3 The Patient's Voice
Conscious and Unconscious Agency in Romantic Surgery

Introduction

In the previous chapter, we explored the emotions of the Romantic surgical relationship largely from the perspective of the surgeon. A key aspect of the emotional intersubjectivity that was at the heart of this idealised encounter was the ability of the surgeon to put himself in the place of his patient and consider the case 'as [his] own'.[1] Such imaginative projections were a feature of surgical writing in this period. For example, in his *Discourses on the Nature and Cure of Wounds* (1795), John Bell effects a remarkable literary transportation into a patient suffering from an arterial aneurysm:

> The tumour is large, hard, circumscribed, and beating very strongly; the skin over it begins to inflame, the wound of the knife threatens to open again, the whole limb is feeble and cold; the surface of the tumour is livid, and in a few days the beating from such an Artery as the Femoral Artery is most alarming, and to the patient very awful; he spreads his hand broad over the tumour, feels its beating, like the heart in its strongest palpitations […] He is laid with tourniquets round the limb; he sees by these precautions, and he feels, as it were, that if the tumour burst during the night, he must lose his life with one gush of blood. Lying in this anxious condition, he is watched from hour to hour, till the time appointed for the operation arrives; and it is only then (however great the surgeon's fears about this operation) that the patient is in any degree safe.[2]

Despite the embodied vitality of this passage, such imaginative projections were inherently rhetorical, a testament to the surgeon's sensibility rather than an expression of patient experience. Indeed, even in such a compelling description as this, Bell's subjectivity hovers awkwardly between the surgeon and the imagined other. Thus, his own haptic expertise ('he spreads his hand […] feels it beating, like the heart in its strongest palpitations') stands in for the embodied consciousness of the patient, while he cannot help but slip from the patient's fear of bleeding to death in the night to the more familiar anxiety of the surgeon anticipating an operation. In order to recover the patient's

[1] Astley Cooper and Benjamin Travers, *Surgical Essays*, Part 1 (London: Cox and Son, 1818), p. 102.
[2] John Bell, *Discourses on the Nature and Cure of Wounds* (Edinburgh: Bell and Bradfute, 1795), pp. 68–9.

emotional experience of surgical care, or at least their emotional articulation of that experience, we must, then, look to a different body of material, or at least read the sources in a different way.

The search for the patient's voice has been one of the signal projects of the social history of medicine ever since Roy Porter sought to write a 'medical history from below' in the mid-1980s.[3] In surgery, as in medicine more generally, one of the greatest impediments to that project has been the nature of the source material. Aside from the famous example of Frances Burney's letter to her sister, or retrospective accounts such as that of George Wilson that opened this book, first-hand patient accounts of the experience of pre-anaesthetic surgery are relatively hard to come by. This is not to say that they do not exist. Doubtless there are similar accounts, potentially uncatalogued, in local archives somewhere. But the difficulty of recovering such material has meant that, for the most part, historians have relied on published, or at least well-known, patient testimonies in order to balance their accounts of surgical practice. In his history of early nineteenth-century British surgery, Peter Stanley grapples with precisely this predicament. The patient's voice is 'faint and elusive', he claims. While acknowledging that it is 'possible to devise a "celebrity ward", assembling operations from the great figures of the period' including Lord Nelson (1758–1805), the Earl of Uxbridge (1768–1854), and Sir Walter Scott (1771–1832), Stanley proposes to move 'beyond these well-known figures'.[4] He does this, firstly, by searching for patient voices in the reports of *The Lancet* and, secondly, by using a number of case studies of lesser-known figures taken from published sources or archival collections. The first approach is a reasonable one. This book also mines *The Lancet* for material, especially in Chapter 4. As we shall see, however, *The Lancet* is not a source that can necessarily be taken at face value, and it is important to consider the politics that inform its representation of operative practice, particularly where it concerns the sufferings of patients. The second approach is also appropriate. And yet, while illuminating, Stanley's case studies are presented largely in narrative form and are subject to relatively little analysis, leaving the reader to either flinch at their agonies or marvel at their 'courage in the face of an incurable disease and intense suffering'.[5]

