The Case of the Archive

Warwick Anderson

As medical students, we routinely searched the hospital wards for cases, for the "good cases" of some particular disease. By early morning, rumors spread about which cases had come in overnight and their disposition. We clustered around the good cases, trying to avoid the bad and routine ones. Even around 1980 our clinical teachers were insisting we should not regard patients simply as cases of whatever it is that afflicts them, as medical or administrative objects. But we continued to do so; indeed, the creeping sense of misconduct seemed just to make more tantalizing our quest for the case. We wanted exemplary cases of some disease, not sick people. It made us feel like grown-up doctors, whatever our instructors might say.[1] But what makes someone a case? How does one authorize a case? Does the case boast a genealogy? What are the consequences of becoming a case or making cases? These are not the questions that medical students ordinarily ask, but they began to trouble me as I drifted away from the profession.

This essay primarily concerns the case file, the administrative dossier, not the long case study, which is a distinct modernist genre—though the two are not unrelated. Michel Foucault connected the emergence of clin-

Around 1994, Homi K. Bhabha asked me about the history of the case, a question that at the time I found intriguing and unanswerable. I would like to thank Joy Damousi, Birgit Lang, and Alison Winter for getting me to reflect again—belatedly perhaps—on case making. Laura Doan, Volker Hess, Sarah Igo, Hans Pols, Charles E. Rosenberg, Haun Saussy, John Harley Warner, and Alice Wexler also gave helpful advice. Cecily Hunter provided extensive research assistance. For guidance through the Freud archive, I thank Leonard C. Bruno at the Manuscript Division, Library of Congress, Washington, DC.

1. For an analysis of what constitutes a good case in the hospital, see Michel Wieviorka, "Case Studies: History or Sociology?" in *What Is a Case? Exploring the Foundations of Social Inquiry*, ed. Charles C. Ragin and Howard S. Becker (New York, 1992), pp. 159–72.

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ical sciences toward the end of the eighteenth century with the "problem of the entry of the individual (and no longer the species) into the field of knowledge; the problem of the entry of the individual description, of the cross-examination, of anamnesis, of the 'file' into the general functioning of scientific discourse." In closed institutions like prisons, asylums, barracks, schools, and hospitals, "*the examination, surrounded by all its documentary techniques, makes each individual a 'case'*: a case which at one and the same time constitutes an object for a branch of knowledge and a hold for a branch of power." The case becomes the "individual as he may be described, judged, measured, compared with others, in his very individuality; and it is also the individual who has to be trained or corrected, classified, normalized, excluded, etc."[2] Here I want to focus on one of these documentary techniques: the development of the hospital case file and its archive in the early twentieth century, more than one hundred years after the clinical sciences, according to Foucault, began making cases. For the first time, a unitary dossier necessarily accompanied patients along their "illness trajectories," circulating with them through the modern clinics, waiting in the hospital records department for their return, available to turn them again into serviceable individuals within the bureaucratic matrix.[3]

Despite Foucault's discovery of the disciplined individual in the clinical case, we still know remarkably little about the documentary techniques that came to stabilize this identity. The bureaucratic entailments of mak-

2. Michel Foucault, *Discipline and Punish: The Birth of the Prison*, trans. Alan Sheridan (New York, 1979), p. 191. See also *On Record: Files and Dossiers in American Life*, ed. Stanton Wheeler (New York, 1969), and John Forrester, "If P, Then What? Thinking in Cases," *History of the Human Sciences* 9 (Aug. 1996): 1–25.

3. On illness trajectories and the work of patients, see Anselm L. Strauss et al., *The Social Organization of Medical Work* (Chicago, 1985).

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ing a diagnosis, fixing someone as a case, remain frustratingly obscure.[4] We know that during the nineteenth century the medical record assumed a more standard form, almost ritualized, with more emphasis on "objective" physical examination and laboratory results and a tendency to discount the patient's own impressions of his or her illness. Mostly, these accounts consisted of brief notes, accumulating piecemeal in casebooks and bundles, usually arranged chronologically but sometimes according to diagnostic category. Not until the early twentieth century were the patient's records commonly collated in a unitary file, organizing and consolidating the ordinary concatenation of medical events and interventions into an individual life.[5] The hospital record then comes to resemble the dossier, yet another example of the bureaucratic mode that produced during this period the police file, the military record and service number, and the anthropometric data card in physical anthropology. In the unitary administrative file, the individual case finally takes form in serial order, accompanied by rules of accessibility.

Case Studies

The bureaucratic case file, which usually required secrecy, should be distinguished from the contemporary genre of the case study, which demanded full disclosure. Lauren Berlant wryly observes, "case history tends to be what physicians *take*, while case study is what academics and psychoanalysts *write*."[6] At the beginning of the twentieth century, Sigmund Freud wrote five long case studies that served as exemplars of psychoanalytic technique and literary style: Dora (1905), the Rat Man (1909), Little Hans (1909), Paul Schreber (1911), and the Wolf Man (1918). These narratives artfully described in each case a continuity of experience, suturing together apparent disjuncture, eventually revealing the hidden cause of the individual's distress. Unlike hospital case files, these studies emphasized the in-

4. Charles E. Rosenberg's plea for a "careful study of the hospital record as a genre" is still pertinent (Charles E. Rosenberg, *The Care of Strangers: The Rise of America's Hospital System* [New York, 1987], p. 382 n. 37). See also Rosenberg, "The Tyranny of Diagnosis: Specific Entities and Individual Experience," *Milbank Quarterly* 80, no. 2 (2002): 237–60.

