault’s criticisms of it. Consider the following highly compact statement: “I’m not one of those who try to elicit the effects of power at the level of ideology.”⁷ What

⁷ Michel Foucault, “Body/Power,” in *Power/Knowledge: Selected Interviews and Other Writings*, ed. Colin Gordon (New York: Pantheon, 1980), 58.

Foucault attempts to express here is a suspicion that ideology critique, while fashioning itself as uncompromisingly materialistic, registers the effects of power only to the extent that they reach the threshold of ideology. Foucault, of course, is thinking primarily of the Marxist version of ideology critique, which presents itself as a relentlessly materialist approach to culture. What Foucault wants to suggest, then, is that although the promise of Marxism is to reveal cultural phenomena as determined by material, primarily economic, forces, rather than by the intentions of people, these material forces get registered only insofar as they are represented in ideological consciousness. Now, Foucault often uses this rejection of the centrality of ideology as a prelude to his positive proposal to shift attention from the contents of ideological representations to power effects that operate at a more bodily level. As Foucault puts it: "What I want to show is how power relations can materially penetrate the body in depth, without depending even on the mediation of the subject's own representations."⁸ In other words, Foucault wants to replace ideology critique with a project that examines the effects of power on the body "before [it] poses the question of ideology."⁹ Thus the chief drawback of the Marxist approach is that it "had a terrible tendency to occlude the question of the body."¹⁰ Attacking the fundamental Marxist model of the economic base and the ideological superstructure, Foucault suggests that it implies denigrating the discursive as something secondary, without a determinant impact on the material: "[i]deology stands in a secondary position relative to something which functions as its infrastructure, as its material, economic determinant, etc."¹¹ As promised above, I shall expand on Foucault's positive views on power in Section 1.2, while in Section 1.4 I shall concentrate on the concept of the body. Let me, however, conclude this review of Foucault's commentary

⁸ Idem, "The History of Sexuality," in *Power/Knowledge*, 186.

⁹ "Body/Power," 58.

¹⁰ Ibid., 59.

¹¹ Idem, "Truth and Power," in *Power/Knowledge*, 118.

on ideology critique by pointing out one more underlying assumption that he uncovers in this approach—namely, ideology critique’s dissociation of knowledge from power. Foucault notes that some twentieth-century Marxists—most prominently, Herbert Marcuse—try to abandon the notion of the representative subject assumed by the orthodox ideology critique. Instead, they adopt, say, a Freudian concept of the unconscious. However, Foucault wonders whether thinkers like Marcuse, who try to endow the subject with unconscious depths, do not ultimately retain the modernist view of knowledge based on a fundamental distinction between knowledge and power.

Consider:

I would also distinguish myself from para-Marxists like Marcuse who give the notion of repression an exaggerated role—because power would be a fragile thing if its only function were to repress, if it worked only through the mode of censorship, exclusion, blockage and repression, in the manner of a great Superego, exercising itself only in a negative way. If, on the contrary, power is strong this is because, as we are beginning to realize, it produces effects at the level of desire—and also at the level of knowledge. Far from preventing knowledge, power produces it.¹²

Foucault thus suggests that even unorthodox Freudian Marxists such as Marcuse nevertheless hope to uncover, beneath the layers of power effects, a power-free knowledge.¹³ According to Foucault, what we must abandon is precisely the model that sees power and knowledge as mutually exclusive. As he puts it, “we should abandon a whole tradition that allows us to imagine that knowledge can exist only where the power relations are suspended and that knowledge can develop only outside its injunctions, its demands and its interests.”¹⁴

¹² “Body/Power,” 59.

¹³ For a commentary on Foucault’s criticism of this aspect of the Critical Theory, cf., e.g., David Hoy, “Power, Repression, Progress: Foucault, Lukes, and the Frankfurt School,” *Tri Quarterly* 52 (1981): 43-63; repr. in *Michel Foucault: Critical Assessments* 5, ed. Barry Smart (London and New York: Routledge 1995), 173-191.

¹⁴ Foucault, *Discipline and Punish*, 27.

I would like to suggest, with respect to Brandt's study of anti-*vd* campaigns in the early twentieth-century United States, that he is committed to a distinctly un-Foucauldian thesis about the relationship between knowledge and power. In other words, Brandt seems to assume that a genuine knowledge of venereal disease—and thus its efficient cure—was possible; however, it was clouded by the mists of moralizing ideology. If only doctors were able to abandon the preconceptions of their middle-class morality, they would be able to cure syphilis and gonorrhea in no time. It is one of the objectives of my study to dispel this assumption. In revealing the difficulties involved in transforming old dispensaries into modern, efficient *vd* clinics, in Chapter 2, I will be, in effect, arguing that the knowledge of how to cure *vd* is not reducible to the knowledge of an appropriate medication. Such a knowledge does not suffice without an efficient treatment that, in turn, involves important interventions in the lives of patients. Far from being readily available, the efficient treatment must have been figured out—"hammered out"—through a complicated trial and error process. The nature of this process is surely, at least at a first glance, political but—precisely in virtue of the necessity of a proper treatment for the capability to cure venereal disease—it cannot be treated as epistemically neutral. Similarly, when I describe in Chapter 3 the conflicts between the American Medical Association and public health, I again question the assumption of a separation between power and knowledge. These conflicts should not be construed as mere ideological arguments between two factions of "bourgeois" health professionals, obstructing an efficient treatment. Again, such a treatment could not be seen as something available independently of, and just obscured by, these conflicts. Rather, these conflicts were the means by which the efficient treatment was constructed. Finally, by inspecting the behavior of *vd* patients in Chapter 4, I hope to show that new treatment methods were not merely superficial ideological images, as if stuck to a timeless substance of the subjects. I resist the idea that ready-made subjects were to be seen under the surface

of ideology. Instead, new treatment methods were productive of a new kind of patient, indeed a new kind of subject, and thus had a deeply political import.

1.2 Against Medicalization

Brandt's history of anti-*vd* campaigns seems to belong to a broad stream of the social studies of medicine generally referred to as "medicalization critique." Since Foucault's work—at least the part dealing with the history of medicine and psychiatry—is often pigeonholed as belonging to the "medicalization critique," it might be useful to examine the similarities and differences between his approach and that of other proponents of the "medicalization critique."

The diffuse family of social studies of medicine categorized as "medicalization critique" have their origins in the 1960s, a time of heightened social unrest when even academics began to challenge the fundamental assumptions of their own disciplines. The dominant approach to the social study of medicine in the 1950s, Parsonian functionalism, was being challenged for its inherent political conformism.¹⁵ Critics began pointing out that, as modern medicine improved in efficiency, it had permeated—thus "medicalized"—more and more aspects of modern life. Far from being a politically neutral science of health, modern medicine had in fact amassed so much power that it could rival religion and the law in becoming a chief mechanism of social regulation. Some of the critics of this "medicalization" went even as far as suggesting that modern medicine weakened rather than strengthened the health of its patients since, by making them dependent on its political apparatus, it diminished their capacity for autonomy.¹⁶ Some neo-Marxist proponents of the medicalization critique modeled the doctor-patient

¹⁵ For a critical survey of the functionalist paradigm in the sociology of medicine, see Bryan Turner, *Medical Power and Social Knowledge* (London: Sage, 1987), chap. 1.

¹⁶ See especially Ivan Illich's sociology bestseller *Medical Nemesis* (New York: Pantheon, 1975).

relationship quite explicitly on the capitalist-worker relationship.¹⁷ Feminists described the medical profession as a paradigmatically patriarchal institution.¹⁸ Finally, the academic medicalization critique also influenced the whole range of politically less radical “consumerist” and “alternative medicine” approaches to medicine, encouraging patients to join advocacy groups, look for help from healers rather than professional physicians, and so on. Brandt can also be seen as committed to a variety of medicalization critique, though politically of even less radical sort, when he assumes that modern medicine is at least potentially beneficial and not inherently implicated in keeping the bourgeois politico-economic order.

Where does Foucault with his thesis of the inseparability of power and knowledge fall in? If he believes that no epistemic situation is ever free of political effects, he cannot probably be taken to expect alternatives to Western scientific medicine to be politically neutral, let alone believe that scientific medicine was separable from its political import. Nor should we expect—given Foucault’s rejection of the Marxist notion of ideology—that his approach could be assimilated to the work of those neo-Marxist or feminist authors, who assume that although every form of knowledge serves to support political power under class or patriarchal systems, it could be stripped of any political uses in the post-revolutionary classless or matriarchal societies. If Foucault understands knowledge as necessarily intertwined with power, does he assume, then, that power is by definition repressive? In order to find an answer to this question, and thus better assess the relation of Foucault’s work to the medicalization critique, it will be necessary to further analyze his concept of power.

¹⁷ See Howard Waitzkin, *The Politics of Medical Encounters: How Patients and Doctors Deal with Social Problems* (New York: Yale University Press, 1991).

¹⁸ See Barbara Ehrenreich and Deirdre English, *Complaints and Disorders: The Sexual Politics of Sickness* (Old Westbury, NY: Feminist Press, 1973).

It appears that the notion of power presupposed by various Marxist, or Marxist, writers is modeled on the most visible modern agency of power, namely *the state*. However, such a view of power as visible and centralized would blind us toward less visible, discrete, and omnipresent forms of power. Accordingly, Foucault proposes that power should be understood

in the first instance as the multiplicity of force relations immanent in the sphere in which they operate and which constitute their own organization; as the process which, through ceaseless struggles and confrontations, transforms, strengthens, or reverses them; as the support which these force relations find in one another, thus forming a chain or a system, or on the contrary, the disjunctions and contradictions which isolate them from one another; and lastly, as the strategies in which they take effect, whose general design or institutional crystallization is embodied in the state apparatus, in the formulation of the law, in the various social hegemonies.¹⁹

Foucault's fundamental insight that power is primarily a set of *relations* is opposed to the view of power as a *property*, which seems to be implicit in Marxism—in particular in its vision of class struggle as an encounter between capitalists who presumably hold power and proletarians who do not, yet who can wrest it from the capitalists. But a fundamentally identical notion of power as a property is implicit in the work of traditional feminists, whether or not influenced by Marxism, and even liberals. Although liberalism is seemingly opposed to the worldview propagated by Marxism, it is also committed to the view of power Foucault calls “economism.” That is, even if liberals oppose the category of “struggle” central to Marxism and prefer to use the mercantile concept of “contract,” they also, in effect, view power as an attribute, or rather a sort of “commodity.” This commodity is also viewed as being unequally distributed and

¹⁹ Michel Foucault, *The History of Sexuality: Volume 1: An Introduction*, trans. Robert Hurley (New York: Vintage, 1978; the French original published in 1976), 92-93; cf. *Discipline and Punish*, 26-27.

transferable, albeit not necessarily by violent means.²⁰ We saw this notion of power as an attribute operative in all the varieties of medicalization critique summarized in the previous paragraph: in the Marxist view of the doctor-patient relationship as an instance of the relation of exploitation; in the feminist idea of medicine as a patriarchal institution oppressing women; and in the “consumerist” attempts to tip off the distribution of medical power in the patient’s favor. Yet there is a theory of power that rejects the view of power as an attribute—Nietzsche’s theory. Foucault is greatly influenced by Nietzsche’s insight that power is everywhere and nobody really owns it.²¹ Rather than ever possessed by anyone, power is “exercised” and exists only “in action.”²²

One of Foucault’s ways of introducing his novel concept of power is by situating it historically. He makes it clear that the origins of power as relation do not reach farther in the past than the eighteenth century. On the other hand, the concept of power as attribute or commodity—ultimately owned by the supreme social agent, the state, and expressed in the form of law and ideology—reaches back to the Middle Ages. In the medieval model, power was conceived of as a property of a sovereign.²³ In this monarchical conception, power is the right of a sovereign to punish those who oppose

²⁰ Idem, “Two Lectures,” 88.

²¹ For Foucault’s confession of the predominant impact of Nietzsche’s philosophy on the formation of his mature views, see Foucault, “The Return of Morality,” *Foucault Live*, ed. Sylvère Lotringer (New York: Semiotext(e), 1996), 470. Scott Lash, among others, also argues that the most important contemporary source of inspiration of Foucault’s mature conceptions of power and the body was another French Nietzschean, Gilles Deleuze. See Scott Lash, “Genealogy and the Body: Foucault/Deleuze/ Nietzsche,” *Theory, Culture & Society* 2 (1984): 1-17; repr. in *Michel Foucault: Critical Assessments* 3, ed. Barry Smart (London and New York: Routledge, 1995): 14-32. I shall discuss Nietzsche’s influence on Foucault further in the next two sections, where I survey Foucault’s elaboration of Nietzsche’s notion of “genealogy” and his conception of the body, respectively.

²² “Two Lectures,” 89. In addition to “relation,” other terms used by Foucault in characterizing modern power are those of “network,” “strategy;” the terms for describing its effects are “dispositions,” “manoeuvres,” “tactics,” “techniques;” and the appropriate model is “war” or “a perpetual battle.”

²³ In theory, perhaps his exclusive property, although Foucault documents how the supposedly absolute power of a sovereign in medieval times through the Classical Age was constantly contested and compromised by powers of aristocracy, the state bureaucracy and other subjects. See *Discipline and Punish*, Part I, chap. 2.

him. As is demonstrated by Foucault's gruesome description of the 1757 execution of Damians the regicide, used as an opening of *Discipline and Punish*, the kind of punishment meted out by the sovereign was spectacularly physical and severe. It needed to be spectacular, because each offence posed limits to the sovereign's power, so that he had to reinstate it—and the reinstatement had to be the showier the more serious was the challenge posed by the offender. At the same time, however, despite the public torture and death, sovereign power was highly unsystematic, rather easily avoidable, and mostly uninterfering with the practice of everyday life. As Foucault puts it, "[t]he sovereign exercised his right of life only by exercising his right to kill, or by refraining from killing;" in reality, it was "the right to *take* life or *let* live."²⁴ By contrast, modern power does not take life, but it does not just let live, either: "One might say that the ancient right to *take* life or *let* live was replaced by a power to *foster* life or *disallow* it to the point of death."²⁵ In order to achieve this purpose, modern power had better not be ostentatious and erratic, but rather hidden and ever-present. To sustain and support life, rather than destroy or ignore it, modern power must be systematic and unceasing. (I shall return to these themes momentarily).

How it is possible that the monarchical model of power, if it is indeed as anachronistic today as Foucault portrays it, nevertheless continues to be the leading concept of power, shared by the dominant ideologies? Foucault answers this question by pointing to the seemingly liberating effect of the monarchical view of power. Power as a property of a sovereign—be it a medieval king or the modern state—is imagined as a mere limit on a free exercise of agency by the sovereign's subjects. Consequently, the subjects are free as long as the sovereign does not exercise his power; alternatively, the absolute sovereign or a totalitarian regime can be overthrown and the subjects can

²⁴ *History of Sexuality*, 136 (emphasis in the original).

²⁵ *Ibid.*, 138 (emphasis in the original).

reach freedom. At any rate, the belief that power is basically repression and that, consequently, there is in principle a chance for escaping from it makes life feel easier—and it makes power tolerable. This belief, according to Foucault, is the reason why the anachronistic concept of power as property is still widespread in modern societies. As he says, “power is tolerable only on condition that it masks a substantial part of itself.”²⁶ This is why the monarchical model still plays a role in the legitimization of modern power.

Yet it must be admitted that certain aspects of Foucault’s studies of modern power make them susceptible to a reading consonant with the orthodox medicalization critique. Let us examine three of these aspects:

1.2.1 *The Carceral*. In *Discipline and Punish*, Foucault appears to represent modern society using the prison as a model. A critic might ask: Does not such a model suggest notions of repression and confinement? And does it not imply the idea of the subject responsible for implementing and maintaining the mechanisms of repression and confinement? In order to answer these questions, we need to have a closer look at *Discipline and Punish*, as well as Foucault’s important late papers “The Politics of Health in the Eighteenth Century” and “Governmentality.” It is indeed true that, although the nominal subject of *Discipline and Punish* is the development of modern penal practices—and the forms of knowledge intertwined with them—Foucault’s basic contention is that the kind of power that gave rise to these practices became typical of modernity in general. This might suggest an interpretation supportive of the conventional medicalization critique, according to which Foucault proposes to view the modern hospital as a carceral institution. However, such an interpretation would be mistaken. For one thing, according to Foucault, “[d]iscipline’ may be identified neither with an institution nor with an apparatus [...] it is [...] a technology.”²⁷ If disciplinary

²⁶ Ibid., 86; cf. “Two Lectures,” 105.

²⁷ *Discipline and Punish*, 215.

power is separable from particular institutional settings, then it is possible that discipline is “invested” in institutions inherited from the past—which is exactly what Foucault is saying: “[discipline] may be taken over either by ‘specialized’ institutions (the penitentiaries or ‘houses of correction’ of the nineteenth century), or by institutions that use it as an essential instrument for a particular end (schools, hospitals...).”²⁸ Thus, what sets Modernity apart from the Classical Age (i.e., approximately the seventeenth and eighteenth centuries) is not so much different institutions as the fact that they are now “invested” with the new, disciplinary, technology of power.

1.2.2 *Bio-power*. This new power is not, as we saw above, repressive and destructive, but rather enabling and productive. Thus, even the modern reformatory prison is primarily an institution for turning defective individuals into re-educated and functioning citizens, instead of a place of detainment and woeful inactivity. Similarly, the clinical hospital is a site of advanced knowledge opened up onto the outside world to which health is supposed to radiate, instead of a “space closed in on itself, a place of internment for men and diseases,”²⁹ a filthy repository in which “vagabonds, beggars and invalids mingle together.”³⁰ Indeed, Foucault eventually came to recognize another form of power—in addition to sovereignty and discipline—which he chose to label “government.”³¹ Presumably, this is not meant by Foucault as a revival of *étatisme*, or of the sovereign notion of power. Rather, after he explored the micropractices of discipline in his book on prison, Foucault realized that he could use a similar approach to more global practices of governing, such as the caring strategies of the modern welfare

²⁸ *Loc. cit.*

²⁹ “The Politics of Health in the Eighteenth Century,” *Power: The Essential Writings of Foucault 3*, ed. James. D. Faubion, trans. Robert Hurley (New York: The New Press, 2000), 101.

³⁰ *Ibid.*, 99.

³¹ Foucault, “Governmentality,” *Power*, 220. (The French original was presented as a part of Foucault’s lecture course at the Collège de France in the 1977-1978 academic year.)

state.³² Far from proposing a conventional study of government institutions, he planned to shift attention to the things that government *does* to a specific object of its attention—neither family, nor the individual, but *population*. In a seminal text on these issues, “Governmentality,” Foucault even suggests that government is *the* dominant form of modern power. He explains that it does not necessarily supplant other—that is, sovereign and disciplinary—forms of power. Rather, it comes to dominate them through a process of the formation of discourses, practices, and institutions that have population as their target. Somewhat confusingly, Foucault calls both this process and its result *governmentality*, which suggests that there is a special “mentality” accompanying the practices of governing—the mentality, which is concerned with the welfare and multiplication of population.³³ Foucault offers an alternative view of the relationship between discipline and government in the first volume of *The History of Sexuality*. Here, rather than seeing governmental power as dominant, he takes it to be one of the two forms of the modern “power over life”—the other form being discipline—which he now brands “bio-power.”³⁴ Discipline targets the individual body—the “body as a machine:”

³² Cf. Colin Gordon, “Introduction,” *Power*, xxv.

³³ “By this word [i.e., “governmentality”] I mean three things:

1. The ensemble formed by the institutions, procedures, analyses, and reflections, the calculations and tactics that allow the exercise of this very specific albeit complex form of power, which has as its target population, as its principal form of knowledge political economy, and as its essential technical means apparatuses of security.
2. The tendency that, over a long period and throughout the West, has steadily led toward the preeminence over all other forms (sovereignty, discipline, and so on) of this type of power—which may be termed “government”—resulting, on the one hand, in the formation of a whole series of specific governmental apparatuses, and, on the other, in the development of a whole complex of knowledges [*savoirs*].
3. The process or, rather, the result of the process through which the state of justice of the Middle Ages transformed into the administrative state during the fifteenth and sixteenth centuries and gradually becomes ‘governmentalized’.”

“Governmentality,” 219-220. For an attempt to make use of the notion of “governmentality” in sociological research, see Peter Miller and Nikolas Rose, “Governing Economic Life,” *Economy and Society* 19 (1990): 1-31; repr. in *Michel Foucault: Critical Assessments* 7, ed. Barry Smart (London and New York: Routledge, 1995): 146-173.

³⁴ *History of Sexuality: Volume 1*, 140. For an illuminating analysis of the concept of “bio-power,” see François Ewald, “Bio-Power,” *History of the Present* 2 (1986): 8-9; repr. in *Michel Foucault: Critical Assessments* 5, ed. Barry Smart (London and New York: Routledge, 1995): 281-284.

its disciplining, the optimization of its capabilities, the extortion of its forces, the parallel increase of its usefulness and its docility, its integration into systems of efficient and economic controls, all this was ensured by the procedures of power that characterized the *disciplines: an anatomo-politics of the human body*.³⁵

Government concentrates on population, or “the species body:”

The body imbued with the mechanics of life and serving as the basis of the biological processes: propagation, births and mortality, the level of health, life expectancy and longevity, with all the conditions that can cause these to vary. Their supervision was effected through an entire series of interventions and *regulatory controls: a bio-politics of the population*.³⁶

1.2.3 *The Medical Gaze*. As bio-power sustains and cares for—rather than represses and holds down—it affects this result through the proliferation of knowledges. For discipline, or anatomo-politics, there were sciences studying the individual body; for government, or bio-politics, there were new fields of inquiry utilizing statistical methods. A prime example of the latter is social medicine, of which the reader will find a great deal—with respect to the case of venereal disease—in the following chapters. Let me, however, confine myself here to the epistemic accompaniment of anatomo-politics. In *Discipline and Punish*, Foucault showed how prisons became institutions for reforming criminals through a continuous development, and an application of, the new science of criminology. Nineteenth century was the heyday of criminology and other discourses of deviancy—sexology, psychiatry, pedagogy, etc. In an intriguing speculation, Foucault submits that these “strange sciences” are no more implicated in a form of power than serious natural sciences—or, rather, that the latter are no less implicated than the former. Whereas social sciences arose in connection with disciplinary power, the natural sciences had as their model the

³⁵ *History of Sexuality: Volume 1*, 139 (emphasis in the original).

³⁶ Loc. cit. (emphasis in the original).

investigative mode of the thirteenth-century Inquisition. And yet, there is an important difference between the two spheres of knowledge with respect to their relations to power: while the natural sciences separated themselves from their uncanny origins, the social sciences were unable to do so: "these techniques merely refer individuals from one disciplinary authority to another, and they reproduce, in a concentrated or formalized form, the schema of power-knowledge proper to each discipline."³⁷ The notion that social sciences are implicated in power relations may sound amenable to the purposes of anti-psychiatry or anti-medicine. However, Foucault's celebrated *pouvoir-savoir* is not easily reducible to a Marxist thesis that bourgeois science necessarily supports domination. Foucault refuses to relegate criminology, psychiatry, and other social sciences to the sphere of false consciousness for two closely related reasons. First, it is misleading to suppose that there is any reality which an alternative, allegedly power-free, science could be reflective of; second, it is important to see that the reality described by the social sciences is constituted by them. The latter claim is hardly preposterous, if we understand it, with Hacking, as suggesting that the distinctions among sorts of offenders charted by (say) nineteenth-century criminology became a basis for how individuals were being treated in real life. Similarly, clinical hospitals became institutions for restoring the health of the patient through the growth of scientific medicine. As the primary tool for gaining the information necessary for advancing criminological knowledge

³⁷ *Discipline and Punish*, 226-227. In view of this difference between natural and social sciences with respect to their entanglement in power, Foucault should probably revise the following sweeping claim from an earlier part of the book: "We should admit [...] that power produces knowledge (and not simply by encouraging it because it serves power or by applying it because it is useful); that power and knowledge directly imply one another, that there is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time power relations." (Ibid., 27) The claims should be limited to the case of the social sciences.

was an observation of individuals in reformatory prison, so was a close observation of the sick the source of the modern "clinical" medicine. Indeed, "the clinic" has a double meaning for Foucault, referring both to the new kind of research hospital and to the new kind of medicine, based on the primacy of the medical "gaze." Many defenders of the orthodox medicalization thesis have appealed to this gaze, which seems to presuppose the eye of an examining doctor reifying, objectifying the patient. Again, however, such a recuperation of Foucault's theory is a misinterpretation. The concept of *regard médical* appears probably for the first time in Foucault's early work, *The Birth of the Clinic*, in which "gaze" is clearly not meant to imply the gazing subject. Rather, the notion of gaze is supposed to refer to a certain form of perceptual problematization, which brings together forms of knowledge, vision and enunciation in such a way that they determine what a clinical doctor can see, feel, teach and know. Although Foucault's writing here is somewhat obscure, he indicates that "gaze" is not just a matter of seeing, but also describing. Without a certain kind of description—without some sort of intelligible ordering—there is no way of knowing what to look at. And without such ordering, there is no instructing others in seeing, either. Foucault writes:

It is description or, rather, the implicit labour of language in description, that authorizes the transformation of symptom into sign and the passage from patient to disease and from the individual to the conceptual. And it is there that is forged, by the spontaneous virtues of description, the link between the random field of pathological events and the pedagogical domain in which they formulate the order of their truth. To describe is to follow the ordering of the manifestations, but it is also to follow the intelligible sequence of their genesis; it is to see and to know at the same time, because by saying what one sees, one

integrates it spontaneously into knowledge; it is also to learn to see, because it means giving the key of a language that masters the visible.³⁸

To sum this point up: modern doctors could not simply open their eyes to see what was always there. The eye of an observer is just one term in a complex set of relations.³⁹

Although various orthodox forms of the medicalization critique are still very much alive today, in the last two decades or so there has appeared an intriguing body of work by a loosely connected group of scholars who try to pursue the sociology of health and illness in a genuinely Foucauldian manner. These scholars, most of whom reside in Britain or Australia—hence I shall refer to them as “the British School”⁴⁰—reject the dogmas of the mainstream forms of the medicalization thesis: the assumption of there being an intentional subject of medicalization; the separation of knowledge and power; a prospect of liberation from the domination by medical power; etc. Here is Deborah Lupton, a leading representative of the British School, summarizing some of these charges:

³⁸ Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception*, trans. A. M. Sheridan Smith (New York: Vintage, 1973), 114. (The French original was published in 1963).

³⁹ Cf. Foucault's forthright rejection of a crudely empiricist notion of modern medicine as being based on an uninhibited observation:

At the beginning of the nineteenth century, doctors described what for centuries had remained below the threshold of the visible and the expressible, but this did not mean that, after over-indulging in speculation, they had begun to perceive once again, or that they listened to reason rather than to imagination; it meant that the relation between the visible and invisible—which is necessary to all concrete knowledge—changed its structure, revealing through gaze and language what had previously been below and beyond their domain. A new alliance was forged between words and things, enabling one to see and to say.” (*Birth of the Clinic*, xii; emphasis in the original.)

For an excellent discussion of Foucault on medical gaze (as well as on other aspects of the relationship between his doctrine and the medicalization critique) which inspired my short commentary, see Thomas Osborne, “Medicine and Epistemology: Michel Foucault and the Liberality of Clinical Reason,” *History of the Human Sciences* 5 (1992): 63-93; repr. in *Michel Foucault: Critical Assessments*, vol. 4, ed. Barry Smart (London and New York: Routledge, 1995): 266-267.

⁴⁰ Among the chief representatives of the British School are David Armstrong, whose *Political Anatomy of the Body: Medical Knowledge in Britain in the Twentieth Century* (Cambridge: Cambridge University Press, 1983), has already become a classic. Other researchers associated with the School include Deborah Lupton, Sarah Nettleton, Thomas Osborne, and others.

Unlike those who assert the orthodox medicalization critique, a Foucauldian perspective argues [...] that it is impossible to remove power from members of the medical profession and hand it over to patients. Power is not a possession of particular social groups, but is relational, a strategy which is invested in and transmitted through all social groups. [...] Proponents of the orthodox medicalisation thesis tend to view members of the medical profession as consciously seeking to gain power and status and limit other groups' power, largely by eliciting the state's support. In contrast, Foucauldian scholars tend to argue that the clinical gaze is not intentional in terms of originating from a particular type of group seeking domination over others. [...] The state is, of course, involved in the reproduction of medical dominance, including regulating the conditions for the licensing of medical practitioners, but there are also other agencies and institutions involved beyond the state, and indeed the interests of the medical profession and those of the state often clash."⁴¹

As already made clear in my previous discussion, I am in agreement with the critical charges against the conventional understanding of the medicalization critique summed up by Lupton. However, I am afraid that some of the charges raised here could be made against some members of the British School as well.⁴² For example, David Armstrong, in his celebrated study of the medical knowledge in twentieth-century Britain, *Political Anatomy of the Body*, opened up for inquiry topics such as the role of dispensary in the medicalization of society. In concentrating on concrete material practices, rather than mere ideological representations, his book surpasses Brandt's ideological methodology. In Chapter 2, I will follow Armstrong's lead by exploring the role of the vd clinic in the transformation of the social space of early twentieth-century America and the constitution of a new kind of patient. Moreover, Armstrong advances an hypothesis, intended as an extension of Foucault's original idea, of the medical gaze as a tool for determining new identities. While, in *The Birth of the Clinic*, Foucault spoke

⁴¹ Deborah Lupton, "Foucault and the Medicalisation Critique," *Foucault, Health and Medicine*, ed. Alan Petersen and Robin Bunton (London: Routledge, 1997), 106.

⁴² Some, but not all—see Osborne, "Medicine and Epistemology."

of the *clinical gaze* determining a new anatomy of the discrete, accessible, analyzable, passive and evaluable body, Armstrong discerns the *dispensary gaze*, which, in his opinion, constituted the social as an autonomous stratum of reality corresponding to “social” diseases like tuberculosis and syphilis.⁴³ And yet, when I examine Armstrong’s descriptions of the establishment and functioning of the alleged dispensary gaze, I cannot help feeling that he takes it to be a conscious subject that cunningly implements measures necessary for increasing his grip on hapless human beings. Commenting on the fact that the pathologies of social diseases are not localized at a precise point on a discrete body, but rather moved around the social body, Armstrong writes that “[t]here was therefore a need for an organisational [sic.] structure which could both survey and constantly monitor the whole community. Hence, also, the emphasis on a close scrutiny of details of patients’ contacts and relationships, and the creation of a thorough record of family networks, friends and acquaintances through which to coordinate home-visits, checks and follow-ups.”⁴⁴ Or, consider the following passage on fighting TB: “The gaze of the Dispensary identified and construed a social and sanitised area between individuals by the single device of using the knowledge that tuberculosis could be transmitted through ‘respiratory contact’. The space between mouths and between noses became subjected to medical surveillance and the relationships, both familial and casual, which brought people into contact, became an item of medical record.”⁴⁵ In my opinion, the fiction of the autonomous subject of the dispensary gaze is created in these passages because Armstrong virtually ignores the real-life difficulties of introducing any of the measures for defeating syphilis or TBC which he mentions—such as record-keeping, home-visits, check-ups and follow-ups. However, the impression of the

⁴³ *Political Anatomy of the Body*, 11. However, notice that Foucault himself analyzes modern medicine as *social* in his 1974 lecture, “The Birth of Social Medicine” (*Power*, 134-156).

⁴⁴ *Ibid.*, 8.

⁴⁵ *Ibid.*, 11-12

diabolical dispensary gaze, triumphantly extending its hold on the community, would quickly dissipate, should we get into the nitty-gritty of the actual history of establishing dispensaries in early twentieth-century England. I admit I did not do this history in the case of England, but I have done it with the United States. What I have found is an overwhelming evidence of confusion, lack of direction, setbacks, sectional fights—certainly no unity of intention and of the best means towards a clearly envisaged end.

Finally, even those who explicitly reject the assumptions of the orthodox medicalization critique are not immune from it. Consider the following passage from Lupton's textbook on the sociology of health and illness, *Medicine as Culture*. Lupton here describes pretty much the same developments in late nineteenth- early twentieth-century social medicine that Armstrong described above. She writes:

The public health movement in the late nineteenth century developed a new rationale for the surveillance of bodies in the interests of gathering information to better target the health problems of populations. The emergence of the field of epidemiology, focused upon the documenting of patterns of disease across groups, intensified such practices, involving constant record-taking, measuring and reporting and reporting back to a system of government agencies. The medico-social survey became an important instrument in the disciplining of populations [...] Disease became constituted in the social body rather than the individual body, and deviant types were identified as needful of control for the sake of the health of the whole population. As a result, by the early twentieth century everyone became a potential victim requiring careful monitoring.⁴⁶

What we have here is the same schematization, which invites the misleading fairy-tale of history marching "by necessity" forward, that we found in Armstrong's book. In such schematizations, real people become appendages of a transhistorical subject that does the "real job." One would expect such a concept in authors who blame all the developments in the modern world on mysterious entities such as "capitalism" or

⁴⁶ Lupton, *Medicine as Culture* (London: Sage, 1994), 31.

“patriarchy,” but it is surprising when they turn up in the texts of self-professed Foucauldians who are supposed to study the “micro-physics of power.”⁴⁷ I shall expand on Foucault’s method in the next two sections, by taking up Foucault’s emphasis on contingency and lack of intentionality of events. One of the authors I shall frequently invoke will be a foremost interpreter of Foucault, Judith Butler. Let me conclude this present section with a quote from her which is a fitting commentary on the mistake committed by the upholders of the orthodox medicalization thesis as well as some representatives of the British School. The mistake in question is that of “personifying” power, viz., making power into a quasi-autonomous subject responsible for historical events. As Butler notes, Foucault himself has frequently been accused of committing this very mistake (this might be a consolation to those who commit it in earnest, thinking they are Foucauldians). If she is right, however, the interpretation of Foucault as a power-personifier misses the most fundamental motivation for his approach:

if power is misconstrued as a grammatical and metaphysical subject, and if that metaphysical site within humanist discourse has been the privileged site of the human, then power appears to have displaced the human as the origin of activity. But if Foucault’s view of power is understood as the disruption and subversion of this grammar and metaphysics of the subject, if power orchestrates the formation and sustenance of subjects, then it cannot be accounted for in terms of the “subject” which is its effect.⁴⁸

1.3 From Archaeology to Genealogy

Ian Hacking usefully points out, as I already quoted him in the Introduction, that “construction stories are histories.”⁴⁹ That is, all social analyses in the social

⁴⁷ On p. 12 of *Medicine as Culture*, Lupton notes that one of the problems pointed out by the critics of social constructionism has been “making broad generalizations and avoiding a detailed examination of the micro-context in which discursive processes take place.” The fact that she goes on to commit that very mistake is doubly ironic.

⁴⁸ Judith Butler, *Bodies that Matter: On the Discursive Limits of “Sex”* (New York and London: Routledge, 1993), 9.

⁴⁹ Hacking, *The Social Construction*, 51.

constructionist vein attempt to challenge the naturalness of some present practice by exposing its contingent, humble, or politically embarrassing historical origins. Foucault's critical histories have been basically of two sorts and they were, correspondingly, based on two sorts of methodologies: archaeological and genealogical. *Archaeology* was Foucault's predominant methodology in his early works on the histories of psychiatry, medicine and the "human sciences." The point of archaeology was, as suggested by the literal meaning of the term, to dig deeply in the history of a variety of fields of inquiry in order to uncover its underlying conceptual structures. Thus, in his magisterial 1966 work, *The Order of Things*, Foucault maintained that the unifying element behind the knowledges produced in the sixteenth-century was the concept of "resemblance;" the underlying concept of the Classical (i.e., Enlightenment) knowledge was "representation;" and the fundamental concept shared by the "human sciences" of Modernity (nineteenth-century till the present) was that of "man." This approach was meant by Foucault to open up a space for criticism of present knowledge and institutions, since he could point out the limitations of the conceptual foundations of the "human sciences" such as psychology, sociology and literary criticism. Whereas the modern empirical sciences of biology, economy and philology were built on the assumption that man is a part of nature, the "human sciences" were built on the idea that man is a subject rather than an object. However, the history of the "human sciences" reveals a constant tendency to overcome the model of man as an author of his own destiny, since they show him as a result of processes that are hardly ever represented in the subjective consciousness. Foucault accordingly announces, rather dramatically, the demise of man and with it, by implication, the end of grand liberation schemes that were connected with the concept of the subject.⁵⁰ On the territory left by the humanistic

⁵⁰ This idea is succinctly expressed in the famous antihumanist slogan of *The Order of Things*, which prophesies that "man would be erased, like a face drawn in sand at the edge of the sea."

disciplines will arise the "countersciences"⁵¹ of psychoanalysis, ethnology and linguistics, which Foucault envisions as formal sign systems making no reference to subjectivity or intentionality.

It is clear that Foucault once saw a great critical potential in the countersciences, and his own archaeological method was meant to have a similar effect of peeling off the humanistic pretensions of the modern "sciences" of psychiatry or criminology. The study of such discourses should reveal that they are built on a conceptual structure prevalent during a certain historical period. As this structure abruptly changes at particular points in history, we become aware of the contingency of all pretensions to knowledge. We do not have to accept any form of knowledge and its corresponding practice as necessary: such forms are likely to restructure themselves again, as they have several times before. Accordingly, the key methodological prescription for archeological study is to look for the "ruptures," i.e., the profound transformations of knowledge that mark the contours of a specific era. As Foucault puts it in a manifesto, or rather a testament, of his archaeological method, *The Archaeology of Knowledge*:

In every *oeuvre*, in every book, in the smallest text, the problem is to rediscover the point of rupture, to establish, with the greatest possible precision, the division between the implicit density of the already-said, a perhaps involuntary fidelity to acquired opinion, the law of discursive fatalities, and the vivacity of creation, the leap into irreducible difference.⁵²

Foucault argues that the structural ruptures he is looking for can be traced to the statements of authors considered obscure or insignificant by official histories, rather than in the pronouncements of the recognized figures. Consequently, archaeology should surpass the opposition of originality and banality, and give up the traditional humanistic

See Foucault, *The Order of Things: An Archaeology of the Human Sciences*, trans. Alan Sheridan (New York: Random House, 1970), 387.

⁵¹ *Ibid.*, 379.

⁵² Foucault, *The Archaeology of Knowledge & The Discourse on Language*, trans. A. M. Sheridan Smith (New York: Pantheon, 1972), 142.

quest for authorial intention. Foucault even suggests that the customary term "science" is misleading in implying the notion of authorial continuity. Accordingly, he proposes a new phrase, "discursive formation," that should roughly correspond to the "unity" previously picked up by the name "science." And he suggests that the undifferentiated mass of historical texts that is the source of an archaeological dig into the character of a certain discursive formation, should be conceived of as so many "monuments," rather than "documents"⁵³—the latter term being an undesirable vestige of the humanistic approach.

Foucault's methodology began to change at some point after 1970. The exact character of change is a matter of ongoing controversy in scholarly commentaries, but it could perhaps be described as shifting of emphasis from the topics of *knowledge* and *language* to that of *power*.⁵⁴ It could be well argued that Foucault never completely abandoned archaeological method.⁵⁵ Besides, there is no question that both archaeology and genealogy are anti- or posthumanist and subject-less methodologies. Nevertheless, it is a safe assumption that Foucault came to see archaeology as limited. The main limitation of archaeology, apparently, is its concentration on discursive phenomena to an exclusion of their causal implication.⁵⁶ Thus, archaeology was

⁵³ *Ibid.*, 7.

⁵⁴ This is what Foucault himself usually says in his interviews when questioned about his intellectual development. Yet his pronouncements can sometimes also be misleading, for instance when he suggests that he had been—unwittingly—studying the effects of power all along. Thus he says: "When I think back now, I ask myself what else it was that I was talking about, in *Madness and Civilization* or *The Birth of the Clinic*, but power?" ("Truth and Power," *Power/Knowledge*, 115).

⁵⁵ Thus Gary Gutting argues persuasively that the analysis of "discursive formations" is used in *Discipline and Punish*. See Gutting, *Michel Foucault's Archaeology of Scientific Reason* (Cambridge: Cambridge University Press, 1989), 270. Phil Bevis et al. maintain that Foucault returns, despite his promise of genealogical analysis, to archaeology in the last two volumes of *The History of Sexuality*. See Phil Bevis, Michèle Cohen and Gavin Kendall, "Archeologizing Genealogy: Michel Foucault and the Economy of Austerity," *Economy & Society* 18 (1989): 321-345, repr. in *Michel Foucault: Critical Assessments* 6, ed. Barry Smart (London and New York: Routledge 1995): 172-193.

⁵⁶ On a lack of causal element as a distinguishing mark of genealogical analysis, cf. Gutting, *Michel Foucault's Archaeology*, 271, and especially Gutting, "Foucault's Genealogical Method,"

concerned with the identification of epistemic ruptures between, say, the Classical form of knowledge and the modern one, but it lacked the causal explanation of these ruptures. By contrast, *genealogy* is concerned with extra-discursive causes of discursive interventions, as well as with their extra-discursive effects. In a 1977 panel discussion, "The Confessions of the Flesh," Foucault aptly distinguished the objects of archaeology and genealogy as, respectively, *épistème* and *dispositif*.⁵⁷ The latter term, usually translated into English as "apparatus," does perhaps manage to convey the sense of heterogeneity, which is supposed to include discursive as well as non-discursive elements: "discourses, institutions, architectural arrangements, regulations, laws, administrative measures, scientific statements, philosophic propositions, morality, philanthropy, etc."⁵⁸

Lest there be confusion, it is important to further explain the causal thrust of genealogy. Foucault emphatically does *not* claim that historical process exhibits any sort of lawful necessity or finality (that would, indeed, be a strange reversal of the standpoint of his archaeological studies). He says: "I am trying to work in the direction of what one might call 'eventalization'."⁵⁹ This means, first, "making visible a singularity," where one tended to see an instance of universality; second, it means "multiplication or

Midwest Studies in Philosophy 15: Philosophy of Social Sciences (Notre Dame: The University of Notre Dame Press, 1990): 327-343. Foucault himself does not usually use the vocabulary of "causal analysis." Yet he explains, in retrospect, a key feature of his project in *The Order of Things* as follows: "I left the problem of causes to one side; I chose instead to confine myself to describing the transformations themselves, thinking that this would be an indispensable step if, one day, a theory of scientific change and epistemological causality was to be construed" ("Foreword to the English Edition," *The Order of Things*, xiii). In one of his later interviews Foucault also expresses a hope that his later studies are more adequate, since they encompass discursive as well as *institutional* (that is, non-discursive) phenomena in their (presumably causal) "connection." See Foucault, "The Confession of the Flesh," *Power/Knowledge*, esp. 194. For a detailed analysis of the limitations of archaeology from a philosophical point of view, cf. Dreyfus, Hubert and Paul Rabinow, *Michel Foucault: Beyond Structuralism and Hermeneutics* (Chicago: The University of Chicago Press, 1982): chap. 4.

⁵⁷ Foucault, "The Confessions of the Flesh," *Power/Knowledge*, 194ff.

⁵⁸ Loc. cit.

⁵⁹ Foucault, "Questions of Method," *Power*, 226

pluralization of causes.”⁶⁰ Eventalization is “a way of lightening the weight of causality [by] constructing around the singular event analyzed as process a ‘polygon’ or, rather, ‘polyhedron’ of intelligibility, the number of whose faces is not given in advance and can never properly be taken as finite.”⁶¹ Let me contrast Foucault’s approach with that of traditional histories. These could be of two sorts.⁶² Either they pick a contemporary practice or institution, project it into a past epoch and claim that its significance has changed. Or they claim to uncover the essence of the present somewhere in the past and then declare its finality in the present. In the former case, the traditional historian postulates the uniformity of practices throughout history; in the latter, he posits a finality. In contradistinction to these traditional histories, Foucault proposes a “history of the present.”⁶³ When he picks a practice of current interest, such as the practice of imprisonment, he does not expect to find it was central in earlier historical epochs. In other words, he does not posit continuity. To analyze a practice as an “event,” he tells us, means to discover ways in which already existing practices of, e.g., internment, became inserted into the forms of legal punishment. Here one discovers, however, that “starting from a certain conception of the basis of the right to punish which can be found in the penal theorists or the philosophers of the eighteenth century, different means of punishment were perfectly conceivable”⁶⁴—and thus one’s sense of historical necessity gradually dissipates. And as one goes into details of the process of “carceralization” of penal practice, “the more one is led to relate them to such practices as schooling, military discipline, and so on”—hence one adds further and further faces to one’s

⁶⁰ *Ibid.*, 226, 227

⁶¹ *Ibid.*, 227

⁶² Here I am following the account given by Dreyfus and Rabinow, *Michel Foucault*, 118-120. They label the two tendencies of traditional history “presentism” and “finalism,” respectively.

⁶³ The full quote of this significant passage reads: “I would like to write the history of the prison with all the political investments of the body it gathers together in its closed architecture. Why? Simply because I am interested in the past? No, if one means by that writing a history of the past in terms of the present. Yes, if one means writing the history of the present.” (*Discipline and Punish*, 31)

⁶⁴ Foucault, “What is Called ‘Punishing’?,” *Power*, 387.

polyhedron of intelligibility. This way, more and more is brought to vision, nothing is, in principle, hidden from view. There is no grand scheme behind the appearances.

Following Nietzsche, the father of genealogy, Foucault distinguishes two forms of this pursuit. One concerns "descent," which concentrates on accidents and deviant cases, as opposed to continuity and regularity, as the origin of the contemporary. The focus of this pursuit of "descent" is on the *body*. "Genealogy, as an analysis of descent," says Foucault, "is thus situated within the articulation of the body and history: Its task is to expose a body totally imprinted by history and the process of history's destruction of the body."⁶⁵ Spelling out the details of Foucault's idea of the penetration of the body by history is actually very difficult. Since the concept of a socially constructed body is a key theme of my study, I reserve the next section for a further analysis of Foucault's ideas on this topic. The other type of genealogical program concentrates on "emergence." Whereas the pursuit of "descent" uncovers the contingent past, the study of "emergence" destabilizes the seeming finality of contemporary events. Under the appearance of a sealed whole, the contemporary is revealed as a transient result of a confrontation between forces. Accordingly, the genealogy of "emergence" focuses on *power*. The present generation might believe that the rules structuring their lives are a result of an essential historical process, thus confirming the finality of history. Foucault, after Nietzsche, finds this delusive:

Rules are empty in themselves, violent and unfinalized; they are impersonal and can be bent to any purpose. The success in history belong to those who are capable of seizing these rules, to replace those who had used them, to disguise themselves so as to pervert them, invert their meaning, and redirect them against

⁶⁵ Foucault, "Nietzsche, Genealogy, History," *Aesthetics, Method, and Epistemology: Essential Works of Foucault 2*, ed. James D. Faubion (New York: The New Press 1998): 375-376. This paper contains Foucault's most systematic and abstract explanation of the genealogical method. For a helpful analysis, cf. Gutting, "Foucault's Genealogical Method," and Dreyfus and Rabinow, *Michel Foucault*, chap. 5.

those who had initially imposed them; controlling this complex mechanism, they will make it function so as to overcome the rulers through their own rules.⁶⁶

Such features of genealogy appear to be, understandably enough, somewhat distressing. The success of Foucault's program should shake us from a complacency offered by globalizing conceptions of history. Genealogy makes us aware of just how coincidental, and thus insecure, our situation is. Hopefully, this insecurity threatens primarily those who benefit from it—the rulers. For the ruled, the effect of genealogy may be liberating, because once they see that their situation was by no means dictated by a natural necessity, but rather based on accidental power relations, a change is conceivable. To be sure, there may be no way of knowing how a change could be brought about, or how deep it could go—especially if we accept Foucault's point that power relations are unceasing. This suggests that Foucault's genealogy implies, to use Hacking's terminology, an "ironic" attitude to the powers that be. (Here Foucault differs from Nietzsche whose own genealogies express a sense of moral outrage at the petty origins of grandiose narratives.) In order to issue its liberating effect, genealogy uncovers the "subjugated knowledges"⁶⁷ and "lowly" topics—e.g., on the experiences of the criminally insane⁶⁸ or the sexually unfit⁶⁹—that are silenced or rationalized away by globalizing theories. Idiosyncratic events and topics have been suppressed precisely because of their disruptive effects for official histories.

Let me apply these points to the topic of my own research—the practice of medical treatment. I see a significant feature of our times in a relatively high level of the

⁶⁶ "Nietzsche, Genealogy, History," 378.

⁶⁷ "Two Lectures," 81.

⁶⁸ Foucault, *I, Pierre Riviere, Having Slaughtered My Mother, My Sister and My Brother: A Case of Parricide in the 19th Century*, trans. F. Jellinek (New York: Pantheon, 1975; the French original published in 1975).