This approach is not uncommon. Patient voices from this period are often allowed to speak for themselves, if only because their relative scarcity, and the fact that we are separated by the phenomenological gulf of modernity, means that their words have an intrinsic power to move us. That power is impossible to deny

[3] Roy Porter, 'The Patient's View: Doing Medical History from Below', *Theory and Society* 14:2 (1985), 175–98.
[4] Peter Stanley, *For Fear of Pain: British Surgery, 1790–1850* (Amsterdam: Rodopi, 2003), p. 261.
[5] Stanley, *Pain*, p. 279.

and many of the experiences recorded in this chapter are certainly affecting. But beyond the ghoulish frisson characteristic of much popular history of surgery, or the humanist impulse to feel for our fellow beings, even if removed in time, such accounts serve little *historical* purpose unless they are subject to analysis and read for meaning. In this regard, there is an exemplary model to follow in Stuart Hogarth's essay 'Joseph Townend and the Manchester Infirmary: A Plebeian Patient in the Industrial Revolution'. Townend, a Methodist missionary, wrote a biography of his life, including his 1827 stay in Manchester Infirmary when he was a 21-year-old textile worker. Using this account, Hogarth draws attention to the importance of emotional relationships between patients and practitioners in negotiating treatment. He also demonstrates that being a patient in hospital did not simply involve being a supplicatory recipient of paternalistic largesse, but could also be a profoundly emotional, even spiritual, experience.[6]

Hogarth is exceptionally fortunate in having access to a source as rich as Townend's diary. He describes this as 'possibly the most detailed description of hospital life by a working-class patient in the nineteenth century' and he is almost certainly right, at least for the period prior to the introduction of anaesthesia.[7] Even so, his sensitivity to the emotional relationships between patient and practitioner and the role of emotions in shaping experience, as well as in the exercise of patient agency, are concerns that are applicable to a range of sources from this period, including those examined here. The twin poles of experience and agency are central to the project of recovering the patient's voice, and it is perhaps easier to approach these through manuscript sources, produced by patients themselves, than through printed sources or formal records. This chapter therefore looks to a particularly rich body of archival material that has to date been almost entirely unexplored. In Chapter 2, we used the archives of Astley Cooper to analyse his emotional relationships with the women he treated for breast cancer, drawing primarily on his hospital casebooks. But we also got a glimpse into another dimension of this archive, namely the letters that Cooper received from his patients, their relatives, and medical assistants. These letters are particularly numerous in regard to his breast cancer patients. In her work on breast cancer in the eighteenth century, Marjo Kaartinen explores the agency and experience of women suffering from this disease. But her sources, apart from some manuscript receipt books, are almost entirely printed, and in many cases medical texts.[8] By contrast, the

[6] Stuart Hogarth, 'Joseph Townend and the Manchester Infirmary: A Plebeian Patient in the Industrial Revolution', in Anne Borsay and Peter Shapely (eds), *Medicine, Charity and Mutual Aid: The Consumption of Health and Welfare in Britain, c.1550–1950* (Aldershot: Ashgate, 2007), 91–110.

[7] Hogarth, 'Joseph Townend', p. 97.

[8] Marjo Kaartinen, *Breast Cancer in the Eighteenth Century* (London: Pickering and Chatto, 2013), ch. 4.

letters that Cooper received from his patients allow for a greater degree of insight, not just into the experience of disease, or rather its articulation and representation, but also into the ways in which emotions were deployed in corresponding with surgeons and in negotiating treatment.