5. Although individual case files occasionally circulated in hospitals in the nineteenth century—as medical student souvenirs, exceptional examples of pathology, or for legal and accountancy purposes—this did not constitute a unit medical record *system*. The continuing research of Volker Hess and colleagues in the records of the Berlin Charité hospital suggests a more complex history, at least at their exceptional institution; see Volker Hess and Sophie Ledebur, "Taking and Keeping: A Note on the Emergence and Function of Hospital Patient Records," *Journal of the Society of Archivists* 32 (Apr. 2011): 21–32, and Hess, "Formalisierte Beobachtung: Die Genese der modernen Krankenakte am Beispiel der Berliner und Pariser Medizin (1725–1830)," *Medizinhistorisches Journal* 45 (2010): 293–340.

6. Lauren Berlant, "On the Case," *Critical Inquiry* 33 (Summer 2007): 663 n. 2.

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teraction of patient and analyst, dramatizing the transference implicated in the clinical encounter, thereby providing examples of how to perform psychoanalysis. Freud makes himself self-consciously present in his narratives in ways forbidden to ordinary physicians in their hospital case notes.[7] Indeed, these ideographic case studies convey the impression of resisting, perhaps even subverting, the bureaucratically serviceable, and hence nomothetic, case file. Thus Freud's strategy of avoidance and denial parallels the rise of photographic modernism in opposition to the Bertillon system of photographic realism, then a common means of criminal identification.[8]

"It still strikes me myself as strange," Freud observed as early as 1895, "that the case histories I write should read like short stories and that, one might say, they lack the serious stamp of science."[9] In the study of the Wolf Man, his last major case, Freud proclaimed: "I am unable to give either a purely historical or a purely thematic account of my patient's story; I can write a history neither of the treatment nor of the illness."[10] Instead, he wrote a modernist short story in which the author became the central character. At least since the 1960s, Freud's case studies usually have been taken as evidence of his literary bent, not read as scientific reports.[11] To be

7. See *In Dora's Case: Freud—Hysteria—Feminism*, ed. Charles Bernheimer and Claire Kahane (New York, 1985); Julia Epstein, "Historiography, Diagnosis, and Poetics," *Literature and Medicine* 11 (Spring 1992): 23–44; Susan Wells, "Freud's Rat Man and the Case Study: A Genre in Three Keys," *New Literary History* 34 (Spring 2003): 353–66; and Anne Sealey, "The Strange Case of the Freudian Case History: The Role of Long Case Histories in the Development of Psychoanalysis," *History of the Human Sciences* 24 (Feb. 2011): 36–50. While Freud's case studies are iconic, others contributed to this literary genre, especially Pierre Janet, who published in the 1890s a series of studies of hysterics from the Salpetrière hospital, Paris. For example, see Pierre Janet, "Histoire d'une idée fixe," *Revue Philosophique de la France et de l'Étranger* 37 (1894): 121–68. The relative obscurity of the journals in which Janet published diminished his influence. More generally, Thomas Laqueur argues the case report or study, developing along with the novel in the nineteenth century, contributed to the "production of humanitarian sentiment and reform" (Thomas W. Laqueur, "Bodies, Details, and the Humanitarian Narrative," in *The New Cultural History*, ed. Lynn Hunt [Berkeley, 1989], p. 197).

8. See Alphonse Bertillon, "The Bertillon System of Classification," *The Forum* 11 (May 1891): 335 and *Identification anthropométrique; Instructions signalétiques* (Paris, 1893). For an extended contrast of photographic modernism and the images in Bertillon's criminal archive, see Allan Sekula, "The Body and the Archive," *October*, no. 39 (Winter 1986): 3–64.

9. Sigmund Freud and Josef Breuer, *Studies on Hysteria* (1895), *The Standard Edition of the Complete Psychological Works of Sigmund Freud*, trans. and ed. James Strachey, 24 vols. (London, 1953–74), 2:160. Freud was referring to the case of Fraulein Elisabeth von R.

10. Freud, "From the History of an Infantile Neurosis" (1918 [1914]), *The Standard Edition of the Complete Psychological Works of Sigmund Freud*, 17:13.

11. For example, see Steven Marcus, "Freud and Dora: Story, History, Case History," *Representations: Essays on Literature and Society* (New York, 1975), pp. 247–309, and Peter Brooks, "Fictions of the Wolf Man: Freud and Narrative Understanding," *Reading for the Plot: Design and Intention in Narrative* (New York, 1984), pp. 264–85.

