Evanescent Lives: Archival Dissolution in a Montreal Psychiatric Hospital

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ABSTRACT

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This thesis examines the medical files of women suffering from neurosyphilis at the Montreal psychiatric hospital Saint-Jean-de-Dieu at the beginning of the 20th century. I argue that history and the hospital functioned differently for these women, as their lives, bodies, relations of care, and narratives were left to dissolve into dust. In the very institutions meant to preserve their bodies (i.e. the hospital) and their records (i.e. the archive) and keep them whole, my participants were evanescent, passing out of sight and out of time. This thesis examines this motion towards dissolution as things go from present to absent and material to dust and the underlying administrative and ideological mechanisms of the hospital and the archive which encourage this process and target specific histories and lives for burial. I move away from traditional methodological and representational styles of ethnography which seeks to gather and tell stories, which, if not whole are at least complete, and ask instead what stories I can tell from partial, fragmented, and unknowable subjects.

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Introduction
Microfilm Box #7

Anxious and just a little stunned, I shifted uncomfortably in my swivel chair, gazing at the bright screen of the microfilm machine, its glare the only light illuminating the general darkness of the hospital's basement. Microfilm box number seven was lying empty beside me, its reel looped through the threads of the reader, and in the blank space projected onto the screen, between case file number 9941 and 9943, I saw my project falling to pieces a little over a week after I had finally started.

Sitting in my lap was my notebook scrawled with numbers, each number a case file and corresponding date of death. The first four were crossed out. It was these four, now obsolete file numbers, that worried me. I had collected these numbers the day before, after having gone through the hospital archive's index searching for women who had died at the institution from neurosyphilis related causes in the 1910s. I collected a little under 30 file numbers in the register, and after browsing briefly through the paper files the hospital archives kept for research purposes, I realized that my files weren't there, they were too old for the shelf. So I turned instead to the filing cabinet full of reams of microfilm, where some of the earliest records of the hospital had been transferred in the 1960s in an effort to preserve the decaying matter. But the first four files I collected were missing from the sixth and seventh reel. In between case number 9941 and 9943, there was nothing, no gaps to mark the absence, no explanation as for why the film jumped a number.

I was in the Institut Universitaire de Santé Mentale de Montreal's (IUSMM) archives, a space I had worked to get access to for close to 6 months. I had written proposals and ethic forms, gotten permission from half a dozen offices, all in anticipation of accessing the files of women who had been treated for neurosyphilis over a hundred years ago, in Montreal's oldest psychiatric hospital. Formalized in 1873 under the name ‘Asile Saint-Jean-de-Dieu’, the hospital was an institution by the 1910s, housing all of the city’s and surrounding area’s catholic mentally ill. Run as a split hospital, with the medical side managed by Quebec appointed doctors and the day-to-day managed by the Catholic order, the Sisters of Providence, I thought the hospital’s history would offer an interesting site for the study of care at oscillating scales of intimacy. I hoped to assemble an ethnography of women’s care and pain, as they went through brutal injections of the arsenic compound neosalvarsan, the newest and most effective drug on the market at the time to treat syphilis.

Following in the methodology and style of ethnographers and historians like Lila Abu-Lughod (2008) and Ranajit Guha (1987), who explore how individual’s live and manage within their social and political systems, my project was meant to explore the “patient’s view” of the hospital (Wright, Saucier 2012: 66). This entailed an exploration of how *individual* women dealt with sickness and care at the hospital while suffering the debilitating effects of neurosyphilis, rather than an overarching history of the institution of care and treatment at the hospital. Called ‘ethnography from below’, this style of research begins first with the stories of individual participants and then scales out to trace how systems of power come to function in their narratives (Abu-Lughod 2008).

Unfortunately, narratives of the marginalized in history are hard to come by. They are often absent from the archive, ephemeral because a) no one thought to record their stories and b) they didn’t have the means to record their own. The marginalized consequently exist in the archive in few and specific places, caught in the records of institutions like the legal courts, the prison system, and the medical system (Strange 1997)

In the medical system, patients' lives are visible to a certain degree through their case files. These objects record a patient's history and the details of their lives at the hospital, like their treatment regimen, their reaction, and any odds and ends scribbled by staff during their rounds (Berkenhotter 2008). Patients' voices come through sparingly in the case files, in the answers to their doctor's questions, or their complaints at the hospital, and sometimes, if lucky, in letters enclosed in the file (Nevert 2009). The medical histories and treatment and response regimen make little bits of a patient's life visible, even if they are translated by the doctors into notes. In these small ways, a patient's story unfolds in the archive, becoming legible over time and space. The case file is essential to this task, one of the few media in the medical archive that exists just to record the story of a single patient.

So with each new file that the microfilm skipped, I grew a little more anxious, a little more convinced that my project was crumbling. I had been doomed from the start, after the lengthy approval process delayed my work by months. Now that I was finally there, granted a key to the much-protected archive, the files and the lives contained within were disappearing on me from the register to the shelves, obliviated from the record. The fifth file was there, and each file after that, present, if much thinner and sparser than I had been anticipating. But those four first files stayed missing during my time at the hospital, my unsolved mystery.

The anxiety I felt as I crossed out file after unfound file stayed with me even as I moved past what was missing into what was there. Because what was there was much more partial than I had anticipated. Files were short, despite the lengthy stay of patients. Treatments were all but absent, despite the common use of different syphilitic cures in Montreal at the time at other hospitals like the Montreal General (Campbell, Patch 1912; Patch 1920). Even patients were next to invisible, popping up momentarily during admittance exams and then sporadically, despite the daily rounds doctors went on. While my project was saved, it was radically changed. No longer could my study be about patients' lives alone. Rather I sought instead to examine how their lives disappeared in the hospital and in the archive.

Every archive is full of these gaps; things go missing over time, get lost, fall apart (Stoler 2010; Steedman 2001a, Weld 2014). Everything is material, and everything material decays (Ogborn 2004). In the archives I was combing through, however, these dissolutions occurred on more than one register. Even as records went missing and dossiers frayed at the edges, time and space, and bodies and lives also came undone *within* the files. Women suffering from neurosyphilis experienced their bodies crumbling from the disease, their memories fading, their relationships dissolving, and their stories becoming illegible.

The bacteria that caused neurosyphilis dissolved patients' neurons and senses, creating memory loss, disorientation in time and space, and failing bodies. Overworked doctors and administrative gaps at Saint-Jean-de-Dieu meant that many symptoms, tests, treatment regimens, and responses fell through the hospital's cracks, rarely finding their way to patients' case files. In these moments of crisis, patients' networks of care and kin dissolved as family members disowned, abandoned, or reluctantly transferred the responsibility of care onto the hospital. Certainty and the search for fact also frayed as doctors struggled to identify illness and truth amid patients' kaleidoscopic ensemble of symptoms and stories.

Those four missing files and the general partiality of the archives point towards more than just administrative errors and archival gaps. They speak to the ways marginalized women's lives evanesce out of sight, memory, and existence, even in those spaces and institutions designed to preserve and keep them whole. Whether it be in the hospital or in the archive, the women I encountered were ghosts, hovering between life and death, and more permanently, balanced on a fine edge between memory and amnesia.

Working With What's Left

Met with only fragments and traces, with partial files telling partial truths, I began to ask what's left in the spaces of absence, in the dissolution of things as they come undone? That is, in its broadest sense, what this thesis is about, the *evanescence* of things as they pass out of sight, out of memory, out of time. A motion towards dissolution as things go from present to absent, from remembered to forgotten, from material to dust, this attention to evanescence requires a turn away from the traditional methodological and representational styles of ethnography, which seeks to gather and tell stories, which, if not completely whole, are at least complete. Rather, this focus requires a turn to things I cannot know, to things I cannot prove, to stories I cannot write about with certainty and lives about which I can only speculate. This focus requires a turn towards dissolution and dust, towards ghosts and the unknown.

Caitlin DeSilvey (2007) uses a similar method of speculation in her work on "Salvage Memory" amid a collection of lost objects in a homestead heritage house in Montana. Bringing together disparate threads of narrative and a household worth of objects from a 100-year-old farmhouse, DeSilvey writes a history for a past that is largely inaccessible. She lets her imagination shape what she terms her "poetics of suggestion and conjecture" (2007: 420). Using Walter Benjamin's (1997) theory of constellations, DeSilvey creates histories by assembling things into a story thread. Not in any way systematic, her narratives are a constellation in that they are disparate objects brought into alignment through observed and imagined relations. The result is a beautiful history of mood and tone rather than facts and events; a history that would go untold if she stuck to the historian's classic project of facts and figures and relations of cause and effect. My project of evanescent lives functions similarly; I move along the tentative lines of fact and fiction, bridging the known with the conjectured and amassing a hodgepodge of discordant narratives in order to tell a different kind of tale.

Towards a Theory of Evanescence

There isn't, as of yet, a theory of evanescence, apart from its use in the hard sciences as a type of oscillating wave. It is briefly touched on in literature, though more as a descriptor than a theory in itself. Robin Riley Fast (1989), in her article "Reading Evanescence", provides an interesting application of the term to Emily Dickinson's poetry. Evanescence, in this sense, becomes a theme rather than a theory. Its characteristics, however, are still useful to think with in building the theory. Fast argues that there is a deliberate lack of solidity to Dickinson's poetry, which she terms 'evanescence', where meaning and sensation are reached for but ungraspable, tantalizingly out of reach, hovering on the edge of things. This is meant to reflect the "transient, provisional qualities of experience and meaning" as "we acknowledge the utter mystery that we face every day". Dickinson's poetry embraces this ambiguity, "balancing on the edge between the familiar and the inscrutable" (1989: 215).

Fast's evanescence invites ambiguity and the unknown into my reading, where meaning and experience is necessarily fleeting, always in a process of disappearing. But this is a very broad way of looking at evanescence, almost to the point where it is voided of meaning. Of course everything is fleeting, of course everything comes undone. The question is why is this a productive way to talk about the lives of women dead and gone, caught momentarily by time and the archives? In order to answer this question, I need to turn to three perfectly disparate theories and bring them under the thumb of evanescence in a constellation of ideas.

The spectral turn in the 90s occurred when theorists like Jacques Derrida (1996) and Avery Gordon (1997) began to exam history outside of the classic western lens of linear time, using revenants and ghosts as its central metaphor (Del Pilar Blanco, Peeren 2013). Approaching the past as something haunting, the turn towards specters in history and social sciences collapses the distinctions between past, present, and future and looks instead at how some temporalities come to inhabit others, as traumas refuse to fade, lingering on and producing material effects (Gordon 1997).There are, however, many different ways to attend to ghosts. Some traumas and pasts become ghosts because their effects curl outward, like Veena Das's (2007) event, "attach[ing] itself with its tentacles into everyday life and fold[ing] itself into the recesses of the ordinary" (2007: 1). This is the way that Derrida (1996) and Gordon (1997) attend to the ghost, looking at the way the past lingers out of time.

A theory of evanescence, however, brings with it a different type of ghost, made through dissolution and decay. This perspective is more in line with the work of historian Carolyn Steedman (2001a: 2001b), who talks about the past and archives in terms of dust. Steedman's theory of dust plays with the historian's notion that "*nothing goes away*, that the past has deposited all of its traces somewhere, somehow" (2001a: 77). Admitting that time, much like physics, is bound by the laws of conservation, Steedman argues while the past might leave behind traces, they are literally and metaphorically dust; material, tangible, but in the end, also illegible. Everything is dissolving in the archive and the traces that historians use to build history are partial objects, caught in the process of coming undone. Taking Steedman's argument into the realm of specters, we could argue that the ghosts that haunt the archive exist not because they continue to persist, but because they are in the process of fading out of memory.

These ghosts have the same properties as those of Gordon's and Derrida's, they are absent presences, occupying impossible zones between visibility and invisibility, between the known and the unknown. What differs is the stakes of their impermanence; the ghosts whose tentacles latch into the everyday forever threaten to spill into the present, the ghosts who evanesce into nothingness forever threaten to disappear. The women I encountered were not ghosts who haunted my time in the archive. I never stumbled across a frightening or desolate specter in the lonely hallways and darkened basements of the archives. Neither were they ghosts in the more metaphorical sense, haunting the everyday despite efforts to bury them, a trauma unable to heal. Rather than being haunted, I had to seek out my participants, search for what was left of their lives, stories, and bodies in the case files, death indexes, and cemeteries. The women I encountered in the archives were *ghostly* because they were evanescent, shifting out of sight, time, and existence.

Sarah Pinto's (2012; 2014) notion of dissolution occupies a very different literature. She uses the term to discuss the ways that families, lives, narratives, and truths come undone in moments of crisis. Her ethnography on women in psychiatric institutions in India looks at the ways women's lives are often unknowable, to both herself as a researcher, but also to women's doctors and families. The intimacies of their lives blur easy truths. As much as this thesis is about the way the past dissolves into dust, becoming spectral in its partiality, it is also about the women whose files I read whose lives and bodies were evanescent subjects to themselves and those around them. They too were in the process of dissolution, admitted to the hospital with a disease that undid their lives, their bodies, their relations, and their stories.

When I am talking about evanescence, I am talking about this process of partiality, whereby concepts that we typically like to construct as whole, like facts and truths, narratives and certainty, come undone in and through the archives. Chapter one will explore how the hospital and the archives are made evanescent by the oscillating efforts of administrative values and bureaucratic mechanisms to bury and excavate the hospital's past. Chapter two delves into the silences surrounding patients' lives as their experiences at the archives disappear in the too-thin case files. Chapter three deals with disappearance of a different kind, of bodies. Both in the files and in the hospital's forgotten cemetery, bodies become ghostly as they move in and out of sight. Chapter four and five turn the ethnographic lens inside the archive, exploring the evanescent lives the women suffering from neurosyphilis experienced. Chapter four deals with the relations of care and kinship, as women's families faded from the picture, present mostly in their absence. Finally, chapter five deals with the way certainty and fact came undone in women's lives as their doctors tried to pin down a disorienting disease.

In each of these chapters, evanescence functions subtly, as the movement that the archives and the lives held within make towards disappearance. There are many different underlying administrative and ideological mechanisms that cause this movement, ranging everywhere from bureaucratic errors, to the neglect or protection of patients, and the sacrifice of the past for the sake of development. Functioning steadily and unrelentingly behind all these mechanisms is also just the simple reality that all things eventually move towards dissolution and dust. It is important to note, however, that those administrative and ideological mechanisms at work encourage the process of dissolution and target specific histories and lives for burial. So while underlying my thesis is a notion of inevitable decay, I don't want the reader to forget that political motives are also at work, speeding up the process by which *certain* lives and *certain* stories evanesce out of time.

Chapter 1
Buried

Housed underground in the basement offices of the hospital, the case files of the women I call my participants are caught in a bureaucratic interplay between conservation and destruction, burial and excavation. In many ways, they live in what Carolyn Strange (1997) has called the 'shadowland': that shrouded space where marginalized women's history ends up, accessible only through the accounts of others, obtained and preserved through objects of representation like police reports or sensationalized newspaper articles. The stories contained within the files of the archive certainly live up to this assessment. Many of the cases recorded by the hospital's doctors and their investigator were caught rather than told willingly. They are replete with moments of angry and frustrated patients who refuse to cooperate with the hospital's fact-finding mission.

But my participants live in another shadowland as well, that of the hospital's archives, guarded and locked away underground, kept inaccessible and illegible in service of notions like privacy, confidentiality, and heritage. They are, in a sense, buried. To complicate matters, however, it is these same notions of privacy, confidentiality, and heritage that has ensured the maintenance and preservation of the hospital's 150 years worth of files. But it isn't just the women's case files and the stories held within that are buried at the hospital; the institution's landscape is replete with different histories, some of which get memorialized, others of which are paved over in the 'progressive' scheme of things.

This chapter looks at the interplay of those things, between privacy and access, between conservation and destruction and between burial and excavation. In all these *in-betweens,* created by the mundanities of administrative values and bureaucratic mechanisms, ghosts are made.

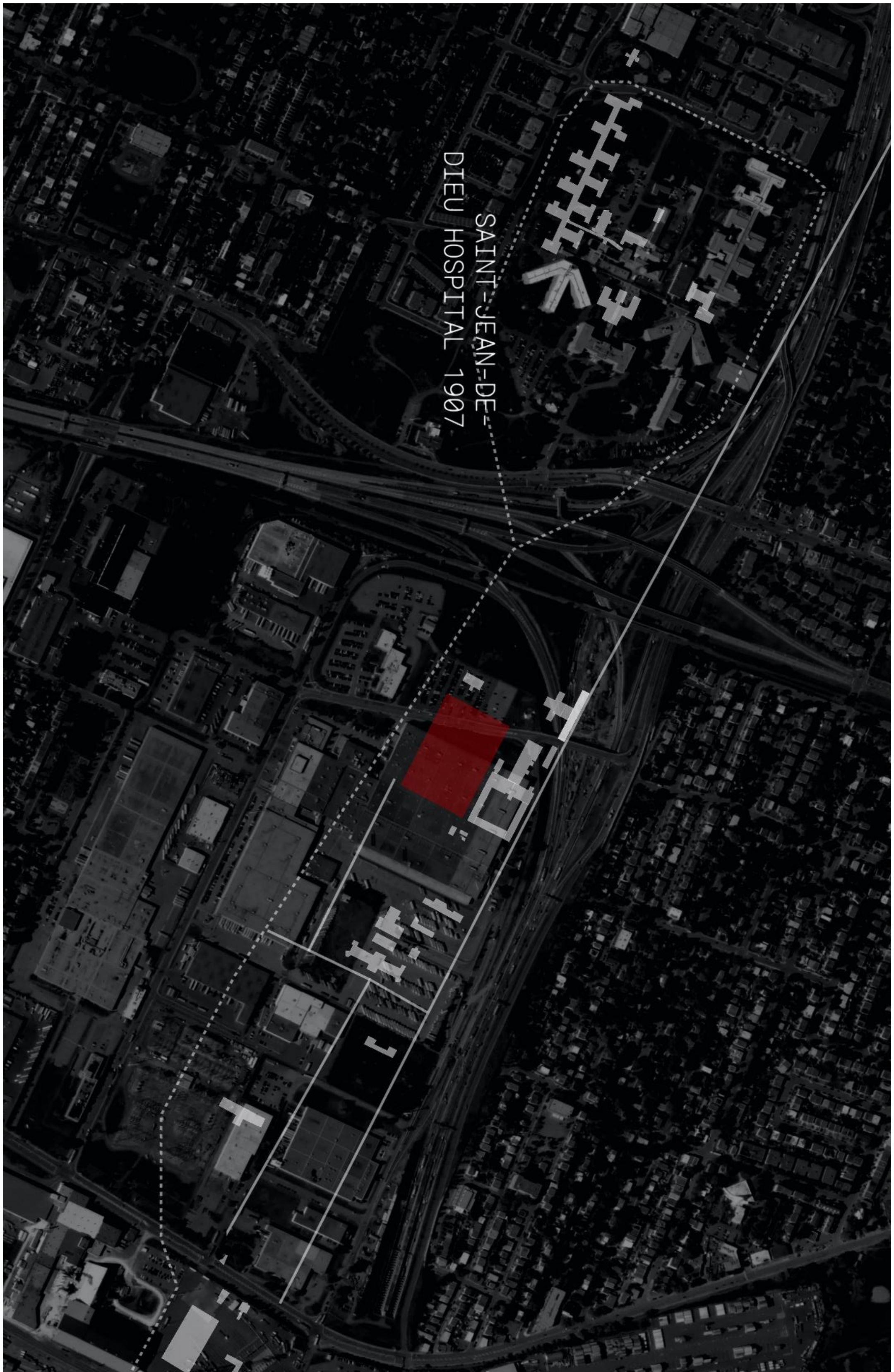


***Figure 1** Ghostly Landscapes*

Ghostly Landscapes

My visits to the archives always started with a walk across the hospital's ghostly landscape. Winding through the grounds, I passed over the buried history of the hospital; the old buildings and farmland that are now occupied by streets and parks, and parking lots. But, as I walked along the bones of the hospital, I also passed through parts of the landscape that have stood for over 100 years, past the greenhouses and gardens, wards and residence halls. Everywhere I went in and around the hospital's grounds, history haunted the landscape in odd moments of absence and presence.

Take, for example, the park I crossed every day to the get to the hospital. Playful in its reinvention of the literal jungle gym, with treelike structures to play on, it is known as the park Vaisseau D'Or (the Golden Ship), in honour of the famous Quebec poet Emile Nelligan. It was the first thing I noticed the day I started at the archives. It was a rainy September morning and the grounds of the hospital and the park across from it were enshrouded in a heavy mist. Through the mist, I noticed a number of different plaques popping up amid the park's benches and water fountains. They all spoke of Emile and his Vaisseau D'Or. A patient at the hospital at the beginning of the twentieth century, Emile was interned at Saint-Jean-de-Dieu in 1901 and diagnosed with schizophrenia. The park commemorates not just the poet, however, but the poet's time at the hospital, where he lived out his end of days until 1941, as the plaque so nicely puts it, though I'm not sure how nice it was for him. The poem, about the sinking of a golden ship, was written two years before his internment and speaks uncannily of the ship's descent into the abyss, an "immuable cercueil" (a changeless coffin).

The hospital's past has been calcified into the present beyond the park. Streets like Guillaume-Lahaise and Hyppolite Bergeron, which encircle the hospital, commemorate key actors in the hospital’s history. A contemporary of Nelligan, Lahaise was a poet who published under the pen name Delahaye. Oddly enough, he was also the psychiatrist who treated Nelligan in his later years. Bergeron, the hospital’s architect, designed the ever so imposing tri-winged pavilions and columned front building. In the hospital itself, pavilions are named similarly, with a Lahaise pavilion, and even a Riel residence building, named after Louis Riel, who was one of the hospital’s earliest patients.

