SYPHILIS, SKIN, AND SUBJECTIVITY: HISTORICAL CLINICAL PHOTOGRAPHS IN THE SAINT SURGICAL PATHOLOGY COLLECTION

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ABSTRACT

This study concerns an archive of disused historical clinical photographs within the Saint Surgical Pathology Collection (SSC) that originally served as teaching aids for the benefit of student doctors at the University of Cape Town's (UCT) medical school. Focusing on images of patients diagnosed with syphilis produced between 1920 and 1961, this study represents the first critical visual enquiry of these images and, as such, has directly contributed to their current life within a (publically accessible) learning collection at UCT's Pathology Learning Centre (PLC).

Set against a backdrop of psycho-social notions of health and disease, this study engages the visual coding of syphilis in relation to Cape Town's medical history, and the developing conventions of photography within this scientific field. Through close readings of selected images, a critical focus on extra-clinical details, inconsistencies, and emotive qualities within the photographic frame allows a consideration of how these photographs take part in a continuous meaning-making process that troubles any easy, fixed, or disinterested reading.

By focusing on concepts of sublimation and projection, I unpack the photographic depiction of ruptured skin in the SSC as an attempt to render the syphilitic patient-body a passive object of medical knowledge. To achieve this the work of Hal Foster, Erin O'Connor, and Jill Bennett form the theoretical foundation to address the affective potential of imaging disease necessarily limited in efforts to secure the diagnostic function of this clinical material. However, while these photographs emerge in this discussion as decisively structured and composed, I likewise address how the 'Syphilis' images offer a way of seeing beyond their institutional use.

While acknowledging the disciplinary motivations of the Foucauldian medical gaze, my argument ultimately privileges the subjects of these images while critically considering how the conspicuous nature of this disease may have seen it pose a particular threat to a notion of stable subjecthood. This was especially the case in the context of 20th century South Africa where those most vulnerable to the disease were in many respects second-class citizens.

Ultimately, this investigation seeks to (re)address the SSC in an attempt to unpack how these photographs may speak beyond their historical medical purpose. By examining how photographic representations of patients provide a means of seeing beyond their institutional intent, I suggest ways in which these images offer up points of fracture that offset and even resist a medical gaze and instead provide an opportunity for the human subject to be retrieved from the objectifying tendencies of medicine.

OPSOMMING

Hierdie studie vervat 'n argief van historiese kliniese foto's wat deel vorm van die Saint Surgical Pathology Collection (SSC) en oorspronklik gedien het as onderrighulpmiddels ten bate van die student-dokters aan die Universiteit van Kaapstad (UK) se mediese skool. Hierdie studie van foto's van pasiënte wat met sifilis gediagnoseer is en wat tussen 1920 en 1961 geneem is, is die eerste kritiese visuele ondersoek van hierdie beelde en sodanig dra dit direk by tot hul huidige bestaan binne 'n (openbaar toeganklike) opvoedkundige versameling by die UK se Pathology Learning Centre (PLC).

Teen 'n agtergrond van psigososiale begrippe van gesondheid en siekte, betrek die studie visuele kodering van sifilis in verhouding tot die mediese geskiedenis van Kaapstad en die ontwikkeling van konvensies van fotografie in hierdie wetenskaplike veld. Deur noue evaluering van geselekteerde beelde, 'n kritiese fokus op buite-kliniese besonderhede, teenstrydighede, en emosionele kwaliteite binne die fotografiese raam, kan oorweeg word hoe hierdie foto's deel uitmaak van 'n proses van deurlopende-betekenis wat enige maklike, vaste, of belangelose interpretasie kwel.

Deur te fokus op konsepte van sublimasie en projeksie, ontleed ek die fotografiese uitbeelding van geskeurde vel in die SSC in 'n poging om die liggaam van die sifilispasiënt as 'n passiewe voorwerp van mediese kennis daar te stel. Om dit te bereik, vorm die werk van Hal Foster, Erin O'Connor en Jill Bennett die teoretiese grondslag om die affektiewe potensiaal van die uitbeelding van siekte, wat noodwendig beperk word deur pogings om die diagnostiese funksie van hierdie kliniese materiaal te verseker, aan te spreek. Alhoewel hierdie foto's in hierdie bespreking as beslissend gestruktureer en saamgestel na vore kom, spreek ek ook aan hoe die 'Sifilis'-beelde 'n manier bied om hulle buite hul institusionele gebruik te betrag.

Met inagneming van die dissiplinêre motivering agter Foucault se *medical gaze*, bevoordeel my argument oplaas die menslike onderwerpe van hierdie fotografiese beelde, terwyl dit die opvallende aard van hierdie siekte se besonderse bedreiging tot die denkbeeld van 'n stabiele subjektiwiteit krities oorweeg. Dit was veral die geval in die konteks van 20ste eeu Suid-Afrika waar die kwesbaarste vir dié siekte in vele opsigte as tweedeklas burgers beskou was.

Ten laaste word die SSC in hierdie ondersoek aangespreek in 'n poging om die foto's buite hul historiese mediese doeleindes te laat getuig. Deur verdere ondersoek in te stel namate fotografiese uitbeeldings van pasiënte 'n manier kan voorsien om buite hul institusionele doel gesien te word,

stel ek wyse voor waarop hierdie beelde fraktuurpunte bied wat die *medical gaze* kontrasteer en selfs teenstaan. In hierdie studie bied die beelde eerder ‘n geleenthheid om die menslike onderwerp vanuit die objektiverende neigings van geneeskunde te verwyder en hierdeur hul menslikheid te herstel.

DEDICATION

This thesis is dedicated to my father for his unshakable faith, to my mother for her unflinching tolerance, to Ben for his patience and support in spite of it all, and to Hanna without whom this study would never have seen the light of day. Thank you.

I would also like to thank Pathology Learning Centre curator Dr Jane Yeats for not only sharing the recently re-discovered collection with me, but recognising the contemporary significance that historical medical photographs have, and supporting my applications to allow research access to the images.

ACKNOWLEDGEMENT

I want to express my gratitude to both Kathryn Smith and Lize van Robbroeck for their supervision and support.

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A NOTE ON THE USE OF PHOTOGRAPHS AND THE PATIENTS THEY DEPICT

Study approval for the Saint Surgical Pathology Collection (SSC) photographs was granted under the University of Cape Town's Faculty of Health Sciences Human Research Ethics Committee HREC REF: 454/2015.

As an investigation into the extra-clinical aspects of this collection, I have elected to reproduce the photographic cards from the 'Syphilis' folders of the SSC as close to their original size and state as possible in order to retain the integrity of the material.

It was decided not to visually censor these photographs when nudity or identifying features are present as forms of manipulation (cropping, blacking out, or blurring the subjects' features) would directly tamper with the value of these visual documents as cultural artefacts. While such practices are historically intended to safeguard the privacy of those depicted, for the purposes of this study they would serve to reinstate an objectifying gaze and lead to further dehumanisation. The photographs reproduced for the purposes of this study have been done so with due consideration, while similarly it was decided that some of the examples discussed not be shown.

By addressing precisely those attributes deemed irrelevant for diagnostic purposes, the choice to leave the featured photographs in their unaltered state was necessary to allow for the critical relationship between subjectivity and illness to be unpacked.

Along similar lines, it was decided to introduce the first names or initials of those depicted in the final (re-)address of the SSC's 'Syphilis' photographs. While the first two chapters engage this visual material as medical documents – thus referring to them according to (and thus as) their clinical characteristics – Chapter III follows the lead of Sally Swartz (2015), Rory Du Plessis (2015), Caroline Bressey (2011), and Susan Sidlauskas (2013) in referencing the patients by name. Although conducted to prevent reinstating the kind of dehumanising tendencies of medical depiction, this practice likewise serves to prompt a sense of both discomfort and empathy otherwise denied by anonymising strategies.

A vital aspect to this project is the reinstating of individual subjectivity so often lost in the process of clinical engagement. Retaining identifying features and introducing (first) names serves to grant the reader a sense of complicity in looking at these photographs. As such, these decisions were made to prompt critical awareness of both the deliberate structuring of medical images and, more crucially, to recognise what clinical depiction often elides.

ABBREVIATIONS

CDA Contagious Disease Act of 1868

HBC Cape Hospital Board

GSH Groote Schuur Hospital

KAB Cape Town Archives Repository

MOH Medical Officer of Health

NSH New Somerset Hospital

PHA Public Health Act of 1919

PLC Pathology Learning Centre

SAMJ *South African Medical Journal*

SAMR *South African Medical Record*

SSC Saint Surgical Pathology Collection

UCT University of Cape Town

VD Venereal Disease

INTRODUCTION

0.1 BACKGROUND AND AIM OF STUDY

Housed at the Pathology Learning Centre (PLC), a disused collection of clinical photographs was recently discovered in the surgery department at the University of Cape Town (UCT). Stowed in the 'Old Medical Building' at Groote Schuur Hospital (GSH) alongside a collection of wet pathology specimens known as the Saint Surgical Pathology Collection (SSC),[1] this assembly of visual material includes images of head-shots, body parts, as well as depictions of removed organs and x-rays. The photographs, comprising eighty-six faded green files, depict patients suffering from an array of medical maladies; of these, the dominant number attributed to a single ailment are those placed within folders labelled 'Syphilis' dated from 1920 to 1961. Historically used for the purposes of surgical teaching (Dent, Personal correspondence 2015) and recently reactivated as an archive within the PLC, this portion of the photographic collection serves as the primary focus of this study.[2]

While the collection may have been produced within a variety of academic hospitals in and around the Cape Town area, the lack of written records associated with the photographic material of the SSC sees its origins largely shrouded in mystery and formed by speculation. Thus – although many of the photographs show signs of having been produced at GSH[3] – the age, stylistic variation, as well as spatial context evident in some of these images speak to indefinite and inconsistent origins.[4] What does appear certain, is that the visual material within the SSC as a whole forms one of very few if not the only clinical photographic archives of its kind within the Cape.

Unlike institutions for the 'insane' and the chronically contagious where patients were routinely photographed on admission or discharge (Deacon 1994:185-186; Deacon 2015 [Online]; Swartz 2015:xii), this does not appear to have been the standard protocol at Cape hospitals. Indeed, as the production of patient-photographs does not seem to have been widely practiced in South Africa

[1] While the collection of wet specimens is so-named as they formed the content of the Saint Museum of Surgical Pathology (named after Professor CFM 'Charlie' Saint who was appointed as the medical school's first head of surgery in 1920 (Levy 2010:359; Louw 1962:668)), the connection between the photographs and this material remains tentative.

[2] Why there was a need for such a large collection of photographs depicting syphilis for surgical teaching remains largely unclear (Yeats, Personal correspondence 2015), the tendency of this disease to cause surgical complications as well as diagnostic difficulties suggests a necessary knowledge thereof for surgeons-in-training (Phillips 1938:35-36).

[3] The GSH branded hospital gowns and bedding used by patients, as well as the sporadic annotations of 'G.S.H.' on the back of numerous of the SSC cards indicates an affiliation between this collection and the hospital.

[4] The origin of photographs that predate the opening of GSH in 1938 prove particularly difficult to trace, as multiple hospitals including New Somerset Hospital (NSH), the Cape Town Free Dispensary, the City Infectious Disease Hospital, Victoria Hospital, as well as an array of public and municipal clinics and homes were all frequented by the medical school's students (Louw 1969:227; Louw 1979:865).

during the 20th century except in the case of teaching hospitals,[5] clinical renderings appear to have functioned solely to educate student doctors (De Villiers, Personal correspondence 2015; Dent, Personal correspondence 2015; Yeats, Personal correspondence 2015). Thus, while casebooks originating from institutions such as the Grahamstown Lunatic Asylum as well as the Robben Island Leper Station see such illustrative documents serve as a mode of identification (Deacon 1994:185-186; Swartz 2015:xii), clinical patient-photographs generated within Cape Town's medical school appear to have operated less as a mode of surveillance and rather as a diagnostic toolkit. Although the utilisation of the SSC photographs as teaching aids until the 1970s is well remembered (Dent, Personal correspondence 2015),[6] the presence and proportion of examples depicting syphilis raises questions as to the prevalence of this disease within Cape Town and thus local clinical interest in its depiction.[7]

While Cape Town was historically comprised of almost equal numbers of 'European' and 'non-European' citizens (Higgins 2013(1942):92; Klausen 2004:74),[8] the high rate of syphilitic infection recorded during the 1930s and 1940s indicated a dramatic discrepancy between racial groups. Documented in the official reports and published writings of both Dr TS Higgins (Cape Town's Medical Officer of Health or MOH) and Dr CK O'Malley (the city's Venereal Disease Officer and lecturer at the medical school until the 1950s), the high level of syphilis recorded in 'Municipal Treatment Centres' spoke to the correlation between poverty, racial intermingling, and illness. Offering subsidised diagnoses and treatment options in impoverished, racially intermixed areas across the city (O'Malley 1932:51, 79), both venereal disease (VD) clinics and pre-natal clinics provided statistical data that pinpointed a prevalence of syphilis in Cape Town's so-called 'Cape Coloured' population.[9] While these demographic differences can be attributed to the singular origin

[5] Other than this collection associated with UCT's medical school and a large number said to be located at the Chris Hani Baragwanath Hospital harnessed by the University of the Witwatersrand (WITS) (Parle, Personal Correspondence 2015), I have been unable to locate any other historical collections of clinical photographs produced in South Africa.

6 While according to the GSH annual reports clinical photographs continued to be produced by the hospital during this decade, this material fell largely out of use for educational purposes along with the teaching of gross pathology (Dent, Personal correspondence 2015).

[7] Indeed, the eight files labelled 'Syphilis' make up 10% of the entire collection and is the largest assembly of images of any single disease or body part in the SSC.

[8] Throughout this study the terms 'European', 'non-European', 'Cape Coloured', and 'native' are drawn from the contemporary writings of medical professionals published during the first half of the 20th century. Recognising race as a social construct, this study harnessed this terminology not to legitimise its use but rather in an attempt to indicate the historical classification and legislation that had a very real impact on the individual as well as social lives of South African citizens.

[9] Due to the small minority of 'natives' within the city, Higgins either excludes African people from his statistical reports, or, if included, considers their numbers too minute to make any notable impact (Higgins 2013(1942):92). As such, when using the term 'Non-European' in relation to Cape Town, medical professionals mean the 'Cape Coloured' population.

of medical data (that crucially excluded affluent and primarily white individuals who could afford private care) (Cohen 1952:50; Jochelson 2001:82), locally-published discussions and reports nonetheless framed concerns surrounding this disease according to these limited statistics. As such, what emerged as a particular concern with regards to the incidence of syphilis in Cape Town during the first half of the 20th century was the prevalence of 'endosyphilis' in non-European women – a 'new' term used from the mid-1940s to describe instances of the disease that showed no clinical signs and was diagnosable via blood tests alone (O'Malley 1944:51). However, rather than speaking to the 'true' incidence of syphilis within the population, it appears to have been the routine testing for the disease conducted at public pre-natal clinics and maternity homes catering to an indigent and predominantly non-European population that saw this statistical correlation between these women and this insidious form of the disease emerge.[10] Despite its notoriety as a highly conspicuous illness,[11] it was the obscure and discrete nature of syphilis that proved to be a cause for concern in local medical literature and the city's health statistics.

Although numerous historical descriptions and depictions of this disease propose a clear knowledge of syphilis and its effects, the highly variable nature and concomitant complications witnessed in practice saw this disease emerge as a particularly troublesome condition to define, categorise, diagnose, and treat (Quétel 1990:109). While the clear medical classification of syphilis into primary, secondary, and tertiary stages during the 19th century suggest that a degree of clinical certainty surrounding this disease had been achieved,[12] actual experience with syphilitic patients saw symptoms rarely follow this strict and conspicuous pattern. As evidenced by its long-standing handle as "the great imitator" (Barnett 2014:182; Harrison 1959:3; Shmaefsky 2010:13; Parker & Parker 2002:10), syphilis posed a particular problem for diagnostic delineation and thus likewise for clinical depiction; its vague and imprecise clinical definition and its exclusion from 19th century atlases on skin disease (Crissey 1951:418; Palfreyman 2012:318) proving indicative of its inherently troublesome, multifarious, and often unpredictable progression even when conspicuously manifest on the surface of the body. Likewise, despite 20th century advancements in testing and treatment options, the diagnostic difficulty posed by syphilis persisted. And as a result, the education and

[10] Despite the abolition of compulsory notification, testing, and incarceration with the passing of the Public Health Act (PHA) in 1919, the expectant mothers were nevertheless routinely tested for syphilis at municipal institutions (O'Malley 1947:47).

[11] See Harriet Jane Palfreyman's Visualising Venereal Disease in London c.1780-1860 (2012), as well as Rebecka Klette's Inventing the Nose, Inventing the Other (n.d.) and Depicting Decay (2013) for more discussion.

[12] Despite its conspicuous manifestation in and on the body, it was only with the clinical work of Phillipe Ricord in the 19th century that the diagnostic outlining of syphilis was established (Quétel 1990:111).

practical training of medical students remained perpetually troubled by the disease's indefinite symptomology and ineffective remedies.

Despite or potentially because of the difficulty in pinning down this disease, images of the patient-body long served as an attempt to visually fix symptoms in order to aid clinical teaching. Claiming the status of pictorial evidence, photography in particular professed a depictive transparency useful for scientific inquiry. As witnessed in the early use of this medium within the fields of criminology, psychiatry, and comparative anatomy (to name but a few),[13] photography garnered its status as evidence due to the mechanised nature of its making as well as its institutional use (Sturken & Cartwright 2009:280-285; Tagg 1988:5, 11-13, 76-87). By making use of depictive techniques to limit contextual noise, remove irrelevant detail, and consistently structure content, photographs harnessed for scientific purposes served to render the human subject a stable, definable object of inquiry. In depicting disease, clinical photographs similarly appear as an attempt to turn material illness into a recognisable entity that could be known according to its observed and observable manifestations – both on the human body and in an image. Perceived as a wholly objective and transparent medium, photography harnessed within the medical field essentially provides visual proof of disease, turning the patient into little more than a physical host, a conspicuous platform on which disease is made manifest. Rendering the multifarious reality of conspicuous diseases such as syphilis into a locatable, quantifiable, and essentially recognisable condition, clinical photographic collections like the SSC operate as functional instruments for medical teaching.

Considering the complex interrelated institutional, medical, and representational pasts relevant to the 'Syphilis' photographs of the SSC, this study is an attempt to touch on both the historical function of these images as well as the collection's contemporary life as a visual archive. Thus, simply put, the aims of this study are:

> To position the 'Syphilis' photographs within the SSC in relation to the historical, institutional, and representational practices of (clinical) photography;
>
> to investigate the visual coding of these photographs and unpack how they operate to render the material nature of syphilis as well as the human subject a fixed and clinically decipherable entity;

[13] Alphonse Bertillon and Havelock Ellis centred their engagements on the bodies of criminals (Green 1984; Sekula 1986), Hugh Welch Diamond and Jean-Martin Charcot focused on the faces, bodies, and gestures of the mentally ill (Gilman 1982; Gilman 1985; Gilman 1988; Didi-Huberman 2003(1982)), and Cesare Lombroso studied the male and female 'offender' – be this in the form of the criminal or the prostitute (Gilman 1985; Green 1984).

and finally, to expose how these clinical depictive strategies harnessed within the collection may fail, and foster an empathic (rather than disinterested and diagnostic) engagement.

A study such as this is necessarily limited, and various potential avenues of investigation, exploration, and extrapolation have been duly elided. For example, a deeper historical as well as ideological engagement (particularly along lines of race and gender) seemed the most obvious framing of this material, yet such manners of address proved difficult on both practical and theoretical grounds. My first encounter with these visual documents did indeed foster an attempt to read them as products of a gendered and raced institutional gaze, yet engaging the photographs more closely revealed such an analysis to be far too narrow and deterministic. Lack of institutional knowledge and available supporting documentation made a thorough historicising and contextualising of these archival images, while desired, an impossible endeavour, and an ideological engagement felt too heavy-handed. An exploration of local popular and social attitudes, as well as symbolic constructions of syphilis, were other possible vantage points, yet the limited distribution and publication of these photographs produced such engagements as supplementary rather than central to this study.

Similarly, while ethical debates surrounding consent, distribution, and publication of these photographs emerged as a potential avenue, such concerns were felt to be better tackled by authors in other disciplines. Along similar lines, this study sees the South African context per se play but a secondary role in this thesis; although Cape Town's medical context is harnessed to set the scene for my discussion, focus remains chiefly with the representational techniques harnessed as a response to conspicuous and insidious disease. The scope of this thesis therefore focuses on the SSC's historical function as a collection of clinical documents and its contemporary life as complex set of polysemous visual texts.

0.2 LITERATURE REVIEW

Although early engagements with 19th century medical photography of Europe and America appear in the writings of Alison Gernsheim (1961) and Stanley Burns (1979; 1980), and Sander Gilman (1982; 1985; 1988) has repeatedly published on Hugh Welsh Diamond's photographs of the mentally ill (widely considered to be the oldest evidence of photographic patient-images), it appears that medical photography has received only a sporadic degree of scholarly attention. Indeed, except for a special medical edition of the journal *History of Photography* (released in 1999), and a single

thesis tracing the history of medical photography in the UK (McFall 2000) little appears to have been published on the use of the medium within the clinical terrain until the late 2000s.[14] Evidenced by Jeremy Mifflin's (2007) endorsement of the usefulness of such images for social historians, and Shaw and Reeves's (2009) joint engagement with personal photographs produced at the Craig-y-nos tuberculosis sanatorium, photographs originating from the medical field have to a large extent elided a direct address of clinical patient-photographs. While Caroline Lam (2008-2009) and Carly Dakin (2015) have respectively contributed a historical contextualising of photographs produced in London's St Bartholomew's Hospital and Bristol's University Hospitals, both remain rather brief and refrain from an engagement beyond their historical context and role as educational material. Suzannah Biernoff has focused on depictions of facial reconstructive surgery of wounded WWI veterans (Biernoff 2010; 2012), and Mieneke te Hennepe has addressed patient photographs in both her doctoral dissertation (2007) as well as in her recent writings on 20th century depictions of tubercular children (2015), yet detailed engagement with this kind of material has remained largely rooted in the products of 19th century asylums for the 'insane'.

Indeed, photographs of the mentally ill have been addressed independently by Caroline Bressey (2011) and Susan Sidlauskas (2013) in the UK context,[15] while in South Africa it is the work of Sally Swartz (2015) and Rory du Plessis (2014; 2015) that has seen patient-photographs come to the fore. While such images would appear likely to fall victim to a Foucauldian address, both Swartz and Du Plessis have engaged how patient-photographs may indeed offer insight into the very experiences of those treated at such institutions. In the case of Du Plessis in particular, a poignant argument has been made for an interpretative reading of casebook photographs due to the depictive looseness of even these institutionally-produced images. Rather than following the ideological tenet of uniform "archetypical images of classification, control and surveillance" (Du Plessis 2015:89), Du Plessis argues that patient-photographs may point to private and public lives outside the space of the asylum that spawned them. By focusing on the inconsistent and idiosyncratic nature of many such photographs,[16] Du Plessis's analyses serve to identify glimpses of agency and resistance (Du Plessis 2014), as well as offer insight into a patient's sense of self – despite their subjection to both physical and pictorial regulation.

[14] The exception is Erin O'Connor's article 'Camera Medica' (1999) that was featured in the special medical edition of History of Photography and is greatly used in this thesis.

[15] Bressey specifically addressed the 19th and 20th century casebook photographs and patient records of the City of London Asylum Archive, while Sidlauskas focuses on 19th century photographs from the Holloway Sanatorium in London.

[16] In particular, Du Plessis addresses how pose, expression, and attire all serve to indicate a patient's personal and social identity.

This form of engagement appears to touch on the kind of critical response Glen Ncube (2012) calls for in relation to historical clinical depictions, as evident in his discussion of colonial patient photography of 19th and 20th century Zimbabwe. Here Ncube highlights the ease with which a Foucauldian or colonial lens may be applied to biomedical images of patients – one that would inevitably produce a reading of such images as instating the African patient as "sick 'native'" in need of "biomedical civilisation" at the hands of white nurses and physicians (Ncube 2012:npag). In relation to scientific depiction both internationally and in South Africa, historical photographs have been primarily limited to a reading that positions them as products of an imperial gaze.[17] Focusing particularly on the use of photography in relation to race and culture, investigations into the scientific depiction of the body have remained largely rooted in the use of this medium as a tool that served to create and perpetuate notions of inherent racial difference as well as foster a sense of cultural fixity and distinctness – both witnessed in anthropological images.[18] Seen for instance in conferences such as *Encounters with photography* (1999), as well as exhibitions and concomitant publications like *An Eloquent Picture Gallery* (Dietrich & Bank 2008) and Stevenson's *Surviving the Lens* (2001), local historical (and scientifically-orientated) photographs have remained entrenched in such a colonial framework. However, despite fitting the kind of engagements conducted by cultural historians on anthropological photographs of racial 'others', Ncube suggests that the contextual uncertainty that particularly torments clinical patient-photographs subverts such singular readings.

Many engagements with photographs of 'native' populations see this medium function as a 'technology' of the state – a tool harnessed to both generate and perpetuate knowledge about human subjects in order to regulate bodies and behaviour (Lalvani 1996:30; Rose 2001:168; Tagg 1988:7, 62-65, 70-71, 89; Sekula 1986). Interpreted as an extension of the institutions that used and produced them, photographs harnessed as visual records (by prisons, asylums, or colonial governance for instance) are thus framed as a permanent mode of surveillance and as instrument for correction and control. However, while such an engagement dominates writings on anthropological and anatomical

[17] See Patricia Hayes, Jeremy Silvester, and Wolfram Hartmann's The Colonising Camera (1998).

[18] The former, biological understanding of race has emerged as a particular interest for scientific photography. Seen in critical writings on Louis Agassiz's daguerreotypes of African American slaves (Wallis 1995; Maxwell 2008), Arthur Chervin's study of Bolivian Indians (Poole 1997; Zamorano 2011), Thomas Henry Huxley and John Lamprey's respective images of colonised subjects (Maxwell 2008), Carl Dammann's documentation of (non-)European sailors (Edwards 2002; Kauyasu 1999; Maxwell 2008), as well as John William Lindt and Charles Woolley's independent efforts to visually document Australia's Aboriginal population (Edwards 2009).

depictions of criminality and madness,[19] Elizabeth Edwards and Christopher Morton (2009) have highlighted how this kind of ideological address sees "an uncomfortable tendency to dichotomize and over-determine the dynamics of power relations and their visualizing rhetoric, sometimes to almost nihilist effect" (Edwards & Morton 2009:3). Offering an essentially 'static' form of engagement counter-productive to many post-colonial attempts to re-frame photographs of subjugated individuals, more recent writings on this form of imaging has largely sought to address the ambiguities, nuances, and polysemous nature of such photographic material (Edwards & Morton 2009:4).

Despite being contra-indicative to traditional assessments of medical representations as wholly detached and objectifying – Ncube offers a similar critique of the limited and limiting readings a wholly ideological engagement with scientific photography produces. Instead emphasising the *emotive power* and extra-clinical attributes of patient-photographs, Ncube suggests that such material is "crying out for liberation from its position of relative obscurity or residual storage in the archival collections" as well as "to be opened up to different explanatory possibilities" (Ncube 2012:npag). Thus, while Du Plessis addresses the potential of asylum photographs to "give voice to the patients" (Du Plessis in Conradie [Online]), Ncube sees clinical photographs offer potential avenues for critical engagement in relation to the contemporary responses such images may elicit. Drawing on Sekula, he suggests that while medical photography is essentially a product of its institutional frame, images of patients likewise:

> possess the potential for being invested with new meanings and interpretations […] they are now merely glimpses of that past, serving the knowledge and analytical needs of the present. The present is now in charge of their reproduction and semiotic uses (Ncube 2012:npag).

Ncube's address of the 'presentness' of historical clinical photographs thus offers the prompt for my engagement with the SSC.

0.3 THEORETICAL FRAMEWORK

[19] In particular, such discussions have been conducted by the likes of Andrew Evans (2002), David Green (1984; 1985), Suren Lalvani (1996), Peter Hamilton (2001), Mark Jackson (1995), and most notably Allan Sekula (1986) and John Tagg (1988).

Owing to the overall lack of (local) engagement with clinical patient-photographs beyond historical assessments, I have greatly relied on authors outside of the history of medicine or that otherwise speak to a largely Western context in order to address the SSC.

In an attempt to outline and unpack the institutional framing and visual structuring of this collection, the study addresses authors such as Elizabeth Edwards and Deborah Poole whose critical writings on anthropological photographs offer a way to engage the SSC as archival scientific renderings of the human body. While John Tagg (1988), David Green (1984; 1985), Suren Lalvani (1996), and Alan Sekula (1986) have been harnessed to address the institutional framing of this collection, I have attempted to refrain from reproducing the kinds of deterministic Foucauldian legacy these authors have largely contributed to. Instead, while harnessing their photographic critique to address the institutional use of the visual material within the SSC as well as its (historical) function as evidence of pathology, I hope to avoid imposing an ideological reading that the coercive history of scientific depiction offers. By engaging the SSC photographs first and foremost in terms of how they may have operated within the clinical domain, I both address and push against the analyses applied to the fields of criminology, psychiatry, and the racial sciences that largely saw photographs serve as a means of identification and ultimately subjugation.

To engage the appearance of this material, the study moves to trace a history of clinical image-making – particularly in relation to diseases affecting the face and skin.[20] Leaning largely on the writings of Lorraine Daston and Peter Galison (1992; 2010), Erin O'Connor (1999), Te Hennepe (2007), and to a lesser extent Barbara Stafford (1997), these authors offer a means to understand the historical aesthetic of depicting (conspicuous and disfiguring) disease. However, serving to construe the visual structuring of the syphilitic patient-body within the SSC, this approach is supplemented by a psychoanalytic framework: by drawing on understandings of the affective potential of seeing the damaged, wounded human body,[21] this study engages how clinical images serve to render the material nature of disease and the diseased a fixed, stable, and decipherable entity.

While Du Plessis's interpretative analysis of asylum images offers Roland Barthes's (1982) notion of the *punctum* (a detail within a photograph that deeply 'touches' an individual viewer) as an avenue for subjective engagement, I have attempted to push such readings further. By drawing on

[20] Venereal disease was allocated as a 'subfield' of dermatology (the study of the skin) during the 19th century and has remained allied with this field in contemporary medical practice.

[21] While I predominantly address Kristeva's notion of the abject in relation to conspicuous syphilitic rupturing of the human body, I supplement this reading by drawing on both Elaine Scarry (1985) and Jill Bennett's (2001) writings on the manner in which visually witnessing the wounds or wounding of another may prompt a bodily response in the viewer.

psychoanalytic understandings of the affective potential of images, this study attempts to outline how representation can both pacify and prompt emotive, even visceral responses to (clinical) images. Fundamental to this study is thus how photographs of the damaged, broken, syphilitic body have the potential to evoke an affective viewing experience – an unsolicited and instinctual psychological as well as bodily response (Barrett 2011:63; Shouse 2005 [Online]).

Framed according to the Kristevean notion of the abject (an essentially ambiguous and boundary-breaking psychological as well as physical threat)[22] and Hal Foster's appropriation of sublimation (the transformation of psychological and bodily instincts into language),[23] syphilitic symptoms and the clinical depiction thereof are addressed as respectively provoking and preventing a sudden psychological as well as physical experience of disgust and withdrawal (Kristeva 1982:3; MacAfee 2004:46). Drawing on subjective and embodied understandings of affect in this way, I also take a cue from Tina Campt's use of the term in her own engagement with photographic depiction. Calling it "a relatively simple approach" (Campt 2012:16) to the affective capabilities of the medium, I similarly focus on "how certain photographs move people […] why they catalyze forms of emotion, sentiment, meaning, and value" and function as "objects of feeling and relation" (Campt 2012:16).[24]

In order to interrogate the affective and even visceral qualities that (potentially) underlie the clinical images of the SSC, I thus draw from a variety of fields including film theory via the writings of Steven Shaviro (2006(1993)), art history and contemporary artistic practices as engaged by Jill Bennett (2001; 2002; 2005) and Michael Shapiro (2008), and even (though selectively) from disability studies via the work of Rosemarie Garland-Thomson (2009). In a critical return to the image-by-image address conducted, however, I turn to writings on documentary photography by the likes of Susie Linfield (2010), Mark Reinhardt (2007), and Mieke Bal (2006; 2007), as well as those of more traditional theorists on photography such as Barthes (1982), Susan Sontag (1973; 2003) and Judith Butler (2004; 2009). However, as many of these authors are neither strictly visual theorists nor have they written on clinical representation, this study essentially engages in an interdisciplinary approach in order to answer Ncube's call for a (re)assessment of historical clinical photographs.

[22] As neither subject nor object, the abject essentially comprises entities that cross the borders between inside and outside, that threaten limits and produce ambiguity (Kristeva 1982:1-4; Mansfield 2000:81).
[23] To make this argument I supplement Foster's address of the Lacanian image-screen (1996a; 1996b) with the writings of both Kenneth Clark (1957), and Lynda Nead (1992) as well as notions of externalisation and projection as discussed by Robert Crawford (1994) and Sander Gilman (1985; 1988).
[24] Like Campt I similarly draw on the writings of Eric Shouse (2005) in my outlining and use of affect.

By addressing the SSC in this way, I attempt to grapple with the contemporary archival life of the SSC that – while originally seeking to foster a necessarily disinterested, objective, and analytical engagement with the characteristics of disease – now sees their affective potential offered an opportunity to emerge.

0.4 METHODOLOGY

As this study marks the first enquiry into this disused collection of clinical photographs, I have attempted to incorporate relevant historical and contextual information where both necessary and possible.

Elizabeth van Heyningen (1984), Karen Jochelson (2001), and Allan Jeeves (2009) have addressed the historical prevalence of syphilis in South Africa via its concomitant social as well legislative effects (particularly towards non-European individuals), yet little attention has been paid to this disease in relation to Cape Town as a particular locale.[25] Although Maynard Swanson (1977, 2001), Harriet Deacon (1989; 1996; 2000; 2008), Howard Phillips (1979; 2012), and Sally Swartz (1996; 2010; 2014) have focused on other clinical conditions and their effect on this city (including mental illness, bubonic plague, influenza, smallpox, and polio), syphilis has remained conspicuously absent. Similarly, although the history of the medical school has been thoroughly (if somewhat romantically) catalogued in Louw's *In the Shadow of Table Mountain* (1969), information regarding the production of photographic material for teaching purposes remains sparse. Thus, while recent tracings of the history of GSH by Phillips, Digby, and Deacon in publications such as *At the Heart of Healing* (2008) have surfaced, these likewise provide few clues as to the facilities and protocols for clinical photography – and thus (potentially) the images of the SSC.

The lack of critical engagement with syphilis in Cape Town as well as the medical school's production and use of clinical photographs thus required a large degree of primary investigation to provide a discursive framework and historical background to this study. By incorporating personal

[25] Harnessed as a rest-point and filling station of the Dutch East India Company from the 16th century, Cape Town was soon transformed under British occupation into South Africa's 'gateway' as it provided access to the country's rural interior. Having witnessed a tremendous influx of foreign interest and industry by catering to mercantile and military movements, the city's history is punctuated by epidemics as well as some of the country's earliest instances of racial segregation driven by the threat of contagious disease. As such, the absence of literature on syphilis is a conspicuous hole in the historiography of both Cape Town and this disease in relation to South Africa.

correspondence with relevant medical school alumni,[26] articles published in the *South African Medical Journal* (*SAMJ*), the annual reports of Cape Town's MOH, the annual reports of GSH (only published from 1960 onwards), the 1948 report on the 'Inquiry into the Organisation and Administration of Groote Schuur Hospital', the archival documents affiliated with the 'Groote Schuur Hospital Collection' housed at UCT, as well as relevant resources in the Cape Town Archives Repository (KAB),[27] I have thus attempted to tentatively trace these intersecting histories.

In order to decipher the visual coding of subjects diagnosed with syphilis in the SSC, the study thus seeks to connect the discursive authority of medical knowledge and photography, as well as the bio-social nature of syphilis. As a fundamentally visual analysis, however, my engagement remains largely rooted in concerns surrounding the representational attributes of this collection of images. Thus, although material aspects of the 'Syphilis' photographs (such as physical wear and tear, processing errors, and inscriptions) as well as historical notions and popular understandings of syphilis are taken into account, the study of these images primarily focuses on how their depictive strategies produce the diseased body as an object of medical knowledge. It is thus an engagement with the deliberate stylistic structuring of the photographs that is fundamental to this study; however, it is likewise those instances of representational instability, of affective rupture, and a prompting of extra-clinical engagement that this project serves to address.

By retaining a hold on the multi-faceted, fractured, ambiguous, and possibly contradictory qualities that emerge within this clinical archive, my study seeks to forgo an overly deterministic reading of the visual material of the SSC. While such an engagement offers a largely inconsistent, unpredictable, and highly subjective interpretation, it has been conducted in an attempt to prevent forcing a predetermined reading on these images. As Edwards offers in her engagement with colonial photographs:

> Rather than starting from a series of observations and assumptions imposed on a body of material, the starting-point here is always with photographs themselves, the entangled histories and their significations, to look for an intelligible structure that will recognise both possible closures of meaning, and open spaces of articulation (Edwards 2001:2).

[26] I have been in conversation with emeritus professors DM Dent and JC 'Kay' de Villiers (prior heads of the surgery department), the ex-head of 'Medical Graphics' Eddie Wesselo, as well as engaged with Dr Jane Yeats, pathologist and curator of the PLC.

[27] Documents drawn from the KAB have been primarily minutes of Cape Hospital Board (CHB) meetings, correspondence of MOH and VD Officers (particularly those of O'Malley), as well as discussions surrounding the requirements and planning of VD clinics in Cape Town.

In order to conduct an analysis of the photographs within the SSC in this way, I have again taken a page from Campt in her description of a happenstance encounter with a photograph of a young, African American patient (Campt 2012:71-82). Framed by white linen and a glimpse of clinical stirrups, Campt's impression of the young woman changes during her engagement as the image shifts from a simple decontextualised snapshot to a gynaecological instance – with all the historical connotations of racial science and enforced sterilisation this implies. Thus in the final section of this thesis, an auto-ethnographic method of visual analyses is applied in order to 'open' and 'liberate' the SSC as a visual archive. Outlined by Deborah Reed-Danahay as a form of "autobiographical writing that has ethnographic interest" (Reed-Danahay 1997:2) in which an author's personal experience, history, and context is reflexively engaged, this concluding and reflexive engagement with the clinical material essentially operates as a kind of "self-narrative" (Reed-Danahay 1997:9) similar to that performed by Campt. To reflect on this highly subjective and personal analysis, I finally turn to the writings of Bal, Linfield, Reinhardt, Sontag, Butler, and Garland-Thomson amongst others in an attempt to theoretically reflect upon and ground this non-diagnostic (re-)address.

0.5 CHAPTER OUTLINE

Due to the historical, institutional, and representational complexities at work in the SSC, this thesis is divided into three discrete chapters, each seeking to address the 'Syphilis' photographs from distinct – yet ultimately interlinked – points of view.