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sure, historians have traced the Freudian case study's genealogy—its family romance, perhaps—and noted legal, philosophical, and clinical antecedents to reasoning in cases.[12] But the Freudian literary style obviously is distinct from the bureaucratic dossier, which gained form about the same time. Although sharing a focus on the case, they boast different functionality. Still, their potential relations are intriguing. How, one wants to know, did Freud organize his own case notes? In the Freud archive there are numerous patient files from his days at the Allgemeines Krankenhaus, Vienna (1881–83) and from the Bellevue Sanatorium, Kreuzlingen, in the early nineteenth century.[13] Those from the 1880s seem to have been bound together in a larger journal or case book while the later ones are bound individually, with the patient's name on the cover. In each case, Freud filled out two pages of preprinted physical examination sheets, then wrote ten to twenty pages of progress notes. The file's progress notes—exceptionally extensive, yet clinically detached—surely represent the first draft of the modernist case study, which soon diverged in style, scope, and mandate. In 1904, Freud gave his last lecture to a medical audience; in 1905, he stopped publishing in medical journals.[14]

The modernist case study and administrative case file, both pedagogic instruments, accumulate dissimilar collectives or publics.[15] The exemplary psychoanalytic case is addressed to a bourgeois readership interested in new explanations of their mental constitution and the nature of psychological and sexual individuality. Through the process of interpretation of such closed, retrospective narratives, modern subjects can self-consciously reframe their complex selves, entering into the field of psychoanalytic interiority. In contrast, the case file becomes part of the machinery for making individuals into normative collectives, for rendering them bureaucratically knowable and serviceable.[16] Case files are interoceptive, evolving, often "heteroglossic" documents, oriented toward the future, shaping the prognosis. Sometimes, as a form of closure, the file can be written up and published as a case report, perhaps even turned into a psychoanalytic case study. Although related, locating identity in a case study and finding it in a case file are distinct disciplinary maneuvers, one promiscuously generating subjectivities, the other serializing clinical objects.[17]

12. See Forrester, "If P, Then What?"

13. See Freud, box 45, box OV 1, and box 46, Sigmund Freud Papers, Library of Congress, Washington, DC.

14. See Ernest Jones, *The Life and Work of Sigmund Freud*, 3 vols. (New York, 1953–57).

15. See Michael Warner, "Publics and Counterpublics," *Public Culture*, no. 14 (Winter 2002): 49–90.

16. See Berlant, "On the Case."

17. It is tempting, if reductive, to cast the case file as a form of mechanical objectivity and

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The Unit System

Since Hippocrates, European medicine has used exemplary cases to structure and inform clinical reasoning. Explaining cases has proved an especially powerful pedagogical technique, a conceptual tool demonstrating the natural course of disease, the means of diagnosis, and the effects of therapeutic intervention. But the case record did not become a bureaucratic instrument until the nineteenth century. Even then, most hospitals failed to keep systematic records. The Massachusetts General Hospital, established in 1821, appears to have been unusually rigorous initially in registering and documenting the histories of the patients on its wards. From 1837, a daily progress report was required for each patient, noted in the hospital casebook, which was ordered chronologically. Physicians sought to simplify and standardize accounts of the presenting complaint and the personal history, to make them brief, pithy, and comparable. The tally of findings on physical examination also became more succinct and coded, less impressionistic and more evidential or "objective." By the 1870s, the record contained charts for respiratory rate, pulse, and temperature. Later still, standard forms for new laboratory tests—for biochemical, bacteriological, and radiological results—became available. Photographs might even appear in its pages. The hospital appointed its first custodian of records in 1897, but only after 1904 were records kept systematically for outpatients.[18] These changes in the patient record represent, according to John Harley Warner, "the emergence and consolidation of a new epistemological and aesthetic sensibility, expressed as a narrative preference for what was universal and precise over what was individual and discursive."[19]

At the beginning of the twentieth century, the case report emerged as a recurrent motif in medical training.[20] In the 1870s, Christopher C. Langdell

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to discern in the case study or report the exercise of trained judgment, referring to the styles of objectivity described in Lorraine Daston and Peter Galison, *Objectivity* (New York, 2007).

18. See Stanley Joel Reiser, "Creating Form out of Mass: The Development of the Medical Record," in *Transformation and Tradition in the Sciences: Essays in Honor of I. Bernard Cohen*, ed. Everett Mendelsohn (New York, 1984), pp. 303–16. See also Walther Riese, "The Structure of the Clinical History," *Bulletin of the History of Medicine* 16 (1944): 437–49, and Harriet Nowell-Smith, "Nineteenth-Century Narrative Case Histories: An Inquiry into Stylistics and History," *Canadian Bulletin of Medical History* 12, no. 1 (1995): 47–67.

19. John Harley Warner, "The Uses of Patient Records by Historians: Patterns, Possibilities, and Perplexities," *Health and History* 1, no. 2–3 (1999): 109. See also Guenter Risse and Warner, "Reconstructing Clinical Activities: Patient Records in Medical History," *Social History of Medicine* 5 (Aug. 1992): 183–205.

20. See Reiser, "Creating Form out of Mass," and Forrester, "If P, Then What?" See also Reiser, "The Clinical Record in Medicine: Learning from Cases," *Annals of Internal Medicine* 114 (May 1991): 902–7.