Cooper's archive is by no means restricted to breast cancer, even if it is an especially prominent presence. Indeed, this chapter includes a range of patients with different afflictions and supplements Cooper's archive with evidence from other sources. Nonetheless, despite the extraordinary richness of this resource, a word or two of caution is necessary. For one thing, while this book pays particular attention to the operative aspects of Romantic surgery, these sources do not contain particularly full descriptions of going under the knife. Many refer to the fear of such procedures, while in other cases we can gain a brief glimpse into the pain and suffering they caused. But the fact remains that Frances Burney's visceral account of surgery remains something of a rarity. In most cases these sources testify to more chronic forms of suffering, and to the anxiety and dread that accompanied serious illness and non-operative forms of surgical treatment. For another, while many of these letters were penned by patients themselves, others were written by family members or by their medical attendants. Mediation is therefore an issue to be reckoned with. There has been much historical debate about the role of mediation in the articulation of non-elite subjectivities in this period. For example, historians of the Poor Law have explored the cultures of pauper correspondence, and have shown the ways in which these letters, even if generic in form or written by amanuenses, often described real circumstances and conveyed authentic sentiments.[9] Others have pointed out the ways in which the cultures of sensibility and an appeal to the emotions were deployed in the pursuit of relief.[10] Likewise, legal historians have considered the extent to which the voices of litigants and other parties were mediated by the lawyers, clerks, and other officials who shaped the public record.[11] In the case of medicine and surgery, it is clear, as we have

[9] Thomas Sokoll (ed.), *Essex Pauper Letters, 1731–1837* (Oxford: Oxford University Press, 2001); Steven King, Thomas Nutt, and Alannah Tomkins (eds), *Narratives of the Poor in Eighteenth-Century Britain, Volume 1. Voices of the Poor: Poor Law Letters and Depositions* (London: Pickering and Chatto, 2006); Steven King, 'Pauper Letters as a Source', *Family and Community History* 10:2 (2007), 167–70; Peter Jones and Steven King, 'From Petition to Pauper Letter: The Development of an Epistolary Form', in Peter Jones and Steven King (eds), *Obligation, Entitlement and Dispute under the English Poor Laws* (Cambridge, UK: Cambridge Scholars Publishing, 2015), 53–77; Jones and King, 'Testifying for the Poor: Epistolary Advocates and the Negotiation of Parochial Relief in England, 1800–1834', *Journal of Social History* 49:4 (2016), 784–807.

[10] Joanne Bailey, '"Think Wot a Mother Must Feel": Parenting in English Pauper Letters c. 1760–1834', *Family and Community History* 13:1 (2010), 5–19. See also Bailey, *Parenting In England, 1760–1830: Emotion, Identity and Generation* (Oxford: Oxford University Press, 2012), pp. 42–7.

[11] For example, see Joanne Bailey, 'Voices in Court: Lawyers or Litigants?', *Historical Research* 74:186 (2011), 392–408.

already seen, that practitioners interpreted the patient's narrative in forming their diagnosis. At the same time, however, given the importance ascribed to emotions in the generation, management, and treatment of disease, it seems likely that medical attendants and other interested parties would be concerned to communicate as accurate an account of the patient's state of mind as possible. Therefore, while undoubtedly mediated and imperfect, such sources do allow us to make tentative observations, if not necessarily about the subjective experience of disease, then certainly about the representation and communication of suffering.[12]

The significance, or otherwise, of the patient's narrative in the conceptualisation and treatment of disease has been an underlying concern of much scholarship on pre-modern medicine. If social historians of the early modern period, such as Roy Porter, sought to recover the patient's voice, assert the agency of patients in determining their care, and demonstrate their knowledge of medical theory, historians of the nineteenth century have, for the most part, held to the notion that the patient's narrative was effaced by the rise of 'clinical' or 'hospital' medicine.[13] This idea can be traced to the mid-1970s, more specifically 1976, the year in which Nicholas Jewson published his influential article on 'The Disappearance of the Sick Man from Medical Cosmology' and in which the English translation of Michel Foucault's *The Birth of the Clinic* (1963) was first published in the United Kingdom.[14] Although approaching the issue from very different disciplinary and intellectual perspectives, Jewson and Foucault jointly established the idea that the patient disappeared from the perceptual and conceptual apparatus of nineteenth-century medicine, that subjective testimony was superseded by the medical 'gaze' of clinical investigation and objective measurement, and that the patient became, in Foucault's words, a mere 'accident' of their disease.[15] Though often taken as read, relatively few historians have sought to expound on this phenomenon. A notable exception to this is Mary Fissell, who, in her 1991 essay 'The Disappearance of the Patient's Narrative and the Invention of Hospital Medicine', argues that, by the turn of the nineteenth century, 'the patient's narrative of disease was made utterly redundant' as hospital doctors came to focus on 'symptoms and

[12] For a good account of the communication of suffering within the context of eighteenth-century medical epistolarity, see Wayne Wild, *Medicine by Post: The Changing Voice of Illness in Eighteenth-Century British Consultation Letters and Literature* (Amsterdam: Rodopi, 2006).