Chapter I sketches the institutional production and use of syphilitic patient-photographs within the SSC to unpack how historically locating disease within the social body as well as the body of an individual served to bring certain kinds of 'sick' subjects under (medical) management. Drawing on Foucault's writings on medical perception, this chapter seeks to explore how disease (and more specifically syphilis) was historically produced within the clinical as well as social terrain. While briefly touching on the discursive and representational construction of this disease both internationally and in Cape Town, what is crucial to this engagement is how this disease's simultaneously conspicuous and insipid nature saw it emerge as a thing of both popular and scientific fascination and fear, scrutiny and uncertainty. As such, the appearance of syphilis on the body's surface is postulated as providing both public and institutional evidence of disease – visual and material proof that could be photographically captured and clinically controlled. By directing attention towards the strict structuring of photographic representation within the (human) sciences, this chapter seeks to uncover how clinical photography served to extend and visually fix the clinical

gaze. In relation to the SSC, this comes particularly to the fore with the development of a photographic department in GSH that sees a relatively consistent depictive strategy emerge during the 1940s – lending these images not only evidentiary status but also functional value. By focusing on the institutional origin and use of these visual documents (produced within the teaching hospital, harnessed for diagnostic use, clinical teaching, as well as medical research and publication) this chapter serves to contextualise syphilis and its photographic depiction within Cape Town's medical school.

Chapter II addresses the visual coding and aesthetic qualities harnessed within the collection in an attempt to locate how depictive strategies limit the affective potential of seeing disease and the diseased body. Focusing particularly on a series of depictive strategies evident within photographs produced during the 1940s, I explore how representational methods harnessed within these images serve to foster a diagnostic reading of their content. Drawing on a broader history of clinical illustration and photographic imaging of disease (particularly in the field of dermatology), this chapter unpacks how stylistic strategies serve to structure viewing experience. In the case of syphilis's conspicuous and disfiguring tendencies, medical depictions necessarily defer the visceral and affective attributes of this disease in order to render them useful as clinical evidence – and thus functional as teaching aids. As such, this chapter addresses how the structuring of content, composition, and technical attributes of the 'Syphilis' photographs serves to sublimate the material nature of the disease – essentially turning it into a legible entity for intellectual and objective engagement. However, while many of these photographs draw on a heritage of medical depiction to limit extra-clinical excess (including a visual 'grammar' of illustrating the symptomatic body, as well as standardised photographic protocols outlined in Chapter I), instances within the collection see the abject nature of the diseased body disrupt easy viewing. As such, the chapter concludes with an indication of the failure of representational attempts within the SSC to wholly render the syphilitic body an easily observed object of clinical enquiry.

The final chapter addresses how photographs within the SSC may thus foster a profoundly engaged and even empathetic response. In this section I therefore propose that even photographs produced and used for clinical purposes may nevertheless prompt readings that are not exclusively disinterested. By honing in on the affective potential of this image-collection, Chapter III operates on a case by case basis to unpack how individual photographs may function beyond their objectifying tendencies. Rather than fostering a sense of mastery and knowledge about the disease and the patients photographically pictured, I address how these images incite other forms of engagement beyond such visual and scientific absolutes. Adopting an extra-clinical gaze and auto-

ethnographic stance, I thus approach a selection of photographs as a possible gateway to look differently and engage medical representations beyond their clinical incentive. By adopting an alternative point of view, by fostering a different kind of look, by opening my own interpretation up to the nuances, ambiguities, and details of these images, I seek a reading that upends the singular diagnostic interpretation so rooted in a strict institutional framework. To reflect on this highly subjective and personal analysis, the chapter turns to debates surrounding the photographic depiction of pain, suffering, and trauma in an attempt to theoretically ground my non-diagnostic (re-)address. In this critical return, the potential problematics as well as usefulness of engaging (medical) photographs in this way is assessed along lines of empathic response and a recognition of subjectivity so limited (if not lost) in clinical image-making.

0.6 CONCLUSION

Imbued with extra-clinical excesses and unforeseen interpretations, this study sees patient-photographs offer a valuable yet greatly unexplored research area that Ncube suggests should be incorporated into a social history of medicine. By allowing for localised medical histories to be addressed in a way that opens up discussion beyond a singular, generalising, disinterested, and text-reliant investigation, this form of exploration provides the opportunity for the emergence of 'counter-narratives' to biomedical as well as social assumptions surrounding disease and the diseased. It is a means of engagement that Du Plessis refers to as a "hermeneutics of recovery" (Gewurtz in Du Plessis 2014:26) – one that sees the omissions and silences within casebooks and patient records somewhat retrievable. As such, this form of investigation provides an alternative mode of making sense of, and coming to terms with, patient-subjectivity beyond the kind of (textual) documentation produced by authoritative figures and institutional records. While photographs produced for and within such institutions are undeniably structured in accordance with and infused by medical discourses, the extra-clinical excess and diagnostically irrelevant inclusions within the SSC thus offer insight into the kinds of histories otherwise elided.

CHAPTER 1: ON SURFACE AND DEPTH: PHOTOGRAPHY AND THE PRODUCTION OF CLINICAL EVIDENCE

1.1 INTRODUCTION

As a highly prevalent illness in Cape Town during the first half of the 20th century, syphilis was a persistent subject of discussion in relation to health within this city. However its often insidious nature saw this disease likewise emerge as a clinical concern, particularly as it pertained to diagnosis, treatment, and prevention. Indeed, though fundamentally produced for purposes of research, education, and publication, the demarcated 'Syphilis' folders within the SSC bear evidence of this disease's troublesome nature. As a collection of photographic material, these images speak to both the disease's heritage as well as the institutional production of photography within the medical terrain. Seeking to place both syphilis and the SSC in context, this chapter thus addresses the social history of the disease as well as the clinical production and use of photography both historically and as it relates to Cape Town's medical school.

This chapter thus begins engaging the collection of photographs by attending to syphilis both as a clinical as well as a public health concern within Cape Town. Moving to unpack medical depiction more broadly, Foucault's understanding of the development of modern medicine, and its resultant way of seeing the human body and disease is outlined. By applying the clinical logic of health and pathology as well as the connection between individual and aggregate, this foundation serves as the starting point to engage the photographic depiction of both biological disease and social deviance more broadly. However, while both the depictive technology of the photograph and the highly conspicuous nature of syphilis suggests an easy conflation of appearance and knowledge, surface and depth, this chapter proves such assumptions to be highly unstable. Indeed, by coupling John Tagg, Elizabeth Edwards, and Erin O'Connor's respective writings on (scientific) photography with those of Mieneke te Hennepe, Rebecka Klette, and Harriet Palfreyman on conspicuous disease, I engage the evidentiary nature of the SSC's 'Syphilis' photographs as highly constructed. Cradling visible symptoms with unseen interior processes, these visual documents prove dependent on the depictive protocols of the medical school.

1.2 DISEASE AND PUBLIC HEALTH IN COLONIAL CAPE TOWN

During the first two decades of the 20th century, developments in the diagnosis and treatment of syphilis made tremendous strides. The isolation of the syphilis organism (the spirochete *Treponima Pallidum*) in 1905, the development of the diagnostic Wassermann (blood) test in 1906, as well as the effective fine-tuning of mercuric and arsenical compounds that at their zenith with the development of the so-called 'magic bullet' Salvarsan or 606 in 1910 ushered in growing international optimism surrounding the possible cure of this disease (Jochelson 2001:79; Shmaefsky 2010:75-80; Van Heuningen 1984:195). While the previous century had seen the diagnosis and treatment of syphilis remain largely speculative and palliative, the clinical strides made during the early 20th century saw syphilis emerge as a disease that could be both prevented, managed, and remedied.

Within South Africa, the consequences of these international developments found particular expression in shifts not only in diagnosis and treatment but in the very management of individuals suffering from the disease. While the British-inspired Contagious Disease Acts (CDA) of the 19th century had implemented compulsory registration and confinement of syphilitic individuals in designated lock hospitals,[28] the 20th century saw a decisive move to treat this disease like any other (De Korte 1914:20; Jochelson 2001:79-82).[29] Culminating in the abolition of the repressive CDAs that had disallowed those infected with the disease access to general hospitals, the Union of South Africa began to implement subsidised, anonymous treatment with the passing of the 1919 Public Health Act (PHA) (Jochelson 2001:81; MacPherson 2001:176).[30] As such, the state began to take on the responsibility of syphilis-related public health initiatives including free diagnosis, the funding of voluntary treatment, as well as the partial subsidy of educational material (Jochelson 2001:80-81; Van Heyningen 1984:194). No longer forcibly confined and notifiable, the management of this

[28] In Cape Town women who had been admitted to the New Somerset Hospital (NSH) for clinical treatment were suddenly to be confined in the Cape Town Lock Hospital alongside registered prostitutes, whose inspection and medical supervision had likewise taken hold in this facility (Laidler 1940:72). Incarcerated in this institution situated alongside the Roeland Street gaol (now the Cape Town Archives Repository), Cape Town's syphilitic women became physically as well as discursively associated with criminal activity and both materially and visibly removed from society through legislative management (Setel, Lewis & Lyons 1999:225). The conflation of venereal disease, improper sexual conduct, and criminality in this city thus echoed those prevalent throughout Europe in the 19th century.

[29] The legislation that had emerged in the late 19th century was considered locally and internationally to have led to nothing but the unwitting spread of disease by encouraging an atmosphere of silence and concealment (De Korte 1914:19; Quétel 1990:145; SAMR 1914:240). As a result, South Africa witnessed a push to abolish health legislation and procedures that had fostered this behaviour – a development evidenced by the emergence of the National Committee for Combating Venereal Disease (NCCVD) – a British philanthropic public health organisation that established a Cape branch in 1917 (Jochelson 2001:78-80; MacPherson :176).

[30] The PHA marked a distinct shift in the treatment of European syphilitic patients in South Africa – one that saw welfare initiatives, public education on moral sexual conduct, and out-patient treatment as a solution to VD (Jochelson 2001:7). While Jochelson contends that in comparison 'African' sufferers remained highly regulated by pass laws and areas acts, it is unclear how Cape Town's predominantly 'coloured' non-European population were affected.

disease and those infected with it necessarily shifted towards fostering popular knowledge surrounding prevention, diagnosis and treatment – all while fostering a sense of personal responsibility for both individual and collective health.

Having undergone various stages of industrial development and geographic expansion, the city of Cape Town was both prosperous and pauperous (Louw 1969:82, 211). With the perpetual influx of unskilled rural job-seekers of all races, the city became ever more overcrowded and its municipal resources ever more overextended. The swamped labour market saw impoverished mixed-race, inner-city areas (such as Observatory, Woodstock, Salt River, and District Six) overpopulated as gainful employment became ever more difficult to obtain in the context of the 1930s and the Great Depression (Klausen 2004:114-115). As a result, Cape Town (like many other urban centres in South Africa) witnessed contagious disease and poverty emerge as coterminous conditions.

While the previous decade had seen political and public concerns target the social and physical decline of South Africa's 'native' (in the form of influx control and segregationist policies) as well as the white population (via preferential hiring and the Carnegie Commission),[31] the 1930s saw the cementing of concerns surrounding the economic and geographic proximity of poor whites to other racial groups.[32]

Perceived as hotbeds for immoral conduct in the form of crime, alcoholism, prostitution, and racial intermingling (Louw 1969:17), the city's slum-like areas received ever greater attention as a target for medical management.[33] Culminating in the Slums Act of 1934, the 'problem' of poverty, racial intermingling, and contagious disease amongst the working-class had come prominently to the fore in Cape Town specially, as well as throughout the country (Hyslop 1995:64). Seemingly verified by national medical data (Dubow 1995:186), assumptions about what was held to be the unnatural and immoral nature of Cape Town's (principally coloured) non-European population was validated by its apparent susceptibility to syphilis. [34]

[31] Published as five reports in 1932, the Carnegie Commission essentially sought to investigate South Africa's 'poor white problem' in the span of 1929-1930 (Dubow 2010:282; Jochelson 2001:55).

[32] Framed in accordance with poverty's 'levelling' ability (Klausen 2004:20), concerns surrounding both contagious disease and miscegenation saw ever greater focus placed on segregation, slum clearance, and housing schemes (Dubow 1995:181).

[33] Evidenced by the national discourses of the Tuberculosis and Influenza Commissions of 1914 and 1918 respectively (Maylam 1995:25), the correlation between infectious disease and urban slum environments manifested themselves in Cape Town particularly in the aftermath of the flu epidemic.

[34] Historically it was the spread of contagious and thus potentially epidemic disease that saw the indigent classes emerge as both an economic necessity as well as a medical, social, and political danger (Foucault 2000:152-153; Gougelet 2008-2010:60; Sekula 1986:33). As such, the need to medically manage diseases that had the potential to cripple the economic and producing power of the state (via its crippling of individual labouring bodies) may be

Documented in the official reports and published writings of both Dr TS Higgins (Cape Town's Medical Officer of Health) and Dr CK O'Malley (the city's Venereal Disease Officer), the high level of syphilis in Cape Town's non-European community painted a picture of ill-health that appears to have confirmed national fears surrounding the disease-ridden, mixed-race body. Emphasising the effects of poverty and overcrowding on social, moral, and physical health of impoverished citizens of all races (Higgins 1929:301, 303; Higgins 2013(1942):99; O'Malley 1940:459), discussions motivated by data on venereal and contagious diseases in Cape Town validated the need for ever greater medical management of these individuals. As such, both in Cape Town as well as the country as a whole, concern regarding the undetected and unhindered spread of syphilis within the population appears to draw on an understanding of individual illness and public health similar to that identified by Foucault (2003(1963)) as having emerged in Europe centuries earlier (Armstrong 1985; Gougelet 2008-2010; Gutting 1989).

1.3 THE ORIGINS OF MODERN MEDICAL PERCEPTION

Locating the development of modern medicine at the cusp of the 19th century, Foucault indicates how 'the clinic' (an institution for medical teaching) emerged to cater for the growing poor urban working classes. Within the communal space of the clinic, medical study had shifted its focus from the primacy of generalised, abstracted, and theoretical knowledge of old to ever closer engagement with the material bodies of patients: isolated in beds, examined, extensively described, compared, and finally (upon death) dissected, the human body emerged as a legible entity – an object for medical inquiry (Butchart 1998:22; Gutting 1989:119).

In addition to the new-found focus on the individual corporeal body, the patient was shifted from the private home to the communally occupied clinical ward. Moved into the 'neutral', ordered, yet shared space of the clinic, the physical status of patients and the progression of disease was annotated and documented via detailed and exhaustive description that secured their unique set of clinical characteristics (Armstrong 1995:395; Dreyfus & Rabinow 1982:159; Foucault 1995(1975):192; Gutting 1989:122; Rose 1994:59-60). Placed under medical scrutiny, patients within the wards of the clinic were rendered perpetually visible: turned into a highly individualised

understood to have prompted the development of modern, clinical medicine. In Cape Town, concerns surrounding the prevalence of syphilis in the non-European community were seemingly confirmed by the particularly high level of venereal disease noted in 'Municipal Treatment Centres' such as that of impoverished, racially intermixed Woodstock (O'Malley 1932:51, 79).

'case' in which the discrete patient was secured in an objective "field of writing" (Dreyfus & Rabinow 1982:159) in the textual form of the medical case-file or 'dossier'.

Crucially, these practices hinged on the belief that the clinical environment fostered a 'pure' gaze – a kind of perception that saw not only the individual body of the patient take precedence but one that likewise professed a perfect correlation between what could be seen and what could be known.[35] The ideal of a "speaking eye" (Foucault 2003(1963):114) appears at the very heart of the clinical endeavour: seeing all occurrences of disease, achieving ever more clarity and transparency, gleaning ever more knowledge through experience, the medical gaze allowed for that which was observed to be seamlessly translated into language and thus available for dissemination (Foucault 2003(1963):114-115). For clinical teaching and the progression of medical knowledge, the ability for what was seen to be sublimated into speech and writing was crucial to allow discoveries to be shared without the need for primary engagement or personal viewing. As such, knowledge about the body and about disease could be acquired and distributed so that clinical care could be provided without prior first-hand encounter with illness.

Through this transcription of individual ailing bodies as highly particularised cases of disease, the process of documentation within medical practice (and made manifest in the written 'case') is seen by Foucault as a distinctive kind of clinical 'apparatus' – a mechanism or strategy that produces and fixes the individual as an entity that may be categorised and ultimately known. However, while the "new classroom of the ward round" (Butchart 1998:22) and the manufacture of the clinical case can be seen to have opened up the discrete body and instance of disease for detailed scrutiny, this practice likewise produced the possibility for aggregated assessment. The compilation of clinical information (both in the communal space of the ward and the filing cabinet) allowed for regularities and discrepancies *between* and *across* multiple bodies and instances of disease to be collected, described, and assessed (Foucault 1995(1975):190; Rabinow 1984:22; Sekula 1986:16-18).

However, while in the clinic, this aggregated understanding of the (diseased) body came to the fore, medical interest also moves from a study of disease across symptomatic patients towards ever more individualised and localised instances within bodily lesions (Foucault 2003(1963):140, 169; Gutting 1989:132). Indeed, it was in the combined study of disease across multiple bodies in both life (the ward round) and death (autopsy and dissection) that the human body could emerge an object of inquiry in and of itself, rather than in confirmation of historical writings and contemporary theories. Most notably with the development of anatomical pathology, medical practitioners began to focus

[35] This way of seeing will be further addressed in the following chapter.

on discrete manifestations of illness – grounding medical knowledge ever more in the very material state of the individual body. Through the process of anatomical dissection, the human body was understood and represented as a fixed and functional machinic interior (Butchart 1998:72) – an aggregated, idealised model achieved through the comparison of multiple and varying bodies made available within the communal space of the ward (Butchart 1998:22; Gutting 1989:130). Thus, as anatomical knowledge saw the model of the healthy body emerge as an ordered and predictable hidden internal structure, disease emerged as an infiltrating and corrupting influence upon this 'normal' condition of 'health' – an unseen presence operating *within* the body that could be identified via dislocated symptoms. The human body thus became understood as a disease-containing depth in which illness was located as material change (Butchart 1998:98). No longer an autonomous entity with essential properties, disease was seen to develop coterminously and interactively with(in) the patient, and so the body *itself* became understood as ill (Foucault 2003(1963):136; Gutting 1989:130). Disease was thus made sense of as an essentially corrupting entity – one that resulted in the normal body becoming essentially 'deviant' in relation to its state of health.

The (anatomo-)clinical gaze thus emerged as a model of *perception* to illuminate the dark, invisible, internal aspects of disease made materially manifest in the body and rendered visible via the autopsy. As it was in death that the disease could be studied and made legible and its findings applied to the bodies of the living, the (dead) body became foundational to inspection and the construction of medical knowledge. This 'projection' of the knowledge of the corpse onto living patients (what Foucault calls "*embodied* in the *living bodies* of individuals" (Foucault 2003(1963):196, original emphasis)) thus marks for Foucault the first instance in which the human body could be engaged as an object. As such, it was the gaze fostered within the medical terrain that saw the kind of visibility of the clinic and of anatomo-clinical medicine "inscribed in social space" (Foucault 2008(1977):9) and to practices in institutions outside the strictly medical field (Rajchman 1988:98). The medical model of observation fostered by the 'examining apparatus' of the hospital thus emerged as a kind of 'visibility' appropriated for the differentiation and evaluation of individuals (Rajchman 1988:98-99). The "individualization techniques" (Rabinow 1984:14) fostered by the clinical case thus saw the objectification of the human being become a model for surveillance more generally. And so, the authoritative observation and documentation practiced by the clinician within the clinic (and made

manifest in the case-file) emerged as but one of various instances in which Foucault identifies a 'reconfiguring' (Butchart 1998:24) of the human body in relation to state power.[36]

1.4 MEASUREMENTS AND AGGREGATES

Positioned within a correlated framework, 19th century medicine saw both the body and illness positioned in relation to statistical norms and means traced via a correlation of discrete clinical cases (the human body known in all of its individuality). Becoming ever more standardised, individual inscription and group assessment saw 'man' and 'disease' emerge as quantifiable entities that could be mathematically traced along a fixed mean – an aggregate or 'pattern of distribution' that could be charted and mapped (Gould 1996:33; Rabinow 1984:20; Rose 1994:60). As a study of illness across bodies, the 'clinical case' provided not only an abstract logic within medicine, but in addition offered a means by which the health of populations could be assessed (Rose 1994:55). As a result, the individualising practices of clinical medicine provided a macro understanding of health and illness that served to identify, categorise, and document groups of people in relation to a binary model of health and disease, of the normal and the pathological (Foucault 2003(1963):36; Gutting 1989:117, 136; Lock & Nguyen 2010:45).[37] Taking root in the latter half of the 19th century, this "medical bipolarity" (Foucault 2003(1963):35) was to find particular expression in relation to society at large.

Rendered an object of scientific scrutiny, investigation, and ultimately knowledge, the medically deciphered human body was placed at the forefront of opening up this objectifying possibility particularly with the development of anthropometry, phrenology, criminology, but also psychiatry and sexuality (Downing 2008:36). The study of the human body within emerging social sciences (including criminology and psychiatry) began to follow a similar pattern of observation, documentation, and display that had been fostered by and within the clinic. An adoption of the modern medical way of seeing produced the human being as a 'describable individuality' as fostered by the case (Lalavani 1996:24-25). Seen in the social application of statistical data – facilitated by strategies of case-analysis and comparison – the collective health of a population was made available

[36] Particularly in his Madness & Civilization (1988(1965)) and Discipline & Punish (1995(1975)), Foucault identifies how the incarceration, observation, and correction of the 'insane' and the 'criminal' drew on a need to maintain a healthy and economically productive state.

[37] What is significant about this development is that the normative body emerged as a numerical (rather than corporeal) ideal, and that unyielding, disparate, and anomalous anatomies and manifestations of disease were thus recognised not merely as inconsistencies but as deviant and abnormal (Gutting 1989:123; Lock & Nguyen 2010:45).

for monitoring and improvement (Gougelet 2008-2010:46). Measured in the form of birth and mortality rates in particular, the health of the communal body of society – the 'social body' – served to indicate how discrete individuals within society impacted the health of the general public and thus required regulation for common wellbeing (Foucault 1978:139-140; Gougelet 2008-2010:45).

The 19th century's notion of 'deviance' thus focused on individuals whose physical, mental, and moral behaviour posed a threat to social order and thus required 'correction'. Consequently, the prison, asylum, and hospital became spaces where the surveillance of individual bodies enabled a production of knowledge about those housed within and without institutional walls through techniques of seeing and writing. While the case-file provided a textual description of "everyday individuality" (Foucault 1995(1977):191), the development of photography in the mid-19th century saw this imaging technology begin to supplement and even supplant these evidentiary documents. As such this representational medium was harnessed to capture the likenesses of those convicted of criminal behaviour, the mentally ill, as well as the clinically unwell in a manner that saw not only individuals visually located as discrete instances of pathology, but harnessed to produce knowledge of what 'the pathological' looked like.

1.5 PHOTOGRAPHING DIFFERENCE

Fuelled by concerns surrounding the health of the population, the fear of unseen social threat and the future of the race seem to have fostered the need to identify and classify individuals along an axis of normal and abnormal, healthy and pathological. To achieve this, the so-called 'human sciences' largely drew on the logic of physiognomy – a (pseudo-)scientific study of the face that suggested an inherent link between appearance (the biological body) and character (an individual's internal essence). As a scientific study of the body and the face, physiognomy was "predicated on the ability to draw inferences from "known" surfaces to unknown depths, and from parts to wholes" (Stafford 1997:107).[38] Photographic depictions of the human body were harnessed to illustrate and thereby *locate* deviance within certain kinds of bodies and conditions – presenting threatening traits (and individuals) for identification and thus as potential subjects for regulation. By cementing notions surrounding the corporeal manifestations of character – essentially the reading of the body

[38] While physiognomy is not key to this study, the fact that a reading of bodily surface became ever more fixed as an objective and thus legitimate investigation is crucial to make sense of how photography became so easily absorbed into the human sciences. Essentially, the long-standing study physiognomy seemed to confirm the link between external appearance and internal essence as offered by the facial features and expressions (Stafford 1997:89, 107-108).

as an index of unseen internal organic goings-on – photography operated to evidence deviant characteristics.[39] In no other practice is this more evident than eugenics and its push to inhibit racial degeneration and promote "social betterment through breeding" (Sekula 1986:42).[40] By focusing on individuals and individual conduct deemed detrimental to the stability of the social order (such as madness, criminality, and contagious disease) intellectual, emotional, and behavioural traits became locked down as inherently deviant.

Photography's primarily indexical[41] attribute – its self-evident ability to directly trace the material world – saw the medium emerge as the ideal tool for scientific investigation and documentation. As a mechanical image-maker, the camera was held to embody a mode of depiction untainted by human intervention and unconscious bias – to turn reality into representation. Able to literally re-present the natural world, the photograph was quickly harnessed as a technology to produce visual evidence within the scientific domain. Adequately timed for use in the developing human sciences of the 19th century, the invention of photography was celebrated for its ability to allow objects to seemingly 'paint' themselves "without the help of art, without the least contribution of the hand of man, by the sole effect of light, and always identical in the least details" (Alfred Donné & Léon Foucault cited in Daston & Galison 2010:131). Offered up for detailed observation, measurement, and (visual as well as textual) description, those depicted appear to have been rendered ever more legible and thus knowable across various scientific disciplines (Lalvani 1996:115-130; Green 1985:128).

In order for its use within the sciences to be maintained and indeed valorised, however, both the body and its perceived re-production professed by photographic representation required specific framing in order to function as evidence (Tagg 1988:4-5). In particular, Tagg underscores a decided

[39] Photography could thus be harnessed for scientific purposes due to not only its ability to concisely capture and confirm scientific assumptions and its unblinking ability to record bodily phenomena, but essentially due to its capacity to let the "telling language of nature" (Diamond 2010(1856):2) speak for itself.

[40] Taking mental, behavioural, and physical characteristics as inherent traits that could be hereditarily passed on, eugenics validated social and particularly class hierarchies (Green 1984:8, 14). Thus naturalised, class differences provided validity to the regulation of marginal groups. Eugenics proposed a scientific, objective, irrefutable means by which individuals and peoples could be biologically demarcated and differentiated in relation to their productive place in society in comparison with their potential to threaten social stability and public wellbeing (Green 1984:9). By turning societal threat into an anatomical or hereditary entity, the physical control of certain threatening individuals (as exemplified by the late 19th and early 20th century practices of incarceration, compulsory treatment, and even sterilisation) was deemed to prevent the 'spread' of dangerous and deviant characteristics.

[41] "[F]orced to correspond point by point to nature" (Chandler 2007:43), the photographic process essentially generates a trace of that which it represents – chemically fixing the light reflected off objects before its lens (Jay 1994:128-129). The almost physical connection between an object and its photographic likeness thus sees this form of representation as indexical – a term used by Peirce to describe a direct, almost tactile relationship between an image and that which it depicts (Chandler 2007:37). In a similar vein, Barthes's (1977:196-197) discussion on photography likewise sees this form of representation as an 'analogue' of the real – an unmediated reproduction whose purely transparent quality hinges on the photographs mechanical and chemical production. For Barthes photography thus presents itself first and foremost as solely denotative, message-less medium.

hollowness of the photographic medium despite its apparent evidentiary density: resting on institutional, social, and representational processes, photographic truth, like medical knowledge, is seen to function only within a particular framework. As put forth by Tagg:

> Photography as such has no identity. Its status as a technology varies with the power relations which invest it. Its nature as a practice depends on the institutions and agents which define it and set it to work. Its function as a mode of cultural production is tied to definite conditions of existence, and its products are meaningful and legible only within the particular currencies they have. Its history has no unity. It is a flickering across a field of institutional spaces. It is this field we must study, not photography as such (Tagg 1988:63).

The evidentiary nature of the photographic medium was essentially constructed via the scientific authority of the institution in which it operated, the faith in the 'experts' who used it, and the legitimacy of the intellectual field that both produced it as evidence and harnessed it as proof. It is what Daston and Galison refer to as the 'ideological force' of photography and the instilled trust in its direct relationship to reality that saw its continued use within the scientific domain (Daston & Galison 1992:111, 114). To aid these efforts, scientific photography appears to have harnessed those individualising strategies of isolation and detailed description established within the individuated case-file. Unlike its textual counterpart the visual nature of this medium seemed to offer its content up for immediate consumption and inspection in addition to making individual 'cases' available for comparative scrutiny. As a result, the need to develop methods of exact, uniform depiction became ever more pressing towards the end of the 19th century and finally culminated in a standardised method of portraiture developed by Alphonse Bertillon.

Driven by the intent to combat criminal recidivism, Bertillon championed the standardising of the photographic portrait via a combination of precise bodily measurements, a methodically posed frontal and profile portrait (the taking of which was stipulated down to the lighting conditions and distance between sitter and the camera), the description of unique physical marks (scars, birthmarks, tattoos, and the like), as well as those aspects the monochrome nature of the medium at that time was unable to indicate (including colouration and pigmentation of the eyes and skin) – all transcribed on a single identification card (Ewen & Ewen 2008:258-260). By producing a corpus of precisely individuated visual-textual documents, Bertillon's method allowed for repeat offenders to be readily recognised as such by locating their visual and metric likeness amongst those previously apprehended.

What Bertillon's system appears to have most crucially provided, however, is the first means by which photographic images became comparable. By ensuring that the methods of posing, lighting, and finally photographing the body remained consistent for every individual imaged, the homogenous depictive strategies ensured not only an accurate replication of a person's physical features but that the similarities and differences between one image and the next could be attributed to *real* variations between one person and another – rather than attributing them to representational imprecision or depictive errors. As such, the photographic strategy developed by Bertillon saw photography emerge to serve a fundamentally instrumental function – one that had consequences for the bodies imaged (Sekula 1986:7, 58).[42] Bertillon's development of "technical rules and protocols" (Tagg 1988:9) for photographing the unique and individual human being can be seen to have not only confirmed the indexical character of photography and thus the potential application of this medium for identification (due to the similarities recognised between the photographic image of the individual and an experience of them in real life), but likewise the potential of this medium to highlight unique features as well as commonalities across an array of images and thus an array of bodies. Setting up the possibility for comparative study, the case-files created via Bertillonage thus produced a collection that, in their detailed description of individual lawbreakers, generated a body of knowledge about this delinquent 'group' as a whole.[43]

Photography thus proved similarly useful for the identification, quantification, and confirmation of racial difference during the 19th century. Following an anthropometric tenet, the precisely positioned face and body was deemed to produce visual documents that not only provided complete and accurate renderings of discrete individuals, but opened up the possibility of anatomical comparison across multiple depictions (Maxwell 2008:29-30). Harnessed particularly for the appraisal and measurement of facial or cranial characteristics, the full-frontal positioning of the body stems from the necessary scientific scrutiny of the face and head to render the body a legible, demonstrative, and ultimately quantifiable entity.[44] Often stripped of clothes as well as context, the uniformity

[42] In the case of the criminal portrait for instance, the very real consequences of this kind of imaging would be arrest and incarceration.

[43] Despite these developments, it is evident that photographic practice in the sciences continued to lack standardised application or, at the very least, that standard methods of depiction were inconsistently applied across institutions, disciplines, and countries. The troublesome nature of assuming the influence of the historical representational developments in depicting physical as well as social pathology is evident in the photographic representation of prisoners in Britain: despite the long history of and legislative permission to photograph those accused of criminal activity, Tagg namelly indicates that it was only during the late 1930s that attempts at standardising and overall 'improvement' of prisoner-photographs emerged (Tagg 1988:76). It would appear that despite the representational developments of the late 19th century strategies of scientific and institutional depiction thus continued to vary.

[44] Rendering both body and image an a-historical, decontextualised, universal entity, this standardised method of depiction was seen to be an essentially 'purified' mode of scientific image-making.

achieved within anthropometric photographs a la Bertillon saw a limiting of the 'visual noise' created by personal attire, background, and compositional variations (Zamorano 2011:440).[45] Thus, despite the accurate rendering of individuating detail offered by such photographs, this form of precise depiction saw the human emerge less as an individual person and more as a wielder of particular physical features that spoke to the characteristics of a group. This functional, scientific coding of the discrete body saw the direct eye-level gaze and mug-shot front-and-side depiction indicative of the body-made-image – a calculable and scrutiniseable entity. As a result, during the 19th century this form of picturing spoke within popular understandings to a certain 'bluntness' associated with the lower classes (Te Hennepe 2007:161). While the precisely posed body of aristocracy (an off-centre positioning of the body accompanied by averted eyes harnessed within portrait painting) suggested leisure, nonchalance, and (in effect) of conscious self-presentation, the "head-on stare" (Lalvani 1996:66) instead suggested a body *put* on display – of an inexperienced, naïve and powerless arrangement that renders the individual subject *to* the camera, the photographer, and the viewer's inspection.[46] Used both historically (in the depiction of the criminal and the non-Western subject) as well as in contemporary forms of administrative or institutional depiction (in the case of visual identity documents, like passport photographs for instance), the frontal mode of depicting the face is thus underwritten with associations of enforced inspection and the requirement to present facial features for the scrutiny of another – of being compelled to show oneself, for one's body to 'speak', rather than a personal and considered self-display.

Bertillon's method of standardisation thus saw the photographic medium operate as an evidentiary and administrative tool for identification. For Edwards, this faith in the photographic image (what Barthes calls "the special credibility of the photograph" (Barthes 1977:200)) is, however, wholly dependent on a strict *regulation* of this technology. In her writings on the use of photography within the field of anthropology, Edwards demonstrates that in order for this medium to wield "evidential authority" (Edwards 2011:162) it was necessary to ensure the invisibility of its operations through decisive management of that which fell before the camera's lens. Indeed, the need for strict protocols and procedures was likewise recognised as necessary to ensure the production of usable clinical photographs as outlined by Albert Londe, a key figure in the institutional establishment of medical photography during the latter half of the 19th century (Te Hennepe 2007:162). What emerges in

[45] Bertillon's method was harnessed by the likes of Arthur Chervin who famously displayed both the naked and clothed bodies of Bolivian 'Indians' from both frontal and profile view. For a more detailed address of Chervin's work in Bolivia see Zamorano's 'Traitorous Physiognomy' (2011).

[46] These associations are clearly indicated by the popular 1853 caricature of Honoré Daumier's Pose of the natural man. Pose of the civilized man (Lalvani 1996:66).

Londe's outlining of appropriate photographic techniques of depicting disease is the need to 'rein in' and essentially control this depictive medium in order to render it useful to this discipline.[47] Thus, the utility of a 'complete' rendering of the human face and body according to Bertillon's technique was not lost on the medical field. Although this method was taken up somewhat sporadically,[48] the coupling of full-frontal and profile view was harnessed to comprehensively represent symptomatic features. Like in the case of Bertillon's *portrait parlé* (speaking likeness), clinical 'mug-shots' similarly see the patient emerge two-fold: to reveal symptoms on the body in all their detail and totality as well as offer a comparable case for aggregate scrutiny.

1.6 SYPHILITIC STIGMATA

For the sciences such as medicine that saw images harnessed for the dissemination of clinical knowledge (particularly that surrounding the identification, recognition, and treatment of disease), the photograph promised a kind of depiction that offered a "rigorous fidelity" (Alfred Donné in Daston & Galison 2010:131) between an object in nature and its two-dimensional double. The medical field (like many of the sciences) was thus quick to adopt this pictorial technology and its promise of verisimilitude (Te Hennepe 2007:146-147). However, the use of this medium within the field of medicine drew on a broader (scientific) understanding that the surface of the body spoke of unseen internal processes. This belief that appearance served to indicate the hidden condition of a human being was rooted in an overall understanding of the body as a legible text – a concept harnessed within the medical sciences as well as other fields of investigation that took the human being as its object of study (including psychiatry and criminology).[49] As ever more emphasis

[47] With the intent of establishing a standardised process of photographic image-making for physicians wishing to immortalise their own clinical cases, Londe was one of the first to systematically outline and publish his method for depicting the symptomatic patient-body. Londe's efforts thus facilitated both the move of clinical photography from the portrait studio to the hospital, as well as professionalised depictions created within this domain (Te Hennepe 2007:163). The control of medical photography thus shifted both spatially and aesthetically, and the clinical photograph became ever more functional for medical purposes.

[48] This representational strategy appears to have been harnessed to depict (plastic) surgical procedures – particularly in the form of pre- and post-operative imagery as evident in the photographs of the Macalister and Gillies Archives (UK and Queens Hospital, Sidcup respectively). Originating during WWI, these are the earliest examples I have located that clearly don this kind of 'mug-shot' format. Indeed, the representational style of the police 'mug-shot' so prominent in the human sciences of the late 19th century are absent from the great collections of historical medical photographs including those of the Mütter Museum of Philadelphia, the Burns Archive of American medical photographs, the photographs of London's St Bartholomew's Hospital (hosted by the Wellcome Collection), as well as the Bristol Royal Infirmary.

[49] Paralleling conceptions of the diseased body, the notion of criminality as an essentially biological condition allowed for the locating of inherent 'criminal' characteristic within the physical body. Promoted by figures such as Cesare Lombroso, Havelock Ellis as well as Francis Galton, the measurement and identification of distinct cranial formations,

became placed on the body as an object that could be 'read', its pathological ‘stigmata' deciphered and decoded by experts trained to tell normal from deviant, scientists believed that physical, mental, and moral degeneration could be identified in the individual body and thus located in society (Jackson 1995: 322-324).

Championing the use of photography for these means, Francis Galton created a technique of composite photographic portraiture in an attempt to provide evidence of generic characteristics of criminality, insanity, Jewishness, as well as disease (Hamilton 2001:97-98).[50] Believing that his generic images provided a visual statistic of deviant traits common to particular types of human beings, Galton envisioned that the photographic identification of commonalities could be subsequently used to identify hereditary traits within individual members of society. Applied in relation to disease for example, Galton sought to locate the typical facial characteristic of those suffering from consumption (Galton & Mahomed 1882:476; Hamilton 2001:97-98). Leaning on the notion of 'diathesis' (the belief that the face could indicate an individual's proclivity for certain ailments) (Galton & Mahomed 1882:475), the physiognomic faith placed in both the body and the photograph can similarly be seen to have manifested itself in the medical terrain. As such, this belief in the ability to read the physical features of the body for (inherent) signs of disease saw a similar linking of surface and depth, of the conspicuous and unseen as fostered by physiognomy.

By drawing on physical anthropology in particular, this belief in such "'typologies' of deficiency" (Jackson 1995:332) spoke to the wider application of this need to locate deviance within the social body. Carefully individuated through precise forms of writing and picturing, bodies that posed a threat to societal well-being were subject to a "compulsory visibility" (Lalvani 1996:224), distinct from the invisibility or chosen self-representation granted to the normal and the healthy. Providing a means by which degenerate traits of individuals could be visually represented, societal threat was thus turned into a locatable corporeal entity that served to rationalise legislative practices of incarceration, compulsory treatment or other forms of 'correction'.[51]

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facial features as well as qualitative details saw the criminal body framed and located as a particular 'type' of human being (Green 1984:10).

[50] By exposing multiple photographic negatives of faces successively atop one another, Galton's method of composite portraiture saw unique details of faces become blurred while common features remained clear. Galton believed that he was thus producing generalised images of human 'types' with particular facial attributes (Pavlich 2009:175). For further discussion see George Pavlich's 'The Subjects of Criminal Identification' (2009) and David Green's 'Veins of Resemblance' (1984).