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had introduced the case method of teaching to the Harvard Law School. Its success inspired a rising Harvard medical student, Walter B. Cannon, to promote around 1900 the use of clinical cases as exemplars in the medical school, too. These illustrative cases, expressed in standard and exact form, offered guidance in diagnosis and therapeutics to medical students and young physicians. Cannon extolled the power of cases to "rouse enthusiasm" and "its great value drilling the mind of the student."[21] A few years later, Richard Cabot began setting up clinico-pathological case conferences at the Massachusetts General Hospital. These turned into gripping performances, where physicians contended with one another in determining correct diagnosis and treatment, learning of their success or failure only when pathologists dramatically provided the answer at the end of proceedings. The record of such case conferences became a regular feature of the *Boston Medical and Surgical Journal*, later the *New England Journal of Medicine*. They helped generations of physicians to reason in cases.[22]

The transformation of hospitals in the early twentieth century into large, complex institutions with proliferating bureaucracies spurred efforts to reform and systematize record keeping.[23] Gradually, flexible individual case files replaced cumbersome casebooks and bundles. In 1907, the Mayo brothers started a trial of singular records, or unitary files, at St. Mary's Hospital in Rochester, Minnesota. Presbyterian Hospital in New York City made the first major investment in individual records around 1916, as the United States entered armed conflict in Europe. It was the first hospital to demand that information from all clinical encounters in every division be inscribed in a single file, assigned a serial number, and then supplemented on further admissions.[24] Unlike the casebook, the unit system exerted considerable influence on clinical work, aiding the coordina-

21. Walter B. Cannon, "The Case Method of Teaching Systematic Medicine," *Boston Medical and Surgical Journal*, 11 Jan. 1900, pp. 34, 35. On Cannon, see Saul Benison, A. Clifford Barger, and Elin L. Wolfe, *Walter B. Cannon: The Life and Times of a Young Scientist* (Cambridge, Mass., 1987). See also Steve Sturdy, "Scientific Method for Medical Practitioners: The Case Method of Teaching Pathology in Early Twentieth-Century Edinburgh," *Bulletin of the History of Medicine* 81 (Winter 2007): 760–92, and Seth M. Holmes and Maya Ponte, "En-case-ing the Patient: Disciplining Uncertainty in Medical Student Patient Presentations," *Culture, Medicine, and Psychiatry* 35 (June 2011): 163–82.

22. Christopher Crenner, *Private Practice: In the Early Twentieth-Century Medical Office of Dr. Richard Cabot* (Baltimore, 2005).

23. On the American hospital at the turn of the nineteenth century, see Rosenberg, "Inward Vision and Outward Glance: The Shaping of the American Hospital, 1880–1914," *Bulletin of the History of Medicine* 53 (Fall 1979): 346–91.

24. See Hugh Auchincloss, "Unit History System," *Medical and Surgical Report of the Presbyterian Hospital in the City of New York* 10 (Oct. 1918): 30–72, and Dorothy L. Kurtz, *Unit Medical Records in Hospital and Clinic* (New York, 1943). See also Reiser, "Creating Form out of Mass" and *Medicine and the Reign of Technology* (New York, 1978), pp. 206–10, and Barbara L.

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tion of multiple specialists in the bureaucratic hospital and clarifying the illness trajectory of their patients. Although physicians remained the primary authors, other groups within the hospital, including nurses, could contribute to limited parts of the file. The unit record collated the patient's history, examinations, test results, and clinical progress through multiple admissions; correspondence and administrative forms, some in typescript, soon become attached to it; and it came to serve both as aide-mémoire and prognostic indicator for the doctors managing the case. (Particularly thick case files, and multiple volumes, did not augur well.) Before long, other hospitals were following Presbyterian's lead—and not just in the United States.[25] We know that Canadian, British, and Dutch hospitals took up the unit record system in the 1920s. "The explicit discussion and implementation of novel record-keeping methods occurred first in the United States, and then spread to Europe," according to Stefan Timmermans and Marc Berg. "Hospitals in Europe followed suit in remarkably similar ways."[26]

The new paper technology not only defined more coherently the case, thereby regularizing and mobilizing the individual patient; it also enhanced standardization and efficiency within the hospital.[27] It was, crucially, a record *system*. According to Stanley Joel Reiser, the unit record system "would become an organ for measuring success and failure and for fixing responsibility" within the modern medical institution.[28] Serialized case files were flexible, standard, portable, accessible—and readily available for comparison and audit. The record system therefore appealed to the rising cohort of hospital administrators, a group that tended to praise efficiency and order, to admire the "business ethic." E. A. Codman at Massachusetts General Hospital was one of the more strident promoters of

Craig, "Hospital Records and Record-Keeping, c. 1850–c. 1950: The Development of Records in Hospitals," *Archivaria* 29 (Winter 1989–90): 57–87.

25. Massachusetts General Hospital, however, did not introduce the unit system until 1937.

26. Stefan Timmermans and Marc Berg, *The Gold Standard: The Challenge of Evidence-Based Medicine and Standardization in Health Care* (Philadelphia, 2003), p. 34. For Canada and Britain, see Craig, "Hospital Records and Record-Keeping, c. 1850–c. 1950." Further study of the globalization of this paper technology is needed.

27. Berg and Geoffrey Bowker claim the medical record performs not only the patient's body but also the clinic; see Berg and Geoffrey Bowker, "The Multiple Bodies of the Medical Record: Toward a Sociology of an Artifact," *Sociological Quarterly* 38 (Summer 1997): 513–37. See also Berg, "Practices of Reading and Writing: The Constitutive Role of the Patient Record in Medical Work," *Sociology of Health and Illness* 18 (Sept. 1996): 499–524.

28. Reiser, "Creating Form out of Mass," p. 312. Systematic individual records also made possible the clinical research enterprise; see Harry M. Marks, *The Progress of Experiment: Science and Therapeutic Reform in the United States, 1900–1990* (New York, 1997). The American Society of Clinical Investigation was established in 1909, the same year Freud embarked on a lecture tour of the US.