⁶⁹ *Idem, Herculine Barbin, Being the Recently Discovered Memoirs of a Nineteenth-Century French Hermaphrodite*, trans. Richard McDougall (Brighton: The Harvester Press, 1980; the French original published in 1978).

compliance of patients with doctors' orders.⁷⁰ I have gathered the data that suggest that this compliance is not a natural attitude, but a recently emerged phenomenon: it can be traced back to the painstaking efforts to achieve patient compliance in the early twentieth-century vd clinics. This is surely "lowly" enough a topic. I do not claim that the early anti-vd efforts were central incidents in recent history—there is no underlying continuity. And I certainly do not believe, after what I have found in the archives, that the discipline doctors and public health officials were trying to enforce was bound to prevail—there is no historical necessity. The new patterns of behavior had to be hammered out through countless trials and strategic shifts characterized by resistance on the part of patients, on the one hand, and petty fights between the medical professionals and public health officials, on the other. In this history, there is no grand intentionality, only humble efforts to make the vd treatment efficient through technologies by which patients' bodies were inscribed and reinscribed. Most of this comes to an end with the discovery of penicillin, which made such a discipline unnecessary. Yet, it just so happens that the effects of discipline were already well entrenched. Hence we have the contemporary relatively compliant patient who disciplines herself with little enforcement. We have reached our present by starting from humble origins in the vd campaigns.

Foucault writes:

So I was aiming to write a history not of the prison as an institution, but of the *practice of imprisonment*: to show its origin or, more exactly, to show how this

⁷⁰ By speaking of a relatively high level of patient compliance, I am not suggesting that the late-twentieth century patients rigidly follow doctors' orders. The data on patient compliance are actually controversial. Some researchers report even today as high as 93 percent noncompliance with therapeutic regimens; others report that compliance is rather high, from 40 to 80 percent. For more data and commentary, see Donna R. Falvo, *Effective Patient Education: A Guide to Increased Compliance* (2nd Ed., Gaithersburg, MD: Aspen Publ., 1994, 16ff. Cf. also James A. McNamara, J. and Carroll-Ann Trotman (eds.), *Creating the Compliant Patient*, An Arbor: University of Michigan 1997). While it is undeniable, from what can be gathered from the scattered data from the 1910-1940, that the current rate of compliance is considerably higher, the main point is that the patient compliance only recently became an *issue*. A disciplined patient is not a natural given, but a social construct. And we need to get clear on the history of its construction.

way of doing things—ancient enough in itself—was capable of being accepted at a certain moment as a principal component of the penal system, thus coming to seem an altogether natural, self-evident, and indispensable part of it.⁷¹

If you just replace the word “prison” with that of “clinic,” and “imprisonment” with “treatment,” you get a rough description of my project.

1.4 Genealogy of the Body

I mentioned in the previous section that the focus of Foucault’s genealogy is the body. Indeed, he announces his research project in *Discipline and Punish* as “the history of the body.”⁷² In addition to Foucault’s genealogy, the body has been the focus of two other methodologies: Marxism and phenomenology. Let me explain the distinctness of Foucault’s approach. In Section 1.1, I quoted Foucault’s charge that Marxism “occlude[s] the question of the body.”⁷³ Presumably, Marxism concentrates on global meta-phenomena such as “productive forces” and “relations of production,” thus neglecting what happens to concrete bodies. In *The History of Sexuality: An Introduction*, when discussing the “repressive hypothesis,” Foucault adds another charge. Since virtually all except Foucault (and, of course, Nietzsche) understood power negatively, the last two hundred years of the history of sexuality were conceptualized as the period of an increasing repression. This underlying understanding of the relationship between power and sexuality was, then, at the root of Marcuse’s Freudian Marxism with its call for sexual liberation. “We are informed,” explains Foucault, referring to the theories of Marcuse and Reich, “that if repression has indeed been the fundamental link between power, knowledge, and sexuality since the classical age, it stands to reason

⁷¹ Idem, “Questions of Method,” 225.

⁷² Idem, *Discipline and Punish*, trans. Alan Sheridan (New York: Vintage, 1995), 25.

⁷³ “Body/Power,” *Power/Knowledge*, 58.

that we will not be able to free ourselves from it except at a considerable cost."⁷⁴

Despite its putative radicalism, Freudian Marxism uncritically accepts the picture of the body as a receptacle of pleasure which does not pour in in significant amounts due to repression. Thus, given Marxism's dual tendency either to abstract from the particular facts of embodiment, or to take for granted the ahistorical mechanistic image of the body, this theory does not stand up to the task posited by Foucault: to thematize the body as the focal point of social intervention.

On the other hand, the charge of thematic neglect with respect to the concept of the body cannot be leveled against phenomenology, focused as it was on the concrete facts of bodily existence as subjectively experienced. The crucial distinction here is between the objective body (*Körper*) and the subjective body (*Leib*). The former is a physical object studied by science; the latter is an incarnate experience described by phenomenology.⁷⁵ For instance, medicine, understood as a scientific enterprise, could accurately track the causes of a disease in the body, utterly disregarding the subjective experience of the disorder. It would be an object of phenomenology to describe how the disorder—be it "organic" or "mental"—is experienced by patients and how it affects their overall perception of the world. Blurring the commonsensical distinction between the bodily (presumably, the objective) and the mental (the subjective) was precisely one of the most valuable innovations of the phenomenological method. Nevertheless, although it brought interesting insights into the interdependence between mental events, such as perceptions, and bodily actions, the legacy of phenomenology is problematic. For one thing, it appears that phenomenology never escapes the tendency to reduce social and institutional phenomena to the subjective experience of a subject. Yet it is precisely the intersubjective, social and institutional, forces shaping the human bodies—the forces

⁷⁴ *History of Sexuality: Volume 1*, 5.

⁷⁵ See Bryan Turner, *Regulating Bodies. Essays in Medical Sociology* (London and New York: Routledge, 1992), 56.

irreducible to the representations of a subjective consciousness—that are the focus of Foucault's studies. As he noted in his earliest studies on mental illness, the social forces of which consciousness is a contingent result may totally elude it. Whereas a disease may present itself to consciousness as an authentic phenomenon, and "being sick" as an authentic form of existence, both disease and the sick person could in fact be revealed as conditioned by social influences transcending an individual consciousness.⁷⁶ Secondly, even the innovations brought to phenomenology by Maurice Merleau-Ponty, who had direct influence on the young Foucault, and who tried hard to avoid modeling intentionality on perception, fell short of conveying the sense of the historical contingency and specificity of the social practices that mould modern bodies.⁷⁷

⁷⁶ Foucault, *Mental Illness and Psychology*, trans. Alan Sheridan (Berkeley: University of California Press, 1987; this is a reprint of a 1962 translation of Foucault's 1954 essay). See esp. p. 69 for the claim that mental illness is not a transhistorical feature of the subject, but rather a result of certain social forces—capitalist forces of production—in the modern age. For a discussion of Foucault's early interest in, and subsequent retreat from, existential phenomenology in *Mental Illness and Psychology*, see Gutting, *Michel Foucault's Archaeology*, 55-69. Interestingly enough, even Peter L. Berger and Nicholas Luckmann—who actually coined the phrase "social construction"—were led by their phenomenological methodology to positing the body as a substrate of construction, rather than a social construct itself. In their classic statement of social constructionist thesis, they contend that "there are always elements of subjective reality that have not originated in socialization, such as the awareness of one's own body prior to and apart from any socially learned apprehension of it" (Berger and Luckmann, *The Social Construction of Reality: A Treatise in the Sociology of Knowledge* [New York: Doubleday, 1966], 134). Elsewhere in the same book they say bluntly that the human body is a product of nature, not culture: "man is a body, in the same way that this may be said of every other animal organism" (*ibid.*, 50). This just shows how far social constructionism expanded its reach since its origins forty years ago.

⁷⁷ For Merleau-Ponty's late attempt to move away from the notion of intentionality derived from sense perception, see his unfinished work, *The Visible and The Invisible* (ed. Claude Lefort, trans. Alphonso Lingis, Evanston, Ill: Northwestern University Press, 1968), in which he proposes the new ontological category of "flesh" as a replacement for the previous category of "lived body." For the critical discussion of Merleau-Ponty's late ontology of flesh, see Drew Leder, "Flesh and Blood: A Proposed Supplement to Merleau-Ponty," *The Body: Classic and Contemporary Readings*, ed. Donn Welton (Malden, Mass. and London, UK: Blackwell, 1999): 200-220. For a feminist reading of the same material, see Chapter 4 of Elisabeth Grosz, *Volatile Bodies: Toward a Corporeal Feminism* (Bloomington and Indianapolis: Indiana University Press, 1994). Merleau-Ponty certainly would not concur with Berger and Luckmann's opinion that the human body is like any other animal body, although he could hardly accept Foucault's Nietzschean notion of the body's cultural malleability. For a discussion of Foucault's objection to Merleau-Ponty's notion of the body, see Dreyfus and Rabinow, *Michel Foucault*, 111-112.

In what sense is the body socially constructed, according to Foucault? In *Discipline and Punish* and elsewhere, he appears to accept Nietzsche's view that almost anything could be made out of the body. For example, he postulates a profound change in bodily constitution between the Classical Age and Modernity. What we call "the natural body" is no more than two centuries old—prior to that we had Cartesian mechanical bodies:

Through this technique of subjection a new object was being formed; slowly, it superseded the mechanical body—the body composed of solids and assigned movements, the image of which had for so long haunted those who dreamt of disciplinary perfection. This new object is the natural body, the bearer of forces and the seat of duration; it is the body susceptible to specified operations, which have their order, their stages, their internal conditions, their constituent elements. In becoming the target for new mechanisms of power, the body is offered up to new forms of knowledge. It is the body of exercise, rather than of speculative physics; a body manipulated by authority, rather than imbued with animal spirits; a body of useful training and not of rational mechanics, but one in which, by virtue of that very fact, a number of natural requirements and functional constraints are beginning to emerge.⁷⁸

Again, in *The History of Sexuality: An Introduction*, he maintains: "We have had sexuality since the eighteenth century, and sex since the nineteenth. What we had before that was no doubt the flesh."⁷⁹ Should we understand these striking assertions as claiming that there could be no recourse to anything natural, that even the most intimate facts of embodiment, such as our own sexuality, are a construct of cultural practices of one sort or another? Let me consider the opinions of three authors who share a deep sympathy towards social constructionism in general and Foucault's in particular, but who differ as to their respective interpretations of both. Or, perhaps, they just appear to differ—we have to find out. The three interpretations I am going to discuss may not ultimately

⁷⁸ Foucault, *Discipline and Punish*, 155.

⁷⁹ Idem, "Confessions of the Flesh," *Power/Knowledge*, 211.

oppose each other, but rather highlight different aspects of an underlying thesis. This discussion should help clarify how I myself will understand the notion of the social construction of the body (especially the body of the patient) in the remainder of this study.

Judith Butler is a self-professed radical social constructionist who does not think that Foucault goes too far in his genealogy of the body; rather, she thinks he does not go far enough. In her acclaimed book, *Gender Trouble*, Butler makes two principal charges against Foucault. First, she accuses him of an inconsistency in his view of sex. The alleged discrepancy is between the standpoint of the concluding chapters of *The History of Sexuality: An Introduction*, and the view sketched in the "Introduction" to the memoirs of a nineteenth-century hermaphrodite Alexina a.k.a. Herculine Barbin. For the Foucault of *The History of Sexuality*, sex is the preeminent form of modern power. Sex, considered by the followers of the "repressive hypothesis" a hidden secret—indeed, the essence—of the individual to be wrested out by confessional and medical techniques, turns out to be a construct of a power/knowledge formation with a rather short history, namely, of the apparatus of sexuality. However, Butler discovers that a remarkably different view of sex is outlined in Foucault's short piece about the life of Alexina a.k.a. Herculine Barbin. According to this alternative theory, the hermaphrodite's bodily pleasures were free of a causal dependence on our alleged secret essence, i.e. sex.

Consider:

One has the impression, at least if one gives credence to Alexina's story, that everything took place in a world of feelings—enthusiasm, pleasure, sorrow, warmth, sweetness, bitterness—where the identity of the partners and above all the enigmatic character around whom everything centered, had no importance. It was a world in which grins hung about without the cat.⁸⁰

⁸⁰ Idem, "Introduction" to *Herculine Barbin*, xiii.

For Foucault, then, whereas individuals homogeneously identified as men or women have their sexual experiences determined by the sexes attributed to them, Alexina/Herculine had her/his pleasures only occasioned, not caused, by her anatomical anomaly. Even after doctors reclassified the female Alexina as the male Herculine, she/he still did not experience her/himself as definitely either masculine or feminine. Foucault holds that what she evokes in her journals, written shortly before her/his suicide, is "the happy limbo of a non-identity."⁸¹

As Butler sees it, Foucault's account of sex in Herculine Barbin is anachronistic. She comments: "Here we see Foucault's sentimental indulgence in the very emancipatory discourse his analysis in *The History of Sexuality* was meant to displace."⁸² Butler then goes on to point out diverse stylistic elements and rhetorical figures in Alexina/Herculine's memoir—classic as well as romantic literary conventions, Christian legends, both masculine and feminine self-stylizations. The presence of these discursive conventions, peculiarly left out in Foucault's commentary, demonstrates that the hermaphrodite's experience was not outside the governing apparatus of power/knowledge. Accordingly, Butler concludes that instead of a *multiplicity* claimed by Foucault, we find in Alexina/Herculine's text merely an *ambivalence*—a hapless motion back and forth within the binary posited by the apparatus of sexuality.⁸³

⁸¹ Ibid.

⁸² Butler, *Gender Trouble* (New York and London: Routledge, 1990), 96.

⁸³ Ibid., 99. Although he prefers to interpret the hermaphrodite's experience as unique, Foucault himself also occasionally slips into suggestions of female homosexuality—a common practice in female convent schools. Thus Foucault's interpretation of Alexina equivocates between hermaphroditic non-identity and female homosexual identity. But, as Butler surmises, perhaps he wants to "have it both ways," i.e., to propose that homosexual practice, although identifiable as male or female, at the same time moves beyond the extant apparatus of sexuality with its binary division. Cf. suggestions that in male homosexual practices, a "whole new art of sexual practice develops which tries to explore all the internal possibilities of sexual conduct." In Foucault, "Sexual Choice, Sexual Act," *Ethics, Subjectivity, and Truth*, , 151. Without a mention of homosexual practice, but with a language reminiscent of his remarks on hermaphroditic experience, Foucault also urges us to "invent with the body, with its elements, surfaces, volumes, and thicknesses, a non-disciplinary eroticism: that of a body in a volatile and diffused state, with

Butler's second objection to Foucault concerns his treatment of the relationship between the body and discourse (or culture). In the very manifesto of his genealogical approach—his "Nietzsche, Genealogy, History"—Foucault calls the body "the surface of the inscription of events."⁸⁴ In doing so, he seems to imply that the body is a passive medium, a "blank page" on which culture writes its significations. History is a process of a gradual destruction or sublimation of the body by the "text" inscribed on it. Butler sees this dichotomy of body and culture as a vestigial dualism in the project known for its relentless dissolution of traditional binaries. While we expect Foucault the least to make a room for transhistorical unities, Butler reveals that the assumption of a primordial body lies at the very center of his theory. Leaving the depths of the body outside the reach of power, Foucault thus unwittingly resuscitates old humanism—the body's authentic depths serve as the reference point of those longing for liberation. Unlike Foucault, with his image of a *thickness* awaiting cultural inscription, Butler recommends that we take the body as a *surface*, upon which gender and sex identities are *performed* through public enactments. Butler's favorite example of such enactments is performances by female impersonators—drag queens—because they exemplify the superficial character of what we ordinarily take to be biologically fixed identities—and because they do this in a parody form, thus at the same time subverting the notion of the transcultural body. "Such acts, gestures, enactments, generally construed, are *performative* in the sense that the essence or identity that they otherwise purport to express are *fabrications* manufactured and sustained through corporeal signs and other discursive means."⁸⁵ According to Butler, this performative concept of the body has two striking consequences. First, the body "has no ontological status apart from the various acts

its chance encounters and unplanned pleasures." In Foucault, "Sade, Sargeant of Sex," *Aesthetics, Method, and Epistemology*, 227.

⁸⁴ "Nietzsche, Genealogy, History," 375; cited in Butler, *Gender Trouble*, 129

⁸⁵ Butler, *Gender Trouble*, 136 (emphases in the original).

which constitute its reality;" and second, the body has no interior, if that is supposed to signify an essence independent of cultural inscriptions; indeed, "that very interiority is an effect and function of a decidedly public and social discourse."⁸⁶ We might conclude that the body is, for Butler, a complete posit—not a medium—of a cultural activity.

Later on, in Chapter 4, I will appeal to the details of Butler's view of a performative construal of the body, especially to her elaboration of a suggestion by the psychoanalyst Julie Kristeva, that kinds of bodies are constituted through the acts of rejection, expulsion, or—as Kristeva puts it—"abjection." At this point, however, I want to contrast the general concept of the body offered by Butler with another that, though also inspired by Foucault, opposes the kind of radical constructionism, which appears to be the message of *Gender Trouble*. Feminist theorist Susan Bordo worries that the performative concept of materiality threatens to dissolve the body into an effect of discursive practices. She says: "Butler's world is one in which language swallows everything up, voraciously, a theoretical pasta machine through which the categories of competing frameworks are pressed and reprocessed as 'tropes'."⁸⁷ In Bordo's view, Butler commits the mistake of *textualism*—the idea that in order to alter a material practice, one only needs to "rewrite" it—because she understands bodies too abstractly. Talk of performativity and enactment makes it seem as if there is *no one in particular* who has to make an *effort* to engage in these practices. This unfortunate position may be avoided, as long as one attends to concrete facts of embodiment. This concreteness constitutes Bordo's notion of materiality. "The body's materiality, for me," she says, "is first and foremost about concreteness, and concrete (and limiting) *location*."⁸⁸ Her

⁸⁶ Loc. cit.

⁸⁷ Susan Bordo, "Postmodern Subjects, Postmodern Bodies, Postmodern Resistance" *The Unbearable Weight: Feminism, Western Culture, and the Body* (Berkeley, Cal.: University of California Press, 1993), 292.

⁸⁸ Idem, "Bringing Body to Theory," *Body and Flesh: A Philosophical Reader*, ed. Donn Welton (Malden, Mass. and Oxford, UK: Blackwell, 1998): 92 (emphasis in the original).

complaint about Butler's evocations of drag shows is precisely that they are too vague, too general. In her book, *The Unbearable Weight*, Bordo analyzes some very tangible interventions in the bodies—especially the female ones—of popular culture preconceptions whose significance often escapes us: preconceptions concerning fitness, beauty, and health.⁸⁹ She self-consciously tries to go beyond a mere description of cultural images of the body to what we *do* to our own bodies because of certain ways we (mis)understand the message of these images (e.g., we mistakenly believe that fashion gives us choice, when in fact it leads us to sculpt our bodies in a very specific way). "My work on the body is more 'material' than many," writes Bordo,

[b]ecause I believe that the study of representations and cultural "discourse"—while an important part of the cultural study of the body—cannot by itself stand as a history of the body. Those discourses impinge on us as fleshly bodies, and often in ways that cannot be determined from a study of representations alone. To make such determinations, we need to get down and dirty with the body on the level of its practices—to look at what we are eating (or not eating), the lengths we will go to keep ourselves perpetually young, the practices that we engage in, emulating TV and pop icons, and so forth. Our assessments of gender and race inequities must consider not only the most avant-garde images from *Details* or *Interview* magazine, but what people are doing to their bodies in the more mundane service of the "normal"—the kinds of cosmetic surgeries they are having, the hours they spend on the stairmaster, what they feel about themselves when they look in the mirror.⁹⁰

Bordo believes that it is precisely this stress on concreteness and localization, which characterizes Foucault's notion of the social construction of the body, and thus she finds Butler's presumed textualism peculiarly un-Foucauldian.

Within Foucault's understanding of the ways in which the body is "produced" through specific historical practices, "discourse" is not foundational but is, rather,

⁸⁹ The most well-known among these essays are "Reading the Slender Body," about eating disorders, and "'Material Girl': The Effacements of Postmodern Culture" (*The Unbearable Weight*, 245-276), about the minute disciplinary effects of commercial advertising and popular music.

⁹⁰ "Bringing Body to Theory," 91.

one of the many interrelated modes by which power is made manifest. Equally, if not more, important for him are the institutional and everyday *practices* by means of which our experience of the body is organized: institutionalized monitoring, "normalizing" examinations, the spatial and temporal organization of schools and prisons, the "confessional" mode between physicians and patients, teachers and students, and so forth.⁹¹

I think Bordo is exactly right in emphasizing the multiplicity of material practices in Foucault—as we saw, his concept of “apparatus” was meant exactly to signify a heterogeneity of practices as the object of genealogical research, as opposed to the predominantly discursive “episteme” of the earlier archaeology. I also sympathize with Bordo’s opposition to reducing practices to a play (which is, not surprisingly, a consequence of textualism): material practices are serious enough. While Bordo focuses on how we manage to transform our bodies with food and fashion, I am interested in how we handle an invasion of our bodies by a disease. Unlike hers, my interest is more historical—how did we get to where we are, i.e. how did we become quite willing to take good care of ourselves? Yet our two projects are similar: they are concerned with the ways in which we take care of our bodies, subjecting them to a disciplinary norm. Bordo’s studies confirm, and hopefully mine will too, the Foucauldian point that we are not usually aware of what our ways of taking care of ourselves do to us.

It might seem, then, that the Butlerian Foucault and the Bordo-esque Foucault are irredeemably opposed to each other. The former holds there is no sense in talk of the body as prior to a discursive practice; the latter insists the body is always more than a discursive effect. Yet this disagreement might be less serious than it appears. Recall that Bordo does not claim that the body of the anorexic precedes cultural interventions from which it results—only that we should not regard its sufferings as *fictional*. Butler,

⁹¹ *The Unbearable Weight*, 293 (emphasis in the original).

however, responds to critics such as Bordo by underscoring the material character of disciplinary practices and of the resistance they meet. In her later book, *Bodies that Matter*, she explains:

“sex” is an ideal construct which is forcibly materialized through time. It is not a simple fact or static condition of a body, but a process whereby regulatory norms materialize ‘sex’ and achieve this materialization through a forcible reiteration of those norms. That this reiteration is necessary is a sign that materialization is never quite complete, that bodies never quite comply with the norms by which their materialization is impelled.⁹²

It would be nice to end on this up-beat reconciliatory note, but I think there is still space for a further inquiry into what exactly is meant by the social construction of the body.

I want to conclude this section with a discussion of some ideas of Ian Hacking and Arnold Davidson, two philosophers whose work should prove useful in answering this question. Neither Hacking nor Davidson is a commentator on Foucault, but their innovative studies on the social construction of disease and deviancy—and the diseased and deviant bodies—are Foucauldian in spirit.⁹³ As I am going to devote Chapter 4 to the problem of the constitution of the vd patient, it should be useful to review Hacking’s and Davidson’s arguments.

⁹² Butler, *Bodies that Matter*, 1-2. For a convincing defense of a basic commonality between Butler and Bordo, see Susan Hekman, “Material Bodies,” *Body and Flesh*, 61-70.

⁹³ See Ian Hacking, *Rewriting the Soul: Multiple Personality and the Sciences of Memory* (Princeton, NJ: Princeton University Press, 1995), on the multiple personality disorder; and *Mad Travelers: Reflections on the Reality of Transient Mental Illnesses* (Charlottesville and London: University Press of Virginia, 1998), on the epidemic of compulsive walking. In addition to these studies with a discernibly Foucauldian flavor, Hacking wrote several occasional pieces—reviews and articles—directly on Foucault’s work: e.g., Hacking, “Night Thoughts on Philology,” *History of the Present* 1 (1988): 3-10, repr. in *Michel Foucault: Critical Assessments* 2, ed. Barry Smart (London and New York: Routledge, 1994): 266-277, on archaeology; and “Self-improvement,” *University Publishing* 13 (1984): 4, 6, repr. in *Michel Foucault: Critical Assessments* 2: 23-26, on Foucault’s later work in ethics. For Davidson’s work, see “Closing Up the Corpses: Diseases of Sexuality and the Emergence of the Psychiatric Style of Reasoning,” in *Meaning and Method: Essays in Honor of Hilary Putnam*, ed. George Boolos (Cambridge: Cambridge University Press, 1990): 295-325; “Sex and the Emergence of Sexuality,” *Forms of Desire: Sexual Orientation and the Social Constructionist Controversy*, ed. Edward Stein (New York and London: Garland, 1990): 89-132.

Foucault hints that the natural body is the accomplishment of the Modern Age; Butler proposes that the alleged inner sanctums of the sexed body are effects of publicly staged spectacles; and Bordo argues that how we shape our bodies is a result of a disciplinary discourse masquerading as emancipatory. It would seem that what these writers suggest is that not just the "idea"—i.e., a particular classification—of a body, but rather the very "object," the body in its materiality, is socially constructed. How plausible is that? Let us consider some examples. When Foucault says that the natural body is a timeless entity but a paradigmatically modern object, he seems to mean more than that in the Classical *épistémè* bodies had been classified together with machines, whereas with the onset of Modernity they began to be grouped with living things.⁹⁴ He appears to propose a much more striking thesis that the modern body itself—this very thing—is different from the Enlightenment body and, furthermore, that this remarkable material transformation occurred within a relatively short time-span of decades. Hacking himself considers the cases of the nineteenth-century TB patient and the late twentieth-century abused child, among a host of others. He claims, in a manner reminiscent of Foucault, that the consumptive was a typical nineteenth-century creature with no late twentieth-century equivalent; conversely, the abused child came into existence only in the second half of the twentieth century. When Hacking tells us that the consumptive ceased to exist in the twentieth century, while the abused child emerged as a novel kind—does he mean that society simply regrouped the same objects under different headings, or that new objects popped into existence?

Let me explain Hacking's point in two steps. First, he argues—in his important article "Making Up People"—that what gets socially constructed is not bare *individuals* but rather individuals as members of *kinds*. Individuals are subsumed under this or that

⁹⁴ More precisely, Foucault argues in *The Order of Things* that "life" is—together with "language" and "labor"—one of the three categories of object that separate modern thought from the Classical one.

kind on the basis of a variety of types of behavior and activity that they exhibit. Thus, when in *Discipline and Punish* Foucault maintains that the delinquent person, as a subspecies of the human being, had not existed before nineteenth-century criminology constructed it, he ought not to be understood as claiming that criminologists—presumably by writing down some novel classifications—conjured up as yet non-existent individuals. Instead, when claiming that vagabonds and freaks, rather than criminals, were the kinds of people that roamed premodern Europe, Foucault should be understood as saying that vagabonds, freaks *as well as* criminals could be, as kinds, comprised of the very same individuals; moreover, these individuals could exhibit some of the same types of behavior—e.g., both vagabonds and criminals could exhibit idleness. However, criminals literally came to existence only when some of these types of behavior ceased to be regarded as contingent properties, and came to be seen as essential properties, defining a putative subspecies of human beings instead. The second step of Hacking's view is this: The constructed kinds are *interactive* rather than *indifferent*. The indifferent kinds are studied by the natural sciences; these collections are "indifferent" in the sense that it makes no difference to the members of these kinds that they are grouped in such and such a way. The interactive kinds are the groups of objects recognized in the social sciences; these kinds are "interactive" because they affect, and are affected by, the objects they group together—usually, human beings. The examples of the latter are natural kinds like *horse* and *planet*; the examples of the former are artificial kinds such as *criminal*. What makes the interactive, though not the indifferent, kinds constructed is not just the fact that their members are subject to certain descriptions; rather, it is that the descriptions and labels that constitute this kind make a difference to the behavior and activity of its members. In other words, labels and descriptions applied to people are more likely than not to form—or deform—their conduct: when an individual is consistently described as a criminal, and handled

accordingly, she will soon enough start acting like one. Accordingly, criminals constitute an "interactive" kind.⁹⁵ This fact—that labels and objects in the social sciences interact—is significant. Presumably, it essentially affects human behavior if humans are classified as *organisms* (soldiers' or schoolchildren's bodies can be subject to dressage, when they are classified as animalistic); or as *consumptives* (when this is not just a medical category but rather a medico-moral category, as in the nineteenth century);⁹⁶ or as *victims of child abuse* (when this classification is based not just on the fact that one has suffered cruelty as a child, but rather on the fact that one exhibits particular bodily symptoms, revealed through the procedure of "anal dilation").⁹⁷ And human beings can and do resist, in their behavior, various labels attached to them, so that classifications have to be changed. Consequently, there are three candidates for an object of social construction, when this object is a sort of body. To take an example that will play a central role in the rest of this study, the three candidates for the social construction of a syphilitic patient are: (a) the "idea" of the syphilitic; (b) the syphilitic her- or himself in her or his materiality; and (c) a specific pathology responsible for the symptoms of syphilis.⁹⁸ According to Hacking, (c) is an indifferent kind; in the case of syphilis the bacterium *Treponema pallidum*. It would be ludicrous to call *it* socially constructed.⁹⁹ However, (a)

⁹⁵ See Hacking, *The Social Construction of What?*, 103-4. In this book, Hacking writes extensively on the typical late twentieth-century kind of human being, the *sexually abused child*. In his previous books, he studied the rise and fall of such kinds as multiple personality (in *Rewriting the Soul*) and compulsive traveler (in *Mad Travelers*).

⁹⁶ Hacking, "Making Up People," in *Forms of Desire*, 76. Cf. Davidson, "Sex and the Emergence of Sexuality," 89-132. I shall return to Hacking's and Armstrong's texts in 4.2 below, where I write on the constitution of the vd patient as a novel kind.

⁹⁷ *The Social Construction*, 148.

⁹⁸ *Ibid.*, 121.

⁹⁹ On the other hand, I should stress that Hacking is not claiming that the mere colonization of the body by a bacterium is sufficient for categorizing a condition as disease. That depends on many other factors, many of them surely of a social character. In this respect, cf. Lawrie Reznek's *The Nature of Disease* (London: Routledge, 1984). Though he is engaged in philosophical analysis rather than sociological research, he makes a forceful argument for the thesis that the classification of a condition of the body as a disease depends on whether or not we can do something about the condition, whether it bothers people, etc. Now, if not social, such factors are clearly at least historical.

is surely socially constructed, because the ways people have historically been classified as syphilitics are loaded with politically and morally significant meanings. Furthermore, even (b) can be regarded as socially constructed, because the ways people get grouped in a particular category has tangible impact on what happens to their bodies and how they regard themselves. And, as can be seen in light of Foucault's notion of power that cares rather than oppresses—and in light of Bordo's studies of the eating disorders—what happens to bodies need not be seen in terms of an external intervention. People sculpt their bodies in accordance with a disciplinary norm quite willingly.

Hacking credits Arnold Davidson with articulating this version of social constructionism. Like Hacking and Foucault, Davidson argues the human sciences such as criminology or psychiatry do not discover the kinds of human beings they describe; rather, these sciences construct the relevant kinds in response to a social interest by making a particular behavioral trait part of the essence of the putative kind. Thus, in a paper "Sex and the Emergence of Sexuality," Davidson explains how a certain type of behavior whose occurrences are reported throughout history—e.g., having oneself whipped for sexual pleasure—came to define a specific kind of human being—i.e., a masochist—only in the nineteenth century.¹⁰⁰ Davidson means that the kind of behavior that has probably always existed, such as getting oneself flogged for sexual pleasure, was only recently described as perverse, i.e. symptomatic of a disease. In premodern times, the identical type of behavior might have been described as a vice, which had nothing to do with the scientific definition of what kind of human being one was (it might have only meant that one had a bad character). Elsewhere, Davidson finds the clues for grasping the nineteenth-century obsession with various kinds of perverts in the discourse of "degeneracy," which explained the prevalence of perverts by postulating the

¹⁰⁰ See Davidson, "Sex and the Emergence of Sexuality," sec. II (pp. 120-132). For Foucault's parallel notion of the modern pervert as different from the libertine, cf. *History of Sexuality*, 40-5.

heredity of abnormal features. Davidson thinks that the concept of degeneracy "functioned as one of the central ties between what Foucault has called the anatomo-politics of the human body and the bio-politics of the population."¹⁰¹ In other words, the conceptual framework of degeneracy could encompass both the medical attention paid to an "abnormal" individual and the public health policies that should protect the "normal" populace. It is against the background of such modern protective policies, claims Davidson, that the emergence of perverts or degenerates must be understood. In conclusion, the perverts of the nineteenth century are not creatures that the medical discourse of that era discovered, but rather "made up," in the sense clarified by Hacking and Davidson.

Hacking's distinctions help, I believe, to make the idea of the social construction of the body more lucid and respectable. It might be thought that so much caution is unnecessary, yet it is a sad fact that a lot of the social construction talk in contemporary social science is imprecise and ambiguous at best. For instance, David Armstrong writes that "[a] body analysed for humours contains humours; a body analysed for organs and tissues is constituted by organs and tissues; a body analysed for psychosocial functioning is a psychosocial object."¹⁰² This statement is meant to be in keeping with Foucault's view in *The Birth of the Clinic*. Yet the notion that because Foucault is a social constructionist he would understand the bacterium *Treponema pallidum* as something like a figment of nineteenth-century doctors' minds is totally unfounded. That interpretation would, again, invite the image of a foundational subject, or a secretly conspiring group, that is able to deploy power as it suits their interests.

¹⁰¹ Davidson, "Closing Up the Corpses," 317. Foucault introduces the terms "anatomo-politics" and "bio-politics" on p. 139 of *The History of Sexuality: Volume 1*. The former term refers to disciplinary power targeting the individual body; the latter term refers to governmental power targeting the population. Cf. Section 1.2, 26-7.

¹⁰² Armstrong, "Bodies of Knowledge/Knowledge of Bodies," *Reassessing Foucault: Power, Medicine and the Body* (London: Routledge, 1994), 25.

Quite the opposite, actually, is true for Foucault. Instead of suggesting that facts and entities simply “pop into existence” to suit the purposes of some well-defined power holders, Foucault must be understood as claiming that construction is a grueling chore that involves ongoing interactions between variously competing subjects and material facts not under their control.¹⁰³

To sum up the main points of this chapter: I showed how the mainstream studies on the origins of social medicine in general, and the early twentieth-century anti-VD campaigns in particular, concentrate on representations and assume a centralistic notion of power. I criticized the shared methodological assumptions of these studies from a Foucauldian point of view, by concentrating on Foucault’s three key concepts—power, event, and the body: power as a network of relations; an accidental and marginal event as the main locus of genealogical research; and the body as a platform on which power is inscribed. In the rest of this thesis, these concepts will play the central role in illuminating the conflicts behind the organization of anti-VD efforts, the origins of the clinical VD treatment, and the constitution of the modern patient.

¹⁰³ A passage from a paper by Thomas Osborne on the epistemological import of *The Birth of the Clinic* brilliantly captures this radically materialist sense of Foucault’s understanding of “social construction,” which seems to be twisted by authors such as Armstrong:

Knowledge, in *Birth of the Clinic*, is not just a matter of invention or convention. One cannot just say anything. Ideas constantly meet resistance, be it from reality (for example, the lack of empirical information for the early clinicians of the “free field” [...] who were hostile to the hospital, from other ideas (such as that of the “free field” itself) or other people (for example, the Faculté). *Foucault characterizes knowledge as above all an arduous and complicated “labour”*. It is not a matter of inventing or constructing what is real, but of juxtaposing and aligning concepts and concerns (within, and aligned with, given political and institutional arrangements) so that the real makes sense and can be made workable and manipulable; specifically so that disease can become both “seeable” and “sayable”. (Osborne, “Medicine and Epistemology,” 255-256; emphasis added)

In this connection, cf. Hacking’s plea to the social constructionist—which I used as a motto to this chapter—to take the meaning of the term “construction” seriously: “Anything worth calling a construction was or is constructed in quite definite stages, where the later stages are built upon, or out of, the product of earlier stages. Anything worth calling a construction has a history. But not just any history. It has to be a history of building.” (*The Social Construction*, 50).

Chapter 2: Sites of Discipline

People write the more general, more fluid, but also more determinant history of experiments on those born blind, on wolf-children or under hypnosis. But who will write the more general, more fluid, but also more determinant history of the 'examination'—its rituals, its answers, its systems of marking and classification? For in this slender technique are to be found a whole domain of knowledge, a whole type of power.

—Michel Foucault, *Discipline and Punish* (1975)

Any public health clinic, no matter how efficiently conducted, only scratches the surface of its potential usefulness unless it includes in its organization and personnel adequate provision for projecting its activities outside the walls of the clinic into the remote nooks and crannies of the community.

—Charles W. Waddell, "Some Phases of the Conduct of a Venereal Disease Clinic" (1931)

As I stated above, my central concern is the construction of medical *treatment*, by which I mean a set of procedures and practices by and through which a new kind of subject—the modern patient—originated. In this chapter, I concentrate on treatment; the constitution of the subject is reserved for Chapter 4. Section 2.1 provides an analysis of the spatial organization of the new institution—the vd clinic—assigned with the task of taking care of the vd victims around and after WWI. I will be taking clues from Foucault's analysis of the Panopticon in *Discipline and Punish*, his notion of the clinic as a social relationship rather than a place, and his idea of the medical "gaze" (introduced earlier in *The Birth of the Clinic*). In 2.2, I outline the ideal treatment at the vd clinic—that is, I try to reconstruct what the successful treatment at the clinic *should* look like. Foucault suggests that discipline works by means of adjustments to a norm, but he is well aware of the fact that the norm does not pre-exist the mundane process of adjustments and improvements. He makes it perfectly clear that the norm is articulated during the very

process of its implementation. However, for clarity's sake, I shall present the disciplinary ideal and the actual practice of treatment in separate sections, 2.2 and 2.3, respectively.

I shall begin by questioning assumptions shared by many students of social medicine in general, and the early twentieth-century vd epidemic in particular. The first assumption is best illustrated by Allan Brandt—the most prominent social student of vd—who argues that the anti-vd campaigns failed to eradicate vd because the organizers of these campaigns approached syphilis and gonorrhea as a moral not medical problem. In other words, middle-class morality was responsible for misguided efforts—such as the incarceration of prostitutes, the advocacy of physical exercise for recruits as a safe channeling of the sex drive, etc.—and the lack of public funds for the treatment of syphilitic patients. I will argue, however, that no amount of funds could have possibly helped stamp out vd, when the whole administrative and organizational structure of clinical medicine—especially the *techniques* such as record-keeping and follow-up—was not yet in place. Put simply, Brandt underestimates the difficulty with which these techniques had to be devised—and then implemented. Yet this underestimation is understandable: the techniques in question seem almost natural to us nowadays. The second assumption is best illustrated by David Armstrong, the author of the modern classic on the origins of socially oriented health care, who painstakingly studied the devices by which the clinic reached out into the social world. Despite his allegedly Foucauldian depiction of these practices, he introduces them as readily available tools of a demonic disciplinary gaze, intent upon taking control over the patients' bodies. In my view, it is much more realistic—as well as closer to Foucault's objectives—to bring a good measure of confusion, muddle and uncertainty into the picture, in order to dispel the false notion of an underlying intentionality.

2.1 Architecture of the Clinic

In Part Three, Chapter 3, of *Discipline and Punish*, "Panopticism," Foucault suggests that we understand Jeremy Bentham's plan for an ideal prison as the model of modern power. In order to appreciate the novelty of Bentham's design, let us first examine the space of the premodern carceral building. The Classical prison structure served for incarceration or detention of those awaiting trial or execution, or for putting pressure on debtors. Architectural critic Paul Hirst describes two different types of premodern prison structures, one imaginary, another actual.¹⁰⁴ The former example can be seen in the famous cycle of etchings, the *Carceri*, by the visionary eighteenth-century artist Gian Battista Piranesi. The *Carceri* depicts a monumental labyrinth of dungeons, bridges, balustrades and scattered instruments of torture with no apparent plan. The tiny figures of prisoners that can be seen here and there must be intimidated by the sheer magnitude of the structure, which is an ostentatious expression of the arbitrary power of the sovereign. In *Discipline and Punish*, Foucault identifies the scaffold as the proper site for *supplice*—that paradigm of punishment in the Classical Age, whose public nature was necessitated by the character of Classical power. As power was incorporated by the sovereign, every crime was ultimately an affront to his body; accordingly, the penalty for such an affront must have been accompanied by a spectacle of sovereign power, in order to show that order was restored. It is true that the space of Piranesi's prisons is not the public space of the scaffold but, as Hirst persuasively argues, one should see such a space as a punitive theatre equivalent to the scaffold since, due to their vastness, they admit the spectator as a voyeur.

Hirst's second example is the actual design of 1763 of the Newgate Gaol by architect George Dancy. This is an example of the custodial prison in which inmates

¹⁰⁴ See P. Hirst, "Foucault and Architecture," *Architectural Association Files*, no. 26 (1994), repr. in *Michel Foucault: Critical Arguments 4*, ed. B. Smart (London and New York: Routledge, 1995): 350-71.

were isolated neither from one another nor from the outside world (they could purchase food and receive visitors). The internal design did not make any provisions for an easy isolation and inspection of inmates. If it had any functional design, this type of prison exhibited it on the outside rather than the inside. Newgate Gaol had a massive ornamental façade, which was intended to impress and intimidate passers-by. The façade should be readily identifiable as an inescapable place of detention prior to execution—i.e., as a temporary stop on the way to the scaffold.

Newgate Gaol immediately precedes Bentham's proposal for the Panopticon, but the two designs belong to two entirely different—to use Foucault's idiom—"epistemic regimes." A "philosophical radical," who strove to fashion public policy along the lines of his utilitarian system, Bentham proposes that the Panopticon be a circular structure, empty on the inside—except for an inspection tower at the center—whose peripheric wall is divided into individual cells built in such a way that each extends the whole width of the wall, with a window at the outside as well as the inside. As light enters through the outside windows on the circumference of the Panopticon, so that each cell is backlit, the guardian stationed at the inspection tower is able to observe the happenings in each cell without being himself seen. Moreover, he need not even be on duty at all times; inmates have no way of knowing whether or not they are being inspected, yet they must at any given moment assume that they are. In addition to their ignorance of whether or not they are supervised at any particular moment, inmates are also unable to communicate with each other. Hence, the guardian is not confronted by an undifferentiated crowd, but rather by separate individuals that can be described, supervised—and *reformed*. However, the major effect of this design, according to Foucault, is to make possible "the automatic functioning of power."¹⁰⁵ The Panopticon need not display any ornaments of power—either on the inside, like Piranesi's carceral

¹⁰⁵ *Discipline and Punish*, 201.

labyrinths, or on the outside, like Dancy's custodial prison. Betham's Panopticon is thus the first example of a perfectly functional structure. Indeed, his architectural design so perfects the operation of power that its exercise is actually unnecessary, or—which comes to the same thing—that the objects of power submit to it without any actual external pressure. Hence “the Panopticon must not be understood as a dream building;” rather, “it is the diagram of a mechanism of power reduced to its ideal form,” which may be used “whenever one is dealing with a multiplicity of individuals on whom a task or a particular form of behaviour must be imposed.”¹⁰⁶

The principle of Panopticism thus extends over irregular behavior in general, in which the objective is discipline rather than a subjection to sovereignty. Examples of the influence of Panopticism include prison reform, education reform, the treatment of the insane, the supervision of industrial workers—and the treatment of the patients, including those afflicted with vd. In an article published in a 1923 issue of *The Modern Hospital*, Michael M. Davis, in his day a well-known social reformer and hospital administrator, complains about the design of the traditional dispensary and makes suggestions for improvement. The spatial organization of the Old Dispensary—the kind of facility that was being built in the eastern states of the US since the 1800s—was inscribed in its very name: “dispensary” was literally a place where medicine was being dispensed to patients, most of them poor. Accordingly, one should imagine a building with “many large rooms in which patients sat around. The doctor went from one to another, or more frequently called them to his desk, gave them a look over and a prescription.”¹⁰⁷ There was hardly any examination in the Old Dispensary, no files on individual patients, and no privacy. Also, visits were usually limited to just one (i.e., there were no return visits). Yet it would be anachronistic to think of this Old Dispensary as

¹⁰⁶ Ibid., 205

¹⁰⁷ M. M. Davis, “General Principles in Planning Dispensaries,” *MH* 20 (March 1923), 224.

failing in its surveillance function. The truth is that it did not have any such function, because it was not a kind of facility colonized by disciplinary power yet. To a nineteenth-century mind, dispensaries were quite adequate to their task of assisting the sick poor by dispensing medicine to them, which did not imply any surveillance of their lives. The anachronism is actually implied in Davis's comment on the alleged failures of the traditional dispensaries. Davis can complain about these failures only because he ascribes to the dispensaries the purpose, which they acquired only at the turn of the twentieth century, of maintaining public health by means of efficient diagnosis and treatment. The New Dispensary belongs to a different *dispositif*, or apparatus, if you will.

It must be admitted that until the rapid advancements of medical science in the last decades of the nineteenth century, doctors could not do much more for their patients than to provide comfort and support, relieve the pain, and reduce symptoms of a disease. Also, until the end of the nineteenth century, dispensaries were established in structures independent of hospitals. However, by the late 1800s, hospitals ceased to be just repositories for the poor and started to be transformed into technological centers for complex procedures, especially surgeries, and so they began to become attractive even for middle-class patients. This had caused a boom in hospital building in the United States, which lasted since the final decades of the nineteenth century until the 1920s.¹⁰⁸ As successful surgeries became the source of enormous income for hospitals, dispensaries also started to change. Since they could not afford increasingly expensive diagnostic equipment, autonomous dispensaries were being closed down and the new ones were established, by the early twentieth century, as outpatient departments of

¹⁰⁸ To be more exact, hospitals began to emerge in the US in significant numbers only after the Civil War. For a concise overview of various aspects of hospitalization in the late nineteenth-century Boston, see Morris J. Vogel, "Patrons, Practitioners, and Patients: The Voluntary Hospital in Mid-Victorian Boston," *Sickness and Health in America: Readings in the History of Medicine and Public Health*, 3rd Ed., ed. Judith Walzer Leavitt and Ronald L. Numbers (Madison, Wis.: The University of Wisconsin Press, 1997): 323-33. Cf. Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century* (New York: Basic Books, 1989), chap. 2.

hospitals providing free care for low-income patients who could not afford to pay for the services of a private physician. In the first outpatient departments, the same space was initially used for different services at different times—say, prenatal service in the early afternoon, tuberculosis service in the evening. The hours in which these particular medical services were provided were what the term “clinic” originally referred to. Later on, when the undifferentiated space of outpatient departments was partitioned into separate sub-departments, the term “clinic” assumed its contemporary spatial, rather than temporal, reference.¹⁰⁹

Efficient diagnosis and treatment, for those who could not afford a private physician, is what M. M. Davis had in mind when he urged that modern treatment must involve “individual attention to each patient.”¹¹⁰ And such individual attention could be realized precisely only in an efficiently structured space. Hence, the outpatient departments that replaced dispensaries must incorporate, in Davis’ view, new architectural principles:

- (a) In large out-patient departments special waiting rooms for each clinic or group of related clinics (unless corridors are so located in relation to the examining rooms that patients can wait on chairs or benches there without crowding).
- (b) Small examining rooms or booths for history taking, physical examination, etc., in such departments as medicine, neurology, pediatrics, gynecology, etc. and cubicles for such special work such as ophthalmology or laryngology; each unit just large enough for one patient and doctor with the necessary assistants.

The principle of individualization of patients also requires the rooms to be so planned that an executive assistant can control the intake and outgo of a considerable group of patients from a single point. This means saving a large amount of doctor’s time from non-medical duties for medical work... A single

¹⁰⁹ For the history of the American hospital care, see esp. Stevens, *In Sickness and Wealth*; cf. *Idem*, *American Medicine and the Public Interest* (New Haven and London: Yale University Press, 1971), and C. E. Rosenberg, *The Care of Strangers: The Rise of America’s Hospital System* (New York: Basic Books, 1987).