[51] In examining the development of scientific imagery, Gilman posits a clear correlation between the photographic representation of criminality, prostitution, and madness as having drawn on physiognomic assumptions. In depicting figures of 'the criminal', 'the prostitute', and 'the insane', deviant characteristics were not only rendered "immediately

Considered a particularly syphilitic threat during 19th century, the body of the prostitute was likewise thoroughly deciphered and imaged along these lines: her seemingly anomalous or even enlarged sex organs (particularly labia and buttocks) construed as the result of exposure to syphilis as well as an indication of her innate primitive and promiscuous nature. However, her face (and particularly ears) too was understood to bear the markers of her deviance (Gilman 1985a:221-223).[52] Pinned down via conspicuous 'visual markers', the tainted condition of the face exposed the both late-stage and congenital syphilitic status to the scrutiny of others (Klette 2013:17; Klette n.d:20-21). As such, the visual characteristics of syphilis served to fix not only disease but also racial degeneration, physical decay, moral pollution, and overall societal deviance in certain locatable bodies. Identifiable for both the scientific and the popular beholder, syphilis and its (potential) distributer could be discursively fixed as dangerous, threatening entities in need of regulation and control (Gilman 1985a:229-231).[53] Cementing the connection between excess sexuality, disease, and physical appearance within the scientific domain as observable, decipherable, and essentially locatable traits (Gilman 1985a:212), the prostitute was betrayed by both genitals and face.

Indeed, while not hinging on the theory of diathesis, syphilis was popularly understood to be highly conspicuous and legible to both the scientific expert as well as the public at large. As the nose was commonly disfigured in the tertiary stages of syphilis, this most characteristic and visible body part betrayed the syphilitic condition of its bearer. While other symptoms could be hidden beneath clothing or disguised with makeup (particularly genital sores, rashes, and skin eruptions that commonly emerged during the secondary stage of the disease) the nose could reveal the otherwise hidden symptoms of the disease (Klette n.d:15). Indicating not only physical deformity and material corruption but also immoral behaviour. The misshapen structure or complete decay of the nose compounded physiognomic readings of the face. In the case of congenital syphilis, the conspicuous nature of the disease likewise comes to the fore in relation to what is medically known as the 'facies' of disease – a term used to describe the characteristic distinct set of physical features, expressions, and movements typically caused by a particular kind of disease (Kinirons 2010:175; Mir 2003:1,

and visually identifiable" (Gilman 1987:103) but also 'limited' to those visually and discursively allied with the condition.

[52] See Gilman's discussion of the scientific conflation of the prostitute and the 'Hottentot' female in *Difference and Pathology* (1985b).

[53] This need to locate syphilis likewise appears to have been made manifest in 20th century South Africa via a harnessing of the 'clinical logic' of aggregates. While not leaning on visual references, Cape Town's MOH reports serve as an attempt to locate this disease within the social body – to render it and its sufferers known and thus subject to regulation and medical management. However, the most prevalent cases of syphilis within the city were likewise the most surreptitious.

3).[54] Made manifest in certain facial, ocular, and dental abnormalities, the facies of congenital syphilis (particularly the signature 'saddle-nose' and notched teeth) likewise draws on a conviction that the underlying activities of the syphilis organism are directly impressed upon the face.

Within the SSC, this is seen most clearly in a single-card summary of congenital syphilis (Fig. 1) . In this series of depictions, the workings of the disease are jointly displayed: the "1. Deformed Bridge of Nose.", "2. Clutton's Joints." (syphilitic arthritis of the knees), "3. Chronic Interstitial Keratitis." (corneal inflammation), and "3. Hutchinson's Teeth." (notched or peg-shaped teeth) described on the card's reverse make up the clinical hallmarks of this condition (French 2011:176). Cropped and cut to allow for both focused depiction and adequate spacing, these photographs illustrate manifestations of the disease that appear to make up the 'facies' of congenital syphilis. While not speaking to the eugenic concerns of diathetic types, the accumulative effects of depicting these various syphilis-induced symptoms suggests a quasi-physiognomic logic and aesthetic – of visible surface speaking to unseen internal activities – particularly evident in the use of profile-view and the close display of the teeth.

The presence of fingers seems to draw on an established mode of depicting teeth, tongue, and mouth for medical scrutiny.[55] Seen in historical illustrations as well as photographs of this and symptomatically similar conditions, such tactics of display serve to both reveal as well as visually frame the symptomatic site between lips and fingers. Thus rooted in a singularly clinical incentive, this card and the mode of depiction harnessed therein create a diagnostic signature of congenital syphilis – defining both the patient's physical state and those most telling characteristics attributed to this condition. Thus professing this manifestation of the disease as locatable according to a fixed and predictable set of diagnostic signs, the card serves to both summate and reproduce this syphilitic state – offering the disease as something to be viewed and absorbed in a single glance.

O'Connor (1999) identifies how the photographic depiction of disease serves to represent not merely the visibly pathological surface of the body but fundamentally presents disease *as* surface. While providing only the superficial occurrences of the clinical condition, the medical photograph

[54] While physiognomy and the notion of diathesis are no longer considered scientifically sound theories, the concept of facies continues to be used as a diagnostic tool.

[55] Unlike many similar historical imagings, this example indicates the racial discrepancy between patient and medical practitioner. While not the primary concern of this study, it is notable that the clinical hierarchies within GSH reflected the social hierarchies in South Africa – particularly with regards to race the hospital was designed to be racially segregated and until 1964 it had an all-white nursing staff (Digby 2014:778). As a result, images like this prompt an awareness of not only the institutional powers at play in depicting disease, but likewise the broader narratives of (racial) inequality within the South African (medical) terrain.

promises to utter the 'truth' of the disease despite the indirect representation of what was essentially "a deep problem" (O'Connor 1999:234). Presenting itself as pure presence, this medium perpetuates the 'fantasy' already evident in the illustration of cases during the 19th century, namely: that "diagnosis was possible on the basis of the image alone" (O'Connor 1999:234). As such, despite the merely oblique correspondence between illness and its photographic rendering, the form of depiction seen in this instance of congenital syphilis serves to flatten both space (from three-dimension to two) and experience (disease as pure appearance) – essentially limiting how illness may be not only seen but crucially understood (O'Connor 1999:234). Photographs of disease thus see illness come into (representational) existence only once externally (and thus visually) evident. Likewise the progression thereof – in essence the very reality of the diseased condition – becomes coterminous with the degree of bodily distortion and conspicuous deviance from 'health' and its visual corollary of a normative corporeal outline (O'Connor 1999:234).

1.7 DEPICTIVE AND DIAGNOSTIC UNCERTAINTIES

The problem with syphilis, however, is that while the conspicuous nature of this disease professed easy identification, clinical diagnosis and public recognition proved more difficult than both popular and scientific notions suggested. Due to its tendency to enter a stage of latency (during which no symptoms are apparent), rendering this societal threat visible and consequentially controlled appears to have been perpetually troubled in the face of this disease.[56] While the clinical progress made during the early decades of the 20th century saw syphilis become ever more identifiable and seemingly manageable, the certainty offered by diagnostic developments appear to have fallen consistently short of 'real' experiences of the disease. Commonly referred to as "the great imitator" (Barnett 2014:182; Harrison 1959:3; Shmaefsky 2010:13; Parker & Parker 2002:10), misdiagnosis was rife both internationally as well as in South Africa. While the disease could lie dormant for years, it also disseminated throughout the body – thus leading to its highly varied symptomatology. As a result, many infected with this disease went unseen and thus untreated. In addition to its highly varied (if not wholly invisible) symptoms, the unreliable nature of laboratory testing procedures likewise provided little confidence in diagnoses. Throughout the first half of the 20th century medical

[56] The identification of the prostitute-body within 19th century society likewise proved more difficult than both popular and scientific notions of her inherent degeneracy and stigmata may have one assume. As wealthier prostitutes able to attain a certain amount of economic mobility saw them go unnoticed within polite society (Klette 2013:82), concerns surrounding the 'infiltration' or 'contamination' of the civilian population emerged. Similarly, this kind of narrative appears to have been awakened in Cape Town at the end of WWI when potentially infected military men were to return to the city (De Korte 1914:19-20; MacLeod 1916:264; *SAMR* 1915:213)

practitioners both internationally and in South Africa continually complained about the unclear and inconsistent results generated by the Wassermann Reaction (Anderson 1921:48; Bernstein 1919:355-356; De Vos Hugo 1911: 42; De Vos Hugo 1915:107; Fraser 1924:98; Fraser 1926:82; Kooy 1933:150; Shmaefsky 2010:88).

Without compulsory notification and enforced treatment regimes, syphilis and its spread emerged as a particular problem in Cape Town during the first half of the 20th century. As a result, it was the threat to public health posed by syphilitic individuals saw particular emphasis placed on the unseen and unregulated cases of endosyphilis as well as the congenital form of the disease. While the PHA had done away with the disciplinary health practices associated with the disease, the routine blood tests conducted on every expectant mother at pre-natal clinics saw the non-European female emerge as the dominant syphilitic figure within the city's health statistics (O'Malley 1947:47).[57] What emerges within the contemporary medical discussions and concerns surrounding syphilis in Cape Town, is thus the need to not only identify but also *remedy* those individuals within the population whose syphilitic status went unseen, untreated, and thus threatened to disseminate this ill condition. This manifested itself within Cape Town via the official notions surrounding 'self-induced' illness and the persistent references to the promiscuity of the young non-European population, as well as the carelessness of pregnant non-European women who bore illegitimate as well as syphilitic offspring. As Crawford (1994) contends, this strategy of blame emerges to construct the sick as being at fault in their corporeal breakdown; they are rendered somehow culpable in their collapse, responsible for their own demise as to deflect responsibility from the failings of society and state (Crawford 1994:1355-1358). By locating syphilis in particular kinds of (already marginalised) subjects, the diseased individuals emerge as threatening to both individual and social order, yet because they are also identifiable they are locatable within the social body and thus potentially subject to surveillance, regulation, and medical management.[58]

[57] 20th century health statistics came predominantly from public clinics including St Monica's Maternity Home. Because such facilities catered predominantly to the impoverished citizens of the city (the majority of which were non-European), these numbers could but reflect this racial discrepancy regardless of the 'true' incidence of syphilis.

[58] However, the (public health) assumptions surrounding syphilis in Cape Town do not appear to be validated by the collection of photographs labelled 'Syphilis' within the SSC. Despite the repetitive concerns surrounding the non-European body within medical debates surrounding the disease (in relation to the persistent spread, innocent infection, unique manifestations, and overall high statistical number diagnosed with this disease) the photographic collection indicates a relatively even number of both white and coloured patients – although the fluid nature of racial attributes and categories makes an exact number problematic to assert.

1.8 DESCRIBING AND DEPICTING DISEASE

However, the historical difficulty posed by syphilis for medical practitioners in their attempts to characterise, diagnose, and depict this disease is evident in not only its characteristics as a biological organism, physical disorder, and clinical concern, but also in its relation to the education and diagnostic training of future medical practitioners. The problem posed by syphilis for clinical depiction during the 19th century – indicated by its vague and imprecise clinical definition (Quétel 1990:109) as well as the exclusion of its illustration in atlases on skin disease (Crissey 1951:418; Palfreyman 2012:318) – spoke not only to the disease's often unseen and silent progression through the body but its inherently troublesome, multifarious, and often unpredictable nature even when conspicuously manifest. What emerges in the historical depiction of this disease is thus an almost excessive need to define its symptoms via visual representation – seen in the countless images of its various manifestations, the variety of methods harnessed to record these symptomatic instances, and the often penetrative manner in which the syphilitic body is rendered visible.[59]

Until the turn of the 19th century, depicting pathology, illness and disease had largely been restricted to sporadic investigation, publication, and visual representation. While healthy anatomy has a long pictorial tradition (Meli 2015:8-9),[60] the visual 'fixing' of disease experienced various difficulties in comparison to the healthy human body. Unlike anatomical illustration that required only a small number of bodies and dissections to provide insight and reference to the body's standard mechanistic-hydraulic make-up, the ability to pin down typical manifestations of an illness or the commonplace progression of disease needed a far greater number of examples for it to be correctly identified and exhaustively studied (Daston & Galison 1992:86-87; Meli 2015:8). As such, while the depiction of pathological organs had steadily emerged since the early 18th century, it was the external appearance of symptoms that enabled students to read the surface of the body for disease – allowing pathological conditions to be deciphered from a living, breathing patient. As such, diseases whose symptoms were made manifest on the skin became the primary object of such clinical depiction.

[59] Featuring representations of both external and internal sites of disease in a combination of image-making methods (including illustrations, diagrams, and photographs of patients, bones, microscopic organisms and tissues, and even photographic reproductions of wax moulages), the dermatological atlases of Franz Mracek (1899) and Raymond Sabouraud (1903) among others indicate attempts to depict and consequently disseminate every aspect and effect of syphilis both on and in the body.

[60] The ancient and medieval schematic depiction of human anatomy was refined during the Renaissance by the likes of Andreas Vesalius (Sappol 2002:12).

Alongside the rise of professionalised clinical investigation in Europe and the US towards the mid-19th century, the study of the skin gained support as a teachable aspect of medicine (Te Hennepe 2007:125, 131). The emergence of dermatology as a specialised field of medical study critically hinged on the use of visual material to illustrate cutaneous conditions. As the minute and subtle variation of colour and texture between different skin diseases troubled diagnosis as well as treatment, diseases of the skin including venereal disease[61] prompted the use of images more than any other pathological condition (Barnett 2014:45). Due to the multifarious forms skin affections could take, the imaging of illness become valuable for both the development of dermatology (particularly in attempts to consolidate and standardise the classification of disease within this emerging field) as well as the circulation and teaching thereof (Te Hennepe 2007:21-23, 138). For early dermatologists "[t]o recognise was to name, to name was to know, and knowing implied better treatment" (Te Hennepe 2007:28). As such, textual and visual description became vitally coupled within this newly professionalised medical field. Strongly advocating the use of visual references for the purpose of both identifying skin disease and disseminating diagnostic knowledge thereof, Robert Willan's illustrations served to visualise the physical characteristics of cutaneous conditions that verbal description could not wholly capture (Benthien 2002:54; Te Hennepe 2007:29).

Due to the conspicuous nature of skin disease, dermatology (and its subfield study of venereal disease) soon recognised the evidentiary possibilities and potential usefulness of photographic depiction for clinical teaching. As Te Hennepe offers, "[f]or physicians studying patients with skin diseases photography was considered a visualisation technology *par excellence* […] The outward manifestations of skin diseases seemed the perfect prey for the all-registering eye of the camera" (Te Hennepe 2007:128). Promising a kind of representational accuracy out of the reach of established yet mediated and thus 'artistic' illustrative technologies (such as engraving, woodcut, and illustration), the photograph was predominantly harnessed to capture patient likenesses across a variety of specialist fields during the latter half of the 19th century (Te Hennepe 2007:125, 127-128). Due to its ability to limit the mediating human hand and 'safeguard' representations from

[61] While a distinct branch of medical study, 'syphilology' (later venereology) remained tightly bound to the study of the skin as seen both in the joint establishment of departments of dermatology and syphilology as early as 1879 and in the establishment of journals, conferences, and compendiums of illustrations in which syphilis was placed under the general study of skin disease (Quétel 1990:136-138). As by the 1960s the study and practice of venereal disease was no longer economically viable in South Africa, practitioners of venereology shifted towards dermatology (*Dermatology Society of South Africa* [Online]).

subjective interpretation or judgement, the clinical photograph was considered particularly useful to and thus greatly endorsed for the recording of disease (Daston & Galison 1992:98).[62]

Promising to reproduce a patient's illness in all of its distinct detail, photography essentially served to visually recreate the experience of the ward-round in a way that illustrations could not. Indeed, a clinical photograph offered a distributable, reproducible likeness available to repetitive, long-term, and wide-spread scrutiny in a way not even the material reality of the patient could achieve. However, the detail and accuracy offered by photography also meant that this medium could not produce exemplary, idealised, or abstracted versions of the disease that allowed for ease of recognition and application.[63] Thus while clinical photographs followed a similar trend to illustrations as diagnostic teaching aids (Te Hennepe 2007:134-136), the ability for the camera to capture distinct cases of disease proved somewhat problematic for clinical teaching (Daston & Galison 1992:93-96).

Rather than providing a visual exemplar of 'the disease' as an abstract, generalised, transcendental entity that could be easily learnt and recognised in the body of a living patient, photographs offered highly detailed, distinct, unique instances of illness. As such, in order to serve their purpose as material for medical teaching, photographic renderings of conspicuous (skin) diseases needed to be multiple in number in order to grant an overall impression of the manner in which a specific illness could emerge in the human body. As such, clinical collections required numerous photographs of the same condition as well as individual renderings of extreme, rare, or unique instances to 'signpost' the potential forms a disease could take (Daston & Galison 1992:107). This strategy of using multiple, varying images to construct a collection of examples was sought to create a sense of an interpretable aggregate of the disease and the emergence of a recognisable 'pattern' that required a trained eye to decipher (Daston & Galison 1992:109, 117; Daston & Galison 2010:331). Accompanied by textual descriptions including patient history (the distinct, individual features of this occurrence of the disease) as well as a more general description of features, diagnosis, and treatment, saw the use of photography within medicine produce a complex conflation in which the clinical 'case' emerged as both a unique instance of illness (with its own conditions and progression)

[62] Framed by Daston and Galison as an essentially moral task requiring self-discipline and the denial of interpretative 'temptation', image-makers needed to 'reign in' their own readings and projections in the production of a new 'science-directed' form of representation produced by automated and mechanised means (Daston & Galison 1992:82-83, 99-100).

[63] This *was* the case in Willan's work in which illustrations primarily aimed to divide, order, define, and ultimately classify the physical manifestation of skin disease through appropriate textual as well as visual description in order to establish standardised, consistent terminology and ensure appropriate and effective diagnosis, treatment, and communication between medical professionals (Te Hennepe 2007:23-28).

as well as an exemplar of 'the disease' as an abstract, generalised, transcendental entity independent of the patient on display (Te Hennepe 2007:140, 141). The clinical photograph functions as a trace of the unique and evidence of the discrete physical body and instance of illness while it simultaneously functions to communicate a type, an aggregate, a 'case of' disease. Thus cohabiting the space of the individual and the general, photographs of disease become an instance amongst many whose unique qualities and distinct details disappear into a data bank of similar depictions to be recognised, learnt, and applied in clinical practice.

1.9 GSH AND THE SSC

While the clinical strides made in the diagnosis and treatment of syphilis during the first decade of the 20th century paved the way for syphilis to be thought of as any other *treatable* disease, in Cape Town these scientific developments were promptly followed by institutional shifts as well. As the passing of the PHA in 1919 granted those diagnosed as syphilitic access to treatment in general hospitals and public health fell ever more under the city's watch,[64] the need for medical practitioners to recognise and know how to treat this disease appears to have seen its study become a general necessity. While primary clinical instruction in venereal disease took place at the City Infectious Disease Hospital as well as municipal treatment centres (Louw 1969:129, 183, 255), public hospitals such as GSH likewise admitted patients suffering from the disease's concomitant complications.[65] As the primary facility for clinical teaching since its opening in 1938, GSH would have served in the preparation of student-doctors to recognise this prevalent disease within the patient-body.

Despite the large reliance on blood tests in the detection of syphilis, the unreliability of these procedures and the general diagnostic uncertainty the disease posed saw ever more emphasis placed on *clinical* evidence (physical symptoms and patient history) (De Vos Hugo 1911:42; MacNab & Lewin 1948:733). Due to the prevalence of syphilis and the threat it posed to public health, the need for medical students to be trained in the gross identification of this disease in particular thus appears

[64] The city saw the establishment of its first VD clinic in 1920 followed by the appointment of its first full-time VD officer in 1921 (Higgins 1942:111).

[65] While the admission of patients positively diagnosed with syphilis remained firmly rooted in the City Infectious Disease Hospital and out-patient treatment facilitated by municipal clinics, GSH nevertheless adopted the practice of administering a routine Wassermann test upon every admission (Brock 1967:744). Thus while a 'department' of venereology did not exist in the hospital as such, in-patients diagnosed with and suffering from syphilis or its concomitant effects at GSH were nonetheless attended to (*GSH Committee of Enquiry* 1948:64-65). It would appear that medical students at this institution would have thus required knowledge about this disease and its multifarious and often insidious manifestations.

highly likely. However, while internationally the medical field remained troubled by the surreptitious nature and multiform symptomatology of this disease, in South Africa these uncertainties were compounded by the supposedly 'rare' forms it would take in non-European patients (Leipoldt 1933:135; O'Malley 1940:460; McArthur & Thornton 1911:23).[66] While not unlike those of Europe prior to the widespread adoption of penicillin, the diagnostic and curative familiarity with 'local' manifestations of the disease required by medical practitioners offers insight into the motivation to produce such a large amount of visual exemplars of syphilis seen in the SSC.

Outnumbering even photographs depicting tuberculosis,[67] the 'Syphilis' files and their photographic contents seem to testify to both the prevalence of the disease in Cape Town while likewise pointing to the importance for student-doctors to recognise symptoms available to the naked eye. Isolated on separate cardboard mounts and assembled as a collective within faded green folders, these photographs within the SSC appear to draw on those strategies of the clinical examination and its resultant 'case'. Each card captures an individual's conspicuous symptoms both visually and textually, as photographic depictions are correlated with loosely scrawled descriptions of name, date, and diagnosis.

Rendered in black and white, the photographs within the SSC remain monochromatic throughout the decades, despite the availability of colour film during the period when some of these images were produced. While practical and economic concerns would have likely seen hospital-produced photographs limited to monochrome (due to economic, spatial, and reproductive constraints),[68] from a depictive standpoint this quality likewise reads as 'evidentiary'. While historically technological constraints of photography had seen a necessary use of black and white in scientific imaging during the 19th and early 20th century, the tendency to add colour via darkroom or post-production

[66] While the understanding of the disease shifted away from inherent biological notions of racial difference during the 20th century (an outdated theory clung to by the 'authority' on syphilis, Johnathan Hutchinson (Cairns 1911:68; Mathias 1920:102)), cases were nevertheless discussed as 'fascinating rarities' that turned patients into "faceless creatures" (Dr Patricia Massey cited in Louw 1969:186) no longer seen in Europe and North America (Louw 1969:349; O'Malley 1940:460). Non-European syphilitic patients at GSH were considered such a clinical phenomenon that visiting physicians from overseas were invited to bear witness to the effects of this disease in the hospital's 'coloured' wards (Brock 1949:1007).

[67] This discrepancy is as both syphilis and tuberculosis had been recognised as the largest threats to public health in South Africa during the first half of the 20th century (Jeeves 2009:82).

[68] As clinical photography fell within the domain of the hospital's radiographic services (and thus the Department of Radiology more broadly) it is likely that facilities used for producing and processing x-rays would have seen the photographic services confined to the restrictions of these premises. Because x-rays and other forms of (internal) clinical imaging would unlikely have needed the additional equipment and chemicals for the processing and printing of colour film, clinical photographs would have likely been confined to monochrome for practicality's sake as well as cost. Thus, while the use of photographs for clinical teaching was a key driving force in the production of this material, the use of clinical photographs in publications such as the *SAMJ* (printed predominantly in black and white) may likewise have factored into the choice to continue to produce monochromatic images.

manipulation of hand-colouring saw chromatic images speak to subjective alteration.[69] As a result, the monochrome image was "equate[d] […] with 'realism' and the authentic" (Clarke 1997:23) rather than the interpretative and the manufactured.[70]

While in 1941 GSH saw an allocation of permanent (though notably 'humble') accommodation and equipment for a photographic section of the Department of Radiology (Louw 1969:383), early photographs within the SSC embody the informal nature of photographic production. Varying in composition, tone, point of view, often including extra-clinical content such as a patient's personal attire, and bearing evidence of being taken outdoors or in ill-lit settings, the collection speaks to photographic documentation of syphilis as having been somewhat haphazardly performed. While most practical lectures took place at GSH, prior to its opening in 1938, training in venereal disease would have been confined to municipal treatment centres, pre-natal clinics, and the City Hospital for Infectious Diseases.[71] While the latter institution offered accommodation and thus in-patient care for those suffering from the early contagious stage of the disease, municipal clinics functioned on an out-patient basis. Consequently, the opportunity to photographically capture the disease would likely have taken place in spaces with neither formal imaging facilities, specialised staff, nor standardised procedures for clinical image-making.[72] The inconsistencies experienced within the 'Syphilis' collection thus point to not only the clinical multiplicity of this disease, nor the lengthy period over which symptomatic bodies are recorded within the collection, but also the possibility of the diverse institutional origins, equipment, and image-makers. Although the large degree of variation in composition and style within the SSC appears to speak to the lack of any formal

[69] The early use of photography within the field of medicine did paradoxically incorporate hand-tinted images to ensure the 'life-like' nature of the clinical image (Te Hennepe 2007:146, 169). Photographs of patients were literally coloured-in to highlight a particular area of diagnostic concern or the distinct nuances of the disease on display. Meant to aid the recognition of disease and mimic the experience of illness when confronted with it in real life, this 'artistic' addition of colour sought to "intensif[y] the link between the realistic case of the patient and the photographs" (Te Hennepe 2007:146) and essentially enhance a "naturalistic approach for the faithful representation of diseases" (Te Hennepe 2007:146).

[70] Along similar lines, the popular adoption of colour film during the early 1940s for personal and amateur use saw the colour-filled 'snap-shot' aesthetic discredit the use of colour within the sciences (Clarke 1997:23-24). In addition, the inability of early colour film and its processing to recreate the kind of colour seen by the human eye (Newhall 1949:246) may have seen chromatic photography remain uncomfortably situated within the sciences.

[71] By the 1920s, medical students were required to frequent various hospitals and care centres including the City Infectious Disease Hospital, St Monica's Maternity Home, the Peninsula Maternity Hospital, the Municipal Venereal Disease Clinic, the Cape Town Free Dispensary, and the Old Somerset Hospital – all of which housed patients affected by syphilis (Louw 1969:150, 183, 186, 227; Louw 1979:865; Wells 1925:399).

[72] Considering the prevalence of syphilis in Cape Town as well as the various hospitals, homes, and out-patient facilities known to treat the disease, it is safe to assume that by the 20th century photographs harnessed for clinical teaching would have originated in a variety of spaces and would have been produced by both trained and amateur photographers.

photographic process or photographer, the likelihood that the early images were the contribution of independent (and possibly untrained) producers speaks to a heritage of clinical photography.

The technical constraints of 19th century photographic processes – a fundamentally cumbersome suite of apparatuses – saw medical images produced by professional (portrait) photographers in their studios (Mifflin 2007:41; Te Hennepe 2007:149; Worden 2007:19). Yet the value of such material as records and educational aids saw the eventual adoption of the medium by enthusiastic physicians, followed by the development of photographic departments within hospitals (Te Hennepe 2007:154-155).[73] As exposure time was shortened and the photographic process simplified,[74] clinical photography was subsequently freed from the confines of the studio of both the portraitist and the hospital. With the development of portable cameras towards the end of the 19th century, the medium could potentially penetrate previously unyielding spaces including the hospital ward, the patient's home, and (in all likelihood) the space of the out-patient clinic (Worden 2007:19). The production of technically as well as aesthetically inconsistent and even amateurish clinical images thus appears to have not only been a possibility but a common occurrence within clinically-produced photographic collections.[75]

Spanning more than four decades, the images within the 'Syphilis' photographs of the SSC appear to speak to their irregular and diverse origins. Essentially serving to 'sign-post' syphilitic symptoms for clinical teaching, the number and variation of these photographs suggest both concerns surrounding the troublesome nature of identifying and depicting this disease as well the inconsistent and multifarious manner of their making.[76]

1.10 A CASE OF SYPHILIS IN THE SSC

Many early or undated photographs within the SSC evidence a general inconsistency. Their haphazard nature speaks to a disregard for representational coherence or stylistic consistency. However, by the late 1930s ever greater efforts appear to have been made to create images that could

[73] This was seen as early as the 1880s in the Salpêtrière Hospital in Paris (Didi-Huberman 2003(1982):45).
[74] It was particularly with the development of the first portable (Kodak) cameras as well as the production of celluloid film at the turn of the century that photography become ever more available to lay users.
[75] This can be seen in collections originating from St Bartholomew's Hospital, the Bristol Royal Infirmary, as well as those now held by the Mütter Museum, or linked to the Burns archive.
[76] While some see these annotations condensed, typed and pasted alongside the photographic renderings on the card's front, many bear little or no text. Likewise, while some indicate glimpses of surrounds (the outdoors, the hospital ward, as well as what appears to be a photographic studio), the tightly cropped photographs limit such contextual information.

be harnessed for clinical demonstration. Seen in repeat attempts to standardise the photographic capturing of patients, the visual material within the 'Syphilis' folders appears to showcase the use of somewhat makeshift, studio-like environments from the late 1930s onwards. Particularly noticeable in the use of sometimes awkwardly wrinkled sheets hung as backcloths, the occasional appearance of wooden backings that suggest large cupboards or wall-panelling, or simply the placement of a patient before a bare wall, sees the bodies depicted ever less contextually placed. Likewise, the use of blankets and sheeting produce almost 'floating' and seemingly disembodied limbs – indicative of a focus on symptom over context. However, the remaining visual hints of the patient's location also speak to the camera's entrance into the hospital ward and the 'make-do' attitude of the photographers attempting to image the syphilitic bodies of patients.

Made evident in cards such as 'Gumma of Tibia & Pyogenic Osteitis of Skull' (Fig. 2), the visual material generated by the medical school works to present a complete picture of the patient for singular, easy scrutiny. Including both photographs and radiographs as well as a neatly typed diagnostic description, this case of syphilis is presented in all of its clinical totality. Textually devoid of biographical information, the card offers immediate visual access to the symptoms described – both in the conspicuous form encountered in the hospital ward as well as the material proof of syphilitic erosion offered by the penetrative imaging of radiography. Typed, miniaturised, cropped, and glued in a grid-like "Panoptical layout" (Butchart 1998:101), this mini collection couples symptoms rather than imaging techniques: the photograph of the patient's head with an x-ray of the skull; a photograph of the patient's leg with an x-ray of the tibia. This linking of 'like' with 'like' offers a logical reading of surface symptom with its concomitant lesion, the external manifestation of disease with its internal workings. Thus this particular instance of syphilis is rendered to show conspicuous, clinically recognisable signs alongside evidence of its insidious, internal workings that they point to.

By harnessing multiple images of the same body and thus the same 'instance' of the disease (a single positive diagnosis of syphilis), the card provides the viewer with the 'complete picture' of its progression and effects on this particular body. All textually located and classified, the collective depiction offers a superficial as well as penetrative glimpse of this specific occurrence of syphilis – rendering symptoms legible and learnable, and thus the 'logic' of visually reading the card applicable to the bodies of patients encountered as 'real' material presence. The photographic assembly that makes up this case thus acts as both an example of a singular and unique case of the disease while simultaneously providing a generalised and replicable understanding of how the body's surface and depth may be seen and read. As such, the photographs that make up 'Gumma of Tibia & Pyogenic

Osteitis of Skull' not only indicate a faith in the textual as well as visual knowledge accumulated by the medical school, but likewise propagate the insular practices of looking and knowing fostered by the clinical examination. Once seen and read, the textual description locks the images *as* symptomatic instances – perpetually confining the patient to their singular, clinical reading. Similarly, the decisive sizing and placement of the photographic and written material in relation to one another, the cropping and minimising of both visual and written data, as well as the comparative alignment between outside and inside (a kind of transparency unavailable to the naked eye), provides a reconfiguring moment in which interpretations and connections (otherwise impossible in the physical space of the ward) emerge.

By coupling photographic with radiographic depictions, disparate anatomical elements and distinct symptoms become visibly as well as conceptually related. What such examples thus illustrate is how the strategic production and management of image and text serve to produce a single, legible instance of disease. In rendering the multiple and insidious activities of syphilis as discrete yet tightly bound corporeal manifestations, the patient's body appears to 'speak the truth' of the disease lurking within. As such, this card and those like it see the body made legible to clinical scrutiny and rendered an object of medical knowledge.

1.11 STANDARDISING STRATEGIES WITHIN THE SSC

While the ebb and flow of representational consistency and overall lack of uniformity within the SSC remains conspicuously evident in those photographs produced prior to the 1940s, those dated thereafter suggest a radical shift in the imaging protocols of the medical school. Unlike older cards, these later photographs indicate the almost exclusive photographing of hospital in-patients as seen in the repeated glimpses of distinct pyjamas, nightgowns, evening shirts, and nightcaps.[77] However, the dramatic increase of photographs within the SSCs 'Syphilis' folders dated during and after this decade – as well as the rise in the medical school's publication of photographs in the *SAMJ* – likewise suggests a shift in the institutional production and dissemination of this material.

[77] The 1962 GSH Annual Report confirms that at least during the 1960s the (by then officially formed) Department of Clinical Photography indeed photographed only in-patients. While photographs in the SSC sporadically indicate the place of origin (for instance "G.S.H" in the case of Groote Schuur Hospital or "R. + Hospital" in the case of the Red Cross Children's Memorial Hospital), earlier examples devoid of this kind of insignia indicate the almost exclusive photographing of hospital in-patients.

Following the establishment and opening of GSH in 1938 and the allocation of a grant in 1941, a clinical photographic section formed part of the Department of Radiology that due to growing demand would eventually become the Department of Clinical Photography (HBC 1945:28; HBC 1946:20; HBC 1947:24; Louw 1969:383; GSH Committee of Enquiry 1948:89-90).[78] Although the use of white sheets, wooden panelling, and personal attire sporadically remains within the post-1940 photographs of syphilis within the SSC (as seen for instance in the depiction of the symptomatic skull and tibia), what prominently emerges in images taken during the 1940s is that they appear to have originated from a single source.

While the inclusion of photographs taken in a ward-like environment persists throughout the collection, the introduction of a quasi-'mug-shot' style of representation during the 1940s speaks to a decisive move towards standardised protocols of image-taking at the medical school. Capturing the patient in both a full-frontal and profile view, such photographs offer the most obvious attempts to render syphilitic symptoms in a consistent and complete manner for easy diagnostic recognition, learning, and application. A case depicting a patient with a syphilitic chancre (Fig. 3) appears to serve as a case in point: rendered in a full-frontal position, the conspicuous symptom (indicative of the disease's initial stage) is imaged from various points of view. Providing a head-on, full-frontal shot of face and upper torso, the photograph sees the primary chancre almost perfectly centred within the image. The second photograph (to the right of the first) sees the patient turned at 90 degrees and captured in profile. Thus offering the viewer visual information about not only the size of the syphilitic swelling but also the degree to which the chancre protrudes from the patient's lip, the level of bodily distortion suffered becomes evident as a result. A unique addition in the 'Syphilis' collection, however, the third photograph – one that sees the symptom imaged as if from above – provides yet another visual vantage point while strategically hiding the patient's body behind a solid

[78] Considered both valuable for the training of student radiographers while simultaneously used for clinical records, teaching, and research, the material produced by this facility appears to have been undertaken by largely unsupervised students (GSH Committee of Enquiry 1948:96). While by the 1960s this facility serviced the Red Cross Memorial Children's Hospital, the Orthopaedic Department, the Maxiollo-Facial Unit, and produced images of gynaecological as well as dermatological interest (GSH Annual Report 1963:38; GSH Annual Report 1966:69; GSH Annual Report 1969:62), the production of clinical photographs at and for the medical school appears to have been scattered across various departments, facilities, and thus image-makers (Wesselo 1988:41; Wesselo, Personal correspondence 2015). While I have been unable to verify the photographers working at GSH prior to 1960 (as the hospital only began publishing its annual reports during that year), both a Mr G McManus as well as Mr CC Goosen are mentioned in relation to the production of clinical photographs used in the *SAMJ*. In addition, McManus is remembered for his role as photographer within the medical school's surgery department (Dent, Personal correspondence 2015; De Villiers, Personal correspondence 2015). Although both he and Goosen worked as 'technical assistants' in the surgery department (Louw 1969:116, 337, 363) – a position that commonly included clinical photographic duties (Fitz-Simon 1989:23) – the SSC photographs themselves show no indication of authorship. While A Mr EJ Henderson held this post prior to both McManus and Goosen (Louw 1969:173-174, 363) and may thus have had photographic responsibilities in the department, due to the lack of documentation this is impossible to verify.

sheet of white. The three-part visual rendering of the primary chancre thus as a whole attempts to offer this symptom in its entirety – as if to mimic the scrutinising encounter that a 'real', face-to-face examination would offer. What this card provides is thus an aggregate understanding of a particular symptom within a particular body similarly seen in the case of 'Gumma of Tibia & Pyogenic Osteitis of Skull'. While not imaged internally and remaining fixed on a single symptom and body part, the three-part depiction of a syphilitic chancre offers this case as both visually and (with the addition of the typed description) diagnostically complete. Thus rendered clinically legible, the qualities of this symptom are likewise made learnable and subsequently applicable to engagements with other patients, other bodies, and other suspected instances of syphilis.

While the decontextualising and neutralising procedures of angle, focus, background, and dress serve to limit a reading of the photograph to an imaging of disease, this neutralising of the patient appears to be paradoxically compounded by this individual's direct gaze at the viewer. Although traditionally an averted gaze operates to disguise the presence of the photographer and the image-making process (hiding both the act of intervention and posing of the body), it likewise serves to uphold the viewer's own disembodied gaze – allowing one to linger and peruse the content of an image (Edwards 2011:162). Thus facilitating a wholly detached and disinterested engagement, the body on display is easily looked at, unflinchingly scrutinised, and unashamedly objectified. However, while the kind of self-aware pose before the camera witnessed in this case of a primary chancre would seem to speak to an 'unnatural' interruption of reality and an artificial interference with normal goings-on, the frontality of the patient's look draws instead on representative traditions of the human sciences that serve to nullify these qualities.

Essentially adopting what Barthes refers to as a "historical grammar" (Barthes 1977:201) of scientific images, the physical posing of the body in this depiction appears to employ the objectifying function of scientific depictions. Highlighting 'pose' as a fundamental feature in physical anthropology and ethnographic photographs, Edwards indicates the power of a collective visual archive or a "popular storehouse of images" (Gilman 1987:95) to grant such material evidentiary value.[79] In particular, Edwards suggests that by mimicking the appearance of images resonant with scientific authority, photographs such as those harnessing the mug-shot aesthetic seen in the depiction of a primary chancre are referentially granted a similar objective and institutional

[79] While Gilman speaks particularly to the shifting of iconographic images of leprosy, syphilis, and HIV/Aids, Barthes addresses this concept more broadly. In addition to pose, Barthes also identifies the strategic inclusion and arrangement of content, visual effects, aesthetic choices, the grouping and display of images, and the more blatant harnessing of 'trick effects' (post-production manipulation) as serving to create the connotative message within the photograph that surreptitiously shape its meaning and message (Barthes 1977:199-204).

weight (Edwards 2009:189).[80] Referring specifically to what she calls a "scientific reference" (Edwards 2009:174), the 'style' or 'format' of an image may thus serve to transfer associations of impartial intent and scientific rigour. Thus, by drawing on a representational history of sciences that utilised methods of reading physical characteristics of the face (such as criminology and anthropology), the direct eye-level frontal pose, coupled with the neutralising functions of background, angle, focus, and dress nullify the patient as a unique individual and instead see the focus directed ever more towards the distinctive characteristics not of the person but of the disease. Seemingly submitting to the process of being photographically captured, the direct gaze evidenced in the depiction of the syphilitic chancre is not so much confrontational as one that speaks of an acquiescing to both the photographic process. As such, this seemingly affirming gaze allows for an ease of inspection, in a sense channelling a sense of permission similar to that granted in the process of the clinical examination and a consent to closely observe and become proximate with the patient.[81]

1.12 COMPILING CLINICAL EVIDENCE

While the particular depictive strategy of the mug-shot offers an indication of how photographic procedures within the SSC became ever more standardised to produce seemingly 'complete' and wholly evidentiary depictions of disease, such images likewise indicate how the production of photographs within the medical school became ever more rooted in a single space. While the head-on shot sees the depiction of the face emerge at eye-level, other photographs taken during the 1940s and particularly those capturing the legs and feet of patients show a decisive change. Taken instead at a distinctive downwards angle, these photographs indicate the likely use of a tripod – harnessed in the production of head-shots to standardise the resultant images. While a seemingly innocuous detail, the introduction of this technical aid speaks to the adoption of photographic equipment and a shift from inconsistent, hand-held and thus 'bodily' forms of image-making to a deliberate attempt

[80] Speaking particularly to the use of frontal and profile depiction harnessed by the late 19th century to depict non-Western races, Edwards suggests that this 'scientific reference' granted scientific authority to images of racial difference (Edwards 2009:189).