Only some histories, however, are kept above surface level, like Nelligan’s and Lahaise’s. Others are buried. In the case of the archives, it is in the name of privacy, confidentiality, and heritage. In the case of the hospital’s landscape, it is done in the name of progress, as buildings and graves were paved over to build bridges, parking lots, and highways.

The maps I’ve made are meant to interrupt these acts of burial and instead highlight the ground’s ghostly landscape. Overlaying older maps from Charles E. Goad’s 1907 survey of the island with the hospital’s contemporary landscape, I sketched out the bones of the older hospital and the Sisters of Providence’s residence. Much of the buildings from the early 1900s on the primary lands of the hospital are still erect, like the residence ward (see figure 2). It used to be the men’s ward and an administrative hall, but because the hospital’s population dropped drastically in the 1960s, it now houses all of the hospital’s patients. The women’s ward is gone, as is the sewing room and the iron lined corridor which connected them, the kitchens, the machine shop, the car house, and the Notre Dame des Lourdes pavilion. Now they are just translucent figures on my map.

Today, the farm grounds in figure 3 are an SAQ warehouse. The stables for the cows, pigs, horses, and fowls are gone, as is the abattoir and beef store which held their meat. The hospital’s graveyard, which housed Saint-Jean-de-Dieu’s unclaimed dead from the 1880s to the

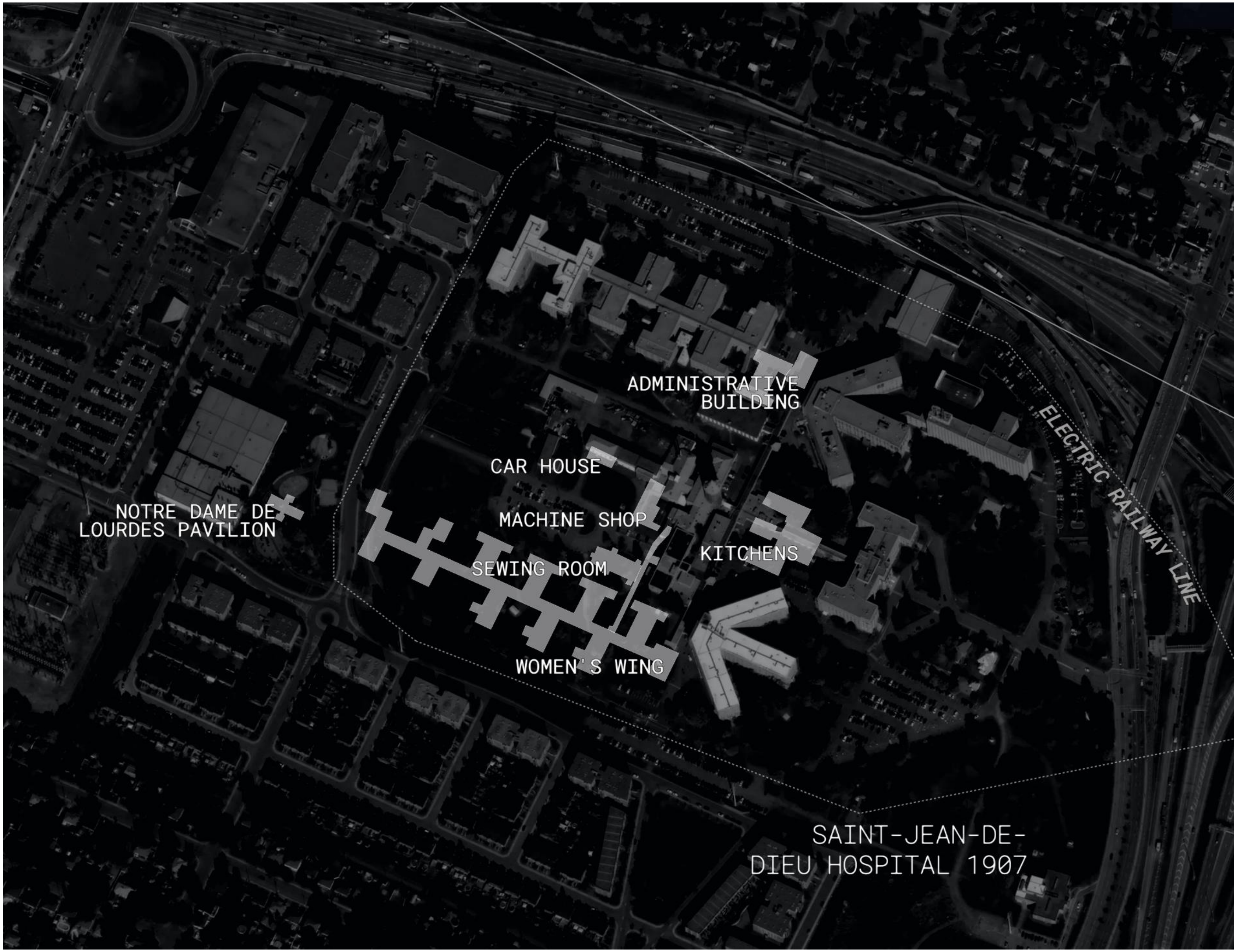


Figure 2 Hospital Grounds

Figure 3 Hospital's Farm and Cemetery

1960s, is rumored to have been nicknamed the ‘pig sty’, due to its proximity to the farm’s piggeries (Labelle 2019). The cemetery, however, didn’t show up on Goad’s map of 1907 even though the nun’s cemetery was recorded. The only map I could find it in was compiled in 1949, less than 10 years before it was sold and became the SAQ warehouse’s parking lot (1949 Plans d’Utilisation du Sol de la Ville de Montréal).

The hospital scaled back considerably after deinstitutionalization in the 1960s, when the Bédard report showed dramatic overpopulation and poor conditions in many of Quebec’s psychiatric hospitals (Thifault, Perreault 2012). The result was a dramatic decrease in patients, as many were released (Kwon, 2014). After a fire in the 1970s destroyed a large section of the women’s ward, the rest of the structure was demolished rather than rebuilt because of the drop in the hospital’s population. In 1976, when the hospital was renamed and reformed, the province also took over complete control of its day to day functions, removing the Catholic church as its partner in the institution’s administrative management (Ricard 2014). The grounds which housed the farms and cemetery supporting the hospital were bulldozed in 1963, for the building of the Louis-Hippolyte-Lafontaine Bridge-Tunnel. The bodies were moved to St-François-d'Assise cemetery a few streets down (Labelle 2019). The bridge-tunnel, built in order to facilitate the incorporation of the Trans-Canada highway through the island of Montreal, also displaced some 300 residents in Longue Pointe and resulted in the demolition of the hospital’s church as well (Robert 2004)

Funnily enough, the highway was finished just in time for Montreal’s Expo 67, a year meant to showcase the progress of the city while celebrating Canada’s 100-year anniversary. Amid these moments of commemoration, however, unhappy histories were actively made silent. Working class boroughs like Griffintown and Saint-Henri were cleaned out and road

Figure 4 Sisters of Providence Residence

infrastructures, like the Turcot and the Louis-Hippolyte Lafontaine Bridge-Tunnel quite literally bull-dozed over residential housing and archeological digs (Barlow 2017: 22). At the hospital, the city's mad and dead were quietly moved from their graves.

In figure 4 is the Sisters of Providence's residence, which despite having been named a national heritage site in 1990, was sold by the order and demolished only 6 years later. While there was a controversy at the time surrounding the site, considered by some as *public* property because it was a piece of national heritage, it was legally owned privately, by the order. The Sisters no longer had any stakes in the hospital after its deinstitutionalization in the 1960s and its renaming as the Louis-H. Lafontaine Hospital. What's more, after the Louis- Hippolyte Lafontaine Bridge-Tunnel went in, the port of Montreal expanded into the water and the space adjacent became the site of CAST's shipping terminal. As a result, the convent was precariously situated among monstrous amounts of grey infrastructure that cut it off from the city (Martin 2004). The nuns moved out in 1984 and sold it to the port a little more than 10 years later. Figure 4 shows that the small convent and the other unnamed buildings which were torn down are now in the middle of an industrial wasteland, surrounded by shipping containers, warehouses, and concrete.

Ghosts and Dust

Avery Gordon's (1997) classic *Ghostly Matters* brought ghosts into the foreground of the social sciences as "social figure[s]" back in the 90s (1997: 8). But her work remains startlingly poignant today, exploring the ways that ghosts haunt moments of absence and exclusions, where the dead surface after burial, evanescently partial. Gordon argues that even in a "post-modern, late-capitalist, postcolonial" world where hypervisibility and certainty are reached for, ghosts as barely visible and uncertain, exist as ever before (1997: 12). It is, in fact, those things that post-modernity, late-capitalism, and postcolonialism repress and hide, forget and misremember, “banished to the periphery” that haunt the contemporary world (1997: 196). To identify these things as ghostly and to explore what being ghostly means, is to try to put “life back in where only a vague memory or a bare trace was visible to those who bothered to look” (1997: 22).

Consequently, I call these landscapes ghostly in the same way Gordon called those who disappeared during the conflicts of terror in Argentina, and those who were “lost” in the American slave trade ghostly. Like the disappeared and the lost, the hospital’s landscape is ghostly because it is irretrievable. It is gone and buried with only faint and fragmented traces left of what once was, resurfacing and haunting the social imagination. Consequently, reaching for these ghosts and attempting to put *life back in* is an act of remaking, rather than revival. It is an act of imagination and fiction, which is why Gordon only talks about these ghosts through the fiction of authors like Toni Morrison and Luisa Valenzuela.

Like the names of the streets and parks that surround the hospital, and the names of the buildings in the hospital itself, these pasts had to be actively remade in the present, an attempt at a specific kind of heritage. My maps are another reiteration of this, an imaginary which tries to read the past through the lens of the present. Yet, my maps are not heritage, they are imaginative work, imperfect representations, overlaid to the best of my abilities, but full of misaligned roads and guesswork. Much like the way that Morrison and Valenzuela’s ghosts are captured only through fiction, the ghostly landscape of the hospital is only expressible through a different type of epistemology, one that is inaccurate and faulty, slippery and imagined, rather than ‘known’.

The narratives we create of the past in the present are what Carolyn Steedman (2001a) call ‘the historian’s dream’. Even when equipped with aisles and aisles of archives, with traces of what once was, the historian can never truly recover the past, instead they produce "something else, a creation of the search itself and the time the search took" (2001a: 77). Katie Kilroy-Marac (2019), in her work on the historiography of a Senegalese psychiatric clinic, notes that the past's haunting of the present is a matter of traces; a relationship which may involve "correspondence and connection" but which necessarily also "stands apart from its referent" (2019: 19). A trace is an absent presence, bringing into focus more what is missing rather than what remains. As a result, making sense of "what really happened in the past is necessarily an imaginative endeavor", dependant on creative remembrances and conjectures (2019: 17). The past is unsettled and uncontainable, full of ghosts and spectres that resist factual certainties. Kilroy-Marac argues that to make sense of these ghosts is to "move[] between and hold[] together the 'real' and the 'true', the factual and the fictitious, and the ghostly" (2019: 17). In other words, it is a narrative halfway between "history and fairytale" (2019: 16)

The ghostly maps I have created work similarly to Steedman's dream, Kilroy-Marac's history-turn-fairytale and Gordon's ghosts; while it shows the many ways that the past is ever-present, as dust, remembrances, revenants, and ghosts, for the most part, this past is inaccessible, illegible, and in a constant state of dissolution. Rather, all we have access to are our imaginations of the past, the historian's dream, or the ghostly specters, and the fairytales that we make ourselves. The motion to remake the past in the present is an effort to reknit what has dissolved.

Yet, there are differences between how things are remade. Emile Nelligan's inhabitation of the park, for example, is not the same as the ghostly traces of a displaced grave. In fact, Nelligan's inhabitation of the park, which was intentionally concretized through municipal plaques and pictures, slips into heritage, rather than spectrality. It is rather the half-remembered landscapes and half-forgotten people that are ghostly, hovering in between moments of burial and excavation, preservation and destruction. It is those specters living in the shadows and silence in between moments of light and sound, or rather simply *in-between*, that I want to turn to next.

Ghosts in the Machine

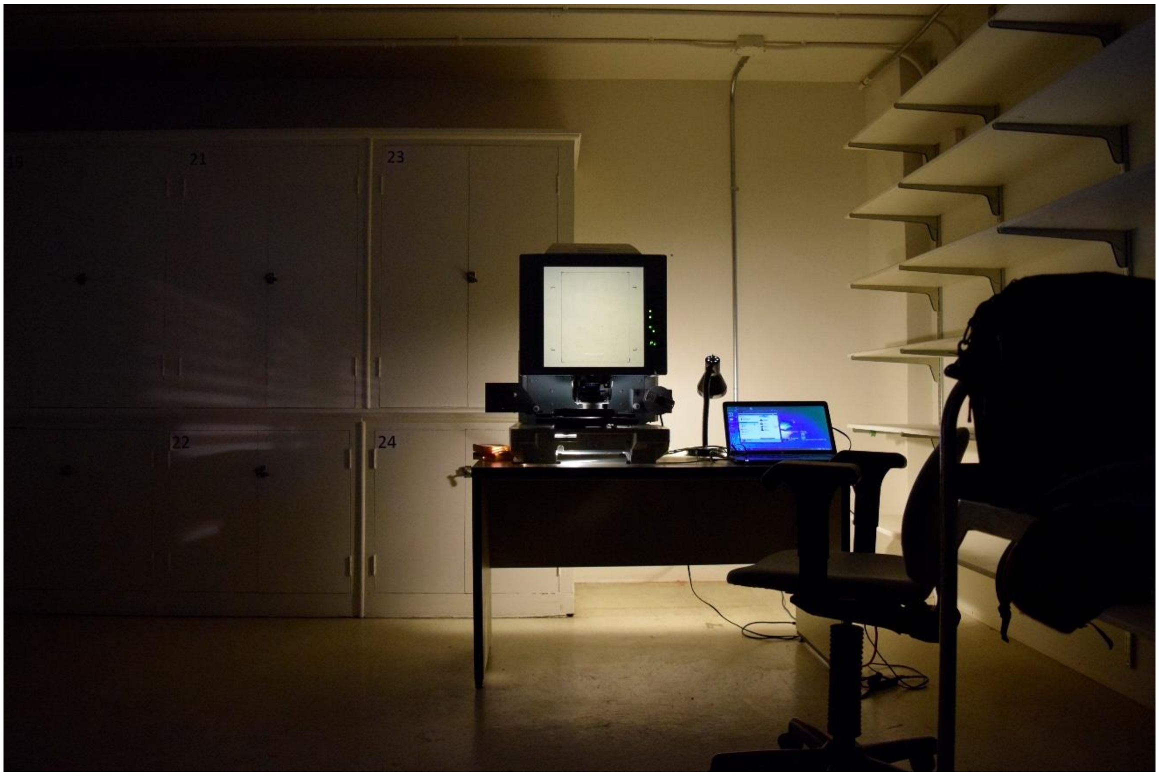
Once inside the hospital, I traveled down into the basement, into the wide hallways through which miniature trains used to run, and now transport machines zip along. Walking underneath the layers of exposed piping running up and down the corridors, I was always surprised at how the space is at once painfully mundane, yet oddly morbid. Full of empty rooms and dark hallways, some doors lead to offices chattering with the noise of photocopy machines and general administrative hums, while others don't open at all, with small windows revealing concrete rooms replete with ominous looking hoses and grates.

I worked primarily in two rooms, the archives themselves, where stacks of documents line the shelves that fill the long space, and the microfilm room, full of empty cabinets and open floors. The archive room keeps all the files in the hospital, with the active files running along the left side of the room, the historical files on the right, and the inactive files occupying the in-between, waiting to get moved to the other side. I didn’t interact with most of the files; the active and inactive ones were strictly off limit, though out in the open. The historical files were my purview, but I only ever flipped through a handful of the hard copies, trying to figure out what years they ran from.

At the far end of the archives is another room full of indexes and ‘hebdomadaires’ (weekly logs of the hospital) detailing patients’ admittance, release, escape, or death. In between the giant volumes are odds and ends; a small book detailing births at the hospital, rows of autopsy reports, a couple of files on the hospital’s doctors, some holding nothing, others holding letters of correspondence and salary requests. In the bottom shelves, I found a play written by the Sisters for the entertainment of the patients and even a collage of news clippings mentioning the hospital. I spent of good deal of time pouring over these papers, wearing my white cotton gloves to protect the documents and wrapped in heavy scarves to keep from freezing in the basement during the beginnings of a cold winter. But it was with the microfilms that I spent most of my time. Held in two filing cabinets at the back end of the archive room were rows of small orange boxes with green handwritten numbers scrawled across indicating the box numbers and the range of case files held within. Each box contained a long ribbon of film, onto which the files of hundreds of patients had been imprinted. It was these boxes I went to fetch most mornings.

From there I went to the microfilm machine room, where I worked in a state of semi-darkness, keeping only the light from the microfilm reader and a small desk lamp on, in order to better see the documents. The microfilm reader was, while old simply because of the datedness of the technology, still a nicer machine than I had used before. With a flick of the side switch it quickly came to life, the backlight lighting up and the fan a constant background rmmmmmmmmm. Threading the microfilm tape through the base, I quickly rolled through it, trying to find where I had left off during my previous visit. It was at that microfilm reader, with my face aglow in a florescent backlight, that I came to understand how specters proliferate the mundanity of the archives.

It was a few weeks into my research and I had brought my camera along for the first time, hoping to take photos of my fieldsite. I loaded the microfilm reader with the last roll I had used and scrolled to the last file I had looked at. I connected the laptop the archives supplied me with every morning to scan any files I wanted to take with me at the end of my research. I opened my notebook just so and stacked the empty microfilm boxes one onto another at a jaunty angle, trying to get a photo with the feel that I had caught the site in a moment in-between use. Snapping a shot I looked down at my digital camera and noticed something wrong; the microfilm screen I had loaded with my latest case file was blank, an empty screen illuminating the



shadows. I adjusted the camera and tried again and again the file disappeared. I adjusted the brightness on the reader itself, but still it captured an empty projection. A ghost in the machine.

I later learned that even if I had managed to capture the file on screen, it would have been erased from my camera by the archivist. I had asked permission beforehand to take photos of the site, and the archives agreed with a clause; any shots I took had to be reviewed in order to ensure they didn't hold any 'sensitive' information. Photos of the main archive room where file numbers were visible, though too tiny to be legible, were deleted. Nothing confidential left the archives, nothing personal escaped. Even the scans I took directly from the microfilm had to have patient's names, dates of birth and/or addresses blacked out, in order to protect their anonymity.

My participants really were ghosts, haunting the hospital, present only as specters. While in some ways the sheer materiality of the archive and the files held within were ghostly, appearing and disappearing on camera, rendered translucent and illegible on strips of microfilm. But mostly it was the women themselves and their lives that were transformed into ghosts by the ghostliness of the materiality of the files that held them and the administrative regulations that bound them. They exist now as traces on film, names in indexes, and statistics in PhD theses by other academics (Thifault 2003; Perreault 2009) who have gone through the same arduous process of access. They are locked away, unintentionally made illegible and invisible to most because of privacy regulations. Those instances when access is granted, when my participants lives and names again become visible, are few and far between. These are brief moments of surfacing in between a near constant state of burial, as administrative, provincial, and ethical regulations unintentionally erase patients from the record for the sake of anonymity. These ghosts don't come about through spectacular supernatural events or otherworldly visitations.

They are made, the inadvertent by-products of mundane archival regulations and mishaps, as mundane as my story of trying to take a picture.

Almost all the case files from the period 1910 to 1920 had been transferred to microfilms in the 1960s (Thifault 2003: 72). The rest of the files continue to exist in their original state, on paper, in dossiers, on shelves, in the basement of the archive. An unfinished project, the microfilmed files were part of a technological wave of the 1950s and 1960s that sought to condense and preserve objects of Canadian history in order to make archival management more streamlined and accessible, a “total archive” (Cook 2005: 197). Yet, the product today is instead a number of files hovering on the edge of visibility, because they were transferred onto a mode of technology that has quickly become outdated and expensive to access. Now, the hospital keeps and maintains a single microfilm reader, a headache to the department who moved and didn’t move the machine with them. Legible only on this single machine, kept in a room locked and separate from the already locked archives, the files resist representation.

Copies can be made of the files, with the right laptop and software uploaded onto it. Yet, the scans I took during my research are largely illegible and inaccessible. The backlight of the scan is often too pale, making the writing unreadable. The machine also requires recalibration, something the archivists noted, but never offered to fix until after my fieldwork had ended and my scans were trashed. From there, the scans were loaded onto a USB, which was kept in a perpetual state of disuse, because it had to be checked over by the head archivist, who never got around to it. She still has my USB, making my hand notes and my ghostly photos the only route through which the materials escaped (or failed to).

But my participants are kept buried and ghostly by more than just locks and keys and old technology. To even get access to the archives themselves I went through a six-month process of review, bolstered primarily by my status as a researcher backed by a recognized institution. The process is controlled by Le Centre Intégré Universitaire de Santé et de Services Sociaux (CIUSSS) de l'Est, which filters all incoming research requests for hospitals in the East end of the city. The application requires approval from a scientific research board, as well as an ethics board, the president of the CIUSSS, and the head of professional services at IUSMM. To say it was difficult to get access was an understatement. My first application was rejected, and my second application got lost in the administrative gaps of the process multiple times, delaying my project by months.