¹¹⁰ Davis, “General Principles,” 224.

clinic executive may be sufficient for several departments or subdepartments which have medical independence of one another, but are put in conjunction as administrative units. *Entrances and exits from and to corridors or waiting rooms and dark space for the clinic executive must be planned accordingly.*¹¹¹

The new vd clinic—let us call it the “New Clinic,” for short—as imagined by reformists such as Davis, clearly does not exactly follow the overt spatial organization of Bentham’s ideal prison. Unlike the Panopticon, with the site of supervising authority at the center of a building, the modern vd clinic is supposed to have an entrance room with reception desk at the front, so that every incoming patient must pass by it. Inside, we have a row of cubicles for individual meetings between a patient and a doctor, who can swiftly pass from one cubicle to another. Despite these dissimilarities, dictated by the different purposes of the prison and the vd clinic, we can see that the latter, as much as the former, is an example of the Panoptic architecture. It is a type of fully functional architecture, which pursues a certain political strategy, whose chief principle is facilitating a certain form of power—the kind of power that is not itself visible or ostentatious—rather than an aesthetic or a style. M. M. Davis points out quite explicitly that a disregard for sufficient supervision was the main drawback of the design of traditional dispensaries and hospitals. “Perhaps the most common error in existing dispensaries [...] is failure to provide sufficient administrative space. Not infrequently, the area assigned to individual department, medical, surgical, orthopedic, etc. will be

¹¹¹ *Ibid.*, 225 (my italics). Davis urges a re-organization of the space of the clinic, in order to improve the efficiency of treatment at the moment when the advancement in medical technology made it possible, in many of his other publications. In a 1926 article, he writes that “[m]edical work with patients should be complete, and its various branches should be coordinated, both in diagnosis and treatment. With the growing variety and complexity of medical resources and medical service, these two points of completeness and coordination have become essential both to efficient medical practices by physicians as individuals and to efficient medical practice in institutions.” Accordingly, he recommends to “plan space and arrangements so as to individualize the patient, avoiding mass action,” and to “plan space and arrangements so as to invite and facilitate cooperative work among clinical departments, their coordination with one another and with the laboratory, educational, therapeutic and administrative activities.” (M. M. Davis, “Planning Buildings for Out-Patient Service: General Principles,” *MH* 26 (March 1926), 221-2.)

found reasonably sufficient, whereas the space near the front door for the admission and reception of patients, for waiting room, and for the care and distribution of records will be entirely inadequate."¹¹² The urgent tone of Davis' *plaidoyer* for the reception desk may sound misplaced if not laughable to the contemporary reader. But we should discern in this urgency a reminder of the recentness of the spatial and political arrangement which we are inclined to accept as natural and a matter of course, and thus presumably devoid of any political implications whatsoever. Yet marginal texts such as Davis' bear a testimony to the fact that the institutions of modern medical care, to which we may not even be able to contemplate an alternative, incorporate a desire to take care of patients as much to control them—or, rather, they incorporate a desire for control, as long as control is, in modern times, exercised increasingly by means of care. Once again, Davis expresses this modern notion of discipline by means of care in the following passage:

An idea is gradually permeating the minds of those who plan dispensaries that much time can be saved by doctors, much saved in administration, and a great gain in efficiency be brought about if the clinic rooms of a given department, are so planned as to bring the patients in from the waiting room through a single entrance and out again, so that *a complete control can be kept of intake and outgo; so that patients can be distributed by a secretary or "clinic executive" to the physicians in order, on time, with their records, and the doctor be assisted by being relieved of administrative functions.*¹¹³

Davis' ideas for the New Clinic give us a sense of a gap between the ideal and an actual practice that existed, and of the efforts that must have been involved in filling in the gap. Yet the ideal of the New Clinic was, unlike the Panopticon, pretty much achieved. What is, then, the point of comparing the ideas for the New Clinic with Bentham's design of the Panopticon, which has never been built as planned? In other words, can we hope to learn anything about the investment of power in the modern clinic

¹¹² M. M. Davis, "Some Common Mistakes in Planning Dispensaries, *MH* 19 (March 1922), 490.

¹¹³ *Ibid.*, 19, 491 (my italics).

by likening it to the Panopticon, which is a purely imaginary architecture? Interestingly enough, Foucault himself answers a similar objection to his claim, in *Discipline and Punish*, that the nature of modern power could be gleaned from Bentham's Panopticon: How could one learn about modern power from a utopian architecture? "If I had wanted to describe 'real life' in the prisons," counters Foucault, "I indeed wouldn't have gone to Bentham. But the fact that this real life isn't the same thing as the theoreticians' schemes doesn't entail that these schemes are therefore utopian, imaginary, and so on. One could only think this if one had a very impoverished notion of the real."¹¹⁴ Foucault goes on to point out that ideal schemes are connected with a real search for effective penal mechanisms, and they "crystallize into institutions," "inform individual behavior," and "act as grids for the perception and evaluation of things."¹¹⁵ The most important point is that ideal designs such as the Panopticon set the mark by which to judge practice; they became operative in practice. As Foucault puts it,

¹¹⁴ Foucault, "Questions of Method," *Power*, 232.

¹¹⁵ *Ibid.* In *Discipline and Punish*, Foucault provides real-life examples from the history of prison reform, in order to establish the complexity of the search for a perfect prison. The Panopticon did not remain a mere utopian dream, since many modern prison buildings did pursue the goals of efficient inspection and individual reformation by means of isolation. In connection with the requirement of isolation, Foucault mentions the debate on two American systems of imprisonment—the Auburn Prison in New York, and the Philadelphia Prison. The Auburn system implemented the combination of solitary confinement with silent work in company of other inmates. The advantage of this system, according to its designers, was that its workshops were "the microcosm of perfect society in which individuals are isolated in moral existence, but in which they come together in a strict hierarchical framework," thus preparing inmates for their return to society at large. The creators of the Philadelphia system favored combining solitary confinement with isolated work. Here the expectation was that total isolation will effect an internal self-transformation, and thus rehabilitation: "It is not, therefore, an external respect for the law or fear of punishment alone that will act upon the convict but the workings of the conscience itself." Foucault acknowledges that there were all sorts of religious, economic and architectural differences between the two proposals; yet they shared, in his view, a fundamental assumption of Panopticism: "at the heart of the debate, and making it possible, was this primary objective of carceral action: coercive individualization, by the termination of any relation that is not supervised by authority or arranged according to hierarchy" (*Discipline and Punish*, pp. 238-239). As Dreyfus and Rabinow aptly note, both models of subjection described by Foucault presuppose the disciplinary model of power: "The project itself was not a topic of dispute. It was the unquestioned acceptance of hierarchical, coercive individualization which made possible a wide range of techniques of implementation" (Dreyfus and Rabinow, *Michel Foucault*, 197). (For an illuminating history of modern prisons in America and Italy, see Dario Melossi and Massimo Pavarini, *The Prison and the Factory: Origins of the Penitentiary*, trans. Glynis Cousin (Totowa, NJ: Barnes and Noble, 1981.)

[i]t is absolutely true that criminals stubbornly resisted the new disciplinary mechanism in the prison; it is absolutely correct that the actual functioning of the prisons, in the inherited buildings where they were established and with the governors and guards who administered them, was a witches' brew compared to the beautiful Benthamite machine. But if the prisons were seen to have failed, if criminals were perceived as incorrigible, and a whole new criminal "race" emerged into the field of vision of public opinion and "justice," if the resistance of the prisoners and the pattern of recidivism took the forms we know they did, it's precisely because this type of programming didn't just remain a utopia in the heads of a few contrivers.¹¹⁶

Hence, the critics who dismiss the plan for the Panopticon as a useful source of information about modern power mistakenly ascribe to Foucault an idealist notion that political ideas are effective directly and without any resistance and struggle. The real point of Foucault's genealogical procedure, however, is to trace the transformations of a practice precisely through the mire of micro-struggles and unforeseen—and unforeseeable—interventions.

Foucault's view of the relations between the ideal design and an actual practice applies to the history of the clinic as well. On the one hand, Davis reports in 1926 that of the "some 3,500 clinics that have been established in this country during the last twenty years, a large majority have been located in converted quarters."¹¹⁷ Things hardly ever went as planned. I will have an opportunity to describe the obstacles and unforeseen difficulties on the road towards the ideal of the New Clinic in the pages ahead. On the other hand, the success of rebuilding the undifferentiated area of the original dispensary into the individualized and inspected space of the new clinic should not be underestimated. Sometimes this "rebuilding" can be understood quite literally. As I explained in Chapter 1, Foucault acknowledges that prisons and hospitals predate Modernity; for him, the onset of a new era is not necessarily marked by the emergence

¹¹⁶ Foucault, "Questions of Method," 232-3.

¹¹⁷ Davis, "Planning Buildings for Out-Patient Service," 219.

of new structures, but rather by the “colonization” of the old, inadequate structures by a new power. Yet this colonization could and did in time lead to an actual spatial restructuring. Margaret L. Plumley of the United Hospital Fund of New York, provides this update on “Advances in Out-Patient Service” in 1925: “Types of construction varied from the announcement of institution in Philadelphia that it had just completed a five-story laboratory and out-patient building, to the statement of a small hospital in Colorado that *it had obtained more space by dividing two large rooms turned over to them for out-patient use into four medium-sized ones.*”¹¹⁸ These are minor interventions, but this is exactly how disciplinary power works. A brochure entitled *How Laymen Cut Medical Costs*, published in 1948 by the Public Health Institute of Chicago, a non-profit venereal disease clinic, proudly reports that during the past 27 years of its existence, it gave “5,973,801 examinations and treatments to 359,496 individual patients or better than 10% of [Chicago’s] *entire population*!”¹¹⁹ This treatment was provided in “private treatment booths, each open at the back to permit physicians to pass rapidly from one case to another, [thus making] long waits for attention a rarity.”¹²⁰ This is a description of an ideal treatment turned real; let us not forget, however, that treatment was supposed to represent only one phase, or aspect, of the clinical process (as we shall see next).

2.2 Rites of Passage: The Norm

Foucault describes the modern penitentiary as “an exhaustive disciplinary apparatus,” meaning that “it must assume responsibility for all aspects of the individual, his physical training, his aptitude to work, his everyday conduct, his moral attitude, his

¹¹⁸ Margaret Lovell Plumley. “Advances in Out-Patient Service.” *MH* 25 (Sept. 1925), 248 (emphasis added).

¹¹⁹ *How Laymen Cut Medical Costs* (Chicago: Public Health Institute, 1948), 3.

¹²⁰ *Ibid.*, 10.

state of mind."¹²¹ Precisely because of its reach into all aspects of the life of inmates, he calls the prison "omni-disciplinary;" because of its uninterrupted action on the individual, "unceasing;" and because of its almost total power over the prisoners, "despotic."¹²² "It carries to their greatest intensity all the procedures to be found in the other disciplinary mechanisms." These other mechanisms include the monastic cell, the workshop, and the hospital, since modern prison is based on the idea of character reform through isolation; socialization by compulsory labor; and cure by adjusting the length and intensity of penalty to the rehabilitation accomplished. Thus, "the carceral apparatus has recourse to three great schemata: the politico-moral schema of individual isolation and hierarchy; the economic model of force applied to compulsory work; the technico-medical model of cure and normalization."¹²³

According to Foucault's proposal, then, we should see the prison as a total institution, where disciplinary power has no obstacle in reaching the bodies of prisoners. The clinical hospital is presumably limited in this respect, because it can access only the sick. Yet I would like to argue that the vd clinic in the early twentieth century was also developing into a kind of all-encompassing disciplinary institution, although it could never have reached the intensity with which power operated inside the prison. I do not, of course, mean that the vd clinic came to resemble the prison as a confining institution. As I pointed out in Chapter 1, Section 1.2, modern medical institutions—primarily the research hospital—were less, rather than more, enclosing than old hospitals in which the sick and the poor were dumped indiscriminately. But then again, confinement is not the essential feature of the modern prison either: more than anything, it is a place for a complete remodeling of the delinquent by means of the techniques of disciplinary power. I propose that we look at the vd clinic in this way, too. There is a lot to be said in favor of

¹²¹ *Discipline and Punish*, 235.

¹²² *Ibid.*, 236.

¹²³ *Ibid.*, 248.

David Armstrong's thesis in his book, *The Political Anatomy of the Body*, which discusses the emergence of what he calls the "new dispensary" in the early decades of the twentieth century in the United Kingdom. According to Armstrong, whereas the old-fashioned outpatient department and dispensary had access only to the individual patients who entered them on their own will, the new dispensary reached out, through monitoring the networks of patients' contacts and relationships and through careful recording of this information, to the "spaces between people."¹²⁴ As Armstrong documents, the new dispensary emanated out of tuberculosis and VD campaigns.

When trying to conceptualize this spatial feature of the New Dispensary, it is useful to notice that Foucault deals, in *Discipline and Punish*, with two configurations of disciplinary power. There is, on the one hand, what we might call "institutional" disciplinary power, whose incorporation in the Panopticon I have already analyzed; on the other hand, there is what might be called "community" disciplinary power. Foucault sees the latter incorporated in two responses to disease: the "exile enclosure" and the "plague."¹²⁵ Exile enclosure requires that the diseased be isolated from the healthy. Arguably, the Old Dispensary of the eighteenth and nineteenth centuries should be understood in terms of this model of community power. Consider the eighteenth-century handling of the leper, as described by Foucault: "The leper was caught up in a practice

¹²⁴ Armstrong writes (in *The Political Anatomy of the Body*, 8):

Traditional hospital medicine, which had emerged at the end of the eighteenth century, had defined illness in terms of specific pathological lesions located within the confines of the body and the medical gaze aimed to observe the map—through signs and symptoms—the course of the disease within the space of the body.

The new gaze, however, identified disease in the spaces between people, in the interstices of relationship, in the social body itself. In this new conceptualisation pathology was not an essentially static phenomenon to be localised to a specific point, but was seen to travel throughout the social body, appearing only intermittently.

¹²⁵ See *Discipline and Punish*, 197-8. I take the terminology of the "institutional" and "community" disciplinary power from a book by Sarah Nettleton, *Power, Pain and Dentistry* (Buckingham, UK: Open University Press, 1992), 116-7. I also credit Nettleton for applying Foucault's distinction between the "exile enclosure" and the "plague" in the field of the sociology of health and illness (in Nettleton's case, the sociology of dentistry).

of rejection, of exile-enclosure; he was let to his doom in a mass among which it was useless to differentiate."¹²⁶ The New Dispensary incorporated the model of "plague," in that it involved a complex segmentation and surveillance of the plague stricken community: "those sick of the plague were caught up in a meticulous tactical partitioning in which individual differentiations were the constricting effects of a power that multiplied, articulated and subdivided itself."¹²⁷ Foucault adds that there was a definite political vision implied in the plague style of managing disease; that of "the penetration of regulation into even the smallest details of everyday life through the mediation of the complete hierarchy that assured the capillary functioning of power."¹²⁸ The image of the plague-stricken town under surveillance—"this is the utopia of the perfectly governed city."¹²⁹

In my view, the community response to disease along the lines of plague management was operative not only in the early twentieth-century British New Dispensary, but also in the parallel developments in the US: in the campaigns to eradicate TB and syphilis, and in the TB and vd clinics. The widened horizon of the new type of clinics and dispensaries did not go unnoticed by contemporary observers.¹³⁰ For example, Michael M. Davis wrote in 1917:

But with the growth of medical science, in power to prevent wholly or largely in number of diseases, a new point of view has arisen, which now dominates all progressive public health work. This point of view is not the passive attitude of the old dispensaries or of the old public health departments. The modern public health department does not merely wait until complaints come to it; it feels

¹²⁶ *Discipline and Punish*, 198.

¹²⁷ Loc. cit.

¹²⁸ Loc. cit.

¹²⁹ Loc. cit.

¹³⁰ When these contemporary commentators say—and when I repeat after them—that the clinic reached the "whole community," it is important to remember that this term refers only to those individuals and groups who were eligible for medical care at the dispensary and/or the outpatient department. The chief function of the outpatient department and its clinics, and of the dispensary, was to provide medical care to those who could not afford paid service from the private practitioner—to those who were, in the idiom of the period, "medically destitute."

responsibility of being an active factor in the community. So the tuberculosis dispensary starts in a neighborhood as part of an aggressive attempt to find all the cases of tuberculosis that it can and to cure and prevent all that it can. [...] Good medical service, accurate diagnosis, effective treatment—these are the foundation of all work in dispensary, and the basis of its usefulness as a public health factor. Hasty examinations of patients, loose prescribing, inadequate follow-up, are fatal to the realization of the dispensary's service in either cure or prevention.¹³¹

A decade or so later, Charles Waddell, a medical director of a vd clinic in Fairmont, West Virginia, made a similar comment about the expansion of the domain of the clinic from the examination and treatment room into a larger community in a passage which I used as a motto to this chapter:

Any public health clinic, no matter how efficiently conducted, only scratches the surface of its potential usefulness unless it includes in its organization and personnel adequate provision for projecting its activities outside the walls of the clinic building into the remote nooks and crannies of the community. Too diligent efforts in the clinic itself to determine sources of infection are capable of defeating their object and must be employed discreetly. Much could be done along this line by a social worker or nurse trained in follow-up work.¹³²

Waddell's remark on the "nooks and crannies" of a community which should be reached by the clinic as it is "projecting its activities outside [its] walls" is striking in the way it echoes Foucault's description of the political dream implied by the plague, that of "the penetration of regulation into even the smallest details of everyday life." Waddell captures the character of power typical of the New Clinic: diffuse but productive, modest but persistent. Here it is important to remember that the picture of a perfectly policed community was admittedly utopian. Yet it is equally important to remember what

¹³¹ Michael M. Davis, "The Dispensary as a Factor in Public Health Work," *MH* 9 (Oct. 1917), 269.

¹³² Charles W. Waddell, "Some Phases of the Conduct of a Venereal Disease Clinic," *JSH* 17 (1931), 330. Cf. Ida M. Cannon, "Relation of Hospital Social Service to the Successful Treatment of Gonorrhoea and Syphilis," *MH* (1918), 202: "The hospital of today is a social institution."

Foucault means by "utopia." He means a model which, though never fully realized, is nevertheless unceasingly effective in countless minute ways.

According to Foucault, modern disciplinary power works by segmentation, or "distribution." Disorderly dispersed individuals must be distributed so that they are best accessible for discipline. Foucault lists several techniques by which this is achieved: (a) enclosure, (b) partitioning, (c) the creation of functional sites, and (d) ranking, or the creation of hierarchies. For the present purposes, I single out (b) and (c) for special notice. By means of *partitioning*, unruly collectivities are broken up into basic units and each individual is assigned to its proper place. "Disciplinary space," says Foucault, "tends to be divided into as many sections as there are bodies or elements to be distributed."¹³³ Moreover, some places not only serve a need for supervision and breaking up collectivities into manageable units, but become *functional sites*. Foucault's example of such a site is the hospital, in particular the naval hospital at Rochefort:

A port, a military port is—with its circulation of goods, men signed up willingly or by force, sailors embarking and disembarking, diseases and epidemics—a place of desertion, smuggling, contagion: it is a crossroads for dangerous mixtures, a meeting-place for forbidden circulations. The naval hospital must therefore treat, but in order to do this it must be a filter, a mechanism that pins down and partitions; it must provide a hold over this whole mobile, swarming mass, by dissipating the confusion of illegality and evil. The medical supervision of diseases and contagions is inseparable from a whole series of controls: the military control over deserters, fiscal control over commodities, administrative control over remedies, rations, disappearances, cures, deaths, simulations. Hence the need to distribute and partition off space in a rigorous manner.¹³⁴

Foucault claims that techniques of medical observation were made possible by a prior implementation of economic supervision (a safe storage of medicines, developing a patient file system, a separation of different kinds of patients, etc.). He observes:

¹³³ *Discipline and Punish*, 143.

¹³⁴ *Ibid.*, 144.

"Gradually, an administrative and political space was articulated upon a therapeutic space; it tended to individualize bodies, diseases, symptoms, lives and deaths; it constituted a real table of juxtaposed and carefully distinct singularities. Out of discipline, a medically useful space was born."¹³⁵ Following Foucault's lead, I propose to approach the vd clinic as a segmented space, in which utmost care is taken to examine and treat the individual patient most efficiently. I see the clinic as segmented into five functional stages or sites. At the *Entrance* (1), the patient's socio-economic standing is determined. If eligible for dispensary treatment, the patient then proceeds to have her *Physical Examination* (2) done. Next step is the actual *Treatment* (3). Then she receives an *Education* (4) about the nature of vd. Finally, there is an elaborate *Follow-Up* (5) system, by means of which the clinics attempt to contain the epidemic by keeping patients under treatment. A word of caution is necessary at this point. I am *not* suggesting that this functional organization should be understood as somehow immediately leaping into existence so as to satisfy the requirements of disciplinary power. Such a proposal would involve a gross simplification of the real, petty history of the establishment of the system of treatment as we know it.¹³⁶ I am presenting the functional organization of the clinic in an ideal, perfected form—which it may have never reached in practice—only to facilitate exposition. Foucault, as I mentioned above, believes that discipline operates by adjusting an unruly reality to a norm, so in the rest of this section, I am offering what emerged from countless discussions, sectional fights, trials and dead-end attempts as a disciplinary ideal. I will provide illustrations of some of the endless trials and dead-end experiments in the following section. But in the interim, let us follow a typical patient *en route* through the ideal, well-functioning New Clinic:

¹³⁵ Loc. cit.

¹³⁶ Although something approaching such a gross simplification can unfortunately be found even in the works of some self-professed Foucauldians—see my criticisms in Chapter 1, Section 2.2.

2.2.1 *Admission*. In the Old Dispensary, whose sole purpose was the distribution of medicines, the coming and going of patients was completely undifferentiated. In contradistinction to that, the very process of admission is highly structured in the New Clinic. At the American Hospital Association Convention at Atlantic City in 1926, the Committee on Dispensary Development drew a lot of attention with their chart depicting "The Trail the Patient Travels to the Clinic Room," which consisted of as many as twelve separate steps.¹³⁷ Each of them is described in detail in a paper by Dr. John R. Howard, Superintendent of New York Nursery and Child's Hospital, and Janet M. Geister, a nurse:

- I. Patient enters the building.
- II. He is directed along his way (revisit patients diverted at this point).
- III. Medical eligibility and placement determined.
- IV. Patient's identification items taken (name, address, etc.).
- V. Patient "cleared" with card index to check against previous registration.
- VI. Identification and other non-medical items entered on new history sheet.
- VII. Social and economic eligibility and fee rate determined.
- VIII. Patient receives admission card.
- IX. Patient pays admission fee (revisit patient rejoins line here).
- X. Given clinic ticket numbered according to arrival.
- XI. Sent to clinic waiting room.
- XII. Called by name or number into clinic room.¹³⁸

At each step, we see a partitioning of the mass of patients coming to the clinic: new patients are separated from revisit patients, the social status and the financial ability of new patients is determined through a thorough questioning and an examination of

¹³⁷ Committee on Dispensary Development, "Following the patient through the clinic," *MH* 27 (Nov. 1926), 125.

¹³⁸ John R. Howard and Janet M. Geister, "Admission Systems for Dispensaries," *MH* 24 (Feb. 1925), 162-163.

habits, clothes and manners by an experienced social worker, information is entered in history sheet, etc. All this sounds excruciatingly banal, but this is only because many such transactions between the patient and the medical staff are by now well entrenched. During our exchange with a receptionist at a contemporary well-organized clinic, we do not usually reflect on the arbitrariness of the way such encounters are structured and organized. Speaking of "arbitrariness" here, I do not mean that there is *no reason whatsoever* why the handling of patients is structured one way rather than another; what I mean is that the current practices had alternatives that might have won instead. In other words, the current practice of hospital admissions is not "natural" (and, by the same token, not necessarily the best one).¹³⁹ Reading of the reports of early social workers reveals how the control of the patients—making sure that they are eligible—was predicated on the practical employment of the methods of social science. One could see in this a concrete instance of that symbiosis of political and epistemic concerns, which Foucault calls power/knowledge.¹⁴⁰

¹³⁹ To appreciate the sense of arbitrariness I am urging, see the following passage from Howard and Geister's sequel to their report on admission systems. The passage interestingly reveals how the role of admitting officer was filled:

The question of how medical distribution shall occur, whether by a lay registrar, an admitting physician who sees all new cases, or through general medical (or diagnostic) clinic, was submitted to the committee of the medical section. The reply stated: "The committee is of the opinion that it does not consider the admitting physician an absolute essential to effective admissions' work. It is desirable at least to have as admitting officer a fully trained nurse with social service training, or a trained social worker with medical experience." (Howard and Geister, "Admission System for Dispensaries: Part II," *MH* 24 [March 1925], 276.)

¹⁴⁰ In this connection, consider the following passage from a report by Miriam Lincoln, a social worker who calls for a social science education for admissions officers at the clinics:

The difference in the spirit back of the work is manifest to anyone who has worked in an institution where admitting is done by medical social workers instead of nurses as was formerly the practice. It stands to reason that the nurse, carefully trained in the art of bedside care, sterilizing of instruments and operating room technique, even with district practice, is less well equipped for this work of admitting than is the trained medical social worker with her theoretical background of social science received through college and graduate study, enhanced by the practical experience of intimate acquaintance with poor people in their homes. She is constantly in touch with employment conditions and thoroughly familiar with the community's social resources for the care of the

The crucial objective of the admission process was supposed to be the financial examination of the patient. The vd clinics, whether those affiliated with hospitals or those run by the Department of Health, were meant to accommodate lower-class patients, who could not afford treatment at a private office. Miriam Lincoln, the registrar at Amherst H. Wilder Dispensary in St. Paul, Minnesota gives some insight into a range of factors an admissions clerk was supposed to look at in order to correctly tell an eligible prospective patient from a "dispensary shopper," who merely intends to abuse charity:

Poverty and illness, resulting in the need of dispensary medical care, are so entangled with far-reaching social conditions—unemployment, immigration, racial standards and customs, illiteracy and a dozen other factors, that in order to judge fairly whether a given individual should be allowed charity medical care, many matters must be considered. The individual's age and the number of persons dependent on him, his trade, with its "off seasons" and "on seasons," its strikes and their effect, these all have a bearing on his ability to pay for medical care. What are his standards of living? Is he "down-and-outer," perfectly willing to ask for help or is neatly dressed, of proud bearing but at his last stand, so proud that the mere fact that he asks for help means he needs it? What is his nationality? Does he belong to a racial group that dresses up for the doctor or dresses down? Does he own an automobile or a home? What are the implications of his physical condition? Is it chronic or acute and therefore temporary?¹⁴¹

poor. *She is able to see beyond the mere individual applying for care to the problem of community welfare.* (Lincoln, "Differentiating Between Worthy Poor and Dispensary Shoppers," *MH* 31 [Dec 1928], 80; my emphasis.)

¹⁴¹ Lincoln, "Differentiating Between Worthy Poor," 79-80. Notice how detailed a knowledge of the socio-economic standing of the vd patients the admissions officer had to acquire:

The admitting officer must know the city and the types of homes in the different sections, and must be familiar with the current wage scale. A woman who says her husband is a milkman and makes twenty-five dollars a week will be suspected of falsehood if one knows the wages paid. Milkmen get about \$35 a week. (*Ibid.*, 83.)

The fact that all these socio-economic data become relevant for the health care of citizenry confirms the point argued by Armstrong and other followers of the British School that medicine in the twentieth century enters a social phase—that it permeates the space in-between people. As I indicated above, I agree with this observation. Yet I would urge that the material such as the report by nurse Miriam Lincoln should lead us to carefully distinguish Armstrong's thesis about the social medicine from the questionable claim about medicalization. Documents such as Lincoln's article reveal, I think, that the staff of the vd clinic were not, by collecting data about the economic status of their patients,

Lest there be any misunderstanding as to the factual tenor of Lincoln's remarks here, let me reemphasize that they are meant to have a *normative* force—to set an example to be followed by social workers in other clinics. (The editors of *The Modern Hospital* annually sent to outpatient departments a questionnaire concerning the performance of the various clinics, which also included a question as to which topic the readership wanted addressed in the journal. The method of determining the financial eligibility of patients—the topic of Lincoln's article—was one of the most popular requests.) As can be seen from the range of questions suggested by Lincoln, the admissions clerk should be able to compile a fairly complete socio-economic profile of the clinic's patients. Ideally, the clinic should have access to information on patients' income, rent, savings and debt; it should update its files on the status of its patients in regular intervals; and should perhaps contact even the patients' employers to verify the reported data. Miriam Lincoln says that at her dispensary, "[e]ach person is asked about previous medical care and any person who has been treated by a private physician within a year is not admitted until his doctor has been consulted."¹⁴² The doctor would have to recommend his former patient for a dispensary treatment. The consultation with the doctor was to ascertain whether the patient had either depleted her financial resources, or was already treated free of charge anyway (so that the transfer of the patient to the clinic would amount to no more than a substitution of one form of charity by another). Other authors note, however, that ineligible patients do not necessarily try to intentionally deceive the admissions officer. In many cases, dispensary abuse was due to a mistaken notion that

intentionally seeking control over their patients' lives. Rather, the clinics were forced to do this by circumstances—the shortage of funds, etc.—and the disciplinary effect was achieved independently of the intentions of the participants in the practice in question. This, I take it, is just one instance which exposes the redundancy of an intentional subject behind events, postulated by the proponents of the medicalization thesis.

¹⁴² *Ibid.*, 82.

the clinic is for everybody, or that only there one can find specialists, or that letting oneself be studied by a physician is a substitute for payment.¹⁴³

2.2.2 Physical Examination. Once eligible, the patient either paid a fee or moved directly over to the waiting room. Ideally, the patient would not wait long, because the clinic would have an appointment system enabling it to process a large number of cases. Nurse Janet Thornton reports, in her 1924 article, that the first clinic in the U.S. to adopt an appointment system similar to those familiar from private offices was the children's clinic of the New Haven Dispensary, in October 1921. Similar experiments were undertaken shortly thereafter by the clinic at Cornell University, the outpatient Department of the Presbyterian Hospital in New York, and the John Hopkins Children's Hospital in Boston. As a result, "more patients may be cared for by the same staff in the same rooms, during the same hours. Thus, in one institution, there were about 1,000 more visits and 250 more new patients a month accommodated after the appointment system became established."¹⁴⁴ Also ideally, separate clinics would be held for men and for women. So, after a brief waiting time, individual patients would be invited to private booths for examination and treatment.

Each patient would first be interviewed about her medical history and undertake a thorough physical examination. The examination would be not merely genital because syphilis is by nature a systemic disease, which means that it affects, especially in later

¹⁴³ Cf. Julian Funt, "Throttling Charity Abuse. A Practical Way to Weed Out the Financially Able," *ME* (Aug. 1936): 51-52. As for payment methods, different methods were being recommended or experimented with at different clinics. At the Genito-Urinary Department of the Brooklyn Hospital Dispensary in 1915, "[t]he afternoon service is free, except for fees of ten cents per visit, but for the evening service a charge of one dollar per visit is made, covering both treatment and medicine" (Alec N. Thomson et al., "The Genito-Urinary Department of the Brooklyn Hospital Dispensary," *JSH* 2 [1915-16], 93). At the Lakeside Hospital Dispensary in Cleveland in 1917, a charge is made of "\$5 for a dose of Salvarsan. Whenever, in the social worker's opinion, this should be given free, no charge is made. In other cases the price is adjusted to the patient's pocketbook, by either receiving payments on the installment plan, or with the doctor's sanction, allowing the exchange three days' labor in the hospital workshops for his medicine" (Marguerite Tupper, "Dispensary Treatment for VD, The Lakeside Hospital, Cleveland," *MH* 8 [Mar. 1917], 224).

¹⁴⁴ Thornton, Janet, "Clinic Service by Appointment," *MH* 22 (June 1924), 598.

stages, various organs of the body, in ways that are not immediately apparent. The goal of the designers of the clinic was to provide medical services comparable to the standards of private care—that means, individualized care. For this, a thorough examination that would determine the overall condition of the patient was necessary. If the patient had a lesion, the so-called “dark-field examination” would be applied, involving an examination of a sample of a lesion secretion against a dark background under a microscope. Using this test, a skilled physician could determine immediately whether or not the lesion contained the bacteria that caused syphilis (gonococci, too, were detectable through a microscope). If no lesion were present—as was often the case with secondary syphilitics—the doctor would draw a blood sample and send it to a lab for analysis. The first conclusive serologic test for syphilis—the so-called “Wassermann” test, named after its inventor, the German immunologist August Wassermann—had become available in 1906.¹⁴⁵

It was imperative that the patient’s medical history and the results of his or her physical examination be on file during the entire period of treatment. Crucially, the very possibility of speaking of the progression of cure was predicated on the availability of data about the patient’s condition throughout the development of the disease. A 1930 report from the Peter Bent Brigham Hospital at Boston says that “[r]ecords of individual patients are being improved gradually. Just how complete they should be is open to discussion. All essential positive findings and all important negative findings should be

¹⁴⁵ A year before the Wassermann test was introduced, German science made another breakthrough by the discovery of the causal agent of syphilis in the bacterium *Spirochaeta pallidum* (a.k.a. *Triponema pallidum*), by Schaudinn and Hoffmann. The gonococcus was discovered by another German, Neisser, already in 1879. As I mention below, the first effective cure for syphilis, Salvarsan, was discovered by still another German in 1909. These facts testify to a relative backwardness of the American medical science in the early 1900s. However, the best-educated American doctors welcomed the new scientific advances with enthusiasm. The modern diagnostics and treatment of syphilis and gonorrhea were popularized in the US in the books such as J. H. Stokes, *Modern Clinical Syphilology* (Philadelphia and London: N. p., 1926) and P. S. Pelouze, *Gonorrhea in the Male and Female: A Book for Practitioners* (Philadelphia: N. p., 1928). Cf. Brandt, *No Magic Bullet*, 40.

recorded. Social service records, the important data, at least, should be combined in some way with the medical and surgical out-patient department cards."¹⁴⁶ Social service records included the information on a patient's socio-economic status, and the quoted passage suggests that the information was kept separate from the medical information. This, it must be noted, made the social service records virtually useless, as they could not be consulted either by the doctor or a nurse during the patient's visit. We can thus see that as relatively late as 1930, the problem of how to store in a manageable format all the necessary information about vd patients who were expected to return to the clinic many times had not been solved. "The readmission of patients after long intervals of time is another difficult feature of record keeping, since it necessitates the perpetual handling of each history as a unit in some form that is inexpensive, strongly bound and so planned that new pages may be inserted easily."¹⁴⁷ I suggest that the author of this passage begins to articulate an ancestral form of the file which records medical history that we see handled by a receptionist or nurse when we go to see a doctor at a contemporary clinic.

2.2.3 *Treatment.* Upon completion of the physical examination, which determined the presence of a disease or its developmental stage, the doctor would proceed with a treatment. The first efficient cure of syphilis became available only in 1909.¹⁴⁸ That

¹⁴⁶Peter B. Brigham. "Problems That Clinics Have Solved and Those They Still Face." *MH* 34 (Feb. 1930), 132.

¹⁴⁷ Loc. cit.

¹⁴⁸ There was no efficient treatment for gonorrhea until the discovery of penicillin, which is why I mainly concentrate on the techniques of treating syphilis. For a history of early modern attempts at treating vd, see the collection *The Secret Malady: Venereal Disease in Eighteenth-Century Britain and France*, ed. Linda E. Merians (Lexington: The University Press of Kentucky, 1996). The studies in this collection reveal that early modern treatment dealt with vd only *ex post*, and even then only in those individual patients who expressed interest in being cured. This does not mean that vd was not a serious problem, or that there did not emerge, in the early centers of bourgeois culture such as London, a flourishing industry of vd treatment. Rather, the point is that vd was not an object of policies—it was placed firmly within the sphere of private life, outside the reach of unsystematic and erratic sovereign power. The most widely used treatment of syphilis consisted in extensive applications of mercury solutions, with horrific side effects, including death. Although it sounds shocking, mercury was still used by some physicians as late as the 1930s.

year, in the midst of experiments with assisting natural immunologic responses of the body to disease, immunologist Paul Ehrlich came upon arsenic compound which, when injected to syphilitic patients, caused a rapid disappearance of symptoms of the disease. The drug, Salvarsan (also known as arsphenamine), became the first efficient cure for syphilis. Although a tremendous improvement over the draconian mercury treatment, Salvarsan was initially also highly toxic. Moreover, the mercury treatment was not completely abandoned until the introduction of penicillin: intramuscular shots of mercury or of less toxic bismuth were applied in combination with Salvarsan.¹⁴⁹ However, in 1912 Ehrlich offered a somewhat less toxic, albeit also somewhat less effective drug which became known as Neosalvarsan. Toxic or not, the treatment by Salvarsan or Neosalvarsan had an additional difficulty: it heavily tested patients' perseverance, as the treatment normally took at least a year. The length of treatment would be determined by the stage of a patient's disease at the time of her visit at the clinic. Most patients hesitated to visit the clinic until they found themselves in the secondary stage of syphilis with more visible lesions, which required a longer treatment. Only the minority of patients in the primary stage would attend, either because they first tried quacks and druggists, or because their lesion temporarily went away and the problem thus seemingly disappeared.

A 1934 report, "Standard Treatment Procedure in Early Syphilis," co-authored by the leading authorities on syphilis of the time such as Dr. John Stokes and Dr. Thomas Parran, gives a clear idea of the aims and the nature of the treatment at that time. According to the authors of the report, the syphilis clinic is in the business of treating patients in the early stages of syphilis, as these "proved beyond question to be amenable to a considerable degree of routinism, standardization and mass technique, the principles of

¹⁴⁹ For a discussion of the early reception of Salvarsan in the US, see Patricia Spain Ward, "The American Reception of Salvarsan," *Journal of the History of Medicine and Allied Sciences* 36 (1981): 44-62.

which have so wide a degree of applicability that they can be formulated into definite rules and systems for all but universal use."¹⁵⁰ In contrast, treatment of the patients in the late (tertiary) stages of syphilis requires an individual approach, which makes standardization hard to achieve. As for the aims of treatment, in early syphilis it is, first, prevention of transmission and, second, complete cure. With late syphilis, the aim should be a more modest preventive and symptomatically curative treatment, since complete cure is probably impossible.¹⁵¹ Stokes and his colleagues further propose a set of "principles governing the control of infectiousness." I find the following ones the most significant:

5. Infectiousness is controlled and syphilis will be extinguished, if ever, as a health problem, by treatment of the infectious person.
6. The public health responsibility of the physician is therefore with the early months and years of the disease.
7. Treatment to control infectiousness must be with the arsphenamines. No other drug will do.
9. Treatment to control infectiousness must be continuous, not intermittent, and last at least eighteen months. Rest periods encourage relapse.
13. The amount of arsphenamine required is not less than twenty injections. The critical point is between 5 and 9.

¹⁵⁰ John H. Stokes et al., "Standard Treatment Procedure in Early Syphilis. A Résumé of Modern Principles," *JAMA* 102 (Apr. 1934), 1267. It is important to note that the suggestion that the clinics should treat merely the cases of primary syphilis was addressed only to the publicly—federal or state—funded clinics, not the outpatient departments in privately owned hospitals. By arguing that the publicly funded clinic should limit itself to fighting the epidemic, public health officials like Parran hoped to convince private physicians represented by the American Medical Association that publicly funded clinics would not steal from them the lucrative business of treating syphilis. For more discussion of the conflict between public health and the AMA, see Chapter 3.

¹⁵¹ Parran further elaborates on the question of who should be treated at the publicly funded vd clinics in his important 1937 lecture at Atlantic City. He singles out three categories of eligible patients: "1. Any patient for diagnosis and emergency treatment if infectious. 2. Any patient referred by a private physician either for treatment or for an examination, consultation and return to private care. 3. All other patients who are unable to pay private physicians" (Thomas Parran, "Control of Syphilis," *JAMA* 105 [Jul., 1937], 206). This precise definition is based on the same principle that was stated already in the 1934 Stokes *et al.* article: the task of the clinics is battling an epidemic undermining public health, rather than the treatment of every patient.

20. The great promoter and source of relapse is the *short arsphenamine course* (one to four injections) unsupported by other treatment.¹⁵²

These “principles” bring home the sense of *effort* that was expected from the vd patient, and they make vivid what a *nuisance* this kind of treatment must have felt to him. I will discuss the significance of these features of vd treatment in the next section. Moreover, Stokes et al. make it clear that “[t]here are no available criteria of ‘cure’ at this time,” although one might speak of “satisfactory result” after “the patient has been followed for two years or more and [...] during one probationary year he has had no symptoms of syphilis, examination of his blood has been consistently negative, and he has had a negative spinal fluid examination and a negative physical examination or has had a reinfection.”¹⁵³

Let me now make a slightly revisionary move. I propose to extend the reference of the term “treatment” so as to include not only the treatment in a narrow sense—i.e., the weekly shots of Salvarsan and bismuth—but also such activities as the instruction of the patient about the nature of vd and the practices of follow-up. In other words, I would like to include under the category “treatment” all the activities that emerged through the trial-and-error process of fighting syphilis by the clinic. Now someone might object: The outline of this chapter given above promised a picture of the ideal clinic to be followed by a description of its real-world failings. The inclusion of sections on “patient’s education” and “follow-up,” however, contravenes this outline, since emphasis on education and follow-up emerged only as a reaction to the clinic’s failures. I reply: It is true that concerns with the patient’s education and follow-up appeared only in reaction to the clinic’s inefficiency. Yet it is still possible to distinguish between the patient’s education

¹⁵² *Ibid.*, 1268 (emphasis in the original).

¹⁵³ *Loc. cit.*

and follow-up system as they were supposed to work, on the one hand, and as they really did—or did not—work in reality, on the other hand.

2.2.4 *Patient's Education.* Hereby we leave the space of the clinic proper and enter the surrounding social realm, which the clinic—in correspondence with the dream of perfect surveillance of a plague-infested community—sought to penetrate and transform. Soon after the introduction of Salvarsan, the surveys of the efficiency of the vd clinics demonstrated that, due to the bothersome length and unpleasantness of treatment, patients tended to drop out after a few visits.¹⁵⁴ The tendency to discontinue treatment was supported by the character of syphilis, with its two latency periods in which lesions disappear—which an insufficiently informed patient was prone to misinterpret as a restoration of health. The first, short latency period begins with the disappearance of the primary syphilis lesion; the second latency period follows after the flair-up of the secondary lesions. The second latency period is the beginning of the tertiary syphilis, which often enough leads to death. Whether or not a patient did eventually die of the effects of the tertiary syphilis in a particular case, the disease was no more infectious at this phase. This was crucial from the point of view of public health, which targeted only the syphilitics in the primary stage, when they were still infectious. As early as 1919, Dr. H. E. Kleinschmidt writes that “[t]he venereal disease clinic is established primarily as a public health measure in an attempt to gain control of carriers,

¹⁵⁴ A concern with the patient's education can be traced back to 1911, when Michael M. Davis conducted the first efficiency study at the vd clinic of the Boston Dispensary. The idea of efficiency studies caught on and by 1914 the results of several such studies were published in various periodicals. The findings were shocking to administrators, physicians, investigators and reformers alike. In particular, it was astonishing news to physicians, who volunteered their time and tried to help as many patients as possible, that patients received on average only two treatments (see Alec Thompson, "It Pays to 'Follow Up'," *MH* 16 (1922), 80). It was a no less shocking news to doctors in one clinic that during a year they discharged only two patients as cured, while the rest of their patients dropped out (see Philip Platt, "The Efficiency of Venereal Clinics. Suggested Remedies for Present Defects," *JAPH* 6 [1916]: 953-958).

thereby curbing the spread of disease; and not merely to relieve the suffering and distress of individual patients, commendable as that objective may be."¹⁵⁵

Therefore, in order to prevent patients from discontinuing the treatment and thus thwarting the efforts of the vd clinic, doctors and social workers realized early that they must educate the patient about the cunning nature of syphilis, and about the danger they still pose to society. In this connection one must understand the urgency of a plea by Dr. William F. Snow, General Secretary of the American Social Hygiene Association, in a 1916 lecture: "Clinic patients should receive full instruction concerning the nature of their diseases and methods of protecting others with whom they associate. The opportunity for this service is commensurate with the time and attention the staff may devote to it."¹⁵⁶ Social worker Kathryn Loughrey urges the shared responsibilities of physician and social worker in educating the patient in a 1937 paper:

The responsibility for informing patients as to the nature of their diagnosis and the importance of regularity in treatment is that of the physician in the first instance. It then becomes the duty of the medical social worker to see that patients thoroughly understand the instructions given them by the physician. [...] Patients should also be given a clear understanding of the diagnosis in relation to family and society.¹⁵⁷

Accordingly, the vd clinic was to be not only a place of health restoration, but also a place of enlightenment. The walls of the waiting room were to be covered with posters, and leaflets should be available. Since a large proportion of the clinic's patients were recent immigrants, the personnel was to be able to communicate with the patients in

¹⁵⁵ H. E. Kleinschmidt, "The Treatment of the Venereal Disease Patient," *SH* 5 (1919), 533. For a similar statement of the purpose of the vd clinic as a public health institution, cf. the above cited Stokes *et al.*, "Standard Treatment Procedure in Early Syphilis," 1267 *et passim*.

¹⁵⁶ William F. Snow, "Clinics for Venereal Diseases—Why We Need Them—How to Develop Them, II," *MH* 11 (1916), 54. For another call to put emphasis on the patients' education, see Alec Thomson, "The Elements of Social 'Follow-Up'," *MH* 16 (1921), 284.

¹⁵⁷ Kathryn A. Loughrey, "Medical Social Service in Syphilis Clinics," *JSH* 23, (1937), 264. For similar views, cf. Ruth E. Lewis, "Contribution of Social Service to the Medical Control of the Venereal Diseases," *JSH* 16, (1930), esp. 275-277.

their native languages, or at least offer printed materials in those languages.¹⁵⁸ These humble, piecemeal moves to accommodate and reform the unruly patient can hardly be underestimated. In my view, they testify both to the recentness of that creature of today that we find quite natural—namely, the self-disciplined and health-conscious patient—and to the ad hoc and inadvertent nature of the means by which this creature was created. (On the constitution of the patient, see Section 4.1 of Chapter 4.)

2.2.5 *Follow-Up*. Originally, the term “follow-up” referred to a long-term observation of post-surgical patients who received a yearly note inquiring about their health condition. The practice emerged in hospitals with the advance of medical science and technology since the late nineteenth century, which made them the centers for complex surgical procedures.¹⁵⁹ Later follow-up procedures became associated with the treatment of long-term illnesses, in particular syphilis. The follow-up system was a technique for keeping patients under treatment, as they tended to drop out of the lengthy and disagreeable procedure as soon as symptoms disappeared, while they might still have been infectious or sick. The follow-up system was conducted in the form of written or printed notes that were sent to the patients' home when they missed a scheduled appointment at the clinic. In some cases, the social worker made a home visit after the clinic received no response to the third note or when the postal office returned the notes.

¹⁵⁸ Cf. *ibid.* A 1920 report on the St. Louis vd clinic includes an admiring passage on the advantages of posters providing essential information on the nature and prevention of syphilis and gonorrhea. We should understand such passages as a reminder of the recentness of the minute disciplinary techniques that are integral parts of our lives nowadays, and that we thus easily overlook.

One of the outstanding features of this clinic is the placard wall exhibit displayed in the waiting rooms for men and women. These placards describe and illustrate gonorrhea and syphilis. They explain why treatment is necessary, why it takes time to cure, and how, if an adequate course of treatment is followed, the disabling complications can be prevented. It is believed that this method of placard display saves the staff much time in answering questions and also acts as an important factor in impressing upon the patients the necessity of continuing under observation until pronounced cured by the doctor. (VD/H, “St. Louis VD Clinic,” *MH* 14 [Feb. 1920], 152.)

¹⁵⁹ Ora M. Lewis, “The Phagocytosis of Follow-Up,” *MH* 25 (Oct. 1925), 329-32.

However, the follow-up became possible only after the invention of the so-called *cross-index card*, which recorded all the patients of a clinic with a given disease—syphilis, for example. Only with the introduction of the cross-index card was it possible to find out which patients were supposed to return.¹⁶⁰

Historical sources suggest that the first rudimentary follow-up system was introduced at the Genito-Urinary Department of the Brooklyn Hospital Dispensary in 1912, "at which time, handwritten notes by the doctors on the dispensary prescription blanks were sent to special cases."¹⁶¹ The Department introduced printed forms in 1914 and extended the follow-up system to all delinquent patients. In a 1915 report on the system employed by the Brooklyn Dispensary, we read:

In order to keep control of cases until they are no longer a menace to the community we feel that something must be done to regain our control if the patient ceases attendance before being discharged as cured. To do this in the usual manner of social service work is obviously difficult. Personal visitation is not practical unless under the direction of unusually qualified and tactful persons. In addition it is expensive. The use of a card, requesting a return visit, is simple, of modest cost, and in our experience, efficient.¹⁶²

¹⁶⁰ We can trace the invention of the patient's record, to be pulled out of a filing cabinet, to these early years of the new vd clinic. As Dr. Philip S. Platt reports in 1913, in a study of twenty-seven genito-urinary clinics:

The difficulty generally lay in the filing system. As a rule, a case-history card, filled out at the first visit and sent to the central file of the dispensary remains there in unbroken rest until the patient himself returns to claim it and put it in the physicians hands. If the patient at any time ceases to come, no one is the wiser. In such a filing system, by far most common, is hidden alike the fruitful and the barren work of the clinic. The remedy is exceedingly simple. A cross-index by diseases would change a great sarcophagus of records into a vitally important, active file. In a mere handful of cards, representing the possible diagnosis of a dispensary, the filing number of every patient's history card would be found according to diagnosis. A clinic chief could then ask the dispensary registrar to send him his gonorrheal, or his scoliosis, or his adenoid cases for any desired period, and in a short time a complete analysis of his work could be had. (Platt, "The Efficiency of Venereal Clinics," *JAPH* 6 (1916), 954).

¹⁶¹ Henry A. Fisher, "A Study of the Value of a Follow-Up System in a Syphilitic Clinic," *JSH* 10 (1924), 476.