[81] Despite its appearance of unmediated transparency and spontaneity, the photographic image emerges for Barthes as dependent not on its material characteristics as an optical trace but in its ability to disguise the method of its making – to pledge a purely denotative character by concealing its operations (Barthes 1977:200). The 'reality effect' of the photograph is thus for Barthes little more than an illusion: photographic meaning – like any other form of representation – is one structured through the conditions of its making (Barthes 1977:199). The façade of pure denotation thus essentially "allows the photographer to *conceal elusively* the preparation to which he subjects the scene to be recorded" (Barthes 1977:200). By disguising the manner of its making, it was the automated nature of photography that served to qualify its production of the world-as-image.

at mechanised consistency and acuity if not simply the use of the 1941 grant. In addition, what becomes present in photographs that break from the eye-level, head-on, and relatively close depiction of faces are the edges of the white backdrop that accompanies such images. Indeed, photographs that include areas of the body such as the feet see glimpses of the edge of backdrops (Fig. 4), while evidence of lighting and other equipment features on the fringes of some photographs.

What the repetitive (though consistently marginal) presence of these aspects offers is an indication of not only the depictive standardising but moreover the spatial consistency offered for photographic production within the medical school. The large backdrop, the complex and robust lighting, and the repeated wall and floor texture thus suggest a stable and consistent space designated for the production of such material at GSH for institutional use.

While these developments all speak to who was imaged, where photographs were produced, and how they were made (allowing for insight into the collection's ever more singular origin), the visual result of these shifts in image-making at the medical school likewise sees the emergence of a representational consistency that allows the photographic cards function in ever more targeted ways as evidentiary material. While increasing their functional value as diagnostic teaching aids, these standardising strategies and the uniform rendering of the body within the 'Syphilis' folders offer the potential for not only singular scrutiny but also comparability. The 'mug-shot' method of depiction seen in the SSC provide both a detailed, and diagnostically 'complete' picture of disease as well as the potential for assessment across images, symptoms, cases, and patients. Through depictive methods of isolation and collation, these photographs thus appear to draw on those strategies described in relation to Foucault's notions of the clinical examination and its resultant 'case'. Coupled with the standardisation strategies developed at GSH during the 1940s, these depictions fix individuals ever more firmly as medical evidence and promote the unrequited scrutiny and comparison of bodies and diseased conditions. Grouped together as both the 149 individual documents under the banner 'Syphilis', as well as the eight thusly demarcated folders sees both symptoms and bodies emerge on the same plane of visibility and legibility.

Compiling symptoms as they erupt on the surface of bodies within the picture plane, this collection of photographs depicting the symptomatically 'syphilitic' allows for both discrete scrutiny as well as a sense of the greater, more general effects of this disease on the human body. As such, this compendium of possible signs and symptoms across lines of age, race, and gender, serves as a visual aggregate of this disease. As a permanent visual and textual record outlining a clinical condition, the 'Syphilis' photographs fix those represented within a state of perpetual pathology in which the

individual is rendered forever frozen as a patient, as infected, as perpetually symptomatic and syphilitic. While thus secured, the isolated patient imaged within the photographic file may be both read in a linear fashion in relation to similar cards within the binder, or otherwise removed and laid out for comparison. However, although these images offer a visual fidelity to the clinical experience of the examination and a literal re-presentation of syphilitic symptoms, they remain limited. As two-dimensional, miniaturised, and monochromatic renderings, these photographs – like much of scientific imaging – deny their production and the highly selective nature of their representational coding. Through the ever greater prevalence of flattened, 'neutral' background evident in the SSC from the 1940s onwards, patients emerge within an a-historical void as entities of a purely optical encounter. Thus propelling those depicted forward, beyond the space and time of each patient's initial photographic capture, the clinical photograph secures the body in a universal moment in which they are forever labelled as syphilitic.

1.13 CONCLUSION

By cementing individual characteristics through forms of looking, writing, and picturing, the clinical photograph serves to both extend and visually fix the medical examination and case-file. Although not harnessed for surveillance in the same manner as photographs of repeat criminals or asylum runaways, these clinical counterparts are nonetheless formed according to the spatial and temporal structures of the institutional space of the hospital. In providing a platform for the prolonged, repeat, and detailed scrutinising of bodies, such documents simultaneously served to create new (objects of) knowledge through the process of inscription, accumulation, aggregation, and comparison (Tagg 1988:88-89). Thus functioning as a mode of knowledge-production as well as providing a permanent representational recording of the individual body, the clinical photograph operates as a visual document that may be continuously referenced and read – a tool to gain insight into the disease more generally. Visually fixing and indeed reproducing those afflicted by the disease within the SSC, these photographs offer themselves as clinical evidence that may be closely scrutinised or compared at a distance, rifled through or removed from their binders, and even reproduced and published outside the confines of Cape Town's medical school.

Extending beyond both discharge and death, the photograph maintains its representational grasp on its subject – holding it fast, and thus allowing the diseased condition to remain forever rooted in the present and reawakened upon each viewing. Thus perpetually offered up for scrutiny, the patient-photograph maintains a reading of the body as an object of clinical inquiry – legible to the expert

eye and instrumental in the teaching of those yet untrained in this way of seeing and knowing. By presenting the patient as nothing but the characteristics of disease to rifle through and compare, these photographs allow for an ease of both looking and learning. Harnessing depictive and curatorial strategies to reinforce and promote their function as diagnostic training aids sees these images allow syphilitic symptoms to be visually located, educationally disseminated, and crucially rendered recognisable.[82] Indeed, the clinical photograph serves to indicate the belief held by medical science that both body and this medium could serve as index of disease. Thus despite the "representational completeness" (Jackson 1995:332) offered by the 'Syphilis' folders, the coupling of visual exemplar and textually rendered diagnostic result provides an immediate connection between visual appearance and pathological condition. Through the visual depiction, textual description, as well as physical filing, categorising, and shelving, the photographs within the SSC operate as a visual database of disease made both legible and learnable.

The ability to appropriately make (medical) meaning of these images, however, is one structured not by the kind of 'pure' gaze Foucault suggests, but rather speaks to a viewer necessarily informed by diagnostic know-how and a faith in the legibility of the body and the transparency of the photograph. Thus, in the following chapter, I thus seek to extend this reading of disease and its depiction to explore how syphilis as a bodily threat prompts a visual coding as well as fosters a way of seeing in line with the diagnostic intent of the SSC.

[82] While early clinical illustrations hinged on a true-to-life size and chromatic rendering of the body to provide a sense of the patient's material presence, the compact size of the SSC photographs sees them far removed from any sense of the living body. Thus confronted not by the physical presence of the sick and syphilitic but with easily handled, portable documents the experience of the ward is all but removed.

CHAPTER 2: (DE)CODING DISEASE: THE VISUAL LANGUAGE OF CLINICAL DEPICTION

2.1 INTRODUCTION

Following the understanding of health and pathology outlined in the previous chapter, ill health is understood as being corporeally corrupted by disease. Being 'sick' thus appears to function as a fundamentally abject state – a perpetual risk necessarily cast out of personal and social consciousness, placed outside the perimeters of what it means to be a normal and healthy individual. While the previous chapter emphasised the medical and photographic structuring of the 'Syphilis' photographs within the SSC, this chapter explores how the corporeal nature of this disease posed a particular representational difficulty in medical as well as psychological terms. While troubling easy clinical depiction, syphilis also holds the potential to refute easy viewing and decipherment. Thus, while in Chapter 1 I dealt with the institutional and instrumental use of photography within the (medical) sciences, here I wish to engage how precise visual coding of this bodily threat prompts a particular way of seeing – one that ensures such images serve their intended diagnostic function. Here I therefore address how images of syphilis within the SSC see the sick body rendered knowable and decipherable by transforming the material, visceral nature of disease into representation.

In order to frame this engagement, I address the psychological as well as social need to see the body as whole and stable – and thus the conspicuous defilement of the skin caused by syphilis as inherently threatening. Here I make reference to Julia Kristeva's notion of the abject that must be both individually and socially controlled. However, while Robert Crawford and Sander Gilman are harnessed to unpack this management of disease-as-threat, the crux of this chapter rests in how visual (and particularly photographic) depiction serves to render syphilis a stable and decipherable scientific sight. To engage this conversion of the corporeal into a clinically decodable entity, I draw on the writings of Hal Foster, Kenneth Clark, and Lynda Nead in engaging the importance of depiction in this process, as well as the work of Mieneke te Hennepe and Erin O'Connor to relate this discussion to medical representation more specifically. Yet, although this chapter outlines the strategic coding of the symptomatic body in the SSC, the depictive protocols and clinical conventions prove unable to wholly control the abject nature of syphilis.

2.2 DISEASE AND THE 'LOGIC OF REJECTION'

In her psychoanalytic engagement with subjectivity, Julia Kristeva offers the physical body as a vital element in the construction and experience of a unified, controlled and differentiated self. Offering a reading of the psyche's development from infancy, Kristeva argues that a sense of self as a contained, bordered entity is established via a psychological "logic of rejection" (Oliver 1998:40) provided in infancy (McAfee 2004:48; Oliver 1993:46).83 Based on the bodily functions of ingestion and excretion, the subject forms a sense of itself as a 'vessel' into and out of which material matter enters and exits (McAfee 2004:48; Oliver 1993:46). This process is facilitated by what Kristeva calls 'abjection' – a psychological process of radical exclusion based on bodily functions – that is understood to structure all subsequent attempts to delineate the self.

While beginning in infancy, efforts to cast away that which is not part of the self continues to function throughout an individual's life. Through the 'logic' of bodily exchange, the subject continues to cast away that which threatens its sense of self as autonomous and stable. As such, substances such as excrement, urine, faeces, vomit, sweat, saliva, and blood become stuff that not only crosses the physical boundary of the body (entering or exiting through openings in the skin) but must remain outside, external, jettisoned to stabilise the psyche and thus the self. As a result, these abject substances that trespass on the body's limit pose a psychological threat – challenging the definition of what is inside (and thus part of the self) and what is outside (and thus other/object). In continued attempts to stabilise its boundary and cordon off the psyche, interactions with these material substances thus usher in a sense of disgust and horror (Kristeva 1982:3; McAfee 2000:75). Securing the self through the physical and psychological rejection of such matter is both that which creates the subject's notion of an "imaginary outline" (Grosz 1994:39) that divides inside and out/self and other, while simultaneously posing a threat to the solidity of this border. As the nature of abject matter is to cross the bodily boundary, the stability of the psyche is perpetually precarious – simultaneously put at risk the moment its borders are established (Mansfield 2000:81). Neither

[83] Despite having its own discrete, and physically bound body, a new-born child is thought to not yet experience itself as a separate entity. Born into a state of flux in which the psyche is as yet unformed, the child experiences all that surrounds it – smells, tastes, sounds, and crucially the body that touches and feeds it – as part of itself. Thus, even after birth a child's sense of self is one unified with its mother – essentially denying their material separation (Mansfield 2000:31). In order to develop a sense of self, however, an infant must begin to differentiate itself as an individuated being. For Kristeva, this process fundamentally begins in relation to bodily processes and functions – particularly those of ingestion and excretion (Oliver 1993: 32; Oliver 1998:40). Through the act of consuming milk and expelling excrement, urine and spittle, the child is thought to achieve a sense of itself as contained, discrete entity. As the infant's first and most fundamental frame of reference, the mother's body is the first entity necessarily discarded for delineation to take place (McAfee 2004:48; Oliver 1993:46). This primary act of jettisoning – physically experienced in birth and psychologically experienced thereafter – is for Kristeva what constitutes the first act of 'abjection'.

wholly object/outside/other nor subject/inside/self, the abject is never completely discarded and instead lingers on the peripheries of consciousness – threatening the tentative stable experience of self throughout its existence.

While predominantly focusing on social organisation and moral values, Douglas (2001(1966)) similarly considers that a process of casting out 'dirt' (what she defines as "matter out of place" (2001(1966):36)) is crucial to making sense of, giving meaning to, and fundamentally stabilising the physical world. Placing crucial weight on the maintenance of boundaries, margins, borders, and outlines, the chaos and general 'untidiness' of experience is turned into something stable and structured (Douglas 2001(1966):4). As such, 'dirt-avoidance' acts as an essentially productive response to the boundary-transgressing nature of disorder. By supressing and prohibiting that which does not respect borders and by creating distinct categories and protocols for behaviour, a uniform experience and social stability is ensured. As such, the regulation of individual subjects, the establishment of strict social mores, and the casting out of 'inappropriate' transgressing individuals or actions emerges as a social impetus to "reward conformity and repulse attack" (Douglas 2001(1966):115).

Biological disease and socially threatening identities take on similar status as 'abject' or 'dirt'. Posing a threat to both bodily and societal order, the unpredictable, chaotic, and corrupting tendencies of both organic disease and social transgressors sees these conditions made necessarily conspicuous as deviant, disease, disorder.[84] Rather than a merely biological corporeal occurrence, disease may be understood as "a symbolically charged event" that "represents a danger both to the individual and to the social order" (Crawford 1994:1355). Essentially, health and illness emerge not as purely material states in which the body is seen to be (dys)functional, but instead, the state of health is both formed by and informs a variety of social needs, communal notions of self, and institutional forms of regulation.

Focusing his discussion on the consequences of the underlying individual and social need to delineate health from disease (or healthy from diseased), Crawford suggests that notions of the 'sick' have emerged in relation to the psychological need to cement the boundaries of the self through a constant act of negation and differentiation (Crawford 1994:1355-1356). Therefore, Crawford argues, one's own identity is stabilised and confirmed as a healthy whole by cementing the threat

[84] Like the abject, the threat of disease and becoming sick perpetually lies on the periphery of both the physical body and consciousness. The 'unhealthy other' is thus the product of externalisation – an embodiment of characteristics and behaviours that speak to that place of risk and of ill-health that must be shunned, denied, and located elsewhere and identified in the bodies or identities of others (Crawford 1994:1355).

of disease in the body of (an)other. A similar argument is posed by Gilman (1985a; 1985b; 1987; 1988) who, through his address of disease-icons85 sees the representation of the sick operate in this self-protecting way (Gilman 1985a:204). This psychical self-defence inherent in the externalisation of vulnerability and risk onto another is known as 'projection' (a psychological act of shunning and displacing). By placing disease at a safe distance and fixing it outside the self through the act of projection, the threat of losing control of the self and the potential experience of instability may be (temporarily) appeased (Crawford 1994:1359; Gilman 1988:1).86 As Douglas (2001(1966):4) offers, "by exaggerating the difference between within and without, about and below, male and female, with and against", that which is threatening to both self and society is rendered ever more present and locatable, its problematic nature confirmed, its rejection necessary, and thereby its management certain. This need for clear (or even exaggerated) categories is fundamental to "the boundary-maintenance of any system" (Crawford 1994:1359). The visibility of social deviance can thus be understood as vital to ensure continued displacement of otherness and stabilisation of both society and self.

Displacing abject threat (be it the material condition of disease, or the social risk of otherness) thus emerges in line with Crawford's thinking particularly in the form of stigmatisation: by rendering syphilitic individuals as well as those identities associated with the disease readily identifiable, the regulation and organisation of both bodies and society is achieved via medical management. As a result, healthy, normative subjectivity is made ever more stable. Rendering subjects conspicuously different (and therefore legible as deviant) serves to ensure distinction between legitimate behaviours and identities, as well as locate otherness within the concrete body of another. In the

[85] Gilman suggests that depictions of disease have the potential to take on an iconographic function – to take on meaning that is essentially independent from the physical reality of illness or symptoms. For Gilman, it is this ability that sees depictions of particular icons of disease (such as the prostitute and the 'Hottentot' female for instance) serve as a social defence against types of behaviour and identities perceived as inherently 'sick' (Gilman 1985a; Gilman 1985b).Images of disease are iconic insofar as the qualities and association they evoke are not connected to the specificity of the individual depicted but rather to certain aspects of their diseased state. As such, it is the supposedly common qualities amongst those who similarly suffer that serves to exemplify sickness or what it means to be ill (Gilman 1985a:204; Gilman 1987:88).

[86] It is in this process of displacing the threat of disease that both Crawford and Gilman see society and culture take on a prominent role. Drawing particularly on Western social history, Crawford identifies the socio-political pathologising of the diseased as a means of projecting blame away from its root cause – the very organisation and underlying structure of society (Crawford 1994:1358). By placing blame on individuals or groups that prove symptomatic of its failings and thus already at a structural disadvantage (the poor, the non-European, the female), the social order remains safeguarded by marginalising those who pose a threat. Similarly, the maintenance of a particular 'social self' likewise requires this casting out of attributes that threaten the maintenance of (group) identity and jeopardise one's place within a collective framework (Crawford 1994:1358). By rendering certain identities deviant, social relations are (tentatively) solidified; by 'corporealising' projection – by fixing disease in the physical bodies of others – social identities are granted "signifying power" (Crawford 1994:1359). As such, the discursive structuring of disease and the diseased body functions as a reaction to both individual/material and social/signifying threat – what Crawford refers to as "psycho-cultural responses" (Crawford 1994:1354).

case of syphilis in particular, the distorting and disfiguring effects of the disease on the body and particularly the skin and face results in a social need to 'see' the illness in the body of another made quite literally manifest. This allows for the denial and rejection of weaknesses and vulnerability in the self, or what Crawford calls a "quarantine of identity against the 'unhealthy'" (Crawford 1994:1356).

2.3 SKIN AND SELF

With the ever more detailed exploration of the skin within the sciences during the 18th and 19th century, this organ became scientifically understood as its own entity with its own operations – a barrier between inside the body and outside contaminants, a shield whose functioning (or lack thereof) impacted the body's interior (Te Hennepe 2007:86, 95, 99).87 As a result, the overall health of the body was recognised as dependent on the visual condition of skin – a development that saw its integrity emerge as an object of medical, public, social, institutional, as well as individual concern. As a result, those conspicuously impacted by syphilis become easy targets for projection and externalisation as their deviance is indicated by the ruptured condition of the skin, by contamination made visible.

As a highly contagious and conspicuous disease, syphilis proves indicative of a physical weakness of the body's borders (via the physical eruption of symptoms through the skin). In addition, this material instability infers a collapse of subjectivity: the dissolution of the self as well as a breaking of social stability and legitimacy. The external manifestations of this disease – most prominent during its secondary and tertiary stages – has historically offered a means to visually distinguish between not only healthy and unhealthy bodies but also controlled and uncontrolled subjects. The skin's position in upholding the integrity of the body, coupled with its highly conspicuous vulnerability, saw an understanding of external appearance take on ever greater significance within the personal and public sphere.88 As external evidence of health, corporeal regulation and the

[87] What emerged in accordance with both these scientific and social concerns (the shift in biological understandings of the skin as well as the requirement for a publically distinct social self) is what Benthien describes as "the gradual shift of the dirt boundary from the inside to the outside" (Benthien 2002:42) that saw a growing fear of *external* contaminants and the safety and impregnability of this bodily border. The late 18th century witnessed a shift towards a drastic upholding of the skin-barrier – placing a premium on the strict monitoring of this organ and contagious matter (Benthien 2002:41-42; Te Hennepe 2007:56-57).

[88] The need for the rising bourgeoisie to publically maintain the integrity of the physical body is evident in the privatising of processes such as abluting – "where 'inside' becomes 'outside' and, conversely, where 'outside' threatens to penetrate 'inside'" (Crawford 1994:1350). The regulation of the body and its borders began to play a fundamental

patrolling of bodily borders became "an essential component of what it meant to be modern, progressive, rational, and distinctive" (Crawford 1994: 1349), it is the external manifestation of the pristine, controlled nature of the body as a whole that spoke to an appropriate state of individual and social selfhood.

From a psychoanalytic standpoint, the constant maintenance of the 'clean and proper' body (what Kristeva calls the "corps propre" (Roudiez in Kristeva 1982:viii)) allows for retaining an illusory sense of the self as completely sealed and wholly controlled via the fixed separation of inside and outside. In order to cement this experience, the subject undertakes a continuous process of self-stabilising through the almost vicious exclusion of the abject – a process that results in a visceral experience of physical disgust and intense ambivalence. Thus presented with a border that visually and spatially establishes where the exteriority of the world ends and the self begins, the body – and the skin as the border of that body – takes on ever more significance in the production and maintenance of subjectivity.

As the first of the sensory organs to develop in the embryo, Didier Anzieu (1989), Mark Lafrance (2007; 2009), and Elizabeth Grosz (1994) understand the significance of skin as a key component in the structure of the psyche in the very earliest instance of subject-development. As the material boundary of the body, the skin is also the place where primarily scattered and disjointed sensations play out and thus the first sense of individuation and containment take place (Lafrance 2007:267; Lafrance 2009:7, 15, 19; Handcock 2012:1).89 With such a psychological weight placed on the body and notably the skin, the conspicuous breaching of this boundary proves particularly threatening. As the skin serves both a psychical and physiological function, the conspicuous corruption of this surface speaks not only to the inability to maintain the body's material integrity but likewise a stable self. When the boundary of the skin is crossed, when it is punctured by wounds or (as in the case of syphilis) inflamed, ruptured, and oozing, its serves as an external indication of a corrupted and essentially pathological interior. The leaching of the body through the skin thus speaks to not only a fundamental breakdown of the barrier between inside and out, but an ambiguous and fragile separation of self and other, subject and object. While usually prohibiting the body's corporeal interior from spilling out into the world (while simultaneously preventing the outside

role in both private conduct and social etiquette. As the skin became understood as the safeguard of the body, its fallibility was seen to render the body vulnerable to infiltration and corruption.

[89] While the skin offers up this physical and psychological boundary for the infant, it is crucially the tactile, 'skin-to-skin' contact with its mother that affords the sense of containment necessary for delineation and the development of a sense of self. As body and mind continue to be experienced as one, the skin provides a sense of both the physically bounded body and a psychological perimeter (Lafrance 2007:267).

world from contaminating the flesh encased within), conspicuous disease announces itself by rupturing this border and making the internal chaos of material corruption physically and visually present. Thus, while providing the protective sheath that separates the subject from the dangers of external contagion, the skin is also the platform that betrays the fallibility of the body and hence the fallibility of the self when disease is made materially manifest on its surface. Rather than a material surface that separates inside from out, the skin operates as a highly invested psychological and social boundary. It is namely the conspicuous nature of this surface – its position on the very extremity of the body – that sees it play a crucial role for not only individual identity but social identity as well. Exposed to both the physical and social environment, the skin provides a place of scrutiny for others.

In the witnessing of abject bodily rupture, the sense of disgust and horror that may be evoked speaks to an essentially 'affective' response. As Steven Shaviro offers, a confrontation with the abject:

> brings me compulsively, convulsively face to face with an Otherness that I can neither incorporate nor expel. It stimulates and affects my own body, even as it abolishes the distances between my own and other bodies. Boundaries and outlines dissolve; representation gives way to a violently affective, more-than-immediate, and nonconceptualizable contact […] It assaults the eye and ear, it touches and it wounds […] This touch, this contact, is excessive: it threatens my very sense of self (Shaviro 2008:259-260).

For the Kristevean thinker, affect is an internal experience that speaks to how those unconscious (as well as bodily) drives and energies are made manifest in the subject (Barrett 2011:63-64; McAfee 2004:23). Affects are an inherent part of the human being, to both the body and the psyche. Applying Kristeva's understanding to the visual arts, Estelle Barrett suggests that what underlies a viewer's emotional response to an image is precisely this notion of affect: it is the internal, unseen, and unutterable workings at play in engaging a work of art. It is essentially that which "underpins the power of art to make us feel and act differently" (Barrett 2011:63), the 'force' at work when one is moved to engage emotionally rather than intellectually. For Eric Shouse, affect is crucially 'pre-personal' – an innate "experience of intensity […] a moment of unformed and unstructured potential" (Shouse 2005 [Online]) that escapes consciousness, evades articulable awareness, and is essentially embedded in the body (Seigworth & Gregg 2010:2). It is subjective as it essentially "dissolves" (Shouse 2005 [Online]) into experience – into what we think, feel, and sense. It cannot be fully translated into language or even thought as it emerges outside of both. Despite this slippery description, what is crucial for Shouse is that "affect is what makes feelings feel" (Shouse 2005

[Online]) – it is that which gives intensity to experience. As such, an affective response is one that emerges without solicitation and remains somehow inexplicable, uncontrolled, and ultimately defies easy clarification or description. It speaks to intense moments of experience that emerge outside of consciousness and are neither feeling, sensation, nor emotion but something that lies beneath them, fuels them.

Confronted with the ruptured body, with abject corporeal mess, it is precisely this kind of affective experience that is evoked – particularly that of horror and disgust. However, Kristeva's abject is not the only means by which the affective potential of the broken body may be understood. By prompting pain into representation (particularly via the depiction of wounds or potentially wounding objects),[90] Elaine Scarry sees it possible for "something of the *felt-experience* of pain [to be conveyed] to someone outside the sufferer's body" (Scarry 1985:15, own emphasis). While troubling easy reference,[91] Scarry nevertheless argues pain may be communicated to non-suffering persons – making it somehow 'shareable' (Scarry 1985:15-16). As such, depictions of the wounded or wounding of the body offers a means for the sensate nature of pain to be relayed. Rendering pain 'known' in this way, however, speaks less to an intellectual sense-making than a 'bodily' experience – implied and rendered accessible via (visual) representation. For Scarry, this 'making visible' of pain is an imaginative re-enactment that hinges on the ability to envision the wounded body of another. As she elaborates, "because [the physical wound] either exists […] or can be pictured as existing […] at the external boundary of the body, it begins to externalize, objectify, and make sharable what is originally an interior and unsharable experience" (Scarry 1985:15-16).

Pushing Scarry's notion to the domain of visual representation, Jill Bennett (2001; 2002) addresses how depictions may awaken the "felt-attributes of pain" (Scarry 1985:13) in the body of a viewer. Images may themselves inflict a type of painful recognition in its audience – that instant and instinctive flinch experienced when confronted with an image of bodily destruction – triggering a recognition of what Bennett calls a "bodily memory of physical pain" (Bennett 2002:343). Evoking physical sensation and affective response, visual depiction thus can be understood to activate a kind of 'emotional' memory, one that holds the potential to make viewers *feel* rather than merely perceive

[90] While a fundamentally physical and subjective experience, Scarry suggest that (verbal) metaphors offer a means that allows for physical injury and experiential distress to be communicated. Taking particular shape in the harnessing of weapons or wounds to describe pain-as-produced (the 'stabbing' of a knife) or pain-as-bodily-damage (the 'splintering' of bone) makes up what Scarry calls "a language of "agency"" (Scarry 1985:13).

[91] Scarry describes pain as essentially 'shattering' representation, arguing that this state of being "has no referential content" and thus essentially "resists objectification in language" (Scarry 1985:5).

(Bennett 2001:5).[92] In Bennett's model, bearing visual witness to the damaged body prompts a kind of immediate and close 'confrontation' that resonates with a spectator's *own* past experience of physical pain. This sees disinterested viewing "[give] way […] to a more diffuse and a bodily sense perception" (Bennett 2001:8), engendering an affective bodily empathy, and ultimately transforming vision into an embodied experience. For Bennett, this unsolicited emotional response, one that acts as to physically 'touch' and even hurt a viewer,[93] is at work in representations of physical wounding, material suffering, and bodily damage.

What both Bennett and Scarry propose therefore is a kind of spectatorship that may be fostered by images of pain and suffering, rendering a viewer vulnerable to the unsolicited affective potential of the body in pain, exposing them to being touched, stabbed, shocked, jolted, hurt by an image. Because clinical photographs are meant to function instrumentally as diagnostic records and educational material, however, it is precisely this kind of "expressive potential" (Scarry 1985:17) and affective response that must be removed to ensure legibility. The affective potential of images displaying the ruptured, broken body is necessarily silenced in order to achieve this material's functional aims. As such, experiences beyond purely clinical, disinterested engagement require careful 'reining in' – the diseased body requires sublimation.

Used to denote the channelling of the psyche, the body, and thus ultimately the extra-linguistic into signification, sublimation sees the corporeal relegated to a state of ordered, controlled, external objecthood. Essentially, ritual practices of dirt-avoidance (Douglas 2001(1966)), metaphoric language (Sontag 1977), social ordering (Crawford 1994), and cultural sense-making (Gilman 1985b; Gilman 1988)) may all be considered necessary maintenance of subjectivity against abject threat.

[92] Rather than fostering a disinterested acknowledgement or intellectual awareness, images of the wounded body may essentially transfer painful experience to a viewer by prompting a kind of immediate and close 'confrontation' that triggers not merely a recognition of the pain on display, but one that has the potential to resonate with a spectator's own past experience of physical pain. In order to make her point, Bennett relates the triggering of this 'sense memory' to medieval representations of Christ's crucifixion – images that sought to stimulate an intimate engagement and a sense of deep connection with the physical suffering of divine sacrifice (Bennett 2001). Medieval imagings of the Passion were produced with the intent to evoke affective and embodied experience of Christ's pain. Prompting its onlookers to bear direct, close witness to the anguish of Christ, Bennett suggests that the pictorial focus on the wound (the nail entering the Christ's feet) could bring spectators face to face with His suffering.

[93] In her discussion Bennett draws on Barthes' notion of the *punctum,* a visual detail within a photograph that cuts into the otherwise reasoned, detached, and interpretative viewing experience (Barthes 1982). While not addressed here, the following chapter engages this notion in relation to the affective potential of the SSC.

2.4 SCIENTIFIC SIGHT

The (photographic) depiction of syphilis poses a particular problem for the act of sublimation due to not only the conspicuous nature of this disease and its symptoms, but its immensely destructive impact on the human body. While images of the ruptured body have the ability to offer a visceral and affective experience of the material damage visually witnessed, the institutional intent of clinical images sees this potential critically denied in the act of viewing. Thus, while images of the ruptured body have the capacity to evoke shock and disgust (rather than disinterest and intellectual engagement), elements within the photographic frame as well as disruptive facets of experience are necessarily excluded in order to channel a disinterested, matter-of-fact medical gaze.

In his reading of the systematic development of vision in the Western world, Suren Lalvani sees the development of imaging technologies as having fostered a particular understanding of sight and depiction in relation to camera optics. Drawing on Greek optical theory and Euclidean geometry (Lalvani 1996:4), linear perspective harnessed during the Renaissance emerged as a method to accurately relay the physical, three-dimensional scene onto the two-dimensional representational plane (Jay 1988:6-7; Jay 1994:51; Lalvani 1996:4-5). During the 16th century it was the harnessing of the camera obscura[94] as the primary technology to aid depiction that saw a privileging of sight that was monocular and essentially machinic (Crary 1992:38-39). By separating seer from seen, observer from observed, subject from object through the use of optical instruments, vison became something standardised, calculable, and fixed (Jay 1994:52-53). While the body saw in three dimensions (binocular, two eyes, two points of view), the camera obscura and similar technologies fostered monocular vision and singular, two-dimensional depiction. Mechanically mediated, this kind of vision was considered 'purified' from the subjective, inconsistent, and interpretative form fostered by direct, bodily perception (Crary 1988:32-33; Crary 1992:47-48; Lalvani 1996:13-14). By offering what was perceived to be an "infallible vantage point" (Crary 1988:32), the viewer was provided a sovereign position in relation to both depictions and the objects depicted – one that rendered the world calculable, ordered, fixed, and essentially external to the viewer (Lalvani 1996:5). Turning the world into a stable, innate, passive object ever open to scrutiny, this disembodied way of seeing offered by the camera obscura saw Cartesian perspectivalism[95] emerge

[94] The camera obscura was an optical device and mechanical precursor to the photographic camera often harnessed by artists to achieve perspectival accuracy.

[95] Cartesian perspectivalism is a model of vision drawing on a combination of Renaissance linear perspective and Descartes' emphasis on vision as essentially mind-centred (Jay 1988:5).

as the dominant model of vision within the sciences.[96] With the development of ever more advanced viewing devices and the refinement of optical lenses during the 18th century, sight emerged as the most privileged of the senses due to its ability to grant visual access to domains out of reach of normal, bodily human sight (Jay 1994:65; Stafford 1997:345). Establishing an essentially distanced and de-eroticised visual encounter, experiences such as desire, identification, and emotional engagement were replaced with abstract, mathematical, and wholly disinterested representations in which verisimilitude was the ultimate goal (Jay 1988:8-9). Scientific sight essentially sought to remedy bodily observation with all its subjective sensate inconsistencies and extra-visual influences. With the advent of the 19th century, the sciences thus became ever more invested in a search for not only objective perception and representation but also methods to objectify the material world via its depiction.

The emergence and proliferation of photography during the mid-19th century thus saw a cementing of these aspirations of disembodied mathematised vision and mechanical representation come to the fore. As mechanised sight was seen to provide a "purity of observation [a] new way of looking […] liberated from the second sight of prior knowledge, desire, or aesthetics" (Daston & Galison 2010:124, 161), the camera promised a wholly objective and non-interpretative form of depiction. As seen in the previous chapter, 'reigning in' the interpretive potential of both medium and maker saw photography facilitate new forms of 'science-directed' representations.[97] As such, this medium was harnessed in an attempt to limit the mediating human hand or otherwise 'safeguard' depictions from subjective judgment (Daston & Galison 1992:82-83, 99-100). However, while other mechanised forms of image-making including x-rays, glass tracings, lithography, and even illustrations made with the camera obscura were similarly harnessed by the sciences (Daston & Galison 1992:98), photography emerged as "the realist tool par excellence" (Edwards 2011:161).

Hinging on the optical characteristics of the camera obscura, the 'realist fiction' professed by the photograph drew on these notions of monocular vision and mechanical image-making that saw the world-made-object: a material domain to be captured, reproduced, studied, inscribed, and

[96]Both Jay and Crary are highly critical of this model of vision as dominating the 19th century. While it does appear to have been the prevalent way of seeing in the sciences, both Crary and Jay discuss how the development of recreational viewing technologies for popular use saw sight emerge as a far less disembodied sense than this model professes (Crary 1992; Jay 1988).

[97] However, photography per se posed a problem even during the last decades of the 19th century due to the expense, troublesome reproduction, and excessive detail associated with this medium. As a result, photographs served to assist in the preparation of atlases – seeing them translated into illustrations that required strict 'policing'. However, the continued faith in and use of photographic depiction is evidenced by the frequent declarations of the medium's usage or the harnessing of alternative photomechanical methods of reproduction (Daston & Galison 1992:101-103).

distributed (Lalvani 1996:17). Capable of directly transferring a moment in space and time into a preserved, fixed, and stable two-dimensional image (without the interference of the physical body nor illustrative mediation), the appeal of photographs for scientific use appears self-explanatory. By generating a visual 'trace' of that which it represents, photography was conceived as an essentially indexical medium.[98] Indeed, the very optical mechanism and chemical processes inherent to the photograph fostered the notion that such images operated as direct, unmediated imprints of reality. The use of this medium in the medical field thus likewise hinged on such understandings of photography as a wholly objective depictive method.

Essentially mechanising the clinician's gaze, the camera harnessed within the hospital and used to depict the diseased body appears as an extension of this model of vision. Monocular, mechanical, and wholly based on surface appearance, photography served – in theory – to remove subjective interpretation and corporeal intervention from medical sight as well as representation. Despite the ability for illustration to produce images with more detail, clarity, and colour than early photographic renderings of disease, the automation and accuracy of photography saw this medium favoured (Daston & Galison 2010:324). Indeed, it was the ideal of "[n]onintervention, not verisimilitude" (Daston & Galison 1992:120) embodied by photography that saw this representational mode take up a privileged position within the sciences.

However, while seemingly "untouched by human hands" and shielded "from subjective projections" (Daston & Galison 2010:43), photography's usefulness for objective instruction was nonetheless highly contested (Daston & Galison 2010:135). [99] While within the field of medicine illustrations of disease had served to mediate the viewer's reading by excluding unnecessary detail and accentuating clinically relevant characteristics, photographic images made no such discernment. Instead, the ability for photographs to convey useable diagnostic information that could be recognised, reproduced, and reapplied shifted from the discerning hand of the image-maker to the eye of its audience (Daston & Galison 1992:109, 117; Daston & Galison 2010:331). Particularly in the case

[98] Drawing on 'Peircian semiotics' (see footnote 41 in Chapter 1) the indexical nature of the photograph appears to draw a semiotic parallel with disease. As Daniel Chandler notes, a sign is indexical if there is a direct link between an object and its representation. For Chandler, symptoms (including rashes, pulse, and pain) are thus likewise indexes – in this case of disease (Chandler 2007:37).

[99] While assumptions surrounding the purely indexical nature of photography saw this technology readily harnessed by (medical) science, distrust of the medium soon emerged as artists and entertainers likewise made use of the camera for creative expression as well as popular amusement. Although the artistic and illusory possibilities of the photographic image saw doubt cast on the inherent objectivity of the medium (seen particularly in the double-exposure harnessed in spirit-photography (Kaplan 2008) and forms of optical entertainment (Crary 1992)), the scientific use of the photograph was likewise accompanied by a recognition of the inherent flaws of the medium including its 'relative' perspective, potential for distortion, and its inability to capture both highly contrasted fields and subtle gradations of tone (Daston & Galison 1992:106, 110; Jay 1994:128-130).

of depicting disease, the need for multiple photographic examples (in order to map out its potential pathological manifestations), saw diagnostic interpretation firmly rooted in the viewer. No longer a passive recipient of carefully structured images, the use of photography within the sciences necessitated the adoption of a "disciplinary eye" (Edwards 2011:168) – a structured way of looking at images to ensure appropriate reading. The excess detail supplied by the photograph thus required "suppress[ing] some categories of visual information while privileging others" (Edwards 2011:168).

In particular, it was the 'excess' of the photographic medium, its "random inclusivity" (Edwards 2011:167) that Edwards posits as indicative of photography's inherent 'instability' – necessarily tempered by training viewers to discern the relevant and pertinent from the superfluous (Edwards 2011:168).[100] As such, the "technical rules and protocols" (Tagg 1988:9) implemented by the likes of Bertillon and Londe (as discussed in the previous chapter) appear to speak directly to the inadequacy of this medium for use within the sciences when not strategically managed.[101] Although its representational accuracy and depictive transparency proved valuable for scientific use, the functional potential of the photographic image hinged on its visual control, regulation, and structuring of content, composition, as well as the viewing experience. In photographically depicting *disease*, however, it is not merely the excess nature of the medium that requires reigning in, but moreover the affective, abject potential of the body conspicuously corrupted and corroded by disease.