This process is meant to assure the "dignité, le bien-être, la protection, les droits et la sécurité des sujets participants" (dignity, the well-being, the protection and the rights and security of the participating subjects) and the administrative hurdles I went through ensures this protection (Règlements du Comité d'éthique de la Recherche 2014: 2). The process, however, is primarily designed for researchers trying to get approval to do research with human subjects, rather than 100-year-old documents. For participants dead a little under a hundred years, the question becomes, who or what do these privacy and anonymity laws and regulations serve and protect? Because I doubt my participants care much anymore.

Despite the difficulty of accessing the hospital's archives, IUSMM is unique in its maintenance of such extensive patient archives. Legally, Canadian hospitals are required to maintain active patient files for 7 years after the last entry in the file. Then they have a choice to conspicuously and securely destroy the documents or maintain them and their confidentiality (P-9.0001, r. 1 2019). After a wave of administrative overhaul in Canada in the 1950s radically changed how the state, archivists, and the public interacted with archives, document management became a delicate interplay between conservation and destruction. Given the amount of materials coming into state-run archives at the time with little going out, W. Kaye Lamb, Dominion Archivist of Canada, created a calendar of conservation. In this calendar of conservation, inactive documents were kept for a set amount of time and assigned a date at which they were either destroyed or transferred for permanent conservation (Cook 2005). IUSMM, however, has classified all of their patient's files as permanent documents, keeping them for "history and research" (Private Correspondence with IUSMM Archives, May 2nd, 2019).

Many hospitals, however, choose the first option, as maintaining patient archives requires a good deal of space, money, and labor (Craig 1985). Some hospitals choose to outsource the work of maintaining archives, transferring them to companies that specialize in confidential document maintenance. When I first began this project, I tried to get access to the Douglas Hospital's archives. An English psychiatric hospital in Verdun, only slightly younger than Saint-Jean-de-Dieu, the Douglas was a promising option. However, after emailing with them for a couple of months, they told me that access to the documents I requested required too much labor on their end; they would have had to go through their indexes and order requests to IronMountain, their information management firm, file by file (Private Correspondence with Douglas Hospital Archives April 18th, 2018). As a result, my request for access was denied.

While the IUSMM might have buried their archives under layers of prohibitions and administrative hurdles, they have still worked to create a channel of access, even if it is limited. In fact, the hospital has put in a lot of labour over the years to ensure that the archives are legible to researchers. Established in 1950, it took five years to collect and assemble the documents into an archive (Nevert 2009). Even today, however, there are still pieces missing; departments not yet folded into the archives. The administrative archives for the hospital, for example, are in the process of being gathered, indexed, and organized. With such efforts put towards maintaining the archives and establishing a system of access, while also limiting and regulating that access, it is clear that the archives are caught in-between the varying values that drive records management.

At once buried in order to maintain the privacy and confidentiality of patients, the archives manage to momentarily surface to service the hospital's notion of *heritage*. That is why the archives were created in the first place, and case files over 100-years-old are still maintained and managed. That is why hundreds of documents were microfilmed in the 1960s, as their yellowing pages began to grow fragile. Yet, these moments are haphazard and disjunctured, like all administrative motions. That is why only a portion of the historical files were microfilmed and why the machine is kept in a state of disarray. That is why, despite the archive's establishment in the 1950s, it is still in the process of unifying all the hospital's documents.

These moments of heritage and preservation crop up at the archive over the years. One such moment must have happened in the 1950s, to spur the creation and organization of the archives themselves. Another must have occurred in the late 1960s when a portion of the files were microfilmed. In June of 2015, the hospital had a celebration of their archives entitle "Journée d'étude: Témoins de l'Histoire de la Folie" (Study Day: Witnessing the History of Insanity) inviting a group of researchers into the belly of the beast, so to speak, marking another moment of *heritage* (Thifault 2017: 26). Huge information banners and posters sat unused and folded up in the back room of the archive while I was there, pointing to the moment of *heritage* and its passing.

Yet, there were also moments of disarray in-between. Michèle Nevert (2009), for example, talks about the state of disorder in which he found the archives in the early 2000s when he and a team of historians undertook a massive survey of the files. Claude Marie Thifault (2003) talks of a different kind of in-between in her thesis on Saint-Jean-de-Dieu, created by political dramas. Working in the early 2000s, Thifault gained preliminary access to the private archives held by the Sisters of Providence about their work at the hospital. But when the infamous Duplessis Orphans story broke in Quebec at the same time, revealing the abuses that unfolded in Catholic-run provincial institutions like Saint-Jean-de-Dieu, the Sisters doubled down and refused access to anyone. When I did my research, access to the Sister's fund was open, but you paid the price, 20$ a day plus reproduction fees.

I also entered into the archives during an in-between moment. While the documents themselves were in an organized state, the archival department was in the middle of upheaval. The offices were set to move to the other end of the hospital, but the moving date kept getting postponed. Notices framed the archive office's busy doors well into December, warning of the move in early November. During that time, massive black boxes and extra chairs cluttered the archival room, appearing one day and disappearing the next. Administrative documents would appear on the floor of the archives and remain for months, heaped one on top of the other in plastic bags. When the department finally moved in mid-December the archivist I spoke to didn't know if the files themselves were moving along with the offices, their future unsure.

This is how ghosts are made, in these administrative *in-betweens*; between privacy and heritage, preservation and neglect, and burial and excavation. Notions of privacy keep the archives locked away and difficult to access. Next to invisible, they are buried under layers of bureaucratic hurdles. Notions of heritage, on the other hand, open up the archives on special occasions, like the 'Journée d'étude' and keep lines of access open for researchers. Here, the archives become visible and legible, but only to a select few. But notions of privacy also ensure that case files are kept securely for over a hundred years when they could have been left to succumb to neglect and decay. Moments of preservation also become moments of neglect, when transferring files onto microfilms also means making the files harder to read because of how quickly the technology becomes out of date.

It is a messy jumble of actions, intents, and consequences working in the archive, and the case files are made to sit in-between all these contradictory motions. The patients held within the archive's files become ghostly not because they are supernatural specters, but because they are subject to these contradictory motions. There is nothing inherently otherworldly about the archive or the women I looked at. They are made into specters by the oscillating bureaucratic mechanisms functioning in the archive, situating them in between dissolution and preservation.

Their names and the stories told within their case files are protected under bureaucratic laws of conservation, but their lives and bodies have turned to dust. For all intents and purposes, my participants disappear during most days, their names unsaid, their bodies unmarked, their files unseen, and their lives illegible to most. Still they continue to exist at the edges of things, visible only during moments of intervention. Those moments of intervention, when the files are reorganized and microfilmed, or when they are read by those precious few archivists and researchers given access to the room in the basement, are also moments of haunting when what has disappeared and turned to dust is reimagined and remade.

Chapter 2
Silences

I didn't start off my search in the archives looking for partial objects and evanescent lives. Rather I entered the archives in search of pain. Intending to study how embodied experiences of pain were translated and transformed into text, filed away to be read decades after patients' bodies stopped feeling anything, I wanted to see if I could try to read the body viscerally through paper. But embodiment slipped through the pages, popping up rarely as small add-ons to doctor's notes. Sometimes a doctor would ask their patient if they were in pain, the answer a brief yes or no. Sometimes it would slip in through the rare treatment notes, a dosage of belladonna to soothe a stomach-ache, a pack of ice to soothe a wound after surgery. But overall, what I found was the uncanny absence of pain. Rather, there was a blackbox on patients' bodily experiences and their time at the hospital. Files would end abruptly after admittance and huge gaps of time sat heavily in between entries in the case files. After initial admittance forms were filled out, patients might show up again if they were transferred to a different room in the hospital, or if they applied for temporary release. Sometimes these absences would last months, sometimes years. Most of the time, however, they only showed up again after death, the time and date recorded in the death index, the cause listed, and the fate of their remains made note of.

This chapter explores this process of evanescence and the silence it engenders, as my participants' experiences of neurosyphilis disappeared under the constraints of time and the archives. They lingered tantalizingly on the edge of the files, hinted at, pointed to, but always just out of reach, an absent presence. Because of the silences that brought it about, this chapter is also a space of speculation. I speculate about how neurosyphilis might have been experienced, as gleaned from modern sources. I speculate about how women's experiences got lost in the archival shuffle. I even speculate about how life in the hospital might have unfolded for women suffering from neurosyphilis. This style of speculation brings me to the very edge of fiction.

Speculating Pain

By concentrating on patients with tertiary syphilis, I thought I was setting myself up for a rich data set. During the period I chose to frame my study, the 1910s, tertiary syphilis was, for all intents and purposes, a new disease for doctors to contend with. Though the disease was named in the 15th century, it wasn't until 1905 that the bacterium associated with syphilis, Treponema Pallidum, was identified and labeled. It wasn't until 1908 that a new test was devised to check patients' bodies for residues of the bacterium. And it wasn't until 1910 that a new treatment option became available, which treated the disease itself rather than the disease's more visible symptoms like chancres (Fleck 1979). Yet, all these waves of discovery tumbled one into the other, making identification, diagnosis, and treatment a very new and experimental process. Nothing was sure about the new magical treatment, salvarsan, an arsenic compound. Its dosage, its effectiveness, and its side effects were all to be determined. Patients treated with salvarsan were consequently often given an experimental therapy program with alternating dosages of syphilis's older treatment, mercury (Campbell, Patch, 1912)

Both the mercury treatments and salvarsan were toxic. It was an early chemotherapy process used to kill the disease before it killed the patient. While doctors were careful with dosages, treatment was painful. While the mercury treatments caused "neuropathies, kidney failure, severe mouth ulcers, and loss of teeth", as well as death from poisoning (Frith 2012: 53) salvarsan also included a wide range of side effects. The injection of the compound was itself incredibly painful and caused patients to be bedridden for days between the intensive treatment schedule, injected at worst three times a week for five years. The treatment could shock the patient’s body, causing fatigue, irritation, abscesses, and, at its worst, death (McGinnis 1990). Patients with tertiary syphilis were usually treated with injections not to the circulatory system, but rather directly into the spinal fluid. By the 1920s, an alternative therapy was discovered, where patients were infected with malaria to induce fever and kill off the bacteria. Saint-Jean-de-Dieu started using it in 1928 (1975 Un Heritage de Courage et d’Amour*)*.

Syphilis itself has an odd relationship with pain. It unfolds as a staggered disease, with three main stages; primary, secondary, and tertiary. Primary syphilis is characterized by a chancre that develops on the body at the inoculation site. This can be either very visible, like on the face, or hidden, inside the vaginal walls. The sores themselves are mostly painless, making them difficult to detect when they are out of sight. They heal on their own and typically only last 2 to 6 weeks, making them often unremarkable to the patient. Secondary syphilis appears 4 to 10 weeks later as a rash, often non-itchy, but accompanied by a fever, malaise, headache, sore throat, etc. While more visible than primary syphilis, if left untreated, this turns into tertiary syphilis, with a long latency period in between, where the disease goes incognito. In early latency, relapses of secondary syphilis do occur, but in late latency, generally, 12 months after initial infection, patients experience next to no symptoms other than general fatigue. Treponema Pallidum goes into hiding at this point, slowly reproducing until tertiary syphilis develops. Tertiary syphilis can manifest as gummatous (a form of necrosis), effecting the skin, cardiovascular, effecting the heart, or as neurosyphilis, effecting the nervous system and cerebral cortex (Radolf et al 2016). In a psychiatric hospital, patients would generally have been admitted with neurosyphilis.

During the time period I studied neurosyphilis was very rarely identified as such, it was either referred to as *general paralysis* or *tabes dorsalis*. General paralysis is marked by the gradual loss of feeling and proprioception of the body. Patients slowly lose the ability to walk and talk, their reflexes and pupils no longer responding to stimuli. People are generally bed bound at this point, prone to bed sores, seizures, and extreme gastric pain. Patients with tabes dorsalis experience the gradual fraying of their nerves, leaving them exposed and highly sensitive. Sufferers are said to experience the progression of the disease as bursts of intense pain and painlessness. Hide's (2012) study of tabes dorsalis in late 19th century England, for example, notes that patients interpreted their experience of the disease as shocks of lighting or electricity, as animals tearing their flesh apart, or sometimes even as demonic possession (Hide 2012). Though not named as such at the time, individuals with neurosyphilis could also be suffering from meningovascular syphilis which is experienced as extreme headaches and nausea (Singh, Romanowski 1999). These alternating progressions of the disease are marked by a general lack of pain as paralysis develops, and the explosion of pain, as the bacteria wears away at sufferer's nervous system and meningeal membranes. All, however, also cause gradual dementia, loss of memory and cognitive faculties, radical changes in personality as well as delusions, ideas of grandeur, and hallucinations (Gayle 2008).

I developed my project in anticipation of the individualized accounts of these experiences. I thought I'd find files filled with women's responses to the doctors, nurses, and nuns when they were given weekly spinal cord injections. I thought I'd find accounts of patients impatient or depressed or angry with being bedridden for weeks, confused or maybe resigned to the painful process of their treatment. I thought I'd find accounts of doctors and nuns trying to manage their patient's reactions, seeking to control their side effects, treat their abscesses, and manage their fatigue. I thought I would meet with cycles of pain and relief as the treatments wore on. What I found instead was silence.

Disappearances

I started off with around 30 case file numbers that I had collected from the hospital's death index, all of which had general paralysis listed as the primary or secondary cause of death. Only two of those files showed any trace of treatment for neurosyphilis. Instead, patients disappeared after their initial admission exam. The first four of those files, as I mentioned above, were all mysteriously absent.

By most accounts, this wasn't the way case files were meant to unfold in psychiatric hospitals in the early 20th century. Carol Berkenhotter's (2008) exploration of Scottish asylum files, for example, shows that doctors had to follow a set formula for detailing their medical notes, recording a patient's sex, age, occupation, medical/behavioral history, observable symptoms, initial and secondary treatment and effects and outcome of the patient's condition. Emma Spooner (2005), working similarly in a New Zealand hospital's archives from the turn of the century, noted that record keepers were forced to keep to their notes ordered through prescribed headings like 'family history', 'previous history', 'present condition'. Funnily enough, for Spooner, it is through these administrative constraints that patient's lives at the hospitals became partial and sporadic representations, forced to fit within the confines of the casebook. At the Saint-Jean-de-Dieu archives, it is precisely through doctors' refusal to keep to a set and consistent recording format that patients' experiences got lost.

It was not that doctors didn't have a set form to fill in, there were a couple of different forms floating around in the files, each with a different level of detail required. Files always started off with the patient's initial admittance form, which listed the basics of their first physical, recording characteristics like height, weight, hair color, visible scars, eating, sleeping, drinking habits, reflexes, and pupil dilation. This form was usually well filled out, though as I got closer to the 1920s, the more social details about the patients, like their occupation and education level, often went unrecorded. The secondary form was used during a patient's follow up exams, which reserved a good deal of space for detailing their histories, their symptoms as well as their treatment process and response. While I came across a couple of these forms in the archives, they were never filled out, rather just blank documents floating between the files. Finally, there was a more basic follow-up form, which gave an eighth of a page for details around diagnosis, like cause, history of illness in the family, etc. The rest of the file was blank, subject to the doctor's whims. These were the forms doctors used and their open-endedness left several holes and gaps in the files.

How consistently doctors filled in each patient's initial and follow up forms varied considerably over time, but one thing remained consistent. Patient's treatment regimen was almost never recorded. In the 30-some files I had initially collected, two files showed a treatment regimen for syphilis, and two recorded a patient's healing process after surgery. The rest were silent on those accounts. It could have been that the patients weren't treated at all, or maybe they had been and their treatments were lodged in the pharmacy's archives, which has yet to be incorporated into the archives to which I had access. Either way, patients' experiences in the hospital were blind spots, absent, yet haunting every entry.

Classic archival ethnographies warn of the silence of the archives. Academics like Carolyn Steedman (2001a) and Ann Laura Stoler (2010), emphasize over and over the way that silence shapes the historian's time in the archive. The historian is met with "*nothing*" when faced with rows and rows of documents, “only silence, the space shaped by what once was, and now is no more” (Steedman 2001a: 163). Steedman points to this odd tension in the archives, where they at once hold “Everything” and “nothing”; full to the brim with files, but really nothing compared to what once was. Instead, the archives act as an imprint whose contours point to what is missing rather than what is present. Stoler, rather than point to the complete absence of knowledge, argues that the archives reveal the “piecemeal partiality” of it, full of disjunctures and faultlines into which things fall, irretrievable (2010: 19).

Even recovered archives can be stubbornly silent. Kristen Weld (2014), for example, explores a lost archive in her ethnography *Paper Cadavers.* Working in a collection of files and records amassed by Guatemala’s secret police discovered in 2005, Weld helped as hundreds of volunteers sifted through, sorted, and categorized the archive in order to shed light on the atrocities committed by the secret police and recover the missing and dead whose end of life had been obscured by the state. Yet, despite the literal mounds of new information available to families who had lost loved ones in the terror, many were disappointed, “their memories of the conflict” irreconcilable with the “lacunae, silences, and bureaucratic euphemisms of the documents”. While the recovery of the archives was meant to “liberate” the truth of what had happened and reveal what had been obscured, many times the archives could “not speak, enclos[ing], silenc[ing] and disappoint[ing]” (2014: 168).

These silences particularly enshroud the histories of marginalized peoples. Gayatri Spivak (1988) in her chapter “Can the Subaltern Speak?”, argues that those who occupy the margins of history, the “general nonspecialist, non-academic population across the class spectrum, for whom the episteme operates its silent programming function” are just as easily called the “silent, silenced center” (1988: 78). Speaking against the Foucauldian turn in history which seeks to recover lost pasts, Spivak argues that subaltern voices are not recoverable. Even when they make an appearance in the archives, they are spoken for rather than speaking and used instrumentally; a “fabrication” serving a specific kind of “historical reality” (1985: 271). Take, for example, Spivak’s (1985) exploration of the Rani of Sirmur, the wife of a deposed Raja. Her story is only recorded in so far as it is in the interest of the state. When she decides to follow the tradition of Sati, i.e. self-immolation, after the death of her husband, the colonial figures who are trying to stop the tradition write of their efforts to convince her not to go through with the act. Her life and intentions are only visible through these short clips, of British officials writing to each other, trying to solve a problem. Spivak writes that there is no “‘real Rani’ to be found”, she is lost, silenced (1985: 271).

Nameless

The files in the basement of the IUSMM acted similarly, enclosing pages of documents with brief notes and scribbles that pointed to what was absent rather than what was present. Each file, at the very least, showed the results of the patient’s physical, describing their bodies at length (a subject I will be discussing in the next chapter). If lucky, the file would contain a half a page of notes detailing a patient’s symptoms and their family history. In a select few files, most of which I collected, not through the death index, but by hopelessly scrolling through the microfilm rolls at random, there was an expanded set of notes of how the patient came to be at the hospital, compiled by the hospital’s investigator, Marie Mignault. These notes, however, rarely said much of anything concerning a patient’s life at the hospital itself.

Instead, the cases repeated the same symptoms that most patients with neurosyphilis had, blurring together each file one into the other. The women were disoriented in time and space, their memory and cognitive abilities were deteriorating, as were their reflexes. Their pupils were unequal and non-reactive to light and when their plantar reflex was stimulated their big toe flexed upwards, a sign of disease in the spinal cord or brain. They were paranoid about poisoning and saw certain individuals as threatening, held ideas of grandeur and experienced either visual or auditory hallucinations. While patients' symptoms were never so consistent as to tick off all these boxes, their repetition in one case file or another overwhelmed my search. I came to know the typified syphilitic case rather than the multiple ways syphilis was experienced by particular patients. I lost the individual within the pattern.

There were, of course, the small tidbits that would differentiate patients. Katherine Grantham (10253)[1] told of a hallucination she had, seeing the dead at her door during the night. Madame Desjardins (11054), when questioned about the date in May of 1913, noted that because her daughter died in 1901, it must be 1902, because her child's death wasn't too long ago. Julie Decarie (10724) broke down into tears during her interview, and the nuns relayed that she cried a lot at night as well. Madame Beaumont (11207) described in detail all the luxuries she had at her house in Montreal; the electric lights, velour carpets and fresh fruit for her children.

Despite the ways that these women's lives and experiences were of course, particular to their situations, the records once collected blurred together to represent instead the 'typified' patient. Even their names are erased from view, blacked out by the hospital's and my own

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[1] While I was not allowed to bring patient's names out of the hospital with me, I did bring their case numbers. These numbers next to a patient's name refer to their case file as it is lodged in the archive. These numbers act as both a guide for myself, so I can find the patient in my fieldnotes, and for future researchers to track down the files I have referenced. While I am uncomfortable reducing women's identities to numbers, I am restricted by both archival and anthropological codes of ethics, as well as provincial laws. As a result, I have obscured any identifying characteristics of patients, like their dates of birth, their admittance dates, their addresses, etc. However I have tried to give them pseudonyms that reflect their original names. For example, I replaced French names with French pseudonyms and English names with English pseudonyms. In my research, quite a few very classic Montreal names came up, that anyone who lives in the city would recognize. As a result, I also tried to reflect that in some of my name choices, using surnames like Decarie and Desjardins, which proliferate in the city.

academic requirements of anonymity. Julie Decarie and Katherine Graham are pseudonyms, names I came up with to protect the privacy of patients who have been dead almost a hundred years. Any *identifying characteristics* had to be scrubbed from my notes and my scans; their dates of birth, their place of residence, even their family's names blacked out. Instead, I have to list their case file numbers in order to maintain their particularity, and in order to remind myself who is whom. That is what occurs when so little effort is made to record patient's experiences and particularity, and every effort is made to efface them; their presence in the archive becomes one marked by the thing which unified them, their symptoms and their diagnosis.