¹⁶² Thomson *et al.*, "The Genito-Urinary Department of the Brooklyn Hospital Dispensary," *SH* 2 (1915-1916), 97. Another successful early follow-up system is reported in 1917 from the Lakeside Hospital Dispensary in Cleveland:

In 1917, the New York Public Department of Health adopted the so-called Regulation 7 regarding the standards for syphilis clinics, which was part of the New York City Sanitary Code. In the text of the Regulation we read an injunction that “[a] follow-up system approved by the Department of Health, to secure regular attendance by patients shall be established and maintained.” Interestingly, the VD clinic at the Brooklyn Hospital Dispensary was also chosen, in the early 1920s, for a two-year study which was to determine the value of the follow-up system for syphilis clinics and the guiding principles they should all adopt.¹⁶³ The study confirmed the efficiency of the follow-up system and made additional recommendations. Two of them are notable. Recommendation no. II states that “all patients who are neither discharged nor transferred shall, at each visit, be assigned a *definite date for return* and be instructed in the importance of continued treatment,” whereas no. III implores that “*records of the date of the expected return visits be*

In 1914 the social service department began systematically to record and to follow up every case of lues attending dermatological clinic. Within eight months the staff of clinicians was doubled and the clinic was opened six days instead of three. A social worker is now stationed in the clinic, to whom every luetic patient must report with his chart after he has received his treatment. She then checks up the patient's visit and tells him when to return [...] Dr. Cole, who is in charge of the clinic, tries to send every case of primary or fresh secondary lues to the City Hospital for at least two weeks' treatment. [...] Within twenty-four hours the social worker checks with the City Hospital upon these admissions. If the patient has not been admitted, a home call is made immediately and admission secured either through further persuasion or, that failing, through the efforts of the commissioner of health. The policy of the health department in these cases is to send a sanitary police officer, who threatens to placard the patient's door with a venereal disease poster. The City Hospital reports back to us the discharge of every luetic case which we have referred to them.

If after eight days' absence from the clinic the patient has not reported, a dispensary postal is mailed, asking him to return by a certain date. [...] If three postals fail to get a response, a home call is made. If repeated calls fail, the case is referred to the health department for the attention of the sanitary police. [...] Besides following the cases already referred to this clinic, the social worker sees that all patients having a positive or doubtful Wassermann reaction return to the dispensary. (Tupper, “Dispensary Treatment for VD,” 223-224.)

¹⁶³ “How Follow-Up Aids in Maintaining an Effective Syphilis Clinic,” *MH* 27 (1927), 122, 124.

maintained."¹⁶⁴ I find these recommendations highly significant, since no. II implies, in effect, that until quite recently a practice which we find so natural today, namely setting a definite date for a return visit, simply did not exist. No. III, in its turn, implies that it did not occur to anyone prior to 1924, that doctors should take a note on the return visits of individual patients!

2.3 Rites of Passage: Failures and Adjustments

In the rest of this chapter, let me attempt something like a genealogy of the "descent" of the clinic. With the benefit of hindsight, one might be tempted to construe the history of modern vd treatment as a process of an ever more efficient care of bodies by means of modern medicine. One might tend to believe that only moralistic prejudice or class bias could temporarily hinder this triumphant development. Such construals, however, inadvertently posit continuity and intentionality where a closer look would reveal accidents, irregularity, unexpected petty obstacles, and ad hoc solutions. By exposing conflicting views, confusions as well as sheer ignorance as to what would constitute an efficient treatment of vd, I mean to uncover the "lowly origins" of our contemporary practices.

Let us revisit, now, each of the steps of a passage through the clinic that I described in an ideal or finished form, in their real-life messy complexity.

2.3.1 Admission. Although the desirable state of affairs for the admission to the clinic was—as I showed above—a well-organized, social research-based examination procedure of the social status of the prospective patient that was to guarantee that only the eligible, i.e., poor, people were admitted, this was far from reality. Some clinics implemented this step and followed the guidelines closely; others only redundantly and awkwardly; still others failed to organize their admissions process due to lack of

¹⁶⁴ *Ibid.*, 124; emphases added.

administrative or financial resources; finally, in some clinics the staff simply did not care. Teaching hospitals were most reluctant to conduct financial investigation, because they were interested in drawing as many patients with as great a variety of diseases and symptoms for teaching purposes as possible. In some places, particular steps of the admissions process were implemented, but not others. For instance, some clinics might contact private physicians diligently, but others would not do it at all.¹⁶⁵ A good example of a delinquent case is a report of 1932 of the Social Hygiene Clinic in San Francisco, which reveals that “[n]o adequate investigation is made of the economic status of patients, and it is not really known how many are treated free who might be referred to private physicians.”¹⁶⁶ Fairly typical is a complaint about poorly trained and ignorant social workers and nurses at the clinics: “Non-medical social workers and some public health nurses are astonishingly and sadly ignorant of the prevention, treatment and cure of syphilis. So much so that frequently [...] they have antagonized doctors and lost for their clients possibilities for treatment which should have been available.”¹⁶⁷ (This complaint is relevant to other sections below as well, since the alleged incompetence of social workers and nurses affected admission procedures no less than the education of patients and the follow-up procedures.)

Now I think the evidence of slowly and sloppily implemented admission procedures poses a problem for any variety of the medicalization thesis. The defenders of this thesis claim that the members of the medical profession—as representatives of

¹⁶⁵ For an example of the clinics that contacted private physicians, see Waddell, “Some Phases of the Conduct,” 331.

¹⁶⁶ William F. Snow and Walter Clarke, “Medical Aspects of Social Hygiene in San Francisco,” *JSH* 18 (1932), 258. The article further details the results of a study of the economic status of 244 of the clinic’s current patients: “Of all women registered (111) 41 percent were ‘prostitutes.’ Of all women 68 percent were ‘low income,’ and 32 percent ‘high income.’ In the high wage group 94 percent were prostitutes and 6 percent were not. Of the total prostitutes, 73 percent were high and 23 percent were low wage groups. Of 133 men, 100 percent were in low wage group. These figures suggest that it is the prostitutes in the high wage group who pay a very large proportion of the cost of operating the clinic” (ibid., 258-9).

¹⁶⁷ King, Edith S., “Relations and Duties of Public Health Nurses and Social Workers in the Diagnosis, Treatment, and Control of Syphilis,” *JSH* 8 (1922), 364.

the dominant class, according to Marxists, or the dominant sex, according to feminists—have always sought more control, extending their power by systematically medicalizing ever larger parts of their patients' lives. As I pointed out in Chapter 1, one sometimes finds this argument even in the writings of adherents of the British School.¹⁶⁸ The basic assumption of all these approaches is that of an underlying intentionality, of a subject that chooses the most efficient means to achieve the desired end: power. However, it seems that an examination of the actual workings of the vd clinics demonstrates the absence of such a centered intentionality. As we saw, the admission procedures at the clinics were ideally supposed to let in only eligible patients. And as we shall see in Chapter 3, this requirement was itself the result of a conflict of interests between public health and the medical profession, where the former wanted to stop the epidemic, whereas the latter desired to keep as many paying patients as possible. The members of the medical profession thus tried to limit, rather than extend, the grip of power of the vd clinic over the patients. Consequently, the intentions of the medical profession were quite the opposite of those ascribed to them by the proponents of the medicalization thesis. However, if the clinics ended up treating even ineligible patients, this was due to the fact that the methods that should have kept the solvent patients out of the clinics were undeveloped or poorly implemented. The intentions of public health officials, perhaps under pressure from the American Medical Association, were to limit the access to the clinics. If more people eventually had access to free or cheap treatment at the clinics, this was—paradoxically enough—an unintended consequence of the poor admission procedure.

2.3.2 *Physical Examination.* In order to appreciate the impact of the appointment system known to us today, it is important to remind ourselves of the early days of the vd clinic. The clinic would just open its doors at a given hour, soon whereupon it was

¹⁶⁸ See the quote from Deborah Lupton's book on p. 33 above.

mobbed by a crowd of patients. Sitting or standing, patients would spend long hours surrounded by walls covered with posters warning against the dangers of syphilis and urging the necessity of prolonged treatment. Often enough, some patients would have to leave without treatment because physicians were either unable to take care of everybody during the clinic hours, or did not arrive on time.¹⁶⁹

In the corresponding analysis of the ideal physical examination above, I also pointed out the importance of a thorough medical examination and of proper records for the overall success of treatment. Firstly, being a systemic disease, syphilis potentially caused a variety of disorders. A patient who might check into a hospital with (say) an eye condition might learn, upon an examination at the eye clinic, that the ultimate cause of her problems was syphilis in its tertiary stage. Upon her transfer to the vd clinic, however, the results of the physical at the eye clinic would not be automatically available. Secondly, due to its nature as a prolonged disease, syphilis required records that would enable the doctor to notice a progress in cure. Unfortunately, both the practice of a thorough physical examination and the central record keeping proved extremely difficult to put into practice. As for the practice of the physical, there was the whole question of inadequate space. The following quote, from Carr and Goldberg's

¹⁶⁹ "Great drawback to the success of many dispensary organization is irregular attendance and lack of punctuality on the part of the staff" (Thomson, "The Genito-Urinary Department of the Brooklyn Hospital Dispensary, *JSH* 2 [1915-1916], 91.) As late as 1937, Parran writes that
No patient who can pay a physician is willing to subject himself to the inconvenience of a crowded public clinic. This is true even of a good clinic. Very few of our clinics as yet are good clinics. More often they are treatment mills with scant individualized attention to patients. In one city recently my representative reported that 'they give more attention to the examination of the dairy cattle supplying milk to the city than they do to the syphilitic patient in their clinic.
(Parran, "Control of Syphilis," 206.)

On the other hand, I do not want to deny that a progress, in terms of appointment system, had occurred. Thus, in 1927, Minott A. Osborn of the United Hospital Fund of New York, writes that "[a]t least forty institutions [of the total of approx. 172 in New York City] have introduced into one or more departments [i.e., the outpatient departments of hospitals, some of which would be the vd clinics] an appointment system" (Osborn, "Vertical Versus Horizontal," *MH* 29 [Jul. 1927], 148). Thus, the conclusion we should make is that, if there was a progress, it was difficult and uneven.

survey of fifty-two clinics in New York, refers to treatment, but I believe it also makes vivid the sense in which a physical examination must have often seemed a luxury:

In regard to privacy of treatment, in twenty-four clinics [...] the intravenous injections were given in private rooms or behind curtains. In twenty-eight clinics intramuscular injections were given to patients singly and privately. In eighteen clinics the patients lay on a table for intravenous injections, but in only nine clinics for intramuscular injections. *In all other clinics the patient sat on a stool or chair for the intravenous, and stood upright for the intramuscular injection.*¹⁷⁰

Carr and Goldberg's actual numbers concerning the physical examination are, then, as follows: "in 7 clinics thorough physical examinations were made, in 29 they were limited. In 16 the referring departments made the examinations but the records were not transferred."¹⁷¹

As for the problems in implementing a central record system, consider a finding by nurse Margaret Plumley. In a 1925 article, she reports on the results of an annual questionnaire sent by *The Modern Hospital* to 300 hospitals and clinics, noting that only "ten institutions reported that they were using a central record system."¹⁷² A 1930 report on the Peter Bent Brigham Hospital in New York mentions that "[n]o plan, so far, suggested, however, has seemed practical enough in the detail of its working to justify a step in the direction of the single history system."¹⁷³ Finally, a 1937 study of two county clinics serving the cities of 125,000 and 55,00 inhabitants, respectively, revealed both obsolete diagnostic methods and inadequacies in record-keeping: "Since 1,200 records in one clinic and 130 in the other contained no statement concerning past history of venereal disease the number of case records that gave information on both venereal

¹⁷⁰ Carr and Goldberg, "Syphilis Clinics in New York City," 343 (emphasis added). The term "limited" means that the examinations were not thorough.

¹⁷¹ Gladys L. Carr and Jacob A. Goldberg, "Syphilis clinics in New York," *JSH* 20 (1934): 340-348.

¹⁷² Margaret Plumley, "Advances in Out-Patient Service," *MH* 25 (Sep. 1925), 248

¹⁷³ "Problem that Clinics Have Solved and Those They Still Face," *MH* 34 (Feb. 1930), 132. On the other hand, Dr. Osborn, in the article cited in the previous footnote, writes (in 1927) that "[c]entralized record systems now exist in thirty institutions [out of approx. 172 examined], about double the number found six years ago" (see Osborn, "Vertical Versus Horizontal," 148).

disease history and the serologic reports were so few that a full diagnosis was impossible on the majority of patients."¹⁷⁴ Significantly enough, the authors of this report found it necessary to urge that a thorough physical examination is an "essential of a complete diagnosis." The survey showed both clinics very much lacking in this respect:

Neither clinic supplemented its meager diagnostic findings with the facts which would have been revealed by examination. Clinic S did go as far as to provide space on its forms for a description of examination results, but the information was never recorded. Clinic L gave slight recognition to the importance of organic conditions in that its record forms contain blanks to be used for describing the state of the heart and lungs, but on only 129 records was any record made. Each of these records, with the exception of one with a notation of "aortitis," carried only an "O. K."¹⁷⁵

What do these facts suggest? I do not think that the above data supports Brandt's conclusion that the removal of moralistic prejudice against syphilis would change a lot in terms of the clinics' efficiency. Also seriously affected, I submit, is the view, propounded by the medicalization critics and some followers of the British School, which postulates a central subject of medical power out to dominate the lives of the patients. In order to control the bodies, it is necessary to keep as much information about them as possible. Yet given the above evidence of the difficulty and unevenness in the adoption of effective systems of recording the results of the physical examination—the very prerequisite of successful cure—it seems unwarranted to construe the development of modern medicine in terms of an irreversible progress towards the systematic examination and control of the bodies. We make a mistake if we interpret our present as a necessary result of the past. Such a teleological reading of

¹⁷⁴ Thomas B. McKneely and Kay Pearson, "Does This Describe Your Venereal Disease Clinic?," *JVDI* 18 (1937), 184. One gets a sense of the laxness displayed in the physical examination of vd patients from an article by Dr. Stokes who felt it necessary to urge as late of 1937 that the success of treatment is predicated on an "adequate complete physical examination, not mere listening through the shirt and tapping the knee" (Stokes, John, "Clinical Problems in Syphilis Control Today," *JAMA* [Mar. 6, 1937], 783).

¹⁷⁵ Loc. cit.

the past produces the illusion that the present was *bound* to happen. Instead, micro-histories of such a lowly phenomenon as an (in)efficient record-keeping system in the vd clinic should help remind us of the randomness of events. From our vantage point, we may see a centered subject behind appearances; yet a contemporary, witnessing the awkward implementation of efficient record-keeping methods, saw "inertia, lack of appreciation of accepted standards or fear of expense."¹⁷⁶

2.3.3 *Treatment*. Davis's description of the doctors quietly proceeding from one examination and treatment cubicle to the next was more utopian than real in most clinics. A survey of fifty-two clinics in New York City in 1932 showed that "in 19 clinics 6 to 16 patients—and even more—were crowded together waiting for or receiving treatment, observing others being treated and able to hear all that was said between doctor, technician, or nurse and other patients."¹⁷⁷ Lewinski-Corwin, in his eye-opening 1920 report on the state of vd clinics, reveals the abysmal space conditions of the clinics:

Without exception the clinics have inadequate space facilities. The clinic with the largest attendance has only one small treatment room; only two clinics have suitable places to interview patients privately. [...] Men and women are usually treated together, except in two clinics where they come on different ways. In one of the best-known clinics the overcrowding is so great that during the visit to the clinic Salvarsan injections were being administered at the same time to two patients—a man and a woman—in a small room with two tables in it.¹⁷⁸

This sort of inadequacy was not easily overcome. Shockingly, as late as 1938 one could find "the inexcusable practice of compelling patients to receive their intravenous injections in 'cafeteria style' standing up [...] The same system is often used in giving intramuscular treatment. Patients are made to pass before the operator in rows, one

¹⁷⁶ Osborn, "Vertical Versus Horizontal," 148.

¹⁷⁷ Carr and Goldberg, "Syphilis Clinics," 344.

¹⁷⁸ Lewinski-Corwin, "Venereal Disease Clinics," 339.

letting down his trousers (or pulling up her skirt), one receiving the injection and another readjusting his or her clothing after injection, all in sight of the whole line."¹⁷⁹ The lack of equipment and appropriate facilities did not mean only humiliation for the patients. It also led to slackness in examination, treatment and record taking. A noted physiologist, Joseph Earle Moore, said at a conference on VD control in 1936 that

[a] clinic undertaking to diagnose and treat syphilis should be manned by clinicians who practice competent history-taking and physical diagnosis, and who are capable of interpreting data supplied to them by the laboratory. In most syphilis clinics operated by health departments, history-taking and physical examination are hopelessly inadequate. This is an inevitable result of clinic overcrowding and of insufficient medical personnel to permit time for even most elementary study of the patient.¹⁸⁰

Last but not least, physicians and staff of the clinic were largely unsuccessful in convincing most patients to finish the treatment. As I mentioned above, prior to the discovery of penicillin, the treatment of syphilis was not only an unpleasant, but also a prolonged experience. In the corresponding section on the ideal treatment I described some of the methods devised by the social hygienists to keep patients under treatment, but the results were hardly satisfactory. Dr. John E. Ranson, Superintendent of the Central Free Dispensary at Chicago, spoke for many at a symposium on syphilis in 1917, when he complains that "[o]ne of the great shortcomings of what we have done in the past is that we have not cured the patients."¹⁸¹ Based on the records of his clinic from 1914-1915, he found that most of the patients came only once, and only a few completed the treatment. His co-symposiast, Dr. B. C. Corbus reported that he had questioned the heads of each of the twenty-seven dispensaries in Chicago as to the

¹⁷⁹ Nels Nelson and Gladys L. Crain, *Syphilis, Gonorrhoea and the Public Health* (New York: Macmillan Co., 1938), 64.

¹⁸⁰ Joseph E. Moore, "Treatment as Factor in the Control of Syphilis," *Proceedings of Conference on Venereal Disease Control Work*, 1936: 84-98.

¹⁸¹ William T. Belfield, "Symposium on Syphilis," *JAMA* (Jan. 6, 1917), 62.

number of cured patients: "One said 25 percent. I challenged the statement. In fact, only 1 or 2 percent are discharged as cured."¹⁸² There is a wealth of statistical data from the later years. A good representative is a statistic published in a 1933 issue of the *Journal of Social Hygiene*. On the basis of a comparative study of three clinics, it was found that the percentage of patients who continued treatment for a year or more was 50, 49 and 28 percent, respectively. The percentage of patients receiving forty (i.e., a half) treatments or more was 81, 43 and 15 percent, respectively. The percentage of "released" (i.e., either cured or transferred) patients was merely 2, 11 and 3 percent, respectively. Finally, the proportion of "delinquent or deserted" patients was 57, 65 and 79 percent, respectively!¹⁸³

2.3.4 *Patient's Education*. The ideal of educating each individual patient about the nature of syphilis was never achieved, mainly due to the lack of personnel. Although there seemed to be some confusion as to who exactly at the clinic should be responsible for educating the patients, there was a tendency to see this as primarily social workers' responsibility. Yet there never were enough of these social workers. In a 1922 study of the vd problem in New York City, Lesley Funkhouser, of Charity Organization Society at NYC, writes that

the chief lack in personnel is that of social worker. Two of the [55] clinics [in NYC] have no social worker and only two have more than one. It is obvious that in a venereal-disease clinic, individual attention and follow-up care is essential, and that clinics carrying from 500 to 1000 patients cannot expect to do this work successfully with only one social worker. In most of the clinics the social worker's time is so taken up with the mechanical details of record-keeping, filing,

¹⁸² Loc. cit.

¹⁸³ See Walter Clarke and Max J. Exner, "The Medical Aspects of Social Hygiene in Delaware County, Pennsylvania," *JSH* 19 (1933), 391. One piece of evidence of low expectations concerning the patients compliance is the appraisal form issued by the APHA for the purpose of evaluating municipal health work. According to this form, the desired standard was ten visits to a clinic per each new patient—when, as we remember, a minimum number of visits was forty visits (i.e., twenty shots of Salvarsan and twenty of bismuth). Cf. "A Social Hygiene Survey of New Haven," *JSH* 14 (1928), 228.

and routine office procedure, that she has no opportunity to carry out this important phase of the work.¹⁸⁴

Funkhouser urges for a division of labor between the social worker and clerical staff to enable the social worker to pay all her attention to individual patients. "It was found that the clinics whose social worker gave attention to this necessity for individual attention and follow-up showed the highest percentage of patients who continued under care until cured."¹⁸⁵ It is important to realize that the lack of social workers whose job it would be to keep files on patients and to make sure they stay under treatment was not necessarily due to, say, moralistic prejudice that would presumably deprive the clinics of necessary funding. An hypothesis that the failure of anti-*vd* campaigns is due to the prejudice against sexually transmitted diseases, deeply ingrained in bourgeois morality, is the basis, we might recall, of Brandt's *No Magic Bullet*. While I would not want to deny completely the influence of middle-class prejudice over the lack of funding for social work—or, indeed, for filing cabinets, record cards, and leaflets explaining the nature of *vd*—I wish to claim that the inefficiency in *vd* treatment was as much due to the negligence and ignorance of already accepted standards for social work. For example, the surveys of the New York dispensaries and outpatient departments reveal that their expenses for salaried personnel—nurses, clerks and medical social workers—significantly increased, as a matter of fact, throughout the 1920s.¹⁸⁶ This means that the New York outpatient departments and clinics were able to raise money independently of federal funding. There is no question that these institutions were still suffering from a lack of resources. However, one wonders what number of social workers would suffice to make the clinics finally efficient? I wish to make essentially two points. First,

¹⁸⁴ Lesley W. Funkhouser, "A Study of the Venereal Disease Problem in New York City," *JSH* 8 (1922), 314-15.

¹⁸⁵ *Ibid.*, 315.

¹⁸⁶ Osborn, "Vertical Versus Horizontal," 148.

government funding of public health could never sufficiently increase, not due to middle-class prejudice against vd but rather due to competitive pressures by the American Medical Association (see Chapter 3 for a discussion of this topic). Second, even if the funding were unlimited, it would still—all by itself—likely not solve the problem of the vd epidemic before the change in our attitude towards disease in general that was happening in the early decades of twentieth century was complete. By this change I do not mean just a change in our representation of a disease such as syphilis, but rather a shift in its positioning in the “apparatus of health.”¹⁸⁷ Let me elaborate on the particular nature of this shift in the remaining part of this section, on the follow-up system.

2.3.5 *Follow-Up*. Although as early as 1918 Michael M. Davis singles out the follow-up system as one of the six “essential requirements of efficient clinics,”¹⁸⁸ not all the clinics followed up delinquent patients. A survey of fourteen vd clinics conducted by the Public Health Committee of the New York Academy of Medicine in 1920 reads:

The Sanitary Code requires the establishment in the venereal clinics of a follow-up system for the proper control of patients under clinic care. Of the clinics under consideration, five have no follow-up system whatsoever, six use postal cards to some extent, while the assistance of the social service workers in finding cases which fail to respond to letter is invoked in only three institutions. The same workers are frequently requested to investigate the financial status of the patients, to determine whether they are entitled to free treatment. None of the clinics, with one exception, are supplied with the clerical help indispensable for the proper functioning of a clinic.¹⁸⁹

And consider a survey of fifty-two clinics in New York City in 1932: “In five clinics there was no follow up. In some clinics as many as 80 percent of patients were delinquent.”¹⁹⁰

¹⁸⁷ Cf. Foucault on the “apparatus of sexuality” in “The Confessions of the Flesh.”

¹⁸⁸ Other elements are staff; equipment; laboratory facilities; social service; coordination with the local public health authorities. See M. M. Davis, “Venereal Disease Clinics,” *MH* (Dec. 1918), 436.

¹⁸⁹ Lewinski-Corwin, “Venereal Disease Clinics,” 341.

¹⁹⁰ Carr and Goldberg, “Syphilis Clinics,” 340-348.

Of the Social Hygiene Clinic in San Francisco, we read that “[o]nly a few visits are made to patients’ homes, and little is done to seek out sources of infection, follow up delinquent patients or persuade contacts to be examined.”¹⁹¹

Sometimes, a reason for this failure to follow up on the delinquent patients seems to have been the lack of personnel. Indeed, in some clinics, there was just a clinician and a nurse.¹⁹² It is puzzling, however, why the lack of personnel should be an excuse, because follow-up is not either time-consuming or expensive technology: “Clerical labor is comparatively inexpensive and both clerical labor and postage for sending out reminders of lapsed attendance may be saved in direct proportion to the effort of the doctor and social worker to understand and instruct the patient while he is in the clinic, especially on his first visit.”¹⁹³ Another reason for the absence of follow-up might have been the failure in keeping records that are a prerequisite for follow-up. A survey of twenty-seven genito-urinary clinics in New York in 1916 revealed that as many as twenty six of them were “unable to discover that such information as the percentage of gonorrheal patients cured, the percentage ceasing treatment improved, the percentage ceasing treatment unimproved, the number of visits per patient, the number of patients coming once and never returning, indeed, even the number of patients treated per month, had ever been recorded in any of these clinics.”¹⁹⁴ Yet there were clinics where the record system was—in comparison with others—exceptional, but these clinics still failed to follow-up. In the report of a 1927 survey of the New Haven Dispensary—which was affiliated with the excellent Yale University Medical School—we read that “[t]he case record system of the New Haven Dispensary compares favorably

¹⁹¹ Snow and Clarke, “Medical Reports of Social Hygiene in San Francisco,” *JSH* 18, (1932): 245-276.

¹⁹² See Funkhouser, “A Study of the Venereal Disease Problem.”

¹⁹³ E. C. Taylor, “What Do We Mean by a Follow-Up System?,” *MH* 23 (1925), 82.

¹⁹⁴ Philip Platt, “The Efficiency of Venereal Clinics. Suggested Remedies for Present Defects,” *JAPH* 6 (1916), 954.

with that of other university clinics of similar high standing, except that lack of a diagnostic file makes it impossible to extract records on specific subjects. [The clinic fails] to meet the needs for adequate social service and follow-up of [its] cases."¹⁹⁵

Why did clinics, even if their performance was in most other respects of a relatively high standard, not follow-up? This question is puzzling given the fact that the recipes for an effective follow-up system kept reappearing in the pages of the professional journals such as *The Modern Hospital* and the *Journal of Social Hygiene* ever since modern efforts to stop the vd epidemic had begun in the 1910s. It is all the more puzzling, given the significant successes in the application of those procedures by the clinics that chose to apply them. Alec Thomson compared in 1920 two New York City clinics, one without and the other with follow-up system. After ten treatments, the former clinic lost seventy one percent of patients, whereas the latter clinic only fifty nine percent.¹⁹⁶ The most publicized success story was that of the syphilis clinic of the Brooklyn Hospital, where "[o]f the 1,028 cases treated during the first year of the study, 1922-1923, 72 percent were controlled satisfactorily."¹⁹⁷ I think I have shown clearly that the suggestion of insufficient funding does not provide an adequate answer to the question that we are dealing with here. If the clinic affiliated with the Yale University medical school had funds to maintain a record-keeping system, they should have had enough to set up a follow-up system as well. Why, then, did it still fail to do so?

To tackle this problem, I want to take up the suggestion made at the conclusion of 2.3.4. It seems incomprehensible to us now, some eighty years since the events I am describing here, that an institution established with a purpose of promoting public health could fail to implement already known methods whose beneficial effect was virtually

¹⁹⁵ "A Social Hygiene Survey of New Haven," 227-8.

¹⁹⁶ Thomson, "It Pays to Follow-Up," 80.

¹⁹⁷ M. M. Davis and Alec N. Thomson, "How Follow-Up Aids in Maintaining an Effective Syphilis Clinic," *MH* 27 (1930), 124.

guaranteed. And, in a sense, the conduct of the staff of the New Haven clinic is incomprehensible, in that we are incapable of rationalizing it. Yet this is not because their conduct was always irrational, but rather because the space of reason that we occupy now is somewhat different from the one occupied by *them*. Of course, I do not mean to posit an overall rupture between the world of 1920s and today. I do, however, believe that the early decades of the twentieth century constitute a transitional period in the development of what might be termed, after Foucault, the “apparatus of health.” It was a transitional period in the sense that the health of a population was becoming a focus of governmentality, but it still retained some of the older attitudes towards health and illness. By “attitudes,” I do not necessarily mean conscious representations of health and disease, but the place of these phenomena in a whole range of practices, institutions and knowledges. Concerning the practice of the New Haven clinic, we can, I think, say the following: although we know that the staff of this facility strove for the eradication of syphilis—let us call this a “new attitude”—they at the same time did not care about the follow up—an “old attitude.” Hence the practice expressed both a “new attitude” and an “old attitude.” I believe that this is all we can say about the attitude of the staff of this clinic. We should certainly avoid rationalizing past practices in a way that would make them more comprehensible to us. The price of such a comprehension is a loss of the sense of the randomness of events.

In this chapter, I began applying the Foucauldian approach by shifting attention from representations of *vd* to actual material practices—namely, the practices of *vd* treatment. The crucial finding is that the very spatial outlay of a new kind of institution designed to deal with the *vd* epidemic—namely, the *vd* clinic—embodied power relations. This whole problematic is invisible to those who limit themselves to the study of representations—and thus they also miss the level of analysis that would reveal the construction of the patient by the practices of treatment. But I shall not return to the

issue of construction before Chapter 4. In Chapter 3, I shall rather look at the power conflicts that characterized the implementation of the new methods of treatment.

Chapter 3: Power Networks

The idea that the State must, as the source or point of confluence of power, be invoked to account for all the apparatuses in which power is organized, does not seem to me very fruitful for history, or one might rather say that its fruitfulness has been exhausted.

—Michel Foucault, "The History of Sexuality" (1977)

It is well known that the doctors have persistently opposed every measure that has been conceived and dedicated to increasing the health and longevity of the community. We opposed the establishment of boards of health, we opposed the reporting of communicable disease, and we have opposed practically every step along the arduous course of the public health movement.

—statement by a professor of surgery
in a New York City medical school (1937)

This chapter analyzes multiple conflicts among different fractions within the health care system concerning the proper approach to the vd epidemic. I make two related contentions: First, I argue for diverting our attention from the lofty realm of ideology to that of humble everyday practices. Therefore, I am opposed to Allan Brandt's hypothesis about the influence of bourgeois ideology of sexual propriety as the main cause of the failure of anti-vd efforts in the US during the interwar period. Second, I reject the notion of the health care system as a unified agent, characterized by purposiveness, and working systematically and relentlessly at widening and deepening the scope of its power. This notion is shared by various versions of the medicalization critique. Curiously, a similar notion of power infiltrates even the works of some British Foucauldians, who misinterpret Foucault's concept of governmentality as if it signified a power possessed by a supreme agent—presumably, the government—that is applied without any friction to the bodies of citizens. The notion of power as a commodity that can be appropriated and manipulated is, however, distinctly pre-Foucauldian. Instead, I

shall try to restore Foucault's notion of power as a network of relations—which is, in any case, better suited for a description of the relations between private physicians and public health, and private physicians and their patients in the early twentieth-century history of the US health care. The two notions that I reject here—i.e., Brandt's idea of ideology as primarily responsible for the failure to stop the vd epidemic, and the medicalization critics' idea that health care is a unified subject—are related in that the second notion often involves the first. That is, institutions are claimed to be unified agents by assuming that they are animated by a shared ideology.

The chapter is organized into three sections. The first two sections prepare the ground for the key third section. In Section 3.1, I continue my criticism of Brandt's hypothesis concerning the alleged failure of the interwar campaigns against vd. While in Chapter 2 I argued that the interwar efforts did succeed, in the sense that they helped develop new methods and organization of treatment, here I maintain that American physicians, far from being in the grip of the ideology of social hygienists, were positively hostile to them. As I explain, the hostility on the part of the medical profession stemmed from their conviction that social hygienists lacked credentials requisite for making a valid contribution in the medical field. Section 3.2, I provide information about the components of the health care system left out from Chapter 2, especially private care. On the basis of statistical data about the proportions of the patients treated by private physicians and vd clinics, I try to explain the ineffectuality of private vd treatment that points to the costliness of the procedure and the incompetence of doctors, rather than to the ideological image of vd. The data about private care also provide a background for Section 3.3, in which I study tensions between private physicians—represented by the AMA—and public health with respect to the issue of the treatment of vd. Contrary to the thesis of the critics of medicalization about modern medicine as a unified subject, I contend that the American health care in the interwar period was characterized by a

multiplicity of conflicts—primarily, the conflict between the medical profession and public health. Far from there being a single medical power, presumably exercised by the members of the medical profession in a concerted effort to extend their control over the patients' bodies, the medical profession was in fact actively thwarting efforts to discipline patients by engaging in struggles with public health.

3.1 Medical Practice and Ideology

Let me remind you briefly of the central hypothesis of Allan Brandt's *No Magic Bullet*. It says that Americans failed to get rid of vd between the two world wars because medical men were in the grip of bourgeois prejudice, seeing vd as "moral disease" or "wages of sin." In short, they were unwilling to cure vd—although they were quite capable to do so—because they were convinced that the victims of syphilis and gonorrhea deserved their predicament. The proponents of this view did not mean that nothing could be done about vd. However, they held that efforts ought to be directed at the roots of this "social evil," not its consequences. Hence the emphasis on moral uplift, suppression of vice, support for bourgeois family values, etc. According to Brandt, the responsibility for this moralization of vd lays with the proponents of "social hygiene"—bourgeois philanthropists with no scientific understanding of the nature of vd—who succeeded in clouding the minds of medical professionals with their ideology. Had the minds of doctors been clear, contends Brandt, syphilis would have been successfully eradicated. He concentrates on the government-sponsored anti-vd campaigns during the two world wars, when authorities feared that the high percentage of vd-infected recruits could undermine the military capacity of the country. These efforts, Brandt contends, could have eradicated vd, had they been continued after WWI (of course, things are different in post-WWII times, when antibiotics became available). Unfortunately, the concentrated governmental sponsorship of anti-vd campaigns was

over as soon as the vital interests of the country were no longer threatened, and the moralistic ideology of vd took over again. Brandt summarizes his analysis as follows:

The war had demanded unprecedented interventions by the federal government that, it was argued during the 1920s, should properly be abandoned. In peacetime, public mores held no place for the apparently unseemly subject of venereal disease. In this respect, America had returned to the Victorian era; the conspiracy of silence regarding these diseases had been reconstituted.¹⁹⁸

I took issue with this hypothesis already in the previous chapter, when I argued that the discontinuation of federal funding for vd treatment at the close of WWI did not necessarily mean the end of endeavors to develop efficient treatment methods at the new vd clinics. I argued that, in a way, these endeavors succeeded, at least to the extent that they developed many new techniques of treatment—i.e., the techniques of interviewing, filing, and follow-up. Without these practices and techniques, physicians lacked proper tools to deal with the vd epidemic. It is, therefore, a mistake typical of the ideology critique approach, to suppose that all that was needed to get rid of vd was to remove the false consciousness of bourgeois representations of vd as a moral transgression.

I would like to move my rejection of the ideology critique approach a step further in the present section. Brandt claims that the American medical professionals were in the grip of the ideological images promoted by social hygienists, and *therefore* slow to cure vd. I argue that American physicians were in fact hostile towards, and contemptuous of, social hygienists. The responsibility for the failure to eliminate syphilis, I contend, should be attributed to the prevalence of traditional practices of treatment, which the AMA tried to defend against modern treatment methods that were better suited to eradicate vd. Contrary to Brandt's thesis, the social hygiene movement was

¹⁹⁸ Brandt, *No Magic Bullet*, 129.

often attacked in professional medical periodicals, such as the *Journal* of the AMA. These attacks went on as part of a general crusade against all manner of voluntary organizations that the medical profession considered incompetent—groups of wealthy philanthropists, municipal and state boards of health, and other subjects. Dr. Wendell C. Phillips, in his presidential address to the AMA meeting in Dallas in 1926, complains that “[n]ational, state and municipal departments of health have gradually become *powerful and controlling factors* in preventive medicine, sanitation and hygiene. Health and welfare organizations, both national and local, have also *invaded the field of preventive medicine.*”¹⁹⁹ A stronger language appears in a paper read at a public health conference in 1927: “We [physicians] are not [...] a class prone to accept without due consideration the *vaporings of every volunteer amateur Moses.*”²⁰⁰ Again: “We [physicians] have a quite natural suspicion of those lawyers, politicians, business men, preachers, and otherwise unoccupied ladies, grouped so loosely and so thoughtlessly as ‘social workers,’ who do not have basic training or understanding” of medical matters.”²⁰¹ In another statement, it is reported that the medical society of New York City reached a consensus with a local voluntary agency that “the advice and counsel of the county or local medical society must be sought before a new activity is inaugurated, in particular in regards to matters relating to the appointment and remuneration of physicians.”²⁰² That is, far from being submissive to the propositions of social hygiene initiatives, doctors insisted that these propositions go into effect only after they review and approve of them. Dr. Stanley Osborn critiques, in 1929, the “official and voluntary health agencies” for allegedly taking over the responsibilities of physicians. “The most important duty of the

¹⁹⁹ Wendell C. Phillips, “The Physician and the Patient of the Future,” *JAMA* 86: 17 (Apr. 1926), 1260 (emphases added).

²⁰⁰ Harlow Brooks, “The Physician and the Public Health,” *JAMA* 89: 1 (Jul. 1927), 11 (emphasis added).

²⁰¹ *Loc. cit.*

²⁰² Linsly R. Williams, “Relation of voluntary Health Agency to Physicians and Health Departments,” *JAMA* 89: 1 (Jul. 1927), 82.

latter two groups is to aid the physician in carrying on his work in this preventive line and not to carry out a single piece of preventive medicine that the physician can do and should do." Even

[i]f it is felt that the physicians in a community are not doing their work, it is not the duty of the department of health or voluntary agencies to assume at once the neglected activity until they have earnestly and conscientiously brought the matter to the attention of the physicians and tried to have the physicians of the community assume the burden.²⁰³

The medical profession was also fiercely opposed to the anti-vd propaganda and educational campaigns (by means of posters, pamphlets, and movies) whose aim was to acquaint the lay public with the nature, symptoms, and basic prevention of vd. Brandt generally discusses these propagandist efforts as an ideological means of stigmatizing vd as immoral and anti-social. Had doctors been left alone to carry on the business of scientific medicine, more people would have gotten cured, and more efficiently. Yet physicians rejected public education on the grounds that it constituted dishonest "advertising," forbidden by the medical code of ethics. Dr. John Lawrence points out that the demands of the public for more information about vd "are not met by the medical profession due to its code of ethics."²⁰⁴ This might endanger the medical profession's position of authority because, as a result, "questions concerning medical guidance are directed to lay organizations such as social welfare societies, life insurance companies and public health departments of cities and counties."²⁰⁵ One can recognize the signs of the medical profession's hostility towards social hygiene not only in expressions, but, curiously enough, also in silences. Thus, consider the seemingly accidental omission, in an article published in the *Journal* of the AMA, of the name of the American Social

²⁰³ Stanley H. Osborn, "The Physician's Obligation," *JAMA* 93: 17 (Oct. 1929), 1269.

²⁰⁴ John V. Lawrence, "The Part the Health Clinic Lays in Modern Medicine," *MH* 33 (Jul. 1929), 150.

²⁰⁵ Loc. cit.

Hygiene Association from the list of venerable lay organizations in the field of health care with whom the AMA had working relationships.²⁰⁶ So the medical profession was, contrary to Brandt's hypothesis, hardly overpowered by the ideology of social hygienists.

Now one could regard the hostility of the medical profession to voluntary organizations in general, and social hygiene in particular, as evidence that social hygiene was viewed by the medical profession as a serious threat to its interests. Yet that would also be a mistake. Brandt provides an innovative survey and analysis, in *No Magic Bullet*, of the imagery of the social hygiene propaganda during the two world wars—especially its association of vd with prostitution and unpatriotic attitudes.²⁰⁷ However, one should not overestimate the impact of this imagery on the day-to-day workings of medical practice, and the policies of the AMA. I am not saying that doctors rejected the ideological imagery of vd and stressed a purely scientific approach. It is undeniable that many doctors, as members of the middle class, did accept the ideological representations of vd as true, and some did refuse to treat syphilis on those grounds. At the same time, however, they did not want any outsiders to interfere in the business of health care, the least of all outsiders deemed ignorant laymen, such as many participants in the social hygiene movement were.

With respect to the social hygiene movement, one could be misled into thinking that it represented a modern conception of "social medicine" in comparison with the largely individualistic conception of medicine represented by the AMA. In stark contrast

²⁰⁶ W. W. Bauer, "The Physician's Place in the Health Program," *JAMA* 107: 7 (Aug. 1936): 485-

7. The list of organizations with whom the AMA established relations includes: the National Education Association, the General Federation of Women's Clubs, the National Congress of Parents and Teachers, the National Committee for Boys and Girls 4-H Club Work, the State and Territorial Health Officers, the United States Public Health Service, the United States Children's Bureau [...] the National Tuberculosis Association, the American Society for the Hard of Hearing, the American Society for the Control of Cancer [and] state and city health departments, schools, civic organizations, women's clubs, parent teacher associations, and other local groups too numerous to mention. (486)

²⁰⁷ See esp. chaps. II and III of *No Magic Bullet*.

to many critics of medicalization, who condemn modern medicine as overly individualistic, Foucault argues that the distinguishing mark of modern health care is its social nature—its preoccupation with the health of total population, rather than an isolated individual.²⁰⁸ Now it is true that the social hygiene movement appeared to share some of the goal of modern social medicine, in particular in its quest for regulating and disciplining the behavior of population. In contrast, the conception of medicine represented by the AMA and its membership promoted the ideal of a general practitioner, a “country doctor” whose “activities had less to do with saving of life than with relieving a patient’s pain and the mental suffering of the family.”²⁰⁹ With the development of hospital medicine in the late nineteenth century, and the progress of medical science in the early decades of the twentieth century, this conception of medicine appeared increasingly inadequate. However, as far as its scientific respectability goes, social hygiene did not represent a genuine alternative to the individualistic conception, either. The ideas of social hygiene were based more on moralistic preconceptions about the viral epidemic, than on modern epidemiology. As we shall see in Section 3.3, a genuine competitor of the concept of medicine defended in the early decades of the twentieth century by the AMA was the public health movement. The origins of the latter date back to the late nineteenth century, but it got its main impetus from the US engagement in WWI. Before I shall come to my analysis of the conflicts between the American medical profession and public health, however, I will survey the crucial data concerning the organization of American health care in the interwar period—primarily the data concerning private care—and look for the causes of

²⁰⁸ Cf. Foucault’s point in *Discipline and Punish* that modern health care is an outgrowth of the late medieval management of plagued cities, discussed in 2.2. Foucault develops this point in greater details in “The Birth of Social Medicine” (*Power*, 134-156), to which I come back in 3.3. Cf. also Armstrong’s Foucauldian conception of social medicine based on his notion of the “Dispensary gaze,” discussed at pp. 30-31 and 78 above.

²⁰⁹ Arthur E. Hertzler, *The Horse and Buggy Doctor* (New York and London: Harper & Bros., 1938), 96.

the inefficiency of private vd treatment other than ideological causes. This will be the topic of the following section.

3.2 The Character of Private Care

Chapter 2 concentrated on the vd dispensary as a special space, at which a new biomedical power grew in the form of new, gradually and *ad hoc* developing, methods of treatment. The reader might have acquired an impression that an overwhelming majority of vd patients received treatment at the new clinics. However, that was never the case. Although attendance of the clinics grew steadily—probably reaching its peak during the 1930s—the proportion of syphilitic patients at the clinics never exceeded sixty percent of the total number of syphilitic patients. Accordingly, I shall supplement, in the present section, the information from Chapter 2 by the data about other parts of the health care system, especially about private care. Most importantly, I shall compare clinic and private care in terms of cost and quality. But first, let us look at some figures concerning the scope of the vd epidemic in the early twentieth century. As the surveys were not carried out regularly, and the data collected were not necessarily processed according to a unified method, such figures are difficult to find. Mostly, we have to make do with rough estimates. Thus, Thomas Parran and Linda Usilton estimate in 1930 that “there are in the whole country 643,000 cases of syphilis and 474,000 cases of gonorrhea constantly under medical care.”²¹⁰ As for the total rates of syphilis for males and females across the US, these were estimated at 9.65 and 4.85 per thousand,

²¹⁰ Parran and Usilton, “The Extent of the Problem of Gonorrhea and Syphilis in the United States,” *JSH* 16 (1930), 33 (the survey they base their estimate upon was conducted in communities of roughly 17,000 and bigger). Elsewhere, Parran points out the fact that many cases of vd are hidden: “When syphilis is looked for at least one hidden case is found for each previously recognized” (Parran, “Control of Syphilis,” *JAMA* 109, no. 3 [1937], 205). To be sure, this fact frustrates the hopes of efficient treatment and curbing of the epidemic: “One half of known cases are not recognized or do not seek medical care during the first year of the disease when the chance of spread and the opportunity of cure are greatest [...] One in five men and three in five women coming for treatment were unaware of their disease until it was recognized in the course of some other examination” (ibid.: 205-206).

respectively.²¹¹ Parran and Usilton also assess the distribution of patients between the clinics and private practitioners: "Thirty-one percent of the cases probably are indigent patients since they are being treated at public expense in clinics, hospitals and other institutions. The remaining 69 percent are being treated by private physicians as private patients. [...] Twenty-one percent of the cases of gonorrhoea and 40 percent of the cases of syphilis are treated in public clinics."²¹² Especially alarming was the number of pregnant women diagnosed with *vd*. A study based on reports from 1916 to 1927 showed that 6.9 percent of women admitted to maternity wards had a positive reaction to the Wassermann test.²¹³ Parran reports in 1937 that "[a]ccording to the best estimates, 60,000 children are born each year with congenital syphilis."²¹⁴ Now, the pressure on the clinics during the early 1930s was enormous, since their clientele was growing faster than that of private physicians. In 1935, Linda Usilton reports that over fifty percent of syphilis patients were treated in the *vd* clinics, whereas only forty-five percent of private physicians ever treated syphilis.²¹⁵ Most of the privately treated cases were handled by specialists rather than by general practitioners: e.g., most syphilis cases in Chicago were treated by specialists who, although making up merely one percent of the city's physicians, treated twenty-four percent of all private *vd* patients.²¹⁶

²¹¹ Today's rate in the US is 3.5 per 100,000, in males and females combined.

²¹² Parran and Usilton, "The Extent of the Problem," 34.

²¹³ See *ibid.*, 36.

²¹⁴ Parran, "Control of Syphilis," 205.

²¹⁵ Linda Usilton, "The Treatment of Syphilis and Gonorrhoea in the United States, Based on Treated Cases," *JVDI* 16 (1935), 147. However, Parran, in "Control of Syphilis," p. 205, writes that as of 1937 "[o]ne half of all practicing physicians are constantly treating one or more cases, representing 59 percent of the total. The remainder is being cared for in the 1,343 clinics, dispensaries and public institutions of the country." Yet other reports confirm the trend of increasing pressure on free clinics. A special morbidity report of April 1935 revealed that of the total of 18,960 syphilis cases under treatment in New York State outside of NYC, 8,859 or 46.7 percent were being taken care of at the clinics. This constituted an increase of 16.8 percent since 1930, when a similar survey was conducted. See "Conference on Venereal Disease Control Work," (Dec. 1936).

²¹⁶ See Linda Usilton, Howard Hunter and R. A. Vonderlehr, "Prevalence, incidence and trend in syphilis in Chicago," *JAMA* 110: 1 (Mar. 1938), 865.

So far two distinctions emerged from our data: first, a distinction between the *public clinic* and the *private office*, which concerns the location and organization of the care; and, second, a distinction between *specialists* and *general practitioners*, which concerns the quality and level of care. The second distinction cuts across the first: specialists would often, as we shall see, treat vd at the clinics, aside from their own private practice. The importance of the distinction between general practitioners and specialists will become clearer in the rest of this chapter. Yet let me make some explanatory remarks at the outset. Specialists of various sorts—including urologists, who handled most private cases of vd—began to differentiate themselves from the originally rather homogenous group of general practitioners in the late 1800s, and this process peaked in the 1920s. The growth of the specialist class thus roughly coincides with the early stage of the period I cover in this study, and we shall have an opportunity to see that the two groups of private physicians had often differing views concerning the treatment of vd. In brief, we might say that general practitioners represented an increasingly retrograde, prescientific conception of medicine, centered—as I pointed out in the previous section—around the figure of a family doctor, who compensates for a relative incompetence in the scientific methods of effective cure by offering a comforting personal contact with his patients. In contradistinction to this traditional figure, modern specialists were men who received proper scientific education in reformed medical schools, and many of them were exposed to the new methods of mass management of health care as army doctors during WWI.²¹⁷ Now it is true that the number of general practitioners treating vd increased over the years. Between January 1, 1923 and October 1, 1923, 19 percent of physicians in Syracuse, N. Y., treated 80 percent of

²¹⁷ For an excellent discussion of the difference between general practitioners and specialists in the early twentieth-century America, and the importance of the emerging specialist class, cf. Paul Starr, *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry* (New York: Basic Books, 1982), chaps. 3 and 4; cf. also Stevens, *American Medicine and the Public Interest*, chap. 5.

syphilis patients.²¹⁸ As of 1927, 38.5 percent of practicing private physicians in New Haven reported treating more than one case of syphilis or gonorrhea.²¹⁹ And in 1933 in Delaware County, Penn., 39 percent of physicians reported they had one or more cases under treatment.²²⁰

Yet it remains the case that most private patients were treated by specialists rather than by general practitioners. Let me suggest three factors that might explain the high concentration of private patients in the hands of relatively few specialists. In the first place, general practitioners, as already suggested, lacked proper education in the current methods of diagnosis and treatment. Secondly, some private doctors did not even have requisite equipment. It might have been the high cost of equipment necessary for diagnosing syphilis during the first few days following infection—before the diseased person becomes seropositive—that prevented some physicians from accepting patients with syphilis. Consider an astonishing fact, reported as late as 1938 by Nels Nelson and Gladys Crain, that a survey of “some fifteen hundred doctors’s offices in Massachusetts disclosed that only 14 percent” owned a microscope!²²¹ Last but not least, some members of the medical profession shared the moral outlook with the rest of their society, in which syphilis was linked with moral transgression. Many private physicians feared that they might lose their respectable patients, had it become known that they treated syphilis. No one desired to be branded a “clap doctor.”²²² In his

²¹⁸ Cf. “Venereal diseases in private practice (A report of an inquiry addressed to the physicians of Syracuse, N.Y.),” *JSH* 10 (1924), 271.