2.5 IMAGING ILLNESS

While fixing another as essentially 'unhealthy' has the potential to reduce the anxiety of falling ill (Crawford 1994; Gilman 1985b; Gilman 1988), the visual depiction of the diseased body may likewise serve to tame the visceral, threatening experience of illness. Indeed, for Gilman, the perceptual distance produced in the very act of seeing the sick essentially cements a healthy sense of self: postulating a hierarchised relationship between observer and observed, those who look at the diseased experience a more secure sense of self as they stare at a fixed, stable object – an ill counterpart, an antithetical 'I' that reaffirms their own status as healthy (Gilman 1988:7). As such, images of the sick serve to indicate where disease lies – elsewhere and happening to someone else

[100] While this concern speaks directly to the use of photography in Edwards's field of inquiry (namely anthropology), it likewise speaks to a trouble with scientific photography more generally.
[101] Seen with reference to the need to disguise patient identity within the clinical portrait, the medium was deemed "too 'honest' and real" (Te Hennepe 2007:156) – essentially exposing and revealing too much.

(Gilman 1991:1-2). The act of looking at the bodily collapse of another within an image thus sees the observed relegated to an object that may be both spatially and psychologically placed at a distance. Trapped within the depictive and discursive confines of the visual medium (the borders of an image, the frame of a painting, the margins of a page, or between the covers of a book), the threat of disease is managed and an experience thereof restricted (Gilman 1987:107).

Similarly, Foster (1996a; 1996b) understands representational strategies to mediate the affective potential of the abject, essentially servicing to 'pacify' it (Foster 1996a:109-110). Drawing on Lacanian screen theory, Foster suggests that the affective potential of the material body may be tamed via its visual coding: rather than inducing a sense of horror or disgust, depictive strategies can essentially 'rein in' these kinds of responses otherwise prompted by a face-to-face encounter with abject mess.[102] Instead of the affective experience that witnessing bodily mess and corporeal collapse may induce (particularly in the face of conspicuous and disfiguring disease), visual codes and stylistic strategies may serve to placate these kinds of responses. Indeed, "picture-making" (Foster 1996a:110) (and arguably representation more broadly) thus "allows the subject […] to behold the object" at a distance (Foster 1996a:109) – essentially serving to 'arrest' any prompts beyond objective engagement.

Reading depictions of the naked female body, Clark and Nead suggest that the aesthetic coding of art has been similarly harnessed to 'contain form' and transfigure the corporeal nakedness of the human body into a cultural object that fosters an experience of contemplation rather than carnal arousal (Clark 1957:22). In her reading of Clark, Nead identifies the depictive devices and "stylistic procedure[s]" (Nead 1992:21) of art to be the crucial facilitator of this "transmutation of matter into form" (Clark 1957:23) that transforms the human body from a *naked* material entity into an image, and thus the *nude*. By clothing the naked body in a "coherent style" (Nead 1992:21) it is rendered an object that 'elevates' viewing experience, that fosters a kind of looking that is intellectual and contemplative, rather than moving and affective. The ability for visual depiction to sublimate the

[102] In order to make his argument, Foster makes use of "the Lacanian diagram of visuality" (Foster 1996b:146). Unlike Renaissance perspective that sees the viewing subject placed in a position of mastery, Jacques Lacan's model of vision sees objects exert their own gaze and 'stare back' back at viewers. The viewing subject is thus "fixed in a double position" (Foster 1996a:108) in which the seeing individual becomes both subject and object in the act of looking. Thus "under the regard of the object […] pictured by its gaze" (Foster 1996a:108), the viewer is essentially captured by a returned look over which they have no control. However, Foster's chief concern with Lacan's model lies at the interface of the look of the subject and the gaze of the object – where representation takes place. It is a point that Foster refers to as the 'image-screen' and defines as "the conventions of art, the schemata of representation, the codes of visual culture" (Foster 1996a:109). It is the place where the material world is turned into language. What is at stake in Foster's discussion of the image-screen thus lies in the way it 'protects' the viewer from the violent gaze of the object – acting as a barrier where meaning is made and the material world becomes signifiable.

fallible material body thus sees representational strategies serve a vital role in ensuring a sense of mastery over that which is seen. Within the field of medicine in particular, the categorising, describing, and picturing of disease renders the corporeal mess and chaos of illness discursively stable and suitably 'known'.

While both Gilman and Foster speak to the representation of abject threat in relation to cultural practices of visual depiction (be this popular (Gilman 1988), scientific (Gilman 1985a), or within the realm of 'high' art (Clark 1957; Foster 1996a; Foster 1996b; Nead 1997))[103], it is possible to argue that sublimation does not necessarily occur within the confines of these disciplines, but instead may emerge whenever bodily mess and the material chaos of disease is written into language. As such, it becomes possible to postulate that visual depiction and classification within the field of medicine provides a similar purification of the abject proposed by Foster and an appeasement of anxiety as evidenced by both Gilman as well as Crawford. The categorical organising, labelling, description, and depiction of disease within the field of medicine appears to offer a discursive and conceptual 'frame' in which disease may be safely engaged as an object of knowledge. Captured within a particular interpretative field, the material mess of the diseased body may instead be visually structured to encourage a clinically useful engagement – rather than the emotional, instinctive, visceral experience an encounter with the abject would otherwise produce. In order to ensure the kind of disinterested, intellectual experience of disease required to render images of illness medically useful (as diagnostic teaching aids as in the case of the SSC for instance) the abject threat of material collapse must necessarily be subdued. To turn the diseased body into a passive object of clinical enquiry, intellectual engagement, scientific investigation, and safe scrutiny, it must be stripped of its affective potential. Thus, while the photographic medium requires depictive control in order for such images to serve their diagnostic purpose (achieved by limiting content, guiding the viewer's gaze, and creating comparative consistency), the bodily chaos of disease is in similar need of precise visual coding to make illness clinically legible.

In order to effectively image the symptomatic body in clinical photographs of disease, these depictions appear to harness a strategic set of representational codes to reduce the affective, material nature of bodily destruction. While the depictive protocols and standards within medical photography (as outlined by Londe) served to limit the inherent excess of the medium, it appears that they also stemmed extra-clinical responses to the broken, diseased body – rendering it a legible text, a 'design', rather than something material, real, and threatening. The visual management of

[103] Gilman's discussion looks at all three of these domains whereas Foster focuses particularly on how artists address the abject.

clinical photographs thus appears to draw on a similar logic in depicting the contaminated corporeality of the patient as that seen in the transformation of the naked to the nude – a conversion of the material body into an object of culture and contemplation. The aesthetics of medical depiction thus appear to perform "a kind of magical regulation" (Nead 1992:7) of disease and the diseased.

2.6 THE VISUAL LANGUAGE OF THE SSC

Within the 'Syphilis' photographs of the SSC, the potentially jarring display of the eroded, broken body as a result of both the disease's distorting capacity and the visual candidness of the photographic medium appears to see its resolution in the standardising practices that emerged at GSH during the 1940s. As O'Connor notes with reference to the naturalism of the clinical photograph, such images were necessarily 'tamed' not only by aesthetic but also experiential conventions – the physical space and institutional framework (such as the teaching hospital or medical journal) as well as the recognisable 'genre' of the images as 'clinical' and therefore scientific and objective (O'Connor 1999:240). As such, what O'Connor appears to suggest is that the viewing of visual material such as that within the SSC is essentially structured – channelled by the medical environment as well as the visual conventions that govern the production of images of disease within this institutional space. Indeed, despite the overall haphazard and inconsistent appearance of the SSC, close scrutiny suggests a number of overaching stylistic strategies that serve to 'rein in' both photographic as well as bodily excess. In particular, it is in the fragmenting of the body into individual and disparate sites, the frontal depiction of the face, and the complete removal of clothing that I have identified as methods harnessed within the 'Syphilis' collection.

2.6.1 FRAGMENT

Nearing the middle of the 19th century, Te Hennepe notes that illustrated medical texts incorporated both distinct and detailed case-study images of patients alongside more typical, abstracted limbs (Te Hennepe 2007:48-49). Seen in the work of dermatologists such as Ferdinand von Hebra and Prince Morrow, depictions of disease saw the body fragmented into various symptomatic areas.[104] Sectioned into dislocated bodily fragments affected by disease, symptoms and their anatomical sites were often depicted emerging from beneath veils, as if breaking through the pages of the

[104] Ferdinand von Hebra is most noted in the history of dermatological illustration for his addition of schematised drawings that would overlay more detailed, naturalistic, and often portrait-like depictions of patients. Even in his use of the portrait aesthetic, von Hebra's illustrations thus continue to evoke both distinct case and general trait (Te Hennepe 2007:48).

dermatological atlas, or floating freely as if wholly severed from their corporeal host. Despite excluding the patient's face, these fragmented body-parts appear to retain a sense of the clinical ward where bed-bound patients would have lifted their sheets, or skirts, shirts, and sleeves to reveal the effects of disease for the scrutiny of medical men.[105] Depicted not as neutral, universal, unidentifiable patches of skin (as seen in the work of Willan)[106] but on recognisable bodily locations such as the buttocks, arms, hands, and groin for instance, this form of depiction served to both focus the viewer's gaze on isolated symptoms while retaining a sense of both the body and the ward round. These images thus provided an impression of illness that was both specific and general, located as a singular symptomatic occurrence as well as a unique and individuated entity. As seen in the fragmentation of the body in dermatological illustration, clinical photography saw a similar donning of this abstracting tradition. Isolating lesions via the tight framing of symptomatic bodily regions sees viewers adopt a necessarily localised engagement with disease. The visual emphasis placed on the surface appearance of disembodied and decontextualised limbs thus produced a "topical photography" (Te Hennepe 2007:142) that served to render the patient (and their remaining, undepicted body and identity) a non-essential, abstracted backdrop to the disease.

Particularly in the depiction of fragmented limbs, the display of syphilitic symptoms within the SSC appears to limit the visceral, affective experience that an encounter with conspicuous bodily destruction may otherwise produce. Allowing little space for more than symptomatic body-parts, photographs such as that depicting a syphilitic arm and leg (Fig. 4) sees these appendages tightly cropped against a dark-grey surface.[107] Clearly rendered, the limbs and lesions appear as if to float above this solid grey plane, isolated from both spatial context while equally detached from the remaining body outside of the frame. Facilitated by the even lighting and focal clarity, the depicted anatomical areas are elevated to a place of focus and interest – optically readied for diagnostic scrutiny and decipherment. Visually dislocated from their specific context, the limbs appear as if removed from any identifiable location as well as time. As a seemingly a-historical, universal exemplar of syphilitic effects, this photograph thus speaks in broader terms as a 'typical' or characteristic image of this stage of the disease. Compounded by the rather generalised annotation of "Male. Syphilis Late Secondary." on the card's reverse (Fig. 5), the photograph appears as a

[105] This characteristic can be seen in examples such as 'Gumma of Tibia & Pyogenic Osteitis of Skull' (Fig. 2) discussed in the previous chapter.
[106] Discussed in Chapter I in relation to the attempts to standardise and classify skin disease.
[107] While difficult to confirm, these limbs appear to be resting on a generic synthetic grey hospital blanket clearly featured in other photographs within this collection.

generic representation of syphilis – one that may be scrutinised, memorised, and subsequently recognised in the living human body.

In this form of clinical photography, the formal qualities of the medium appear to disguise the presence of the patient, the body, and the individual directly affected by the disease visually evidenced. While likely to have required an uncomfortable posing of the patient in order to photographically produce this image, the method of its making seems to float below the level of recognition.[108] Like their illustrated predecessors, this and similar examples within the SSC limit any recognition of its production as well as the remaining patient-body – instead isolating lesions and structuring perceptual attention to turn anatomical fragments into (quite literally) disembodied entities. As the visual juxtaposition of disparate limbs is purely pictorial within these hand-drawn examples, the body as a whole becomes an inconsequential entity – removed both from the artistic rendering as well as the viewer's awareness and thus diagnostic concern. Through the tight cropping of the image, the neutralising of the background, the flattening of the picture plane, and the equalising consistency of focus, tone, and texture of both arm and leg, this photograph appears to mimic the stylistic coding of bodily fragments evident in similarly composed historical illustrations.[109] Essentially, photographs that make use of this illustrative technique render the chaotic corporeal effects of disease easy-to-view objects of clinical scrutiny, diagnostic evidence, and medical knowledge. The success of this card thus appears to rest less in the medium harnessed and more in the coding of the body: that is to say in the stylistic devices and compositional choices made in the process of the photograph's manufacture. However, while these strategies appear to assert and foster the image's functionality as diagnostic teaching aid, there simultaneously appears to be a crucial omission of clinically relevant information, particularly that of colour.

Produced in black and white (the apparent standard within both the syphilis photographs as well as the SSC more generally) depictions of the symptomatic body is one decisively removed from an experience of the physical body of the patient or a material encounter with disease. Devoid of colour, the 'lifelikeness' so prized by early users of clinical photographs (the ability to replicate the experience of the patient as if materially present or within the ward) is essentially stripped from these depictions via their monochromatic rendering of syphilitic lesions. Essentially abstracting

[108] While cases such as this do not directly state that the symptomatic limbs belong to the same individual, the close spatial correspondence between arm and leg within the image as well as the tendency for a single card to depict a single patient appears to affirm this reading. The physical closeness between these appendages required to take the photographs makes it highly unlikely and indeed nonsensical to have positioned two sick individuals and their symptom-bearing limbs in such close proximity.

[109] For an overview of similar illustrations depicting disease see Richard Barnett's *The Sick Rose* (2014).

'real' vision by eliminating colour, the use-value of clinical photographs appears troubled by the depiction of syphilitic sites in black and white. However, despite a seemingly counter-intuitive use of monochrome, this process serves to decisively limit not only diagnostic detail but similarly places a restriction on experiencing the messy, corporeal nature of the disease and its material manifestation. While syphilitic lesions emerge in the body as inflamed, reddened, yellow, pussy, wet, oozing, raised, and rupturing distortions of its surface, the removal of colour tempers the experience of these symptoms as particularly penetrating or erupting. Instead, the subtle gradation of grey tones across the surface of the skin fostered by and coupled with the even lighting and focus within these photographs appears to soften and smooth the transition from healthy tissue to that affected by the disease – as if to 'flatten' the experience of its affects. Rather than indicating a dramatic, immediate breaking of the body's borders that the recognition of reddened, inflamed tissue would provide, within the SSC symptoms instead appear as a gradual shift from healthy skin to diseased lesions.

The black and white photographs within the SSC thus do not render syphilis in as real, as physically present, or as threatening a manner as the indexical nature of this medium would suggest. By limiting a sense of bodily wetness, the degree of corporeal rupture and syphilitic penetration that a material experience (or possibly a coloured rendering) may have offered is greatly limited. Instead, the image offers syphilitic symptoms as somehow aestheticized – creating a visual parity amongst its contents, flattening out the experience of it, removing immediacy and affect. The omission of colour sees critical distance between depicted symptoms and the viewer, allowing for the photographs to be perceived as mere representation rather than a true, visceral, proximate experience of illness. Thus, in addition to the general practicality of using black and white photographs (as well as the evidentiary status associated with monochromatic images in the sciences), this representational strategy grants an almost timeless, a-historical quality to the depictions. Unlike the use of colour that serves to 'date' photographs (as clarity, vibrancy, tone, and saturation and create an overall 'look' rooted within a historical aesthetic), monochromatic images appear less vulnerable to this representational ageing. Visually detached from any particular period, the experience of the SSC photographs provide a perpetual, a-historical "presentness" (Jay 1994:133). Thus serving to distance an embodied encounter with the imaged fragments, the material nature of the body is removed, its proximity in both space and time reduced, and the syphilitic limbs presented ever more as representation – as image.

2.6.2 FACE/FRONTAL

The easy scrutiny seemingly perpetuated by the precise coding of fragmented limbs within the SSC, however, is not the only kind of visual rendering of the syphilitic body that sees a limiting of the material mess of disease. Featured in close to half of the cards within the syphilis folders of the SSC (63 out of 149 to be precise), photographs that include the face of the patient create an almost portrait-like result that, like the visual capturing of the fragmented body, seems to draw on a historical tradition of both clinical depiction as well as photographic practice more generally.[110]

Despite the correlation between clinical photography and its illustrative predecessor, the depictive similarities do not seem to speak of a 'natural' progression towards mechanical means of image-making but rather to the technological potential and limits of the photographic medium. The necessary commissioning of professional studio photographers by 19th century physicians – primarily due to the technical skill and specialised equipment required to produce photographic images (Mifflin 2007:41; Te Hennepe 2007:149; Worden 2007:19) – saw early medical photographs assume the pose, props, attire, and overall pictorial conventions of bourgeois portraiture (O'Connor 1999:234; Te Hennepe 2007:149-150). Thus, while medical illustration offered a visual language on which clinical photography could draw, these images were likewise greatly influenced by the development and limits of this mechanical medium. The continued resonance of this imaging style within clinical photographs – despite the development of ever easier and cheaper methods of photographic depiction – appears to speak to a depictive impetus independent of these restrictions.[111]

As the portrait tradition promised to deliver not only a sitter's physical likeness but also their social, economic, spiritual, and emotional state (Clarke 1997:101-103; Hamilton & Hargreaves 2001:20, 34), O'Connor contends that the adoption of the portrait aesthetic within clinical depiction similarly fostered a sense of the 'defining characteristics' – not of the person but of the disease. Instead of

[110] Conforming to the clinical method of investigating the body, early illustrations of skin disease paid great attention to the naturalistic (rather than schematic) depiction of individual patients. Seen as key to the study and treatment of illness, the value placed in unique cases of disease fostered by the clinic thus emerged in the visual language of dermatology. Described by John Crissey as a 'natural' approach, patients were portrayed in an almost portrait-like manner and with great attention to detail (Benthien 2002:54; Crissey 1951:419-420; Te Hennepe 2007:46). The early work of Jean Louis Alibert exemplifies the early use of this method (Te Hennepe 2007:36, 47). By providing a likeness of the patient as they would have appeared in the flesh (full face, dressed, and at times even reclining in bed) these early pathological images present disease as rooted within its particular manifestation on the individual body – in a sense recreating the clinical experience of the ward. By harnessing a naturalistic approach, Alibert thus embraced individual detail in an attempt to faithfully depict both patient and symptoms.

[111] The harnessing of the portrait-like trope appears to have fulfilled a particular clinical need within medicine – namely to recreate the experience of the ward and a sense of the examination. Authors such as Te Hennepe see the clinical portrait emerge as a trope necessarily recreating the actual experience of the patient as would result from hospital examination (as seen in the one-to-one, life-size renderings of the diseased body in the atlases of skin disease created by Von Hebra (Fend 2012:122)). The use of a portrait-like aesthetic within clinical photographs thus appears to likewise make use of the educational potential offered by this stylistic device.

producing the individual subject as "the centre of aesthetic attention" (O'Connor 1999:234), for O'Connor the 'medical portrait' essentially "merges person and pathology […] collaps[ing] the individual and his traditions (portraiture) into the identity of disease" (O'Connor 1999:235). Inverting the self-definition fostered by portraiture in this way, the clinical photograph instead operates as a quasi-counter-portrait: rather than a (re)presentation of an individual's ideal, essential or aspirational self, the medical photograph instead sees the conspicuity and defining features of disease take centre stage. Thus

> [h]alf artistic interpretation, half documentary device, medical portraiture operates to bring out the individuality not of the sitter but of the sitter's disease. Rendering intensely personal images impersonally […] they are meant not to capture individual character but to illustrate the laws of disease (O'Connor 1999:235).

As such, clinical likenesses emerge as antithetical portraits, as identifications of disease rather than human subjectivity. Essentially taking the place of identity, transcendental symptoms emerge 'across' various bodies – usurping the individuality of the unique subject and rendering them irrelevant to the image's diagnostic function (O'Connor 1999:235). The clinical image thus resonates as a depiction of disease by turning the body into a mere platform on which unique symptoms are made manifest. The essence of illness rather than the essence of personhood is what operates within the clinical photograph as the patient is rendered almost invisible: a mere object of diagnostic inquiry, a site on which the 'true' subject (the symptomatic instance of disease) is made materially manifest.

Within the SSC, the fragmenting of the patient serves to remove awareness of the unseen dimensions of the body. Those photographs that depict symptoms located on or near the face and head similarly see the visual coding of the photographs rendered a frozen, fixed, stable image of illness rather than human individuality. Despite including the distinctive, identity-carrying facial features of the individual patient, what appears to occur both within the standardised photographs of the SSC is a distinct receding of the person in favour of the symptom. Similarly evident in the adoption of Bertillon's 'mug-shot' method, while the patient remains present in the image, their individuality recedes from the (clinical) experience – as if moving below the level of conscious awareness. Instead, such photographs facilitate a purely diagnostic reading of the diseased body via this provisional denial of the individual human subject.

Similar to early illustrated 'clinical portraits', the photographic representation of the patient in cards such as 'Primary Chancre' (Fig. 5) appears to capture the unique details of both patient and disease

as a particular 'case'. Coupled with a textual inclusion of name, age, and date of depiction, both the individual and the symptom become located as a specific instance of illness. Thus seeming to draw on that representational logic of early pathological portraits, photographs such this tap into underlying, historical motivations to reproduce the experience of the physical examination or the ward round. Depicted as head and shoulders before a solid background that serves to decontextualise the patient from her spatial surrounds, this photograph like many post-1940 depictions of the face (quite literally) positions disease at the centre of the image. Coupled with the even focus and neutral eye-level angle, the flattened depth of field and removal of extra-clinical content focuses attention to the 'true' subject in question – the conspicuous manifestation of disease.

While within this image the covering of the patient's hair as well as the donning of hospital attire appear to reinforce an experience within the hospital ward, the replacement of individuating clothes likewise has the effect of removing the individuality associated with such personal sartorial choices[112] – limiting awareness of characteristics beyond those of face and symptom. By homogenising both the individualising content as well as the depictive strategies across multiple photographs within the SSC, lesions appear to take focal precedence. Thus, while the 'life-like' recreation of the clinical experience (including personal attire) is one crucial to historical illustrations of disease,[113] in this case the ward-orientated gown and shirt instead neutralise the experience of the patient and aid in isolating the site of disease – functioning to strip the individual of contextual attributes in a similar manner as does the flattened, emptied background. What occurs in this singling out of the face as seat of disease, is thus a targeted focus on symptoms that essentially renders the photographs ever more useful for diagnostic and educational purposes. As the features of the patient become secondary to the particular symptomatic manifestation of disease on display, these portrait-like photographs within the SSC operate as a "carefully posed, impeccably composed […] portrait of a specific […] disorder that happens to have shown up in this person" (O'Connor 1999:235). Rendered inconsequential except as site of a syphilitic manifestation – a mere backdrop to the true subject of the image – the 'identity' of the illness comes ever more to the fore.

As seen within the harnessing of frontality (drawn primarily from the human sciences), this posing of the patient turns the body on display into an ever more uniform, neutral symptomatic site. Standardised and rendered comparable, the neutralising functions of background, angle, focus, and

[112] Unlike early illustrations that largely retain a sense of the individual sitter (particularly seen in the careful attention paid to clothing and hairstyles by Alibert) the standardised apparel within the SSC sees such unique characteristics rendered not only non-essential but practically if not literally invisible.
[113] This is particularly evident in the work of early illustrators such as Alibert (see footnote 110 and 112).

dress appear to eliminate a sense of the patient as subject – instead shifting attention towards the distinctive characteristics of the disease. As such, these cards within the SSC appear to illustrate O'Connor's argument that despite the seemingly neutral or (in her words) 'stupid' and 'unthinking' camera, the photographic medium nonetheless serves to structure vision. Through strategies of inclusion and exclusion, compositional as well as technical protocols, such photographs channel a diagnostic reading that serves to minimise the connection between the bodies on display and the patients as individual, thinking, feeling subjects. Instead, the familiarity of the frontal coding harnessed during the 1940s produces an almost comfortable viewing experience. Predictable, customary, recognisable, these photographs aid a diagnostic reading by rendering the patient somehow invisible and symptoms amplified. Positioned as the singular focus of the clinical photograph – as emphasised by the accompanying textual description of diagnosis – this coding of disease sees such images emerge as manageable objects within a greater unconscious archive of similar (if not diseased) references.

2.6.3 NAKED/NUDE

The ease of depicting and viewing the diseased, ruptured body created via the coupling of photographic and clinical codes, appears to indicate the ability of visual representation to render potentially distracting or even unnerving aspects of both syphilis and subjecthood tame. One of the most salient examples of this ability for clinical depiction to sublimate both material mess and subjectivity, is the ease with which nudity is experienced within clinical images. While not unique to medicine, the ability for nudity to garner a striking lack of attention within clinical photographs is indicative of the (institutionalised) invisibility of the naked body within this field. Seeming to recede from the viewing experience, the affective potential of nudity (indicated by Clark and Nead) appears to undergo a similar process to that of material mess and patient identity. However, as experienced in the previous two examples, nudity – like the fragment and the face – requires visual structuring in order to render the naked body natural to the clinical experience and the display of disease.

Despite being one of the few photographs within the SSC in which the patient appears completely stripped of clothes and coverings, a card depicting a case of secondary syphilis is indicative of how nudity serves to aid rather than disturb the photographic depiction of disease. Captured from a waist-high angle, displayed against a neutral background, with even focus, lighting, and tonal range, the technical qualities of the image neutralise unique characteristics and contextual markers. While

mimicking the depictive techniques harnessed in the standardised renderings of faces and fragments, this depiction is unique to the 'Syphilis' collection in its almost full-body display of the naked patient – including his face. Standing in a fully frontal facing position, legs shoulder-width apart and arms fixed at his sides, the patient presents his body for thorough and unhindered scrutiny.

Both fully recipient of the medical gaze as well as a showcase of its operation, this image sees the patient emerge as a wholly passive entity to physical (medical) management, photographic depiction, and visual observation. Lacking even the most modest suggestion of bodily coverings, any reference to the physical act of undressing is eliminated. Stripped of all visual concealments, this photograph presents the patient as lacking the desire, modesty, or propensity for shame that even the most subtle and peripheral presence of attire would indicate. Devoid of any reference to an alternative state, the patients is both visually and conceptually fixed as perpetually bared. His body solely exists to showcase the effects of disease.

The (completely) naked body seen here within the SSC thus appears to function in a wholly instrumental fashion, operating as an extension of the physical examination in which this kind of unclothed access is vital to ensure "medical diagnosis and intervention" (Peres, Teplica & Burns 1996:4). By offering a means for total scrutiny, the naked bodies of patients are a routinised part of clinical investigation and care. As such, the complete exposure of the body emerges as an ordinary and commonplace affair within the medical terrain – less an obstacle or distraction to the identification and display of disease than a necessity to facilitate access to symptoms. However, while the medical examination may offer insight into the unremarkable presence of the naked body within clinical photographs, the ability for nudity to be experienced as so wholly normative even to a lay audience – myself included – suggests not only a representational translation of the clinical experience into photographic form but also a broader engagement with the body as something to be placed on display in all of its naked totality when offered up for scientific investigation and demonstration.

Recalling the commonplace nature of nudity in photographic studies of the human body, the "scientific demand for nudity" (Maxwell 2008:31) operated similarly within anthropological investigations of racial difference.[114] Serving to both reveal symptoms on the body in their totality as well as strip it of any distracting contextual excess, nudity offered a certain objective, neutral,

[114] While anthropological investigations of the 19th century regularly saw colonised subjects depicted naked, it appears that since medical photographs often imaged 'civilised' individuals (notably white and Western), these persons were only rarely depicted without clothes. However, when nudity was required in early clinical photographs, identities were anonymised depending on their social class (Te Hennepe 2007:159-161)

and essentially 'scientific' authority. As such, the 'naturalness' of (complete) nudity within clinical photographs appears based on a history of depiction that assumes its need and use, coupled with a learnt coding that speaks to the neutrality, objectivity, and overall 'medical-ness' of the unclothed body. [115] However, the ease with which the explicit and exposed naked body is glossed over in the visual search for diagnostic evidence within the SSC indicates a representational practice at work beyond this mere scientific reference. Instead, what seems to operate in these photographs is how its clinical function is ensured due to an interplay of learnt, institutional norms as well as representational codes.

While the body "as living organism" (Clark 1957:4) may evoke affective responses of shame, vulnerability, or sexual arousal, visual cues of high art have ensured a 'regulation' of both the messy and material body as well the viewing experience of this entity. Although clinical photographs do not directly draw on the conventions of 'high art', the nullifying of naked corporeality within medical photographs does indicate the effects of strategic depictive techniques on the body. Seemingly removing any sense of offense, arousal, or even sympathy, nudity within the SSC appears unremarkable. Rather than inhibiting attempts to decipher disease, the clinical representation of the naked body instead seems to undergo a similar "act of regulation" that focuses and directs a "potentially wayward […] wandering eye" (Nead 1992:6) as seen in renderings of the nude. Through a strategic visual structuring, the naked state of the patient is deferred as instead the techniques of clinical depiction (the removal of context and detail, the wholly frontal positioning, and the cropping of the figure for instance) structure the viewer's gaze away from an experience of the shameful, naked bodily state and towards conspicuous syphilitic symptoms.

Serving to essentially displace the material nature of the body, the messy threat of disease, as well as the subjectivity of the patient, the highly structured representations so far discussed offer a viewing-experience that is clinically-focused, essentially disembodied, and wholly disinterested.[116] The depictive strategies harnessed in the SSC (particularly those standardising techniques of the

[115] Extending Clark's reading of the nude, John Berger has similarly offered 'nudity' as the unclothed (female) body presented as an object – a 'sight' on display for the viewer (Berger 1977:53-54). Rather than seen in its particularity and uniqueness (its nakedness), the body is instead rendered 'nude' in being seen not for its own sake but for the sake of those who look (La Grange 2005:5-7). So too is nudity harnessed in medical depiction as a functional tool for an audience to see disease rather than the singularity of the subject displayed.

[116] Claudia Benthien notes how in relation to illustrations of skin disease symptoms appear as if to 'sit' on the surface of the body like "an externally applied blemish" (Benthien 2002:54). As such, for Benthien they remain non-threatening and as if applied on top of otherwise beautiful visages.

1940s) as well as the institutional framing and viewing of these photographs (in case files and the *SAMJ*) thus ensure that these photographs fulfil their clinical purpose.

2.7 RUPTURING REPRESENTATION

While clinical coding seen in the SSC (as well as medical illustration and photography more broadly) seems to have the potential to sublimate the abject threat of syphilis and render the disease a locatable, stable object of scientific scrutiny, Foster identifies the potential for images to likewise upend this pacifying tendency. While "the schemata of representation, the codes of visual culture" (Foster 1996a:109) may all serve to turn the material reality of disease into a decipherable entity, the aesthetic conventions of medicine appear to at times falter in the photographic depiction of syphilitic infiltration. Rather than reigning in the affective potential of material mess and corporeal chaos, visual representations may produce a feeling of "overproximity" (Foster 1996a:114) with the abject – one that may go so far as to usher in "the glory (or the horror)" (Foster 1996a:110) of a spatially proximate encounter. Serving as a conspicuous reminder of the precarious nature of the body and the instability of the skin, images that depict a body that involuntarily leaks, oozes, or spills out serves to offer an experience of disgust and dissolution. For Foster, putting the abject on display essentially "tests the limits of sublimation" (Foster 1996b:156).

Embracing a similar view to Foster, Shaviro sees the representation of the abject as triggering a complete "loss of control" (Shaviro 2006(1993):104) – a desublimation that sees the viewer 'engulfed' by the visceral experience called forth by mere representation.[117] This evocation of affect is one that is necessarily avoided within clinical depiction in order to secure the functional (diagnostic) use of photographs portraying the diseased body. However, within the 'Syphilis' folders of the SSC, moments appear when the corporeal aspects of bodily infiltration are made undeniably present and the affective abject nature of these images does emerge. Within this collection in which colour is stripped from the representations of the body and in which standardised clinical codes attempt to remove bodily, contextual, and subjective excess, what triggers a recognition of abject decay, infiltration, and corruption are the moments in which the depth of corroded flesh and the wetness of vulnerable and exposed tissue are made undeniably present.

[117] While avoiding direct reference to Lacan's image-screen and object-gaze, Shaviro's understanding of the tactile potential of cinema appears to deem the destruction of distance and upending of subjectivity as provided by the abject to be fundamental.

While various photographs within the SSC depict a level of material devastation done unto the human body, one element within the photographs that appears to prompt an extra-clinical experience is evidence of wetness – of the moist, internal realm of the body that (meant to remain unseen beneath the surface of the skin) - is rendered conspicuously accessible. Although most of the photographs within this collection depict the distorting capacity of this disease, few are indicative of a true penetration of the body's borders. Instead symptoms appear to 'sit' on the surface of the skin, or otherwise merely distort the body's outline (seen for instance in the various depictions of gummatic swellings). As a result, few of these images appear to trouble a diagnostic gaze. However, photographic depictions in which internal tissues are made visually available appear to offer a heightened recognition of the destruction caused by disease. Thus, while the corporeal mess of the body may be tamed via strategic methods of depiction, certain images within the SSC that hint at the depth of infiltration seem to hold a disruptive potential – one that may even see the failure of clinical sublimation.

In an image depicting a perforated gumma (Fig. 6) for instance, the evidence of bodily penetration and syphilitic invasion sees the viewer's gaze gain somehow inappropriate access to the material depths of the body. Rendered open and vulnerable to inspection, the anatomical framework of tendons, bone, and wrecked tissue appears exposed in a most unseemly manner. Jotted across the wound, small points of reflected light grant an understanding of not only the hills and dales of the body's interior, but likewise offer details beyond the merely visual: providing a sense of physical texture, of the tactile qualities, the essential wetness of this internal terrain. Thus elevating the experience of disease beyond the visual, these white specks of light indicate not only moisture but other non-optical characteristics that likewise enter awareness: the temperature of the body, the viscosity of its fluids, the consistency of muscles, bones, and veins. While these can but be imagined, the photograph appears to point to their presence – to the material nature of both body and disease that cannot be visually translated and yet evoke attention. In such instances, the image thus appears to grant uncomfortable access to a body that – despite the lack of colour and despite displaying a mere portion of the patient – offers a visceral awareness of material devastation. However, one photograph of the fragmented body stands out within this collection as particularly affective – not only due to its display of bodily rupture but the force with which it makes the broken, wounded, syphilitic body almost physically present.[118]

[118] As Shaviro offers: "Abjection provides the link between visual fascination and physical sensation" (Shaviro 2008:185)

A quasi-gynaecological photograph, the image of an emaciated woman whose body is wracked by both disease and secondary infections makes a level of corporeal destruction overtly present. While the degree of syphilitic infiltration and bodily rupture sees her depiction appear as one of the most explicit photographs within the SSC, the pathological effects on the body are compounded by the manner of its rendering. With her legs spread and her genitals centrally placed, the photograph sees the diseased region spread out before the viewer, take over the frame, and overwhelm the pictorial plane. Depicted with incredible clarity and tonal depth, the photograph is granted an almost sculptural quality while sores, swellings, and the wrinkling of skin are all rendered in the utmost detail. Enveloping much of the image's frame, the patient's body appears almost physically present and the disease excruciatingly close. While the posing of the body in this manner is not uncommon to historical renderings of (syphilitic) female genitals, this photograph appears to grant a sense of close proximity between the viewer and the disease that in moments upends the distance and mastery proffered by clinical depiction. As spatial and bodily setting are evident in the indistinct blurred hints of the patient's reclining torso, their presence emerges both literally and figuratively behind this disease-ridden region. Although offering a sense of the three-dimensional space beyond the symptomatic site, the photograph is as if flattened into two planes: that of the disease and that of the patient. Indicative of the photographic medium at work, the perspectival distortion and narrow focus produce two visual realms: that of the enlarged and highly detailed syphilitic region and that of the receding, shrunken, and indistinct upper body, face, and with it identity. Thus bringing the symptom and site of disease inescapably close to the viewer while limiting the diagnostically irrelevant areas of the image (the glimpses of a white gown, as well as the darkened gestures of arms and head), this depiction forces a visual engagement with bodily infiltration that is somehow too invasive. Triggering an instantaneous and instinctive response to this display of the living body "anticipat[ing] the horror of post-mortem decomposition" (Sontag 1989:39), such renderings seem to prompt a visceral recognition of the pain and discomfort brought on by the condition on display. Thus, while the patient herself may rest on the cusp of recognition (emerging ambiguously from the indistinct, diagnostically irrelevant areas of the image), the abject nature of bodily infiltration and a corrupted maternal origin[119] appear as if to haunt this depiction.

[119] As the child's primary and central "organizing principle" (Oliver 1993:46), the maternal host-body is the first thing that must be psychically discarded for delineation to take place (McAfee 2004:48). As such, this entity (as well as any material matter that speaks to this physical origin) is particularly abject. The photograph depicting the female sex organs may thus be understood as evocating disgust and horror as it offers an image of both material and maternal origins – that of the genitals as well as the gynaecological moment, a clinical photographic version of Courbet's *L'Origine du monde* (*The Origin of the World*).

2.8 CONCLUSION

While attempts to sublimate syphilis within the SSC appears to stem from the fragmentary depiction of the body, the familiar posing of the face, and the use of an overall 'scientific' visual language within these photographs, see both the disease and the human subject appear to linger on the periphery of perception. Despite serving to silence abject threat, clinical images are as if perpetually haunted by an affective potential – triggered by the recognition of bodily rupture and suffering subjectivity. Although images that harness a depictive consistency of the 1940s see a limiting of extra-clinical content as well as affective experience, these photographs do not wholly succeed in sublimating the 'syphilitic' subject. While generally the images do achieve what such clinical representation requires – to foster a diagnostic gaze – this historical function becomes somewhat tenuous when looking at these depictions beyond their instructional purpose.

Within the SSC, the attempts to sublimate syphilis and ensure a distancing between viewing subject and the diseased body appear in moments to be undone by the very abject nature of corporeal display. Despite the intent to provoke a disinterested viewing experience, the affective nature disturbs the clinical codes and stylistic strategies that seek to contain such an engagement. Indeed, rather than eliding these attributes, photographic depictions within the SSC at times serve to accentuate this potential – as witnessed in the depiction of female genitals.

However, despite the shock or perhaps awe at the often severe conditions, the ability (and at times desire) to look at these distorted bodies speak neither to the type of disinterested and objective perception of medicine, nor the kind of disgust and horror prompted by the abject. Instead, the want to look emerges as a strange fascination and sometimes uncouth pleasure – not clinical, not diagnostic, not instrumental and yet not horrifying either. This ambiguous and even somewhat surreptitious extra-clinical experience ushered in by photographs within the SSC thus seems to necessitate a less singular approach than the one I have offered so far. Consequently, in the following chapter I seek to address the evocative nature of this clinical photographic material in pursuit of coming to grips with the inexplicable and often sensate engagement it evokes.

CHAPTER 3: SEEING SUBJECTIVITY: AN EMPATHIC ENCOUNTER WITH THE SSC

3.1 INTRODUCTION

The previous chapter endeavoured to locate how the 'Syphilis' photographs within the SSC bear evidence of strategic attempts to sublimate the syphilitic body and produce a disinterested and purely diagnostic gaze. This chapter explores instances in which the photographic depiction of patients upset such strategies and instead usher in experiences that trouble a dissociated viewing of another's ill body.

Clinical photographs serve to render the pathological body an object of scientific scrutiny as well as a product of medical knowledge. Within Cape Town's medical school, the syphilitic body appears to have prompted a particular depictive language to secure the diagnostic and educational intent of such material. As can be seen within the SSC, the visual grammar of these photographs fosters the disinterested and disembodied engagement necessary for clinical utility. However, the array of visual material in this now disused historical collection suggests that the tools and techniques of medical sublimation are far less certain than so far described.