[13] For example, see Roy Porter, 'Laymen, Doctors and Medical Knowledge in the Eighteenth Century: The Evidence of the *Gentleman's Magazine*', in Roy Porter (ed.), *Patients and Practitioners: Lay Perceptions of Medicine in Pre-Industrial Society* (Cambridge, UK: Cambridge University Press, 1985), 283–314.

[14] Michel Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception*, trans A. M. Sheridan (London: Tavistock, 1976); Nicholas D. Jewson, 'The Disappearance of the Sick Man from Medical Cosmology, 1770–1870', *Sociology* 10 (1976), 225–44.

[15] Foucault, *Birth*, p. 14.

signs' discernible by 'physical diagnosis and post-mortem dissection'.[16] Fissell only makes a brief reference to Foucault, and her essay perhaps owes more to Jewson's developmental model of change than to Foucault's revolutionary one.[17] Nonetheless, it is in keeping with a post-Foucauldian approach to the hospital that unites a social historical concern with institutional discipline to a more epistemic conception of social control.

In 2007, Flurin Condrau observed that 'a full debate between these two positions – that the patient's view can be unearthed from the sources, against the statement that the patient is a construct of the medical gaze – has, to my knowledge, never taken place'.[18] Fifteen years later, this remains broadly true.[19] In many ways, however, the political context for these positions has changed markedly. As Condrau recognises, Porter's co-opting of a Thompsonian rhetoric of 'history from below' linked his work to a political project with which it was only ambivalently aligned. The patient, though often poor, was not necessarily so, and in their case the 'condescension of posterity' was less clearly the product of political oppression than of 'medicalisation', a prominent bugbear for those at either end of the political spectrum in the 1970s.[20] By the 1980s, this focus on the agency of the individual lent itself, however inadvertently, to a neo-liberal Thatcherite agenda.[21] At the same time, not dissimilar observations have been made of the poststructuralist approaches of Foucault, in that they make the individual, rather than social class, the locus of power.[22] It is perhaps of little surprise, therefore, in our post-postmodern era when medical authority is increasingly tenuous and when internet expertise, anti-vaccination movements, and 'patient choice' abound, that the literature has sought to assert the agency of the individual in the face of clinical medicine, or at least to nuance established ideas about the hegemony of the medical gaze. Thus, even if Hogarth is wary of substituting power for the emotions in his account of Townend's stay in hospital, the effect of his argument is

[16] Mary E. Fissell, 'The Disappearance of the Patient's Narrative and the Invention of Hospital Medicine', in Roger French and Andrew Wear (eds), *British Medicine in an Age of Reform* (London: Routledge, 1992), 92–109, at pp. 93, 100.

[17] Fissell, 'Disappearance', p. 108, n. 28.

[18] Flurin Condrau, 'The Patient's View Meets the Clinical Gaze', *Social History of Medicine* 20:3 (2007), 525–40, at p. 529.

[19] For a response to Condrau's challenge, see Anne Hanley and Jessica Meyer, 'Introduction', in Anne Hanley and Jessica Meyer (eds), *Patient Voices in Britain, 1840–1948* (Manchester: Manchester University Press, 2021), 1–30.

[20] Condrau, 'Patient's View', pp. 530–5. For example, leading critics of 'medicalisation', particularly in the field of psychiatry, included the Roman Catholic priest Ivan Illich, the conservative libertarian Thomas Szasz, and the New Left thinker R. D. Laing.

[21] Condrau, 'Patient's View', p. 535.

