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Notes on Military-Clinical Spaces of the American Civil War

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Contents

Chapter 1

Military-Clinical Spaces

The approach I am taking to the intersection of the military and the carceral during the Civil War has been studied in some depth by McNutt and several others.[1] McNutt makes frequent reference to Foucault's *Discipline and Punish* as a means of understanding the relations of power in Civil War military prisons, and indeed the Foucaultian analysis of spaces is somewhat commonplace in military-geographic studies on POW camps (see, for instance, Moran and Turner). The same cannot be said of the approach I wish to take in understanding the intersection of the military and the clinical.

Indeed, much of the literature on the medical aspects of the Civil War concerns the techniques of care, or otherwise the more individual aspects (Devine 2016). It is this gap, most of all, that I wish to fill. In order to do this, I want to look at the notes of and correspondences of doctors working with the United States Sanitary Commission (USSC) both during and immediately following the war. In these materials (those which are most prescient to this investigation are included in the bibliography), I have noticed several very interesting patterns, and, since I have been reading these records at the same time as I have been reading Foucault's *The Birth of the Clinic*, I have been able to connect theory to content, and *vice versa*.[2]

1.1 Epidemic medicine

I believe that much of the medicine of the Civil War constituted an epidemic medicine, in the sense of the 19th century medical understanding of the term. As Foucault describes, around the period we are considering, an epidemic was "more than a particular form of a disease ... it was an autonomous, coherent, and adequate evaluation of disease".[3] The epidemic is thus described not solely in relation to its effect on the patient, but as a sum of circumstances at once exactly equal to and much greater than its parts. Indeed, no factor, no matter how small or ordinary, was disregarded in the classification of, and response to, the epidemic. What is considered, further, is not merely a set of extrinsic or circumstantial conditions (climate, hygiene, etc.), but also includes intrinsic factors such as time of year, geographical location, and proximity to bodies of

1. Ryan K. McNutt, "The Devil's outriders: a LiDAR and KOCOA investigation of the battle of Buckhead Creek, 1864," *Journal of Conflict Archaeology* 19, no. 3 (June 2024): 187–220, ISSN: 1574-0781, https://doi.org/10.1080/15740773.2024.2365175; Ryan K. McNutt, "Panopticonism, Pines and POWs: Applying Conflict Landscape Tools to the Archaeology of Internment," *Journal of Conflict Archaeology* 16, no. 1 (January 2021): 5–27, ISSN: 1574-0781, https://doi.org/10.1080/15740773.2021.1978208; Ryan K. McNutt, "The archaeology of military prisons from the American Civil War: globalization, resistance and masculinity," *World Archaeology* 51, no. 5 (October 20, 2019): 689–708, https://doi.org/10.1080/00438243.2020.1739553; Ryan K. McNutt and Emily Jones, "For want of a nail? Proxies for analysing POW and guard access to supplies at a Confederate prison camp," *Journal of Conflict Archaeology* 14, nos. 2–3 (September 2019): 181–211, ISSN: 1574-0781, https://doi.org/10.1080/15740773.2019.1732062.

2. Michel Foucault, *The birth of the clinic: An archaeology of medical perception*, Translation of Naissance de la clinique - Originally published: New York, Pantheon, 1973 (New York: Vintage Books, 1994), ISBN: 0679753346.

3. Foucault, pp. 23.

water.

Such a phenomenon, as might be expected, when understood as an integration of all possible variables over all others, poses a unique challenge in terms of medical response. It is for this reason that a medicine of epidemics demands a constant supervision and documentation, and that, through continuous observation of all factors and a ceaseless interpretation and re-interpretation of data, the medicine of epidemics "circumscribes, where gazes meet, the individual, unique nucleus of these collective phenomena".[4] The knowledge of an epidemic, then, requires a complete yet contradictory set of facts, derived from numerous and heterogeneous gazes distributed regularly throughout the social body.

An organizational structure which facilitated the synthesis of a homogeneous picture of an epidemic through superimposing and cross-checking medical gazes was present in the Armies of the United States during the American Civil War, at all levels of administrative functioning. Regimental surgeons and hospitals were tasked with documenting individual cases, meteorological data, and various other information situated at a similar level. Then there were the surgeons of the general hospitals, tasked with investigating and recording extraordinary cases which may be exemplary, but also with conducting research into the nature of various conditions which were difficult or time-consuming to treat. Lastly, and situated near the highest administrative level, were the doctors who worked directly for the USSC, and whose duty it was to visit and write high-level reports on the conditions of hospitals under the Sanitary Commission's control. Taken together, the USSC encompasses four parallel, unlimited series which extend the space of medical knowledge infinitely:[5] the study of topographies (conducted at the top level by doctors like S.B. Hunt[6]), meteorological observations (like those collected by Lyman[7]), monitoring epidemics (see the reports on outbreaks in hospitals[8]), and the description of extraordinary cases (e.g. Howard's report on a case of death during the administration of chloroform[9]).

It is these parallel gazes which, through their integration into the military-political structures of the Armies of the United States, were able to cover a domain which was in many respects broader than that of the institutions to which they were formally subordinate. Indeed, everywhere the Armies of the Union went, they were followed by, or moved in lockstep with, the ever-vigilant gaze of a medicine of epidemics. Furthermore, there is often not just an isomorphism between the realized structures of the military and medical, but a whole series of such correspondences between their possible configurations: that is to say, a reorganization of one institution is accompanied by a similar reorganization of the other. In this sense, the medical gaze which *knows* an epidemic forms a negative copy of the individualizing disciplinary gaze; what the positively-determined structures of the military do not cover, the medical gaze steps in to observe. Through the union of these two institutions, a complete and totally penetrating gaze is inscribed upon a space which is necessarily opposed, at each point, to their very workings.

That this space is in opposition to the disciplinary techniques and careful ordering demanded by the military is well known. At any point in history, when a large mass of men are gathered together and marched into a territory where the typical normative institutions of society are weakened, there will be a problem of how to keep them restrained: to make their violence limited and useful; to render their bodies docile. I argue, however, that the introduction of individualizing military discipline is not alone able to impose an ordering upon this space – or at least that this was the case as the scale and scope of conflict waxed towards the mid-nineteenth century.

4. Foucault, *The birth of the clinic*, pp. 25.
5. Foucault, pp.25.
6. S. B. Hunt, *Medical Topography of the region west of the Mississippi*, United States Sanitary Commission Records (GPD E621 .U657 1996a).
7. Dr. Lyman, *Weather Record Jan.-Feb. 1863*, United States Sanitary Commission Records (GPD E621 .U657 1996a).
8. *An account of the epidemic of hospital gangrene at Chattanooga, Tenn. 1863-1864*, United States Sanitary Commission Records (GPD E621 .U657 1996a).
9. Benjamin Howard, *A case of death during the administration of chloroform*, United States Sanitary Commission Records (GPD E621 .U657 1996a).

1.2 The Medical Gaze

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