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efficiency in medical practice during this period. From 1910 he sought, with little success, to monitor and reform his medical colleagues, urging on them the unitary case record since it allowed more rigorous scrutiny and audits. Codman's "end-result system" demanded "accurate, available, immediate records for scientific, efficient analysis"; for him, the ideal record was the "complete description of the individual from his conception to his grave."[29] But the new American College of Surgeons, deploying its accreditation authority, proved more effective than any nagging Boston physician. After World War I, it took its recent experience assessing military hospitals into the civil sphere, establishing a committee on hospital standardization, which focused on the medical record.[30] Few doubted that paper technology, as Steve Sturdy suggests, made it "possible to divide up or conceptualize populations and their environment in ways which permitted more economical forms of medical management."[31]

29. E. A. Codman, *A Study in Hospital Efficiency: As Demonstrated by the Case Report of the First Five Years of a Private Hospital* (Boston, 1918), pp. 67, 67, 71 and "Case-records and Their Value," *Bulletin of the American College of Surgeons* 3, no. 1 (1917): 24–27. See also Susan Reverby, "Stealing the Golden Eggs: Ernest Amory Codman and the Science and Management of Medicine," *Bulletin of the History of Medicine* 55 (Summer 1981): 156–71; George Rosen, "The Efficiency Criterion in Medical Care, 1900–1920: An Early Approach to an Evaluation of Health Service," *Bulletin of the History of Medicine* 50 (Spring 1976): 28–44; and Morris J. Vogel, "Managing Medicine: Creating a Profession of Hospital Administration in the United States, 1895–1915," in *The Hospital in History*, ed. Lindsay Granshaw and Roy Porter (London, 1989), pp. 243–60.

30. For example, see Carl E. Black, "Securing, Supervising, and Filing of Records," *Bulletin of the American College of Surgeons* 8 (Jan. 1924): 71–78, and John Wesley Long, "Case Records in Hospitals," *Bulletin of the American College of Surgeons* 8 (Jan. 1924): 65. See also Paul A. Lembcke, "Evolution of the Medical Audit," *JAMA*, 20 Feb. 1967, pp. 543–50; Joseph V. Rees, "The Orderly Use of Experience: Pragmatism and the Development of Hospital Industry Self-Regulation," *Regulation and Governance* 2 (Mar. 2008): 9–29; Reiser, "Creating Form out of Mass"; and Craig, "Hospital Records and Record-Keeping, c. 1850–c. 1950."

31. Steve Sturdy, "The Political Economy of Scientific Medicine: Science, Education, and the Transformation of Medical Practice in Sheffield, 1890–1920," *Medical History* 36 (Apr. 1992): 129. In the 1920s, the enhanced administrative reach of the US government generated in parallel "a documentary regime of verification in which documents begat documents to produce official identities verified through the archival memory of the state" (Craig Robertson, "Mechanisms of Exclusion: Historicizing the Archive and the Passport," in *Archive Stories: Facts, Fictions, and the Writing of History*, ed. Antoinette Burton [Durham, N.C., 2005], p. 82). Milton O. Gustafson emphasizes the military origins, through the adjutant-general's office, of the State Department records system in "State Department Records in the National Archives: A Profile," *Prologue: Journal of the National Archives* 2 (Winter 1970): 175–84, esp. 179. See also Roger W. Little, "The Dossier in Military Organization," in *On Record*, pp. 255–74, and Stephen Skowronek, *Building a New American State: The Expansion of National Administrative Capacities, 1877–1920* (New York, 1982). The case record also took form in social work during this period; see Karen W. Tice, *Tales of Wayward Girls and Immoral Women: Case Records and the Professionalization of Social Work* (Urbana, Ill., 1998).

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The Military Record

The military has long provided a model for the management of collective space, especially in the United States.[32] Early in the twentieth century, it became an administrative guide and resource for growing civil bureaucracies, which found that many of its modes of surveillance and discipline could readily be transferred across to the body politic. Its management of fatigue and morale, for example, formed the basis of the medical specialties of industrial hygiene and occupational health.[33] The US military also proved adroit during this period in the development of paper technologies such as unit records, for the identification, monitoring, and deployment of soldiers.

After the debacle of the Civil War, when medical officers became too burdened with the care and transport of the sick to properly document their patients and effectively communicate with their colleagues, the surgeon general of the United States Army decided to implement a new records system. In 1863, an investigating board recommended a series of registers as the most efficient means to secure accurate information. The register books linked individual cases from the battlefield to the general hospital and then to the medical department through separate reports based on registered information. An expanded clerical staff in the medical department ensured no duplication of information on individual soldiers.[34] Between wars, decisions about the allocation of pensions became the major stimulant of paperwork in the surgeon general's office. In 1886, when surgeon Fred C. Ainsworth took charge of the records and pensions division, he calculated that each case was taking almost three months to process, causing a backlog of over nine thousand cases. He therefore introduced a system of numbered index cards, which allowed his clerks to collate all cards referring to a single soldier. Before long, most cases could

32. See Foucault, "The Eye of Power," interview by Jean-Pierre Barou and Michelle Perrot, *Power/Knowledge: Selected Interviews and Other Writings, 1972–1977*, trans. Colin Gordon et al., ed. Gordon (New York, 1980), pp. 146–65.