The blacking out of my participant's names and identifying characteristics reminds me of the mistranslated names that Spivak (1985) speaks of in the files of colonial India. British colonials, seeking to stop the tradition of wife immolation, assembled a list of names of the women who had died from the process. Badly transposed into nouns when translated, the names read as "Ray Queen, Sun-Ray, Love's Delight, Garland, Virtue Found, Echo, Soft Eye, Comfort, Moonbeam, Love-lorn, Dear Heart, Eye-play, Arbour-born, Smile, love-bud, Glad Omen, Mist-clad, Cloud-sprung" (1985: 266). Spivak notes that these butchered names stand in stark contrast to the meticulously archived records for each and every one of the cadets serving the Military Committee of the East India Company, whose General compiled this list of women. These women hover on the edge anonymity because of their instrumentality to the colonial agenda, and at the same time, their sheer inconsequence. While the intent behind both forms of anonymity is different, one the result of dehumanizing colonial agendas, and the other a medical intervention seeking to protect patient's privacy, the result is sadly the same - a violent erasure.

In the Absence of Things

After a patient’s initial admittance, they quickly disappeared, their lives unremarked upon for years. Sometimes the files followed up with patients, with one or two check-ins recorded during the doctor’s rounds. When patients were granted temporary leave, the request would make it into their file, tracking the movement of patients through space. When patients were transferred between the wards, the notes of their departure and arrival was sometimes recorded. Most often, however, women would be admitted, diagnosed with general paralysis, their symptoms recorded, and they would only show up again in the death index, sometimes years later.

The widow Giroux's (12251) file unfolds similarly. Admitted and diagnosed with mania and manic depression, I never would have stopped over her file if I had not first found it in the death index, where her cause of death was recorded as ‘general paralysis’. Admitted in August of 1914, she was described as restless, in continuous movement. Her physical exam revealed signs of deteriorated reflexes and unreactive pupils. She was unresponsive to the doctor’s questions, described as talking incoherently to herself. The last entry in her file was oddly prophetic; she refused to eat, crying emphatically, her physical state badly deteriorated. Two months later she died. What happened in those two months is unknown. Was her death gradual, something which her caretakers tried to treat day-to-day, or was it sudden? All her cause of death really says is that she died from a complication from general paralysis. What that means I don’t know.

Other patients lived much longer in the shadows. Sylvia Laurent (12343) was admitted in 1916, diagnosed early on with tabes dorsalis and organic dementia. How Sylvia dealt with that is an unknown. All that was recorded is that her pupils were unequal, her tongue trembled, diminishing her ability to speak, her movements were uncoordinated, and she responded positively to the Babinski test, a test of her plantar reflex. She was described as disoriented, incoherent, and stationary. On her admittance sheet, they say she drank. They weren’t able to weigh her or take her height on admittance, so those details slipped through the cracks in this particular file. Two years after admittance, Sylvia died.

I want to fill these spaces of absence with speculation. Jason De León (2015) wrote a semi-fictionalized narrative of migrant's experiences in the desert in the absence of his own experience. I write one in the absence of any experience, hoping to speak to the silence with what might have been. Sometimes fiction is the only way to fill in the gaps about what is lost and irretrievable. That is why Avery Gordon (1997) turns to fiction in her work on *Ghostly Matters*, to discuss the ghosts of those lost to the American slave trade and those disappeared in Argentina during conflicts of terror. There are no facts and figures to list in these instances, to create factual accounts of the lost and disappeared. They are, by the nature of the violence inflicted on them, ghostly and illegible. Consequently, I'm taking a leaf from De León and Gordon and turning to fiction to express the unknowable.

I've constructed the narrative below from the bits and pieces I've been able to pick up from a wide array of sources. Patching together things from the files themselves, from medical journals, and from the writings of people rumored to have suffered from syphilis (Hayden 2003; Rudnick 2012), the narrative is meant to speak to what might have been and also to what is silent, absent, and obscured from view. The narrative is not meant to be representative of my participants' experiences at the hospital, rather its particularity is meant to break the typification that happened through my fieldwork.

There are always warnings in archival work against just such a narrative, wherein mourning the silence of the archives, especially the silence of those dispossessed and marginalized, historians attempt to be "resurrectionists", bringing the dead back to life (Steedman 2008: 4). Steedman (2008), in her lecture about "Romance in the Archives" references Benedict Anderson’s tongue-in-cheek critique of the historian Jules Michelet, for whom “the silence of the dead was no obstacle to the exhumation of their deepest desires” (ind. qut. Steedman 2008: 4). The danger here is that a historian’s attempt at resurrecting history is rather a remaking, a fiction masquerading as fact. But my narrative is openly fiction, an attempt not to give voice to anyone, but instead, imagine what a voice might say.

Sylvia

I don’t know how long I’ve been here now, I don’t remember. I’ve been confined to my bed for the most part, the busywomen rushing around me when it’s light. The nights are for the most part still and silent, except for the occasional rupture, an abrupt yell or slow whistle. But sometimes the noise is invasive. Singing running down the halls. A constant muttering beating against the walls of my room.

There is something in my stomach, tearing at me from the inside, nausea bubbling up until I could scream. I’ve stopped eating. I’m sure the doctors are poisoning my food. The busywomen keep giving me something sticky and black[2] to take with the morning’s food. It is sickly sweet, a layer protecting my insides.

I saw my daughter last night. Or maybe… last week. She came in the dark, a night when it was so quiet. She’s so small, smaller than a breadbox. I rocked her back and forth all night, but she never stopped crying.

The doctors are asking me what day it is. I say nothing, I don’t know, but they won’t stop. They’ve come in hoards, with their ridiculous clipboards and their silly questions. Can’t

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[2] A reference to a tincture the nuns would administer, of belladonna, to soothe the stomach.

they find out the day themselves? Shouldn't they know how long I've been here? They want to know if I have money. They want it for themselves, that's why they poison my food. Make my insides roil. I'm talking to myself to keep them out.

The busywomen say its winter. I believe them; I'm aching with the cold. It'll be Christmas soon. Maybe they'll give out rounds of sherry to celebrate or another play. I didn't get to go to the last one, I was too tired.

The electric lights buzz early in the day, it's so dark out. I feel that electricity, shocking my arms and legs. I tell the busywomen about it but they just frown and move on.

Dame Gramme[3] came to see me the other day. Such a kind woman, I couldn't say much to her, my mouth wouldn't form the words. She's my husband's aunt, but she never brings him along anymore. I can't remember the last time I saw Hugo. I tried to tell her the doctors want my money, but she just laughed and said I didn't have any.

The electricity's stopped working on me, but still the doctors are finding new ways to slip poisons in. My stomach is aflame, it's eating itself.

I don't leave my bed anymore. My legs won't move and I can't hear above the constant hum of the lights. My tongue feels fat in my mouth, it keeps tripping over words. I don't know what I'll do if I can't talk. I feel trapped in my own body, a world unto itself. The busywomen

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[3] Sylvia's body was reclaimed by Dame Gramme after her death.

pass by me, the doctors don't ask their stupid questions. I want to scream but my tongue is such traitor. At night, the beast sits on my chest, weighing me down, growling in my face.

I can't form the words but the lyrics to a song I once sang keep ringing in my head. It was called the bad girl's lament, but I am not bad.

When I was a young girl, I used to seek pleasure;
When I was a young girl, I used to drink ale;
Out of the alehouse and into a jailhouse,
Right out of a barroom and down to my grave.

Come, Papa, come, Mama, and sit you down by me,
Come sit you down by me and pity my case;
My poor head is aching, my sad heart is breaking,
My body's salivated and I'm bound to die.

Oh, send for the preacher to come and pray for me,
And send for the doctor to heal up my wounds;
My poor head is aching, my sad heart is breaking,
My body's salivated and Hell is my doom.

I want three young ladies to bear up my coffin,
I want four young ladies to carry me on;
And each of them carry a bunch of wild roses
To lay on my coffin as I pass along.

One morning, one morning, one morning in May
I spied this young lady all wrapped in white linen,
All wrapped in white linen and cold as the clay.[4]

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[4] These lyrics are from a version of the song sung *One Morning in May* by the folk singer, Texas Gladden, recorded by Alan Lomax in Virginia in 1941. But the song itself has a number of different versions, entitled *Bad Lass, Bad Girl's Lament, Young Girl Cut Down in her Prime.* The ballad is part of the *Unfortunate Rake* song family, where the protagonist of the song changes, sometimes a soldier, sometimes a sailor, a cowboy. By the early 20th century, a version of the song was recorded with a female protagonist. Sometimes the protagonist is cast as the victim of the story, betrayed by her lover, other times, as in the version above, the protagonist's sickness is framed as brought on by herself. Historians believe that the song refers to an individual suffering from syphilis because of the repeated lyric "my body's salivated". A notorious side effect of the mercury treatments for syphilis was salivation (Zierke 2019).

I am not a girl anymore either. My hands tell me my age, covered in blue veins and dark spots. My body tells me my age, aching all over. I can feel the growths on my body, sores on my back and legs seeping into the clean white sheets. But the melody is so clear, ringing in my ears.

Chapter 3
In Search of Bodies

While my participant's bodily experiences were uncannily absent from the files, their bodies were anything but. In their admittance files, patient's bowel movements, breathing, and circulatory system were all recorded and assessed. I came to know my participants through their height, weight, hair color, the placement of their scars, the reaction of their pupils, and their age more than anything else. Yet, the presence of patients' bodies was dynamic; a presence continually threatened with absence as they moved in and out of view across different archival documents and even across the hospital's grounds. The files and the archives in themselves, for example, were often incomplete, providing only partial pictures of what happened to patients over time. It became for me a process of searching, trying to find the bodies.

So, while bodies were everywhere in the files, they were always evanescent, the thing recorded, yet also the thing that fades from sight when the record stops. In this way, patients' bodies were also ghostly, hovering in between visibility and invisibility. It wasn't just the representation of bodies that disintegrated in the files, the bodies were also in the process of coming undone. Patients would slowly lose the ability to walk, talk, remember. They would suffer multiple different types of general organ failure, until the fateful day when their name came up in the death index. Death, rather than release, seemed like the inescapable destiny for neurosyphilitic patients in the archives, despite the different treatment techniques that were being tried and tested at the time.

So this chapter is about bodies, how they came to be represented and slipped from view, how they came undone, but also how I came to search for them in odd places. In this way, this chapter is about two different partialities, firstly in the way that bodies were partial in the files, but also in the partiality of my narrative about bodies. Because my search for bodies does not have a satisfying end, it is rather a story without a conclusion.

Cause of Death

My search usually started where you might assume it would end, in the death index. In fact, the death index took on an overarching presence in the way I came to know patients. In spite of the disarray and partiality of the case files that doctors created, the death index was always complete, always ordered and clear, every category filled for every patient. And the index was more generous than I would have expected, complete with a time and date for the patient's death, their familial status (married or celibate), and the cause of their death. The index even recorded the fate of patients' bodies after death, noting whether they had been recovered by family or friends, interred in the hospital's cemetery or donated to scientific labs like the Université de Laval. Because the death index was the only register that pointed towards some type of diagnosis, even if it was only cause of death, it also both began my search and ended it.

The data that I kept with me from the registries hung ominously over my entire search process, from the index, through to the files. It was like reading a tragedy, knowing ahead of time that the main character wasn't going to survive the plot. One of my very first files, for example, that of Amelia Dagenais (3070), felt as if it existed in anticipation of her death, though of course in reality the only anticipation that was present was my own. Admitted in 1910 and diagnosed with degenerative insanity, she died in 1932 from a cerebral hemorrhage, after 22 years of institutionalization. Each new entry in her file escalated forebodingly; she refused to talk, refused to let the doctors examine her. She had bruises around her throat which she said were given to her by 90000 patients giving her 90000 hits. The doctors thought her delusions were intensifying; she said she had 100 billion a year in taxes, and all the empires of the world belonged to her, she was born when ‘Robertson Crusoe’ conquered the world. Soon the files just became a list of her medicines, indecipherable in their loopy script. The next page was a legal notice of her interment, buried at the hospital.

Amelia’s case is more of an exception than the rule, as most files don’t follow their patients over time, or even include the legal notice of interment directly in the folder. But because I started each search into a patient’s file with their death date, that sense of foreboding haunted everything I read, collapsing a past future into the present. In this way, the dissolution of patients’ bodies was constantly on my mind. Sitting in that dim-lit basement, scrolling through file after file, I read and re-read what felt like the same story, of a woman whose body was slowly collapsing, moving closer to death with each new entry.

The causes of death for neurosyphilis are many and varied, depending on the progression of the disease. The initial invasion of the bacterium into a patient’s spinal cord results in either an asymptomatic version of the disease, or its development into general paralysis, tabes dorsalis, or meningovascular syphilis (Singh and Romanowski 1999). General paralysis causes progressive paralysis of the limbs, leading to cerebral seizures and general organ failure as patients’ bodies slowly start to shut down. Tabes dorsalis, translating literally as the decay of the back, wears away the spinal cord, leading to progressive degeneration and atrophied nerve roots (Hughes and Oppenheimer 1967). With Meningovascular syphilis, T. Pallidum attacks the meninges, causing headaches, nausea, seizures, strokes, etc. (Hayden 2003). Neurosyphilis very rarely causes death on its own, but rather works through secondary symptoms, fatal in a myriad of ways. This was reflected in the archive’s death index, where next to ‘general paralysis’ a secondary cause was often listed, like general organ failure, stroke, cerebral hemorrhage, gastrointestinal complication, atrophy etc.

But even after death, patients' bodies continued to capture my imagination; some corpses were recovered, but others were mysteriously donated to labs for dissection, or interred at the hospital, in an unnamed cemetery. As I worked in the archives, coming and going daily across the hospital's ghostly grounds, working in the mundane and morbid file rooms, I kept thinking about those missing bodies, in a cemetery, which, if it still existed, I had yet to find, and in labs around the city, where I had no means of tracking them. How did bodies just disappear when, in one room over, there was black binder after black binder dedicated to recording bodies in death, listed in the indexes, documented on interment certificates, and assessed in autopsy reports?

Slipping In and Out of Representation

Patients' bodies also came to the fore beyond the archive's indexes and registries. The case files contained meticulous records of patients' bodies when initially admitted. Each file started with a physical, one of the first exams to which patients were submitted. Weight and height were taken if patients could move, hair color and visible scars were recorded, along with any other bodily markings that distinguished them. Their pulse was taken, their breathing checked, their reflexes tested, their bowel movements and eating and sleeping habits enquired about. This is the other way I came to know my 'participants'; through their height and hair color, through their age, their scars, their pulse, their reflexes. Yet, despite the initial records, the women's bodies quickly disappeared from view after admittance.

Take, for example, Bernadette Lamontagne (10396), admitted in January of 1911. Thirty-five years old, she was 5ft 2", weighed 138 lbs, had brown hair, partially contracted pupils, exaggerated reflexes, and stumbled over her words. The doctors wrote that she had slow perceptions and unstable thinking. After that, her file became sparse. Her case was revisited a year later, in January of 1912, when the doctors diagnosed her with General Paralysis. In August, the doctors noted that her condition was deteriorating, her reflexes were exaggerated, and she had trembling in her extremities. The last note reads ‘condition worsening’, dated a year before she died. Her body was reclaimed by her husband.

Then there was Esther St-August (11795), admitted in August of 1914, and dying 6 years later in December of 1920. Despite living at the hospital for six years, her file was only three pages long, one of which was her physical form. She was 37 years old, with grey hair and poor sleeping habits. A scar marked the back of her upper right arm. Her doctors described her symptoms when she was first admitted, detailing weak muscles, the paralysis of her ocular functions, and the weakening of her tactile senses. A day after admittance, her file records the worsening of her mental state while her physical state improved. At night she screamed at the top of her longs, asking to see her family. Then the file ends. The index shows that her body was interred at the hospital. That is all we hear about Bernadette and Esther and their ends of life.

Just as quickly as bodies are put in the spotlight at the beginning of the hospital’s case files, so too do they quickly become invisible. The question now becomes how do we account for these gaps in representation? Why do the bodies of patients come and go so flippantly in the files, concrete objects of flesh and blood when first admitted but evanescent as their time at the hospital progresses? Why are dead bodies so meticulously recorded while patients’ bodies fall inconsistently in and out of the archive? Why are some bodies buried while others are donated to labs and universities, lost to the hospital’s records but visible in a radically new way to the doctors doing the dissection? Donna Haraway (1997) argues that we should be asking how invisibility[5] becomes possible, "in a world replete with images and representations" (1997:202). Noting that in the modern era, the "*averted* gaze can be as deadly as the all-seeing panopticon that surveys the subjects of the biopolitical state", she asks both "How is visibility possible? For whom, and of whom?" and "What remains invisible, to whom, and why?" (1997: 202). These are important questions to answer, especially with participants who slip in between the poles of visibility and invisibility, but I've found a straightforward answer elusive.

Ghostly Bodies

There are so many different theoretical frameworks to talk about the ways in which bodies are represented or ignored. Foucault's (2003a, 2003b) theory of biopolitics, for example, is a classic go-to when thinking through bodies. Biopolitics refers to the managing of whole populations through regulating mechanisms, reducing bodies to their "general biological processes" and managing bare life as it is rather than giving attention to particular lives (2003a: 249). Both a political and scientific endeavor, biopolitics seeks to manage life by intervening in birth and mortality rates, biological disabilities, etc. Bodies, as such, are of interest to the state en masse, as "statistical estimates and overall measures" (2003a: 246). Following Foucault, surveillance studies like Caplan and Torpey's (2001) anthology *Documenting Individual Identity* argue that biopolitical regimes use documentary practices begun in the 19th century to manage and survey populations, collecting information through censuses, passports, and medical records. Making

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[5] While much of the literature when discussing bodies refers to their presence through the visual metaphor of 'visibility' and 'invisibility', most of the time, this is simply a reference to bodies being recorded in text, rather than visually captured through images. For example, when bodies are recorded in medical case file, Emma Spooner (2005) refers to this type of representation as hypervisibility, when in fact, bodies are not made visible, but rather made knowable, because their characteristics are recorded. As most of the authors discussing bodies and representation use this metaphor, however, I have decided to stick with it, rather than complicate the text.

bodies visible was consequently part of the process of making bodies manageable and in turn managing life.

Yet, in some ways, dead bodies are more valuable to a biopolitical gaze than living ones. The living body is in many ways opaque and impenetrable. The clinical gaze of medicine, which looks at patients and reads their symptoms, works through a kind of 'invisible visibility', where the body's inner workings are read by the traces they present on the surface (Foucault 2003b). Life, according to Foucault, is that which "hides and envelops, the curtain of night over truth". Death, on the other hand, which renders bodies dissectible, an open invitation for autopsy, "opens up to the light of day the black coffer of the body" (Foucault 2003b: 205). The autopsy, which requires corpses rather than bodies, is a "triumph of the gaze" (Foucault 2003b: 202), rendering flesh and organs, and the movement of diseases, "mappable" (Foucault 2003b: 182). The new biopolitical orientation of social institutions meant that the corpse, as the most visible type of body, was valuable enough that consistent and detailed records were desirable, thereby making them doubly visible.

While Foucault's theory of biopolitics makes sense of the predominance of bodies in the case files and of corpses in the archives themselves, it falls short in explaining the failures of the biopolitical gaze in the files, during moments when both bodies and corpses disappeared from view. Achille Mbembé's (2003) article on necropolitics, which expands on Foucault's work into the realm of the dead, has a better explanation for how patients might disappear. Writing from the context of war, Mbembé argues that the sovereignty of the modern state is expressed in its ability to decide "who matters and who does not, who is *disposable* and who is not" (2003: 12). In the context of war, this entails the state's right to decide not just who is outright killed, but who is exposed to death through other forms of violence, forms of institutional violence and, what Mbembé terms, “invisible killing” (2003: 30). This necropolitics manages death, not through outright massacre, but rather using more subtle modes, like the destruction of social infrastructure and civil institutions. Bodies that don’t matter, that are made disposable by the state, are also in many ways made invisible.

Kevin Lewis O’Neill (2012) expands on Mbembé;s necropolitics into a politics of the necropolis, which accounts for the management, not just of death, but also dead bodies. Working in Guatemala City’s overflowing public cemetery, O’Neill explores how the dead whose families cannot pay their dues are disinterred, “evicted, deported, and pitched into a mass grave” which also happens to sit adjacent to the city’s garbage dump (2012: 513). O’Neill argues that even in death, the bodies of the poor and vulnerable are marginalized, made to be disposable. Much like the missing corpses of patients at Saint-Jean-de-Dieu, who were donated to labs and moved to now-absent cemeteries, certain dead disappear, unremembered, unmarked.

Donna Haraway (1997) also looks at the way certain dead disappear from view despite being in a biopolitical moment where “it seems that demographers and population specialists of every stripe do nothing but count human beings” (1997: 205). Using Nancy Scheper-Hughes’ famous ethnography, *Death Without Weeping* (1993), Haraway explores how dead babies become invisible in a shanty town in Brazil when the state marks them out as disposable. Scheper-Hughes struggles against this erasure, visiting record office after record office, in an attempt to “keep track of” and “number[] the bones of a people whom the state hardly thinks worth counting at all” (Scheper-Hughes 1993: 30). While biopolitics is set on managing, maintaining, and surveying life, inherent in that agenda is also the power of the state to *let die* certain populations, by tucking them out of sight and out of mind (Biehl 2005: 371).

João Biehl (2005) explores this politics of neglect in his ethnography of a clinic in Brazil for the mentally ill. Biehl argues that the state and medical system manage life and death in Brazil by relegating people considered a burden to 'zones of social abandonment'. The state sentences individuals that are "unwanted" to a life of "living death" at Vita, the clinic where Biehl did his fieldwork. There they are kept alive, but just barely. Patients are "almost killed" because they are ignored and let to die (2005: 142).