²¹⁹ “Report. A social hygiene survey of New Haven,” *JSH* 14 (1928): 213-234.

²²⁰ Charles Walter Clarke and Max J. Exner, “The medical aspects of social hygiene in Delaware County, Pennsylvania,” *JSH* 19 (1933): 375-392.

²²¹ Nelson and Crain, *Syphilis, Gonorrhea and the Public Health*, 37 (footnote).

²²² How is this related to Brandt’s hypothesis? Am I not conceding that bourgeois morality was responsible for the failure of anti-*vd* efforts? I don’t think so. Recall that Brandt claims this: if medical professionals were rid of the prejudice against *vd*, they could eradicate the *vd* epidemic. I believe I have provided enough evidence in the previous chapter that no campaign could be efficient without modern practices of treatment, which did not yet exist. Bourgeois prejudice is just one the factors responsible for the concentration of the *vd* patients in the hands of specialists—not for the failure of the anti-*vd* efforts as such.

Memories of Eighty Years, Dr. James Herrick remarks that “[a]n occasional patient with venereal disease wandered in, though he had such a cool reception that he seldom came back.”²²³

Private physicians—general practitioners and specialists included—treated between forty and sixty percent of cases during the 1920s and 1930s. This percentage oscillated depending on the financial circumstances of the patients. It hit its low in the early and mid-1930s when, due to the Depression, large numbers of middle-class patients depleted their funds and sought help at the vd clinics, which were either free or charged a small nominal fee. For example, the proportion of cases being cared for in a New York State clinic outside of New York City increased between 1930 and 1935 from thirty percent to forty six percent.²²⁴ Generally, early syphilis cases were more common in private practice while patients with late syphilis gravitated toward the clinics.²²⁵ The concentration of the late cases in the clinics contradicted the original goals of public health policies. As explained in Chapter 2, the clinics were supposed to stop the spread of infection, not to cure individual patients. One should add that this division of labor between public health and the medical profession was a result of the pressure of private physicians, who did not want the free clinics to steal patients from them. Even some noted specialists, for example John Stokes, believed that early cases of syphilis were treatable by routine methods, and so could be dealt with at the clinics. In contrast, late syphilis was considered complicated due to the fact that its symptoms resembled other diseases.²²⁶ The clinics were known to be crowded, and thus allegedly incapable of providing time and space for individualized treatment: hence, it was generally assumed that only specialists in private practice could successfully treat late syphilis. However,

²²³ James B. Herrick, *Memories of Eighty Years* (Chicago: University of Chicago Press, 1949), 92.

²²⁴ *Conference on Venereal Disease Control*, December 1936.

²²⁵ “Report. A social hygiene survey of New Haven,” *JSH* 14 (1928), 219.

²²⁶ That is why syphilis was called the “Great Imitator.”

the lack of money for prolonged treatment, interruptions of treatment, and “syphilis in disguise”—i.e., tertiary syphilis whose symptoms were misinterpreted—brought more and more patients with late syphilis to the clinics. Let me concentrate in the rest of this section on two topics that I see recurring in the materials on vd treatment in the 1920s and 1930s and that help explain why the treatment of vd failed in private office: the cost of treatment and its overall quality. I shall compare private treatment and dispensary treatment based according to these two criteria.

The treatment for syphilis in private office was expensive. For many physicians it was a source of considerable income.²²⁷ Many also charged higher fees for syphilis than for treating other illnesses. Michael Davis writes in 1915 that the treatment of syphilis, “while requiring less frequent visits [...] often demands several injections,” which would set the patient back \$10 to \$50 apiece. Davis also notes that given the income level of the largest group of males infected with syphilis—between \$400 and \$800 annually for single men, and between \$800 and \$1.200 for married men—the expenditure of 15 to 25 percent of such incomes on the treatment of vd makes it unaffordable. As Davis says, these men “can pay for some treatment, but not for enough or good enough treatment.”²²⁸ We can get a sense of the considerable differences in cost between private and public care from a 1919 article by nurse Janet Thornton. The article is also useful in drawing our attention to a distinction between two kinds of clinics: *free dispensaries* (or *free clinics*), on the one hand, and *pay clinics*, on the other hand, so called because they charged a moderate fee—usually as ten times less the cost of

²²⁷ Dr. Walter Alvarez writes in his autobiography that, when he began to practice in 1910, he “quickly learned to perform the new Wassermann test for syphilis, and soon the money I earned for doing this work for several physicians was adding much to my income, and making life more comfortable for me, my wife and our little daughter.” (Alvarez, *Incurable Physician: An Autobiography* [Englewood Cliffs, N. J.: Prentice-Hall, 1963], 52.)

²²⁸ Michael A. Davis, “Efficient Dispensary Clinics a Requisite for Adequate Coping with Venereal Disease,” *JAMA* 65: 2 (Dec. 1915), 1984. Aside from being an early evidence of understanding that the treatment of syphilis would be a considerable burden for many patients, this estimate also proves that even such an authority in the field of syphilology as Davis still did not know in 1915 that a proper cure would require more than *several* injections.

treatment at a private office.²²⁹ I ignored this distinction in Chapter 2, as it is irrelevant to the topic of the organization of treatment. However, the difference between free and pay clinics becomes relevant in the present context. According to Thornton's survey of private offices, pay clinics and free dispensaries in Boston in 1919 gives a vivid idea of the discrepancies between the charges for vd treatment in these different types of institution. For treating acute gonorrhea in men, with an average duration of 175 days, the charge in private office was \$195; in pay clinic, \$59; in dispensary, \$48.25. For the first-year treatment of syphilis, the cost to the patient in private office was \$260; in pay clinic, \$52; and in dispensary, \$42.²³⁰

While Michael Davis pointed out the unaffordability of a quality vd treatment to the working class, others noted that it was becoming increasingly inaccessible even to the middle classes. One of the first authors who formulated the problem of vd treatment as the problem of middle class was Dr. Albert Keidel, in a study of the cost of treatment in Baltimore published in 1931.²³¹ The cost of treatment at the Johns Hopkins Hospital dispensary amounted to \$1.03 per visit, including the cost of drugs and lab tests; given that complete cure required seventy-six visits over twenty-seven months, the total cost to a patient was \$78. In comparison, the cheapest treatment at a private practice in Baltimore could be bought for no less than \$305—provided that all Wasserman tests were performed free of charge in a lab of the health department; the original examination was charged at \$10; each injection of Salvarsan \$5; and each injection of mercury and bismuth \$2.50. However, as Keidel adds, few physicians actually charged only \$305; since the cost of lab tests had to be charged as well, the total minimum charge rose to

²²⁹ Unfortunately, things are even more confusing. As I found out, most of the free clinics began charging a minor fee during the 1920s because a completely free service proved uneconomical. However, as the fee at free clinics was still lower than the charge at pay clinics, the term "free clinic" was kept in use.

²³⁰ Janet Thornton, "Social Service and Dispensary Admissions Service," *MH* 12 (Apr. 1919), 279

²³¹ Albert Keidel, "Economic Aspects of the Management of Syphilis," *Archives of Dermatology and Syphilology* (1931): 472-484.

\$380. The average fees are \$650, calculating \$10 per a Salvarsan injection and \$5 per an injection of a heavy metal. Moreover, all these estimates assume that we are dealing with uncomplicated cases of early syphilis. Should there be any complications, or the disease were in a later stage, the total charge would rise to a minimum of \$480 and an average of \$1,050. Given these estimates, Keidel concludes that private treatment is out of reach not only for the poor, but for the middle class patients as well:

It seems apparent from these considerations in that to an even greater extent than in other forms of medical care, the main problem lies, not with the poor man who can be treated at cost or even free, not with the well-to-do, to whom the expenditure of money for expert care is no object, but with middle class, the great bulk of the population.²³²

Consequently,

The obvious method of bringing together the physician who wants to provide adequate medical care and the patient in moderate circumstances who wants to receive it is the pay clinic. Such an institution can furnish expert medical service and, if its volume of work is sufficiently high, can even operate at a substantial profit on fees that are impossibly low for the individual practitioner.²³³

Thus we see that a noted specialist is led by an impartial reasoning to a conclusion that the vd epidemic could not be stopped, unless the expense to individual patients were reduced by treating large numbers of them at the pay clinic. It must be noted that Keidel's report was followed by a record of discussion, whose prevalent tenor is the immediate and total rejection of the idea of pay clinic. But I shall describe the details of this opposition and its rationale later in this chapter. Let me compare at this point the charges for syphilis treatment at a private office and at the pay clinic, as reported by Keidel, with some more data about charges at the free as well as pay

²³² Ibid., 475

²³³ Ibid.: 477

clinics.²³⁴ A 1916 report from the Brooklyn Hospital says that the cost of a visit at the afternoon dispensary was 10 cents, and a visit at the evening pay clinic there cost \$1.²³⁵ E. H. Lewinski-Corwin, in his well-known paper on vd clinics says that by 1920, "[t]he municipal clinics [in New York City] make no charge for Salvarsan. The charges in the other clinics vary from \$1 to \$4.00 per dose. [...] The clinics making profit on Salvarsan use it for the purchase of the drug for indigent patients."²³⁶ A 1932 San Francisco social hygiene survey reveals that

The fees to be collected from patients at the San Francisco Board of Health venereal disease clinic range from 25 cents for each registration, examination and one treatment, to \$2.50 for each administration of salvarsan or substitute; but the Board may not refuse examination or treatment in case that the patient is not able to pay.²³⁷

Finally, according to a report about the Chester Hospital Clinic in Delaware County, Penn.,

[w]hile there is nominally fee for medical care in the out-patient department of the hospital, a large proportion is given free. Of the patients attending the clinics for the treatment of syphilis and gonorrhoea only a few pay anything at all and it is rare for the clinic to collect the full fee of \$1.50 per visit for the treatment of syphilis.²³⁸

So much for the topic of cost; I am now getting to the issue of the quality of treatment. I shall distinguish three constraints that I believe determined this level. The first constraint is easy to come upon: as one might expect, the prime determinant of the quality level of treatment that could be procured from a private physician would be the

²³⁴ See the note 225 above.

²³⁵ Alec Nicol Thomson *et al.*, "The Genito-Urinary Department of the Brooklyn Hospital Dispensary," *SH* 2 (1915-16): 91-110.

²³⁶ Lewinski-Corwin, "Venereal Disease Clinics," 343-4.

²³⁷ William F. Snow and Walter Clarke, "Medical Aspects of Social Hygiene in San Francisco," 253.

²³⁸ Walter Clarke and Max J. Exner. "The medical aspects of social hygiene in Delaware County, Pennsylvania," *JSH* 19 (1933), 388.

price a patient were able or willing to pay. Recall the above cited remark by Michael Davis that most patients could not afford to pay for “enough or good enough treatment.” Well-known specialists charged the highest fees, but general practitioners charged a lot as well. Yet the treatment of syphilis could be costly not only to patients, but also to some doctors. The higher the fees, the more difficult it could be to collect them, and so doctors could be discouraged to risk providing such an expensive treatment. This is illustrated by one of the recollections of Dr. Pat Nixon, a country physician from Texas:

It was early in the days of Salvarsan. A man from New York, in the city [of San Antonio] for a few weeks, developed syphilis. I gave him several injections of Salvarsan. His primary lesions healed quickly. The matter of payment was postponed time after time. One day, I was called to Luling in consultation, and on the train was my syphilitic patient. I knew he was on his way home. I asked him to pay his bill, which was quite considerable. He countered by saying my charge was excessive. I reduced it by half. He wrote out a check for the reduced amount. [...] The check bounced.²³⁹

However, a greater expense did not necessarily guarantee a better treatment. Rather, as the second constraint, we have to take into account the *education* of a physician and the *equipment* of his office. Given the rapid advancement in medical science and technology since the late 1800s, the reforms of medical education aimed at putting it on a firm scientific basis, and, accompanying it, a growing split between traditional general practitioners and modern specialists, it is clear that not every physician was equally well qualified in diagnosing and treating syphilis by up-to-date methods. Consider again the significant detail I mentioned previously that even in the late 1930s, only 14 percent of doctors in Massachusetts owned a microscope, a basic

²³⁹ Pat Ireland Nixon, *Pat Nixon of Texas: Autobiography of a Doctor*, ed. Herbert H. Lang (College Station and London: Texas A&M University Press, 1979), 213-14. This kind of problem might be suffered, however, only by general practitioners, not by famous specialists.

necessity for conducting darkfield tests for the presence of *spirochete* bacterium. Other general practitioners had little if any experience with executing intravenous treatment.²⁴⁰

Lastly, the third constraint on the quality of treatment was the ability of physicians to secure those components of treatment that proved crucial in treating at the clinic. I have in mind the components of treatment analyzed in Chapter 2, including *follow-up* techniques, *education* of the patient, and *postal reminders* to those who were skipping treatment sessions. All these techniques emphasized the regularity and continuousness of treatment. Given the nature of their relationship with their patients, private physicians were neither capable, nor willing to police the reluctant patients, let alone track them down with the assistance of a social worker or a health officer. Understandably enough, a paying patient would readily switch to a different physician, should he feel that the current doctor excessively interfered in what the patient perceived was exclusively his private domain. As a high-ranking public health officer Nels Nelson remarked in 1938, “[i]t can also be appreciated that the physician is almost certain to lose permanently any patient whom he causes to be visited by the health officer.”²⁴¹ Thus it is not surprising that private physicians usually did not put any pressure on their patients, for fear of alienating them: they feared losing business. Consequently, it is no more surprising when Linda Usilton reports in 1938 from Chicago that only twenty-three percent of the early syphilis patients stay under treatment in private offices until they received at least (what was then considered) the minimum of twenty injections of Salvarsan combined with the appropriate heavy metal therapy. In comparison, the number of the patients

²⁴⁰ For a criticism of inadequate treatment by private practitioners, cf. especially J. Bayard Clark, “Regarding the Treatment of Syphilis,” *AJS* 12 (1928): 10-12. The incompetence of the general practitioner is also a recurring theme in the articles by John Stokes from the 1920s to the 1940s. The persistence of his exhortations to general practitioners to upgrade their skills suggests that their competence remained low. Cf. the sections 3.3.2 and 4.3 for a more detailed discussion of Stokes’ opinions.

²⁴¹ Nels A. Nelson, “The Control of Syphilis from the Health Officer’s Viewpoint,” *AJPH* (1932), 172.

who reached at least that level at the clinics was fifty percent.²⁴² In conclusion of this discussion of the three constraints on the private treatment of syphilis: even if a patient had the money, he or she might not get a sufficiently qualified physician; yet even if the patient used the service of a highly qualified specialist, the latter might not be able or willing, for fear of alienating the patient, to force him or her to stay under treatment, report his or her contacts, etc.—in other words, to follow through all those unpleasant stages that were necessary in pre-Penicillin days.

How do the three constraints play out with respect to the quality of treatment offered by the vd clinics? As for the money constraint, we have seen it did not apply; the clinics were either free or charged just a fraction of the price current at private offices. Perhaps two caveats are necessary. First, the money constraint was immaterial only to the patients who could demonstrate they really were poor enough to be eligible for free treatment; over the years, the medical profession kept increasing its pressure on the clinics to screen off the solvent patients. Second, although the clinics' patients paid nothing or very little directly, they contributed considerably indirectly: by means of long waits, the patients paid in the form of lost wages; by making their bodies available for demonstrations, they served as teaching tools for the education of medical students.²⁴³ Thus, we might at least say that the quality of treatment patients received at clinics was independent of any direct expense on their part. Moreover, the physicians working at the clinics were as a rule some of the best specialists, who either were public health enthusiasts or welcomed the opportunity to practice on so many specimens. Lastly, the

²⁴² Linda Usilton, Howard Hunter and R. A. Vonderlehr, "Prevalence, Incidence and Trend in Syphilis in Chicago," 864. Also notice that Dr. Pat Nixon, in the above cited memoir, apparently assumes that "several injections of Salvarsan" is all that a complete cure of syphilis asks for: there is no word of requiring the patient to continue treatment, let alone reveal the identity of his sexual partners.

²⁴³ Cf. Starr, *Social Transformation*, 183-4. Long waits at dispensaries were one reason for opening evening pay clinics. On pay clinics, cf. H. H. Hazen, "Dispensary Treatment of Syphilis," *AJS* 16: 1 (1932), 3.

clinics had some ability—however limited and imperfect—to discipline the patients by health education and follow-up. Hence it is apparent that the quality of treatment at the clinics was not determined by any of the three constraints distinguished above.

Paradoxically, the lower-class patients had been considerably better off than the middle class in terms of the quality of medical care they might receive. The contemporaries were not unaware of this paradox: "The patients have received distinctly better care and better diagnostic investigation in the hands of a group of trained men, and the feeling has gradually grown among the lower and middle classes that if they wanted to find out what really ailed them they had better go to a hospital."²⁴⁴

3.3 Medical Profession vs. Public Health

The purpose of the remainder of this chapter is to question the thesis central to the project of the medicalization critique, viz., that modern medicine can be conceived as a unified subject, endowed with agency of its own. My approach is to point out the interwar conflicts between the American medical profession and public health over the access to and patients, in order to show the field of health care as polarized rather than unified. There are two closely related, broadly Foucauldian, aspects to my argument. First, I intend to contribute to undermining the notion of power as a property owned and wielded by a discrete subject. As I shall try to show, the notion of power that characterized the conflicts within the emerging US health care system is best seen in terms of a network of relations. For example, when I trace the contentions between the medical profession and public health, I mean to suggest that neither party was able to completely determine the course of events, but was always constrained by its competitor. The second aspect concerns my claim that developments that appear, in

²⁴⁴ *American Medicine: Expert Testimony Out of Court*. New York: The American Foundation, 1937.

retrospect, to have happened necessarily, are in fact contingent events. Thus, I claim that the course of American medicine was crucially affected by WWI, e.g., in shaping the attitude of young specialists towards mass methods of treatments.

This section is divided into three subsections, corresponding to three sorts of conflicts that I discovered as having determined the shape of the American health care system roughly during the period between the two world wars. First, I discuss how the medical profession contested public health initiatives; second, I look at the medical profession's negative attitudes toward the federal government involvement in anti-vd efforts; finally, I examine the attitudes of noted specialists held with respect to public health.

3.2.1 *Professional Medicine and Public Health.* Let me first mention a few necessary historical facts as a background to our discussion of the conflicts between the medical profession and public health.²⁴⁵ While the AMA, the key representative of American medical professionals, was founded already in 1847, it did not become very influential until late in the nineteenth century, when it reconstituted itself as a bastion of scientific medicine against scores of quacks, healers and druggists. Paul Starr describes this process in terms of the "professionalization" of American medicine, i.e., its transformation into "an occupation that regulates itself through systematic, required training and collegial discipline; that has a base in technical, specialized knowledge; and that has a service rather than profit orientation, enshrined in its code of ethics."²⁴⁶ The AMA helped establish the American medical profession by setting up standards for

²⁴⁵ In this paragraph, I rely on data both from Starr, *Social Transformation*, chap. 5, and from a paper by John Duffy, "American Medical Profession and Public Health," *Bulletin of the History of Medicine* 53: 1 (1979): 1-22.

²⁴⁶ Starr, *Social Transformation*, 15. Starr's overall thesis is that the history of American medical profession is the history of a gradual accumulation of power. Clearly, then, Starr's implicit notion of power is that of a commodity that can be possessed. Though Starr shares this un-Foucauldian concept of power with the critics of medicalization, his province is historical sociology rather than political criticism. Despite the fact that his basic conceptual framework is incompatible with the one I adopted in my study, Starr provides invaluable insights into empirical history.

medical schools and, consequently, regulating the supply of new physicians. Between 1880 and 1900, some sixty new medical schools opened, thus increasing the total number of schools by sixty percent. The AMA dealt with this proliferation through the reforms of medical education starting in 1909, on the basis of which many substandard schools had to close down. The new standards imposed on medical schools also proved a threat to the status of older physicians, who were less well educated than the new cadres. This was the origin of the aforementioned conflict between the older generation of general practitioners and the new generation of specialists. Although it played a progressive role in the standardization of medical education, the AMA soon became a bastion of the more conservative general practitioners, who felt threatened by the culminating dispensary movement. In New York City alone, there were sixty-four dispensaries in 1893; in 1900, the NYC dispensaries treated almost 900,000 patients. Dispensaries were generally perceived by the medical profession as competition, as was any suggestion of following the example of those West and North European countries that set up schemes of ever more inclusive medical insurance. In the US, except for a brief period during World War One when even the *Journal* of the AMA had seriously considered such insurance proposals, the latter met with denunciations of "socialism" and "bolshevism." This crucial period in the history of American medicine also overlaps with the beginnings of public health initiatives. These date back to the mid-nineteenth century, when cholera, yellow fever and other epidemics prompted citizens to organize in sanitary associations to clean up squalid city districts. This emergency situation led to the establishment of the state Boards of Health across the country by the end of the century. American physicians were initially in favor of these public initiatives, since the former sought protection of the government in their licensure efforts.

The division of labor between the medical profession and public health was supposed to be based on the distinction between *curative* and *preventive* medicine:

doctors should cure, whereas public health should only prevent disease, by limiting itself to issues like pure water supply, food and drug regulations, health research and education. However, with progress in medical science—especially in bacteriology, in the late nineteenth century—the distinction between cure and prevention became blurred. Old sanitation efforts were often misguided, because they were based on the assumption that the epidemic carrier was water or food. But modern epidemiology discovered that the real carriers of epidemic diseases were people. Hence an epidemic could be stopped only if preventive action were used to cure the diseased persons. This conclusion was one reason why members of the medical profession grew increasingly alienated with the efforts of public health. To some extent, the conflict between the medical profession and public health corresponded to the conflict between older physicians and new specialists. Modern methods of treatment of epidemic diseases were naturally attractive to educated specialists, less so to the older generation of general practitioners who did not feel competent in this domain. (However, this does not mean that specialists were automatically supporters of public health—see Section 3.2.3.)

We can construe the conflict between the two models of medicine—the one represented in the early 1900s by the AMA, the other by public health—in terms of Foucault's scheme of the transition from the premodern medicine to the "clinical" and "social" medicine of the late 1800s. According to Foucault, the traditional medicine is centered around the family of the sick person: "natural locus of disease is the natural locus of life—the family: gentle, spontaneous care, expressive of love and a common desire for a cure, assists nature in its struggle against the illness, and allows the illness itself to attain its own truth."²⁴⁷ This notion is echoed in the memoirs of the American "country doctors" James Herrick, Pat Nixon, and Arthur Hertzler; they confirm that the ability to establish a trustworthy relationship with a patient and his or her family was

²⁴⁷ Foucault, *Birth of the Clinic*, 17.

deemed a more essential quality in the physician than his knowledge of medical science.²⁴⁸ Foucault argues that the traditional model of medicine in France received a heavy blow from the Revolution of 1789, which set the new task for physicians to restore the health of the whole citizenry, and opened the door for the model of scientific medicine based in research hospitals.²⁴⁹ I think that World War One operated as a similar, albeit less cataclysmic, vehicle of change in the American context, which brought about the confrontation between the traditional, individualistic conception of medicine, represented by the AMA, and the new medicine based on the mass methods of treatment, represented by public health.

Let me now turn to the details of the conflicts between the medical profession and public health's attempts at controlling the spread of syphilis. One of the earliest attempts dates back to a resolution by the NYC Board of Health in May 1912 to make syphilis a reportable disease, and to provide diagnostic and treatment facilities for those individuals who could not afford the services of a private physician. The Board of Health officials believed that both notification and the provision of diagnostic and treatment facilities were of equal importance in an effective administrative action against vd. However, the implementation of a comprehensive vd control program turned out impossible: the opposition of the medical profession against vd clinics run by the Board

²⁴⁸ See the quote from Hertzler on p. 124. For evidence of the all-importance of personal rapport between the patient and the doctor in the traditional medicine, consider the following recollection of Dr. Herrick's:

I once told a young man, when I was unable to explain a malaise and fever which he had had for a few days, that, by the exclusion of other diseases, I suspected typhoid, though I frankly admitted that some characteristic features were not present. To be on the safe side he should remain in bed and go on a restricted diet. At a third visit, still perplexed as to the diagnosis, I again examined him as though I had never done so before. As I percussed his chest, I gleefully announced, "I've found it; it's a pleurisy with a small effusion. You've never had typhoid." "Well, doctor, I never thought I had." "then why did you stick to me?" I asked. "Because I saw you were honest and were all the time looking for something else, and I was sure you would find it." His pleurisy, probably of tuberculous origin, cleared up. He remained one of my most loyal and ardent supporters. (Herrick, *Memories*, 92.)

²⁴⁹ *Birth of the Clinic*, chap. 5

of Health was so great that only an incomplete public health program was eventually implemented in New York City. The Board of Health had been willing to compromise. Its members remembered vividly the reaction two decades earlier of the medical profession to the introduction of measures intended to control tuberculosis.²⁵⁰ Accordingly, the Board's resolution regarding the control of vd already contained a number of concessions. Unlike the administrators of hospitals, dispensaries, clinics, asylums, prisons, and other public institutions, private physicians were to be allowed to report their patients by a number only. Furthermore, private practitioners were only requested, not required, to comply with the resolution. Even more important was a concession to the Committee on Hospitals and Budgets of the New York Academy of Medicine that the Board of Health will not administer vd clinics. The Committee opposed the Board's request for city funds to finance vd clinics by arguing that, instead of establishing new facilities, the existing establishments should rather be stimulated to adopt modern methods of syphilis treatment.²⁵¹ Bowing to the demands of the medical profession, the Board of Health of New York finally adopted a control program that stressed diagnostic aspects of syphilis control, but did not include treatment.²⁵²

²⁵⁰ Protests came not only from the medical profession. According to John Duffy, some of the hospital superintendents refused to comply, and a committee representing three of the city's largest hospitals complained to the mayor about the resolution. Cf. Duffy, *A History of Public Health in New York City* (New York: Sage, 1974), 579.

²⁵¹ Duffy comments on the lack of improvement and lack of compliance with the city regulations for vd clinics that attempted to improve the quality of medical care in the clinics and dispensaries:

As a result of the AICP study, the NYAM's Public Health Committee moved into the picture and recommended the standardization of the city's venereal disease clinics. In consequence, in December 1917 the Sanitary Code was amended to give the Health Department authority to force these clinics to meet certain minimum standards. Having authority and being able to exercise it are two different things, a fact known to all public health workers. Medical institutions, like medical associations, have always bitterly resented any interference by health departments, and in 1919 Dr. Louis I. Harris reported that less than a dozen of the city's 80 clinics had complied with the new regulations. (Ibid., 580)

²⁵² Private physicians argued, of course, that free treatment constituted an unfair competition, luring the patients who should pay at a private office. Since the Board of Health intended to provide care only for the indigents, those who could afford to pay would have been ineligible for treatment at the municipal clinics anyway. Consequently, there was really no economic harm to

In anticipation of a similar resistance to the implementation of municipal vd clinics in other cities, health officials attending the annual meeting of the APHA in 1915 were advised to open vd clinics that would provide diagnostic services only. As to what measures should be implemented, one of the participants stated:

I believe that the New York Health Department, when they began their dispensaries, had in mind complete dispensary; but they met with this opposition from the medical profession, so that they adopted a certain line of dispensary work that does not represent the full work usually done by dispensaries. I do not believe that there will be any immediate change in the sphere of activities of the New York dispensaries. I think that it will be a very good idea if other communities inaugurating venereal dispensaries would lessen the opposition by working along these somewhat limited lines.²⁵³

Indeed, the concessions of public health to the wishes of the medical professionals became a characteristic of the public health measures targeting syphilis and compromised their effectiveness until syphilis was almost eradicated by antibiotics treatment in the late 1940s.²⁵⁴

Despite the efforts to improve the quality of treatment in the existing dispensaries and clinics, very few clinics in New York City possessed the necessary equipment and even fewer of them provided up-to-date treatment. One year after the attempts of the Board of Health to establish municipal clinics, less than ten clinics furnished efficient treatment. Nevertheless, the Board of Health did not insist on opening its own clinics.²⁵⁵

be done to the medical profession that might justify their claim that the city clinics would "steal" paying patients from them.

²⁵³ W. A. Evans, "Municipal Health Officers and Venereal Disease," *JAPH* 5 (1915), 898.

²⁵⁴ The reaction of individual doctors to the syphilis control measures, however, was far from monolithic. Some physicians fully endorsed the public health measures to combat syphilis and regarded the clinics as legitimate and necessary for an efficient vd control. Similarly, not every board of health, hospital, or voluntary organization yielded to the wishes of the medical profession. Many health departments provided treatment to those who could not afford to pay a private physician. The Public Health Institute of Chicago, a pay venereal disease clinic, provided treatment for hundreds of thousands Chicagoans for more than twenty years despite the incessant protests of the Chicago medical community.

²⁵⁵ In fact, the city clinics provided no treatment for syphilis to the indigents, except prostitutes, until 1927. The decision to provide vd treatment was made that year at a joint meeting of city,

As time went by, the position of public health officials concerning municipal vd clinics became almost indistinguishable from that of organized medicine. In reaction to a comment made by Dr. Evans before the Public Health Officials Section of the APHA in December 1914 that NYC diagnostic clinics eventually "will assume all of the legitimate functions of a dispensary," Dr. Haven Emerson, health commissioner of NYC, declared:

Yet the cost of having the city administer these dispensaries would be enormous and would meet with tremendous opposition. The organized physicians are definitely against having any such work taken on by the city. It is accepted that the function of the city department as to notification and diagnosis can have the widest range, but when it comes to assuming treatment of these diseases, there is unanimous disapproval, and I think it would be fair to say that until it has been proven that the dispensaries, either associated with hospitals or other, are unable to accomplish proper treatment of the patients that apply to them, it should not be assumed as one of the functions of the city department of health.²⁵⁶

The diverse views regarding the control of vd articulated by the participants at the annual meeting of the Public Health Officials Section of the APHA, ranging from the regulation of prostitution to social hygiene measures to partial or comprehensive (including treatment of the poor) public health measures, suggest that as of late 1914 both the content and boundaries of the public health programs regarding venereal diseases were far from self-evident or directly determined by the advances in medicine. Rather, they were an outcome of negotiations between public health officials, medical professionals, and social reformers, in which each party promoted its own goals based on conflicting conceptions of the public good. The results of the initial efforts to control vd differed from city to city. In fact, the content and boundaries of anti-venereal disease measures continued to be contested and modified until syphilis was almost eradicated in the late 1940s.

state, and federal health officials in New York headed by Parran, then serving as Assistant Surgeon General. This development, however, was interrupted by the Depression. Cf. Duffy, *A History of Public Health*, 582.

²⁵⁶ Cf. W. A. Evans, "Municipal Health Officers and Venereal Disease," 887 and 894.

The medical profession greeted with similar hostility the attempts by some hospitals and voluntary groups to make treatment for syphilis and gonorrhea more accessible in the so-called pay clinics to those who could not afford the services of a private physician yet were not destitute. The first pay syphilis clinic opened in 1908 on the premises of the Brooklyn Hospital, but it soon closed again due to the protests of the local medical society and the unavailability of a sufficient number of physicians for evening hours. The Clinic reopened in 1914, and again it received a cold reception from the members of the medical profession. Their main objection was that running a pay clinic contradicted the principle on which the Hospital was founded: hospitals were supposed to be places for the patients who were so poor they could not afford care in a private office; pay clinics thus apparently attracted the patients who should pay a private physician. This objection seemingly had a point: the fees paid in a private office were supposedly negotiable, so that a person with moderate means should be able to get a price fitting his budget. In practice, however, very few private practitioners were willing to adjust their fees for treating syphilitic infection; charging as high a fee as possible was in fact prevalent. Furthermore, as shown in 3.2, only a minority of doctors in fact treated vd. Finally, even those doctors who would take up a syphilitic did not hesitate to drop her, if she exhausted her means. Contradicting any serious effort to stop the epidemic, private physicians were cheerfully releasing patients who were still infectious. Unless they were taken up by a vd clinic—and unless the clinic failed to keep them by educational and follow-up methods—such patients continued to spread the epidemic. (Unlike private doctors, the clinics at least tried to keep patients under treatment. Private practitioners did not bother with any follow-up procedures if their patients were broke—nor, as we have seen, if they were solvent.) In view of these facts, the complaint about

the pay clinics appears insincere: private physicians would not try to keep patients with moderate means anyway.²⁵⁷

The largest and most controversial pay clinic—the Public Health Institute of Chicago—was founded in 1920 by Dr. Joseph Berkowitz, a former member of the Army Medical Corps, and Myron A. Adam, a moral officer during WWI. Their motive is well expressed in a pamphlet published by the Institute in 1948:

This increased demand for the Institute's service was a source of great satisfaction to the Trustees, and especially so since completely free treatment at the taxpayer's expense was still being offered elsewhere. It convinced them that the average wage earner does not want to be considered an object of charity, and that he is most willing to pay a reasonable fee for adequate medical attention. Yet there are those high in the councils of government who contend that only through socialized medicine, to be financed by added taxation, can the health of the nation be properly protected.²⁵⁸

As should be obvious from this passage, the intention of the founders of the Public Health Institute was not to provide free, but affordable, medical care. Far from attempting to divert patients from private physicians, the authors of the pamphlet admonish the patients "to consult *either* the Institute *or* the family

²⁵⁷ So much can be inferred from a 1938 statement by Thomas Parran, clearly meant as an indictment of private practitioners, who he believed fell short of their duty to syphilitic patients and to the general public at risk:

The physician who undertakes the treatment of a case of syphilis assumes two general responsibilities. First, to the patient. He must see the patient through a cure, regardless of the patient's financial condition, or he must refer the patient to a public clinic. Second, he must either inquire diligently concerning the source of the infection and contacts, get them under treatment, and inform the health officer that he has done so, or he must permit the health department itself to do this essential public health job. (Parran, "Control of Syphilis," 223-30.)

A year later, answering the doctors' complaint that clinics take patients from them, Parran writes: "At least one half of the syphilitics of the country cannot afford to pay for treatment, but no patient who can afford to pay a physician is going to be willing to subject himself to clinic treatment even in a good clinic, and not all of the syphilis clinics are good ones." (Parran, "Syphilis and Medical Practitioner," *RMMJ* 35 [Aug. 1938]: 595). For the evidence of inaccessibility of private treatment even to middle class, cf. also Keidel, "Economic Aspects."

²⁵⁸ *How Laymen Cut Medical Costs* (Chicago: Public Health Institute, 1948), 18.

physician."²⁵⁹ Yet the Institute was a target of fierce opposition by the medical community of Chicago and beyond. Many practitioners in fact demanded that the Institute be closed. One popular pretext was the fact that the Institute advertised its services in newspapers—a practice that was prohibited by the AMA code of medical ethics. Here is one example of an opposition, a passage from a 1928 article by Dr. William Pussey:

[T]here is an institution in Chicago—the Public Health Institute—which has been in existence now for eight or ten years and which presents a new problem in the business of the practice of medicine. This is an institution incorporated not for profit, and sponsored by a group of nonmedical men, which has been set up for the purpose of furnishing medical services in a certain field at a price below that at which the medical profession can individually furnish them. In order to get its practice it has pursued a policy, continuous and extensive, of newspaper advertising. There can be no question of the motive and character of the men who are behind this enterprise, and that has made this particular case much more difficult to handle. But there is no inherent obstacle to prevent similar organizations from establishing themselves for the frank business of practicing medicine for what there is in it. It is the problem of taking over the business of practicing medicine by laymen through corporation. [...] This is a form of medical practice to which I believe the profession should offer its strongest opposition. The physicians engaged in such methods of practice are little more than employees in technical business. If such organizations were common in our cities, the practice of medicine would lose a large part of its attractiveness and would cease to call to it the only sort of men it needs—men of high ambitions and altruistic instincts. For this reason, if for no other, it is to the community's interest that such organizations should be opposed. Omitting its advertising, this institution does show how business methods can be effectively used in the practice of medicine.²⁶⁰

²⁵⁹ *Ibid.*, 28 (emphasis added).

²⁶⁰ William Allen Pussey, "Some Tendencies in the Business of the Practice of Medicine," *JAMA* 90, No. 23 (June 1928), 1899. Dr. Herrick mentions in his autobiography the incident of dismissal of a physician working at the Public Health Institute of Chicago from professional organizations: "Louis Schmidt was ousted as a member of the Chicago Medical Society and the American Medical Association. The Public Health Institute was officially declared unethical because of its advertising, and all physicians in any way connected with it were notified that their fate would be

In another statement, a certain Dr. Howard Fox comments on a paper by Dr. Keidel, discussed earlier: "The opinion is widely held in New York that many physicians would be willing to reduce their fees to meet those charged by pay clinics and that the work could be done as efficiently."²⁶¹ In view of the above-cited evidence, provided by Keidel and Parran, as to the unavailability of private treatment even for many middle-class patients, Fox's comment sounds preposterous. Yet while hostility towards pay clinics was fierce in New York and Chicago, it was weaker or even absent in other places. "It is unfortunate that opposition has crystallized in New York against evening clinics," remarks Michael Davis in 1915. He goes on: "Fortunately in Boston, and I hope elsewhere in Massachusetts from what Dr. Baker said about the possibility of opening an evening clinic in Worcester, there is at present no aggressive opposition to them here."²⁶²

The opposition of the medical profession towards public health temporarily subsided when the examinations of draftees in the wake of the US declaration of war in 1917 revealed a shocking number of active vd infections. The increased awareness of the high rate of venereal infections, the heightened sense of urgency to preserve the health of the nation, and concerns about combat efficiency, resulted in the passage of the Kahn Chamberlain Act in June 1918 which provided state boards or state departments of health with limited funds for the control of vd. I shall return the federal

that of Dr. Schmidt if they did not drop that connection. They ultimately resigned" (Herrick, *Memories*, 231).

²⁶¹ A panel discussion of Keidel, "Economic Aspects," 481.

²⁶² Michael M. Davies, "Evening Clinics for Syphilis and Gonorrhoea," *AJPH* 5 (1915), 311. In 1915, Davies was still optimistic about an eventual conversion of the goals of the medical profession and public health: "I cannot believe that in the long run the point of view of the medical profession, even as represented by the practicing end of it, and the point of view of the community in health matters, as represented by the public health official, can run counter to one another. In the long run surely the point of view of the community, the needs of the community, must prevail" (*ibid.*).

government involvement in the vd control in the next section. At this point, let it be said that the 1918 Act was, among other things, a great boost to establishing the vd clinics. Throughout the 1930s and into the 1940s, we find private practitioners complaining over and over about an alleged "dispensary abuse," i.e., public health's apparent inability—or, worse, unwillingness—to screen off solvent patients,²⁶³ and the vd clinics' alleged inability to provide the "time-honored" one-on-one relationship between the doctor and the patient.²⁶⁴ Doctors were in general unwilling to acknowledge that public health moved into the area of vd treatment as a result of the failure of the medical profession to provide treatment to all who needed it. Exceptionally, however, we can find frank admissions of this truth. In his commentary on Dr. Keidel's paper, one Dr. George MacKee says: "the reason most patients go to such clinics is because they feel they are being treated by specialists rather than by a family physician and have a better chance

²⁶³ Cf. a typical complaint in the book by Malcolm MacEarchern, whose first edition came out in 1935, but the following passage is unaltered even in a 1949 edition:

The control of venereal diseases is a very important function of government, nor can any fault be found with the state for assuming the responsibility for treatment when the individual is unable to secure the necessary care. But a lack of proper investigation of the patient's financial status has resulted in abuse of clinic for venereal diseases to such an extent that probably in them more than in any other charity service of the community is found a large proportion of patients who are quite able to consult a private physician. This abuse has become so extensive as to materially lessen the practice of the physician who is specializing in the treatment of venereal diseases, and as a result there has arisen an opposition on the part of these specialists which has in it a measure of justice. (MacEarchern, *Hospital Organization and Management*, 2nd Ed. [Chicago: Physicians' Record Co., 1949], 536-7.)

²⁶⁴ Dr. Wendell C. Phillips says in his Presidential Address to a 1926 AMA conference in Dallas that "the physician of the future" must "make the painstaking intimate personal contact with his individual patient so effective, outstanding and unassailable that no other form of medical practice will be permitted by the layman himself." He goes on to attack the new methods of mass treatment coined by the clinics as degrading the humanity of the patient, which can allegedly be upheld only by the family doctor:

The future health need of the public can best be supplied by a more humane, painstaking, better qualified, general practitioner of medicine. *The family physician should remain the foundation of medical service.* [...] The loyal service of the ideal general practitioner of medicine will go far to limit the advent of *insurance method of treatment, state systems, industrial groups, and other socialized principles* which the true psychologists and humanists in medicine look on as *mechanistic, soulless, bureaucratic, card index systems...* (Phillips, "The Physician and the Patient of the Future," *JAMA* 86: 17 [Apr. 1926], 1262; emphases added).

for cure."²⁶⁵ Some other doctors—mostly younger, well-educated professionals inclined towards the methods of social medicine—regret the fact that the AMA became, during the inter-war years, the defender of the interests of the less-qualified general practitioners who felt threatened by both public health and specialists.²⁶⁶

3.2.2 *Professional Medicine and Federal Programs.* In the preceding section, I have used the Foucauldian concept of power as a centerless network of relations to show that the American health care in the early decades of the twentieth century can hardly be viewed as a unified agent, pursuing a single interest. Rather, we have seen at least two subjects—the membership of the AMA and public health—confronting each other. In this section, I would like to add a third contestant: I would like to examine the aspects and consequences of the federal government involvement in vd control in the interwar years, and especially the anti-vd legislation of 1918 and 1938. The Chamberlain-Kahn Act of 1918 was, as mentioned above, passed in the wake of the shocking revelation of the scope of the vd epidemic among recruits after the US declaration of war in 1917. On the basis of the Act, one million dollars was distributed to the states in 1918 for the prevention, control and treatment of venereal diseases. Admittedly, this was a modest sum even by the 1918 standards; moreover, the federal

²⁶⁵ George M. MacKee, a discussion of Dr. Keidel's paper "Economic Aspects," 481.

²⁶⁶ Cf. a number of statements in the 1937 collection *American Medicine*:

I suppose that the chief objection to public health service would come from the organized medical profession. We know that many physicians now object to considerable health work that is already done. For instance, immunization and other methods for control of communicable diseases. This is unfortunate, and the tendency of some medical societies to support the attitude of individual physicians is greatly to be regretted. It can end only in harm to the profession itself. It should be combatted [*sic*] by effort to educate physicians and dentists to realize that the important economic and social changes are necessary great changes in the practice of medicine (871).

The doctors claim that free immunization of school children is taking money out of their pockets, and yet they are unwilling to immunize the indigent. I believe that food handlers' examinations, immunization of school children, venereal disease clinics, free Wassermanns, TB, typhoid, GC, etc. examinations are purely matters for the public health and should be done by them. The health of a whole country is affected by these matters and the doctors should lay aside their selfishness and get in behind these movements wholeheartedly (877-8).

government was willing to provide the money only as matching funds. That means that individual states had to match every federal dollar by one from their own budgets. However, the Act also standardized the control measures by requiring that the state departments receiving federal allotments comply with regulations promulgated by the Secretary of the Treasury. The state boards or departments of health had to adopt health regulations having the effect of law and conforming with the suggestions approved by the Surgeons General of the Army, Navy, and United States Public Health Service. Official suggestions for state health laws stipulated that venereal diseases must be reported to local health authorities and that a penalty must be imposed on those who fail to do so; that public health officials investigate all cases in order to discover and control sources of infection; that patients be given information about measures for preventing further spread of the disease and the necessity of prolonged treatment; that the spreading of vd be unlawful and that provisions must be in place for controlling those who do not protect others from infections; and that the travel of infected persons must be controlled by regulations conforming to interstate regulations.²⁶⁷ The states were also required to establish bureaus for the control of venereal diseases and adopt regulations recommended by the army, navy and the United States Public Health Service for the control of venereal diseases. The venereal disease control work followed four major lines: establishment of venereal disease clinics; education of the population in the nature and prevention of venereal diseases; repression of prostitution; and establishment of detention homes for rehabilitation of prostitutes and institutions for quarantining the individuals believed to be dangerous to public health.²⁶⁸

Although the federal allotments for vd control were cut back already in 1921, and cut off entirely a couple of years later, the short-lived involvement of the federal

²⁶⁷ Cf. "Regulations," *PHR* 32: 2, No. 37 (Sep. 1918): 1537-1540.

²⁶⁸ E. E. Pierce, "Venereal Disease Control in Civilian Communities", *AJPH* 9 (1919): 340-345.

government in vd control validated the efforts of those states and municipal departments of health which had already tried to control vd. Moreover, the federal allotments encouraged the adoption of regulations and vd control programs by boards of health of those states that until then did not confront venereal infections. By 1919, 39 states adopted regulations emulating the model laws recommended by the federal government. By the same time, the states opened 125 vd clinics.²⁶⁹ The new health regulations adopted by the state departments of health changed the landscape of vd control. In contrast with the pre-war practice, health departments implemented more comprehensive vd control programs. The clinics rendered both diagnostic services and treatment, and educated their patients about the nature and prevention of vd. The states also provided laboratory services to private physicians, thus trying to encourage them to test their patients for vd. Yet, as we shall see, medical professionals again perceived all these efforts mostly as an invasion of their territory and welcomed the termination of federal involvement in vd control.

There is not much data concerning the impact of the federal sponsorship of vd clinics in individual states during the 1920s and 1930s—more precisely, the period beginning with the discontinuation of federal funding, in the early 1920s, and ending with the passing of the National Venereal Disease Control Act, in 1938. However, it would be a mistake to believe that the absence of federal involvement destroyed public health activities. The intervening years saw the development of the clinical technologies of treatment that I described in Chapter 2. They were also the time of the continued struggle between public health and the medical profession, some aspects of which I described in the previous section. But it is also instructive to inquire in what ways the cessation of the federal involvement affected the running of vd-control endeavors in individual states. This topic has not so far been researched. I suspect this omission can

²⁶⁹ Ibid.

be partly blamed on the widespread methodological predilections that I have complained about throughout this thesis—namely, the preoccupation of many researchers with global policies and the accompanying ideologies. Many are still reluctant to turn to the local and the material. Admittedly, it is often difficult to uncover the relevant data. Yet I have found some information on the effects and after-effects of the 1918 federal policies in Kansas, which also indicate a comparable situation obtained in other states.

The first vd clinics in Kansas opened in 1918, together with a state laboratory which performed serologic and bacteriologic tests for syphilis and gonorrhea for physicians free of charge. The control program conducted by these institutions was approved by the Kansas Medical Society. Significantly enough, the resolution by which the vd control program was endorsed mentions the following three features of the program: (1) free testing services for physicians at the state labs, as mentioned above; (2) free supply of physicians with Salvarsan for the indigents; and (3) the free distribution of a manual on treating vd.²⁷⁰ There is no mention of free clinics, to which doctors would have surely objected; all the clinics were pay clinics. Earle Brown reports that during the duration of the Chamberlain-Kahn legislation,

Kansas had a venereal disease control program comparable with those in other States, at least of corresponding population. Adequate treatment facilities were available to indigent population through the services of practicing physicians and the operation of 11 clinics located in larger cities. The program was coordinated, not only with medical services for the indigent, but there was an excellent educational and enforcement program.²⁷¹

²⁷⁰ Cf. Earle G. Brown, "The Venereal Disease Control Program in Kansas," *Proceedings of Conference on Venereal Disease Control Work 1936*, 17.

²⁷¹ *Ibid.*, 18.