33. It is revealing to compare Edward L. Munson, *The Theory and Practice of Military Hygiene* (New York, 1901) with his advice to industry in *The Management of Men: A Handbook on the Systematic Development of Morale and the Control of Human Behavior* (New York, 1921). See also Warwick Anderson, *Colonial Pathologies: American Tropical Medicine, Race, and Hygiene in the Philippines* (Durham, N.C., 2006). For military influences on the development of orthopedics, see Roger Cooter, *Surgery and Society in Peace and War: Orthopaedics and the Organisation of Modern Medicine, 1880–1948* (New York, 1993). On the emergence of rehabilitation medicine after World War I, see Beth Linker, *War's Waste: Rehabilitation in World War I America* (Chicago, 2011).

34. See John H. Brinton, *Personal Memoirs of John H. Brinton, Civil War Surgeon, 1861–1865* (Carbondale, Ill., 1996), p. 251. Brinton was a member of the investigating board. See also Mary C. Gillett, *The Army Medical Department, 1865–1917* (Washington, DC, 1995), p. 23.

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be decided within a day, and only 350 or so were in arrears.[35] Army authorities were so impressed they moved thirteen sections of the adjutant general's office over to Ainsworth's division; the adjutant general was failing to muster the military records as quickly as Ainsworth was compiling the medical cases. Later, they made Ainsworth adjutant general.[36]

In the 1890s, the identification of soldiers continued to preoccupy the US military. The attempts of "deserters, bounty-jumpers, and other undesirable characters" to join the army, or to reenlist, caused serious embarrassment.[37] During the Civil War there had been a makeshift effort to tattoo anyone dishonorably discharged; later, vaccination on the left leg, leaving a distinctive mark, was tried, though it often led to infection. In the 1890s, the army shifted from branding the bodies of miscreants to putting their bodies in its archive. Surgeons Charles R. Greenleaf and Charles Smart devised a method of identification based on the Bertillon system, which already was proving popular in prisons and police departments across the United States. A Paris police officer, Alphonse Bertillon had developed in the 1880s a system of criminal identification consisting of a photographic portrait, anthropometric description, and standardized notes on a single fiche or card. The cards were classified according, first, to the length of the head, then by the width, by the length of the left middle finger, and so on. The measurements thus served not only as a means of identification but also as an index of potential recidivists. Comparing the measurements of the suspect with those in the card file, as well as with the photograph and any distinguishing marks, would enable efficient detection of any criminal or degenerate trying to rejoin the army.[38]

From 1889, for every man that enlisted or reenlisted, the medical officer filled in an outline figure on a card bearing his name and organization, age, height, color of hair and eyes, and marks or scars on the skin. This constituted a short cut of the Bertillon system, since detailed anthropometry and photography were too complicated and time consuming for mobile re-

35. See Gillett, *The Army Medical Department, 1865–1917*, p. 23, and P. M. Ashburn, *A History of the Medical Department of the United States Army* (Boston, 1929), pp. 248, 390.

36. See Ashburn, *A History of the Medical Department of the United States Army*, pp. 249, 390.

37. C. H. Alden, "The Identification of the Individual: With Special Reference to the System in Use in the Office of the Surgeon General, U.S. Army," *American Anthropologist* 9 (Sept. 1896): 295.

38. See ibid.; Bertillon, "The Bertillon System of Classification;" and Simon A. Cole, *Suspect Identities: A History of Fingerprinting and Criminal Identification* (Cambridge, Mass., 2001). On the development of physical examination of recruits from the 1880s, which involved Greenleaf, see Anderson, *Colonial Pathologies*, pp. 26–28. For fears of degeneracy in the army and examples of cases, see Charles E. Woodruff, "Degenerates in the Army, " *American Journal of Insanity* 57 (July 1900): 137–42.

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cruiting parties. Each completed card was maintained in alphabetical order in the surgeon general's office until a report of desertion or dishonorable discharge was made, when copies of the original card were transferred to files organized according to body color, features, and dimensions. By 1896, the surgeon general kept almost sixty thousand cards identifying recruits and reenlisted men. That year, his office made over one hundred identifications of miscreants and undesirables. Although some officers had objected at first that *Bertillonage* was too closely associated with the detection of criminals to become a routine practice in recruitment, the army soon became accustomed to it. Assistant Surgeon General C. H. Alden observed in 1896, "it is now relied on as an indispensable agency in maintaining discipline and in improving the standard of character in the ranks of the army."[39] Mobilization for the Spanish-American war after 1898 served to amplify these processes of serial individuation.[40]

After 1905, the success of the identification cards in enlistment and pension allocation led to their replacing the old medical register system and the composite report of sick and wounded sheets.[41] Each medical card showed the individual soldier's name, rank, organization, age, race, birthplace, and date of recruitment, along with a brief description of his disease, his treatment, and the outcome. In complicated or repeat admissions, the case record accumulated additional sheets of paper, clipped together and placed inside an envelope for filing. Before they were archived, these records were used to chart daily the patient's response to treatment; they included temperature, pulse, and respiration forms, progress notes, operation description, medication list, and pathology results.[42] The surgeon general instructed medical officers "to exercise the greatest care and thoroughness in preparing the clinical histories of medical and surgical cases. . . . Whenever possible the text should be illustrated by sketches, drawings, or

39. Alden, "Identification of the Individual," p. 310. See also Alden, "The Identification of the Soldier," *Proceedings of the Seventh Annual Meeting of the Association of Military Surgeons of the United States* (Columbus, Ohio, 1897), pp. 209–26, and Paul R. Brown, "Objections to the System of Identification in Use in the United States Army," *Proceedings of the Sixth Annual Meeting of the Association of Military Surgeons of the United States* (Columbus, Ohio, 1896), pp. 243–49.