Saint-Jean-de-Dieu doesn't actually fit into this typified zone of social abandonment. The hospital had, as of the turn of the century, remodeled itself as a hospital rather than asylum; a space of care and cure. As I will explore in the next chapter, doctors were interested in treatment rather than containment, trying to get patients treated and released from the hospital at a high enough rate to bolster their statistics. However, the patients they deemed 'incurable' were considered a thorn in the hospital's side. The medical superintendents who ran the hospital, for example, complained yearly of having to include 'incurable' patients into the statistics of their reports and even argued for the opening of new institutions to manage chronic patients[6]. While the hospital's statistics didn't change their classificatory fields, patients were categorized unofficially at the hospital as either curable and incurable, and patients diagnosed with general paralysis fell into the 'incurable' category (Thifault 2003: 130).

As 'incurables', syphilitic patients became in a sense disposable; they didn't fit with the hospital's role of "treatment and recovery" and as such doctors felt that they were not Saint-Jean-de-Dieu's responsibility (Thifault 2003: 133). The superintendent of the hospital in 1906[7], for example, complained in his annual report that those patients considered incurable, in addition to

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[6] Baie Saint-Paul Hospital was built specifically to accommodate 'incurable patients' in 1936 (Thifault, Perreault 2012).

[7] He remained superintendent of the hospital until his death in 1918.

exhausting the doctor's and the institution's ability to care for patients, "contribuent ainsi à encombrer l'asile de non-valeurs, et à lui enlever son caractère d'instrument de traitement" (contributes to encumber the asylum with unvaluables and removes its character as an instrument of treatment) (Thifault 2003:178). It's unclear what happened to patients considered incurable. Likely, their care would have been managed by the nuns and nurses in the hospital rather than the doctors.

As a result, patients with general paralysis fit in between a biopolitical and necropolitical regime at Saint-Jean-de-Dieu; neither their bare life nor their death was fully managed by the hospital, but neither were they exempt from the hospital's control. Patient's bodies came into view, recorded and analyzed on admittance in an attempt at managing patient's bodies. When categorized as incurable, however, they fell into a zone not unlike Biehl's 'zone of social abandonment', where their treatment was neglected because they were thought to be untreatable. In this zone, bodies disappeared from their case files because patients were likely no longer under their doctor's gaze. But this theory is, like the rest of my work, full of speculation. There are a number of 'what ifs' that render it moot; what if patients were treated but the treatment wasn't recorded? What if treatment was recorded, but in a department not yet subsumed into the archives?

That leads me to the archival explanation; looking to the administrative holes and managerial gaps to account for the oscillation of bodies in and out of view. Ann Laura Stoler's (2010) *Along the Archival Grain* argues that it isn't absence that pervades the archive, but rather the "piecemeal partiality" of knowledge created by the "current of anxious labor that paper trails could not contain" (2010: 19). For Stoler, the archive is not monolithic, it doesn't catch every letter and record every event. Sometimes things were not recorded because they "could go without saying" and sometimes because they "could not be said" at all. Or sometimes things got lost simply through the "bureaucratic pathways of the colonial administration" (2010: 9).

Maybe general paralytic patients were untreatable, their disease too far gone to help. The nerve damage that neurosyphilis causes, is, after all, irreversible (Singh and Romanowski 1998). Maybe they were being treated and the records of their treatments were lost in the archival shuffle. The IUSMM archive was still in the process of becoming when I was there. While medical files of the patients had always been housed (though not always ordered) in the hospital's archive, the different administrative documents that went along with the patient's medical files were being slowly collected from the hospital's different departments. Maybe patient's treatments were housed in the pharmacy's archives, which, as I mentioned above, had yet to be assessed and incorporated into my site of access. Maybe bodies came in and out of view because of the archival and administrative slip ups, rather than biopolitical oversights. Still, this theory is also full of ifs, uncertain because of my own limited access to the hospital's documents and the unrecorded and unsaid rules of documentary ordering that functioned at the hospital in the early twentieth century.

In all these varying theories of biopolitics, necropolitics, politics of the necropolis, zones of social abandonment, partial archives, etc. there is still something missing, something that doesn't explain the evanescent quality of patient's bodies in and around the archive, as they hover on the edge of dissolution, threatening to disappear completely. So I'd like to bring back the metaphor of the ghost to explain this interplay of absence and presence, using Monica J. Casper and Lisa Jean Moore's (2009) work on *Missing Bodies.* Quoting Gordon, they argue that the "visible and the 'barely present' are intimately related" where visibility is necessarily "punctuated" by those things that haunt the edges of the visible, the ghosts (Casper, Moore ind.

qut. 2009: 10). Casper and Moore use this framework to argue that when we set ourselves the task of investigating those things that are ‘missing’, we are necessarily engaging with the concurrent absence and presence of it as well. Like evanescence, investigating ‘missing bodies’ implies that what was once visible has disappeared. Visibility is a “complex matrix … there is no absolute visibility and illuminating one corner may throw another into darkness” (Casper, Moore 2009: 12). Consequently, ghostly matters, like missing and decaying bodies, are fluid, moving between categories of absent and present, visible and invisible, known and unknown. The bodies of the women whose files I collected are ghostly figures, haunting their own case files, slipping in and out of view and in and out of time.

Alissa Overend (2013) also takes on the metaphor of haunting to analyze disease in her exploration of the ‘undefined illness’ candida. She argues that modernity’s preoccupation with making the body visible and known is what causes these ghostly hauntings of undefined illness. In Overend’s metaphor, the ghostly nature of the illness is again a product of the relationality between the visible and the invisible. Because modern medicine is so concerned with visibility, those things which are invisible become ghosts, ignored and relegated to the edges of sight, yet ever-present, impossible to completely erase. Ghostly illnesses, in Overend’s case study, haunt the “limits of biomedicine” (2013: 71).

So rather than answer Haraway’s question as to why certain bodies become visible and invisible, I am instead met with ghostly bodies and with the limits of knowing. Because that is what it is to investigate ghostly matters, bodies drifting in and out of view and forever liminal, impossible to pin down. It is to chase after a question you cannot answer and attempt to define knowledge you cannot make. Using theories of biopolitics and necropolitics and the archive help to answer some of the ways bodies, as both material objects and forms of representation, are in the midst of dissolution in the medical archives at IUSMM, but they don't account for everything. There are always gaps, loose ends, and irresolvable absences.

By accounting for the ghostly aspect of bodies, it makes those loose ends permissible when normally they would be ignored or shelved for future work. It makes wild goose chases and dead ends productive.

Wild Grave Hunting

The hospital's death index, that morbid document I kept coming back to, eventually pushed me to action. While the bodies donated to science were forever out of my preview, their fates unknowable, I was determined to track down the hospital's cemetery and the dead interred there. Hoping to find a handful of the names I had come across in the files imprinted on a tombstone, I started looking over the hospital's grounds, searching for a section where a graveyard might be hiding amidst the buildings.

I started taking alternate routes in, passing by the hospital's garden, or in front of the large cross in the front, but the graveyard was missing. As I mentioned in chapter one, I eventually found out that in the 1960s, the hospital radically changed its footprint, losing a long stretch of its residence housing, as well as the graveyard and church south of the main pavilions. The hospital stopped interring patients by 1958, and in 1966, moved some 2000 bodies a couple of blocks north to Sherbrooke street, where they were reburied in the Saint-Francois d'Assise Repos. Today, the original grave site is a paved-over SAQ warehouse parking lot (Labelle 2019).

So, I set out to look through the Saint-Francois d'Assise cemetery before the Canadian winter started. I was a little late, and the grounds were covered in snow, the first of many storms that year. Still, it was warm enough to walk around for an hour or two. I mosied through the tombstone rows, with a list of names and dates of death. I found no one's name. On leaving, I passed by a large mound with a stone angel on top. Situated just before the iron gates of the cemetery, the mound contains the bones of those moved from the hospital cemetery between 1723 and 1917.

But I had quite a few names whose date of death happened after 1917, so I continued to look. Wandering around aimlessly, with very little understanding of the layout of the cemetery, I was reminded of the family members O'Neill spoke of in Guatemala city, who "pick[] and peck[] about the dead in search of their loved one" in a labyrinth of graves and vultures (2012: 537). Who, I wonder, is left to mourn the dead who lived, died, and laid in the ground at Saint-Jean-de-Dieu? Who is left to search for them? After another two attempts, I stopped visiting, unable to find a grave with a name I recognized from my list.

Digging through Google, however, turned up a different story about the graves. One about the Duplessis orphans. In the 40s, 50s, and 60s, the Quebec government, under premier Maurice Duplessis, placed over 20,000 children who were either without parents, abandoned, or simply born out of wedlock, into religiously run institutions around the province. A large portion of them were housed in psychiatric hospitals. Saint-Jean-de-Dieu received over 200 of those children. Duplessis was trying to profit from the increased federal subsidies given to psychiatric patients rather than orphans. In 1993, about 2000-3000 plaintiffs came forward, forming the 'Comité des Orphelins de Duplessis', filing a provincial class action suit against the government for wrongfully placing them in psychiatric institutions and the mental, physical, and sexual abuse they suffered while there. Originally the group asked for 1.4 billion in damages, valued at about 700,000 dollars each, and apologies from the provincial government, the hospitals, and the Catholic church (Noel 1992). After the suit dragged on for just under a decade, they finally received ‘fault-free’ individual compensations of 25,000 dollars each, with an apology from the provincial government, but nothing from the hospitals or the church (Marsden 2004c).

In 2004, another group of Duplessis orphans petitioned the government to exhume the same grave I had been trying to track down, now buried under asphalt.

I had known before my research in the archives began of the famous Duplessis Orphans and their connection with the hospital, but it was a line of investigation I didn’t want to go down. The Duplessis Orphan’s story closes doors, archivally speaking. As I mentioned in chapter one, Marie-Claude Thifault (2003) did research on Saint-Jean-de-Dieu around the time when the Orphans began their suit against the government. She had been in contact with the hospital’s archives and the Sisters of Providence archives and both had preliminarily agreed to give her access. But when the story broke, the Sisters of Providence refused her further access.

Files also have a tendency to go missing or come undone when the Orphans are mentioned. Newspaper articles mention missing and incomplete hospital registries detailing the fate of the Orphan’s bodies after death, odd considering the impeccable death index kept during my era of study (Marsden 2004c). When the provincial court was petitioned to exhume and move the bodies of patients in the 60s, the death registry listing the bodies buried in the cemetery had to be provided. While the registry shows what age the orphans buried at the hospital died at, there was no entry for their cause of death, another gap in their otherwise impeccable records (Marsden 2004a). So I stayed away from the subject until it became intertwined with my search for the graves of my participants.

The Duplessis Orphans wanted to exhume the old graveyard as a way to prove that unsanctioned experiments, like lobotomies, had been performed on the children. While most of the bodies were moved in the 1960s to the Saint-Francois D’Assise Repos, the group of

Duplessis Orphans who requested the exhumation claimed that only the bodies in the marked graves were moved. At least 42 children were buried, but Albert Sylvio, an orphan who worked at the hospital in the 1950s getting bodies ready for burial, claims that the children were put in cardboard boxes and buried in unmarked graves (Marsden 2004b).

Sometimes only the leftovers of their bodies got buried. The provincial government passed a law in 1940 letting the hospitals sell their dead for dissection at ten dollars a body. Though the records show a trend of sending bodies off to different medical labs well before the 1940s, these were labeled as ‘donations’. The children, however, were sold and their bodies returned to the hospital after dissection, burying what was left over (Marsden 2004c).

The Orphans’ suit never came to anything and if there are any bones under the SAQ warehouse, they have been left to rot.

Following this story gave me bits and pieces of information about my patients’ remains that I hadn’t and probably couldn’t have uncovered anywhere else. I had never known before that my patients had been buried in marked graves. I didn’t know that those patients who were sent off to be dissected were returned piecemeal, to be buried as well. Before encountering the story of exhumation, I’d even located the grave in the wrong place. I’d known the grave was under an SAQ parking lot from an odd website that tracks graves in Montreal (Labelle 2019) but there is an SAQ to the north of the hospital as well as to the south, which is where I originally thought the grave had been. Yet, these small bits of information only haunt the edge of the Duplessis Orphan story. Instead, following the graves of my participants was a wild goose chase, leading to new questions, not answers.

There are no closed cases when it comes to my patients. No way of nicely tying up their stories, no way of making neat conclusions about their lives, their bodies, their deaths, even their invisibility. Conclusion implies certainty, when all the loose ends are tied up and all the inconsistencies accounted for. But, like the unresolved story of grave hunting and the ghostly invisibility:visibility of my patients' bodies, the archive tells a story without end, caught in dissolution, unraveling at the ends, and decaying in the ground. Even as I reached for answers and a tidy way to finish up my narrative of missing bodies, a way to interrupt this process of unraveling, patients' bodies and the stories they told resisted my attempt at conclusion; they were evanescent. They danced just out of reach at the edge of files and indexes, newspaper articles and odd web pages, mentioned briefly in passing and then passing out of sight.

Chapter 4
Relations of Care and Constraint

As bodies disappear and reappear in the archive, so too do relations of kinship and care. Family networks are essential to most discussions about illness and mental health, they crop up in the literature (Pinto 2012; 2014: Biehl 2005) as sources of illness, care, and even aggravation. As a result, I fully expected to find the presence of patients' family members in the admittance procedures and in the way patients discussed their lives. What I didn't expect, however, was for the files to hold complete webs of relations, where doctors had mapped, charted, and listed sometimes up to three generations of a patient's family tree. These extensive maps of relation were assembled by the hospital's staff to trace two things; disease transmission and a patient's network of care outside the hospital. In terms of transmission, the medical staff and special investigator at the hospital attempted to trace the disease's path across a patient's web of social and blood relations, in order to locate its source. In terms of care, the hospital also mapped patients' social networks as a means of establishing a regime of care outside the hospital.

But just as the files constituted these webs in text, so too were they pulled apart by the stark realities of living day-to-day with neurosyphilis. Patients became estranged from their families, isolated, and contained by the hospital and the progression of their disease. Here, a new type of evanescence was functioning, which occurs not *through* the archives, but *within* them. My participants' families and loved ones were evanescent in the files because they were evanescent in my participants' lives. They were half-remembered specters, haunting them through their absence. As my participants' memories deteriorated, both the hospital and the women themselves continued to reach out to unresponsive family members. But letters went unanswered, leaves of absence were cut short, requests for care declined, and dead bodies were often left to the hospital rather than reclaimed.

These dissolving webs of relation bring into question the dynamics of care and responsibility at the hospital, in relation to notions like constraint, freedom, and abandonment. Who is responsible for the patient's care; is it the state, the hospital, or the patient's network of friends and family? When does care at the hospital slip into constraint? Is a refusal to care an act of abandonment or freedom? Does the absence of family members and of the intimacy that their presence implies translate into abandonment or is it simply a different kind of care, at a distance? This chapter is about these tenuous relations as they are constituted in the files and come undone by a patient's life and death with neurosyphilis. It is about the ways that these relations call into question the concept of care as it slips into constraint and as constraint slips into abandonment, and abandonment into freedom.

But it is also about a different type of care, between the archives themselves, the documents, and its readers. Even as gloves were put on to preserve files and documents were stored in basements to protect them from light, folders fell apart from handling, and the archive bore the stains of water damage, caused by flooding. In the archives themselves, as a physical site and a collection of material objects, 'caring' for the files was done in between moments of responsibility and abandonment, intimacy and distance.

Care in the Archives

Care *in* the archives is engendered through the very materiality of the files themselves. Miles Ogborn (2004), in his short article on "Archives" in the anthology *Patterned Ground: Entanglements of Nature and Culture*, talks of the many ways that the material nature of the archives shapes our relationship with them. Ogborn argues that archives, as objects, are fragile things, susceptible to all sorts of external dangers. There is the fungi that lives on the cellulose and starches found in paper, the book lice which tunnel through registries, the silverfish that eat the film of photographs, and the mice that chew away at binders (Ogborn 2004). These little creatures, who literally turn the archive to dust (Steedman 2001a) can be managed with acids and pesticides, particular temperatures and controlled humidity levels, but only if careful. Use the wrong humidity level and the pages of a book will dry out over time. Apply the wrong chemical and destroy the paper and ink of the archives. Then there are the dangers internal to the archives, the acids inherent in paper that embrittle documents, causing them to break from the slightest manipulation. A varying range of temperatures and humidity levels can cause books to “literally pull themselves apart” as the pages expand and contract absorbing water and drying out (Ogborn 2004: 241).

As much as archives are threatened by the materiality of the site they occupy, so too are readers sometimes put at risk by the materiality of the archives. Some of the molds that grow in archives are poisonous, like the strain uncovered in the 1990s in the Museum of Contemporary Art in New York. Steedman (2001b) dedicates an entire article to the fever-inducing qualities of the archive, calling on records of “brain fever” that academics were diagnosed with during the nineteenth century. Steedman argues that what was identified as an inflammation of the meninges and the cerebrum can be traced back to the toxic components used in bookmaking; the glues, adhesives, and leather covers, all potentially hiding anthrax (2001b: 1168). All these factors need to be mitigated, care taken to protect the documents from decay, and in turn, care taken to protect the readers from the documents.

Then there is the care taken to maintain the privacy of medical documents in particular; laws made and archives established so as to ensure that the medical details of peoples lives are kept private (P-9.0001 2019). This type of care requires locked doors and keys, a scientific review process set to regulate who is allowed access, or an information management firm that “invest[s] in security technology” and “conduct[s] background checks on all employees” (IronMountain 2019).

Consequently, medical archives require a regime of care that regulates both *how* documents are interacted with, and *who* can interact with them. Care, in this instance, is not a process of intimacy and relations, but of distance and constraint. The regime that I observed unfolding in the day-to-day functions of the department, however, occurred amidst dissolution, with acts of care concurrent with acts of abandonment, constraint, and neglect.

The archives were located in the basement of the hospital like most archives are. This is an act of preservation itself, a means of protecting the documents from harmful sun rays. But with the basement also comes the risk of flooding and the destruction of documents from water. Walking briefly with the archivist one morning, as she let me into the index room, a room I wasn’t allowed the key to, I asked if flooding was a problem. She noted that they were in fact, common, pointing out the watermarks on the walls. 100-year-old indexes, however, continued to be kept on bottom ledges and files filled each row of shelving from top to bottom.

The hospital attempted to preserve some of the files in the 1960s when the cases from the 1910s were microfilmed. But the microfilm reader itself was in disarray when I was working there, uncalibrated and often producing wonky, illegible scans of the documents. The oldest documents I interacted with intimately, the death and admission indexes, were slowly dissolving, their now pinkish papers becoming dust as their edges frayed. Instructed to wear gloves in order to protect the paper from the destructive acids and oils produced by my skin, the gloves themselves were awkward to manage, limiting my own delicateness when handling the documents and producing more than a few torn off edges and ripped pages. The gloves were stored in a corner cabinet with the rest of the indexes, taken out and put back over the years. They showed their use, the white of the fabric a discolored pink to reflect the dust of the archives.

Acts of care, like the use of gloves to protect the documents, were constantly unfolding amidst acts of dissolution as well, like the act of handling the documents. That is because care, as an act of intimacy and relation, does not work in the archives. Interaction with the documents themselves is not an act of care, but creative destruction, similar to the way fungi feeds off the paper it grows on and book lice build homes in the books they destroy. The gloves are an effort to mitigate the destructive consequences of interaction, but they only slow down the process of dissolution, rather than completely impede it.

Yet a concept of complete abandonment and distance also doesn't work in the archives. Abandonment of the documents means exposing them to sun and floods, to silverfish and fungi, and shifting environments that cause decay over time. It also means broken down microfilm readers that no one has bothered to fix, and a certain degree of freedom that violates the privacy of the documents. Rather, care for the archives is a set of interrelated acts of intimacy and abandonment, of absence and presence, which actively denies different webs of relation, selectively controlling who does and does not come into contact with the space.

Webs of Transmission

While the webs of relation enacted *through* the archives are radically different than those playing out *in* the archive, they are still enacted through very material means - by the files that the doctors wrote up, and the disease that connected the host to the infected.

Married in the working-class neighborhood of Saint-Henri at the young age of 14 to a man named Guy, Sophie Lefebvre (15033) had a church wedding. After 10 years of marriage, Sophie had two children, dead shortly after birth, a stay in prison after being arrested for grocery shopping undressed, a sentence to the hospital by the courts, and a diagnosis of general paralysis. When she was asked about her family, she told her doctor that her father had been dead for two months, and her mother for four years. She had eight brothers and four sisters. When she was asked how her marriage was going, Sophie told her doctor that Guy had a girlfriend, a blonde. She also told him that the affair "*didn't matter to [her]"*[8]. Still, she did think that everything was going well with her and her husband. He was a tailor and he traveled. When she was asked if she'd ever had an affair, she told her doctor she'd never had a beau, she was "*devoutly Catholic*". When she was asked if Guy gave her "*chaude-pisse*", a euphemism for a number of sexually transmitted diseases, she said she would have killed him if he had. Continuing, she told her doctor that when they first married, she made sure her husband understood who was in charge in the relationship. She died four years later in 1924, from general organ failure caused by the general paralysis. She was buried in the hospital's graveyard, her body unclaimed.