[22] Roger Cooter, '"Framing" the End of the Social History of Medicine', in Frank Huisman and John Harley Warner (eds), *Locating Medical History: The Stories and Their Meanings* (Baltimore: Johns Hopkins University Press, 2004), 309–37.

to emphasise intersubjectivity over alienation, agency over subjugation, and complexity over oppositional binaries.[23] This chapter follows a similar path in that it demonstrates the continued resonance of the patient's narrative, as well the instrumentality of emotions, within the Romantic surgical relationship.

One of the characteristics of the literature on the patient's narrative has been to conflate Jewson's model of 'Hospital Medicine' with all aspects of the nineteenth-century clinical encounter, when in fact the private consultation continued to exemplify many of the features of his 'Bedside' model.[24] Even so, it is still important to acknowledge the different contexts of hospital medicine and private practice. We cannot be sure that Cooper's hospital patients were treated in a radically different way from his fee-paying ones, although the political dynamics pertaining to a dependent hospital patient and a (largely) autonomous patron were clearly distinct. Indeed, the very fact that commentators alluded to Cooper's sympathetic handling of hospital patients suggests that such practices were not necessarily taken for granted (though equally, as we have seen, 'rough treatment' was not unknown in private practice). What is certainly true is that, within Cooper's archive, these patients are represented and 'heard' very differently. Whereas his private patients can be read through letters written by them, their family members, or their medical attendants, his hospital patients are only glimpsed through his case notes. At the same time, however, this might give us pause to think about the nature of agency and how we conceptualise it. Ever since the 1990s, historians of early modern poverty have traced the agency of the poor through similar institutional records.[25] Like them, we might see agency in such acts of resistance as drunkenness on the ward or leaving the hospital under treatment. We might go one step further. If pre-anaesthetic surgery was a collaborative process, then patients might not collaborate as effectively as their surgeons desired. Indeed, this resistance, as we shall see, might even take on 'unconscious' forms, a revolt of the body and nervous system against violation and pain.

This chapter opens by considering the emotional experiences of patients in Romantic surgery, using the letters they sent to Cooper to explore their thoughts, feelings, and the ways in which they negotiated their treatment. Through a close reading of Cooper's hospital casebooks and other sources, it

[23] Hogarth, 'Joseph Townend', p. 108. See also Mary Wilson Carpenter, 'The Patient's Pain in Her Own Words: Margaret Mathewson's "Sketch of Eight Months a Patient in the Royal Infirmary of Edinburgh AD 1877"', *19: Interdisciplinary Studies in the Long Nineteenth Century* 15 (2012), http://doi.org/10.16995/ntn.636 (accessed 12/04/19).

[24] Jewson himself took the scheme from Erwin Ackerknecht, *Medicine at the Paris Hospital, 1794–1848* (Baltimore: Johns Hopkins University Press, 1967), though with scant acknowledgement; Jewson, 'Disappearance', p. 227, n. 7.

[25] For example, Tim Hitchcock, Peter King, and Pamela Sharpe (eds), *Chronicling Poverty: The Voices and Strategies of the English Poor, 1640–1840* (New York: St Martin's Press, 1997).

then proceeds to consider the various ways in which poorer patients asserted their agency and resisted forms of surgical authority and treatment. The final section considers forms of unconscious resistance to surgical treatment, notably the phenomenon of the 'obstreperous' patient and the failure of the individual, or their nervous system, to confirm to the idealised trope of operative fortitude.

'A Sensation of Half Dying': The Patient's Account of Surgical Illness

In October 1832, Astley Cooper was visited by a woman bearing a note from Roger Nunn of Colchester (1783–1844), which read:

> Mrs Ekins the Bearer of this is a Widow Lady with a Large Family and very very small means. This I know will be a sufficient passport to your heart and lay claim to your judgement without a fee – Do her and me the favour to look at her breast and say whether you think it malignant or otherwise, for myself I hope and believe that it is not. Any plan you may suggest for her benefit I shall have pleasure in following up, upon the same feeling and principle, with which I have taken the liberty of sending her to you.[26]