40. See Ashburn, *A History of the Medical Department of the United States Army*. See also Bobby A. Wintermute, *Public Health and the U.S. Military: A History of the Army Medical Department, 1818–1917* (New York, 2011).

41. There is some evidence of scattered efforts to introduce individual medical case files since the 1890s. See Albert G. Love, "The Importance of Adequate Records of the Sick and Wounded in the Military Services in Time of War, and the Best Methods for Obtaining Them," *Military Surgeon* 85 (Dec. 1939): 461–81.

42. For example, see the case records from 1909 in "Medical Case Files of Patients, Walter Reed General Hospital, 1909–1910," box 1, record group 112, National Archives and Records Administration, Washington, DC.

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photographs, which should accompany the clinical report. . . . On the termination of the case, the report should be promptly made out and forwarded to the surgeon general."[43] In 1918, the individual's new military service number (or serial number) could be emblazoned on each file.

The unitary medical record, or individual case file, was commonplace in the surgeon general's office of the US Army before World War I. After the war, the military's medical record system became a model for the American College of Surgeons in its campaign to reform civil hospital administration. In particular, Cleveland surgeon George W. Crile, chief of the US Army's Base Hospital No. 4 in France, returned dedicated to systematic reform of patient records along military lines, working relentlessly through the college's standardization committee. Experience of war convinced him that "mediocrity well organized is more efficient than brilliancy combined with strife and discord."[44] Crile deplored armed conflict, but he recognized that wars "bring order and discipline to men," and "military training is a valuable preparation for any civil career."[45] According to the college's director, John G. Bowman, systematic individual case records had become a crucial test of "medical patriotism." Like his colleagues, Bowman believed that the "history of hospitals is a series of waves of advancement, each stimulated by war."[46] Thus the military mode of tracking disabled or otherwise pensionable soldiers and identifying criminals, degenerates, and undesirables led, perhaps irresistibly, to the development of standard unitary medical records—to the proliferation of modern cases—first in army hospitals, then in burgeoning civilian clinics.[47]

43. "Instructions for Clinical History Form—No. 33," n.d., George Miller Sternberg papers, 1861–1917, MC C 100, National Library of Medicine, Bethesda, Md.

44. G. W. Crile, "The Unit Plan of Organization of the Medical Reserve Corps of the U. S. A. for Service in Base Hospitals," *Surgery, Gynecology, and Obstetrics* 22 (Jan.–June 1916): 68. See also "Report of the Hospital Conference of the Clinical Congress of the American College of Surgeons, Held in the Congress Hotel, Chicago, October 22–23, 1923," *Bulletin of the American College of Surgeons* 8 (Jan. 1924): 5–101, esp. p. 10. On Crile, a founder of the Cleveland Clinic, see Robert E. Hermann, "George Washington Crile (1864–1943)," *Journal of Medical Biography* 2 (Feb. 1994): 78–83. Codman, Harvey Cushing, and William Mayo were also heavily involved in this project; see Franklin H. Martin, "Hospital Standardization: Its Inception, Development, and Progress in Five Years," *Bulletin of the American College of Surgeons* 6 (Jan. 1922): 3–4.

45. Crile, *A Mechanistic View of War and Peace*, ed. Amy Farley Rowland (New York, 1915), p. 43. Crile feared that war led to "race deterioration" (p. 41).

46. Bowman, "The Standardization of Hospitals," *Boston Medical and Surgical Journal* 177, no. 9 (1917): 283. Previously a president of Iowa State University (1911–14), Bowman moved on to serve as chancellor of the University of Pittsburgh (1921–45). He was once secretary (1907–11) of the Carnegie Foundation for the Advancement of Teaching, which gave financial support to the hospital standardization movement.

47. Roger Cooter observes more generally that in the early twentieth century "military organization could be seen as providing an administrative ideal for coping with ever-greater

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Conclusion: Archived Cases

In the clinic, case files shape and monitor work routines, direct and coordinate medical activities, and create alliances between experts. Flexible, transferable unitary records discipline the behavior of those caring for the patient, the multiple authors of the file, training them to think about the sick person as both a singular object, a case to be worked over, and an example of a nosological category, a case of something. As a modern knowledge practice, the case file allows efficient and productive management of patients as it simultaneously produces the individual as an object of medical procedure, organized around an ontological impression of disease.[48] Of course, inscribing someone as a case, and even practicing on cases, does not necessarily transform patients' sense of themselves. Most sick people continue to resist experiencing themselves as cases, and their friends and family rarely imagine them as such.[49] Nonetheless, even if it is not hegemonic, paper technology has made visible the individual or case as a serviceable object in medical work.