While these seem like a disparate set of odd facts about Sophie, they make up most of her case file. Seemingly disconnected from the issue of diagnosis, they actually do the work of situating Sophie within a web of intimacy and transmission. Married ten years prior, Sophie's

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[8] I have italicized any quotations taken directly from the case files in order to differentiate them from my secondary sources. All the quotations I have taken from the case files, however, have been translated from French to English, except in the case where a translation was impossible, like the expression 'chaude-pisse'.

primary sexual intimacy was with her husband. She'd never had an affair and was married young enough that I think it is unlikely (though still a possibility), that she was infected beforehand. Her husband could have contracted syphilis from the woman he was seeing, or anyone else. While she tells the doctor that she'd never had 'chaude-pisse', she could have easily missed the chancres and the rash that mark the first stage of syphilis, unremarkable on their own. The file states that her parents had died not too long ago, from unknown causes. However, I think that it is unlikely that she contracted syphilis from her parents, children with congenital syphilis don't live very long. Sophie's children, however, could have been infected, which would explain why they all died so young.

Syphilis is a disease of relations; of intimate relations between bodies and through those relations, with the bacterium Treponema Palladium. In fact, T. palladium's relation to the bodies it infects has changed the disease itself. Early records of syphilis describe a more virulent disease which caused death much faster than its modern incarnation. By the 1800s however, the bacterium had mutated into the form we interact with today which develops in three stages, staggered by months and years (Firth 2012). Rather than simply killing its host quickly, the bacterium now lives in the bodies it infects for years if it survives the immune system's initial response. It multiplies until it reaches the height of infection during the secondary stage of syphilis, making the patient's body incredibly infectious (Radolf et. al. 2016). During its latent stage, however, it hides in "treponemal sanctuaries", intimate cavities of the bodies, like the eye and the lymph glands, waiting out older treatments like salvarsan, and recently, newer treatments like penicillin (Hayden 2003: 79). Its lowered numbers during this stage dramatically decrease the chance of transmission (Radolf et al 2016). As a tertiary disease, it lives with its hosts for years on end, slowly dissolving a patient's cerebral cortex and nervous system until they die from related complications.

As T. Pallidum cannot survive outside of its host's body it was in its interests to mutate into a strain that did not quickly eliminate the host, but rather prolonged their period of infection (McGinnis 1990). Outside a host, at a lowered temperature, Pallidum quickly dies. As such, the bacterium isn't transmittable through secondary hosts, like mosquitoes or fleas, or through air, water, or food. Pallidum requires direct contact, through blood and bodily fluids. The bacterium itself survives through intimate relations between people, but it also produces a new web of relation, one of disease and transmission. Sophie's doctor tried to draw out those webs, searching for sites of exchange between Sophie and her parents, Sophie and Guy, between Guy and his girlfriend, and between Sophie and her two dead children.

Anne Marie Mol (2008), in her work about the enactment of health care and choice, argues that in a "logic of care" individuals are never disentangled. Simply having a disease and receiving care for it situates them within a collection of different "diagnostic groups, genetic relatives" etc. (2008: 58). Though Mol frames autonomy, choice, and freedom in opposition to care in her work, which I will argue against below, the way she frames health care as enacting different entanglements is useful here. When discussing the heredity of a disease, for example, Mol argues that a patient's entire set of blood relations "enters the scene", conjured up by a question as simple as "is there any diabetes in your family?" (2008: 59). Sophie is similarly positioned into an entangled network of heredity and transmission. T. pallidum produces them, while her file enacts them, mapping out chains of connection.

By saying that the files enact a patient's family network doesn't mean that these webs were conjured out of thin air; they have always existed. What the files do, however, is put them into practice. I borrow the term enactment from another of Ann Marie Mol's (2002) work, *The Body Multiple.* She argues that attending to the way objects are enacted enables us to attend to the ways they "come into being – and disappear" (2002: 5). Using this logic, I can argue that because Sophie's file enacts her position as a subject within a larger web of transmission and heredity, I can also argue that the files constitute those relationships. There are different actors working in this ensemble to enact those relations, like the doctors who record the webs, and Marie Mignault, the hospital's investigator who collects case histories from family and friends. However, it is the bacteria, as the actors which produce these ties of transmission, and the files, as the objects currently enacting, that truly make and remake Sophie's webs of relation in the archive.

Webs of Care

Lizzie

Lizzie Kent (15201) was a 'good time girl'. She owned two Pomeranians, a fur coat, a big trunk full of clothes, a sewing machine and a lot of debt. That debt was owed to her landlord, Madame Bourassa, whose windows she smashed before being sent to the hospital.

She married a Mr. Jack Fulton, a well-off English man who disappeared back to England after the war. At one point after he left her, he asked Lizzie for 75$ so he could pay for his ticket back home, but she didn't have the money, so he stayed in England, with the blonde she thought he left her for. Lizzie wrote to his mother, but she was of little help, he rarely visited her. Before her admittance to the hospital, she had been living with Tim, happily according to her, though Tim was just plain happy to be rid of her, according to Lizzie's doctors.

On admittance to the hospital, she was diagnosed with general paralysis and from there, her doctor's discussion of her illness in the file stops. Instead, the file focuses on finding a space for Lizzie to go, somewhere that isn't the hospital. After three leaves of absence with a friend, Mme Normandin, where she consistently returned early to the hospital after exhausting herself trying to mend and sew cast offs to earn enough to get by, her doctors started looking around for family and friends to care for her. But Lizzie told her doctors that she was quite happy to stay at the hospital long term, at least until her missing husband came back to the city.

Marie Mignault, the hospital's investigator, compiled the rest of Lizzie's file, detailing the names and addresses of her friends and family and their willingness to take her in. Her step-brother, Walter, was the most accessible, though the least willing to help. He hadn't seen Lizzie in more than a year and didn't consider her much of a sister. He offered to contact her *real* family in the States, but he stressed that he couldn't keep her on his own. He suggested placing her in a boarding house and even offered to give her the money to start making a living but rescinded the offer after a second interview with Mignault. He didn't want anything to do with Lizzie. He argued that the responsibility for her care rested with her brothers and sisters, though he wasn't able to contact them.

One of Lizzie's sisters, Gladys, lived in Montreal, but she was hard to pin down. Absent the first two visits Mignault paid to her apartment, she finally tracked her down through her step-brother. A chorus girl making very little pay, Gladys depended on a white-haired Englishman to pay her rent. She told Mignault that she couldn't afford to care for her sister, as much as she might want to. The rest of Lizzie's family never responded to Mignault or Walter's letters.

Even Mme Normandin, the friend who housed Lizzie during her first three leaves of absence, pulled back over time, requesting payment for the money she'd spent on housing Lizzie and caring for her dogs while away. In the end Mme Normandin sold Lizzie's sewing machine to make back some of the funds she lost on her care.

Three years after her admittance, Lizzie died, and her body was unclaimed and unwanted, buried in the hospital's cemetery.

Odette

Odette Boucher (15430) had been married twice, her first husband dying after nine years with her. During their marriage, Odette had three children, the first dead at three weeks, the second at 15 days old and the third dying before birth. She remarried five years before her internment at Saint-Jean-de-Dieu to Pierre, but they had no children to speak of.

Odette and Pierre lived with her sister, Henriette, and her husband in Montreal. After being paralyzed for two months, Odette requested admission to the hospital. While she got along well with her sister, she was no longer able to contribute to the housework and preferred admission. Though the file doesn't say so, her family must have agreed, because she would have needed their help to secure admission. Her father was still alive at the time of her hospitalization, 76 years old, but her mother had died at 53 years old from intestinal inflammation. Part of a large group of siblings, Odette was the second of five sisters and four brothers. The eldest, Susan, was married to a carpenter, living on Saint-Catherine East with no children. Odette lived with the third sister, Henriette. She and her husband Emile were also childless and Emile made a decent salary as a journalist. The fifth girl, Alexina, still lived with their father and cared for him in his old age. The four sons, Louis, Guillaume, Gregoire, and Lucien were all unmarried, a carter, journalist, factory worker, and leather tailor respectively. Part of their salary went to support their father, who no longer worked. Her grandparents on both her maternal and paternal side, died old, with nothing suspicious or worth reporting about their deaths. In fact, there was nothing abnormal about any of Odette's family members according to Madam Mignault, who collected this detailed family tree.

Despite the extensive set of family relations, Odette sought out the care of the hospital rather than remain a burden at her sister's house. But once arrived, she spoke mostly of her family, crying sometimes to go home. Before her admission, she lived for years with paralytic attacks. Her sister kept watch over her, ensuring she was dressed every day. But two weeks before her admittance, she wandered away in the middle of the night. A man brought her home at two in the morning and no one even knew she'd gone. She died five months after admitting herself, from general organ failure. Her husband recovered her body.

Care, Constraint, Abandonment, Freedom

Lizzie's and Odette's oscillating stories of abandonment, constraint, and an ever-shifting responsibility of care shows the many ways through which webs of relation come crumbling down during moments of crisis. From Lizzie's missing husband to her unresponsive parents, and her unwilling siblings, Lizzie was isolated by her disease and the care and costs that were required to manage it. Odette isolated herself, seeking the care of the hospital even though her family had established webs of care. But Lizzie's and Odette's stories also say something about the ways that care functioned across different provincial, medical, and familial institutions in early twentieth century Montreal, oscillating between different scales of intimacy, agency, and attention. It is within these oscillating scales, where responsibility is passed from institution to institution, that care collapses into competing notions of abandonment, constraint, and freedom.

There are a number of different ways to talk about care as a concept. María Puig de la Bellacasa (2017), for example, splits care into three components; affect, action, and politics/ethics. The politics of care is an ideology, while the action of care is something you do, i.e. to care *for*, and the affect of care is something that you feel, i.e. to care *about*. These delineations are useful for understanding the many ways that care functions at different scales. Take for example intimate care versus biopolitical care, where intimate care would include both care as affect and action, while biopolitical care would entail care as an ethics/politics and care as action. Lisa Stevenson (2014), for example, in her work on biopolitics in the arctic, discusses how care can be bureaucratic and indifferent, completely devoid of feeling and the affective component of care. Care in this instance, is “a form of attention that is, at times inattention and indifference” (2014: 5). This way of looking at care works similarly to Sarah Pinto’s (2014), who, in her work on psychiatry and women in India, understands care as occurring as a degree of attention, where abandonment lies on the other end. Mol (2008), looking at it more interpersonally, positions care instead as a process, something to be engaged in, enacted, and negotiated. My discussion of care here encompasses all of these definitions, as a form of work, a politics, a processual negotiation, a form of attention, whether it is intimate or indifferent, and a form of affect. That is because I intend to discuss the ways that care functioned in Lizzie’s and Odette’s stories across a number of different zones of entanglement, through provincial, medical, and familial webs of care.

Let’s start with familial webs of care, which were prominent (if even in their absence) in both Lizzie’s and Odette’s file. In Lizzie’s story, there is the way her husband’s absence and the possibility of his presence played out over and over in the files. Though never present during Lizzie’s time at the hospital, she hoped that his return and the renewal of their relationship would be a means of permanent release from the hospital, ensured by the security of his care. But in the end, he never came back for her. There was also her beau’s absence, who was all too happy to cut his ties with Lizzie when she was interned. There were Lizzie's parents, who remained silent and elusive even after she wrote to them. There was her stepbrother who relinquished all responsibility of care, arguing that his relation to her wasn't strong enough to justify the burden. Then there was Lizzie's sister, with whom she had a close relationship, but who didn't have the means to care for her, living on funds that were not her own.

Then there was Odette's family, who had the means and the inclination to organize themselves in order to ensure her care. She lived with Henrietta, who had both a good income and no other dependents. Her file also shows other networks of care which functioned in her family. Odette's father was both physically cared for by the youngest sister, Alexina, and financially, by his four sons. However, when Odette's illness worsened from a prolonged paralytic attack and behavior which risked her safety, like wandering around alone and disoriented at night, Odette decided that her family's care was not enough. Likely with her family's help, she was instead admitted to the hospital voluntarily.

Lizzie's care outside the hospital is made into what João Biehl calls, a "commonsensical impossibility" (2005: 239). He argues in his work around abandonment and mental health in Brazil that families "organize themselves so that they are no longer part of the treatment and care" of those they consider unwanted (2005: 184). This is done by invoking a constructed common sense, which hinges on who is able to contribute to the household, and who is a permanent drain on it.

Foucault (2006) makes a similar case in his work on psychiatry and the family, arguing that the family is at once dispossessed by psychiatry and complicit with it. Psychiatry, as a medical institution, dissolved family relations of care when the right of confinement was taken away from the family and given instead to the State in the late nineteenth century. Quickly afterward, however, Foucault argues that the family was then reincorporated into the process by making them pay for the care of patients at the hospital, and then in turn giving them back family members who can again be a source of profit, i.e., who can contribute to the household.

Lizzie was slowly progressing towards paralysis, she was not ‘transformable’ or curable in this schema. She was instead made into a burden that her family was trying to pass off. Even in death, Lizzie’s body was abandoned to the hospital, who did with it as they saw fit. They could have donated it to the Université de Laval, to be dissected, but in the end, it wound up in the hospital’s grounds, where some 40 years later, it was again effaced and erased, her grave moved.

Odette’s web of familial care fits better into Marie-Claude Thifault’s (2003) model of care and survival strategies. Studying women at Saint-Jean-de-Dieu at the beginning of the twentieth century, Thifault argues that while many families utilized a number of different survival strategies in order to support sick family members at home, in the end, transferring the responsibility of care to the hospital was a matter of burden management. Sick family members were considered at the very least to be non-productive and at worst an outright embarrassment. Still, transferring the responsibility of care to the hospital was the *last* resort, not the first response. But when family members were considered to be too much, too much of a risk, a burden, an embarrassment, then their care was relinquished to the hospital.

Odette was not ‘abandoned’ in a conventional understanding of the word, but her care did become too much, too much to impose on her family, and too much of a risk to herself. In this schema, what some might paint as Odette’s abandonment was also an act of care, where she was instituted into a new set of relations with the hospital who were better equipped to keep Odette comfortable and safe. What’s more, unlike Lizzie, Odette wasn’t permanently cut off from her family. In the end, her husband recovered her body rather than leaving it to the hospital to cover the expense of her interment.

A Foucauldian discussion of psychiatric institutions paints the hospital merely as a zone of abandonment (Pinto 2014). Here, the modern hospital is a “new and restricted interior” where unwanted subjects which used to be excluded from society are reincorporated (Pinto 2014: 249). Biehl’s (2005) look at *Vita,* a hospice in Brazil which he terms a ‘zone of social abandonment’, also positions the hospital in opposition to care. Vita, an extension of the psychiatric institution of Brazil, is a “sanctioned register of social death” where the state, the family, and the medical institution ‘dump’ patients considered not worthy of care (2005: 22). Biel maintains a strict delineation between care and abandonment at Vita, where care is positive and abandonment negative.

In this schema, care is put at odds with abandonment, made mutually exclusive if we consider Lizzie’s and Odette’s admissions to the hospital to be acts of abandonment and the hospital the zone where that abandonment occurred. But it is not as simple as that. Even as Lizzie was quite literally ‘abandoned’ to the hospital and Odette voluntarily admitted, new networks of care were established, between Lizzie and Odette and the hospital (who did, in fact, care for and house them until their deaths) and between Lizzie and Odette and the state (who paid for their care).

Lizzie’s and Odette’s entanglement with the state was the result of a much larger struggle encompassing much of the hospital’s history, as the Quebec government had been wrestling with the responsibility to *care* for the mentally ill of the province for decades. When Quebec established its first asylums in the mid-nineteenth century, they developed a farming out system for the mentally ill, where private, for-profit hospitals were established and given a set amount of subsidies by the government per patient interned. The first asylum, Beauport, was run according to that model just outside Quebec City. This helped the government alleviate the cost of care in two ways. Firstly, the government didn't have to pay for the costs of building and maintaining the hospital's infrastructure, just the cost of care for each patient. The cost of infrastructure was instead the private hospital's responsibility. Secondly, it helped alleviate some of the government's financial burden in hospitals and jails, where the mentally ill were originally placed. With little supervision, however, the for-profit hospital quickly became over-crowded and ill-managed as the owners tried to squeeze in as many patients as possible in order to maximize subsidies from the government (Moran 2000).

In Montreal, the need for an asylum grew as patients were being transported from the city and surrounding areas to Beauport, right outside Quebec City, at the province's expense. The state finally settled on a contract with the Sisters of Providence in 1873 and Saint-Jean-de-Dieu asylum was built on land in Longue-Pointe in the East end of the island at the cost of the order. This system was even cheaper for the government, as the Sisters freely managed the day-to-day care of patients.

At this time, neither Saint-Jean-de-Dieu nor Beauport tolerated state interference. They had paid for the infrastructure of the hospitals and consequently saw its day-to-day operation as their right and responsibility. However, after a report in 1887 by the *Royal Commission on Lunatic Asylums in the Province of Quebec*, which criticized Beauport and Saint-Jean-de-Dieu for poor living conditions, the Quebec government faced a public outcry and was forced to accept greater responsibility for the care of the sick (Moran 2000).

At first, the government tried to enforce increased supervision by assigning visiting doctors to the institutions, who related back the day-to-day functioning of the asylums. But

Saint-Jean-de-Dieu pushed back, circumventing the visiting doctors and refusing to provide reports. In the end, however, they developed a contract with Saint-Jean-de-Dieu, turning the medical direction of the hospital over to state-appointed doctors in 1897 while the administration was maintained by the Sisters of Providence, keeping labor costs low (Moran 2000). They also agreed to pay out 130$ per patient, per year, to facilitate their care (Thifault 2003). Already, we can see that this is a move away from the abandonment that Foucault's asylum sets up, which required the family rather than the state to subsidize patient's care.

The government's use of the Catholic church to run many of their institutions has nevertheless been criticized as an act of abandonment (Moran 2000). Refusing to take full responsibility to provide *care* is a little more complicated than that, however, because while the provincial government certainly handed off the day-to-day care of patients to religious orders, they were half in and half out of the hospitals, trying to manage care from afar while still refusing full responsibility.

Admitted in 1918 and an almost constant presence in the hospital for three years, Lizzie's care cost the government a grand total of 390$. Odette cost the government much less, only living at the hospital for five months because her family managed her care for as long as possible. Despite the length, however, upon admittance both Lizzie and Odette became enmeshed within the provincial government's web of care by simply inhabiting the hospital and receiving the care that they subsidized, even if begrudgingly.

The provincial government, however, heavily managed who they decided was and was not worthy of care, unwilling to take on a blanket responsibility to care for just anyone. In order to delimit the province's economic and legal responsibility and the hospital's costs, admittance to the hospital required proof that care was necessary. This came either from a court, who sentenced patients to the hospital, or from a petition from a patient, or more commonly, a patient's family.

The petitioner had to have forms A through K completed which included the petitioner's relationship to the patient, as well as confirming the patient's symptoms and underlying cause of sickness, proving their need for hospital care, either as a means of treatment or, in the case of patients deemed dangerous or scandalous, containment. All of these facts then needed to be confirmed by both municipal authorities (as the patient's municipal residence shouldered a portion of the cost of their care) and the Saint-Jean-de-Dieu's doctors (Thifault 200: 66-68). The family was thus reengaged in the care process, responsible for *proving* a need for care or constraint. Yet, even as one family member worked to secure care for another, this was also an act of abandonment, where the family was relinquishing their responsibility to care over to the hospital and the state.

While the forms were absent from Odette's file, she was admitted voluntarily and would have had to prove that she required care. Her nightly excursion just weeks preceding her internment was likely one of the main factors her request was approved, showing that whether or not she required care, she did require containment because her behavior was considered risky and scandalous. Thifault's (2003) work at Saint-Jean-de-Dieu, however, also shows that doctors very rarely refused care. They would even write back to the families of patients seeking internment noting when something crucial was missing from the file and inviting them to resubmit.

Lizzie's family didn't have to go through this bureaucratic process. The hospital's and the state's responsibility to her was instead decided through the courts. Considered a public disturbance and threat after breaking her landlady's windows, neither Lizzie nor her family were given a choice in her internment, her care had been bumped up to the concern of the municipality. This is an interesting space in her story where care collapses directly into constraint. When first admitted, Lizzie was angry at her lack of choice. She had wanted to go to the Royal Victoria, one of Montreal's English hospitals. She thought that the courts and the hospital had played "*a mean trick on her*", making her out as "*insane*". Here, Lizzie's care became a matter of constraint, where the attention she received from the state and the hospital also meant a concurrent diminishment in her autonomy.

The tensions between care, constraint, freedom, and abandonment weren't simply resolved, however, when patients got to the hospital. Despite the tenuous relationship both the state and the hospital had with the concept of care and abandonment, care and treatment were the buzzwords at the hospital come the turn of the century. In 1901, with the official name change of Saint-Jean-de-Dieu from Asylum to Hospital, it was clear that the institution was no longer satisfied with acting as simply an internment facility for Quebec's 'deviant' (Thifault 2003: 173). Rather, the Saint-Jean-de-Dieu hospital sought to improve the quality of life of their patients. They sent doctors and Sisters abroad to investigate new methods of treatment that other hospitals in the United States and Scotland were using. The hospital itself instituted new methods of care for the time, like work therapy, temporary leave, and the discontinued use of mechanical restraints (Un Héritage de Courage et d'Amour 1975). By the 1920s the hospital had new labs to facilitate testing patients for organic diseases and had instituted innovative treatments, like hydrotherapy and malariotherapy.

The Sisters organized pastimes for many of the patients, putting on and sometimes even writing plays, musical nights, dances, etc. The day-to-day of patient's lives was occupied with work therapy programs. The order's now classic review of the hospital's history *Un Heritage de*

Courage et d'Amour is full of photographs of women happy at looms, or tales of lush gardens for the men to work in.