Last but not least, “[t]here was unusual cooperation by the physicians in the reporting of cases.”²⁷² Unfortunately, in consequence of the discontinuation of the federal aid program in 1921,

all aid to clinics was discontinued, except supplying free neoarsphenamine. Due to a lack of funds to pay his salary, the director resigned effective July 1, 1923, and direction of the work was assumed by the secretary. One year later, and with a further reduction in the budget, it was necessary to dispense with the services of educational director; and the work was then limited to *the work of the social investigator and the distribution of pamphlets and posters, slides, moving pictures, and free neoarsphenamine*. The investigator resigned in 1925. [...] *Distribution of free neoarsphenamine was also continued until 1933*, through funds appropriated to the public health laboratory. Due to a lack of funds and also *the opposition of free treatment*, the number of clinics gradually decreased. *Since 1930, clinics have operated in the three large cities only* [...] Further reductions were made in the State health department appropriations by the 1933 legislature. It was then necessary to limit the activities of the public health laboratory and at the annual meeting that year a regulation was adopted requiring applicants for a Wasserman test to sign a blank stating they were unable to pay for the service, and also that they were residents of the State of Kansas.²⁷³

One way of reading the above passage is to interpret it as a depressive account of fall and decline. However, I think we should accentuate the positive. Spearheaded by the 1918 Act, an up-to-date vd control was established in Kansas and, despite all the budget cuts, the clinics survived—at least in the three largest cities, with some form of educational program and the distribution of free treatment to the poor—until the early 1930s. It is also important to note that the program was being reduced not simply for budgetary reasons, but also as a result of constant attacks from the professional medical community. It is imperative that we do not underestimate the likely impact of the continued existence of the vd clinics, with their novel techniques and routines, on their

²⁷² Loc. cit.

²⁷³ Ibid., 18-9 (emphases added).

patients. We also have to be aware of the continued struggle in instituting these techniques and routines against the resistance of the medical profession as represented by the AMA.²⁷⁴

The efforts to fight the vd epidemic received a new impetus in 1936, when Thomas Parran, then the Surgeon General of the USPHS, summoned The National Conference on Venereal Disease Control in Washington.²⁷⁵ Inspired by Franklin Roosevelt's "New Deal" politics, Parran was hoping to reinvigorate the government's involvement in the fight against the epidemic. Under the Title VI of the Social Security Act of 1935, the Public Health Service had already received \$8 million dollars to be distributed to the states' health care programs, ten percent of which was eventually used in support of vd-control programs. This was the first federal money spent on such programs since the discontinuation of the federal aid program in 1921. Yet the greatest success of Parran's lobbying came in 1938, when The Congress passed the National Venereal Disease Control Act 1938. The Act allocated grants to the state boards of health to fund diagnostic and treatment facilities, train personnel, and support research into vd treatment and prevention. From the original unrealistic \$271 million to be spent over a thirteen-year period, the budget was scaled back to \$15 million over the next three years.

Although the 1938 Act meant an important success for public health, we should not underestimate the opposition that immediately rose against it on the part of the

²⁷⁴ Let me provide some more statistical data about the number of the clinics in the US in general and in Kansas in particular in the years between 1918 and 1938: In 1919, there were in the US 253 clinics jointly operated by the USPHS and state boards of health ("Division of Venereal Diseases, November 1-December 31, 1919," *VDI* 35: 1 [1920], 221). Another source reports 237 clinics in 1919, and an increase to 427 clinics in 1920 (John W. Hart, "The Present Status of Venereal Disease Clinics," *VDI* 35: 3 [1920]: 2779). A survey of 1924 covered 502 clinics; there were 9 clinics reported in Kansas in that year ("Division of Venereal Diseases, July 1-December 31, 1924," *VDI* 40: 1 [1925], 722-3). As of December 1926, 410 vd clinics reported admitting 52,033 new, predominantly syphilis and gonorrhea, patients. The number of clinics in Kansas at that time was 6 ("Division of Venereal Diseases, July 1-December 31, 1926," *VDI* 42: 1 [1926], 756-7).

²⁷⁵ I take the data in this paragraph from *No Magic Bullet*, 142-3.

medical profession. Allan Brandt says that American physicians embraced the 1938 Act.²⁷⁶ But remember that he assumes that a crucial factor in the vd control efforts was the availability of funds and argues, in effect, that the funds would keep pouring in, *if* the ideological prejudice against vd were overcome. So support for the 1938 Act by American physicians would help corroborate Brandt's hypothesis. However, this support simply did not exist. I have already cast doubt, in Chapter 2, on the thesis that an increase in funds could, by and in itself, make anti-vd control more efficient in the absence of adequate techniques of treatment—namely, the techniques that were being hammered out in a trial and error fashion at the vd clinics. I extend my argument in the present chapter by claiming that any increase of funds by the government was fiercely opposed by the medical profession itself. The 1938 Act is no exception. First of all, there is evidence that the AMA resented already the opinions expressed at the 1936 Conference on Venereal Disease Control. A year after the conference, Dr. H. Sheridan Baketel wrote that the plans of the delegates of the Conference threatened "to trample private practice unless the profession take immediate action."²⁷⁷ He continued: "The medical profession is glad to extend itself to the utmost in furthering a campaign which will result in a more satisfactory reporting of venereal cases. Emphatically, however it challenges the establishment of clinic which would render free treatment to the public at large!"²⁷⁸ Secondly, there is the official statement of the AMA concerning the 1938 legislation, which appeared in the editorial of its *Journal* published that same year. The editorial finds objectionable that the Act pledges to "provide free diagnostic and treatment facilities for the diagnosis and 'emergency treatment' of *any patient who*

²⁷⁶ Brandt writes: "Even the American Medical Association, noted for its attempts to keep the government out of medicine, offered no resistance to the anti-venereal legislation" (*No Magic Bullet*, 145).

²⁷⁷ H. Sheridan Baketel, "Crusade into Crucifixion," *ME* (Mar. 1937), 38.

²⁷⁸ Loc. cit. Cf. also *Idem*, "Fusion or Confusion," *ME* (Nov. 1937): 38-9; and *Idem*, "Time to Call a Halt," *ME* (Mar. 1938): 40-1.

applies and for any patient referred to by a private physician either for continued treatment or for consultative advice."²⁷⁹ The authors of the editorial continue sarcastically:

There is no requirement that patients in either of the two classes named above be financially unable to obtain from private physician the needed medical care [...] Thus apparently a person who is financially able to support himself with all the necessities and luxuries of life may yet obtain free treatment at the expense of taxpayer if he is referred to a federal-state clinic by a private physician or may, without being referred, receive "emergency treatment," whatever that term may mean in this connection.²⁸⁰

Apparently, the representatives of the AMA were not willing, in 1938, to acknowledge that the Act was, among other things, a reaction to the Depression which impoverished even large numbers of middle-class patients, and thus made expensive private treatment inaccessible to them. Another physician complains: "The goal is, of course, that of Denmark, where 85% of syphilis cases are treated in free clinics at the expense of the tax-payer, but worst of all at the expense of the private physicians."²⁸¹

Characteristically, however, the same author does not find objectionable the idea that the taxpayers subsidize the doctors, by providing them with laboratory equipment or even supplies of Salvarsan:

The expense of the laboratory work in particular makes it difficult for the general practitioner to put into practice the scientific method and often drives him into an approximation of it, which is not so good. In order to obviate this the N.Y. City Department of health has adopted a new attitude. Previously it did such laboratory work only on cases reported by name as absolutely indigent.

Recently in their desire to actively enter the movement for the eradication of venereal diseases they have asserted to the practitioners their willingness to do

²⁷⁹ "Federal Subsidies for Free Treatment of Venereal Disease Patients," *JAMA* 111: 2 (Jul 1938), 429 (emphases added).

²⁸⁰ Loc. cit.

²⁸¹ Irving Simmons, *Gonorrhea and Syphilis: What the Layman Should Know* (New York: E. P. Dutton, 1940), 181.

all laboratory work for any patients unidentified, and will even furnish for his treatment supplies of Salvarsan and other expensive drugs upon request.²⁸²

This arrangement was intended to motivate private practitioners to administer treatment to poor patients; but the doctors, of course, charged fees for administering the drug. Yet, despite the opposition by the AMA, the 1938 Act was a great boost to the anti-vd efforts in the US. The number of vd clinics increased from 1,750 in July 1938 to some 3,000 in July 1940 and, thanks to subsidies, treatment was accessible to many more people. As a result, the number of patients under treatment increased from 15 to 58 percent.²⁸³ These were substantial successes shortly prior to the discovery of penicillin.

3.2.3 Specialists and Public Health. So far I have examined the dynamic of power relations in the US anti-vd efforts by considering the relations between the medical profession, on the one hand, and several of its contestants—public health and the federal government—on the other. As I noted, the clash between the medical profession and public health should not be construed as simply coinciding with the opposition between older-generation general practitioners and younger-generation specialists. Certainly such an opposition was there to a great extent—just consider the following statement by Dr. Jeffrey Michael, which suggests that public health is going to benefit specialists at the expense of general practitioners:

²⁸² Loc. cit. Simmons goes on to recommend, as a solution to everyone's problems, a more efficient use of the general practitioner: "If he lacks knowledge of the last word and the up-to-the-minute methods of diagnosis and treatment he can be instructed by departmental heads of the Health Agencies and the hospitals. He should also be given more power to control through a reporting system with teeth" (*ibid.*, 186). And so on. The only difficulty with such measures is, of course, that they always failed because of the unwillingness of physicians.

²⁸³ Cf. Brandt, *No Magic Bullet*, 147. Again, I beg to differ from Brandt as long as he overestimates a mere increase in funding as a main factor in the success of anti-vd campaign. I believe that the money could have been efficiently spent in the late 1930s and the early 40s only because the methods and techniques of treatment—in the wide sense of the word, including education and follow-up techniques—were in the meantime improved at the clinics.

From a selfish point, state medicine may be a very good thing for the well established specialists. I can conceive of a system in which they would be in a position analogous to the proprietors of high class private schools. They would cater to the well-to-do only, receiving large fees for highly individualistic service. But the great mass of the medical profession and the public would be in no such enviable position, and it is of them we must think.²⁸⁴

Although it is true that many specialists were immediately drawn to the public health movement, with its scientific principles and new methods of treatment, other specialists' relations to public health were much more convoluted. I want to provide additional evidence for this claim in this section. I shall do this by surveying the writings of John Stokes, a foremost inter-war syphilologist whose opinions I have already cited on numerous occasions. The first thing that will be apparent in Stokes' views on the respective tasks of medicine and public health, published over the interval of more than twenty years, is sharp shifts of opinion and a lack of coherence with the previous views (sometimes, alas, also a lack of coherence within a single article). But I suggest that we take Stokes' views seriously. It would be disingenuous to dismiss them simply as a testimony to the confused *mind* of an individual, albeit a very important one. Rather, I propose interpreting Stokes' shifts of opinion as constituting the indeterminacy of relations between the respective *domains* of the professional medicine and public health during this transitional period. In other words, after I have explored the conflicts between the representatives of the medical profession and public health in the previous subsections, I want to conclude by showing how the changing loyalties of an eminent member of the medical profession instantiate the unstable power relation between the two contested domains.

Let me, then, turn to Stokes' views. In an article in the *Journal* of the AMA in 1921, Stokes praises public health for developing "a kinetic energy at least as great as

²⁸⁴ Jeffrey C. Michael, a discussion of Keidel's "Economic Aspects," 481.

that of any other outstanding campaign against a problem in disease," asserts that "[i]mmesurable good has and will come of it," and expresses a conviction that "[a]n antagonism between public activity and private interest [...] would be wholly unnecessary and deplorable [...]. A spirit of mutual consideration and cooperation can utilize the energy of the public attack and the skill of the properly equipped man in private to the advantage of both."²⁸⁵ In the article, Stokes discusses a resolution issued by the United States Public Health Service in collaboration with the vd divisions of various state boards of health for the consideration of the medical profession at large. The resolution urged physicians to raise the standards of vd treatment and asserted that the USPHS and the state boards "have no intention of supplanting effective private effort in this field," if patients could indeed receive adequate treatment at private offices.

Stokes comments on the resolution:

A fair demand is made of us, a demand that the medical practitioner shall practice modern diagnostic medicine in the venereal disease field or to leave the work to those who can, and that he shall refuse to accept patients with syphilis and gonorrhea for treatment unless he has had an amount of training adequate for the work he attempts.²⁸⁶

Stokes thus admits, in so many words, that private practice—at least in the area of vd, but potentially in all infectious diseases—could be gradually replaced by the clinical treatment funded by government. Even more strongly, he says:

The extinction of private practice in venereal disease is not consummation to be wished, but it will be one to be deserved if we cannot measure up by a process of internal organization and adjustment, to the standards of the most altruistic and energetic public agent in the field.²⁸⁷

²⁸⁵ John H. Stokes, "Public Health Activity and Private Practice in Venereal Disease Control," *JAMA* 76: 18 (Apr. 1921), 1266.

²⁸⁶ Loc. cit.

²⁸⁷ Loc. cit.

Stokes' enthusiasm for public health is noticeably guarded in later publications. In a 1927 article, based on a speech read at an annual meeting of the APHA, Stokes says, in effect, that public health should actively envision its activities as a mere aid to the endeavors of private practitioners, instead of pursuing the general end of eradicating an epidemic:

It is a duty of the most unmistakable sort for an association such as [the APHA], concerned with the protection and furtherance of the public health, to support and uplift by every possible means the hands of those who are trying to bring into the struggle with venereal disease an orderly and sustained effectiveness, a permanent field and headquarters organizations and facilities from which alone can come results such as are now being published to the world from the other side of the Atlantic.²⁸⁸

The allusion to the successes of anti-*vd* efforts in Europe—on “the other side of the Atlantic,” as Stokes puts it—seems disingenuous: Stokes does not mention that the treatment of syphilis in, say, England or Denmark was free of charge irrespective of the patient's income level, and thus available even to the middle class with modest resources—a fact which might have been the main secret of the success in *vd* treatment in those countries. Similarly misplaced is a praise of the allegedly systematic effort of physicians over an unstable interest of the government—“The ebb tide of a fiscal program built for war emergency has left the skeleton of a great public health campaign high and dry on the shoals of an unenlightened retrenchment policy”²⁸⁹—when Stokes himself feels it necessary to urge private practitioners in almost every paper to improve their skills in the treatment of *vd*.²⁹⁰ Thus he frankly admits, in 1930, that “this country [i.e., the US] can show no clear-cut evidence of a reduction in the incidence of venereal

²⁸⁸ Stokes, “Venereal Disease Control,” *JAMA* 90: 10 (Mar. 1928), 743.

²⁸⁹ *Loc. cit.*

²⁹⁰ On Stokes' complaints about the incompetence of private physicians, cf. a special Section 3 of Chapter 4 below, in which I discuss these matters in the context of a Foucauldian concern for resistance.

disease after years of care by the practitioner for the infected person."²⁹¹ Yet paradoxically enough, he at the same time—at the same page, in fact—expects a “revivification” of anti-*vd* efforts from the “medical individualist,” i.e., the private practitioner. This incoherent statement is a testimony to the difficulty of a complete shedding of loyalty to the traditional medicine by a specialist, who at the same time believes in the efficacy of modern mass treatment.

In 1934, Stokes seems to admit that early syphilis could actually be best treated at the clinics, since it is “amenable to a considerable degree of routinism, standardization and mass technic [sic.],”²⁹² while the late stages of the disease should presumably be handled by an individualized approach available only at the hands of a private physician. Even this proposal of a division of labor seems to be retracted a year later, when Stokes argues that syphilitic clinics are actually less capable than private practitioners “to reach into the corners and the hidden places, to meet the odd hours, the special circumstances of exposure, of detection of the ensuing infection and control of the ensuing risk which the fine-point epidemiology of syphilis involves.”²⁹³ This is a complete negation of the conviction of Dr. Waddell, cited in the previous chapter, that the New Clinic would be able to permeate “every nook and cranny” of the social body. And yet Stokes acknowledges that private physicians can hardly be induced to carry out contact-tracing. Asking himself rhetorically, “Shall we expect tracing of contacts from the practitioner?,” he answers: “Try it once for yourself to realize the difficulties.”²⁹⁴

The strangest development by far in Stokes’ change of opinion came late in his career. Although he spent his career dealing with concrete issues of medical science and treatment policy, Stokes published in 1944 an unusually general piece about the

²⁹¹ Stokes, “Critical Treatment Problems in Today’s Syphilology,” *JAMA* 94: 14 (Apr. 1930), 1030.

²⁹² Stokes, “Standard Treatment Procedure in Early Syphilis,” *JAMA* 102: 16 (Apr. 1934), 1267.

²⁹³ Stokes, “A Hilltop on the Syphilologic Mame,” *AJSGVD* 20: 3 (1935), 235.

²⁹⁴ *Ibid.*, 238.

meaning of and future prospects of vd treatment. He muses about the role of sex in modern civilization, the decline of morality, and the need for family values. After a lifetime devoted to improving the treatment of syphilis, he now complains that the promise of a complete elimination of vd is not so desirable after all. "If sexual relations lead neither to significant illness nor to unwanted parenthood, only a few intangibles of the spirit remain to guide the children of our science from an outmoded past into an unbridled future."²⁹⁵ One must realize that this is written shortly after the discovery of penicillin, which made speedy cure of syphilis a reality. Although the new cure was not yet available to civilian population, Stokes correctly realized the implications. Yet instead of welcoming penicillin as a means to realizing his lifetime efforts, Stokes recommends—shockingly enough—a return to the approach of social hygiene that he and others in the medical profession long ridiculed. He writes:

We who cannot look upon this prospect [of illegitimate sex without punishment either by vd or unwanted pregnancy] with equanimity had best arouse ourselves. What better form could this arousing take than a revival of our social hygiene ideology, a return to first principles, long obscured by the control authority's stentorian call to treatment rather than to prayer.²⁹⁶

Perhaps we should not dismiss Stokes' late turn to moral conservatism as just an idiosyncrasy on the part of an old, disgruntled man. Until the discovery of antibiotics, the vd treatment had become, as I shall argue in Chapter 4, a useful technique of policing people. Now that syphilis ceased to pose any danger and its cure could be completed within a week, more people began to worry about the consequences of this on society. But more about the impact of treatment on the patients in the next chapter.

Again, let me summarize the key points of this chapter. Following Foucault's lead, I blocked the assumption of a center of power with a single intentionality. Instead, I

²⁹⁵ John Stokes, "Some General Considerations Affecting Present-Day Sex and Sex Education Problems," *VDI* 25 (1944), 198.

²⁹⁶ Loc. cit.

tried to present the implementation of the modern practices of vd treatment as being torn by multiple political conflicts. I found out that this process was characterized especially by the conflict between the professional physicians, with their interest in preserving individual-based type of medicine, and public health, which championed mass treatment methods more suitable for dealing with the vd epidemic. In addition, I discovered other conflicts: professional medicine vs. social hygiene; professional medicine vs. federal programs; and specialists vs. public health.

Chapter 4: The VD Patient: Object, Subject, Resistance

For a long time ordinary individuality—the everyday individuality of everybody—remained below the threshold of description. [...] But disciplinary techniques reverse this relation, lower the threshold of describable individuality, and make of this description a means of control and a method of domination. The description is no longer a monument for future memory, but a document for possible use. And this new describability becomes more marked in proportion as the disciplinary framework becomes more strict: the child, the patient, the madman, the prisoner will become, with increasing ease from the eighteenth century on and according to a rising curve which is that of the mechanisms of discipline, the object of individual descriptions and biographical narratives. This turning of real lives into writing is no longer a procedure of heroization; it functions as a procedure of objectification and subjection/subjectivation.

—Michel Foucault, *Discipline and Punish* (1975)

If every case of syphilis can be given adequate treatment there will be no more syphilis.

—Thomas Parran, "The Treatment of Syphilis in Its Relation to Prevention" (1929)

My aim in this final chapter is to explore the ways in which the treatment of vd helped constitute the modern subject. By the "modern subject," I mean, firstly, an *individual*—not a nameless member of an undifferentiated mass, but a particular character with a unique history. Secondly, I mean a *self-disciplined* individual. That is, the modern subject is not just an object of disciplining and policing, a thing to be described and catalogued, but truly a subject: a *somebody*, not *something*, that directs oneself, rather than being directed from the outside. And yet the process of subjectivation is not really separable from the process of objectification. In other words, the modern subject has been posited by specifically modern discourses and practices. From this point of view, talk of the modern subject *per se* is too general; it is more

appropriate to speak of a variety of modern subjects that were constituted by different discourses and practices. Thus we can distinguish, e.g., the criminally delinquent of criminology, the homosexual male of sexology, the hysterical woman of psychiatry, etc. I attempt to draw a portrait of another personage: the vd patient, to whom—as I argue—we can trace the origins of the modern disciplined subject. The chapter divides into three sections. The first section discusses in some detail the ways of constituting the vd patient as a kind of object. I analyze topics such as turning each individual—originally just an indistinct part of a collective—into a “case” with a specific “history” by means of expert descriptions and labels, and a variety of training and instruction. In the second section, an examination of the constitution of the patient as, in turn, a subject, I am looking at the techniques of interviewing the vd patients about their sexual contacts, as a special case of the practice of the confession to which Foucault traces the genealogy of the modern subject. The patient becomes a subject as soon as it is induced to speak and his speech is heard rather than ignored. Finally, in the third section of the chapter, my goal is to take notice of instances of resistance to that kind of caring power that promised to change the lives of patients for the better. The topic of resistance has been, as is well known, perhaps the most contested area of the Foucauldian methodology, as so many of its critics charged that it makes power inescapable. In my view, the Foucauldians must not answer the charge by making incoherent concessions, such as limiting the scope of power. A consistent answer rather involves recourse to diffuse, humble forms of negotiation between power and its subjects, through which both sides of this struggle constantly redefine themselves in unpredictable ways.

4.1 Patient as an Object

Foucault argues that disciplinary power operates primarily on the body by shaping it according to a norm. This contrasts with the Classical model, in which bodies

are individuated by means of external signs. The two modes of bodily individuation—Classical and modern—are compared in the opening of *Discipline and Punish*, Part Three, Section 1: “Docile Bodies:”

Let us take the ideal figure of the soldier as it was still seen in the early seventeenth century. To begin with, the soldier was someone who could be recognized from afar; he bore certain signs, the natural signs of his strength and his courage, the marks, too of his pride; his body was the blazon of his strength and valour, and although it is true that he had to learn the profession of arms little by little—generally in actual fighting—movements like marching and attitudes like the bearing of the head belonged for the most part to a bodily rhetoric of honour.

By the late eighteenth century, the soldier has become something that can be made; out of a formless clay, an inapt body, the machine required can be constructed; posture is gradually corrected; a calculated constraint runs slowly through each part of the body, mastering it, making it pliable, ready at all times, turning silently into the automatism of habits; in short, one has ‘got rid of the peasant’ and given him ‘the air of a soldier’.²⁹⁷

I read these remarks about the passage from the lump of clay of a peasant to the well-trained beast of a soldier as a general model for the genealogy of the modern body. I wish to concentrate on one aspect of this genealogy, namely the passage from the careless syphilitic, who did not mind his lesions, to the disciplined patient, who is objectified as a “case” with a specific “history”—but who is also a subject, who consults an expert physician concerning the cause and possible effects of any apparently abnormal changes on his body. Of course, it would be both naïve and un-Foucauldian to view this development as a transition from a complete ruthlessness to a complete discipline; what is at issue here is not an absolute rupture, but rather an emergence of new forms of caring power, which gets invested in the bodies and modifies itself as it

²⁹⁷ *Discipline and Punish*, 135.

meets resistance in modifying them.²⁹⁸ And yet the contrast between our present and the relatively recent past is significant. Consider some of the cases described in an early issue of *The Journal of Social Hygiene*, the main periodical of the US social hygiene movement. A 1916 article by Dr. John Stokes, the renowned anti-*vd* crusader whom I frequently cited in earlier chapters, warns of “the menace of irresponsibility in the control of syphilis,” providing the following examples:

A milkman came to the clinic one morning covered with an eruption and with his mouth lined with the most virulently contagious lesions. Two of us cornered him and explained why he should come in, if only for twenty-four hours. He promised to be back the following morning and has never been seen since. Another, a butcher in the same condition, put his wife, whom he had infected, into the hospital and, in spite of every argument by chief, instructor, and resident, went home himself to attend to his business—the selling of meat over the counter. A lunch counter tender came up for examination with mucous patches in the mouth and a mass of syphilitic growths about the anus, literally oozing the germs of the disease. He promised to come in—and disappeared.²⁹⁹

These would be the cases of what came to be called “delinquency” among *vd* patients, where this term refers not just to prostitutes or unusually sexually promiscuous individuals, but generally any infected person who is unconcerned about the disease and unwilling to cooperate with health workers. I interpret these cases as providing convincing evidence of the distance between our present, at which health-consciousness is at least a shared disciplinary ideal—if not a universally followed practice—on the one hand, and the rather health-indifferent past of only several decades ago, on the other. Of course, what is really astonishing is precisely how little time has passed since the early decades of the past century, yet how massive cultural changes in both attitude and practice have happened during that short period. I contend that we

²⁹⁸ See note 68, where I refer to, and comment on, a survey of current patient compliance research.

²⁹⁹ Stokes, John H., “The In-Patient Hospital in the Control and Study of Syphilis,” *JSH* 2 (1915-1916), 227.

have here an instance of a reconfiguration of the “apparatus of health,” to slightly modify Foucault’s phrase “apparatus of sexuality”—a shift from a repressive, monarchical model of power to a caring, capillary power that, by promoting the so far neglected health of a population, targets bodies and thus turns them into individuals. The cases of indiscipline and unruliness uncovered by Stokes and others surprise us because we readily expect milkmen, butchers and others not just to grudgingly *endure* but rather to eagerly *embrace* certain standards of hygiene—but that is because self-discipline and self-policing has become so well-entrenched. Besides, we also wonder about the milkman and the butcher’s customers. While we might comprehend that an odd milkman or butcher would be criminally negligent for infecting others, what really defies our understanding is that their customers apparently did not mind purchasing milk and fresh meat from persons covered with visible lesions oozing a suspicious liquid. I think I am not mistaken in hypothesizing that our contemporaries would be wary of coming into contact with such persons, even if they did not in fact spread any infection. They would still be considered unhealthy and unclean, because of the standards that prevail today.

Now it is true that Stokes’ examples of people showing an apparent disregard for—indeed, a complete lack of interest in—their health, as well as the health of those they might infect, come from the rank of “[l]aboring men, especially foreigners.”³⁰⁰ By “foreigners,” Stokes’ contemporaries would automatically understand “non-white” immigrants, such as Greeks, Italians, Eastern Europeans, and the Irish. The term “non-white”—or “colored”—would thus have a wider extension than today, including virtually all non-Anglos, not just “Negroes.”³⁰¹ Mental inferiority would also be ascribed to vd

³⁰⁰ Ibid.

³⁰¹ For a history of the construction of the Anglo-Saxon racial supremacy, cf. Horsman, Reginald, *Race and Manifest Destiny: The Origins of Racial Anglo-Saxonism* (Cambridge, Mass.: Harvard University Press, 1981).

patients.³⁰² And more often than not, a darker complexion and a lower intelligence would be claimed to coincide among them.³⁰³ Yet it would be a mistake to interpret the references to class, race and IQ as indicators of the prevalence of vd in a certain population as simply evidence of racial bias on the part of doctors and public health officials. A higher incidence of vd among these populations cannot be disputed and cannot be considered just a fabrication of biased researchers.³⁰⁴ That said, I do not

³⁰² As late as 1947, a doctor Billings reports the case of a female patient positively tested for an early syphilis who dropped out of treatment after three injections and, when later brought back to the clinic and advised about the seriousness of her disease, remained perfectly indifferent to that news and even challenged the claim that she had syphilis. The following dialogue unfolded:

She was then asked, "If you do not have syphilis, why did you first come to the clinic?"

"I had worms," said she with assurance.

"What in the world made you think you had worms?" her physician asked her, and to this she replied, "Well, I seen them through that glass thing in the black stand." And this patient had not only been told her diagnosis, but had had an educational interview, and, as a finishing touch, had been shown her own darkfield examination! The sight of white things that wiggled had introduced the only familiar note in the whole procedure. (Terence E. Billings, "Venereal Disease Education," *VDI* 28 [1947], 163).

The author of this article also reports another disappointment, of his discovery that the educational films, which his clinics started using in hope of enhancing the education of patients, "were of little value. Our patient population was convinced that motion pictures were for amusement purposes only" (*ibid.*).

³⁰³ Here is Stokes in 1916:

The gods-defying combination of ignorance with stupidity confronts one at every turn. Within twenty-four hours of the writing of this sentence the writer undertook to persuade an Italian woman, with a chancre of the lip which she wiped with her fingers at every other word, to remain in a large hospital for free treatment. She had already infected her two children from the sore on her lip. She kept two boarders. Did argument prevail? Not a bit of it. ("The In-Patient Hospital in the Control and Study of Syphilis," *JSH* 2 [1915-1916]).

In a late report—from 1945—of a research at the Midwestern Medical Center for vd treatment at St. Louis, Missouri psychologist Robert D. Weitz and psychiatrist H. L. Rachlin report about a group consisting of 500 whites and "Negroes:"

The median intelligence quotient for the 340 white cases was found to be 84, whereas the 160 Negro girls showed a median I. Q. just below 70 [...] With respect to the cases with intelligence quotients above 100, only 63 of the 500 cases, or 12.6 percent, reached or exceeded that level. This group was comprised of 56 white and 7 of the colored cases. In other words, approximately 16 percent of the white girls and 4 percent of the Negroes reached or exceeded the midpoint of the normal mental ability range. (Weitz and Rachlin, "The Mental Ability and Educational Attainment of Five Hundred Venereally Infected Females," *JSH* 31 [1945]: 301).

³⁰⁴ No comprehensive or nation-wide statistics were available in the early 1900s. Something can be gathered from local surveys that were conducted, such a 1938 study of the prevalence of syphilis in Chicago, which showed this disease "to be eight and a half times as frequent in the

doubt that racial or classist prejudice was widely shared among doctors and public health officials of the time. Yet my objective here is to inquire into the *effects* of their findings on the constitution of the social body as well as individual bodies, rather than into whatever the contents of their minds happened to be. That is, I am interested in seeing how the category of the vd patient arose by means of the medical examination and treatment of the initially undifferentiated crowd of infected people, how this kind of person evolved through changing descriptions and disciplinary techniques, and how we have finally obtained the contemporary self-disciplined patient—along a crooked path, reminiscent of Foucault's genealogy of the modern soldier cited above.

In the rest of the present section, I shall analyze this transformation in terms of the emergence of the modern patient as a specific kind of *object*, while a study of his emergence as a *subject* will be reserved for the following section. In making this distinction, I follow the approach chosen by Hubert Dreyfus and Paul Rabinow in their excellent book on Foucault.³⁰⁵ According to Dreyfus and Rabinow, while this division is somewhat artificial, it is nevertheless helpful to distinguish between Foucault's focus—in *Discipline and Punish*—on the techniques by which the modern individual was constructed as essentially docile and mute, on the one hand, and his emphasis—in the first volume of *The History of Sexuality*—on the ways the individual was incited to talk about his sex, on the other.

Among the technologies that were developed to constitute the individual as object, the prominent ones were various ways of *labeling*. The concept of labeling is

Negro as in the white population" (L. Usilton et al., "Prevalence, Incidence and Trend of Syphilis in Chicago," *JAMA* 110: 12 [1938]: 864). More studies, and more reliable ones, were conducted in later years. For a study of a class and race structure of a small town in Georgia with respect to the prevalence of syphilis, cf., e.g., W. Lloyd Warner et al., "Syphilis Prevalence and Community Structure," *JVDI* (Jun 1951): 157-67. For comprehensive studies, cf., e.g., Charles W. Clarke et al., "How Many People Have Syphilis," *JSH* 27: 6 (1941): 269-76. All these studies report a significantly higher incidence among the low-class and the "colored."

³⁰⁵ Hubert Dreyfus and Paul Rabinow. *Michel Foucault: Beyond Structuralism and Hermeneutics* (Chicago: University of Chicago Press, 1982).

more explicitly developed by Ian Hacking and Arnold Davidson than by Foucault, but it neatly captures the theoretical gist of Foucault's genealogical analysis. I discussed the work of Hacking and Davidson in Section 1.4.³⁰⁶ Do objects come into being merely by means of a description, by appearing in a text that presumably plays a certain social role (e.g., by prescribing certain sorts of behavior and prohibiting others)? That would amount to holding "textualism," the view detected in the work of Judith Butler by her critics. For Hacking, it is true that social construction proceeds by means of description, that is, by applying labels, but the story does not end there. Let me remind you of the two components of Hacking's view. First, Hacking argues that the *kinds* of people, rather than *individual members* of these kinds, are socially constructed. The same individual can be classed as a member of different kinds, depending on which types of behavior or activity displayed by the individual are regarded as definitive of the kinds in question. Second, Hacking claims that the socially constructed kinds are *interactive* rather than *indifferent*. *Horses* or *planets* are examples of the latter, *criminals* or *sexually abused children* are examples of the former. Kinds of people, unlike kinds of animals or inanimate objects, are interactive in the sense that the descriptions and labels applied to them make a difference to the behavior of their members: whereas it does not make a difference to a piece of rock whether it is classified as a planet, it does make all the difference in the world to a human being, if it is systematically labeled as a criminal. Davidson develops a similar view of social construction of kinds of people in his detailed studies of the nineteenth-century classification of sexual deviants and perverts in connection with the discourse of "degeneracy," which explained the prevalence of perverts by postulating the heritability of abnormal features. Davidson argues that the concept of degeneracy established the boundaries between the "normal" and "abnormal" population; in other words, this boundary was not discovered, but rather "made up."

³⁰⁶ See above, 56-61.

Let me now connect this discussion with the kind I have a special interest in: the vd patient. I want first to deal with one marginal subspecies of this larger category: that of syphilitic prostitutes and other “sexually delinquent” women. Afterwards I shall relate the result of this analysis to the notion of a “normal” syphilitic patient. Being one of the most vulnerable groups of people, sexually delinquent women could be, during WWI, detained for forced treatment; sometimes, attempts to rehabilitate them into a socially acceptable way of life were made as well. However, the detention of large numbers of these women also gave ample opportunity for medical, psychiatric and sociological study. In 1920, an ambitious research was conducted on the inmates of the detention facilities in Kansas and Kentucky, the results of which were published in the *Public Health Reports* of the same year. What I wish to show is how the combination of the practice of detention with the application of expert discourse helped produce the novel kind of personality that was purportedly merely found—i.e., the personality of the vd patient. To see better what is involved in this approach, it may be useful to contrast it with that of Allan Brandt in *No Magic Bullet*. True, Brandt devotes substantial space in his study to the connections between the vd epidemic and prostitution. Yet, in accordance with his ideology critique approach, Brandt is limited to describing the kinds of ideological attitudes that informed perceptions of prostitution. Accordingly, he discusses the shifts within the social hygiene movement between attitudes of outright misogyny; condemnations of the corrupting urban life; and a moderate view, according to which female prostitutes were victims of the double-standard morality, which condoned extra-marital sex for men, and thus created an endless demand for “fresh meat.”³⁰⁷ What is common to these perceptions of prostitution and prostitutes, according to Brandt, is that they are all more or less false representations of a social reality, which would become visible once the representations were dropped. Characteristically,

³⁰⁷ Brandt, *No Magic Bullet*, 31-7.

however, Brandt does not thematize the body of the prostitute as socially constructed: this is simply not part of the problematic that his methodology allows him to recognize. I would like to fill out that gap.

I find it significant that the methods of medicine as well as of the (recently established) social sciences were applied to the study of the sexually delinquent women, because this was one of the first occasions for expert discourses to make these individuals their object. To be sure, women soliciting sex have always existed. But they existed at the margin, below the threshold of scientific discourse. As with other types of conduct prior to the consolidation of modern society—whether it was whipping for sexual pleasure, sodomy, or bestiality—sex solicitation was not picked by experts to mark out a kind of personality—i.e., a perverse personality with specific bodily and mental features. This is not surprising, given that an interest in marking out morbid segments of the population, so that they could be rehabilitated or at least isolated, could not even be expressed before governmentality determined population as the thematic object of modern power.³⁰⁸ The new urgency of collecting knowledge about promiscuous women—of completing the description of this curious species—is apparent in the report about the research carried out at Kansas State Industrial Farm and at state prisons in Kentucky in 1919. The authors, Treadway and Weldon, call for the application of the methods of cutting-edge science, so that the symptoms that signal the development towards aberration might be discovered and used in the prevention of future cases: “The resources of psychiatry must be more widely drawn upon, and this in earliest years of

³⁰⁸ Compare Foucault:

[I]t's the body of society which becomes the new principle in the nineteenth century. It is this social body which needs to be protected, in a quasi-medical sense. [...] remedies and therapeutic devices are employed such as the segregation of the sick, the monitoring of contagions, the exclusion of delinquents. The elimination of hostile elements by the *supplice* (public torture and execution) is thus replaced by the method of asepsis—criminology, eugenics and the quarantining of 'degenerates'... (Foucault, “Body/Power,” *Power/Knowledge*, 55).

childhood, to find and to correct tendencies in a child's behavior which promise to crystallize into antisocial habits and conduct."³⁰⁹ The authors of the report optimistically conjectured that the prevention of future cases of delinquency could be accomplished by methods that they referred to as "training." They write:

Obviously, recognition at an early age period of mental reactions that may be significant of later social maladaptation is of the utmost importance. For such reactions not only give warning of potential antisocial conduct, but also point to the immediate necessity of methods of training in order to counteract this tendency."³¹⁰

In this, we see an instance of that compound of knowledge and its investments in the practice of discipline which Foucault calls "power/knowledge." Finally, the study of the sexual delinquents was to be comprehensive, covering both physical and psychological aspects of their anomalousness:

The investigation was undertaken with the object of, first, determining among these sexual delinquents the presence of physical diseases and the prevalence of mental deficiency and psychopathic disorders; and, second, of studying the early, so-called normal, period of their lives with special reference to traits of personality which later resulted in antisocial conduct."³¹¹

As far as the sources of data for the study are concerned, they included official records, personal interviews, interviews with the employees of the institution, a sociological survey, interviews with family members and friends, court reports, etc. According to the study, two classes of individuals were confined at the Kansas State Industrial Farm: women quarantined simply because they had VD; and women convicted of crimes against the state. Of the members of the second group, only those who had been promiscuous were included in the study—usually brothel prostitutes or

³⁰⁹ Walter L. Treadway and L. O. Weldon, "Psychiatric Studies of Delinquents. Part I," *PHR* 35: 21(1920), 1195.

³¹⁰ *Ibid.*

³¹¹ *Ibid.*, 1197.

streetwalkers. The first group consisted of 206 women in total—59 “Negroes” and 147 whites—of 14 to 50 years of age. The second group consisted of 100 female inmates of the Jefferson County, Kentucky, jail, and other facilities in Louisville, Ky.

Let me now turn to the actual results of the study: first, results of the physical investigation. In accordance with the discourse of degeneracy, the researchers were looking for the physical “stigmata of degeneration.”³¹² Among those, they detected

malposition of the pinna, facial asymmetry, low and receding forehead, unduly high or low vaulted palate, marked malocclusion, deformities of the hands and feet, arms and legs, or abnormal distribution of the hair.

Of the total white cases observed, 60, or 41 percent, had 2 or more stigmata of degeneration; 23, or 38.9 percent, of the colored cases had 2 or more stigmata. For the whole group, 2 or more stigmata occurred in 83 persons, or practically 40 percent of the group. Only cases with 2 or more stigmata of degeneration were recorded.³¹³

Other findings include information about what, if any, dental hygiene the investigated women practiced; what dental defects they had; and the conditions of their cardiovascular, respiratory, nervous, and genito-urinary system.

Next there are the data concerning mental examination. These are more extensive, due to the researchers’ emphasis on psychiatric methods. First of all, the family and personal history of each case in the study group was investigated. We should remember that this period of time was the highest point of the eugenics movement in the US, when the volunteers conducted surveys of the masses of ordinary citizens for signs of degeneracy in the family tree.³¹⁴ So it is little surprising that these methods would be used in the investigation of the designated degenerates. Especially

³¹² *Ibid.*, 1199.

³¹³ *Ibid.*, 1200.

³¹⁴ For a history of the eugenics movement in the United States, cf. Daniel J. Kevles, *In the Name of Eugenics: Genetics and the Uses of Human Heredity* (New York: Knopf, 1985).

in the case of the 100 women detained in the Kentucky institutions, the symptoms of degeneration were discovered in their parents, ranging from "definite insanity" to an unspecified "nervousness." The study covered the personal history of sexual promiscuity of the women; the history of their partnerships; the number of their children as well as stillbirths; the school records; etc., etc. Further, the researchers were interested in the behavioral data about the inmates; accordingly, "the appearance and conduct of each woman or girl was observed while under examination and during her period of detention in the institution." (However, the report does not reveal any results of these observations.) Finally, the intellectual capacity of the inmates was determined by the Binet IQ test.³¹⁵ It was determined that "[t]he average mental age for white women was 11.3 years, for colored women was 10.8 years." Of the mental aptitude of the Kentucky women, the report says that "[i]t is probable that in this group belong many of the so-called 'degenerates,' but it seems better to consider such persons as having some degree of defect in development, rather as having degenerated."³¹⁶ The following kinds of mental disorders were ascribed to the members of the study group: "feeble-mindedness, feeble-minded epilepsy, idiopathic epilepsy, indefinite epilepsy, and constitutional psychopathic inferiority."³¹⁷ Other disorders were due to drug abuse. In general, the researchers were inclined to fix the causes of a socially unacceptable behavior on mental pathology. Of the Kansas group, "109 of these women—76 white, 33 colored—had a mental disorder preventing proper social adjustment and directly accountable for their life of prostitution."³¹⁸ The Kentucky women were divided into three groups based on the kind of "sexual immorality" they exhibited:

³¹⁵ This test determines the mental age of the testee.

³¹⁶ *Ibid.*, 1265.

³¹⁷ Treadway and Weldon, "Psychiatric Studies of Delinquents. Part I," 1195, 1207. Cf. also Robert D. Weitz, "The Mental Ability and Educational Attainment of Five Hundred Venereally Infected Females," *JSH* 31 (1945), 300-302.

³¹⁸ Treadway and Weldon, 1208.

First, those who had for varying periods of time been inmates of regular houses of prostitution, numbering 20 [...] [S]econd, those who had confined their activities mainly to street soliciting, numbering 28; and third, those who were more or less intermittently immoral, depending on an occupation or a husband for support during intervals. These numbered 52.³¹⁹

When interpreting these findings, we must be attentive to the ways in which they are utilized by the researchers in delimiting a new kind—that of the sexually delinquent carrier of venereal disease.³²⁰ It is important to see how a variety of characteristics—physical, behavioral and mental—are picked out in an effort to hammer together a novel kind of human being. A primary means of such a hammering is—as emphasized by Foucault, Hacking and Davidson—classification. Lest we not make a mistake by treating classification as a purely theoretical, power-neutral enterprise, let us realize that the very act of the isolation of the mass of promiscuous women at a certain place is itself a step in the classification. This originally indefinite group of prostitutes and syphilitics thereby becomes available for analysis and observation. It receives exact contours by means of the labels referring to a variety of mental and physical disorders; the initial group is subdivided according to behavioral and sociological criteria; the unifying framework is provided by the discourse of degeneracy.

Let me anticipate an objection: Surely the majority of vd patients were “normal” people very unlike the inmates of the Kansas and Kentucky facilities, who come out as almost subhuman from the Treadway and Weldon description? If so, why concentrate on the extreme case of the vd infected prostitute? What is there to learn from this case for understanding the social construction of the mainstream vd patient? I answer that

³¹⁹ Weldon, “Psychiatric Studies of Delinquents. Part II,” *PHR* 35, no. 22 (1920): 1255.

³²⁰ It is impossible now to verify if all the women in a facility like the Kansas State Industrial Farm shared all the characteristics that came to define the new kind of the human being, i.e., the sexually delinquent carrier of vd. In any case, the defining characteristics—being promiscuous, carrying vd, scoring low on Binet test, etc.—were picked out from among the inmates of such institutions to define the new kind.

the way sexual delinquents were handled in detention centers encapsulates the general structure of the construction of types of diseased bodies by governmental power. Foucault argued, along similar lines, that the construction of criminal bodies in the modern prison exemplifies the structure of the construction of the modern body in general. Now, it is surely compatible with this thesis to claim that there are significant differences in the ways of construction with respect to different types of bodies—e.g., middle class bodies vs. working class bodies, male bodies vs. female bodies, and white bodies vs. black bodies. I shall list three features of the construction of the diseased bodies that were exemplified in a stark form by the female sexual delinquents in prisons, but that I believe were the model, with modifications, of a governmental construction of the diseased body in general.

First, the bodies of sex delinquents were constructed as *individual* bodies with specific histories that exist in a mutual relationship with other bodies, rather than as parts of some unified social body. The notion of the body as an individual was a novelty made possible only with the ascendancy of the *epidemiological model* of vd infection. The traditional notion of the body as part of a mass was associated with an older, *environmentalist model* of the origin of diseases in the natural setting. The environmentalist model governed the late nineteenth and early twentieth century efforts of the social hygiene movement to clean the urban space of polluted air and water.³²¹ Social hygienists implied, in effect, a dualism of the polluted environment vs. the human bodies *en masse*. By contrast, the epidemiological model drew boundaries between individual bodies. In an article defending the epidemiological approach to vd, Dr. Raymond Patterson argues that “in each community, the diseases are spread by an

³²¹ The origins of vd and other epidemic diseases were construed according to the environmental model. Social hygienists saw polio as born from filth associated with immigrants and the underclass. See Naomi Rogers, *Dirt and Disease: Polio before FDR* (New Brunswick, N.J.: Rutgers University Press, 1996).

unknown, but not necessarily large, number of persons who are sexually promiscuous, who are not under medical treatment, and who remain in an infectious stage of the disease for periods varying from a few months to years."³²² The task of medical and social workers is to make these polluting individuals visible. Detention facilities of sex delinquents could, of course, achieve maximum visibility, thanks to the ideal conditions for observation and surveillance. Such conditions of transparency could never be duplicated in a larger social space with its multiple layers of opaqueness.³²³ Yet the epidemiological approach to vd made possible the tracking down of the individual even in the world outside the walls of a detention center for sexual delinquents; *a fortiori*, this model made possible the notion of the individual vd patient as a separate unit within the social space. Indeed, syphilologists filled their articles with charts representing the sexual contacts among patients, tracing the line of infection to the original source.³²⁴ This ultimate source would often turn out to be someone of "inferior" race, intelligence, or social rank (i.e., working class or underclass). In some cases, several of these characteristics would be combined: the presence at the source of vd infection would confirm the charge of inferiority.³²⁵ How many exactly would fall into this class is hard to

³²² Raymond Patterson, "An Epidemiologic Approach to the Control of Syphilis and Gonorrhoea," *AJS* (1924), 800.

³²³ Admittedly, even a detention center or a county jail did not provide complete transparency. Consider just the fact that the family and personal history of most of the detainees was out of reach due to their and their families' lack of cooperation.

³²⁴ For the charts, cf. especially the following papers: Dudley C. Smith and William A. Brumfield, "Tracing the Transmission of Syphilis," *JAMA* 101, no. 25 (1933): 1955-7; R. A. Vonderlehr, "The Administration of the Syphilis Control Program," *JAMA* 107, no. 10 (1936): 782-4; Smith, Dudley C., "Practical Epidemiology of Syphilis," *ibid.*, 784-6; Weinstein, Joseph, "On the Trail of the Spirochete and Gonococcus," *JSH* 24 (1938): 15-22

³²⁵ Albert Pfeiffer cites cases of the co-occurrence of disease and social unruliness. Here is a case history which, though admittedly extreme, was echoed in countless less spectacular cases:

The investigation started as a result of a visit to a home where three children, age twelve, nine and seven, were being boarded. All had four-plus Wassermann reactions and were being treated at a nearby clinic. Their father was in jail and the mother had abandoned the children. Later, the parents were reunited and had four more children, all of whom occupied the same room where an uncle with a constant cough also slept. Another brother of the father died leaving five children, one in a sanatorium with active tuberculosis, the others attending a

determine because of the lack of comprehensive statistical data, but the sources provide at least some local estimates from which we can extrapolate. For example, based on the records in the State Department of Health, over fifty percent of the patients with syphilis and gonorrhea in two cities in upstate New York lived in areas with "a distinct relationship between the prevalence of these diseases and tuberculosis. [...] Mental disease and crime also reach a peak in these areas, which needless to say are the city slums with the unsavory environment of more or less broken, squalid dwellings, and congested living conditions."³²⁶ We have here a superimposition of vd, TB, and crime—a co-occurrence of pathologies of both body and mind—in more than a half of the vd patients in two cities. If two thirds of the vd patients in the surveyed cities were the working poor or underclass, the remaining one third presumably were recruited from the middle class. Typical representatives are husbands who "erred" and their victims, "virtuous" wives.³²⁷ One important distinction between the underprivileged inmates of detention centers and the middle-class wives is that the latter played an important role in implementing discipline within the family. I shall return to these ways later in this, and in the following, section; but let me only mention here that the medical personnel could

syphilis clinic and living with their mother, entirely dependent upon the county for support. A third brother, a mental defective, had eight illegitimate children, five of whom were alive. One of these lived with the mother's sister and four were boarded out by the county. The great-grandmother of the children, who is still living, had 15 children, 12 of whom are living and from whom 160 descendants have been traced. There were four sets of twins and one set of triplets among the grandchildren and two sets of twins among the great-grandchildren. Altogether, this is a story of 160 individuals in a family tree, with numerous cases of syphilis, tuberculosis, gonorrhea, insanity, feeble-mindedness, illegitimacy, and crime resulting in lengthy jail sentences for theft, non-support, assault and murder" (Pfeiffer, "Social Service Problems among Venereal Disease Cases," *JSH* 21: 4 (1935): 158).