Indeed, the images within the SSC generally conform to certain standards such as the elimination of context and non-essential content, the standardising of photographic procedures, and the reference to a representational history of medical depiction. Yet in many, moments of rupture become apparent. In these instances a sense of discomfort, disgust, pity, empathy, recognition, curiosity, shame, and even guilt emerge – at times in small and subtle ways and, at others, in an almost violent and explosive manner. Despite the visual containment and representational management of abject threat offered by the clinical coding of the body, I thus argue in this chapter that the taming effect of these strategies appears to become unstable in a variety of photographs. I propose that because the 'Syphilis' photographs trouble the ease of looking at the broken, damaged, ruptured, syphilitic, and essentially suffering body, many of them encourage a far more engaged, subjective, and embodied kind of viewing; one that tests the limits of medical perception.

The photographs that serve as a focal point for this chapter are images that I identify as anomalous to the collection and most indicative of breaking the more predictable patterns of depiction discussed in the previous chapter. However, this selection also reflects the photographs within the SSC that affected or baffled me most acutely. As such, my own empathic responses guide this approach as I attempt to unpuzzle how and why the images (or elements within them) pierce me as they do; how

and why they move me to a particular kind of engagement and experience that is neither disinterested nor diagnostic.

Rather than approaching the 'Syphilis' photographs as historical records, in this chapter the images are addressed in relation to how they not only represent, but *re*-present – essentially re-enact – the moment they visually capture. Here, I draw on the work of Tina Campt in an attempt to think through theoretical concepts of affect in relation to the desire to look and the emotive potential of photographic material. I revisit Roland Barthes' *punctum* as applied by Jill Bennett to her model of 'empathic vision', as well as Susie Linfield, Mieke Bal, and Judith Butler's independent reconsiderations of photographic theory in relation to notions of ethics, desire, pain, and personhood to guide my otherwise auto-ethnographic account. By drawing on Michael Shapiro's writings on 'slow' and empathic looking, I indicate a pathway towards an alternative interpretative framework for these images that goes beyond the racialised or gendered readings that might more obviously be applied to such collections.

3.2 AFFECTIVE AND EMPATHIC VIEWING

In her writings on both institutional and personal collections of historical photographs, Campt sees such material as 'sites of articulation' that make their content 'present' in the moment of their viewing. While photography's evidentiary ability sees this medium able to locate a specific social, cultural, or institutional past, Campt engages such material according to its ability to highlight the moment captured in the image-making instant. It is in this reading of photography as re-enacting the past, that sees the photograph provided a kind of agency – a potential to speak of and for itself.[120] Rather than stable or 'dead' things, photographs may be understood as entities that wield "subjective power" (Linfield 2010:17), and hold the capacity to invite the viewer into their frame. By providing "an encounter with the present, the past, and the future" (Campt 2012:20) the photographic image speaks to something beyond its historic, evidentiary value.[121] Essentially, photographs may be understood to produce, evoke, and perform their visual content.

[120] Rather than seeing them as evidence of a particular context already known, Campt suggests that photographs allow histories to be written *through* them. As she states "when we make the photograph the center of, rather than an illustration or documentary supplement to, historical writing" they offer to reveal unforeseen pasts and produce unknown narratives (Campt 2012:7).

[121] Offering photographs as distinct from other depictive strategies, Linfield sees them operate almost 'magically' to absorb a viewer into their frame and make them feel present in the scene offered as a mere image (Linfield 2010:17). As a result, photographs appear to make what they depict undeniably present in both space and time.

As a result, photographic meaning is wholly dependent on who looks, as well as how, when, and where spectatorial engagement occurs. As a kind of depictive enactment, photographs foster an "open-endedness of interpretations" (Jones and Stephenson 2005:1)[122] in the moment of their viewing. Thus, they draw on the conditions and experience of viewing, the spatial, social, and historical context as well as subjective feelings, thoughts, and pasts of the viewer (Jones and Stephenson 2005:2). The viewer essentially becomes the threshold for this form of 'open' interpretation and, crucially, an *affective* reading.

Fundamentally referring "to those […] visceral forces beneath, alongside, or generally other than conscious knowing" (Seigworth & Gregg 2010:1), affect is 'pre-personal' – an innate "experience of intensity [and] a moment of unformed and unstructured potential" (Shouse 2005 [Online]). It is a bodily response that escapes consciousness and articulable awareness (Seigworth and Greg 2010:2).

Drawing on Shouse (2005 [Online])[123] Campt argues for the affective potential of photography, namely, its ability to inexplicably usher in close engagement and intense responses to both deeply personal as well as unfamiliar subject matter (Campt 2012:16). For Campt affect "describe[s] the excess of what registers in and through photographs beyond the visual" (Campt 2012:16) and speaks to their ability to evoke intense responses, to touch deeply, to essentially 'move' the viewer. As she poignantly states:

> They move us to affect and to be affected […] They are objects that engender experiences of intensity that we can often only identify, locate, excavate, and order after the fact. If affect is "what makes feelings feel," then photographs are objects that catalyze affect and make affect register (Campt 2012:16).

It is precisely these qualities of photography described by Campt that medical depictions of the human body and disease deny in order to ensure their clinical, institutional, and diagnostic legibility.

The affective potential of clinical photographs must be necessarily silenced in order to achieve their functional aims. As discussed in the previous chapter, a number of imaging conventions developed to 'rein in' both visually and viscerally excessive content. Within the SSC, attempts to contain the

[122] Amelia Jones and Andrew Stephenson address precisely this kind of 'performative reception' of images: rather than "a static object with a single, prescribed signification that is communicated unproblematically and without default from the maker to an alert, knowledgable, universalized viewer […] viewers/interpretors are caught up within the complex and fraught operations of representation – entangled in intersubjective spaces of desire, projection, and identification" (Jones & Stephenson 2005:1).

[123] Shouse locates the power of "[many forms of media] in their ability to create affective resonances independent of content or meaning" as crucial to representation (Shouse 2005 [Online]).

conspicuous symptoms of syphilis seek to ensure the distancing between viewing subject and the affective nature of the wounded body and disease. In so doing, the sick body is rendered an inanimate, stable object of medical science and clinical scrutiny. However, at moments, these careful strategies come undone – seen for instance in the depiction of pain and the display of the physically ruptured body. As Bennett and Scarry's address of wounds indicated in Chapter II, the affective potential of seeing the damaged body offers an experience beyond that of a merely optical encounter. While both Kristeva's abject as well as Bennett's wound were harnessed as a way to unpack how clinical codes may be shattered,[124] an embodied experience of another's suffering is not the only means by which such photographs may usher in an affective response.

As I have shown, Bennett and Scarry provide a way of reading depictions of pain and the display of the physically distressed body that sees the affective potential of the (photographic) image made manifest in the viewing experience. Yet Bennett's proposition of an image's ability to touch and hurt the viewer – to see the viewing of pain essentially rendered painful – is not one limited to the display of physical hurt nor bodily damage. Instead, her recall of Barthes' canonical model of the *punctum* (1982) as affect-triggering detail offers a useful avenue for further engagement with the SSC. Barthes' writings on the *punctum* speak to a punctual presence that exists in photographs – particularly in erroneous, unexpected and idiosyncratic elements. While not associated with material mutilation or bodily damage, the *punctum* sees photographs nonetheless prick, stab, touch, even hurt the viewer and render the viewing experience affective if not painful (Barthes 1982:42-45). The *punctum* is for Barthes the trigger that jolts him out of analytic, passive, narrative-forming spectatorship. It is a detail that fosters a bodily and intersubjective proximity that is jarring, touching, and even painful without depicting pain per se. Drawing on this, Bennett holds that visual representations offer a means by which events may be 'read' through the viewer's own body by fostering experiences of events that are neither disinterested nor detached. In so doing, what Bennett suggests is an "interactive mode of viewing" (Bennett 2001:12) that sees images forge both "bodily and emotional connections" (Bennett 2002:350). Recognising this, it is my contention that the photographs within the SSC that focus on oozing, ruptured sites of disease – gummatic ulcerations and the like – ultimately resist the kind of response that engenders empathy. Instead, the impulse is a powerfully affective one of abject rejection. In comparison to this theoretical address of horror and disgust conducted in the previous chapter, Bennett offers a productive way of reading those photographs in the SSC that do not depict abject bodily rupture and yet prove highly evocative. It is

[124] This was experienced in examples such as the overt display of syphilitic female genitals discussed in the previous chapter.

in the display of otherwise compromised individuals that this clinical collection appears to prompt affective engagement. In these instances, however, it is an encounter based on connection rather than rejection.

Following both my own experience of the images within the SSC as well as Campt's argument for the affective potential of photography, the following discussion is structured around those photographs within the 'Syphilis' folders that in one way or another 'touch' me when I look at them. They activate responses beyond the calculable, explicable, purely cognitive and conscious. I thus begin by engaging images that visually offer the patient-body, yet see an apparent failure of sublimation. Instead they foster an almost instinctive, immediate, and often embodied response. As such, the following (re-)address of photographs within this historical clinical collection serves to make sense of images that provoke emotive, visceral reactions without abject rupture.

3.3 CASE STUDIES

3.3.1 Josephine

The case of Josephine consists of a series of four numbered cards indicative of a clinical desire to display syphilis in all its symptomatic manifestations. Like most other depictions within the collection, this patient has both her personal details (name, age) and the particulars of her case (date, diagnosis, symptoms) inscribed on the reverse side of every display card. Through portrait-like renderings of face and body (Fig. 9), facial close-ups (Fig. 10), fragmentation (Fig. 11), and x-rays (Fig. 12), this assembly of depictions sees the young patient unfold in a variety of imaging methods and from numerous angles. Beginning with the first photograph taken in the standardised, head-on style of the 1940s (Fig. 9), this image sees her dressed in a hospital-issue gown and facing the camera directly. Starkly evident are both the gummata located on her forehead (a symptom likewise acknowledged on the back of the card) as well as rather severe facial asymmetry – a conspicuous characteristic omitted from the document's list of symptoms.[125] What is evidenced in this photograph, however, is how the subtle deviation of frontal depiction has both clinically strategic (and thus diagnostic) consequences as well as affective ones.

[125] Labelled and broken down in numerical order, the symptoms exhibited by the body on this card is: "1) Gumma of Frontal Bone" (protruding swelling on forehead), "2) Interstitial Keratitis" (inflammation of eyes), "3) Enlarged Liver", and "4) Emaciation with pendulous breasts" – all of which function to fix a reading of this body as both symptomatic and, more pressingly, as clinically decipherable.

Unevenly illuminated from the left, the side of her face hit by the artificial lighting bears the kind of perspectival flatness seen both in similar images within the 'Syphilis' collection as well as photographs publically used for official licensing and in identification documents. While perpetuating this mode of displaying the face, what is striking in this photograph is how the other half of Josephine's face – that bearing the more generally distorted features – is cast in deep shadows.

Although likely harnessed to emphasise and visually clarify the extent of the gumma on her forehead, the subsequent effect of uneven illumination sees the affected side of her face deeply etched – adding a depth to not only the symptomatic site but likewise to the averted eye and somewhat sunken ear, cheek, and lip area below. Likely caused by the underdeveloped left cheekbone associated with her diagnosed condition of congenital syphilis (Yeats, Personal correspondence 2016), her left side (the viewer's right) appears to work photographically in a way that troubles the strategic methods of depiction harnessed elsewhere in the SSC. The quite literal highlighting of the gumma (the first listed and most relevant attribute as evidenced by the addition of an x-ray image and a radiographic diagnosis (Fig. 12)), serves to offer a clearer clinical picture of this primary symptomatic site. However, the photograph also strangely emphasises not only this syphilitic lesion but also what appears to be the clinically irrelevant attribute of the patient's physical state.[126]

While likely an accidental consequence of illuminating the gumma, the effect of the lighting sees erroneous characteristics of Josephine's face similarly heightened and ever more defined. Juxtaposed with the smooth flatness of the evenly lit side in which her gaze appears to meet that of the viewer, the darkened portion seems to function like a grotesque caricature and renders this young woman strangely aged, collapsed, and pitiable. Although this experience may be attributed to the very real material qualities of physical malformation, what becomes evident in the comparison of this photograph with its neighbouring image of the same individual is the potent influence lighting has on the affective quality of photographic renderings of the face.

In looking at the following photograph that sees a shift in both lighting and angle – significantly illuminating the patient from the right rather than left – a dramatic change in her appearance takes place. Smoothing out features that in the portrait-image appear almost monstrous (a quality particularly heightened by the presence of the gummata), the second photograph sees a very different rendering of this previously darkened facial portion by limiting the extreme appearance of

[126] The irrelevance of the facial asymmetry is deduced from its omission from the diagnostic description on the card's revers.

the condition elevated in the first. In comparison, her youthful and beautiful, rather girlish appearance seems to turn gaunt, almost threatening, and somewhat masculine – an effect that could be created by the shadowed upper lip, darkened eye, and ever more angular cheek. Heightened by the sudden presence of an almost ominous partial shadow emerging on the patient's left – a further consequence of the adjusted lighting – the second photograph appears to foster a far less empathetic response than the first. Consequently, what the primary portrait-like photograph illustrates is not only the ability for lighting to offer a practical solution to render characteristics of disease visually prominent and thus diagnostically useful (as seen in the apparent focus on the gumma), but also its ability to influence a more subjective interpretation of the individual on display.[127]

Already impressing a sense of vulnerability and agony as a result of her split expression (particularly fostered by downcast features), conspicuous symptom (gumma), as well as her malformed breasts and overall wasted appearance, this second image additionally grants a sense of vulnerable exposure – to the gaze of medical practitioner, photographer, and viewer. Although the wholly nude body has been seen to express an inherent, neutral, a-historical, universal body, this image of Josephine in a partial stage of undress appears to usher in a sense of enforced nudity, of an individual compelled to disrobe before the camera. By retaining a (partial) presence of hospital attire, the ease of viewing otherwise offered by complete nudity and the institutional as well as instrumental authority it grants appears somewhat disrupted by these sartorial remnants. While the display of the naked torso is not uncommon to this collection nor clinical photography more generally, this particular example sees a less-than voluntary unveiling of the upper body: rather than being tightly fixed around her waist, wholly removed, or replaced by another form of drapery, sleeves remain almost casually pulled below her waist while continuing to cover her arms, fixed above her wrists. In this instance, this unfinished removal speaks to another party having manipulated her clothes by pulling them incompletely from her arms and towards her wrists – a surely uncomfortable and difficult (if not impossible) manoeuvre was she to perform it herself. As such, the photograph creates the impression of an individual whose physical appearance as well as representational presence suggests a body fallen victim to both disease and the influence of another. While by no means equivalent, the

[127] Although not harnessed for physiognomic reasons, this photograph indicates how lighting can in itself inform a reading of the biological body. As addressed in her engagement with ethnographic photographs, Deborah Poole notes how studio lighting was harnessed by both portraitists to highlight 'noble' features of the bourgeoisie while likewise utilised by photographers attempting to scientifically locate supposedly undesirable features associated with social deviance or racial distinctness (Poole 1997:111, 117-118). Thus seeing light and shadow harnessed to accentuate physical traits to speak to a particularly (un)favourable character as well as serving to influence the analysis of essentialised racial types or personality traits, this historical photographic use sees images such as those depicting Josephine resonate with a representational power that offers the subject on display as a legible text that may relay an unseen, internal, and inherent nature.

tradition of revealing the body in this way (through visual unveiling) draws links to a history of depiction other than that of medicine.

Seen in the daguerreotypes of African-American slaves taken by comparative anatomist Louis Agassiz,[128] this method of unveiling and revealing the body as a quantifiable entity in the study of racial difference positions this mode of depiction as one loaded with associations of 'compulsory visibility'. The actions of another witnessed in the seemingly involuntary undress of Josephine's body is made manifest in the presence of another's hand – a hand that makes an appearance on the following card (Fig. 10).[129] Blurred and backgrounded, partial evidence of this other body emerges in the presence of fingers clasped at the back of Josephine's neck in one of three close-quartered depictions that reveals the tell-tale Hutchinson's teeth. Despite the overall success in rendering the body a scrutinisable, medicalised entity, an affective recognition of another's influence (both indicated by the partial undress and made manifest in the physical presence of the hand) seems to throb just below the surface of experience and gently troubles a detached and purely clinical reading.[130]

While neither this imaging of congenital syphilis nor clinical depiction more generally condemns the patient along the kinds of ideologically determinate lines as images of racial science, the combined force of representing a body conspicuously suffering the effects of a highly stigmatising disease and essentially framed within the institutional environment as syphilitic is compounded by the (partial) removal of clothes. Speaking to a loss of agency, the manner of undress, pose, and strategic lighting of the face suggest a manipulation by and intrusion of another's hand – ushering in associations with the historical grammar of subjugating (racial) sciences. However, while these

[128] See Brian Wallis' 'Black Bodies, White Science' (1995) for further discussion of Agasiz's daguerreotypes.

[129] As until 1964 GSH had a singularly 'European' nursing staff (Digby 2014:778), this hand speaks to not only the clinical authority but also the socio-political circumstance of the country as it featured within the space of the hospital. Compounding this, however, is that the history of hospital practice saw non-European patients undressed by staff members while European patients were permitted to undress themselves.

[130] While the photographs in this case may have the potential to upset an easy diagnostic reading of the body, the persistent framing of the photograph as evidence of a medical condition and as diagnostic and educational tool permeates the naked rendering of Josephine. In particular it is the presence of an anomalous, irregular yet distinct line across her bare abdomen that draws this kind of attention. This literal inscription would likely have been achieved by physically drawing the line on the patient's skin prior to her being photographed to highlight the distended area and thus pinpoint the enlarged liver described (Yeats, Personal correspondence 2016). As a result, this feature functions to reaffirm the intended reading of the photograph: to contribute to the mutual support of text and image, of written diagnosis and visualised material symptom. Quite literally rooted in impetus to make the patient-body a legible surface, this attempt to indicate the external effects of an internal abnormality again place emphasis on surface – on rendering of the otherwise unseen manifestations of syphilis (or those only decipherable by an expertly trained eye) overt and evidentiary.

attributes contribute to a level of discomfort in my viewing of these cards, it is the single, seemingly innocuous depiction of Josephine's legs (Fig. 11) that is most striking.

Adopting a slightly off-frontal, and gently downward angle (indicative of the use of a tripod), this rendering of legs – situated before the white backdrop and on the dark floor of the photographic room – is one typical to the SSC. While engulfed in the familiarity of clinical codes, this photograph is one to which I was and am continuously drawn – an image that despite its compositional and stylistic simplicity lures me in again and again due to, I believe, the presence of the Josephine's shoes.

The pair of oxfords typical of the 1930s and 1940s seem to 'do' something to a reading of this body that does not upend the photograph's diagnostic function or its clinical engagement: it is neither violent, nor too close, nor too messy. Instead this feature seems to politely request attention. Breaking with the predominantly barefoot renderings within the photographic collection, this image sees an injection of not only a contextual periodisation, but likewise serves to visually locate the gender of these disembodied limbs. Indicated by both the distance between ankle and floor as well as the upward slant of the shoe, these heeled shoes see their wearer emerge as distinctly female. While this information may be easily gleaned from the preceding depiction that reveals her bare breasts (not to mention the personal details located on the back of the card), the shoes perpetually utter associations of time as well as offer some grasp of identity.

Oddly impractical and out of place, the shoes stand out in relation to the previous, hospital-garbed likenesses as well as similar renderings of the legs and feet within the collection as a whole.[131] Posing a perpetual interruption, the presence of these personal items (accessorised with removable frilled flaps) speak powerfully to the individual on whom they are fastened. Perhaps because they contrast with the standardised, repetitive character donned by most depictions of limbs; perhaps because they stand out against the homogenising function of the starkly contrasted background that remove context and individual attributes; or perhaps because shoes (and particularly heeled shoes) somehow reveal personal taste, reference individual use (comfort over style, practicality over trend), as well as point to economic status and age, that the image evokes an affective response. It punctuates my viewing, draws me close, and intrigues. These shoes are my *punctum* as Barthes would have it – that detail that complicates an ease of viewing and logical sense-making. Unlike the

[131] The photograph depicting 'Syphilitic Osteitis of Left Tibia & Clutton's Joints' (Fig. 4) featured in Chapter I is indicative of the more usual depiction of the legs in the 'Syphilis' folders.

photograph of her face, it is these shoes in which I locate a glimmer of recognition, of identity but also of identification and perhaps even, dare I say, connection.

3.3.2 P.C.

While the SSC photographs produced after the 1940s carry the standardising techniques addressed in the previous chapter, the depiction of P.C. (Fig. 13) appears to bear the marks of classical portraiture otherwise unseen in this collection.

The first of a series of photographic cards of patients annotated with the words "gumma of sternum", this coupled set of images offers a particularly unique depictive instance within the SSC. Rather than following the standard method of front and profile view (seen in many of the 'mug-shot'-like photographs that emerged during this period at GSH) the second image of P.C. sees him positioned at an angle, head gently raised, with eyes directed in line with his body and fixed ahead of him. While surely intended to accentuate the deep ulceration above his chest, the lighting of his face and body likewise changes from one photograph to the next. With the light hitting his face and body at a slight angle, various features are alternatingly cast in light and shadow, both accentuating otherwise unremarkable aspects of the face while hiding others in darkness. His photographic rendering resonates with devices harnessed by portrait photographers during the mid- to late 19th century as the 'bluntness' of a frontal gaze is replaced by the "slightly aloof raised chin and quizzical stare into the mid-distance" (Hargreaves 2001:33).[132] Widely harnessed in bourgeois portraits, this angled pose impresses upon the image a sense of voluntary self-display in comparison to one of 'compulsory visibility' as suggested by frontality.

In P.C., it is precisely this sense of self-representation that appears to emerge. Working somehow stoic, he garners this archetypal position that, compared to the frontal image, sees features like the brow, chin, nose, and cheekbones ostensibly heightened by both angle as well as deep shadows. While his eyes appear illuminated and lightened by his shifted position, his ears that work almost comically in the first photograph are here hidden in darkness. Consequently, his features are somehow reduced to angles and attributes that sees this image appear less that of a patient (harnessed

[132] Largely the result of physiognomic concerns, this visual coding of portrait photographs was the result of ever greater concern for 19th century studio photographers. While likewise originating out of necessity (due to the need for head-supports and stands to hold the sitter in position during long exposure times) – the popular engagement in physiognomy and phrenology had a direct impact on poses that sought to accentuate positive physical (and thus internal) traits while downplaying those less undesirable ones (Hargreaves :33-34). By placing an individual in a three-quarter position, it offered a more complete rendering of their appearance within a single image in comparison to the coupling of two rigorously singular, flattened front- and side photographs of the 'mug-shot'.

to display the nature of disease) than a self-aware individual engaged in representing himself. Despite the conspicuous nature of his symptom, the consequence of this visual composition and coding is an image that ushers in an experience of the individual and a wish to read his face – to locate the person over the disease. Offering a kind of archetypal presentation that reads like those displaying figures of authority and power – military men, political leaders, men of valour but also potentially tyranny – this image sees the diagnostic use of the photograph somehow overshadowed by the presence of his subjectivity.

What this photograph of P.C. fosters in my viewing is a sense of agency, a sense of self-awareness and self-presentation not otherwise present in the collection. Indeed, in paging through the file containing this card, a variety of other depictions of this symptom (gumma of sternum) appear. While his is the first of a series of photographs indicating this particular manifestation of syphilis, it by no means sets the stylistic tone for the subsequent cards. Instead, what follows is a series of seven additional depictions of this condition that – while similarly displaying the patient's face as well as symptomatic chest – do so without much representational consistency. At times faces are blurred, and the method of revealing the gumma ranges from bare-chested displays to lifting a garment, unbuttoning a shirt, or pulling down a collar. However, what does appear to be consistent is a decisive lack of the kind of agency, the kind of self-awareness and self-depiction that I see in the photograph of P.C..[133] Instead of the upright posture and somehow appropriate distance between camera and sitter seen in this example, the subsequent photographs in this file see patients jut their heads towards the viewer or lean too far forward with their shoulders as if to push their symptom close to the camera's lens. While these images also speak to a kind of self-display (the jutting forward of the body or head, hands tugging at or holding back their clothes) it is not the kind of self-aware posing I see in P.C.'s likeness.

Many of the other photographs annotated as "gumma of sternum" see the patients emerge somehow fragile and vulnerable in their rendering – with eyebrows raised or furrowed and the straining of necks and shoulders. Yet the photograph of P.C. seems less about making the disease evident and instead reveals a kind of self-awareness that comes from posing before a camera – from composing oneself when aware of being visually captured. Indead, he appears to have a knowing awareness of the image to be produced, an awareness of the process, and perhaps even a sense of comfort. Posing in this way is somehow familiar, natural, known to him. As such, the disease takes on a strangely secondary position as the image instead speaks to a sense of control, of knowledge, of agency, of

[133] These additional seven cards are all either dated prior to the 1940s or otherwise bear no date.

power, and the ability to choose the final outcome. His personhood pushes at me again and again – encased in the aesthetics of the classical portrait in both its technical qualities (the lighting, focal distance, composition, and pose) as well as in the seemingly self-conscious, if not proud exhibition of the syphilitic symptom. Thus the image provides a representational space where the codes of the portrait and those of the clinical photograph collide.

It is what Garland-Thomson calls 'hybrid' depictions – a merging of seemingly contradictory style and content in which viewers are unable to consolidate incompatible elements and contradictory sights (Garland-Thomson 2009:155-157). The hybrid image here created through the use of portrait-like depiction, offers a visual engagement with the patient that disrupts not only its clinical coding but appears to upend the social as well as medical associations made in relation to 'the syphilitic'. In his pose, stoicism, and strange sense of self-presentation that emerge in my own viewing, this image (or rather these kinds of images) offer an engagement with their subjects that provide an alternate mode of perceiving syphilitic individuals beyond personal, social, popular, and institutional assumptions of 'who' and 'how' these kinds of 'sick' people are.[134] Thus providing a means to see patients differently, hybrid images facilitate an alternative way to think and feel about those they depict.

Speaking to a kind of "aestheticised self-possession" (Sidlauskas 2013:36), the regal, portrait-like manner of display seen in the photograph of P.C. serves to indicates medicine's objectivising codes through this visual and aesthetic resistance.[135] It is this quality of the image that appears to speak

[134] Garland-Thomson in particular applies this in the realm of disability studies. For Garland-Thomson, the crux of the portrait aesthetic is in its ability to 'intervene' in the experience between viewer and viewed, shifting expectations, and fostering a new way of looking at unusual, altered bodies. The portrait image of a 'stareable' individual (otherwise seen only as object of scrutiny within the institutionalised frame of medicine) is one that makes one look differently – linger rather than turn away. Portraits sanction a viewer's stare and – by stylising, aestheticising, beautifying – produce a stare of appreciation rather than a stolen, curious, intrusive look. As a result, such forms of representation serve to "revalue devalued people" (Garland-Thomson 2009:83) by providing the space and time for a kind of prolonged engagement and contemplation otherwise inaccessible in interactions between these kinds of subjects. It is crucially "[t]he invitation to look that a portrait offers [that] precludes our skittish staring and instead allows us to look deep and long into these unfamiliar faces made strangely familiar" (Garland-Thomson 2009:83-84), that brings one closer to the individual depicted – perhaps closer than would otherwise be possible. It is specifically in the drawn portrait of a young woman with Down syndrome that Garland-Thomson sees the familiar "regal profile pose" in which "her nose and chin lift imperially her eyes gaze impassively down at the world beneath her" (Garland-Thomson 2009:82) as offering a way of thinking about this individual that contradicts established understanding of her as 'disabled'. Instead, "[t]he portrait invites us to stare, engrossed perhaps less with the "strangeness" of this woman's disability and more with *the strangeness of witnessing such dignity in a face that marks a life we have learned to imagine as unlivable and unworthy*" (Garland-Thomson 2009:83, own emphasis).

[135] Sidlauskas sees this occur in 19th century patient-photographs from the Holloway Sanatorium in London. As she offers, such depictions "achieve[d] what the subject herself could not: a socially sanctioned, aestheticised self-possession […] If subjectivity posed an 'insistent, unmanageable threat' to modern medicine, as Chris Amirault has argued, then medicine's fantasy of objectivity is exposed by a woman who violently resisted the control of others" (Sidlauskas 2013:36).

powerfully in rupturing clinical codes and upending diagnostic focus. It is one that has me turn my attention away from the disease. I struggle to see him as disease, or diseased, or even as patient.

3.3.3 Charles

Although the look into the camera is one not uncommon to the photographic medium, within the SSC the patient's reciprocal gaze appears in instances to take a particularly powerful form. I am looking at Charles, a 17 year old diagnosed with congenital syphilis (Fig. 14). Or rather, he is looking at me. Taken according to a similar depictive mode as other patient photographs within the collection produced during the 1940s (particularly those of patients likewise diagnosed with congenital syphilis), the depth of field is short, the lighting somewhat off-set, the background emptied and flat except for two signature ripples of fabric that give away the attempts to construct a neutral background devoid of context. Donning the familiar hospital-issued gown, his likeness is visually stripped of personal paraphernalia, context, and history, and his identity defined by diagnostic description. However, while the formal aspects of imaging and dress lean towards a neutralising and decontextualising of this individual (to render him body, disease, clinical, diagnostic), these attributes appear to function only superficially in their suppression of subjectivity in favour of symptomatic detail.

With his head turned to expose the "Gummatic perforation of nose" described, Charles presents his face for the camera's lens and, consequently, the viewer's scrutiny. However, while this tilted pose does not trouble the otherwise more frontal or fully profile portrayal of the face within the SSC, what is striking in this image appears to be the patient's stare that, despite the off-centred angling of the face, remains steadfastly aimed at the camera, with eyes fixed on its lens. My own inquiring look is disturbed by his stare. The intent of this representation, like all the photographs in this collection, is to illustrate the symptomatic bodily destruction of (congenital) syphilis. Yet this image prompts a visual investigation in favour of clinically irrelevant qualities – of clues to the individual depicted rather than the signs of disease.

Despite affecting the very centre of the face and more specifically the nose – that very feature so central to the symbolism surrounding syphilis – the primary lesion (the nasal gumma) is rather unspectacular in comparison to many of the others featured in the collection. The wound itself does not appear as a site of bodily mess and decay, nor does it significantly distort facial appearance. Instead, it appears as an almost sculpted, if anomalous, feature of the face. Rather than the kind of

rupturing seen in other instances of gummatic perforation, here the symptom appears as a smooth visual transition from flawless youthful skin to a dark and unseen bodily interior. It demands little attention and causes minimal discomfort. Instead, the lesion mimics the ordinary nasal opening positioned just below this disease-produced crevice – a quality that sees it function less as evidence of unnatural bodily boundary-breaking and more as an anomalous yet banal feature of the face. As a result, it appears that both the lesion's material characteristics as well as the technical choices of depiction (lighting and pose in particular) see the symptom rendered somehow ordinary and unthreatening. However, I find myself transfixed by this image; not by the disease, not by the symptom, not even by the stylistic devices or aestheticisation as seen for instance in P.C. With Charles it is his steadfast and penetrating gaze in my direction that draws my attention – that holds me fast in my attempts to peruse his body for signs of disease.

The direct, unflinching gaze that looks back at me through the picture plane is what strikes the deepest in this image; mirroring my own, this look in my direction demands attention and as a result, I sense the lesion, the disease, the diagnostic function of this image rendered inconsequential. Holding my own stare as I look at this photograph, the direct and unwavering look returned sees me struggle to pull my eyes away from his, to see the symptom – the intended subject – and assimilate it as diagnostic evidence of a clinical condition. Instead, again and again, I am drawn back to that look, that unflinching, unblinking, and penetrating look that stares at me through the image's surface, making me feel perpetually watched in my attempts to peruse the remainder of the photograph's contents. The powerful presence of this gaze acts as if to break through the flat surface of the photograph, puncturing both the physical and imagined barrier between the world of the image and the imaged, and the world I inhabit. Unlike the "photographic look" (Barthes 1982:111) described by Barthes, the returned (yet not wholly reciprocated) gaze that I sense in many of the 'Syphilis' photographs here seems to stare back with awareness and acknowledgement of my presence.[136] I feel his look as a response to my own; as somehow intimately aware of my actions towards his image. I feel myself before this photograph; or rather before him – as if found out in my observation and my scrutiny. It may be an illusion, this sense of intimacy and exposure; but it is one that seemingly holds me to account for my close scrutiny and casual perusal, one that forces me to

[136] While not uncommon to the photographic portrait(-like) image, the returned look is one that Barthes describes as paradox: while being looked "straight in the eye" (Barthes 1982:111) by an individual photographically rendered may give the impression of being seen by the imaged subject, Barthes suggests that the viewer is never truly seen – a kind of empty gesture made by the depicted. Essentially the photographic subject looks at nothing: the viewer remains looked at but not perceived, sees and senses the stare of the photographed while remaining external to it, separate and untouched by it. The imaged subject is one that for Barthes remains wholly disinterested in their viewing audience – their gaze staring forever outward, unseeing and unflinching.

recognise the power that I hold in looking at his body: the tight curls of hair, the smooth skin and delicate bone-structure, the slightly furrowed brow, the sparse eyebrows, the full lips, defined cupids bow, and gently indented chin, the gentle presence of an Adams apple, a swollen vein, the curves of collar bones, and the bare chest below a tattered bathrobe. I have been granted his permission and generous consent that allow me to look.

In having my gaze returned, I sense the power of my look as an action that is not singular, one-directional, nor without consequence. Instead I am forced to look as if I were looking at him and not his representation, to respect the fact that his stillness and silence is what enables me to scrutinise. But unlike the "open voyeurism" (Lutz & Collins 1991:139) that this sense of permission might be accused of,[137] I feel accountable for my actions and cannot help but be drawn back to his staring eyes, still holding me to account. While 'staring' for Garland-Thomson largely implies a mutual act of looking between individuals physically confronted with one another's bodies, she likewise sees the potential for staring between a living person and a photograph of another (rather than being in another's physical presence) to beget a kind of reciprocal, redemptive act of recognition.[138] Rather than that subjugating "oppressive act of disciplinary looking" (Garland-Thomson 2009:9) suggestive of a hierarchical viewing fostered by a 'gaze', 'staring' essentially upends the sense of mastery that looking at (particularly scientific) images fosters.[139]

It is this concept of staring that resonates with my (seemingly reciprocal) encounter with Charles. While the directness and clarity of the reciprocal gaze that haunts my viewing experience speaks to a kind of challenge, I experience this look less as one of confrontation and instead as one that proves far more ambiguous. Heightened by not only an exact meeting of his line of sight with mine but also

[137] As Lutz and Collins (Lutz & Collins 1991:139) argue, the returned look of the subject on display indicates an "acknowledgement of the photographer and the reader" that has been accused of allowing viewers to look in an uncontested manner at the individual depicted.

[138] What differentiates Garland-Thomson's theorising of 'the stare' from other understandings of viewing 'stareable' bodies (the unconventional, the disfigured, the damaged, the dead), is that in the process of looking there is the potential for both differentiation and distancing as well as validation, identification, and, crucially, a recognition that fosters reciprocity between viewer and viewed – allowing for those seen to be identified as subject in their own right, both as a unique individual as well as generic and familiar (Garland-Thomson 2009:158).

[139] Like many cards within the SSC that depict patients suffering the chronic effects of syphilis (particularly congenital and tertiary), this photograph is accompanied by a second image that focuses in on the specific areas of the body indicating signs of the disease – in this case, a gummata of the palate. Revealed via the upward tilted head, mouth open, and tongue out, this pose sees a forward thrust of the face and a kind of exposure that opens the patient's body up to internal inspection. By granting access to the smooth, rounded, pitch-black cavity. Rendered in varying degrees clarity (focus) and ambiguity (blur), his mouth, chin, and nose so beautifully defined in the previous image melt into semi-obscurity. In the shift from a more distanced yet engaged viewing of the first photograph to this proximate and penetrative one in the second, I cannot help but perceive a kind of erotic unfolding: the first image – the beautiful, the intimate, the reciprocal look – and this moment – the physically close, exposed, open – as a kind of sensual progression. Due to space constraints of this study I can unfortunately go no further in exploring this second image.

the technical quality of the photograph – its clarity of focus, tonal gradation, and the illumination of his eyes – this returned look that offers a potential for confrontation instead emerges as a moment of reciprocity, of acknowledgement, both of myself and my own stare. Due perhaps to the somewhat averted angle of his face, or possibly the gentle pulling together of his eyebrows that grants an almost quizzical look, or maybe it is the disheveled nature of his gown and the bare and somewhat bony chest it reveals that offer a vulnerable quality – a gentleness rather than a confrontational and competitive 'outstaring'.[140] It is this vulnerability fostered by the off-centered pose, the head-tilt, the subtle thrusting forward of the neck, and a kind of gentle lean towards the viewer that communicates as an offering up of symptom and body. It is reminiscent of the moment when, thwarted in a friendly game of rough-housing, an overpowered canine will offer its neck to its companion – rendering its most vulnerable body part open and exposed. Both an admission of defeat and a recognition and acceptance of dominance, this move also serves as an indication of trust: of laying one's body bare and open to damage. Thus a mutual agreement of surrender and benevolence, of vulnerability and yet safety, this symbolic treaty seems to be one channeled in this particular image in which the face, neck, and chest appear offered up for my scrutiny with the full acknowledgement of what this exposure implies. It is thus not defiant, not aggressive, but neither is it passive, wholly submissive. In his stare I am made aware of my presence before him. My body, my eyes, my very self are stared at in return, unsettling me, reconfiguring my experience and forcing me to feel myself in the act of looking.

3.4 REFLECTION

What emerges in my engagement with these photographs is most profoundly the ability for the images to communicate beyond their diagnostic intent and outside of their clinical framework. Through their stylistic qualities and incongruous contents they offer an experience that at times feels invasive, intimate, and even enjoyable. Indeed in the case of P.C. I am confronted by an image that fosters a response similar to that of the classical portrait. Although situated within a fundamentally clinical collection, the syphilitic condition all but vanishes despite its conspicuous nature and central placement within the photographic frame. Instead of a diagnostic specimen it emerges as a pleasing

[140] For Garland-Thomson, it is particularly the ability for this meeting of gazes (that of the viewer and that of the viewed) to "make a subject seem to reach out of the picture to stare down the viewer" (Garland-Thomson 2009:85) that offers the depiction of the maimed, the diseased, the disfigured, the 'stareable', a kind of agency that establishes and validates the individual looked at as person, as subject, as someone (rather than an object of inquiry and knowledge, pity, or disgust) (Garland-Thomson 2009:84-86).

portrait – the composition, the lighting, the tonal range all make it an image that fosters a kind of aesthetic appreciation, a visual pleasure. It does indeed appear to deny the kind of physical pain surely inflicted by the diseased state, the stigma he endures, the bodily degradation and slow decay.[141] By viewing these images with eyes trained not towards the cause and effect of disease but rather the extra-clinical, the accidental, the photographic excess, encounters emerge that push against the images' diagnostic function.

It is in moments where clinical coding falters that these photographs seem to fail to foster a distant clinical engagement with disease – and instead become images of suffering. What emerges are experiences that at times feel strangely intimate – and thus uncouth, inappropriate, and unethical – as in the case of Charles. Yet they emerge, despite my wish to deny them. To deny them would be to silence an evocation that (although highly subjective) makes itself felt and is undeniably present even if only in my own viewing. The guilt, the shame, the sense of impropriety I experience in engaging with some but not all of these photographs, sees me repeatedly and persistently drawn back to them.