The case file requires an archive in order to appear functional once the clinical encounter ends. In the records department, the file gains authority and sometimes permanence, or at least greater longevity than its referent. Once a case is assigned a hospital record number—which functions like the army service number—it gives the patient a retrievable identity, a file available for clinical and administrative correlation. Access to the institutional archive is limited, circulation of the file is restricted, and personal information is regarded as confidential. But what can the archived file *do*? Many years ago, when I roamed the hospital wards, clinical staff members examined obsessively the fresh record of the current admission held in a separate folder, while the battered volume of past admission notes usually was piled up with others on a table in some dark office. We might look briefly at its contents, trying to find traces and fragments of the current

problems of perceived social complexity, waste, and inefficiency. The military offered a model for the application of system, uniformity, and expertise to these problems, in a word a model of rationalization" (Cooter, "Medicine and the Goodness of War," *Canadian Bulletin of Medical History* 7 [1990]: 152).

48. See Owsei Temkin, "The Scientific Approach to Disease: Specific Entity and Individual Sickness," *"The Double Face of Janus" and Other Essays in the History of Medicine* (Baltimore, 1977), pp. 441–55, and Georges Canguilhem, *The Normal and the Pathological*, trans. Carolyn R. Fawcett and Robert S. Cohen (New York, 1989). It would be interesting to compare the disposition of the "normal" in the case file and the Freudian case study.

49. Anthropologists make careers providing examples of this failure. See Carol A. Heimer, "Conceiving Children: How Documents Support Case Versus Biographical Analyses" and Adam Reed, "Documents Unfolding," in *Documents: Artifacts of Modern Knowledge*, ed. Annelise Riles (Ann Arbor, Mich., 2006), pp. 95–126, 158–79.

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complaint, searching for origins and antecedents. The absences in the record usually were more striking than what was there: the question not asked; the sign missed; the test not done or lost. That is, it was just like any other archival document—except in this case it rarely mattered.

Jacques Derrida claimed that the principle of the archive is "in the order of commencement as well as in the order of commandment."[50] In the cases I treated, the issue of origins and antecedents generally was trivial. The authority of the clinical archive seems to depend more on its organization of paper technology, its serial disposition of individual cases, than on the retrievable contents of any file.[51] Derrida suggested something of the sort when he wrote: "The technical structure of the *archiving* archive also determines the structure of the *archivable* content even in its very coming into existence and its relationship to the future. The archivization produces as much as it records the event" (*AF*, p. 17).[52] Certainly in the hospital the archived file did not do much, but the presence of an archive meant a lot. It provided a sort of authorization. In a different context, Ann Laura Stoler also points out that archiving as a process is at least as revealing as the archive is as a thing. According to Stoler, colonial archives "were both transparencies on which power relations were inscribed and intricate technologies of rule in themselves." She urges us to treat the archive, regardless of its contents, "as a force field that animates political energies and expertise, that pulls on some 'social facts' and converts them into qualified knowledge, that attends to some ways of knowing while repelling and refusing others."[53]

Derrida provocatively noted the resemblance of psychological "repositories" to archival collections. Like inscriptions, traces of experience are

50. Jacques Derrida, *Archive Fever: A Freudian Impression*, trans. Eric Prenowitz (Chicago, 1996), p. 2; hereafter abbreviated *AF*. For a challenge to Derrida's notion of "archival violence" (*AF*, p. 7), see Carolyn Steedman, "'Something She Called a Fever': Michelet, Derrida, and Dust (Or in the Archives with Michelet and Derrida)," in *Archives, Documentation, and Institutions of Social Memory: Essays from the Sawyer Seminar*, ed. Francis X. Blouin, Jr., and Rosenberg (Ann Arbor, Mich., 2007), pp. 4–19.

51. On the significance of paper technology and seriality in modern science and medicine, see Nick Hopwood, Simon Schaffer, and Jim Secord, "Seriality and Scientific Objects in the Nineteenth Century," *History of Science* 48 (Sept.–Dec. 2010): 251–85, and Hess and Mendelsohn, "Cases and Series: Medical Knowledge and Paper Technology, 1600–1900," *History of Science* 48 (Sept.–Dec. 2010): 287–314.

52. Derrida went on to write that we have no fixed concept of the archive, only an impression: "an insistent impression through the unstable feeling of a shifting figure, of a schema, or of an in-finite or indefinite process" (*AF*, p. 29).

53. Ann Laura Stoler, *Along the Archival Grain: Epistemic Anxieties and Colonial Common Sense* (Princeton, N.J., 2009), pp. 20, 22. See also Nicholas B. Dirks, "Annals of the Archive: Ethnographic Notes on the Sources of History," in *From the Margins: Historical Anthropology and Its Futures*, ed. Brian Keith Axel (Durham, N.C., 2002), pp. 47–65.

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archived and later recollected or mentally suppressed. According to Derrida, we are involved in a feverish, and ultimately futile, effort to recover what the mind, or the institution, has buried in its archive. But the hospital archive does not operate like Derrida's imagined Freudian or psychoanalytic archive. In the clinic, the mechanism of making an individual file and adding to an archive is more significant than the actual contents of the repository. It is easier to get access to a file than to recover experience, but there is little more indexed in the file than indexicality, a practice of writing. There is no real injunction to remember, only to order. The creation of serial objects, operationalized within a medical bureaucracy, distinguishes the unitary hospital record from the modernist genre of the Freudian case study. Indeed, one might argue that Freud's exemplary cases ultimately act as a counterdiscourse, opening up new possibilities for framing subjectivity, just as the objectifying hospital case archive was closing them down, or limiting them, becoming "clinical." For centuries, the case, whether written up or taken down, has been an important part of our cognitive equipment, but there is more than one way to think in a case.

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