Yet, despite the framework of care and treatment through which the hospital understood itself, there are also notorious reports of constraint associated with Saint-Jean-de-Dieu. Many historical accounts of the hospital report it as overcrowded, a tool of "social control … where patients were commonly abandoned and dehumanized" rather than "healed" (Thifault, Perreault 2012: 127). Work therapy programs are now considered by some scholars as a hidden form of slave labor (Ripa 1986: 54). The less desirable jobs at the hospital, for example, like laundry work, working on paving roads, working in the slaughterhouse, etc. went uncited in the hospital's histories, but are clearly listed in the hospital's yearly reports as some of the more common jobs (Annual Report 1915, 1916, 1918).

Those same theorists that framed psychiatric clinics and asylums as zones of abandonment, like Foucault and Biehl, also understood the clinic as a mechanism of constraint. Meant to regulate behavior (in the case of Foucault), or serve as a space where the unwanted are contained (in the case of Biehl), they consider the asylum to be both a space of containment and abandonment because of a modern biopolitics which has reordered "notions of inside and outside, inclusion and exclusion" (Pinto 2014: 248). Asylums and hospitals act as these sites of inclusion and exclusion, a "catchment area" for the unwanted and unproductive, that is both within the control of the state, yet outside society (Pinto 2014: 249).

The opposite of a model of constraint and abandonment, however, would be freedom and abandonment, which can also have disastrous effects. Take Nancy Scheper-Hughes (2015) examination of an Argentinian psychiatric hospital that gave patients full freedom, resulting in 1350 suspicious deaths and 1400 disappeared or lost patients during the 1980s. Staff took on a no-responsibility attitude, noting "'If they go missing, if they get lost – it wasn't us that disappeared them'; 'If they die of starvation, it is because they have lost the desire to eat'; 'If the food is contaminated, it wasn't us who contaminated it'" (2015: 192).

I don't think that it is one or the other at Saint-Jean-de-Dieu, neither a zone of abandonment and constraint nor a space of abandonment and freedom. Rather, I think the hospital has a more complicated relationship with care and its associations with abandonment, constraint, and freedom.

Doctors and staff, for example, were subject to limitations; the hospital was piteously underfunded and understaffed. During the First World War, this stress increased with the government's conscription of male staff members. Doctors were so overworked, their letters in the archive talk of little else than requesting leaves of absence to recuperate (Correspondance du Surintendant Médical Géo. Villeneuve). The testing labs, newly built at the time of my study, were often slowed down because doctors shared their time between being with patients or in the lab (Annual Report 1915). As a result, short cuts were taken and care was managed heuristically. Patients were divided into two classes, the curable and incurable, and housed and cared for according to those distinctions (Thifault 2003: 148-149).

Those considered incurable were, as I mentioned last chapter, the bane of the hospital's existence, bringing down the cure rates of Saint-Jean-de-Dieu and messing with its image as a space of treatment. As a result, the staff tried to farm out those patients back into their family's care for months on end, under the term 'temporary leave therapy'. It was the job of their private investigator, Marie Mignault, to track down patients' families and see who was and was not willing to take them.

Yet, simply by framing temporary leave as a form of therapy, the concept of care and its relation to abandonment becomes fuzzy. At once a means through which the hospital could dump their patients care into the laps of their families for months on end, to relieve the hospital staff of their care, it was also a useful therapy for a lot of patients, a means of caring through what could be framed as either abandonment or freedom. In fact, in many of the case files I looked at, patients *requested* leaves of absence, preferring the care their family network would give them to what was offered at the hospital.

Despite Lizzie's sentence to the hospital through the courts, when the hospital diagnosed her with general paralysis, they quickly recommended Lizzie's request for a leave of absence. Lizzie, however, on discovering that she could no longer work because of her extreme fatigue, was happy to return to the hospital. Like Odette, she quickly realized that the chronic fatigue and progressive paralysis that neurosyphilis caused were difficult to manage alone. But because Lizzie was lumped into the incurable category by the hospital, they were less concerned with managing her care and focused instead on finding a new source for it in her family. As a result, Lizzie was put through another two leaves of absence, each of which had to be cut short, because she could not manage outside the hospital. Even in Odette's case, Marie Mignault was eventually dispatched by the hospital in order to investigate her family, where she inquired about what funds her husband and family had and her life before admission. Though nothing explicit was stated by the investigator, the file suggests that the hospital was looking for either the funds or family to house Odette, now that she had been admitted and diagnosed. But she died only a few months after the investigation started before anything came of it. Here, we come full circle, with care, functioning through the mechanism of temporary leave therapy, slipping into freedom and freedom, in turn, becoming an act of abandonment as the hospital begins to use the therapy to alleviate its problem of overpopulation.

Sarah Pinto (2014), in her ethnography on psychiatric clinics in India, looks at the way binaries of care and abandonment and freedom and constraint collapse in daily life. She argues that, for women, the psychiatric clinic is a space where things come undone; their lives, their families, their stories, and their mental health. Amidst this space of crisis and dissolution, constraint becomes a matter of protection against abandonment, abandonment a matter of care, and care a matter of confinement. It is the messiness inherent in intimate relations and family dynamics that collapses these categories, when the clinical overlaps with the familial. Labeling actions along axes of attention (where care is in opposition of abandonment), and agency (where freedom is in opposition of constraint) obscures the often "unexpected and uncomfortable ways" in which intimacy, dependency, and responsibility play out in women's lives (2014: 252). Consequently, Pinto treats the categories of care, abandonment, constraint, and freedom as a fluid set of interrelated concepts rather than oppositional binaries.

This framework is useful for thinking about the ways that care gets complicated by the different actors and webs of relation at work at Saint-Jean-de-Dieu. Lizzie's and Odette's care collapsed into varying degrees of constraint, abandonment, and freedom because they were stuck in the faultlines and junctions created by the fractured concept of care and responsibility in Quebec at the time. As the family, the hospital, and the province all struggled to define whose responsibility it was and was not to *care*, Lizzie and Odette got caught up in the struggle, shuffled and moved around, at once cared for yet neglected, at once free, but contained.

Care In and Through the Archives

I want to end this chapter with a look at one last kind of care, which is acted out both *in* the archives and *through* them. This is a care that occurred by handling material documents and microfilms and by reading them and the stories they contained; stories of women lost to time and lost to their families, but whose final days are caught on pieces of paper or listed in indexes. This is a more affective care, created by the intimacy involved in reading another person's medical file and coming to know their end of life. This is also a type of care that is created in the distance of decades and death, as time severs most ties. This is a care created between myself and the women I read about. The case files, in this affective relationship, were both the vehicle through which these relations were created, but also a constraint, managing what I could know and how I could interact with the women held in the files.

But this is also a type of care at odds with others. The affective intimacies created by reading the stories, touching the documents, and rolling through the archive's microfilms threatens the materiality of the archives. As careful as a reader can be, just the act of interacting with archives is detrimental to the integrity of the documents and the privacy regulations that keep them under lock and key, exposing them to an environment that decays and embrittles their fibers and an audience that was never meant to see their pages.

In many ways, materiality trumps affect in the hierarchies of care at play in the medical archive. That is why access is so heavily regulated and limited. Keeping people out means limiting the *exposure* of the archives to manipulation and prying eyes. The unintentional consequence of this hierarchy, however, is that the networks of care that the archives are capable of producing are neglected and abandoned in favor of caring for their materiality. What is most disconcerting about this is that the documents themselves will always be in the precarious state of dissolution. There is no stopping it, despite the regulations the archives keep in place.

Eventually, the pages will crumble and only a few ghosts will remain, captured haphazardly in research papers and theses, sometimes in books, and sometimes just in memories.

Chapter 5
On the Edge of Uncertainty

The further I got into my work at the archive, past the bodies, missing and present, and the stories of treatment and care, or its lack thereof, the more I became overwhelmed by uncertainty. Convinced that I was picking the wrong cases or reading them incorrectly, I felt as though I was missing something, something that would make the cases clear, complete, legible. I started searching for cases beyond those I had collected from the death index, scrolling through the microfilm file by file. Every case seemed to point towards syphilis in half-baked ways. Every memory problem, every twitch of the eye or foot, every illicit relation, a trace of bacteria moving unseen, untested, untreated. I began to see syphilis beyond the archive as well, in historical figures, authors, contemporary media, diagnosing Freud's Dora and Queen Mary the 1st with untreated tertiary syphilis. I started researching different diseases that could be confused with syphilis, slowly adding everything from mania to epilepsy to my list of possible misdiagnoses.

It is an easy state to fall into; the symptoms of neurosyphilis are so far-reaching that they become synonymous with countless other diseases, nicknamed the 'great deceiver'. And the files I did have which pointed to syphilis very rarely mentioned the disease itself. It was almost always coded as 'general paralysis' or simply implied in the file when a Wasserman test came back positive. Rarely did the diagnosis, 'tertiary syphilis', or 'tabes dorsalis' make it into a file. In the end, the case files I collected were built off a haphazard and highly subjective sampling method, taking on any case that was both intriguing and ticked off at least one checkbox on my kaleidoscopic list of neurosyphilis criteria.

The stories of patients I did collect were also precariously seated at the edges of certainty; unraveling time, space, and truth in their telling. Temporalities caved in on themselves in the files, both through the ordering of the archives themselves, and the patient's experiences of time, jumping back and forth across decades. Space became undone for patients as well, uncertain if they were in a convent, a hospital, at home, or often times simply an unnameable place. Both classic symptoms of neurological disorders, the doctors called it ‘disorientation in time and space”.

Truth and the validity of stories also fell apart in the files, as doctors questioned patients for linear, singular, and logical cause and effect style case histories. When unsatisfied with the uncertain accounts collected, Marie Mignault was sent to question friends and family for in-depth family histories. Still, diagnostic certainty and ‘factual’ and ‘verified’ histories came across as forced. Dissolution haunted the edges of certainty in the files, forever threatening to undo the different institutional authorities at play in the texts. Yet, in the end, it is in this space of dissolution, where diagnostic and legal facts and truths came undone, that something else became evident. The frictions created by different actors and institutions attempting to reconstruct certainty from uncertain stories and bodies reveal the ways different institutional gazes tried and failed to make subjects knowable.

This chapter is about that motion towards certainty which played out in the files. A motion which always inevitably led to uncertainty. More precisely, it is about the ways that truth and narrative come undone in and through the archive, as doctors failed to find certainty in their diagnosis and I, in turn, failed to find certainty in the narratives. It is also about the effects that those motions have on the structure of story, truth, and knowledge in the archives.

Ruth

Ruth Girard (15313) was born in Pembrooke, Ontario, a city on the edge of the river. She was by all accounts, namely those of her mother and brother, a curious child. Curious and unnatural. She was smart, with a great talent for school, but obstinate and headstrong. By 13, her mother put her in a convent, the Bon Pasteur, to keep her. She had been working for a woman who told her mother she lied and stole, and her mother decided to place her somewhere she would be kept in line. By Ruth’s account, the story was a lie and her mother was trying to get rid of her.

By 15, Ruth left home and the Bon Pasteur and began to work in service. She worked in hospitals, homes, and hotels, staying no longer than a year and a half in any place, earning sometimes as much 20 dollars a week and sometimes as little as 10. During the odd years she was in contact with her family, her mother criticized her for strange manners and an unkempt person, dressed in rags and dirty. By Ruth’s account, she was simply unable to afford anything better, stuck between helping her mother in her house, and trying to earn a living working part-time.

At 22 she ended up in North Bay, on the lip of Lake Nipissing. There she got pregnant and returned with her mother to Ottawa where she gave birth. What happened to her child is uncertain. Her mother implied she gave it away, Ruth implied it died. For some time afterward, she worked in service in Ottawa, flitting between different positions. It was in Sudbury, working at a hospital, that she met George, her future husband. They ran away together and lived unwed until one of Ruth’s brothers tracked them down and forced them to marry. Which brother it was was unspecified. Together they lived in Sudbury for a while, then Montreal, when the rest of her family moved there. Shortly after, her husband fell ill and stayed in Rawdon for two months requiring care. What illness he had was never mentioned.

Ruth lived again with her family in the meantime, cleaning and mending in order to keep herself from being a burden. Still, her mother was displeased, telling her to take a bath, clean herself. Her father hit her. When her husband came back, she left her family and lived again with him, but she continued her relationship with her family, stopping in every now and then to see her mother and sister, and sometimes her brother.

I assembled this story from the bits and pieces that Ruth's doctor, Devlin, recorded when he interviewed Ruth herself, as well as her mother and brother. Ruth had been interned in 1920, at the age of 36, in the Montreal Fullum Street jail, after accusing her brother, Peter, of incest and rape. Devlin was brought in by the courts to examine her and assess whether she was mentally ill or simply lying. That Ruth may have been telling the truth was not discussed as an option. Even with this brief history, there are many contested bits and tidbits. The reason behind Ruth's confinement to the Bon Pasteur, the outcome of her pregnancy, a different story in each account. Oftentimes uncertainty isn't the product of different accounts, but rather simply silence, like her husband's illness. The certainty that is immediately at stake in the files is that of her rape at the hands of her brother. For the first half of the file, when Ruth is still in jail, it is the question that the file exists to answer. After her confinement to the hospital, however, uncertainty creeps in along and against the grain of the file, unsettling the truth that the courts, Devlin, and even Ruth had settled on.

During Ruth's time in jail, Devlin questioned her and her family for three months, searching for cohesion, linearity, and verifiability among the narratives. In Ruth's first account of the rape, she described visiting her brother three times in the hotel where he worked, the Windsor. Three times she came, visiting his rooms, and on the third visit, something was off. Instead of taking her up the elevator to his room like the first two visits, he brought her by the stairs. Instead of meeting her in the parlor room, he met her at the door. When they got to the room, she says he was strange, nervous, excited. Pulling her into the room, he tore off her hat and coat and threw her on the bed. She told him she'd have him arrested, treating her like a brute.

She fought him until she exhausted herself. Devlin wanted to know if he penetrated her, "*he had trouble, but he entered me, he finished too"*, she said.

Unconvinced, Devlin began to question Ruth as to the small details of the event, fact-checking. He asked if they saw anyone coming up the stairs. "*Not a soul*". Had her brother brought his belongings with him to the room? He hadn't. How many windows were in the room? She didn't know. How many floors up were they? She couldn't remember.

Quickly, Ruth began to accommodate Devlin's desire for linearity and clarity. She answered that maybe they were on the 4th floor, recalling that they went up three floors, crossed the hall and came up another. She couldn't remember the windows, but she remembered a chair and a davenport in the room, nothing else. He got a tissue when he first came in the room. At this small mention, Devlin was quick to remind Ruth that she had already said Peter hadn't had his suitcase in the room. Well, "*maybe he had a few small things of his with him"*.

As the visits went on, extending from March until the end of May, Ruth's story began to dissolve at the edges, no longer certain of her own experiences. Maybe it had been only the one visit, as Dr. Devlin had implied. Ruth didn't *"want to say anything about which*" she was "*not sure"*. When Dr. Devlin told her that he believed she felt so persecuted from her parents that she "*invented this history to protect herself against them to revenge herself*", Ruth hesitated for a long moment. Then she began slowly to conform her story to the doctor's assertion. At first she refused the term 'revenge' but did admit that she was "*almost insane because of their mistreatment*". But after discussing the cruelty of her parents, describing her father's physical and her mother's verbal abuse, she began to agree with Devlin in all parts of his version of events. In the files, Ruth's story of rape was transformed into a fiction for the court and the hospital, what Devlin called a "*complete invention, imagined in a moment of nervous exhaustion*".

Still, moments of uncertainty continue to haunt Ruth's case file, slowly undoing the new truth of things assembled by Devlin. In the same breath that Ruth admitted to imagining her assault, she requested a transfer to the hospital. With her court date drawing near, she could already tell that the trial would not turn in her favor. Not wanting to return to Fullum, she told Devlin she'd much rather go to Saint-Jean-de-Dieu. After being admitted to the hospital, her doctors continued to believe that Ruth was lying, and as such, refused her repeated requests for a leave of absence.

In an attempt to read Ruth's confession against the grain, to find agency in her actions (Guha 1987), we could ask why she only told Devlin she invented her story after three months of interviews in jail. We could also ask why the doctors continued to be unconvinced by Ruth's acceptance of Devlin's version of events. The doctors resisted diagnosing her for months, unsure whether to categorize her condition as one of nerves or insanity. Is it possible Ruth adapted her story to the one Devlin had attempted to impress upon her, as a means of securing a more comfortable confinement?

There are a number of other possibilities as to why Ruth changed her story under Devlin's questioning. Devlin's interviews with Ruth's brother and mother implied that Ruth's husband, George, had attempted to extort money from Peter. In Peter's version of events, George made Ruth write a signed letter to a lawyer accusing her brother and later demanded Peter pay him for the offense. Is it possible that Ruth's uncertain story is the result of her husband's coercion rather than Devlin's?

By all accounts, Ruth was also mistreated by her entire family. Her brother called her disgusting during the interview, her mother called her strange, dirty, headstrong, and unkempt. Her father kicked her out of the house on multiple accounts. Her assertion could have been, as Devlin believed and Ruth later reified, a response to trauma of a different kind. Or maybe Ruth was undone by months of questioning and convinced herself she had invented her version of the events?

Six years after Ruth's transfer to the hospital, after her eventual diagnosis of degenerative insanity, her doctors ordered a Wasserman test. It came back positive, inscribed in the file as ++++. Four positive markers on a Wasserman test show a strong antigen reaction to Reagins, a syphilitic antibody produced by the destruction of tissues in Ruth's body. Such a strong reaction is reserved for tertiary syphilis, having progressed to the point of producing enough tissue damage to be detectable. Tertiary syphilis takes 5-7 years after primary infection to develop (Fleck; 1979). Peter had told Devlin during an interview that he had come down with the French disease during the First World War, a nickname which either referred to gonorrhea or syphilis.

Seven years later, after Ruth began a treatment regimen of neosalvarsan and mercury, again uncertainty creeps into the case file. Is it possible that Ruth contracted syphilis from her brother? The timeline fits perfectly, and the shared disease, transmittable only through sexual relations, creates a tracible link between the two bodies.

Yet, Ruth's positive Wasserman reaction and subsequent treatments don't shut down other possibilities. Ruth's husband had also been mysteriously ill months before her arrest, treated for two months. He was also a possible means of infection. Though tertiary syphilis is temporally demarcated by the 5-7 years it takes to develop, that timeline is fungible (Fleck

1979). Ruth could have contracted the disease long before her arrest, or even during her time at the hospital.

Even after Ruth began treatment for syphilis, the unknowability of her body remained constant. For three years, Ruth received varying treatments for syphilis, injected with different dosages of neosalvarsan, oscillating occasionally with mercury and bismuth treatments. In 1931, her blood tests "*stayed*" negative, meaning that the lab at Saint-Jean-de-Dieu had to conduct multiple Wasserman tests to verify her state as 'cured'. But cured never creeps into the file. Her nervous system continued to degenerate long after her treatments. Ruth lost her ability to speak and walk and experienced intense enough gastrointestinal distress that she was given dosages of belladonna to soothe her stomach, all signs of tertiary syphilis. In sloppy handwriting, what appears to be a quinine dosage was administered four times a day in June of 1935, a treatment for malaria. Malarial therapy had been used at the hospital since 1929 to treat syphilis. She died five years later, of a cerebral hemorrhage, a common death for patients with tertiary syphilis. Consequently, throughout Ruth's case file, the state of her body as 'infected', 'recovered' or 'cured' was constantly in question, consistently uncertain.

When I categorize Ruth's story as uncertain, it does not mean that I am implying truth is absent in the files. In fact, there are a number of different truths vying for primacy in this story. Devlin's truth, that of the distressed daughter who falsely accused her brother of incest to revenge herself against the family, is certainly the one upheld by the courts and the hospital, the one with material effects for Ruth. There is a truth that the modern reader might find, on the coattails of the #metoo movement, that Ruth was assaulted and pressured into reimagining her story. Then there are the other little truths that exist in between these two polar opposites. Uncertainty multiplies truth, enabling all contradictory and ambiguous possibilities to co-exist alongside one another. Consequently, the question is no longer what is the true story, but how do these different contradictions, ambiguities, and uncertainties come into being?

Luc Boltanski (2011) sees uncertainty as underpinning every process of social life and critique. He notes that a radical uncertainty "haunts" the order of things, forever threatening to undo the "arrangements" that we have used to "constitute and organize reality" (2011: 58). While he is arguing for a need to attend to the spaces of disagreement that develop because of the fragility of certainty, I think the more interesting question is how the motions between certainty and uncertainty work. If the certainty of things is constantly threatened, how do things come undone and how are they remade?

Sarah Pinto (2012; 2014) asks this question to great effect in her ethnography of psychiatric hospitals and women in India. Embracing the messiness that uncertainty engenders, she notes that her patient's narratives, mental health status, and intimate relationships were shadowed by the sheer unknowability of their lives. For Pinto, uncertainty comes about as different post-modern regimes of gender, medicine, and kinship attempt to read subjects through illegible practices like intimacy, care, and narrative. These practices are illegible because they do not conform to the structures of accuracy and coherence that the regimes use to order the world. Uncertainty, for Pinto, is consequently a product of powerful systems failing in practice and trying to reconstitute themselves. Uncertainty can consequently be read along and against the grain, revealing both the ways that different "mechanisms of power" (Brown 2013: 21) attempt to operate and coerce certain truths, and the ways that certainty is resisted through the "basic unknowability" of everyday life (Pinto 2014: 22).