The pleasure I obtain in looking remains unnerving, seeming to speak to an instinctive response that Linfield describes as the "innate, unreflective sense that “This is wrong!”" (Linfield 2010:50) so often triggered by photographs of those in pain. However, it is precisely this fundamental incitement to feel rather than think, to react instinctively rather than intellectually that has seen the most moving photographic depictions "denounced as self-indulgent" and met "with suspicion, mistrust, anger, and fear" (Linfield 2010:4-5). However, while my enjoyment in looking at these images is by no means ethically unproblematic nor defendable as an appropriate response to images created with diagnostic intent, to deny this evocation seems unhelpful if not somewhat dishonest. Indeed, it is this very recognition of the SSC photographs as "somehow, disconcertingly, beautiful" (Linfield

[141] It is precisely the erasure that occurs here in the depiction of P.C. that speaks to what has been noted as an inherent problem with photographs that depict suffering individuals – namely that of the camera's inherent tendency to stylise, aestheticise, and beautify suffering *away*. In his writings on photographs of suffering, Reinhardt locates how what is at stake in discussions surrounding the stylising of bodily damage is essentially that in creating a "formally elegant image" (Reinhardt 2007:15) viewers forgo critical engagement with content in favour of disinterested viewing and visual enjoyment – essentially paying attention to form and medium (Reinhardt 2007:22; Sontag 2003:76). It is a critique that has seen Sontag condemn photography for its inherent beautifying tendency: photographs essentially 'transfigure' that which they depict. In her quoting of Walter Benjamin, Sontag confirms how "photography can only say, 'How beautiful.'" and in so doing, turns even the most ordinary or horrific into "an object of enjoyment" (Benjamin in Sontag 1973:83). Thus turning "human misery [into] an object of consumption" (Benjamin in Linfield 2010:18), aestheticising is seen to foster enjoyment and even a relishing of horrifying events and human suffering – essentially turning them into little more than a spectacle. What is thus at stake in the beautifying of suffering is the capacity for an image's formal elements to 'obscure' or 'exploit' the real pain and experiences of real people – to encourage voyeurism and visual pleasure at the expense of another (Reinhardt 2007:23). At the heart of this critique is the prompt to look for all the wrong reasons.

2010:210) that I would rather deny – both in myself when looking at these images as well as in this written work. My shame reveals my recognition that there must surely be something wrong with taking pleasure in these depictions.[142]

But at the same time, viewing these photographs evokes a sense of recognition, a sense of visceral affinity, a sense of somehow being both physically, temporally, and emotionally 'close' to the patients depicted. However, as both Caroline Bressey (2011) and Sally Swartz (2008) argue, to understand something about who patients are and what they experience via official forms of documentation is invariably an illusion. While such records "[contain] a promise of a 'knowing'" (Swartz 2008:291), this sense of intimacy and access to the lives, thoughts, feelings, experiences that photography offers should not be read as providing a 'true' utterance or somehow reflect the 'real' subject behind the clinically structured, framed, silenced identity of the 'insane', 'ill', 'patient'. They remain limited – ultimately interpretations if not projections conjured as a result of attempts to see and hear the subject that appears so very present in their photographic likeness. As such, the "sense of intimacy" (Bressey 2011:7) that historical patient-photographs may provide – the intersubjective connection operating in and through the images – are fundamentally a projection of my own desire to get close to and know those individuals featured. Indeed, even the (seemingly) reciprocal look of those depicted remains a thing of fiction. As Barthes offers, this "photographic look" (Barthes 1982:111) is a returned but essentially unreciprocated regard – an unseeing look made without intent or thought (Lutz & Collins 1991:140; Tagg 1988:64; 85).[143] The photograph can grant no answers, nor render that which it depicts wholly 'known' (Linfield 2010:60). And, as such, it is particularly this quality, this shattering of what Linfield describes as "the photographic ideal" (Linfield 2010:60) inherent in images of the suffering, that has seen such photography come under attack.

In Sontag's view there exists "something of a persistent split between being affected and being able to think and understand" (Butler 2009:70-71) via photographic representation.[144] As such, the

[142] The critiques levied against beautiful photographs of suffering appears as a projection of internal outrage: how dare such an image make me feel this way, tempt me into enjoyment and make me want to look. As Linfield offers: "Simply looking at such pictures can feel morally suspect: the viewer ricochets between the beauty and the violence without finding a secure place to land" (Linfield 2010:142). It is this kind of back and forth that I likewise experience with photographs of the SSC and precisely the kind of emotive experience that critics of aestheticised (documentary) depictions such as Sontag (1973) and Henry Giroux (2012) appear to attack. For further engagement with such criticisms see Bal's 'The Pain of Images' (2007), Linfield's *Cruel Radiance* (2010), and Reinhardt's 'Traffic in Pain' (2007).

[143] Similarly iterating Barthes' reading of this paradoxical look (see footnote 136), Catherine Lutz and Jane Collins contend that while such photographs appear to foster a mutual act of seeing, it is merely an *illusory* identification – the emergence of a *fictitious* and narcissistic affinity between viewer and viewed (Lutz & Collins 1991:138-139).

[144] For Sontag it is less as an issue with what or who photographs depict than the fact that viewers respond inappropriately – that the photograph has the potential to elicit ways of looking and thinking that put the viewer's

problem with the photograph is its proclivity for prompting feeling over thinking, and thus its overall inability to provide a viewer with understanding of the events, the scene, the individual, the pain. It is this failure of the photograph – to provide some greater depth, some truth, some meaning, some knowledge – that is precisely what Sontag criticises photography for. Indeed, it is the fleeting, momentary nature of photographs, their inability to "unfold, go further, and further still" (Sontag 2003:122) or ensure the prolonged, lengthened, slower engagement that narrative provides that is ultimately at fault (Butler 2009:69; Sontag 2003:89).[145] While Sontag critiques photography for its inability to assist understanding and to foster knowledge of events and experiences, it is precisely this critique that the photographs within the SSC appear to counter.

Rather than professing complete access (to know and understand the events and individuals on display) the clinical photographs within the 'Syphilis' folders instead appear haunted by the fact that they *are* limited – that despite the human presence they remain rooted in clinical traditions and intent. Reined in by their perpetually present symptoms and clinical codes (of neutral backgrounds, posing, nudity, and hospital attire for instance) these images are fundamentally unable to show me what I want to see and, as a result, foster a search for subjectivity.

Despite my own, prolonged engagement with these photographs and the extra-clinical (re-)address I have engaged in, the subjects remain shadowed by their place and role within this clinical collection. I am continuously made aware of my inability to ever truly know the patient – neither in terms of their experience of this disease, nor with regards to their personhood and identity outside this state of being. The only persistent experience, the only certainty this collection of images grants is one of ambiguity and flux – of coming close to, of being proximate with those bodies, those faces, those individuals imaged that yet remain just out of reach and somehow ungraspable. These photographs hold me at arm's length while I continually find myself reaching out in an attempt to get closer, to see, to know who those depicted are/were/will be: what they feel, what it is like to be them, to experience things as they do, to be in their place. Yet this knowledge remains out of reach and I am left with only my illusions, my fantasies, my fictions. While for Sontag, this would surely speak of the failing of these images to function ethically outside the clinical sphere, my continued uncertainty and inability to understand or know those depicted seems to be precisely why I engage them beyond their clinical capacity – the reason I search for person over pathology. Not only do

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experiences before those of the victim and sees the pain placed on display rendered secondary to the emotions that looking at such pain prompts (Sontag 2003:101-102).

[145] It is essentially the temporary nature of viewing of the photographs of suffering as well as the brief, temporary, and superficial nature of the emotional response they evoke that makes Sontag highly critical of the potential for viewers "to learn something useful from them and connect to others through them" (Linfield 2010:24).

these examples unnerve easy diagnostic viewing, but they likewise trouble understanding: their stylistic qualities and incongruous content prompting responses that seem inappropriate and emotions I feel I should not indulge.

It is a criticism that has widely been levied against photographs of suffering: that they fail to offer anything beyond superficial or otherwise narcissistic feeling. As Bal contends, the emotive power of photography produces a "bottomless but directionless emotion" (Bal 2007:95) – a kind of sentimentality that does little more than foster "an identification that either appropriates someone else's pain or exploits it to feel oneself" (Bal 2007:94).[146] As such, to identify with those who have suffered, to "believe that you have somehow become" (Linfield 2010:59) the victim of pain depicted, is what is condemned in the act of looking at such images. It is a means of flattening out, simplifying, evading the complexities of bearing witness – a denial of the "inability to understand, the inability to grieve, the inability to *act*" (Linfield 2010:59, original emphasis). For critics such as Sontag, photographs thus simultaneously show too much and too little – exposing their subjects and suffering while at the same time failing to truly relay the horrific nature of the events and experiences they depict (McKinney 2008:1). It is, instead, a kind of 'crude empathy'[147] – a superficial and incomplete identification with the sufferer and the suffering depicted – a kind of 'empty' compassion (Bal 2007:109-110; Bennett 2005:10; Greslé 2015:76) – that such photographs supposedly produce.

However, although the limits of photography (its inability to render known, to foster understanding, to feel without absorbing and erasing, and to prompt action) may be read as the ultimate pitfall of this medium, it would seem that what it *cannot* do and is *unable* to show may ultimately prove redemptive.

Within the SSC, the lack of personal information available and the inaccessibility of who these individuals were clashes with the sense of intimacy the photographs foster as well as the evidentiary knowledge they promise. Due to this incompatibility between their intended purpose (as diagnostic tools) and the affective responses as well as critical reflection they evoke, fleeting feelings of shock or pity are quickly replaced by more complex experiences. Indeed, the primary look becomes a

[146] This kind of 'identification' is widely considered as an "unreflective process" that "points to the act of putting oneself emotionally in the place of another" (Bal 2007:110). As such, identification – the sense that a spectator can feel as the sufferer does – "cheapens the suffering" (Bal 2007:110) and essentially 'cannibalises' the painful experiences of others by rendering it somehow familiar and knowable. Identification in this form thus sees "the suffering all but [disappear] from sight, eaten up by the commiserating viewer" (Bal 2007:110) whose own mediated experience overshadows the anguish of those depicted.

[147] 'Crude empathy' for La Capra thus essentially speaks to the emotional experience that emerges via an identification "with the victim to the point of making oneself a surrogate victim who has a right to the victim's voice or subject position" (La Capra in Greslé 2015:76).

prolonged stare – a lengthened attempt to decipher and make sense of clinical as well as personal content. Rather than granting understanding, however, these photographs seem to prompt uncertainty outside of their diagnostic description – who they depict and how these individuals experience their state as both patient and subject remains unknown. It would appear precisely because these photographs are *unable* to provide understanding or grant access to an encounter with those depicted that they prompt a way of looking that troubles both disinterested viewing as well as facile sentiment.[148] In looking at another's suffering (by coming face-to-face with their circumstances, their faces, their bodily damage)[149] what appears to emerge is less a concern for the photograph's content per se and instead an emphasis on what kind of viewing these images may potentially offer.

Postulating a particular kind of embodied reception of visual representation, Bennett proposes that images have the ability to illicit an "emotional identification" (Bennett 2005:7, 10) that – unlike superficial sentiment or crude empathy – fosters an "affective encounter" (Bennett 2005:10) that likewise prompts critical inquiry.[150] For Bennett, an empathic encounter with images entails both affective and intellectual engagement that 'oscillate' between thinking and feeling – between being touched and engaging critically and cognitively with what is seen (Bennett 2005:10-11). What Bennett identifies in this process as key to triggering an affective viewing response, is the sudden

[148] As Linfield offers, the "fear of sentimentality" (Linfield 2010:10) has seen depictions of pain come under heavy fire by photographic theorists. Pity for instance is considered to reaffirm if not reinstate difference between those who feel pity for and those who are pitied. Described as a quasi-sadistic response to another's suffering, pity speaks to a relationship not of equals but one "predicated on another's weakness" that "presents itself in the maddening guise of generous virtue" (Linfield 2010:128). Pity confirms divisions of power and hierarchises lives according to privilege and need, thereby reaffirming difference and distance between giver and taker, us and them, subject and object, that finally "breeds resentment" (Linfield 2010:128).

[149] For Ball this appears to manifest in a kind of visual engagement she calls 'facing': a three levelled concept that addresses the literal, indirect, and figurative dimension of looking someone or something 'in the face' (Bal 2006:190, Bal 2012:124). In her artworks and writings, Bal understands and makes use of the human face to facilitate the literal act of one-to-one proximate looking at the face of another, the confrontation with and inability to deny potentially difficult knowledge or painful reality, and the recognition of being simultaneously and necessarily 'seen' by a second party – or in Bal's words – "I face (you); hence, we are" (Bal 2012:124). Essentially construed as an alternative mode of looking, listening, and coming to terms with identities and personal experiences that are otherwise alien or seemingly distanced, 'facing' speaks to an acknowledgement of the need to be seen, to be apprehended by another in order to be constituted as a self, a human being. By 'maintaining' and 'protecting' that which makes the seen subject different, unique, a 'self' in their own right, Bal sees 'facing' as a means to resist the kind of assimilation and "vicarious identification" (Bal 2007:105) images of suffering are held to produce (Bal 2007:105).

[150] This "conjunction of affect and critical awareness" (Bennett 2005:10) is one that Bennett (along similar lines to Garland-Thomson and Linfield) considers rooted in an inability to assimilate those whose suffering is depicted, the failure to wholly understand another – essentially what Bennett describes as "an encounter with something irreducible and different [and] often inaccessible" (Bennett 2005:10). It is an understanding drawn from LaCapra's notion of "the attentive secondary witness" (LaCapra cited in Greslé 2015: 76) that sees the act of looking as one in which viewers "puts oneself in the other's position while recognising the difference of that position and hence not taking the other's place" (LaCapra cited in Greslé 2015: 76) – a kind of empathic identification that speaks to a recognition of similarity and difference that is ultimately self-reflexive rather than self-indulgent.

"trace of human presence" (Bennett 2002:347) – a disturbing recognition of personhood or a kind of 'habitation'. For Shapiro, what is crucial when engaging photographs of suffering is similarly *how* looking is fostered rather than *what* is depicted – namely what an image has the potential to *do* to its viewer or viewership through an "activation of affect" (Shapiro 2008:190). It is what Shapiro identifies as a 'slow' way of seeing that is at the heart of engaging suffering. As he suggests, what is required is a kind of looking that:

> slow[s] down the viewing process […] creating a receptive editing that provides for extended reflection and negotiation of the meaning and significance of scenes. More generally, perhaps the ongoing insistence of images of pain and suffering can generate movement from sensation to reflective thinking (Shapiro 2008:196).

Drawing specifically on the writings of Bal and Bennett, Shapiro thus offers 'slow looking' as a means to describe a kind of redemptive, timely, prolonged engagement with images that can potentially result in an empathic and essentially ethical response over one of mastery, identification, or sentimentalism. Unlike Sontag's critique of the 'fleeting' nature of photographs – the passivity it fosters and the tendency to quickly 'move on' – Shapiro draws attention to the ability for static visual depiction (and particularly the photographic image) to permit a viewer to contemplate and mull over content beyond other forms of representation (Shapiro 2008:183). Thus what Shapiro addresses is how particular kinds of engagements with visual material and the encouragement of a certain manner of looking has the potential to foster critical as well as empathic encounter and negotiation over crude empathy.[151]

In the SSC, this kind of engagement appears to manifest itself most acutely in those images that contain personal objects such as Josephine's shoes that usher in the recognition of not merely a sick body but a unique person, a subject, a feeling thinking living individual behind the clinical austerity of the image. What appears to occur in the emergence of incongruous, erroneous, and essentially extra-clinical details is thus a prompting of this 'slow looking' – a breaking of disinterested and diagnostic engagement, and the provocation of an affective response to even these medically motivated images. As such, the 'Syphilis' photographs appear 'haunted' by the potential to unsettle

[151] Linfield makes a similar claim in relation to Hanna Arendt's understanding of compassion as a means by which differences and divisions between individuals may be "bridge[d] rather than maintain[ed]" (Linfield 2010:128). Postulated as a "co-suffering" (Linfield 2010:128), compassion is an acknowledgement of the common experience of what it means to be human. While not based on equivalence of circumstance, experience, identity, or situation, compassion instead speaks to a common emotional terrain based on intuition rather than cognition (Linfield 2010:128-129). Unlike the 'crude empathy' of identification, compassion rests in a lack of equivalence in favour of distinctiveness and singularity.

both the viewer and the viewing experience: while clinical images are intended to turn the body into a passive platform on and through which symptoms emerge, they nonetheless offer a sudden embodied engagement and a realisation of subjectivity.

For Butler, the ability to recognise both pain and personhood relies on the concept of 'grievability' – a notion that speaks to whether or not those depicted qualify as "worth noting […] worth valuing and preserving, a life that qualifies for recognition" (Butler 2004:34). For Butler, affect can but emerge "in relation to a *perceivable* loss" based on "social structures of perception" (Butler 2009:51, own emphasis) rather than innate feeling.[152] The potential for pain and suffering to be perceived as such thus essentially relies on the ability to recognise that another is like oneself, "like me in some way" (Butler 2009:36) and that their loss would be noted, mourned, grieved (Butler 2009:14; 42-43). Residing in this concept of a grievable life are thus assumptions about whether a life may or may not be seen as meaningful, as valuable – essentially, as a life. As such, the experience of another's suffering, another's, pain, or another's death, rests on a precondition that suffering, that pain, that death are perceived as a loss.

It is in this understanding of a grievable life as reliant on the imminence of death (and its subsequent mourning) that sees Butler engage photographic depiction. In reading Barthes, Butler locates how photographs by their very nature enact grievability: resting on the potential for death and bereavement sees Butler's grievability intimately connected with the operations of what Barthes calls the 'future anterior' inherent to photographic depiction (Butler 2009:15). For Barthes 'time' acts as the punctum that underlies every photograph of a person (Barthes 1982:96). Described as an 'intensity' that essentially hovers over all depictions of human beings, this *punctum* is the recognition that those made present within a photograph are inevitably going to die – if they are not already dead. Every photograph is thus for Barthes an utterance of a life that – made present and seemingly alive within an image – will eventually be outlived by its representation. Photographs thus essentially 'defeat' time, 'embalming' it: forever showing one a life that (sooner or later) will die, a loss that is to come if it has not already occurred (Barthes 1982:14, 95-97). 'Haunted' by this presence of "death in the future" (Barthes 1982:96), photographs thus appear to embody Butler's

[152] Unlike the previous engagements that address affect, Butler is adamant that rather than being an innate reaction affective responses are structured according to a set of social and discursive conditions. Instead of understanding feelings aroused by photographs as inherent, Butler contends that "our affect is never merely our own " (Butler 2009:51). Instead, bearing witness to another's pain – and ultimately one's sense of responsibility towards those in pain – is less an innate reaction than one structured according to societal norms.

understanding of grievability: they speak of a loss to come, of life that depicted will be lost, yet whose visual trace remains. As Butler offers in her reading of Sontag, the photograph:

> brings us close to an understanding of the fragility and mortality of human life, the stakes of death […] she wrote: "Photographs state the innocence, the vulnerability of lives heading toward their own destruction, and this link between photography and death haunts all photographs of people." (Butler 2009:96)

The photographic image says that there was a life here, there *is* a life here that may be lost. For Butler, the ability for photography to 'haunt', to 'prick', to touch viewers thus sees it instate grievability to those it (re)presents. However, Barthes' understanding of the future anterior and the inherent link between photography and death, sees photographs of disease such as those within the SSC both speak to the figurative recognition of this inevitability (the photograph's undercurrent that whispers the imminent doom of the individual life it captures) as well as a literal identification of death's imminence in the diseased body.

By making itself so very known on the surface of the skin, syphilis – like the photographic medium– sees the inevitability of death made manifest in both body and image, by both symptom and photograph, via both disease and its depiction. As such, these images appear to be doubly haunted by death and (for this very reason) are precisely the kinds of images that have the ability to trigger the melancholic recognition that both Butler and Barthes appear to offer. Photographic renderings of human beings may thus be seen to hold the potential to make those within their frame recognisably human. For Butler, photographs of suffering in particular carry the power to prompt recognition – to 'perform' grievability, and thus to see the previously ungrievable, rendered meaningful, valuable, and thus *as* life. By offering this medium in particular as one that invests those depicted with grievability, photography essentially has the capacity to make lives matter – to make those otherwise unrecognisable and ungrievable worth mourning, and, consequently to see experience recognised and worth witnessing (Butler 2009:96-98). For a reading of the SSC, Butler's understanding of the medium sees photography capable of introducing the previously unseen into a discursive domain in which their loss may be felt.

3.5 CONCLUSION

What Butler, Barthes, Bennett, Linfield, Garland-Thomson, and Shapiro thus offer in relation to ways of looking at bodies, at faces, and at the (photographic) imaging of pain and suffering, is that photographs of vulnerable individuals (such as those broken and exposed subjects within the SSC)

may offer otherwise unrecognisable individuals an opportunity to be 'seen'.[153] What I conclude from my study of the 'Syphilis' photographs is that it is both in the failure of this collection of images to ensure a purely clinical engagement and their inability to grant me complete access, understanding, and knowledge about those depicted that see them foster an affective and even empathic response. It is in the very uncertainties, the gaps, the omissions, the inability to fully comprehend, that I am thrown into a process of slow looking – a process in which I am able to recognise that those I look at, that those I see, essentially do and will remain forever out of reach. While the fundamental incitement to feel rather than think, to react instinctively rather than intellectually that photographs often offer may easily be "denounced as self-indulgent" and these prompts met "with suspicion, mistrust, anger, and fear" (Linfield 2010:4-5), this kind of looking prompted by the SSC is the most honest form of address I could offer.

[153] While only Butler speaks to such potentials via photographs, my application of Garland-Thomson's 'staring' to P.C. as well as her own engagement with naturalistic depictions of 'starable' individuals (including illustrations, drawings, as well as photographs) sees a similar fostering of recognition as a constitutive act (Garland-Thomson 2009:155-158).

CONCLUSION

As a disused collection of historical clinical photographs, the SSC is an assembly of visual material that juggles moments of diagnostic intent with affective potential. Produced and used by Cape Town's medical school in the training of student-doctors, abandoned, forgotten, unearthed, and finally reawakened as an archive, the life of these photographs and the way in which they 'perform' that which they depict has fundamentally shifted.

The first part of this study sought to position the 'Syphilis' photographs in relation to their visual and medical origins by tracing the representational as well as discursive roots of this disease both internationally and in Cape Town. While cradling clinical and social concerns surrounding syphilis along with a photographic heritage of depicting deviance, this collection essentially operates to 'fix' the clinical gaze. Both individualising and aggregating, these images see disease and the diseased displayed for discrete scrutiny as well as comparison. As Chapter I argued, it was the scientific notion that both body and photograph could accurately trace their respective referents (be this an underlying illness or the material object imaged) that created the conditions for such material to function as clinical evidence. Despite drawing on a belief in the inherent connection between surface and depth, clinical and depictive uncertainties appear to have prompted standardised methods of visually rendering conspicuous symptoms. In providing this background, the first chapter sought to establish how photographs within the SSC produce the body and its image as objects that may be read and known by (medical) science.

Shifting attention to the stylistic attributes within the 'Syphilis' photographs, Chapter II framed this disease as an essentially abject entity. Although a physically as well as socially stigmatising illness, this section focused on how viewing the syphilitic, ruptured body has the potential to provoke an affective response – thereby posing a particular problem for disinterested viewing and objective decipherment. In relation to the SSC, I thus argued that attempts to rein in this extra-clinical capacity were made manifest in the adoption of particular stylistic codes: the fragmenting of the patient-body, a frontal rendering of the face, and the complete removal of clothes as well as colour. Thus fostering a diagnostic gaze, these strategies of abstracting, neutralising, and objectifying the patient operate to sublimate syphilitic symptoms and reign in the visceral and visual excess of disease as well photography. However, while these techniques were implemented to render the diseased body a fixed, stable, manageable, and thus clinically decipherable entity (by removing context, focusing attention on symptoms rather than subjects, and nullifying material mess) the abject nature of the (syphilitic) body may nonetheless serve to trouble purely clinical engagement.

In approaching the collection less as a functioning set of diagnostic depictions than historical images of discrete individuals suffering the effects of disease, I concluded this study with a close but essentially subjective reading. By attending to affect-triggering details, pose, and technical features of selected photographs, this (re-)engagement with the SSC examined how and why such images serve to 'touch' me in my viewing. While the previous section addressed the abject nature of the ruptured body, Chapter III explored and expanded on the affective potential of the photographs beyond this horror-inducing attribute. Attending to the cases of Josephine, P.C., and Charles, the final chapter identified how evidence of vulnerability, personal attire, self-aware display, and a (seemingly) reciprocal look prompt an empathic awareness of lives and selves beyond that offered by clinical engagement. In reading these photographs outside of their historical intent, they emerge less as medical evidence and institutional documentation than as highly evocative depictions of suffering subjects. While heedful that reading photographs of pained and subjugated individuals is contentious, I argued that it is because the images within the SSC fail to provide complete access to the individuals they depict that such images prompt a 'slow' form of looking – one that produces an empathic and reflexive way of seeing, feeling, and thinking.

While this thesis has attempted to explore how and why clinical photographs produce or foster a particular way of looking at the syphilitic human body, the question of why to look at this material in the first place seems to hover over the SSC and its discussion.

As medical documents, the 'Syphilis' photographs speak to the clinical authority that produced them – one that saw bodies turned to specimens and subjects to objects. However, as Bressey indicates in her address of 19th century asylum photographs, looking at such images allows histories of otherwise invisible individuals to come to light – for experiences, identities, and lives that would otherwise remain untraced and unremarked to be spoken (Bressey 2011:3-4). While Bressey focuses particularly on a racial minority in Britain,[154] the history of syphilis in Cape Town is similarly a history of the medically marginalised. Available only through official reports of the city's MOH, hospital records, and the published writings of clinical practitioners, this is a disease and a diseased-identity that emerged as a particular kind of 'problem' for medical science, the wellbeing of the population, and the prosperity of the state during the first half of the 20th century. Unlike these texts, the SSC offers an alternative (though admittedly only partial) picture of those who suffered this

[154] In particular, Bressey addresses photographs depicting 'people of colour' within 19th and 20th century casebooks of the City of London Asylum due to the tendency for official documentation to omit references to skin colour in Britain's history (Bressey 2011:3). For Bressey, these images thus provide the sole avenue for engaging what she refers to as London's "city of others" (Bressey 2011:3) that otherwise remains invisible and untraceable.

disease within the Cape Town area. Although no less regulated by institutional discourses than the contemporary public health statistics and clinical opinions aired during this period, the photographs suggest glimpses of subjectivity outside of this official terrain. While unable to provide an understanding of the experiences pictured, these images do contribute another form of record – one that allows for alternative narratives surrounding the patients and lives touched by syphilis to come to light. Thus revealing a tiny fragment of the city's 'hidden history',[155] an extra-clinical reading of the photographs offers a small window into this disease and the subjects it affected.

Although any non-medical engagement with the SSC may provide a space for smaller and even contested narratives to emerge, the highly personal outcome in attending to the affective potential of the 'Syphilis' images threatens to be unhelpful for thinking about the future of this collection – particularly the storage, display, and accessibility thereof. While these concerns lie outside the scope of this study, they nonetheless require some consideration. Indeed, what is to be become of this collection housing both an outdated medium for clinical teaching as well as displaying a disease that no longer poses the kind of threat to (public) health it once did? Largely stripped of its original purpose (that of clinical instruction), the existence of this collection becomes tenuous and an engagement therewith haunted by concerns allied with the display of human suffering. It is this shift – from functional object to images of vulnerable individuals – that sees the viewing of this material unsettling.

But it is precisely this sense of unease that sees the 'Syphilis' photographs offer a way of thinking and feeling about disease and diseased subjects that proves valuable for avenue for addressing contemporary afflictions. While this study has addressed an illness that has long vanished from public consciousness and greatly receded as a medical concern,[156] the social load carried by syphilis has nonetheless been revived in relation to the HIV/Aids epidemic and understandings surrounding those affected by this contemporary disease (Brandt 1988b:379-380; Brandt 1990:481-483; Crawford 1994:1361; Gilman 1987:98-107; Gilman 1988:245-272; Sontag 1989:16-33). Although this discussion by no means intends to rehash the symbolic parallels between these ailments,[157] a

[155] In her writings on medical photographs displaying facial disfigurement before and after corrective surgery, Biernoff identifies this visual material as providing insight into the publically unseen or even denied aftermath of WWI (Biernoff 2010 [Online]; Biernoff 2011).

[156] While syphilis remains a health threat particularly in developing countries, the cure offered by antibiotic treatment has seen it largely recede as a clinical concern (Shmaefsky 2010:92-96). Indeed, although in South Africa syphilis remained enough of a threat to be addressed in National Antenatal Sentinels, by 2012 focus shifted away from this disease and towards herpes (Department of Health 2013:4, 6, 12, 81).

[157] Sander Gilman (1987; 1988), Allen Brandt (1988a; 1988b; 1990), and Susan Sontag (1989) have all contributed to these debates.

study of this kind does provide a method to re-engage ideas surrounding the 'diseased' body and the stigmatised subject more widely. By offering an interpretative environment, such an engagement may provide an opportunity to reconfigure the identities of those affected by or labelled according to disease. Reflecting on the impact of science on society (particular one as historically fractured and fraught as South Africa) thus has the potential to reveal the origins of contemporary expressions of institutional as well as popular prejudice operating both locally and in other post-colonial contexts. As such, there lies an opportunity for not only individual but also social reflexivity in this method of engagement.

By addressing the 'Syphilis' photographs in a critical, contextualised, and emphatic manner, I have attempted to draw attention to those very practices that visually as well as discursively produced bodies as clinical evidence. In engaging the affective power of this collection, an attempt has been made to address how such images may foster a form of looking that sees the viewer moved beyond diagnostic decipherment. For Butler, it is this potential of the photographic medium – its ability to foster an affective response – that serves to render not only the life and loss of another recognisable, but moreover opens up an avenue to reveal the interpretive frames that produce individuals as either grievable or not. Tenuous as an extra-clinical engagement with historical medical photographs may be, this kind of reading can thus be understood to provide an avenue for critical and reflexive inquiry. However, because photographs of the vulnerable *do* incite strong emotional responses such material and the display thereof is often shrouded in cries of obscenity or calls for censorship (Bal 2007:109-110; Linfield 2010:59-60).[158] Yet, as Linfield suggests, such fears surrounding the photographic display of suffering lies less in the content of depictions than in their potential to foster enjoyment at the expense of the suffering – a fear of finding pleasure "in all the wrong places" (Linfield 2010:43).

However, it is precisely the evocative capacity of this material that sees it offer a powerful means of engaging the past. Reading through affect prompts a consideration of the ethics of display. As Michael Sappol has argued in relation to historical medical images, such collections “don’t belong to us. They belong to everybody […] I could say ‘This person doesn’t want to be on camera, they’re being humiliated.’ But this is something we can learn from. If we never get to see this, who gets to know?" (Sappol in Onion 2014 [Online]). While this is not a view held by all custodians of such

[158] For critics of what is widely referred to as 'victim photography' including Sontag, Sekula, and Martha Rosler (Miles 2014:97), what emerges in the discussions surrounding this kind of imaging of the suffering human body is that such depictions simultaneously show 'too much' and 'too little'" (McKinney 2008: 1) – exposing their subjects and the suffering while simultaneously failing to truly relay the horrific nature of the events and experiences they depict (McKinney 2008:1).

collections, the push within Europe (and particularly the UK) to digitise and render clinical depictions publically accessible speaks to attempts to see beyond the functional, clinical framework in which many photographs remain. Consequently, while collections such as the SSC retain a small semblance of clinical usefulness as well as contextual glimpses (including patient-demography and hospital practices), they also provide an avenue to feel and think differently about 'diseased' subjectivities. Rather than providing complete access to and concrete knowledge about events and experiences, it is what photographs are unable to show and do that is ultimately redeeming. Indeed, photographs fail to "provid[e] answers […] refus[e] to tell us what to feel […] allow us to feel things we don't quite understand, they make us dig, and even think, a little longer, a little deeper" (Linfield 2010:29). As such, they provide a valuable way of bearing witness to the past as well as the pain of others.

It is because what is witnessed through photographs "cannot be easily absorbed into our understanding of […] what human beings are" that images such as those within the SSC can potentially "teach us about our failure—our *necessary* failure—to comprehend the human" (Linfield 2010:xv-xvi). While tantalisingly proximate, photographic depictions illustrate the plight of bearing witness – that regardless of the medium, moments captured and lives depicted remain forever out of reach.

Both affective and inquiring, the empathic encounter with the SSC in this study has served as an attempt to feel *into* suffering. It is my hope that such an enquiry will have contributed in some small part to the developing interdisciplinary fields of the medical humanities, the unwritten local histories of medicine, as well as provided a way of thinking about and looking at historical clinical photographs that may see similar archives opened up to future 'slow' engagement.

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APPENDIX: ILLUSTRATIONS

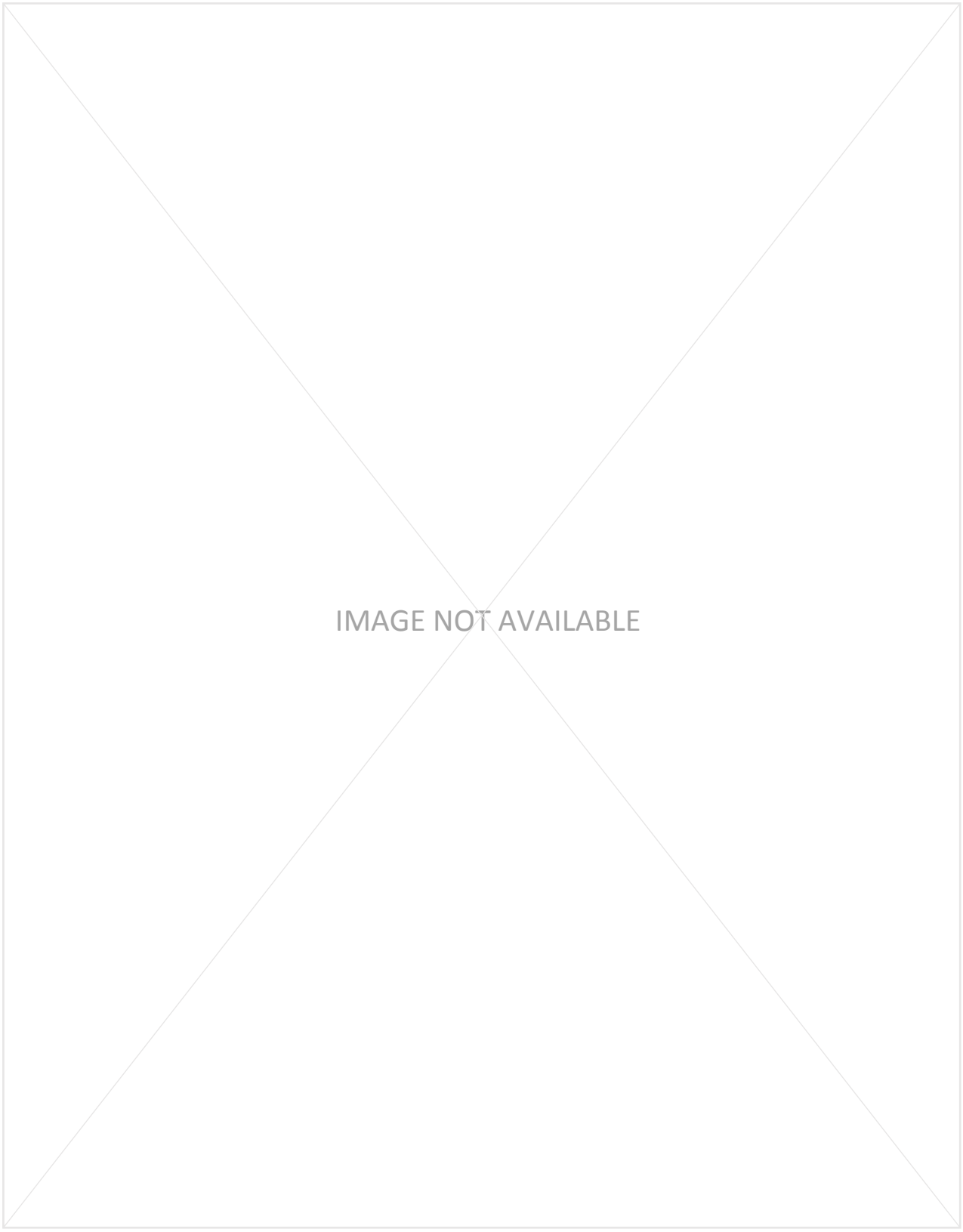

Fig. 1 *Congenital Syphilis* (1943). Saint Surgical Pathology Collection. Pathology Learning Centre, University of Cape Town.

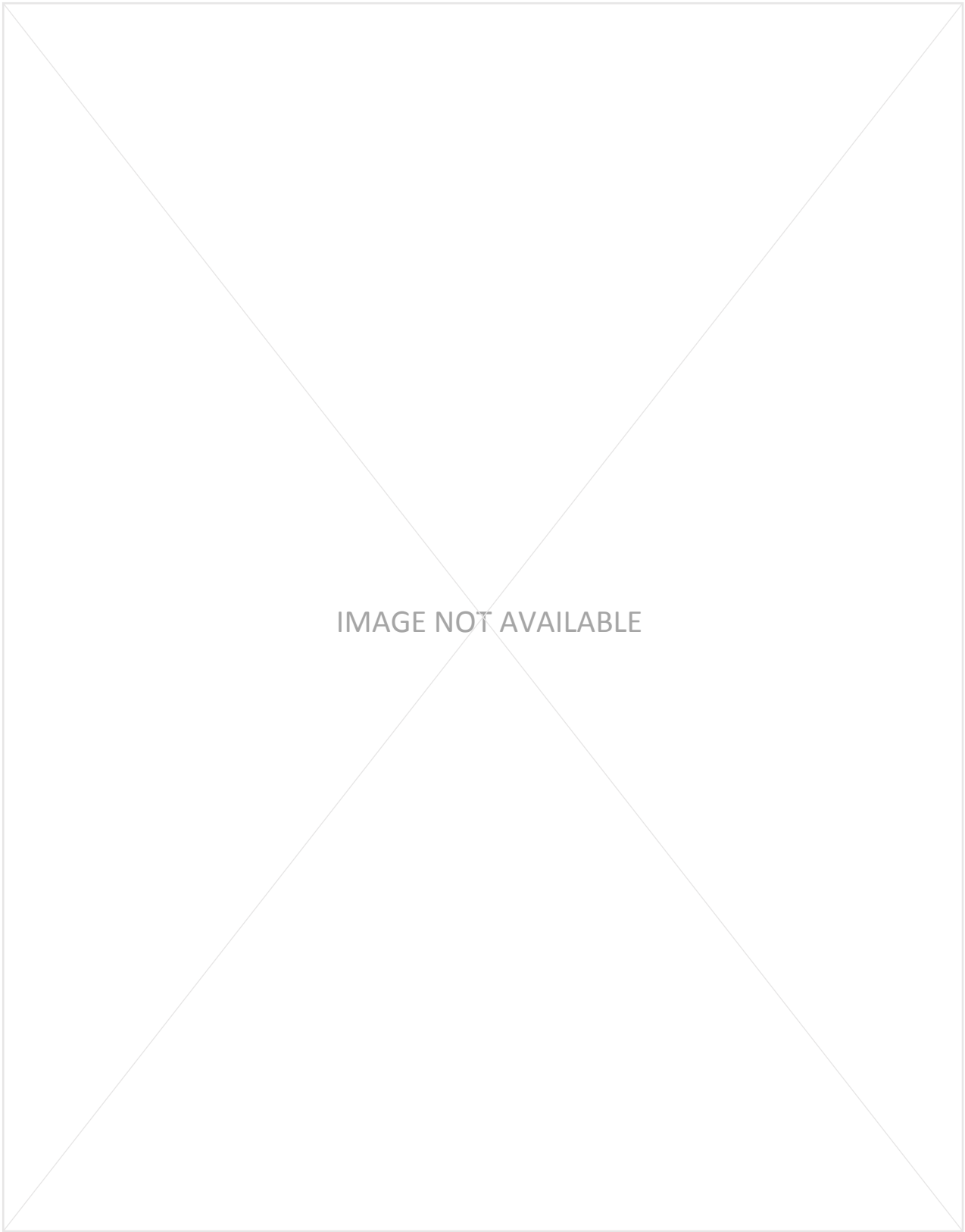

Fig. 2 *Gumma of Tibia & Pyogenic Osteitis of Skull* (1945). Saint Surgical Pathology Collection. Pathology Learning Centre, University of Cape Town.

