The Case of the Archive

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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. 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-
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.”

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.

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-


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. 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. 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.” 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 disjunction, eventually revealing the hidden cause of the individual’s distress. Unlike hospital case files, these studies emphasized the in-


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. 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


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. 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. 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.

The modernist case study and administrative case file, both pedagogic instruments, accumulate dissimilar collectives or publics. 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. Case files are interceptive, 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.

12. See Forrester, "If P, Then What?"
16. See Berlant, "On the Case."
17. It is tempting, if reductive, to cast the case file as a form of mechanical objectivity and
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. 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."

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

The transformation of hospitals in the early twentieth century into large, complex institutions with proliferating bureaucracies spurred efforts to reform and systematize record keeping. 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. Unlike the casebook, the unit system exerted considerable influence on clinical work, aiding the coordina-


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


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 became 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. 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.”

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. 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. 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.” B. A. Codman at Massachusetts General Hospital was one of the more strident promoters of


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


27. Berg and Geoffrey Bowker claim the medical record performs not only the patient’s body but also the clinic; see Berg and Bowker, “The Multiple Bodies of the Medical Record: Toward a Sociology of an Artifact,” Sociological Quarterly 38 (Summer 1997): 533–57. 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.
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." 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. 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."


The Military Record

The military has long provided a model for the management of collective space, especially in the United States. 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. 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. 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


be decided within a day, and only 350 or so were in arrears. 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. 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. 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.

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, 1925), pp. 246, 390.
36. See Ashburn, A History of the Medical Department of the United States Army, pp. 246, 390.
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.”

Mobilization for the Spanish-American war after 1898 served to amplify these processes of serial individuation. 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. 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. 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


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.
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." 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." 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." According to the college's director, John G. Bowman, systematic individual case records had become a crucial test of "medical nationalism." Like his colleagues, Bowman believed that the "history of hospitals is a series of waves of advancement, each stimulated by war." Thus the military mode of tracking disabled or otherwise pensionable soldiers and identifying criminals, degenerates, and undesirables led, perhaps irrevocably, to the development of standard unitary medical records—to the proliferation of modern cases—first in army hospitals, then in burgeoning civilian clinics.

43. "Instructions for Clinical History Form—No. 33," n.d., George Miller Sternberg papers, 1861–1917, MG C 300, National Library of Medicine, Bethesda, Md.
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
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. 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. 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

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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 archivation 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 as it is 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


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).

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.