³²⁶ *Ibid.*, p. 157.

³²⁷ Cf. Bertha C. Lovell, "Some Problems in Social Hygiene in a Clinic for Women's Diseases," *JSH* 2 (1915-1916): 501-516. We know the properties of these women from the surveys, conducted during this period, that exhibit the same classificatory impulse that characterized the approach to the inmates of detention centers. See, e.g., the pioneering study by Katharine Bement Davis, *Factors in the Sex Life of Twenty-Two Hundred Women* (New York and London: Harper & Bros., 1929). Bement's is a truly exhaustive description of its subject matter, with complete personal histories and hundreds of tables establishing kinds of personalities based on variables such as "the frequency of sex feelings," "the frequency of masturbation," etc., etc.

often access the middle-class men only because their wives made them show up at the clinic. Hence, even middle-class men initially shared some of the irresponsibility and ignorance about the requirements of health with the vd patients coming from the lower classes.³²⁸

Second on my list of the three features of the construction of diseased bodies is a way in which the vd patient was established as an object *sui generis* by means of labeling techniques that involved a systematic *exclusion*. That is, one consequence of applying the label "diseased," "degenerate," or "perverted" to certain individuals was the separation of these individuals from the rest. As in the case of the female prostitutes during WWI, the separation did sometimes take the form of an actual physical removal. Dr. R. C. Jamieson, Chief of the Department of Dermatology and Syphilis in a Detroit Hospital, declares in 1917: "I am convinced that the segregation of prostitutes, properly enforced, is the best method of dealing with a necessary evil."³²⁹ By excluding the

³²⁸ Cf. *ibid.* Lowell suggests, however, that "a husband is much less likely to follow his wife to a clinic than is a wife to follow a husband. He tells her that he does not need any treatment; he does not like doctors; he is perfectly well. Or he claims to have been cured by a private doctor he has discovered; or to find all he needs for a cure at the corner drug store" (509). Cf. also: "We believe that ignorance is responsible for more cases of luetic infection than any other single factor" (R. C. Jamieson, "Syphilis in Detroit as an Economic and Social Factor," 526). Complaints about negligence even among middle-class patients are ever-present in the literature from the 1910s and 1920s. For example John Stokes writes that "[o]nly the most conscientious even of the well-to-do are likely to retain the services of a specialist on the seemingly shadowy evidence of a blood test" ("The In-Patient Hospital in the Control and Study of Syphilis," 207). But cf. also articles published in the 1930s: William Snow and Walter Clarke, "Medical Aspects of Social Hygiene in San Francisco" (*JSH* 18 [1932]: 275) and Helen Woods, "Syphilis Control: Principles of Case-Finding and Case-Holding," *VDI* 20, (1939), 371-376. Since the 1930s, however, we also find reports of the middle-classes as more disciplined than the individuals of a lower social status. Cf., e.g., William A. Hinton, A., *Syphilis and Its Treatment* (New York: Macmillan, 1936), 289. This is a disciplinary effect of vd education having begun to impact the patients' behavior at this period. For further evidence of the gradual effect of vd education on the conduct of the middle classes, cf. the results of an interesting sociological study of the population of a town in Georgia in 1950: A. Lloyd Warner et al., "Syphilis Prevalence and Community Structure," *VDI* (June 1951): 157-166.

³²⁹ R. C. Jamieson, "Syphilis in Detroit as an Economic and Social Factor," *The American Journal of Syphilis* (1918), 527. Segregation was actually accomplished at times, but experts complained it was not done systematically and comprehensively enough. Cf. the conclusion reached by doctor L. O. Weldon upon examining the prostitutes detained in Kentucky during WWI:

These cases illustrate the very ineffective way in which the courts often handle our defectives. The early and permanent segregation of such persons would do

bodies designated as “sick,” not only were the members of this group constituted as the components of an *abnormal* kind, but their separation also helped constitute the rest of the community as *normal*. The constitution of normalcy by exclusion of the abnormal is an idea central to the work of Judith Butler, discussed in Chapter 1. Yet literal exclusion was an extraordinary method usable only under extraordinary conditions, such as those prevailing under wartime. As I noted, such a harsh measure was inapplicable in peace even to prostitutes, let alone to the members of middle class. However, we can distinguish between *literal* and *metaphorical* exclusion. The former is implemented in institutions such as detention centers and prisons; the latter is practiced by classifying individuals as abnormal, without literally confining them. Consider the following two sources tracked down by an epidemiologist: a black homosexual cook who spread infection in a college where he worked, and a case of a promiscuous woman responsible for infection in her neighborhood.³³⁰ Unlike the detained prostitutes, nothing about the appearance of these two individuals strikes the doctor as abnormal—indeed, the gay cook is described as “always neat and well dressed [and] popular with the boys.”³³¹ If so, the abnormal must be marked off from the normal using, as Arnold Davidson argues, functional rather than anatomical terms. Since the cook’s perversion had no detectable, and hence visible, location in his anatomy, he was declared “mentally abnormal,” i.e., functionally disturbed.³³² Similarly, the social worker, who tracked down the promiscuous woman as the source of syphilis infection, resorted, in the absence of visible marks of degeneracy, to the arsenal of psychiatry, identifying her as “probably a

much to prevent the spread of venereal diseases, lessen crime, and save the community the burden of worthless offspring.” (L. O. Weldon, “Psychiatric Studies of Delinquents. Part II,” 1257.)

³³⁰ See William Munson, “Practicability of Epidemiological Methods in the Control of Syphilis,” *JAPH* [1931], 137-139.

³³¹ *Ibid.*, 139.

³³² *Ibid.*

nymphomaniac.³³³ Hence, exclusion can be metaphorical, rather than literal, or perhaps internal, rather than external. That is, it need not assume the form of an actual removal from a community, in the interest of better preserving this community. It can take the form of an internal confinement or limitation of freedom, again for the good of the community. For evidence that treatment of syphilis was carried out with this policing effect, consider this passage from an article by nurse Helen Woods:

It is quite reasonable that the community which makes good treatment possible for those who suffer from syphilis should require that patients shall take treatment as long as they are able to transmit the infection to others. In the interest of the common good, therefore, the patient loses some measure of freedom of choice as in other beneficial provisions such as compulsory education and vaccination.³³⁴

The *third*, and final, feature of the construction of the diseased bodies, exemplified by the female sexual delinquents, is a drive for *retooling*, which is connected with the notion of exclusion. It should be noted that Butler's notion of exclusion misses an element present in Foucault's.³³⁵ In *Discipline and Punish*, Foucault sees modern power as striving for making over or retooling—wherever possible—the delinquent, irregular and sick into the conforming, efficient, and healthy. This is the source of the dynamic of modern power: when some of the strategies for recuperation fail, others

³³³ *Ibid.*, 137.

³³⁴ Woods, "Syphilis Control," 371. Cf. also Alec N. Thomson et al., "The Genito-Urinary Department," 97: "The protection of the public demands the greatest obtainable control over the infected individual." For suggestions of some other concrete constraints on personal liberty of the infected individuals for the sake of the public good, such as limits on the freedom of movement, see David Robinson, "Control of Venereally Diseased Persons in Interstate Commerce," *PHR* 36 (1921): 2210-15.

³³⁵ Butler actually claims the work of psychoanalyst Julie Kristeva as much as that of Foucault to be the source of her ideas on exclusion. This may explain why she downplays the element of retooling present in Foucault's conception: it is important to remember that Kristeva, who theorizes the excluded as the so-called "abject," considers it to be beyond the possibility of recovery, because it is the object of an ultimate revulsion. See Julie Kristeva, *Powers of Horror: An Essay on Abjection* (trans. by Leon Roudiez, New York: Columbia University Press, 1982), 3-4. For a useful discussion of Kristeva's concept of the abject, see Chapter 8 of Elizabeth Grosz's *Volatile Bodies*.

emerge. We have seen this in the case of the changing internal organization of the vd clinic: as older strategies for treatment were failing, others were being developed, albeit with many difficulties. The detention camps for female prostitutes during WWI were not just places of confinement, but also—like modern prisons in Foucault's analysis—the places at which individuals could be turned into something socially useful, or at least—when cured of syphilis—something socially harmless. Of course, when the War ended, retooling by means of detention was no longer feasible for the indigent sex delinquents, let alone for other segments of the population. This does not mean that governmental power ceased its disciplining of bodies; rather, it developed other strategies to reach out to individuals belonging to different social classes. These other strategies picked on the fact that persons are not simply *objects* to be manipulated—which is what Treadway and Weldon seem to assume with respect to the hapless inmates at the Kansas Industrial Farm—but *subjects* that somehow react to what is done to them. Even the unfortunate inmates of the detention camps would react to the procedures they were subjected to. And the more would the well-educated and articulate middle-class vd patients. Yet public health officials, physicians and social workers did not ignore the possibility of enlisting the subjectivity of their patients in their efforts in fighting the vd epidemic. On the contrary, they soon tried to approach their patients as psychological beings, able to talk and to be talked to, being able to be retooled through their own cooperation. Let me discuss this problematic in the next section.

4.2 Patient as a Subject

Reflecting back on his overall approach in *Discipline and Punish*, Foucault admits that

[p]erhaps I've insisted too much on the technology of domination and power. I am more and more interested in the interaction between oneself and others, and

in the technologies of individual domination, in the mode of action that an individual exercises upon himself by means of the technologies of the self.³³⁶

Supplementing the analysis of the construction of the modern individual as docile and mute with a discussion of the techniques by which she became posited as a speaking subject appears to be the main purpose of *The History of Sexuality*. Foucault argues that the latter kind of techniques was developed in modern times through a transformation of the Christian practice of confession. Of course, he does not mean to imply that power operative in the technologies of discipline is repressive, as opposed to the presumably more permissive power of the confessional technologies. As I showed, Foucault understands modern power as generally productive. Its chief product is the modern subject; yet it is perfectly possible to concentrate on the objectivizing techniques that shaped this subject to a relative exclusion of the subjectivizing technologies, and *vice versa*.

The subjectivizing technologies—or, to use Foucault's term, "technologies of the self"—are predicated on the assumption that one should tell the truth about oneself. Modern philosophy as well as everyday discourse usually understands the revelation of such a truth as a negation or blocking off of power; they assume that power silences the subject, so that by speaking the truth about himself, the subject asserts himself against power. In *The History of Sexuality*, Foucault calls this assumption "the repressive hypothesis."³³⁷ Recall that he thematizes the repressive hypothesis in connection with Marcuse and the sexual liberation movement of the 1960s. In Foucault's view, this seemingly radical liberation movement was an integral part, not a negation, of the modern apparatus of sexuality, insofar as it shared the assumption that sex is a repressed core of our subjectivity distinct from power. Thus, both a conservative and

³³⁶ Foucault, "Technologies of the Self," *Ethics, Subjectivity, and Truth*, 225.

³³⁷ *The History of Sexuality*, 10-12, and the whole of Part Two.

radical modern discourse of sex took it for granted that truth and its knowledge are opposed to power; conservatives and radicals disagreed only with respect to the desirability of openly expressing the allegedly suppressed truth of the self. The repressive hypothesis overlooks the centrality of the desires of the body that have been interrogated by a variety of confessional technologies starting with the Christian penance and culminating in the techniques of the examination in criminology, psychiatry, pedagogy, and medicine. Foucault's claim is that the incitement to confess the truth about oneself, originally confined to the confessional, has become dominant in modern discourses that have nothing to do with religion. Indeed, they do not have anything in common, except that they all exhibit the type of power that Foucault came to identify, in his very last writings, as "pastoral." It follows that the caring, characteristically modern kind of power—which Foucault calls "governmental"—has its origin in the pastoral power of a Christian priest over his flock. Foucault claims that pastoral power in its original Christian form aimed at an individual salvation; a readiness to sacrifice itself for the sake of individuals in its care; a care for each particular individual rather than just the community as a whole; and a concentration on the contents of people's minds. This power "implies a knowledge of the conscience and an ability to direct it."³³⁸ The modern secularization of the pastoral power has three features:

1. We may observe a change in its objective. It was a question no longer of leading people to their salvation in the next world but, rather, ensuring it in this world. And in this context, the word "salvation" takes on different meanings: health, well-being (that is, sufficient wealth, standard of living), security, protection against accidents. [...]
2. Concurrently, the officials of pastoral power increased. Sometimes this form of power was exerted by state apparatus or, in any case, by a public institution such as the police. [...] Sometimes the power was exercised by private ventures, welfare societies, benefactors, and generally by philanthropists. But ancient institutions, for example the family, were also

³³⁸ Foucault, "The Subject and Power," *Power*, 333.

mobilized at this time to take on pastoral functions. It was also exercised by complex structures such as medicine, which included private initiatives with the sale of services on market economy principles but also included public institutions such as hospitals.

3. Finally, the multiplication of the aims and agents of pastoral power focused the development of knowledge of man around two roles: one, globalizing and quantitative, concerning the population; the other, analytical, concerning the individual.³³⁹

In the rest of this section, I focus on the pastoral “knowledge of man” that Foucault designates as “analytical.” I shall look at the techniques of confession (interview and health and sex education) that were gradually being improved during the first half of the twentieth century as part of the effort to treat VD. With the discovery of penicillin, confessional techniques acquired a new meaning. While earlier social workers could speak to patients over a long period of time, after the introduction of penicillin cure took only a week. Hence, social workers lost their chance to penetrate the patients’ private lives and influence their habits and lifestyles on a regular basis. Thus it was important to improve the interviewing techniques so that results were attainable in a few meetings.

I would like to begin by summarizing a very late—given the time frame I chose for my project—guideline for interviews to be conducted by nurses or social workers at the VD clinics. It is outlined in a 1949 paper by Dr. Nicholas J. Fiumara, “Ten Principles of VD Contact Interviewing.”³⁴⁰ I am starting with this material because it is arguably a result of several decades of tortuous trial and error, discussion and conflict. The proposal is very detailed. We should not underestimate any of these seemingly banal details. After summarizing “Ten Principles,” I shall try to accentuate their significance by

³³⁹ Ibid., 334-5. On the modern reconfiguration of the pastoral power, cf. also chapter 1 of *The History of Sexuality*, “The Incitement to Discourse,” 17-35. Cf. also Foucault’s application of his notion of governmental power in a 1977 lecture on the historical roots of modern public health policies in Western Europe, “The Birth of Social Medicine.”

³⁴⁰ Nicholas J. Fiumara, “Ten Principles of VD Contact Interviewing,” *JSH* 35 (1949): 322-7.

reviewing some key points in the messy and contradictory discussion of the preceding decades that led to the emergence of Fiumara's proposal.

Fiumara's ten principles are as follows: *First*, the interviewer must secure the patient's trust and co-operation. The interviewer's task at this stage is "to relieve patient anxiety and fears, and to develop confidence in the clinic and interviewer."³⁴¹ *Second*, the interviewer has to "re-educate" the patient; part of this re-education is testing the patient's new knowledge: "Is there a good fundamental grasp of prevention, symptomatology, etcetera, or are facts mixed with fallacies and fancies? Correct misconceptions gently but authoritatively." *Third*, the patient must be persuaded to co-operate. The interviewer is advised to "solicit the cooperation of the patient in helping to contact individuals in the same manner in which he himself is now being helped."³⁴² *Fourth*, the interviewer must "classify the patient by social type."

Question the patient about his background, his formal schooling, family, work, religious background, etcetera. Find out about his habits. Does he smoke, drink? ... Is promiscuity associated with alcoholic sprees? Is his home life happy? How often does he go out on a date with a girl...? Is it with a steady girl friend or a number of girls? ... What do they usually do? Where do they go? How much money does he usually spend on them? How many different girls has he dated, for example, during the past year? If single, what are his plans for marriage? If married, why does he go out with other women?³⁴³

Five, the interviewer must "establish the sex pattern." This involves finding answers to the following kinds of questions:

How often does the patient seek for sexual intercourse? With the same girl or with a number of them? How often does he have a nocturnal emission? What does he do when he can't find a sex partner? Masturbation, homosexual

³⁴¹ *Ibid.*, 323.

³⁴² *Ibid.*, 324.

³⁴³ *Ibid.*, 324-325.

practices? Where does he go to find new partners? How many different girls has he had sexual relations with during the past year?³⁴⁴

Sixth, the patient must then be induced to procure "contact information" concerning all his sexual partners, complete with addresses and "where the individual may be located."³⁴⁵ *Seventh*, the interviewer should follow special guidelines concerning specific venereal diseases. For example, patients with gonorrhea ought to be questioned about all contacts starting two weeks before the appearance of symptoms. Patients with primary syphilis should be questioned about all contacts beginning three months before the appearance of symptoms. Patients with secondary syphilis must be convinced to report contacts within six months prior to the appearance of secondary lesions. And so on. *Eighth*, if the interviewer finds out that a patient has friends, who either had sex with the same person as he, or are otherwise promiscuous, such a patient will be encouraged "to act as a goodwill ambassador and round up potentially infected individuals"³⁴⁶ for examination at the clinic. *Ninth*, the patient must be kept under treatment by any means available, including the waiver of the clinic fees if necessary. And finally, *tenth*, it should be so arranged that the patient stop by the interviewer's desk "each time he comes in"³⁴⁷ for treatment, in order to either pick up educational materials or fill in gaps in his contact history.

Fiumara first demands, as we saw, that the clinic personnel establish a relationship of trust with the patient. This presupposes that the patient be regarded as a psychological subject, a bearer of states of *anxiety* and *fear* that must be relieved, if cooperation is to be established. Should the clinic personnel ignore the patient's anxiety, his feeling of discomfort, and his dignity, they could not hope that the patient

³⁴⁴ *Ibid.*, 225. As a matter of curiosity, note that Fiumara insinuates here that a homosexual relation could normally be sought only as a substitute in case a heterosexual partner was wanting.

³⁴⁵ *Loc. cit.*

³⁴⁶ *Ibid.*, 326.

³⁴⁷ *Ibid.*, 326-7.

would be willing to continue treatment. Dr. H. E. Kleinschmidt observes already in 1919 that “aside from the scientific qualifications of members of the staff [of the clinic], there is another consideration, the importance of which is too frequently overlooked, namely, the personal or social attitude of the doctor toward the patient.”³⁴⁸ Kleinschmidt presciently distinguishes between two clinical attitudes to the patient: on the one hand, “[e]very patient is a ‘case,’ and as such should be critically, impersonally, and objectively studied with the same interest as is employed by the biologist in examining a newly-discovered beetle.”³⁴⁹ On the other hand,

[e]very patient is also a tangled bundle of opinions, prejudices, sensibilities, likes, and dislikes, which bundle no psychologist has yet succeeded in unraveling. He *resents* being treated as a mere specimen. He has come specifically to seek physical relief, but *desires* also human sympathy and understanding. He *craves* the good will and favorable opinion of the doctor and *offers his friendship* in return, for in the doctor he has found one who has a real understanding of his physical distress or difficulty.³⁵⁰

The clinic patient must, then, be construed as a creature that has a capacity for resenting, desiring, craving, and reciprocating a social relationship (such as friendship)—an individual rather than a kind of object. In Chapter 2, I showed that in consequence of the highly privatized system of health care in the US, the patients of private physicians already enjoyed the status of psychological beings whose point of view must be taken into account. Even though private doctors were not necessarily most competent, they at least treated their patients with courtesy, since the patients could go to someone else, should they feel slighted. Kleinschmidt now pleads for such an individualized approach

³⁴⁸ Kleinschmidt, “The Treatment of the Venereal Disease Patient,” 535.

³⁴⁹ *Ibid.*

³⁵⁰ *Ibid.* (emphasis added).

towards the clinic patient as well. Such a patient, he says, "is entitled to all the courtesy and consideration which a physician would give his best private patients."³⁵¹

Yet such calls were unheeded for a relatively long time, as is confirmed by Nels Nelson and Gladys Crain's complaints in their 1938 book, *Syphilis, Gonorrhoea and Public Health*, of the widespread practice of a degrading "cafeteria style" treatment of the clinic patients, which meant that the patients had to receive their injections standing up, with their pants down or skirt rolled up, in front of others.³⁵² A more considerate treatment should be administered in

small cubicles, set aside for this purpose, and to admit only one patient at a time. If treatment is given in privacy, with the patient recumbent, and clothing can be adjusted out of the views of others, the patient's gratitude for the considerate handling will make extra effort worth while. Clinics are public enough at best and the patient who is treated with courteous consideration of his comfort and self-respect will remain under treatment longer than the one who is constantly degraded by brutal mistreatment and unnecessary physical exposure.³⁵³

Yet, if doctors like H. E. Kleinschmidt hoped that courtesy towards the patient would make him more compliant with the requirements of syphilis treatment, they were mistaken. Patients turned out to be profoundly ignorant about the nature and effects of syphilis; hence, many tended to drop out as soon as they lost visible lesions, if they found it necessary to seek professional medical help at all.³⁵⁴ That is why it was necessary to

³⁵¹ Ibid. Kleinschmidt implies that courtesy is required especially of the doctor, but interviewing came to be the social worker's task, so their potential for empathy must have been even greater. See, e.g., Edith Baker, "Goals that Beckon the Medical Social Worker," *MH* 37 (1931): 88-92.

³⁵² Nelson and Crain, *Syphilis, Gonorrhoea and the Public Health*, 64. Helen Woods admonishes in 1939: "Where it is known that drastic measures are too readily employed to keep patients under control, there is a remarkable low proportion of new patients who seek treatment voluntarily" ("*Syphilis Control*," 372).

³⁵³ Ibid. For similar calls for individualized treatment, cf. M. M. Davis' 1920s articles cited in Chapter 3.

³⁵⁴ As a proof that mere kindness was not enough to make patients finish the treatment, consider the following polite letter sent in 1917 to Dr. William Snow in response to a follow-up card:

I am returning this card to you to let you know that I did not return to the hospital because I didn't think it necessary of any further treatment or observation. My condition is exceedingly fine. I haven't got any trouble whatsoever. I am very

educate the patients, as emphasized in Fiumara's second principle. Nelson and Crain say that "the control of the patient depends upon education of the patients,"³⁵⁵ thus expressing the notion that disciplining the patient by shaping his beliefs is more efficient than disciplining by external constraints. Obviously, the former kind of discipline presupposes construing individuals as subjects capable of attitude change to begin with—it would make no sense trying to instruct an object devoid of rationality. However, the capacity of patients for receiving information must not be overestimated. I find it very significant when Ruth Lewis says quite plainly that education should involve a fair amount of drill, both on the part of the social worker (in perfecting her skills of explanation) and the patient (in checking the degree of assimilation of information): "Routine testing of one's power of explanation and of the degree of assimilation by the individual is important. It is wise to ask the patient to repeat the instructions he is to follow. Anyone will be constantly surprised to discover how many mistakes he will make."³⁵⁶ Lewis gestures towards an important point: namely, that an individual

much surprised at such a quick cure. I thank you very much for such a quick cure, and am sending your card back because I do not want to lose the privilege of your advice in the future. (Snow, "The Medical Adviser and His Correspondence File," *JSH* 3 [1917], 516)

For evidence of widespread ignorance, cf. e.g. one of the findings of a 1928 survey: Interviews were had on the streets with 80 men in various parts of the city to test the current views of young men. The interviewer asked where an infected person might best go to be cured. Fifty individuals advised him to use "home remedies" for self-medication, or to go to drug stores; some had insufficient information on which to hazard any answer. Of the remaining thirty, nineteen recommended that he go to a physician; and eleven suggested clinics. ("A Social Hygiene Survey of New Haven" (*JSH* 14, [1928], 224)

Cf. also Franklin O. Nichols, "The Attitudes of Patients Towards Syphilis," *JSH* 19 (1933): 151-9, which reports results of a survey of three hundred patients at the syphilis clinic of the Harlem Hospital. It turned out, e.g., that patients did not understand the infectious nature of syphilis—husbands did not know they should not have sex with their wives. This was a typical answer: "Sure, I ain't heard I shouldn't. I'm married and I go with my wife. Is it all right? No, I didn't ask the doctor" ("The Attitudes," 155).

³⁵⁵ Nelson and Crain, *op. cit.*, 201

³⁵⁶ Ruth E. Lewis, "Contribution of Social Service to the Medical Control of the Venereal Disease," *JSH* 16 (1930), 275. On the topicality of education, cf. already an early paper by social worker Edith Shatto King, "Relations and Duties of Public Health Nurses and Social Workers in the Diagnosis, Treatment, and Control of Syphilis" (*JSH* 8 [1922]: 357-67), who says that instruction must not be conducted "in the spirit of preaching or of wholesale instruction, but rather in a

becomes properly self-disciplined only when the rules he adopts become so natural that they disappear from view. Compliance with those rules does not require deliberation anymore. Foucault gives expression to this idea by holding that an individual becomes a subject by being "subject to someone else by control and dependence."³⁵⁷ A refined form of such a subjection involves the assimilation of a discourse to a degree that it comes to express one's inner self—or, better, the adopted discourse comes to constitute the inner self, since there is no self prior to a discourse. There are further instances of this appeal to a full assimilation of discipline in a later literature, with the increasing emphasis on considering the patient as a psychological subject. Consider the following paragraph from a 1947 collection on the rehabilitation of female prostitutes:

patient, untiring, understanding, and individual way" (*ibid.*, 363). On the importance of repetition, cf. also Kathryn Loughrey, "Medical Social Service in Syphilis Clinics," *JSH* 23 (1937), 264: "It then becomes the duty of the medical social worker to see that patients thoroughly understand the instruction given them by the physician. Whenever necessary, the medical social worker should *reiterate* or supplement the information." In addition to her emphasis on repetition, Loughrey is also one of the first authors to suggest the desirability of repeated interviews. In her 1946 nursing manual, Evangeline Hall Morris expands the list of prerequisites of the efficient v.d. education: "The creation of a favorable mind-set, determination of the learner's level of understanding, repetition of a few important facts, allowance for patient reaction and participation and motivation without the use of fear all contribute to a successful learning experience" (*Public Health Nursing in Syphilis and Gonorrhoea* [Philadelphia and London: W. B. Saunders, 1946], 185). Notice that Hall Morris, though she does not consider drill by repetition sufficient, still thinks it necessary.

³⁵⁷ Cf. "The Subject and Power," 330. It is worth noting that this view has a parallel in Althusser's notion of subjection by a dominant ideology. Although expressed in the Marxist idiom, Althusser developed a strikingly un-Marxist concept of the subject as fully constituted by a dominant ideology. The subject is so saturated with the effects of ideology that the notion of an ideology-free subject is inconceivable. According to Althusser, ideology constitutes subjects by "interpellating" them:

I shall then suggest that ideology acts or 'functions' in such a way that it 'recruits' subjects among the individuals (it recruits them all), or 'transforms' the individuals into subjects (it transforms them all) by that very precise operation which I have called *interpellation* or hailing, and which can be imagined along the lines of the most commonplace everyday police (or other) hailing: 'Hey, you there!' (Louis Althusser, "Ideology and Ideological State Apparatuses," in *Lenin and Philosophy and Other Essays* [London: New Left Books 1971], 163).

It seems to me that this theory finds an interesting confirmation in Ruth Lewis' remarks on the drilling involved in v.d. education. An initially unruly individual learns new information and adopts certain rules and thus becomes subject to a discourse. Obviously, all this involves an idealization; in practice, the subjection involves a constant negotiation between the individual and power. This applies to Foucault as well. This points to the issue of resistance, for which cf. 4.4.

It is evidence of the unpredictability of the latent potential strengths which may be touched off by skilled case work help in an authoritative setting, strength to be developed then, by seemingly weak and irresponsible people in their own unique way and with particular appropriateness for their own lives. We believe that this material demonstrates that an individual who has been "walking in darkness," (as one woman described to her worker her feeling about being promiscuous), can find in herself something that wants to use these external limits upon her irresponsible impulse, the free exercise of which has often been unsatisfying and unrewarding, and that *she can increasingly take over these limits as her own, no longer felt as coercion imposed by society's demand for conformity, therefore to be slavishly bowed to, or blindly fought.*³⁵⁸

The passage implies that a patient becomes a subject precisely to the extent she is an *effect* of a particular set of social norms. These norms, so to speak, give a form to the patient's body.³⁵⁹

This brings me to another of Fiumara's principles, namely his requirement that the interviewing social worker determines the social class of the patient. During the period that we are concerned with here, we notice a growing tendency to take heed of the social embeddedness of venereal disease. The patient is increasingly construed as

³⁵⁸ Rosa Wessel, ed., *A Case-Work Approach to Sex Delinquents* (Philadelphia: Pennsylvania School of Social Work of the University of Pennsylvania, 1947), 126 (emphasis added). Contrast the approach to prostitutes adopted by the authors of this collection with that of Treadway and Weldon. Whereas for the latter the conceptual framework is provided by the notion of degeneracy—which leaves hardly much space for rehabilitation—Wessel and her colleagues view prostitution as largely due to a psychological and social maladaptation, rather than to a heritable degeneration. Given this reconceptualization of the nature of prostitution, it also deserves therapy and instruction rather than isolation. Cf. David B. Rotman, "A Psychiatrist Evaluates Personality," *JSH* 29 (1943), 322: "Punishment of crime as a total program is definitely on the way out [...] For the prostitute who is a chronic female sex offender I advocate dealing sternly [...] But the first offender, the accidental offender, the female rebounding from her first psychic trauma deserves all the individual treatment, medical, social, and psychiatric we can afford." A like approach is found in, e.g., Charlotte Rolison, "Social Case Work Among Venereally Infected Females in a Quarantine Hospital," *JSH* 32 (1946): 18-21; Benno Safier et al., *A Psychiatric Approach to the Treatment of Promiscuity* (San Francisco: Psychiatric Service of San Francisco City Clinic, 1947); and Richard A. Koch, "Penicillin is Not Enough," *JSH* 36 (1950): 305-16.

³⁵⁹ I am alluding here to Foucault's remarks on the "soul" as a disciplinary form of the body of the condemned from the first chapter of *Discipline and Punish*. Foucault means that subjectivity was invented by modern criminological discourse as a precondition for punishing by suspending the rights, instead of by physically torturing the body. See *Discipline and Punish*, 29-30.

not just a psychological, but also a socially situated subject. Physicians and social workers began to inquire into the class and economic background of their patients. I mentioned this already in Chapter 3, but within a limited context of establishing a threshold of eligibility for the free clinical service. Here the context is a broader one, namely that of inducing a notion of *social responsibility* in patients, and hence a willingness on their part to cooperate with the physician, divulge as complete as possible information about his sexual partners and—ideally—help convince them to visit the clinic. This sense of responsibility should be understood in terms of a replacement of external discipline with self-discipline. The responsible individual is a subject rather than an object of power: her relationship to the social reality is such that she maintains rather than resists the established order. Thus, when I argue that the treatment of syphilis and gonorrhea in the early twentieth-century vd clinic was one of the processes through which the socially responsible patient was constructed, I mean that the clinic was instrumental in making discipline increasingly less visible, since it could now operate from within the individual. Now this idea of the social construction of the vd patient as a responsible subject could be understood in two different ways. First, one might argue that the staff of the clinics *discovered*—by determining the patients' social background—those types of patients who were more responsible than others. The social construction of responsibility would thus be simply a process of selection of an independently existing class of individuals. Second, one might claim that the staff initially found most of their patients asocial, and set to drill them into responsibility. I follow this second option,

based on the evidence of a widespread neglect of the requirements of health not only among the lower classes, but among the middle class as well.³⁶⁰

There is, then, a largely forgotten history of the modern self-disciplined patient which took place at the desks of social workers and nurses of VD clinics, who tried as they could to wrench information out of their patients about the nature of their sex lives and the identity and whereabouts of sex partners. Ruth Lewis in fact goes as far as suggesting that, by breaking the silence about the sources of their infection, the patients become social subjects rather than just private individuals. She says that the diseases of syphilis and gonorrhea "are ones [...] in which the individual's responsibility to others must be recognized and invoked and ones in which the strongest personal qualities of the patients must be brought into direct combination with the scientific assets of the physician or clinic."³⁶¹ Social workers could rely on the use of the police when patients refused to speak about their sexual partners: "Many times patients refuse to divulge information regarding their sexual contacts, or give misleading data to the social service worker. The psychological effect of police investigation frequently results in the patient's

³⁶⁰ Cf. some of the papers cited in the previous section: Stokes, "The In-Patient Hospital in the Control and Study of Syphilis;" Pfeiffer, "Social Service Problems among Venereal Disease Cases." Dr. Herrick mentions in his memoir a case, described to him by another physician, of a middle-class patient who actually preferred to die rather than divulge he had had syphilis:

The late Dr. Arthur Dean Bevan related to me a remarkable story that illustrates this point. He once told a middle-aged prominent businessman that the lump in the thigh looked like a malignant tumor, but what about syphilis? If the patient ever had this disease, drug treatment would be in order and might save him from an amputation at the hip joint. The man positively denied any history of venereal disease. The patient was anesthetized in preparation for a hip-joint amputation, but Dr. Bevan wisely cut down on the mass and had frozen sections examined. The pathologist declared that the tissue was that of gumma. Of course, no amputation was performed. When confronted with the proof of syphilis, the man admitted that he had had it as a young man but thought he was cured, "Anyway," he said, "I was willing to lose my leg rather than own up to you and my family that I ever had the old disgraceful trouble." (Herrick, *Memories*, 148-150.)

I am sure someone might object that this is somewhat anecdotal evidence of the kind of resistance posed by unruly bodies to the disciplinary efforts of physicians. Yet, I believe with Foucault that it is precisely in such anecdotes and other marginal data that we must seek the genealogy of the modern patient.

³⁶¹ Ruth Lewis, "Contribution of Social Service to the Medical Control of the Venereal Diseases," *JSH* 16 (1930), 274.

revealing information not obtainable by the social service worker."³⁶² When social workers did make the patients tell the truth about their sex life, complicated patterns of sexual relations were sometimes revealed to them.³⁶³

Eventually, however, social workers became more successful in convincing their patients that they owed it to the community to become agents of the clinic in its fight against vd—consider Louise Ingraham's confident declaration of 1936 that "[a] feeling of responsibility for warning of others and preventing suffering can be developed in most patients."³⁶⁴ This "feeling" was most successfully inculcated in middle-class patients, not only by means of interviews, but also by means of educational materials published in

³⁶² George V. Kulchar and Erla I. Ninnis, "Tracing the Source of Infection in Syphilis," *JSH* 22 (1936), 371.

³⁶³ Cf. some of the cases described in Joseph Wettstein, "On the Trail of the Spirochete and Gonococcus," *JSH* 24 (1938): 15-22. Wettstein claims that by "approaching the patient and others concerned in a tactful, kindly, and sympathetic manner, it has been possible to elicit the desired information and to induce the contacts to submit to examination and treatment, if needed" (*ibid.*, 16).

I.R. [...] was thought to have been infected by C.C. [...] male, aged 18, who in October 1936 was found to have seropositive primary syphilis and neglected regular treatment. This man blamed an unknown prostitute for his condition. However, it was later discovered that he had contact with his sister-in-law D.C., aged 19, who was found to be seven months pregnant and to have active secondary syphilis [...]. At first she denied extra-marital relations. After a careful interview by the writer in the course of this investigation, she admitted her relationship with C.C. She was then considered to be the source of his infection. She apparently acquired the disease from her husband W.C. (*ibid.*, 21)

Cf. also Theodore Rosenthal, "The Compleat Case Finder," *JSH* 33 (1947), 425:

Mrs. B.S. was diagnosed on August 8 as having primary syphilis; her husband G.S. was located and examined on August 11, when a diagnosis of primary and secondary syphilis was made. The wife denied all extra marital relations; the husband G.S. refused to divulge his source of infection. By a curious coincidence, Miss M.K. was admitted on August 12 with a diagnosis of early syphilis. She gave as her regular boy friend Mr. M.M. While in the clinic, she was permitted to make a phone call to her friend M.M. and was overheard telling him not to come to the same hospital for treatment, since their mutual friends G.S. and B.S. were also in the hospital being treated for the same disease. However, M.M. was located, examined and found infected with secondary syphilis.

For some late reports on the problems with vd treatment that include a discussion of interviewing and contact-tracing, cf. Ann F. Matthews, "The VD Patient... An Individual to the Hospital Nurse," *JSH* 38 (1952): 131-7; Wilbur D. Akers and John J. Hayes, "A Venereal Disease Story," *JSH* 38 (1952): 354-62; and J. K. Shafer, "American Venereal Disease Control Problems," *JSH* 39 (1953): 357-64.

³⁶⁴ Louise Brown Ingraham, "The Persuasive Approach with the Infectious Syphilis Carrier," *JAMA* (Dec. 1936), 1991.

periodicals such a *Hygeia* and *Journal of Social Hygiene*.³⁶⁵ Particularly interesting is a 1935 paper, which tells a fictional story of a model middle-class family—the husband an executive in a small local bank, the wife volunteering for a number of local philanthropist societies, a son and a daughter—in terms of “progress” they all made over some twenty years since the end of the Great War.³⁶⁶ Initially, they were all ignorant about the dangers of vd in particular and the conditions of healthy living in general. For example, the couple was too uptight to even think of giving their children proper information about syphilis as they mature. Fortunately, they are now interested in all the new ideas about healthy living which they apply in the education of their children; consequently, they can rest assured that their son will know in detail what to watch out for—i.e., prostitutes—as he departs for college, and their daughter will be smart enough to inquire about the past life of her fiancée—i.e., about his premarital sexual experience—before she marries him. Clearly, this fictional story presents an ideal to be implemented, but it also presumably records a transformation that had actually taken place between 1915 and 1935. In his pioneering book, *The Policing of Families*, Jacques Donzelot shows how the modern family became the preeminent site of the operation of governmental power. In middle-class families in particular, this was achieved by establishing an alliance between the wife and the physician: she became the channel through which medical power could access the other family members and remake them into health-conscious, more disciplined individuals. Yet, as we saw in the above-cited fictional story, the family was

³⁶⁵ Many articles in *Hygeia* instruct the readers about proper attitudes to the symptoms of cancer and other diseases, or about the desirability of comprehensive medical examinations. See Marian Castle, “Are You Afraid, Too?,” *H* (Aug. 1932), 700-2; Haven Emerson, “What’s a Health Examination, Anyway,” *H* (Jun. 1923), 135-9; W. W. Bauer, “If I Keep My Health,” *H* (Dec. 1932); Anonymous, “Periodic Health Examinations,” *H* (June 1942), 410-11. The appeals of the authors of these articles to the rationality and decency of their readers, in an effort to convince them that if they see unusual changes in one’s body, they should report them to a doctor, instead of ignoring them, or that they would benefit from having themselves examined once a year, suggest that such practices should not be taken for granted, but rather seen as the result of a sustained effort.

³⁶⁶ Jean B. Pinney, “How Much Does the Public Know About Social Hygiene?,” *JSH* 21 (1935): 32-40.

not simply a passive object of manipulation, but rather an active agent of self-empowerment.³⁶⁷

Eventually, the efforts to turn patients into responsible subjects must have been successful, given the reports such as Dr. John Morsell's from 1952 about "volunteer vd patients:" of one thousand persons interviewed in two Ohio institutions, about "three-fifths of the members of the clinic sample were [...] classified as 'VD conscious,'" meaning they had knowledge of some of the basic facts about syphilis, and were ready to react properly, should they become infected.³⁶⁸ After the mass introduction of penicillin in 1945 (it was discovered in 1928), it became feasible to quickly stop the syphilis epidemic, since the disease was now curable in a week. Interviewing the patients about their sexual partners did not lose its importance, since there was still a probability that the freshly cured person will get quickly reinfected. Of course, with a dramatic reduction of syphilis cases by 1950, even reinfection became less likely. Yet the disciplinary effects installed by the four decades of vd treatment were well entrenched. If we are more responsible, better-disciplined patients today, we should see this in part as an odd heritage—an unintended result—of particular methods of treatment that were designed to cope with the vd epidemic.

4.3 Ways of Resistance

In this final section, I want to single out for brief special attention the concept of resistance. As is well known, resistance is a topic which allegedly poses an insurmountable problem for the Foucauldian methodology. Power that is capillary, ubiquitous, and unceasing apparently has no outside; however, it is assumed by most analysts that the very possibility of resistance is predicated on the availability of a space

³⁶⁷ See Jacques Donzelot, *The Policing of Families*. With a Foreword by Gilles Deleuze, translated by Robert Hurley, Baltimore: The Johns Hopkins University Press, 1979 [1977].

³⁶⁸ John A. Morsell, "Motivation of the Volunteer Venereal Disease Patient," *JSH* 39 (1953), 43.

external to power. Recall the Marxist paradigm, which implies that the working of power would cease with dismantling the capitalist mode of production (thus, there should be, strictly speaking, no political relations among individuals in a post-capitalist society). When applied to the domain of health and illness, this paradigm implies that the relations between doctors and patients could be power-free (e.g., if, as the proponents of the medicalization critique assumed, the medical profession lost its dominant position). According to Foucault, this hope for the cessation of power is illusory: "Power is only a certain type of relation between individuals. Such relations are specific, that is, they have nothing to do with exchange, production, communication, even though they combine with them."³⁶⁹ The exercise of power in general thus does not depend on a specific type of economic relations; the exercise of medical power in particular does not depend on a specific form of the doctor-patient relationship. Moreover—as I have argued throughout this study—subjects themselves are the *effects*, not *bearers* of power; there are no subjects prior to an exercise of power. As Foucault puts it,

[p]ower is employed and exercised through a net-like organisation. And not only do individuals circulate between its threads; they are always in the position of simultaneously undergoing and exercising this power. They are not only its inert or consenting target; they are always also the elements of its articulation. In other words; individuals are the vehicles of power, not its points of application.³⁷⁰

This statement, however, might seem to imply that resistance is illusory; everything is a more or less subtly hidden working of power and action is strictly speaking pointless—or, rather, every action is a tool in the strategies no one controls, not even those who appear to be holding power. Indeed, Foucault sometimes seems to endorse such a view. For example, when he says that power is

³⁶⁹ Foucault, "Omnes et Singulatim": Toward a Critique of Political Reason," *The Tanner Lectures on Human Values*, ed. Sterling McMurrin (Salt Lake City: Utah University Press, 1981); repr. in *Power*, 324.

³⁷⁰ Foucault, "Two Lectures," *Power/Knowledge*, 98.

a machine in which everyone is caught, those who exercise power just as much as those over whom it is exercised. This seems to me to be the characteristic of the societies installed in the nineteenth century. Power is no longer substantially identified with an individual who possesses or exercises it by right of birth; it becomes a machinery that no one owns.³⁷¹

Yet, at the same time, Foucault often writes as if his own research is meant to support resistance to oppression. He associates himself with the figure of the "specific intellectual," who he sees as a post-WWII phenomenon. Unlike the "universal intellectual" of the previous era, who opposed the total regime of power with an alternative vision, the "specific intellectual" has an expertise in concrete material struggles of particular groups such as the mental patients, prisoners, or gays and lesbians, instead of an abstract "proletariat."³⁷² Yet it seems that Foucault does not have conceptual tools for this kind of critical work. Does not such a work presuppose that the critic positions himself outside of power? We have seen that Foucault does not admit any space external to power in his theory. Some such criticism has been leveled against Foucault by a group as diverse as comprising Nancy Fraser, a Marxist of the Frankfurt School lineage;³⁷³ Michael Walzer, a liberal thinker;³⁷⁴ Joan Copjec, a Lacanian psychoanalyst;³⁷⁵ and Dorothy and Roy Porter, empirical historians of medicine.³⁷⁶

³⁷¹ Foucault, "The Eye of Power," *Power/Knowledge*, 156.

³⁷² Foucault, "Truth and Power," *Power/Knowledge*, 126-130.

³⁷³ Cf. Fraser, Nancy, "Foucault on Modern Power: Empirical Insights and Normative Confusions," *Unruly Practices: Power, Discourse and Gender in Contemporary Social Theory* (Minneapolis: University of Minnesota Press, 1989). Fraser sums up her criticism of Foucault as follows:

On the one hand, he adopts a concept of power that permits him no condemnation of any objectionable features of modern societies. But at the same time, and on the other hand, his rhetoric betrays the conviction that modern societies are utterly without redeeming features. Clearly, what Foucault needs, and needs desperately, are normative criteria for distinguishing acceptable from unacceptable forms of power (*ibid.*, 32).

³⁷⁴ Michael Walzer, "The Politics of Michel Foucault," *Dissent* 30 (Fall 1983); repr. in *Foucault: A Critical Reader*, ed. by David Couzens Hoy (Oxford: Blackwell, 1986: 51-68). Similarly to Fraser, Walzer claims that Foucault lacks a normative standpoint from which to critique certain aspects of modernity:

I don't want to ask Foucault to be uplifting. That is not the task he has set himself. The point is rather that one can't even be downcast, angry, grim,

In order to answer this criticism, it might be useful to start by reminding ourselves of Foucault's explanation of what the specificity of the power relation consists in. We know that power relations are irreducible either to economic relations or the relations of communication, even if power "combines with" the latter two kinds of relation. Foucault explains by way of an example:

The characteristic feature of power is that some men can more or less entirely determine other men's conduct—but never exhaustively or coercively. A man who is chained up and beaten is subject to force being exerted over him, not power. But if he can be induced to speak, when his ultimate recourse could have been to hold his tongue, preferring death, then he has been caused to behave in a certain way. His freedom has been subjected to power. He has been submitted to government. If an individual can remain free, however little his freedom may be, power can subject him to government. There is no power without potential refusal or revolt.³⁷⁷

Thus, power is intertwined with production in the sense that it turns individuals into specific roles such as that of the soldier, patient, factory worker, etc.; power combines with communication in that it involves speaking rather than silent individuals. This explains why any relationship of production and communication implies power relationships. However, the passage also explains why, notwithstanding this

indignant, sullen, or embittered with reason unless one inhabits some social setting and adopts, however tentatively and critically, its codes and categories. Or unless, and this is much harder, one constructs a new setting and proposes new codes and categories (ibid., 67).

³⁷⁵ Joan Copjec, *Read My Desire: Lacan Against the Historicists* (Cambridge, Mass.: The MIT Press/An October Book, 1994).

³⁷⁶ The Porters assimilate Foucault to the proponents of the medicalization critique (in particular Ivan Illich), claiming that he portrays patients as totally dominated by doctors:

All too often, historians have simply accepted the doctor as the agent of primary care. People, however, took *care* before they took *physic*. What we habitually call primary care is in fact secondary care, once the sufferer has become a patient, has entered the medical arena. And even under medical control, patients have by no means been so passive as the various 'medicalization' theories advanced by Michel Foucault, Ivan Illich and others might lead us to believe. (Porter, Dorothy and Roy Porter, *Patient's Progress: Doctors and Doctoring in Eighteenth-century England* [Stanford, Cal.: Stanford University Press, 1991], 15.)