The contradictory and messy motivations of people are not an open book for the ethnographer to read. This is particularly true for Pinto, where her participants spoke on a different narrative register, full of “connections and disjunctions at once beautiful and elusive”. Pinto dealt with this “dense opacity” by “cordoning off” her participant’s self-expression and instead looking at their story through the narratives of others with the full knowledge that this move further obfuscated the subject at the center of her story (2014: 46). Biehl (2005) faced a similar problem with his sole participant, Katarina, in *Vita: Life in a Zone of Social Abandonment*, trying to decipher the poetry she used to express herself. Biehl made a different move, using a large section of his ethnography to showcase Katarina’s fragmented and labyrinthian poetry. Though in some ways at odds with each other, both Pinto and Biehl turn to a different kind of knowledge, one that does not position the known and the unknown into opposite categories. Rather, they invite both into their narratives, bringing along with them uncertainty and to a certain degree opacity.

This is a move made against the post-modern epistemologies of medicine and law which function by *knowing*, seeing, and describing (Gordon 1997: 13). Rather, it forces what Avery Gordon (1997) would term “a different kind of acknowledgement” and a “different kind of knowledge” that enables the unknown and the invisible, the ghosts of the world, to exist in a zone of uncertainty and evanescence, hovering between presence and absence, and truth and fiction (Gordon 1997: 64).

The points of dissolution in Ruth’s file, where attempts to create certainty unravel, are the product of different legal and medical desires for visibility; trying to create knowable objects out of unknowable subjects. When Ruth is subject to the judicial courts of Montreal, we can read in Devlin’s attempts to create a linear, cohesive tale of events the legal court's desire to create and maintain testimonial veracity (Pinto 2012; Brown 2013). In her doctor’s attempts to diagnose and treat Ruth, we see the biomedical desire to make bodies visible and manageable (Street 2011; Overend 2013).

Testimony

Devlin's search for testimonial veracity in Ruth's story is maybe the most explicit attempt to force visibility and knowability onto Ruth's experiences. His fact-checking between stories, his request for a linear, detail-oriented account of her rape, and his leading interview style were done with an eye to creating a knowable legal subject. The cooperation of the law with psychiatry means that a legal need for testimonial truth becomes the psychiatrist's truth as well. Devlin collected versions of the event from three different narrators, Ruth, Peter, and Ruth's mother, and then checked one against the other for verifiability. He demanded very specific details from Ruth's narrative, like the floor number of the room and its description down to the number of windows. He also pushed Ruth to give a very exact timeline of the event, detailing precipitating actions and how she reacted afterwards. He even suggested to Ruth his version of events, eventually leading her to his foregone conclusion of a nervous breakdown in the face of familial abuse. When Ruth's original narrative failed to meet Devlin's expectations of 'truthful' because they fractured under the demands of what makes 'valid testimony', like linearity, cohesion, and verifiability, Devlin translated this fragmentation as imagination and used it as proof of a nervous breakdown.

Funnily enough, the work Devlin did, of molding his patient's story of trauma into a testimonial style of narrative became a mode of therapeutic healing in the 1970s. Begun by Chilean mental health professionals who noted the positive effects that ordering, recording, transcribing, and using stories of trauma for "legal and political purposes" had on patients

(McKinney 2007: 280), the style was formalized into a technique now popularly used for survivors of political trauma like genocide. Yet, even in this style of care, a rupture is noted between the fragmented and incomplete memory of patients and the linear and ordered testimony they create.

In the context of therapy, this faultline is unproblematic, it is the process of telling the story and being believed that matters. Kelly McKinney (2007) argues in her work on testimony and memory, however, that when the testimonies are made into objects that circulate in political circles, as oral histories or narratives for social justice, "therapeutic" memories of patients are transformed into "juridical memories" (2007: 287) where things like "veridicality, facticity, and realism" become all-important (2007: 285). The stakes change and patient's memories are no longer evaluated along terms that are helpful for their healing, but along terms of "accurate vs inaccurate" (2007: 287).

In this way, the transformation of memory into testimony is meant to clarify and make visible people's experiences. Though McKinney is arguing that such a transformation flattens out the individual's ambiguous and tenuous psychological experiences, she does recognize that when patients tell their stories, as therapeutic or juridical memories, they are likely to be believed under the context she is studying, i.e. between therapist and patient or as part of oral history projects. Here, "accuracy" is taken at "face-value" because to disbelieve a patient is incredibly harmful (2007: 286).

But this same way of testing memory happens in contexts where "clinics of suspicion" and doubt control the dialogue (Fassin, d'Halluin 2007: 304). Didier Fassin and Estelle d'Halluin (2007), for example, explore the ways that trauma is put on the stand in cases of asylum in France. In this context, trauma has to first be proved, most notably through the use of experts, i.e.

psychiatrists or psychologists evaluating asylum seeker's experiences. This method is just another "technology" of visibility making the 'invisible' traces of trauma admissible in court through psychiatric verifications (2007: 304). Here the invisibility of psychological trauma is made visible by transforming it into a material object, namely a certificate.

Even in this instance uncertainty remains the ground against which legal and medical institutions construct fact and certainty. Though professionals have anxieties around the certainty of the diagnoses they provide for the court, they do not let those ambiguities mar their assessments, because for most patients "it is the certificate or death" (2007: 320).

At the root of this procedure is the assumption that the courts and their partners, in this instance, the medical community, can "extract the truth" from a person "through clinical work", revealing what was "buried deep down" (2007: 304). Yet, the jump made from the vague clinical diagnoses of psychiatrists to the clarifying work that their certification does in court by acting as 'proof' shows the disjuncture between what is known and what is represented as 'known'.

Devlin evaluated Ruth's story under the constraints of these assumptions, measuring her narrative using notions of accuracy vs. inaccuracy, a clinic of doubt, and the accessibility of truth. For the purposes of the court, Ruth's claim was found wanting of tangible proof, her trauma invisible and therefore inadmissible. Devlin was brought in to certify it according to testimonial prescriptions of accuracy. But when the 'facts' didn't add up and Devlin pushed for coherence, memory, and certainty, Ruth broke and these inconsistencies became proof of her lie instead. For Devlin and the courts, however, these inconsistencies pointed towards more than the inaccuracy of Ruth's story, they pointed towards her instability and acted as proof of her mental illness. After all, she was neither freed from jail nor imprisoned, she was transferred to the psychiatric hospital by the courts. This move shows that the courts neither found her guiltless nor completely guilty of falsely accusing her brother of rape. Rather they placed her into a different category, that of insane. So certainty was made anew, knitted into proof of Ruth's instability and mental illness.

In both the legal courts and the hospital, this desire for proof, veracity, and certainty had material consequences for Ruth. Her well-being and her care for a long time came second to this desire. Sameena Mulla (2014) makes a similar argument about the legal and medical system in modern forensic rape kit test protocols. Her ethnographic exploration of the way rape kits are administered and managed in a Baltimore hospital found that despite the good intentions of the actors in the medical and legal system, often collecting evidence was done "at the expense of caring for … patients" (2014: 4). Here, a desire for truth and certainty trumps the needs of the individuals undergoing a moment of crisis. Ruth was put in the same position; her needs were irrelevant to Devlin's search for truth. As a result, Ruth was interned at an asylum for a disease she did not have, and the disease she did have went undetected and untreated for years.

Diagnosis

Even after certainty is reconstructed by making Ruth into a patient at Saint-Jean-de-Dieu, it quickly begins to unravel again in the case file. At first, the ambiguity surrounding Ruth's diagnosis revolved around the severity of her mental health. The doctors debated whether her instability was a case of nervous disorder or degenerative insanity. Ruth tried to convince her doctors it was a case of nervous disorder, something that the hospital had since cured her of. She made this case whenever she asked for a leave of absence. Yet, her doctors remained unconvinced, repeatedly denying her requests. After a few months at the hospital, she was diagnosed with degenerative insanity and housed with the other 'incurable' patients. When her

Wasserman test came back positive six years later, uncertainty undid this diagnosis and her body's state as 'infected', 'recovered', or 'cured' was thrown up into the air.

The medical technologies of visibility, like lab tests, autopsies, and treatment and response regimens (Mol 2002) all failed in Ruth's file. They did not make her body visible but rather revealed the ways that her body was unknowable, a site of possibility rather than certainty.

Syphilis played a big role in this process of dissolution and is a site of medical and even historical uncertainty as well. First recorded in the 15th century, the origins of syphilis are still under debate. The original theory is that it was imported from South America with the onset of colonialism. This theory has come under attack for over half a century, with other scholars arguing it came from Asia, or simply went unnamed in Europe for hundreds of years (McGinnis 1990).

While syphilis was named in the beginning of the 15th century, attempts to assemble the disease into an identifiable "entity" was a messy process (Fleck 1979: 10). Ludwig Van Fleck, writing in the 1930s, even used syphilis as a case study to argue the ways that science culturally constructs 'facts'. Fleck argued that as a disease 'entity', syphilis has resisted symptomological, etiological, parthenogenic, and bacteriological identification and definition. As a result, scientists have constructed syphilis heuristically, using whatever technologies and techniques were at hand, resulting in a fractured concept of the disease.

Early attempts to define the disease through its dermatological symptoms and subsequent treatment, mercury, failed to distinguish syphilis from diseases like gonorrhea, scabies, and leprosy. Known as the "empirical-therapeutic concept" of syphilis, this means of diagnosis also ignored the tertiary, latent, and metasyphilitic stages of the disease (Fleck 1979: 8). Because these stages presented themselves radically differently from the first and second stage of syphilis, as neurological and cardiac problems rather than dermatological, they didn’t present visible symptoms like chancres and sores, but rather more interpretable ones like fatigue, paralysis, memory loss, change in character, etc.

There were also early attempts to identify the disease pathologically, on the “basis of blood” (Fleck 1979: 12). Beginning in the 17th century, syphilis was understood through the framework of humors, caused by the fouling of one of the four humors, i.e. the blood. The pathological identification of syphilis, and disease in general, is important because it is a means of organizing disease which frames the body as an object that can be dissected, charted, and made knowable (Foucault 2003b). This is radically different from the symptomological model, which interprets disease through symptoms, leaving the inner workings of the body as an unknown.

While pathological studies of syphilis have continued from the seventeenth century through to modern day, so have symptomological ones. It was when Philippe Ricords identified the staggered stages of syphilis in 1838, after long term study of patient’s symptoms, that the disease became differentiable from gonorrhea. Despite this new method of differentiation, however, syphilis remained largely undiagnosable unless patients were kept under long-term surveillance. It was when the syphilitic bacterium, Treponema Pallidum, was made visible in 1905 as a white spiral against a dark ground illumination under a microscope, that the disease became testable (Frith 2012)

In 1906, when August Paul Von Wasserman devised a means of testing for the bacterial presence in blood and spinal fluid, a quick means of diagnosing patients was created (Frith 2012). Now able to identify if the bacterium remained active in patients’ bodies, new treatment regimens, like Paul Elrich and Sahachiro Hata's arsenic compound, salvarsan, could be tested as to their efficacy.

Despite these new mechanisms of visibility making syphilis a more certain and treatable disease, its knowability remained a problem. While the Wasserman test assumed that diagnosis was possible through the identification and analysis of specific "distinct disease entities", practice showed that those "distinct disease entities" were difficult to isolate (Fleck 1979: 64).

The spirochete, even after discovery, could only be designated as the bacterium related to syphilis, because disease is so much more than its "causative agent". The bacterium's presence in a patient's blood is "alone insufficient" to define a disease because it is not "identical with its hosts feeling ill" (Fleck 1979: 18). Rather disease is a combination of causative agents, bodily reactions, symptoms, etc. What's more, T. Palladium was visually indistinguishable from many other spirochetes, identifiable only after observing its symptoms in infected animals.

The Wasserman test itself was also unable to completely distinguish the disease. The reaction occurred not just in the presence of syphilitic blood samples, but also in cases of tuberculosis, malaria, and lupus. The test relies on identifying not the bacterium itself, but its traces, i.e. the Reagins produced by its destruction of the body's cell tissue. Consequently, the first stage of syphilis isn't even identifiable using the Wassermann reaction because there isn't enough damage done to the patient yet. The test also produces false negatives and positives. The accuracy of the test is dependent more on the lab technician's skill at interpretation than anything else. Consequently, doctors always suggested multiple tests for comparison (Fleck 1979).

More than that, using the Wasserman test to identify syphilis was only done in response to symptoms. Consequently, the knowability of the disease was dependant on a doctor's ability to accurately read their patients' bodies and histories. But syphilis is adept at hiding, lying latent in the body for years in between stages. A ‘stealth pathogen’, Treponema Pallidum conceals itself from its host's immune system by hiding during latency. Where the bacterium hides is still unknown. The classic ‘inflammatory symptoms’ that characterize syphilis also disappear during latency, making the disease next to impossible to diagnose without blood tests, which of course are not ordered because the patient shows next to no symptoms (Radolf et al: 2016).

The assemblage of syphilis into its modern entity as a singular disease was the result of the “development and confluence of several lines of collective thought” (Fleck 1979: 23). Pathological, symptomological, and bacteriological methods of identification occurred across centuries, across countries, developing and reacting to new and developing technologies and techniques. The result is a fractured and messy identification process that in the end was never fully capable of establishing syphilis as a veritable ‘fact’.

Ann Marie Mol (2002), writing close to 70 years after Fleck, makes a similar argument to Fleck, noting that scientific facts are not a reflection of nature, but in fact, part of the “fierce fight to construct nature” (Mol 2002: 42). Maintaining a ‘fact’ as a discrete identity is a process, one which requires “continuous effort” (Mol 2002: 43). Modern medical epistemologies of symptomology, pathology, and bacteriology do this work, continually reaching for certainty, even when the reality is uncertain and messy. In the end “there is no such thing as complete error, or complete truth” (Fleck 1979: 20). Disease and diagnosis lie somewhere in between, never completely unknowable, but never knowable either.

Ruth’s body falls into this liminal space of knowing at the hospital, with her doctors constantly trying to knit together a diagnosis and efficacious cure and her body constantly unraveling their efforts. By the time she ended up in the hospital, she was in the midst of latency, the bacterium hiding somewhere in her body until 6 years later, it started to produce symptoms.

In the meantime, she was diagnosed with degenerative insanity, considered an untreatable disease. She was packed away to the Dame des Sept Douleurs ward, and her file was silent for the intermittent years.

When her Wasserman test came back positive, her diagnosis of degenerative insanity lost its relevance, and tertiary syphilis became the unsaid diagnosis of the file. After three years of therapy with neosalvarsan and mercury, the Wasserman test produced multiple negative results, putting her in the clear. Her doctors stopped treatment but didn’t release her. She continued to show symptoms of tertiary syphilis well into the 1930s, experiencing extreme stomach pain, losing her reflexes, unable to walk, and losing her hair.

By 1935, her files show that she was on a quinine regimen, likely a response to malarial therapy, newly instituted at the hospital at the time. Malarial therapy was another experimental cure for syphilis, but either Ruth was too far gone or the therapy didn’t work. She continued to have extreme gastric pain into 1940, treated with doses of belladonna. In July of 1940, she fell into a coma and died shortly afterward. Even in death, syphilis remained uncertain and unnamed, her autopsy finding ‘cerebral hemorrhage’ as the cause of death.

Archives

As I explore these back and forth motions that occurred in the hospital’s files, where different actors and institutions tried to reconstruct certainty amidst the constant dissolution of facts, I am also engaging in those motions, trying to make sense of, what are for the most part, illegible files. That is the archival desire, to know the origins, the primary experiences, to recover what is lost, “forgotten, wasted” (Steedman 2002: 2). It is a romantic notion warned against by most historians (Derrida 1996; Steedman 2002; Spivak 1994), the great allure and the great trap of the archives.

Archives are necessarily a copy, an "image of the past" rather than the past itself (Merewether 2016: 513). Take, for example, Charles Merewether's anecdote of the now famous photograph of the storming of the winter palace during the Bolshevik revolution. The photograph is a recreation, the original lost to time. This photo has become so synonymous with the revolution, however, that it has become a "document of the original event" and part of the official archive (Mereweather 2016: 514). The fiction has replaced reality.

Simply the process of recording, organizing, and maintaining an archive necessarily transforms the documents held within, incorporating them into a new frame of reference, and a new time period. Ruth's file, for example, was written as a case history, an anamnesis to track her treatment regimen and her responses. The hospital stored her files at first as a means of tracking heredity and for the purpose of record keeping. The hospital's archives as we know them today keep them for a very different reason, for the sake of the file's *heritage*. Consequently, Ruth's file now would be more often than not read as a piece of history rather than medicine, incorporating it into a radically different epistemology.

Gayatri Chakravorty Spivak (1988: 1985) convincingly argues that as much as historians might romanticize the possibility of resurrecting the lost narratives of subaltern populations by 'reading against the grain' (Guha, 1987) those stories are dead and gone. What we are left with instead are the subaltern's stories told through the words of others, maintained, and preserved because they are instrumentally useful, serving particular political and social interests. Stoler (2010) similarly argues that the colonial archives of India that she studied were not used to reflect facts, but rather to construct a colonial epistemology.

Consequently, knowing Ruth and Ruth's story in clear and certain terms was never a possibility, her life is no longer legible. But does that necessarily mean that the historian, the archivist, and the ethnographer are caught by the trap of the archive, unable to say anything because it is uncertain and interested, a fiction and a dream? Are we just all bad ventriloquists, trying to pretend that our wooden dolls are the real thing? I would argue, and I think Steedman and Stoler and even Spivak would agree with me, that the uncertainty and opacity of the archive doesn't make Ruth's story untellable. Rather, it just requires a different kind of story, one that embraces, rather than attempts to mitigate, that uncertainty and opacity. As such, I have tried to leave things as open and uncertain as possible when telling Ruth's story. I don't know who was telling the truth in Ruth's story. I don't know when to believe Ruth, when she first accused her brother or when she later regretted the accusation. I don't know if she died from ongoing syphilis related symptoms, or if maybe the first cure had been effective and the bacteria had simply done too much damage for her to ever recover. I don't know if many of the patient's files I collected were rightly syphilis cases. I don't know how many I missed. In this space of not knowing, I want to leave as many possibilities open, letting uncertainty haunt the edges of my paper as well. It is only in this space, where Ruth is sick, cured, a victim, a liar, distressed, angry, alive, and dead that her story becomes knowable. This is what it means to study evanescent stories; you reach for certainty knowing it is impossible, trusting that the motion is enough to bring understanding.

Epilogue

As much as my thesis is an attempt to attend to the ways that the archive and the pasts it holds are evanescent objects, fading out of sight, in many ways it also acts as an interruption of this process. My semi-fictional narratives and ghostly maps, my attempts to tell patients' stories anew and try to make sense of the lives, deaths, illnesses, and care, fills in the silences of the archive with speculative possibilities. While I find these creative endeavors a useful and productive way to understand and make sense of past lives, I also want to acknowledge the fact that it is the ambiguity and opacity that evanescence entails which opens the door to these alternative histories/ethnographies.

By inviting the same partiality and transience of the archives into my text and letting narratives exist precariously in between fiction and fact, certainty and uncertainty, and the known and the inconclusive, I am able to tell stories that would normally get left behind. These are the stories too small and piecemeal to tell, which in their singularity say little about historical events or sweeping social dramas. They are the odds and ends; the wild grave hunting, the sad folksong, the torn down buildings, the jungle gym. They are the list of everything Lizzie owned, Odette's family tree, and Ruth's medication list. They are the scraps which would have otherwise been left in my fieldnotes, the quirky side stories mentioned briefly in passing. Following what DeSilvey terms as "salvage memory", constructed by the "materials at hand" I've brought together these archival scraps in order to tell a different kind of story, about evanescent lives (2007: 421).

The Final Scrap

In a coincidence that happens so rarely it is usually fabricated in text, my last story is from the very last file I collected, that of Mary Saint-Michele (15357). Except for the case histories, most of the files at the hospital were written in the present tense. This brought a certain immediacy to much of the interactions recorded in the files, where scenes of dialogue back and forth between patient and doctor and symptoms seemed to unfold on the page. Despite reading as immediate, however, the files also produced a feeling of distance between myself, as the reader, and those represented in text, like watching a television show, or reading a book. There was always a sense of disjuncture, a gulf created by time and the structure of the files.

But as I sat in the dark, with the microfilm machine running its low rumble, alone in the quiet, Mary Saint-Michele talked back. Doctors Devlin, Noel, Laviolette, Plouffe and Bertrand had all gone on their rounds with the nuns in Salle Saint-Marguerite one morning in October. On reaching Mary, a nun told the doctors that Mary had hit her head against the walls overnight in an attempted suicide. Mary's voice jumped out at me "I hit my head because they gave me something that was bad for my health". The remark was unsolicited and marked down in the files as an interruption. The sister continued, saying that they had to force her to eat– "wait, what are you saying, they have to make me eat, when have you had to make me eat" Mary demanded.

It's a small little footnote in Mary's file, irrelevant in the grand scheme of things, but it was the most ghostly moment I experienced at the hospital, hearing that angry voice echo in the dark basement. It was the only time a file recorded a patient speaking out of turn, and in that unexpected statement, I could hear the intonation of her words and the tenor of her voice. Mary's outburst stuck with me, resonating inside my head as I wrote each chapter, trying to find a place for it to fit. But it didn't fit anywhere. Even in my thesis about evanescent stories, it was too small a moment to make much out of, too partial, too speculative, a moment of wild imagination.

But it was a moment I didn’t want to go unheard, as it continued to rattle in my head. I didn’t want this voice to get swallowed up by time and the archives because it didn’t tell a bigger story. Hearing Mary’s voice in a dark basement is an ethnographic story that says little about the politics of medical archives and even less about neurosyphilis and the politics of life, death, and care at the hospital. But it does relate a moment, a rare, precious moment when Mary refused to stay quiet, when all her anger and frustration and humanity rings in your ears.

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