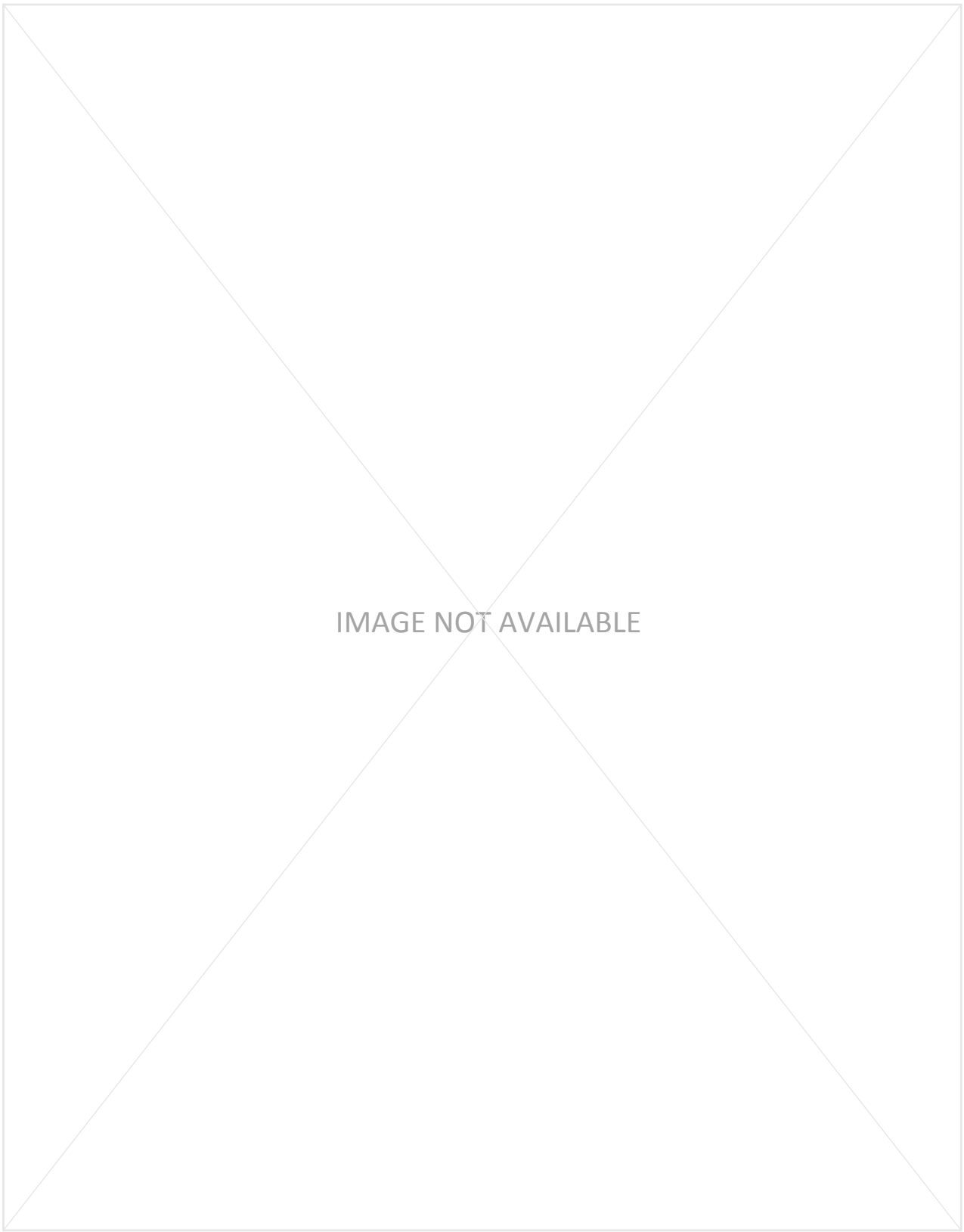

Fig. 3 *Primary Chancre* (1944). Saint Surgical Pathology Collection. Pathology Learning Centre, University of Cape Town.

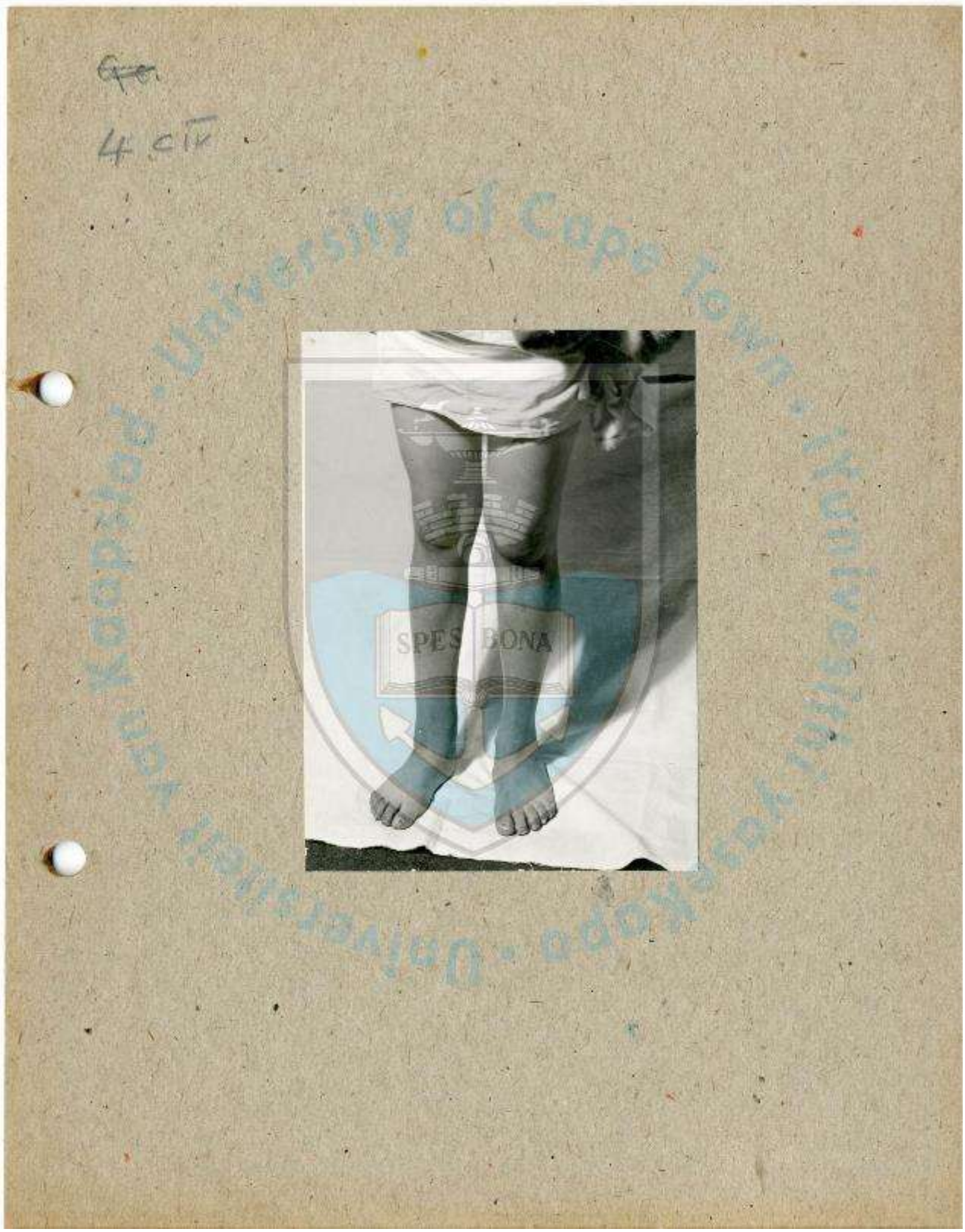

Fig. 4 *Syphilitic Osteitis of Left Tibia & Clutton's Joints* (1941). Saint Surgical Pathology Collection. Pathology Learning Centre, University of Cape Town.

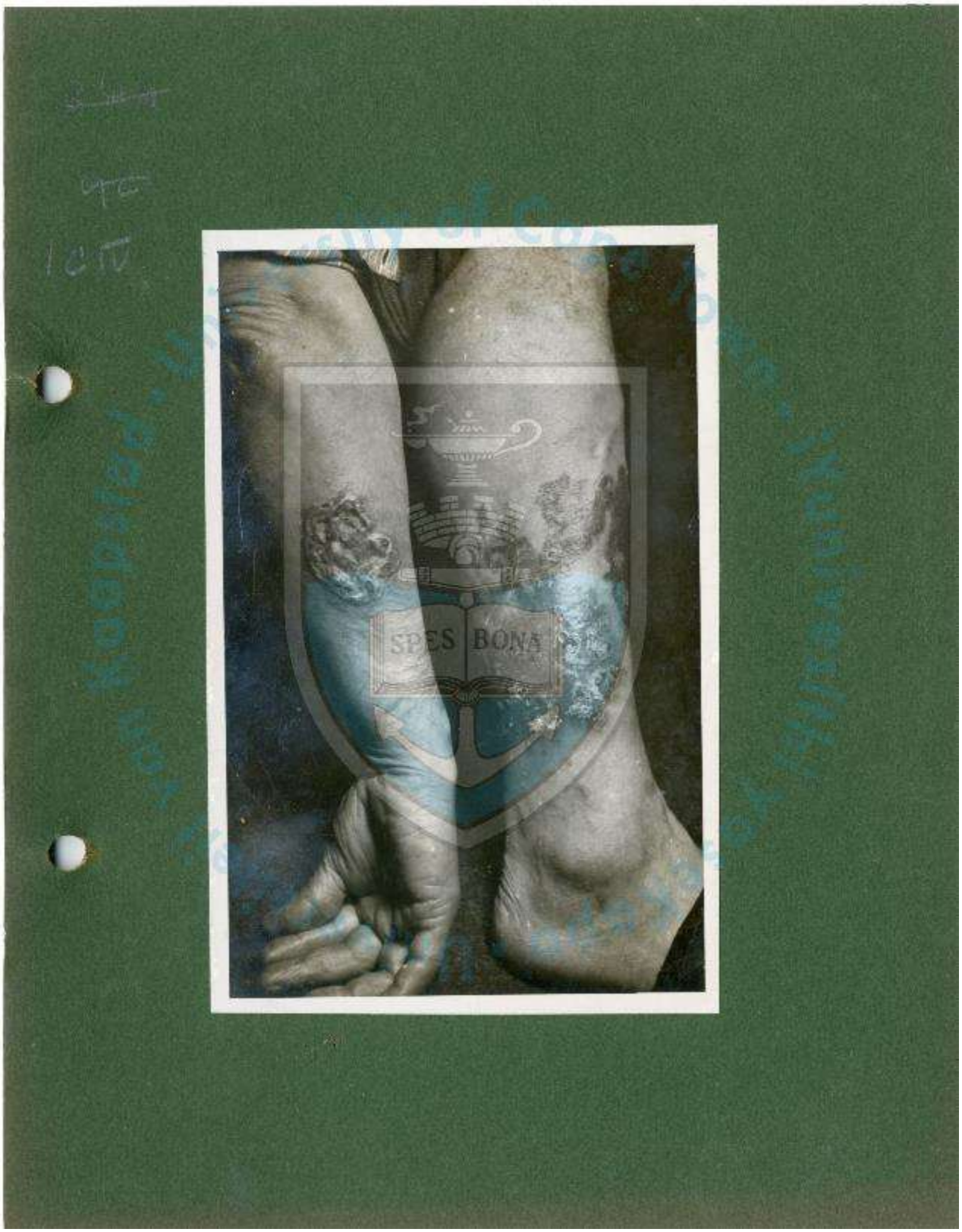

Fig. 5 *Male. Syphilis Late Secondary* (1938). Saint Surgical Pathology Collection. Pathology Learning Centre, University of Cape Town.

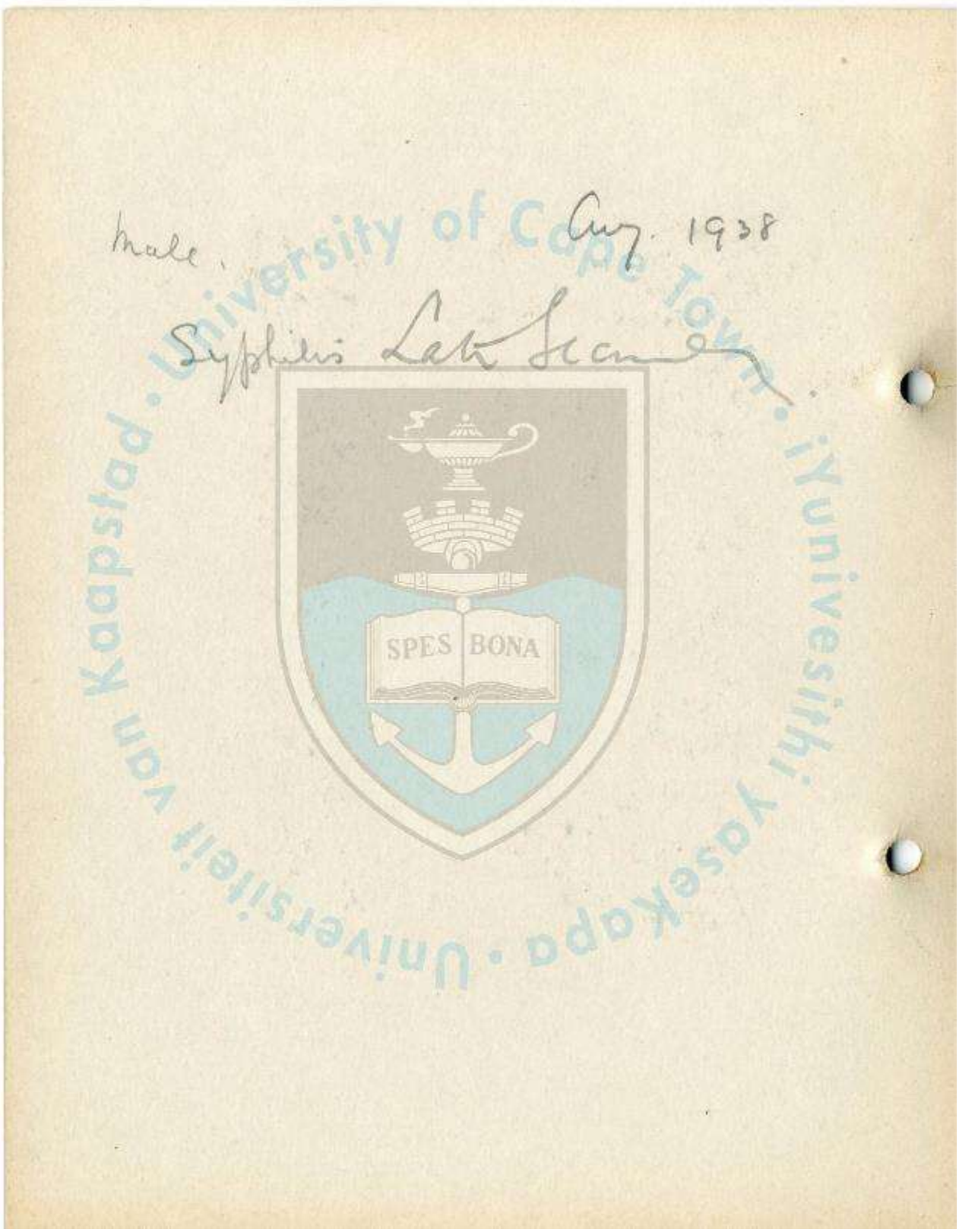

Fig. 6 *Male. Syphilis Late Secondary (back)* (1938). Saint Surgical Pathology Collection. Pathology Learning Centre, University of Cape Town.

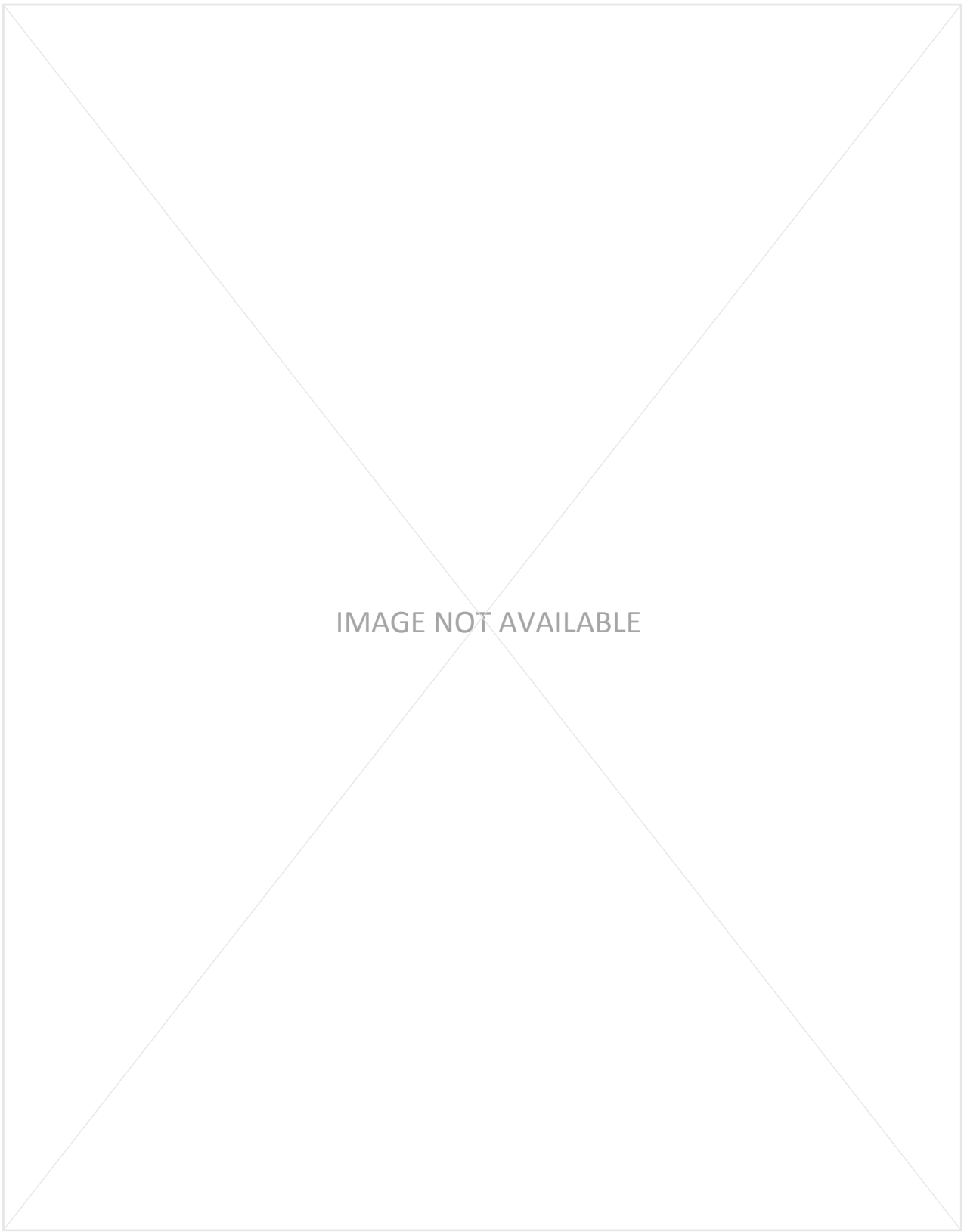

Fig. 7 *Primary Chancre* (1943). Saint Surgical Pathology Collection. Pathology Learning Centre, University of Cape Town.

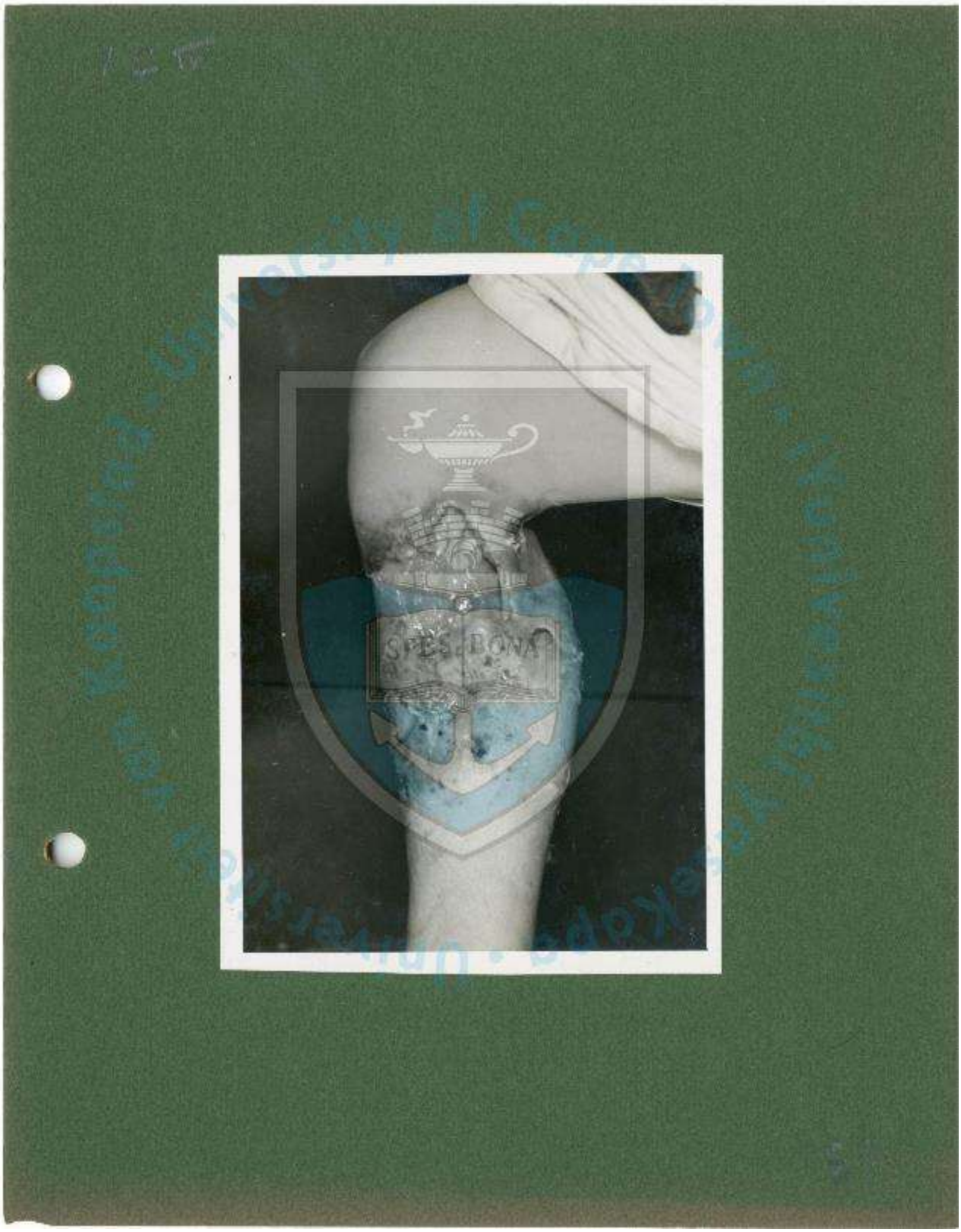

Fig. 8 *Gummatic Ulceration* (1939). Saint Surgical Pathology Collection. Pathology Learning Centre, University of Cape Town.

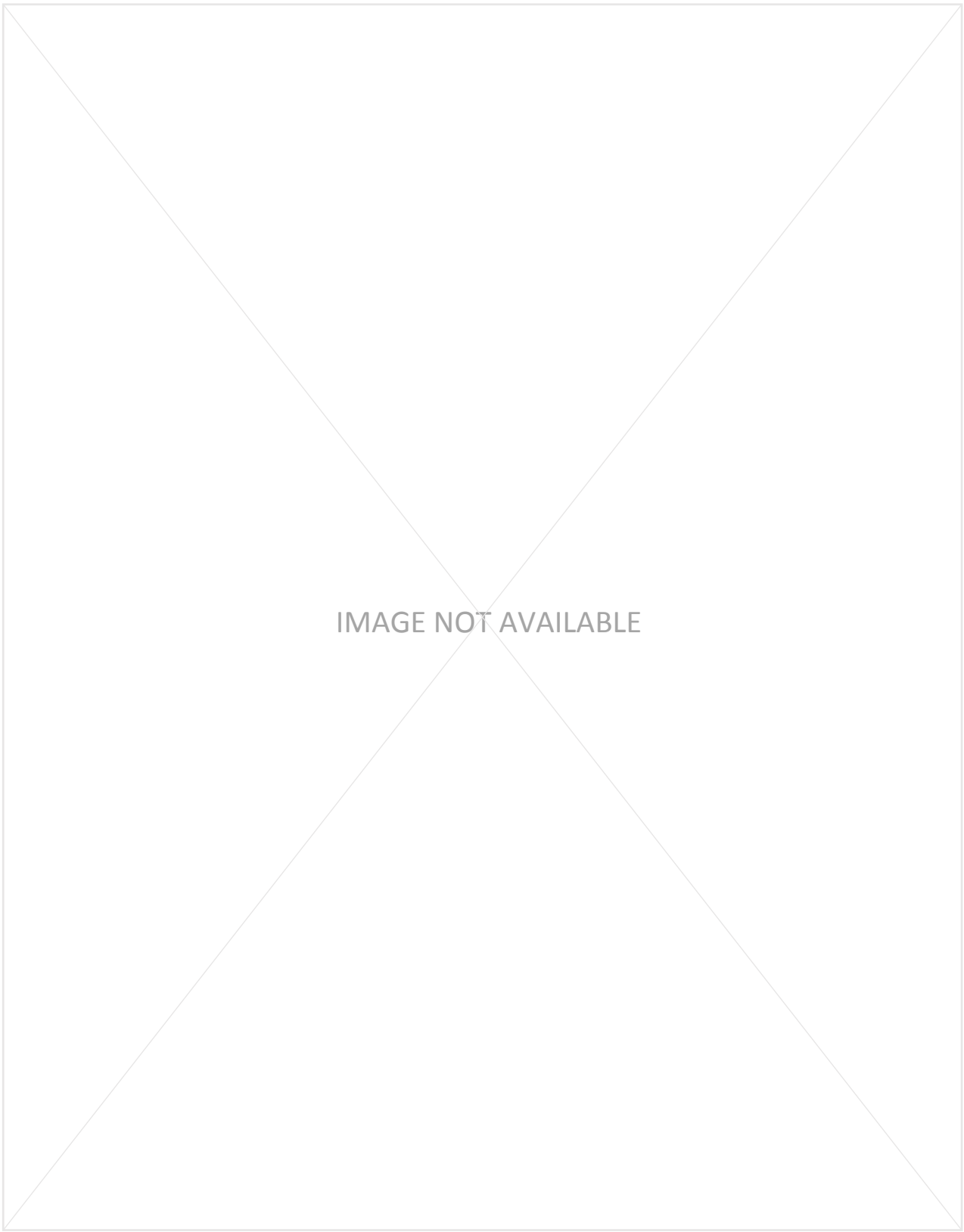

Fig. 9 *Josephine*, *Card 1* (1942). Saint Surgical Pathology Collection. Pathology Learning Centre, University of Cape Town.

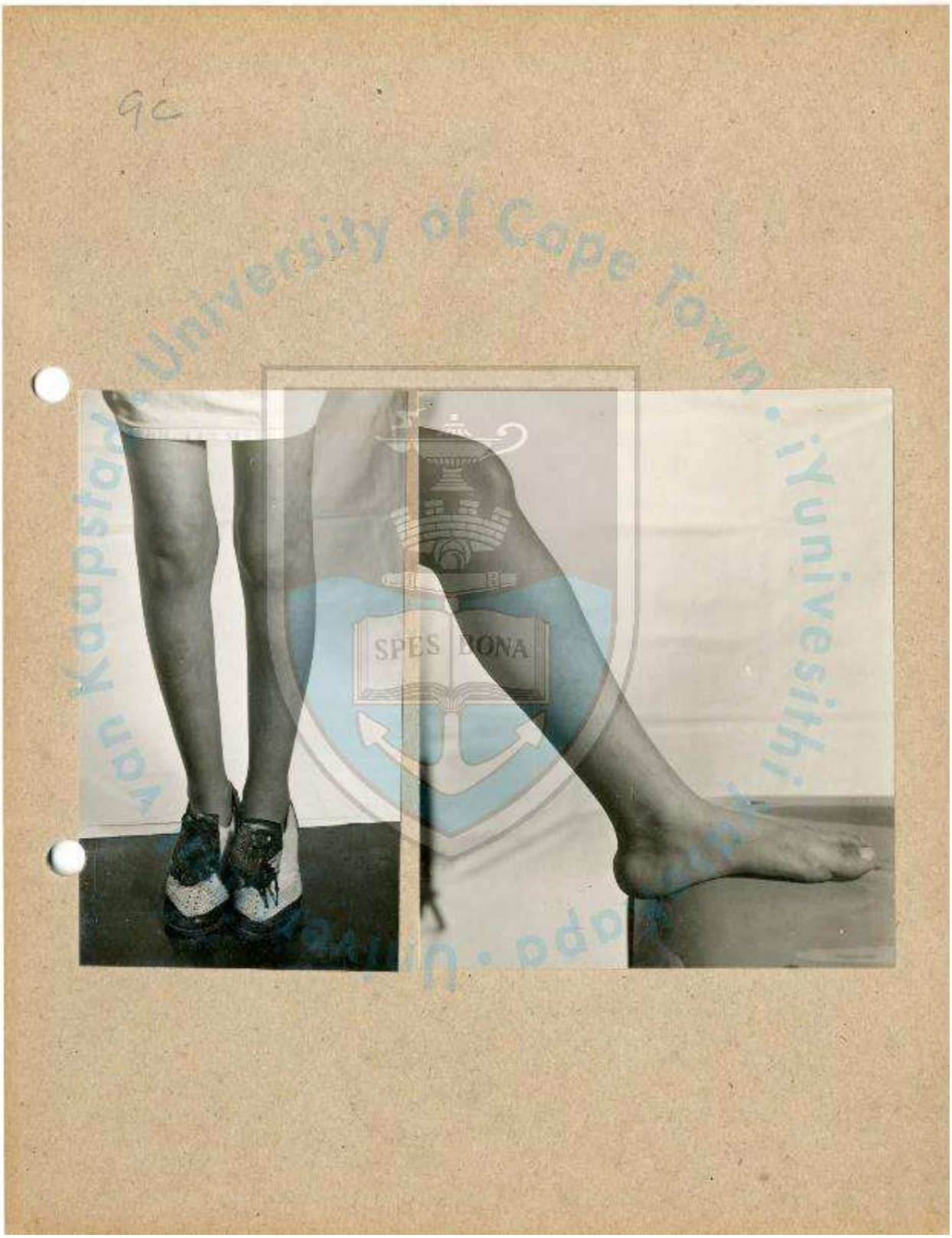

Fig. 10 *Josephine*, *Card 3* (1942). Saint Surgical Pathology Collection. Pathology Learning Centre, University of Cape Town.

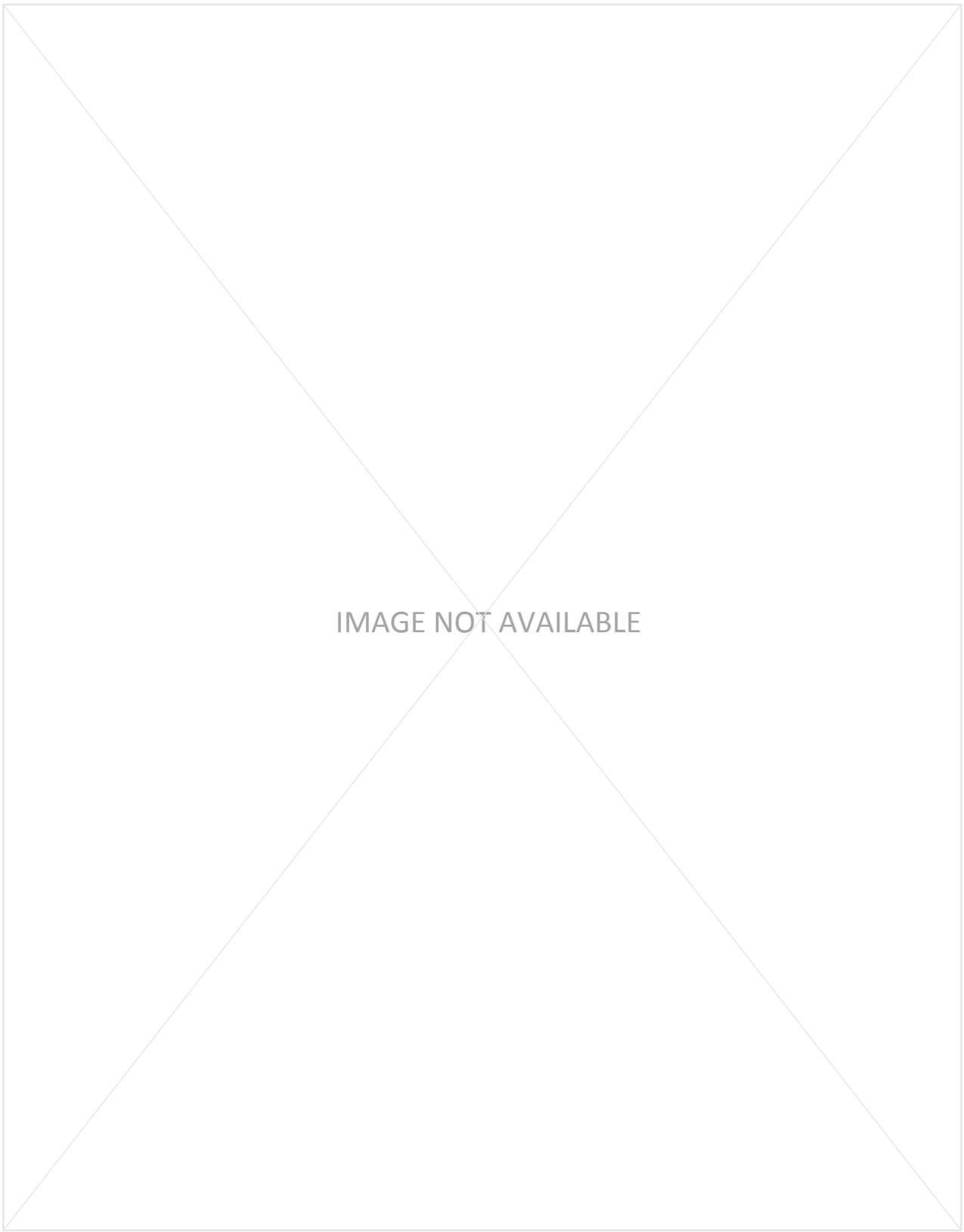

Fig. 11 *P.C.* (1946). Saint Surgical Pathology Collection. Pathology Learning Centre, University of Cape Town.

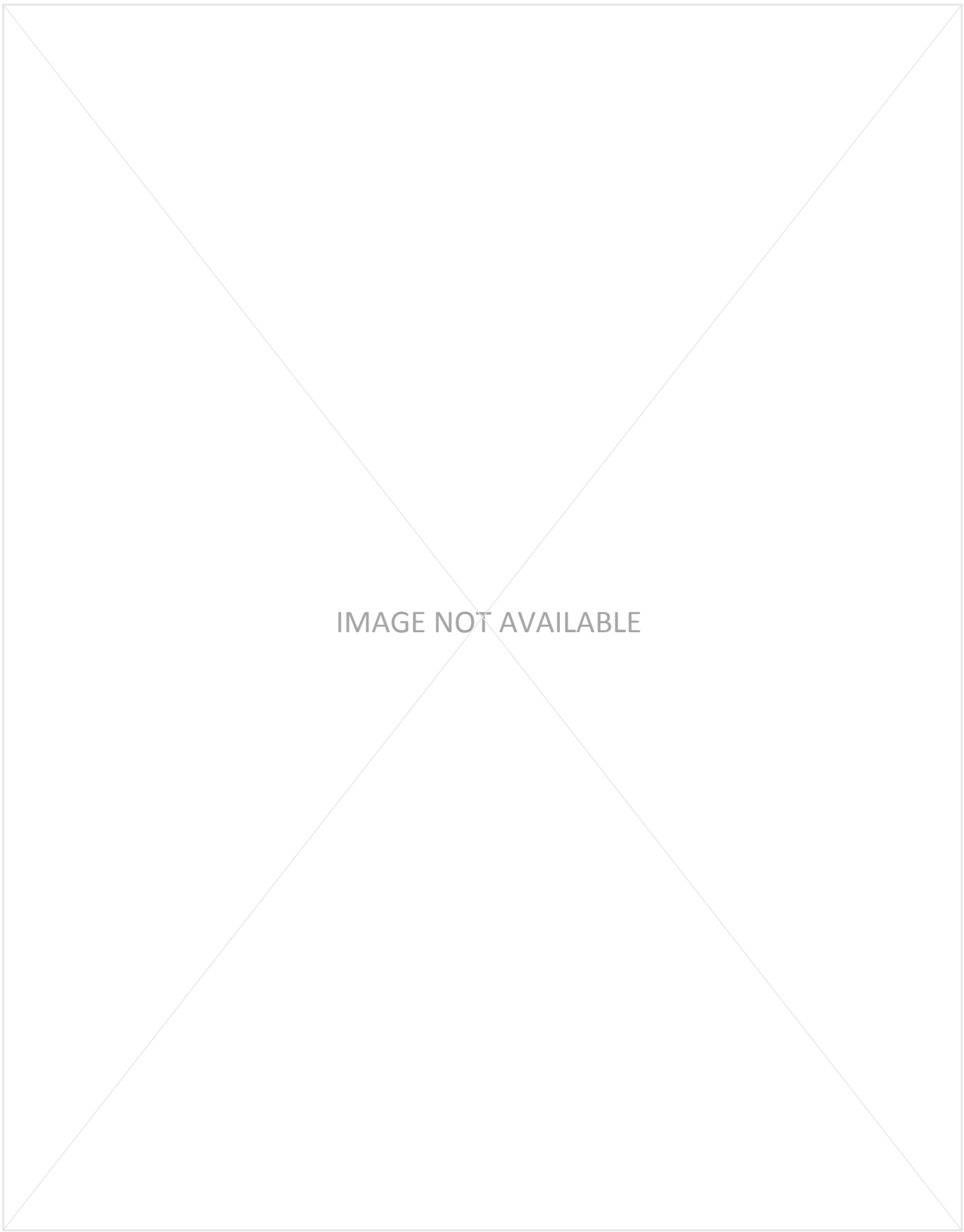

Fig. 12 *Charles* (1946). Saint Surgical Pathology Collection. Pathology Learning Centre, University of Cape Town.