³⁷⁷ Foucault, "Omnes et Singulatim," 324.

inescapability of power, resistance is always possible. This resistance need not be conceived of as anchored outside of power, because it is implied by the power relation itself. Power is unceasing precisely because its exercise over the subject meets with resistance. Strategies and techniques of subjection are being constantly redesigned, because once they become successful, they are challenged in the very same body they constituted. Thus the penal system could be opposed by the criminals despite, or precisely because of, the fact that penal practice succeeded in carving out this new type of subject, namely the criminal. And the vd patients could resist the efforts of public health officials precisely because the latter were able to pick out this new type of individual in need of disciplining. Foucault is thus justified in saying: "Where there is power, there is resistance, and yet, or rather consequently, this resistance is never in a position of exteriority in relation to power [...] These points of resistance are present everywhere in the power network."³⁷⁸

To this, critics such as Walzer and Fraser object that Foucault does not even have a vocabulary in which to express that a certain practice is better than another, or that a resistance is preferable to a practice which it opposes. Foucault answers that asking for criteria by which certain practices could be distinguished as inherently liberating misses the import of his genealogical criticism. One of the most important lessons of the genealogical method as applied, for example, to the development of medical practices, is that we cannot see ourselves as more liberated under the current medical practices in comparison with those of the past. When Foucault makes provocative statements such as "[W]hat happens now is not necessarily better or more

³⁷⁸ *The History of Sexuality*, 95. Cf. also: "[T]here are no relations of power without resistances; the latter are all the more real and effective because they are formed right at the point where relations of power are exercised; resistance to power does not have to come from elsewhere to be real, nor is it inexorably frustrated through being the compatriot of power" (Foucault, "Power and Strategies," *Power/Knowledge*, 142).

advanced, or better understood, than what happened in the past,"³⁷⁹ it is, I think, important to understand him in the sense I just suggested. He does not mean to deny that we can now cure syphilis far more effectively than we could in (say) 1930. In the next paragraph, I shall cast some doubts on the notion that a patient from 1930 was necessarily better-off than his contemporary who resisted treatment. However, I shall grant, as I think Foucault would, that our contemporary way of treating syphilis by antibiotics is objectively better than the treatment by Salvarsan and mercury: it is undeniably better in the sense that it is much faster and painless. However, is the contemporary patient better-off in every other relevant respect than his counterpart from around 1930? Let us not forget that our treatment methods involve a substantial interference of the medical personnel into the patient's private life by means of tracing the patient's sexual contacts—by utilizing exactly the kind of techniques that were developed in the early decades of the twentieth century. True, our contemporary might be more willing to subject himself to disciplining techniques, to the extent that he does not even perceive these techniques as techniques of subjection. However, that willingness is not something natural, but has datable historical origins. Earlier I provided ample evidence that many individuals in the past preferred living with syphilis to subjecting themselves to the disciplining techniques that went with the cure. Genealogy is useful exactly for drawing our attention to such easily overlooked facts. So, when Foucault's critics say that genealogy is unable to mark off some practices as inherently better than others in terms of liberation, they are in a sense correct. That point is easily

³⁷⁹ Foucault, "Prison Talk," *Power/Knowledge*, 50. Foucault's strong claim invites an obvious objection: Are we not better at treating syphilis today than we were in 1910? Have we not made progress at least in that respect? I suggest the following Foucauldian answer to this objection: We can certainly speak of progress in a narrowly technological sense of the word, but Foucault is reacting against the notion of progress that is much more expansive. He is opposing the idea that we have become better off in terms of better expressing our true human potential in our current practices, that we are freer now than ever before, and that this development follows an inevitable logic.

granted. We should be rather suspicious of any practice that is presented as liberating, because the historical examples of situations at which the discourse of liberation helped usher in subtle ways of subjection are too numerous. Genealogy shows that we cannot predict how our practices will develop and what new forms of discipline will emerge. However, by exposing the lowly origins of current practices, genealogy also shows that none of them are natural; none of them have reached a final shape. Hence, they are all open to challenge.³⁸⁰

In the preceding paragraph, I said that the notion that the vd patient from 1930 was necessarily better off than his contemporary who avoided treatment should not be uncritically assumed. On the surface, it seems that there cannot be any doubt about this notion. Did not the practices that were hammered out by physicians and public health officials during the period of 1900-1950 constitute an improvement over those of the previous era of unruliness and indiscipline? Were not patients better off subjected to the discipline of the clinic? Surely the Salvarsan treatment was lengthy and annoying. Moreover, if the development towards health, cleanliness and responsibility is not progress, what is? In this concluding paragraph, I should like to challenge this optimistic diagnosis, thus providing additional support for Foucault's thesis that there is no standpoint from which any practice could be judged as invariably good or bad. I wish to discuss the resistance of patients to the treatment by Salvarsan. This resistance might appear to us as plain ignorance. However, we should not be misled by appearances.³⁸¹ Perhaps it was just as well for the patients to have resisted the treatment. In Chapter 3,

³⁸⁰ For an excellent discussion of Foucault's notion of resistance, with application to queer studies, cf. David M. Halperin, *Saint Foucault: Towards a Gay Hagiography* (New York and Oxford: Oxford University Press, 1995).

³⁸¹ What appears to be ignorance is sometimes revealed as resistance to power. For example, Foucault argues that the pilgrimage to Lourdes by the millions of poor sick, which appears irrational and ignorant in modern times, might be better interpreted as "the contemporary form of a political struggle against politically authoritarian medicine." ("The Birth of Social Medicine," 155.)

I have intentionally omitted some important facts about the Salvarsan treatment connected with its high toxicity. Yet these facts are relevant in the context of the issue of resistance. In a 1930 article, Dr. Stokes reports health risks connected with Salvarsan in the context of critiquing the incompetent physicians, primarily those in private practice, who were slow in learning to administer the new drug properly.³⁸² Let me summarize the main points of Stokes' discussion. The incompetent administration of Salvarsan involved: *First*, incomplete examinations before the decision to inject a patient with a heavy dose of the toxic drug. Alas, a few hours after the first shot, "the patient is perhaps in convulsions or deaf for life. Perhaps he is merely anuric or paraplegic. Perhaps, to descend to the minor frequencies in accidents, he just vomits and can't stop, or has a chill, a high fever and a rash."³⁸³ *Second*, too much emphasis is put on technology and there is little understanding of the perspective of the patient: "too often we just shoot and shoot until the target totters and goes flat."³⁸⁴ *Third*, there is a failure to understand the seriousness of therapeutic shock, which could be reduced by giving only half the full dose the first time. Stokes recommends preparing the patients for the application of Salvarsan by a series of injections of mercury or bismuth for several weeks, although he admits that the effect of bismuth on the heart and the liver is "still a little uncertain."³⁸⁵ *Fourth*, doctors often exhibit a disregard for the "double-edged effect of rapid healing" produced by Salvarsan, i.e., the fact that curing syphilis might create new problems as serious as the original disease—fibrosis, heart problems, etc. *Fifth*, ignorance about drugs caused the killings of a number of patients each year by an incompletely dissolved acid Salvarsan injected "by an intern who was never taught to

³⁸² Stokes, "Critical Treatment Problems in Today's Syphilology," *JAMA* 94: 14 (1930): 1029-1035.

³⁸³ *Ibid.*, 1033.

³⁸⁴ *Loc. cit.*

³⁸⁵ *Ibid.*, 1034.

read a label [!!]"³⁸⁶ Sixth, "[t]he things that the dull needle, the mishandled spinal puncture and the lumpy painful butt do daily to the effective treatment and the hope for extermination of syphilis have not yet been successfully estimated."³⁸⁷ In light of these terrifying problems associated with the administration of Salvarsan, Stokes is not surprised if patients prefer to avoid treatment, and he does not deem this choice completely irrational. And we should be reluctant, on the basis of such evidence, to apply normative labels to any practice with excessive assurance. Unable to readily endorse or condemn, it is best to adopt what Hacking called an ironic attitude toward disciplinary practices.

To sum up: In this chapter, I have applied Foucault's view of the constitution of the modern individual to the issue of the constitution of the modern patient. Given that health care is an important area permeated by the modern caring power, it is instructive

³⁸⁶ Loc. cit.

³⁸⁷ Loc. cit. For later admissions of harmful effects of treatment, let me quote at some lengths from the account by Nelson and Crain, *Syphilis, Gonorrhoea and the Public Health*, 58-9:

The injection of arsphenamine or neoarsphenamine into tissues will cause great pain and may result in serious sloughing and crippling scar formation.

Arsphenamine, if overalkalized, will cause pain up and down the arm, along the course of veins. A painful inflammation sometimes follows which may result in the eventual obliteration of the vein. If the rubber tubing used in administering arsphenamine is not properly treated with alkali before it is used, "tubing" reactions may occur, characterized by chills, fever, nausea, vomiting, diarrhea and headache. Acid arsphenamine will cause pain in the chest, uncontrollable coughing, pain in the back, circulatory collapse and, if enough has been given, sudden death. [...]

Other reactions to the arsphenamines are caused by the drug itself, although its solution may have been prepared properly. They may often be avoided or moderated by cautious administration, greater dilution, and attention to the general condition of the patient. The most common of these is the nitroid reaction or crisis. It occurs during or shortly after the administration of the drug. It is characterized by a feeling of heat, cutaneous flushing, choking, coughing, palpitation, nausea and vomiting. There may also be edema of the lips, tongue, glottis or face, if the reaction is very severe, there may be circulatory collapse and, rarely, death may occur. This reaction may be mild and fleeting or so severe as to terrify both patient and physician.

A delayed reaction may occur within a few hours after administration of the arsphenamines and is commonly marked by malaise, headache, nausea, vomiting and diarrhea. More rarely, jaundice may appear within two or three days, or not until several months after the last injection of an arsphenamine, and may persist for many weeks. Occasionally the liver damage is so great and acute that death is the result.

to observe the emergence of the self-disciplined patient as an effect of objectifying as well as subjectifying health care techniques. And concentrating on the relatively marginal personage of the vd patient enabled me to study these techniques in some detail: first, the labeling techniques, which posited the vd patient primarily as an object of scientific research by differentiating it from other objects; and, second, the confessional techniques, which established the patient as a subject—an individual with an inner life. Finally, I suggested that the seemingly inescapable supremacy of power, assumed by the Foucauldian perspective, makes room for the resistance of the objectifying and subjectifying techniques.

Conclusion

I tried, in the preceding pages, to develop a novel perspective within the sociological study of venereal disease. The theoretical component of that perspective is not my creation; it is the Foucauldian methodology that has been applied in various areas of social research by many others before me. The novelty of my work rather consists, I submit, in two things. First, I took pains (in Chapter 1) in reconstructing the essential points of Foucault's theory without turning it into one of the positions it is actually opposed to. Thus, I made sure not to confuse Foucault's perspective with various theories of medicalization that are currently on the market. For example, I argued that many self-professed Foucauldians maintain, more or less explicitly, the notion of power as possessed by an agent—often construed as supra-individual—that relentlessly carries out her intentions throughout history. The modern medical profession has often been portrayed in that way. Instead, I found out that the data actually suggest that there was no center of power when it comes to the pre-WWII efforts to eradicate vd. Secondly, I applied the Foucauldian methodology to the topic of the sociology of vd, which has been so far dominated by other approaches—primarily, as in Allan Brandt's book, *No Magic Bullet*, by an ideology critique approach. Given the confines of his methodology, Brandt has concentrated on issues such as the imagery associated with vd, and its negative effects on the efforts to effectively eradicate the epidemic that plagued North America in the early twentieth century.

The methodology that I adopted helped me to articulate themes and issues that have remained so far unnoticed. Thus, in Chapter 2, I took as my lead Foucault's innovative work on the spatial investments of power, i.e., the ways in which the political shapes the smallest details of the arrangements of the spaces we inhabit. While Foucault concentrated almost exclusively on the space of the modern prison—although

he also drew parallels between the prison, on the one hand, and school, hospital and mental asylum, on the other—I have researched the spatial organization of the so-called New Clinic—the originally undifferentiated space that incorporated the utopian quest for the efficient disciplining of the diseased bodies. Although it was, of course, a part of Foucault's point that the modern prison—especially its quintessential form, Bentham's Panopticon—is the model of a modern society at large, it is still a relatively self-enclosed space. In contrast, I argued that the New VD Clinic is an architectural-political form that literally spreads onto a community. What I mean is that in addition to its interior functional partitioning into the sites of Entrance, Physical Examination, and Treatment, respectively, there are also the sites or stages of Education and, especially, Follow-Up, transcending the space of the clinic proper and radiating onto the surrounding social realm, which they aim to transform according to a disciplinary model. As I argued, we should see in the humble space of the vd clinic, whose efficient organization was endlessly debated in the long-forgotten articles in the *Modern Hospital* eighty years ago, the origins of the design of a contemporary clinic—complete with reception desk and waiting room, check-room and all the rest—that we take for granted today. The realization that the organization of the medical space that is known to us today originated in rough-and-ready adjustments to patients' non-compliance, tight budgets, and other contingent constraints, helps us see that space as transitory and accidental rather than natural and necessary.

Another theme that I developed by applying Foucault's approach concerns the disunity of the American health care in the period under study. One of the prevalent features of the critics of medicalization, who still dominate the sociology of health and illness, is the assumption that modern medicine is a unified subject that is engaged in a more or less clandestine pursuit of domination. Different variants of the medicalization critique construe this pursuit of domination differently: Marxists see it in analogy with the

domination of the working class by the bourgeoisie; feminists view medical domination as a part of the universal patriarchy. Drawing on Foucault, I see modern power as a relation rather than a property, and reject the notion of a subject that intentionally pursues power. Thus, in Chapter 3, I attempted to expose the conflicts between the medical profession and public health over the organization of anti-*vd* efforts and conflicts that characterized the development of the American health care between the 1910s and 1940s. Following the thesis of the medicalization critique, according to which modern medicine does not waste any opportunity to spread its control over patients, one should expect the medical professionals to have been interested in the best available methods through which they could discipline *vd* patients—viz., the methods that were being developed at the time by public health. Instead of a relentless pursuit of the best methods of discipline, however, I found the US medical professionals of the interwar years positively thwarting their chances to dominate, through disciplining the *vd* patients, the society at large. This confirms Foucault's insight that power should not be viewed as propelled by a conscious design of some subject, or a group of subjects.

Finally, in Chapter 4, I explored another theme well known from Foucault's work—namely, the construction of the subject through social practices. Specifically, I applied Foucault's approach to the topic of the construction of the modern patient, in which the methods of *vd* treatment being developed from the 1910s to 1940s played, in my opinion, a significant role. These methods can be shown to shape the modern patient both as a specific kind of object—i.e., a specific kind of body—and as a kind of subject—i.e., a body endowed with an inner life and intentionality, with its own purposes and interests. The modern patient was constructed as an object through the application of a variety of labels that draw on the conceptual resources of physiology, sociology as well as psychology—thus involving the notions of degeneracy, class and mental development. She was constructed as a subject especially by the methods of

interviewing—intended to track down her sex partners—which induced her to speak and assume responsibility for her acts. The topic of subjectivity brings forth the idea of resistance to discipline. I concur with Foucault's point that resistance cannot be construed in terms of a possibility of getting outside the network of power relations. Rather, calls for resistance predicated on such a possibility should be viewed with suspicion. Hence we should be suspicious of suggestions that our current medical practices, with their origins in the techniques of discipline developed through vd treatment, are necessarily liberating in some unrestricted sense.

If I should name a single most basic concept that underlies my study, it would probably be that of contingency. Throughout this study, I stressed the contingency in the development of different disciplinary practices that constitute and reconstitute the patient. The invention of Salvarsan spurred the development of a particular set of practices that resulted, in turn, in the constitution of a particular type of patient. The invention of penicillin rendered parts of this whole apparatus obsolete, but not everything has been lost. True, the incidence of syphilis and gonorrhea no longer reaches epidemic proportions and the character of treatment has changed substantially. Treatment is no longer prolonged and risky; it rather consists of a series of short treatments, as the patient may get reinfected. But the methods of keeping track of patients have survived, and not just in the case of vd patients. Most importantly, however, the extent to which modern medicine has succeeded in transforming us, in such relatively short historical time, into individuals responsible for their own health, is astonishing. Genealogy helps us feel astonishment, and sometimes indignation, about things that we might not otherwise even notice, and sometimes to our peril.

Appendix: Current Treatment of VD

Throughout this study, I relied on information about the nature and treatment of syphilis and gonorrhea available in 1900-1950. This information can be found in the standard works of the 1920s and 30s, such as Hinton's *Syphilis and Its Treatment*, Pelouze's *Gonorrhea in the Male and Female*, and Stokes' *Modern Clinical Syphilology*. But I think it useful, in conclusion, to put this historical information in perspective by summarizing the latest knowledge about VD, particularly about gonorrhea and syphilis, and particularly about their current incidence and treatment. My source is a recent textbook, *Sexually Transmitted Diseases*, by G. W. Csonka and J. K. Oates.³⁸⁸

As I mentioned in Chapter 2, unlike for syphilis, there was no effective cure for gonorrhea until the discovery of penicillin. However, since the mid-1970s, many strains of gonococci have developed resistance to penicillin, though they tend to be localized, and thus amenable to control measures. In 1985, strains resistant to another antibiotic, tetracycline, also appeared in the United States.³⁸⁹ Both of these strains are effectively curable, though, by antibiotics spectinomycin and a wide range of cephalosporins; they are administered by intramuscular injections for a week. In areas where the strains resistant to penicillin are not reported, penicillin, administered as a single dose either by mouth or by injection, is still the best and cheapest form of treatment. Significantly, Csonka and Oates note that "it is vital [...] that sexual partners are traced and treated."³⁹⁰

With the mass introduction of penicillin after World War 2, the incidence of syphilis fell so dramatically that some experts in the 1950s predicted that the disease would soon be eliminated. This prediction has proved too optimistic. Prior to the AIDS

³⁸⁸ G. W. Csonka and J. K. Oates (eds.). *Sexually Transmitted Diseases: A Textbook of Genitourinary Medicine*. London: Bailliere Tindall, 1990.

³⁸⁹ See *ibid.*, 210.

³⁹⁰ *Ibid.*, 221.

epidemic, an increase in syphilis in the West was mostly due to an increased rate of infection in homosexual men; since the onset of AIDS this trend has been reversed in both Europe and the US. However, since 1984, the rates of early syphilis have increased considerably, the source apparently being intravenous drug users, prostitutes, and their sexual partners.³⁹¹ There have been some recent reports of the resistance of *Treponema pallidum* to penicillin, but they have not been confirmed. Penicillin thus remains the drug of choice; in patients allergic to penicillin, either tetracycline or erythromycin is used. No agreement has yet been reached as to the optimal dose and duration of penicillin treatment: some physicians prefer a single-dose treatment; others repeat the dose in weekly intervals for up to three weeks. Follow-up differs depending on the stage of the disease. Blood tests are performed for up to twelve months in the case of early syphilis; two to three years are recommended in secondary syphilis; in late syphilis, follow-up is for life.³⁹² In conclusion, I would like to quote a passage providing evidence of a continued usage of the disciplinary technique of contract tracing, developed during the interwar years in the VD clinics:

As soon as a diagnosis of syphilis has been made, *the patient should be interviewed regarding all sexual contacts*. In the case of primary syphilis this should cover the previous 3 months; in patients with secondary syphilis the period should be extended to one year, and in patients with early latent syphilis to 2 years because of the possibility of infections relapses during that period. In all cases of late syphilis the regular sexual partner(s) should be seen and investigated for infection.³⁹³

³⁹¹ Ibid., 231.

³⁹² Ibid., 272. There are differences in the character of follow-up among different kinds of late syphilis (such as cardiovascular syphilis and neurosyphilis) and different stages of congenital syphilis.

³⁹³ Ibid., 269 (my emphasis).

Bibliography

Primary Sources

Ackers, Wilbur D., and John J. Hayes. "A Venereal Disease Story." *JSH* 38 (1952): 354-362.

Alvarez, Walter. *Incurable Physician: An Autobiography*. Englewood Cliffs, N. J.: Prentice-Hall, 1963.

American Medicine: Expert Testimony Out of Court, 2 Vols. New York: The American Foundation, 1937.

Baker, Edith. "Goals that Beckon the Medical Social Worker." *MH* 37 (1931): 88- 92.

Baketel, H. Sheridan. "Crusade into Crucifixion." *ME* (Mar. 1937): 38.

_____. "Fusion or Confusion." *ME* (Nov. 1937): 38-39.

_____. "Time to Call a Halt." *ME* (Mar. 1938): 40-41.

Bauer, W. W. "If I Keep My Health." *H* (Dec. 1932): 101-103.

_____. "The Physician's Place in the Health Program." *JAMA* 107, No. 7 (Aug. 1936): 485-487.

Belfield, William T. "Symposium on Syphilis," *JAMA* (Jan. 1917): 60-64.

Billings, Terence E. "Venereal Disease Education." *VDI* 28 (1947): 162-166.

Brooks, Harlow. "The Physician and the Public Health." *JAMA* 89, No. 1 (Jul. 1927): 8-11.

Brown, Earle G. "The Venereal Disease Control Program in Kansas." *Proceedings of Conference on Venereal Disease Control Work*, 1936.

Cannon, Ida M. "Relation of Hospital Social Service to the Successful Treatment of Gonorrhea and Syphilis." *MH* 9 (1919): 198-202.

Carr, Gladys L., and Goldberg, Jacob A. "Syphilis Clinics in New York." *JSH* 20 (1934): 340-348.

Castle, Marian. "Are You Afraid, Too?" *H* (Aug. 1932): 700-702.

Clark, J. Bayard. "Regarding the Treatment of Syphilis." *AJS* 12 (1928): 10-12.

Clarke, Walter, and Max J. Exner. "The Medical Aspects of Social Hygiene in Delaware County, Pennsylvania." *JSH* 19 (1933): 375-392.

Committee on Dispensary Development. "Following the Patient Through the Clinic." *MH*

- 27 (Nov. 1926): 124-126.
- Davis, Katharine Bement. *Factors in the Sex Life of Twenty-Two Hundred Women*. New York and London: Harper & Bros., 1929.
- Davis, Michael M. "The Dispensary as a Factor in Public Health Work," *MH* 9 (Oct. 1917): 268-269.
- _____. "Efficient Dispensary Clinics a Requisite for Adequate Coping with Venereal Disease." *JAMA* 65, 2 (Dec. 1915): 183-186.
- _____. "Evening Clinics for Syphilis and Gonorrhoea." *JAPH* 5 (1915): 305-311.
- _____. "General Principles in Planning Dispensaries." *MH* 20 (Mar. 1923): 221-227.
- _____. "Planning Buildings for Out-Patient Service: General Principles." *MH* 26 (Mar. 1926): 219-26.
- _____. "Some Common Mistakes in Planning Dispensaries." *MH* 19 (Mar. 1922): 221-7.
- _____. "Venereal Disease Clinics." *MH* (Dec. 1918): 436-7.
- _____, and Alec N. Thomson. "How Follow-Up Aids in Maintaining an Effective Syphilis Clinic." *MH* 27 (Dec. 1926): 122-4.
- "Division of Venereal Diseases, November 1-December 31, 1919." *VDI* 35, No. 1 (1920): 221.
- "Division of Venereal Diseases, July 1-December 31, 1924." *VDI* 40, No. 1, (1925): 722-3
- "Division of Venereal Diseases, July 1-December 31, 1926." *VDI* 42, No. 1 (1926): 756-7
- Emerson, Haven. "What's a Health Examination, Anyway." *H* (Jun. 1923): 135-139.
- Evans, W. A. "Municipal Health Officers and Venereal Disease." *JAPH* 5 (1915): 898.
- "Federal Subsidies for Free Treatment of Venereal Disease Patients." *JAMA* 111, No. 2 (Jul. 1938): 429
- Fisher, Henry A. "A Study of the Value of a Follow-Up System in a Syphilitic Clinic." *JSH* 10 (1924): 474-494.
- Fiumara, Nicholas J. "Ten Principles of VD Contact Interviewing." *JSH* 35 (1949): 322-327.
- Funkhouser, Lesley W. "A Study of the Venereal Disease Problem in New York City." *JSH* 8 (1922): 307-326.
- Funt, Julian. "Throttling Charity Abuse. A Practical Way to Weed Out the Financially Able." *ME* (Aug. 1936): 51-52.

- Golub, J. J., and Rebekah F. Dunning, "An Evening Clinic and What Its Services Include." *MH* 35: 1 (Jul. 1930): 140-144.
- Hart, John W. "The Present Status of Venereal Disease Clinics." *VDI* 35, No. 3, (1920): 2779.
- Hazen, H. H. "Dispensary Treatment of Syphilis." *AJS* 16, no. 1 (1932): 3.
- Herrick, James B. *Memories of Eighty Years*. Chicago: University of Chicago Press, 1949.
- Hinton, William A. *Syphilis and Its Treatment*. New York: Macmillan, 1936.
- Howard, John R., and Janet M. Geister. "Admission Systems for Dispensaries." *MH* 24 (Feb. 1925): 162-167.
- _____. "Admission System for Dispensaries: Part II." *MH* 24 (Mar. 1925): 276-9.
- "How Follow-Up Aids in Maintaining an Effective Syphilis Clinic." *MH* 27 (Dec. 1927): 122-124.
- How Laymen Cut Medical Costs*. Chicago: Public Health Institute, 1948.
- Ingraham, Louise Brown. "The Persuasive Approach with the Infectious Syphilis Carrier." *JAMA* 107: 2 (Dec. 1936): 1990-5.
- Jamieson, R. C. "Syphilis in Detroit as an Economic and Social Factor." *AJS* (1918): 519-223.
- Keidel, Albert. "Economic Aspects of the Management of Syphilis." *ADS* (1931): 472-484.
- King, Edith S. "Relations and Duties of Public Health Nurses and Social Workers in the Diagnosis, Treatment, and Control of Syphilis." *JSH* 8 (1922): 357-367.
- Kleinschmidt, H. E. "The Treatment of the Venereal Disease Patient." *SH* 5 (1919): 533-538.
- Koch, Richard A. "Penicillin is Not Enough." *JSH* 36 (1950): 305-316.
- Kulchar, George V., and Erla I. Ninnis, "Tracing the Source of Infection in Syphilis." *JSH* 22 (1936): 370-373.
- Lawrence, John V. "The Part the Health Clinic Lays in Modern Medicine." *MH* 33, (Jul. 1929): 150-152.
- Lewinski-Corwin, E. H. "Venereal Disease Clinics." *JSH* 6 (1920): 337-349.
- Lewis, Ora M. "The Phagocytosis of Follow-Up." *MH* 25 (Oct. 1925): 329-332
- Lewis, Ruth E. "Contribution of Social Service to the Medical Control of the Venereal

- Diseases." *JSH* 16 (1930): 272-278.
- Lincoln, Miriam. "Differentiating Between Worthy Poor and Dispensary Shoppers," *MH* 31 (Dec 1928): 79-84.
- Loughrey, Kathryn A. "Medical Social Service in Syphilis Clinics." *JSH* 23, (1937): 263-267.
- Lovell, Bertha C. "Some Problems in Social Hygiene in a Clinic for Women's Diseases." *JSH* 2 (1915-1916): 501-516.
- MacEarchern, Malcolm. *Hospital Organization and Management*. 2nd Ed. Chicago: Physicians' Record Co., 1949.
- Matthews, Ann F. "The VD Patient... An Individual to the Hospital Nurse." *JSH* 38 (1952): 131-137.
- McKneely, Thomas B., and Kay Pearson. "Does This Describe Your Venereal Disease Clinic?" *JVDI* 18 (1937): 179-89.
- Moore, Joseph E. "Treatment as Factor in the Control of Syphilis," *Proceedings of Conference on Venereal Disease Control Work*, 1936.
- Morris, Evangeline Hall. *Public Health Nursing in Syphilis and Gonorrhoea*. Philadelphia and London: W. B. Saunders, 1946.
- Morsell, John A. "Motivation of the Volunteer Venereal Disease Patient." *JSH* 39 (1953): 47-9.
- Munson, William L. "Practicability of Epidemiological Methods in the Control of Syphilis." *JAPH* (1931): 134-140.
- Nichols, Franklin O. "The Attitudes of Patients Towards Syphilis." *JSH* 19 (1933): 151-159.
- Nelson, Nels A. "The Control of Syphilis from the Health Officer's Viewpoint." *AJPH* (1932): 172-5.
- _____, and Gladys L. Crain. *Syphilis, Gonorrhoea and the Public Health*. New York: Macmillan Co., 1938.
- Nixon, Pat I. *Pat Nixon of Texas: Autobiography of a Doctor*. Edited by Herbert H. Lang. College Station and London: Texas A&M University Press, 1979.
- Osborn, Minott A. "Vertical Versus Horizontal." *MH* 29 (Jul. 1927): 144-148.
- Osborn, Stanley H. "The Physician's Obligation." *JAMA* 93, No. 17 (Oct. 1929): 1269-1270.
- Parran, Thomas. "Control of Syphilis." *JAMA* 109: 1 (Jul. 1937): 205-207.

- _____. "The Eradication of Syphilis as a Practical Public Health Objective." *JAMA* 97, no. 2 (Jul. 1931): 73-77.
- _____. "Syphilis and Medical Practitioner." *RMMJ* 35 (Aug. 1938): 594-8.
- _____. "The Treatment of Syphilis in Its Relation to Prevention." *JAMA* 93, no. 23 (Dec. 1929): 1793-1797.
- _____. and Linda Usilton. "The Extent of the Problem of Gonorrhea and Syphilis in the United States." *JSH* 16 (1930): 31-43.
- Pelouze, P. S. *Gonorrhea in the Male and Female: A Book for Practitioners*. Philadelphia, 1928.
- "Periodic Health Examinations." *H* (June 1942): 410-411.
- Pfeiffer, Albert. "Social Service Problems among Venereal Disease Cases." *JSH* 21, no. 4 (1935): 157-163.
- Phillips, Wendell C. "The Physician and the Patient of the Future." *JAMA* 86, No. 17 (Apr. 1926): 1259-1264.
- Pierce, E. E. "Venereal Disease Control in Civilian Communities." *AJPH* 9 (1919): 340-345.
- Pinney, Jean B. "How Much Does the Public Know About Social Hygiene?" *JSH* 21 (1935): 32-40.
- Platt, Philip S. "The Efficiency of Venereal Clinics. Suggested Remedies for Present Defects." *JAPH* 6 (1916): 953-958.
- Plumley, Margaret Lowell. "Advances in Out-Patient Service." *MH* 25 (Sept. 1925): 248-250.
- "Problems That Clinics Have Solved and Those They Still Face." *MH* 34 (Feb. 1930): 132-134.
- Pussey, William Allen. "Some Tendencies in the Business of the Practice of Medicine." *JAMA* 90 (June 1928): 1897-1901.
- Regenburg, B. H. "Venereal Disease and the Patient." *JSH* 20, no. 8 (1934): 369-377.
- "Regulations." *PHR* 32: 2, No. 37 (Sep. 1918): 1537-1540.
- "Report. A social hygiene survey of New Haven." *JSH* 14 (1928): 213-234.
- Robinson, David. "Control of Venereally Diseased Persons in Interstate Commerce." *PHR* 36 (1921): 2210-2215.
- Rolison, Charlotte. "Social Case Work Among Venereally Infected Females in a Quarantine Hospital." *JSH* 32 (1946): 18-21.

- Rosenthal, Theodore. "The Compleat Case Finder." *JSH* 33 (1947): 423-431.
- Rotman, David B. "A Psychiatrist Evaluates Personality." *JSH* 29 (1943).
- Safier, Benno *et al.*, *A Psychiatric Approach to the Treatment of Promiscuity*, San Francisco: Psychiatric Service of San Francisco City Clinic, 1947.
- Shafer, J. K. "American Venereal Disease Control Problems." *JSH* 39 (1953): 357-364.
- Simmons, Irving. *Gonorrhea and Syphilis: What the Layman Should Know*. New York: E. P. Dutton, 1940.
- Smith, Dudley C. "Practical Epidemiology of Syphilis." *JAMA* 107, no. 10 (1936): 784-786.
- _____, and William A. Brumfield. "Tracing the Transmission of Syphilis." *JAMA* 101, no. 25 (1933): 1955-1957.
- Snow, William F. "Clinics for Venereal Diseases—Why We Need Them—How to Develop Them, II." *MH* 8 (Jan. 1917): 54-56.
- _____. "The Medical Adviser and His Correspondence File." *JSH* 3 (1917): 505-520.
- _____, and Walter Clarke. "Medical Aspects of Social Hygiene in San Francisco." *JSH* 18 (1932): 245-276.
- "A Social Hygiene Survey of New Haven." *JSH* 14 (1928): 213-234.
- Stokes, John H. "Clinical Problems in Syphilis Control Today." *JAMA* (Mar. 1937): 780-785.
- _____. "Critical Treatment Problems in Today's Syphilology." *JAMA* 94, No. 14 (Apr. 1930): 1029-1035.
- _____. "A Hilltop on the Syphilologic Marne." *The American Journal of Syphilis, Gonorrhea and Venereal Disease* 20, No. 3 (1935): 231-242.
- _____. "The In-Patient Hospital in the Control and Study of Syphilis." *JSH* (1915-1916): 207-231.
- _____. *Modern Clinical Syphilology*. Philadelphia and London, 1926.
- _____. "Public Health Activity and Private Practice in Venereal Disease Control." *JAMA* 76, No. 18 (Apr. 1921): 1266-1267.
- _____. "Some General Considerations Affecting Present-Day Sex and Sex Education Problems." *VDI* 25 (1944): 197-203.
- _____. "Standard Treatment Procedure in Early Syphilis." *JAMA* 102, No. 16 (Apr. 1934): 1267-1271.

- _____ et al. "Standard Treatment Procedure in Early Syphilis. A Résumé of Modern Principles." *JAMA* 102 (Apr. 1934): 1272-1274.
- Taylor, E. C. "What Do We Mean by a Follow-Up System?" *MH* 23 (Jul. 1924): 78-84.
- Thomson, Alec N. "The Elements of Social 'Follow-Up.'" *MH* 16 (Mar. 1921): 184-185.
- _____. "It Pays to 'Follow Up.'" *MH* 16 (Jan. 1921): 80.
- _____. "The Management of a Venereal Disease Clinic." *MH* 18: 4 (Apr. 1922): 375-376.
- _____ et al. "The Genito-Urinary Department of the Brooklyn Hospital Dispensary." *JSH* 2 (1915-16): 91-110.
- Thornton, Janet. "Clinic Service by Appointment." *MH* 22 (Jun. 1924): 596-8.
- _____. "Social Service and Dispensary Admissions Service." *MH* 12 (Apr. 1919): 278-80.
- Treadway, Walter L., and L. O. Weldon. "Psychiatric Studies of Delinquents. Part I." *PHR* 35, no. 21 (1920): 1195-1210.
- Tupper, Marguerite. "Dispensary Treatment for VD, The Lakeside Hospital, Cleveland." *MH* 8 (Mar 1917): 223-224.
- Usilton, Linda. "The Treatment of Syphilis and Gonorrhoea in the United States, Based on Treated Cases." *JVDI* 16 (1935): 140-148.
- _____, Howard Hunter and R. A. Vonderlehr. "Prevalence, Incidence and Trend in Syphilis in Chicago." *JAMA* 110, no. 1, (Mar. 1938): 864-869.
- VD/H. "St. Louis VD Clinic." *MH* 14 (Feb 1920): 151-155.
- "Venereal Diseases in Private Practice (A Report of an Inquiry Addressed to the Physicians of Syracuse, N.Y.)," *JSH* 10 (1924): 267-277.
- Vonderlehr, R. A. "The Administration of the Syphilis Control Program." *JAMA* 107, no. 10 (1936): 782-784.
- Waddell, Charles W. "Some Phases of the Conduct of a Venereal Disease Clinic." *JSH* 17 (1931): 322-33.
- Warner, A. Lloyd et al., "Syphilis Prevalence and Community Structure." *VDI* (June 1951): 157-166.
- Weitz, Robert D., and H. L. Rachlin. "The Mental Ability and Educational Attainment of Five Hundred Venereally Infected Females." *JSH* 31 (1945): 300-302.
- Weldon, L. O. "Psychiatric Studies of Delinquents. Part II." *PHR* 35, no. 22 (1920): 1249-1269.

- Williams, Linsly R. "Relation of voluntary Health Agency to Physicians and Health Departments." *JAMA* 89, No. 1 (Jul. 1927): 82-84.
- Wessel, Rosa (ed.). *A Case-Work Approach to Sex Delinquents*. Philadelphia: Pennsylvania School of Social Work of the University of Pennsylvania, 1947.
- Wettstein, Joseph. "On the Trail of the Spirochete and Gonococcus," *JSH* 24 (1938): 15-22.
- Woods, Helen. "Syphilis Control: Principles of Case-Finding and Case-Holding." *VDI* 20 (1939): 371-376.

Secondary Sources

- Althusser, Louis. "Ideology and Ideological State Apparatuses." *Lenin and Philosophy and Other Essays*. London: New Left Books, 1971: 136-169.
- Armstrong, David. "Bodies of Knowledge/Knowledge of Bodies." in Jones and Porter: 17-27.
- _____. *Political Anatomy of the Body: Medical Knowledge in Britain in the 20th Century*. Cambridge: Cambridge University Press, 1983.
- Berger, Peter, and Thomas Luckmann. *The Social Construction of Reality: A Treatise in the Sociology of Knowledge*. Garden City, NY: Doubleday, 1966.
- Bevis, Phil, Michèle Cohen, and Gavin Kendall. "Archeologizing Genealogy: Michel Foucault and the Economy of Austerity." *Economy & Society* 18, (1989). Reprinted in Smart 1995 (Vol. 6): 172-193.
- Bliss, Katherine E. *Compromised Positions: Prostitution, Public Health, and Gender Politics in Revolutionary Mexico City*. University Park: Pennsylvania State University Press, 2001.
- Bordo, Susan. "Bringing Body to Theory." In Welton 1998: 84-97.
- _____. *Unbearable Weight: Feminism, Western Culture, and the Body*. Berkeley: University of California Press, 1993.
- Brandt, Allan M. *No Magic Bullet: A Social History of Venereal Disease in the United States since 1880*. New York and Oxford: Oxford University Press, 1987.
- Butler, Judith. *Bodies that Matter: On the Discursive Limits of "Sex"*. New York and London: Routledge, 1993.
- _____. *Gender Trouble: Feminism and the Subversion of Identity*, New York: Routledge, 1990.
- Copjec, Joan. *Read My Desire: Lacan Against the Historicists*. Cambridge, Mass.: The MIT Press/An October Book, 1994

- Csonka, G. W., and J. K. Oates (eds.). *Sexually Transmitted Diseases: A Textbook of Genitourinary Medicine*. London: Bailliere Tindall 1990
- Davidson, Arnold. "Closing Up the Corpses: Diseases of Sexuality and the Emergence of the Psychiatric Style of Reasoning." In *Meaning and Method: Essays in Honor of Hilary Putnam*. Edited by George Boolos, Cambridge: Cambridge University Press, 1990: 295-325.
- _____. "Sex and the Emergence of Sexuality." in Stein 1990: 89-132.
- Davidson, Roger. *Dangerous Liaisons: A Social History of Venereal Disease in Twentieth-Century Scotland*. Amsterdam/Atlanta, GA: Rodopi, 2000.
- Donzelot, Jacques. *The Policing of Families*. With a Foreword by Gilles Deleuze, translated by Robert Hurley, Baltimore: The Johns Hopkins University Press, 1979 [1977].
- Douglas, Mary. *Purity and Danger: An Analysis of the Concepts of Pollution and Taboo*. London: Routledge, 1996 [1966].
- Dreyfus, Hubert, and Paul Rabinow. *Michel Foucault: Beyond Structuralism and Hermeneutics*. Chicago: The University of Chicago Press, 1982.
- Duffy, John. "American Medical Profession and Public Health." *Bulletin of the History of Medicine* 53, No. 1 (1979): 1-22.
- _____. *A History of Public Health in New York City*. New York: Sage, 1974.
- Eberwein, Robert T. *Sex Ed: Film, Video, and the Framework of Desire*. New Brunswick, NJ: Rutgers University Press, 1999.
- Ehrenreich, Barbara, and Deirdre English. *Complaints and Disorders: The Sexual Politics of Sickness*. Old Westbury, NY: Feminist Press, 1973.
- Falvo, Donna R. *Effective Patient Education: A Guide to Increased Compliance*. 2nd Ed. Gaithersburg, MR: Aspen 1994.
- Francois Ewald. "Bio-Power." *History of the Present*, no. 2 (1986). Reprinted in Smart 1995 (Vol. 4): 281-284.
- Foucault, Michel. *Aesthetics, Method, and Epistemology: Essential Writings of Foucault 1954-1984*, Vol. 2. Edited by James D. Faubion, translated by Robert Hurley et al. New York: The New Press, 1997.
- _____. *The Archaeology of Knowledge & the Discourse on Language*. Translated by A. M. Sheridan Smith. New York: Harper, 1972.
- _____. *The Birth of the Clinic: An Archaeology of Medical Perception*. Translated by A. M. Sheridan Smith. New York: Vintage/Random House, 1973 [1963].
- _____. "The Birth of Social Medicine." In Foucault 2000 [1977]: 134-156

- _____. "Body/Power." In Foucault 1980 [1975]: 55-62.
- _____. "Confessions of the Flesh." In Foucault 1980 [1977]: 194-228.
- _____. *Discipline and Punish: The Birth of the Prison*. Translated by Alan Sheridan, New York: Vintage/Random House, 1977 [1975].
- _____. *Ethics, Subjectivity, and Truth: Essential Writings of Foucault 1954-1984*, Vol. 1. Edited by Paul Rabinow, translated by Robert Hurley et al. New York: The New Press, 1998.
- _____. "The Eye of Power." In Foucault 1980 [1977]: 146-165.
- _____. "Governmentality." In Foucault 2000 [1978]: 201-222.
- _____. *Herculine Barbin, Being the Recently Discovered Memoirs of a Nineteenth-Century French Hermaphrodite*. Translated by Richard McDougall, Brighton: The Harvester Press, 1980 [1978].
- _____. *The History of Sexuality, Vol. 1: An Introduction*. Translated by Robert Hurley, New York: Vintage/Random House, 1978 [1976].
- _____. "The History of Sexuality." In Foucault 1980 [1977]: 183-193.
- _____. *Mental Illness and Psychology*. Translated by Alan Sheridan, Berkeley: University of California Press, 1987 [1962].
- _____. "Nietzsche, Genealogy, History." In Foucault 1998 [1971]: 369-391.
- _____. *The Order of Things: An Archaeology of the Human Sciences*. Translated by Alan Sheridan, New York: Random House, 1970.
- _____. "The Politics of Health in the Eighteenth Century." In Foucault 1998 [1976]: 90-105.
- _____. *Power: Essential Writings of Foucault 1954-1984*, Vol. 3. Edited by James D. Faubion, translated by Robert Hurley et al. New York: The New York, 2000.
- _____. *Power/Knowledge*. Edited by Colin Gordon. New York: Random House, 1980.
- _____. "Questions of Method." In Foucault 2000 [1980]: 223-238.
- _____. "Sade, Sergeant of Sex." In Foucault 1998 [1975]: 223-227.
- _____. "Sexual Choice, Sexual Act." In Foucault 1997 [1983]: 141-156.
- _____. "Technologies of the Self." In Foucault 1997 [1982]: 223-251.
- _____. "The Subject and Power." In Foucault 2000 [1982]: 326-348.
- _____. "Two Lectures." In Foucault 1980 [1977]: 78-108.

- _____. "What is Called 'Punishing'?" [1984]: 382-393.
- Fraser, Nancy. "Foucault on Modern Power: Empirical Insights and Normative Confusions." In *Unruly Practices: Power, Discourse and Gender in Contemporary Social Theory*. Minneapolis: University of Minnesota Press, 1989: 17-34.
- Grosz, Elizabeth. *Volatile Bodies: Toward a Corporeal Feminism*. Bloomington and Indianapolis: Indiana University Press, 1994.
- Gutting, Gary. "Foucault's Genealogical Method." *Midwest Studies in Philosophy* 15. Edited by P. French, T. Uehling and H. Wettstein, Minneapolis: University of Minnesota Press, 1993: 327-343.
- _____. *Michel Foucault's Archeology of Scientific Reason*. Cambridge, UK: New York: Cambridge University Press, 1989.
- Hacking, Ian. *Mad Travelers: Reflections on the Reality of Transient Mental Illnesses*. Charlottesville and London: University Press of Virginia, 1998.
- _____. "Making Up People." In Stein 1990: 69-88.
- _____. Hacking, "Night Thoughts on Philology." *History of the Present* 1 (1988): 3-10, repr. in Smart (vol. 2): 266-277.
- _____. "Self-improvement." *University Publishing* 13 (1984): 4, 6, repr. in Smart (vol. 2): 23-26.
- _____. *Rewriting the Soul: Multiple Personality and the Sciences of Memory*. Princeton, NJ: Princeton University Press, 1995.
- _____. *The Social Construction of What?* New York and London: Harvard University Press, 1999.
- Halperin, David M. *Saint Foucault: Towards a Gay Hagiography*. New York and Oxford: Oxford University Press, 1995.
- Hekman, Susan. "Material Bodies." In Welton 1998: 61-70
- Horsman, Reginald. *Race and Manifest Destiny: The Origins of Racial Anglo-Saxonism*. Cambridge, Mass.: Harvard University Press, 1981.
- Illich, Ivan. *Medical Nemesis: The Expropriation of Health*. New York: Pantheon, 1975.
- Jones, Colin, and Roy Porter (eds.). *Reassessing Foucault: Power, Medicine and the Body*, London: Routledge, 1994.
- Jones, James H. *Bad Blood: The Tuskegee Syphilis Experiment*. New York: Maxwell McMillan International, 1993.
- Kevles, Daniel J. *In the Name of Eugenics: Genetics and the Uses of Human Heredity*. New York: Knopf, 1985.

- Kristeva, Julie. *Powers of Horror: An Essay on Abjection*. Translated by Leon Roudiez. New York: Columbia University Press, 1982.
- Lash, Scott. "Genealogy and the Body: Foucault/Deleuze/Nietzsche." *Theory, Culture & Society* 2, (1984), repr. in Smart 1994 (Vol. 3): 14-32.
- Leder, Drew, "Flesh and Blood: A Proposed Supplement to Merleau-Ponty." In Welton 1999: 200-210
- Levine, Philippa. *Prostitution, Race, and Politics: Policing Venereal Disease in the British Empire*. New York: Routledge, 2003.
- Lupton, Deborah. "Foucault and the Medicalisation Critique," *Foucault, Health and Medicine*. Edited by Alan Petersen and Robin Bunton, London: Routledge, 1997.
- _____. "Doctors on the Medical Profession." *Sociology of Health and Illness* 19 (1997): 480-497.
- _____. *Medicine as Culture: Illness, Disease and the Body in Western Culture*. London: Sage, 1994.
- McNamara, Jr., James A., and Carroll-Ann Trotman (eds.). *Creating the Compliant Patient*. Ann Arbor, MI: The University of Michigan 1997.
- Melossi, Dario, and Massimo Pavarini. *The Prison and the Factory: Origins of the Penitentiary System*. Translated by Glynis Cousin, Totowa, NJ: Barnes and Noble Books, 1981.
- Merians, Linda E. (ed.). *The Secret Malady: Venereal Disease in Eighteenth-Century Britain and France*. Lexington: The University Press of Kentucky, 1996.
- Merleau-Ponty, Maurice. *The Visible and the Invisible*. Edited by Claude Lefort, translated by Alphonso Lingis. Evanston, Ill.: Northwestern University Press, 1968.
- Miller, Peter, and Nikolas Rose. "Governing Economic Life," *Economy and Society* 19 (1990); repr. in Smart 1995 (Vol. 7), pp. 146-173.
- Mooij, Annet. *Out of Otherness: Characters and Narrators in the Dutch Venereal Disease Debates 1850-1990*. Atlanta, GA: Rodopi, 1998.
- Nettleton, Sarah. *Power, Pain and Dentistry*. Birmingham and Philadelphia: Open University Press, 1992.
- Osborne, Thomas. "Medicine and Epistemology: Michel Foucault and the Liberality of Clinical Reason." *History of the Human Sciences* 5 (1992), repr. in Smart 1995 (Vol. 5): 251-279.
- Porter, Roy, and Dorothy Porter. *Patient's Progress: Doctors and Doctoring in Eighteenth-Century England*. Stanford, Cal.: Stanford University Press, 1985.

- Reverby, Susan M. (ed.). *Tuskegee's Truths: Rethinking the Tuskegee Syphilis Study*. Chapel Hill, NC: University of North Carolina Press, 2000.
- Reznek, Lawrie. *The Nature of Disease*. London: Routledge, 1984.
- Smart, Barry. *Foucault, Marxism and Critique*. London: Routledge & Kegan Paul, 1983.
- _____. (ed.). *Michel Foucault: Critical Assessments*. 7 vols. New York and London: Routledge, 1994-1995.
- Spongberg, Mary. *Feminizing Venereal Disease: The Body of the Prostitute in Nineteenth-Century Medical Discourse*. Washington Square, NY: New York University Press, 1997.
- Stein, Edward (ed.). *Forms of Desire: Sexual Orientation and the Social Constructionist Controversy*. New York and London: Garland, 1990.
- Stevens, Rosemary. *American Medicine and the Public Interest*. New Haven and London: Yale University Press, 1971.
- _____. *In Sickness and in Wealth: American Hospitals in the Twentieth Century*. New York: Basic Books, 1989.
- Turner, Bryan. *Medical Power and Social Knowledge*. London: Sage, 1987.
- _____. *Regulating Bodies: Essays in Medical Sociology*. London and New York: Routledge, 1994.
- Waitzkin, Howard. *The Politics of Medical Encounters: How Patients and Doctors Deal with Social Problems*. New York: Yale University Press, 1991.
- Walkowitz, Judith R. *Prostitution and Victorian Society: Women, Class, and the State*. Cambridge, UK: Cambridge University Press, 1982.
- Walzer, Michael. "The Politics of Michel Foucault." *Dissent* 30 (Fall 1983), repr. in *Foucault: A Critical Reader*. Edited by David Couzens Hoy, Oxford: Blackwell, 1986: 51-68.
- Ward, Patricia Spain. "The American Reception of Salvarsan." *Journal of the History of Medicine and Allied Sciences* 36 (1981): 44-62.
- Watney, Simon. *Policing Desire: AIDS, Pornography, and the Media*. Minneapolis: University of Minnesota Press, 1988.
- Welton, Donn (ed.). *Body and Flesh: A Philosophical Reader*. Malden, Mass./Oxford, UK: Blackwell, 1998.
- _____. (ed.). *The Body: Classic and Contemporary Readings*. Malden, Mass. and Oxford, UK: Blackwell, 1999.