So began one of Cooper's many relationships with his patients. His archive is full of such letters of introduction, in which provincial medical practitioners, often exploiting some personal connection, referred their patients to his expert insight. These are particularly prevalent in cases of afflictions of the breast. Indeed, just a few days after Mrs Ekins' visit, Cooper received another patient from Essex, this time a woman by the name of Mrs Durrant, who bore the following note from her surgeon, Thomas King of Chelmsford:

> You will oblige me by giving me your candid opinion as to the Bearer Mrs Durrant's case 1st Whether you consider the disease affecting her Breast scirrhous and likely to become cancerous 2nd Whether it is that kind of case in which extirpation will be likely to prove availing and whether you would recommend it. It would afford me very great pleasure to find that you are of opinion anything can be done effectually to relieve this Patient a Widow with 5 Children whose life is of great consequence to her Family.[27]

Both of these letters are couched in a language of feeling. While Nunn expresses his hope that Ekins' growth is not malignant, King tells Cooper that it would give him 'great pleasure' should he think himself capable of treating Durrant. What is more, the women themselves are presented as objects of pity, deserving, in the first case at least, of *pro bono* treatment. In keeping with Cooper's identity as a man of feeling with a particular attachment

[26] RCSE, MS0008/2/1/9, 'Illustrations of the Diseases of the Breast, Part 1', Letter from Roger Nunn to Astley Cooper, 17 October 1832.
[27] RCSE MS0008/2/1/9, Letter from Thomas King to Astley Cooper, 24 October 1832.

to women and children, these women's medical attendants appeal directly to his 'heart', highlighting their patients' status as poor widows and the mothers of large families. As we saw at the beginning of the previous chapter, Cooper himself imagined the idealised female patient in this way, as the 'mother of a large family dependent on her for protection'.[28] Joanne Bailey has argued that parents and children 'were "good to think with" and "to feel with" in the culture of sensibility'; they 'stimulated the sympathetic identification required for feeling and benevolent behaviour'. Importantly, however, 'the need had to be genuine and the recipient deserving'.[29] Thus, notions of familial 'distress', including the financial burdens of widowhood and dependence, were especially important to the poor, who invoked this language themselves or, as in these examples, had it deployed on their behalf by others. According to Bailey, 'The language of distress was familiar to the elite who read literature and donated to charity. Parental distress stimulated especial sympathy and consideration', in part because it 'signalled that the poor possessed sensibility which made them all the more deserving of relief or charity'.[30]

At one level, then, these expressions of, and appeals to, emotion were generic, having close parallels with other supplicatory relationships. However, Cooper's archive also reveals a more active emotional expressiveness and agency. Perhaps understandably, among the emotions given most prominent expression in this archive are those of apprehension, anxiety, and dread. A particularly powerful example of this can be found in the case of Mrs Sheath of Lincolnshire. Unlike many of the patients in Cooper's archive, Sheath's case appears more than once and provides a sustained insight into the emotional relationship between a patient and her surgeon, albeit one mediated by third parties. The first letter relating to her case was written by her husband in February 1832, revealing that she had already undergone an operation to remove a breast tumour:

> About three years ago Mrs Martin Sheath of Wyberton near Boston, my dear Wife, was in Regent Street with her Sister […] under your Care having a lump in her right breast, and which was skilfully extracted by you; since that time Mrs S has had the misfortune to lose an affectionate Brother and not many months have elapsed since her only Sister, who was her nurse and Companion, departed this life after a very short illness, which

[28] Astley Cooper, *Illustrations of the Diseases of the Breast*, vol. 1 (London: Longman, Rees, Orme, Brown, and Green, 1829), p. 3.

[29] Bailey, *Parenting*, pp. 122–3.

[30] Bailey, *Parenting*, p. 43. See also Donna Andrew, '*Noblesse Oblige*: Female Charity in an Age of Sentiment', in John Brewer and Susan Staves (eds), *Early Modern Conceptions of Property* (London: Routledge, 1995), 275–300; Andrew, '"To the Charitable and Humane": Appeals for Assistance in the Eighteenth-Century London Press', in Hugh Cunningham and Joanna Innes (eds), *Charity, Philanthropy and Reform: From the 1690s to 1850* (Basingstoke: Macmillan, 1998), 87–107.

circumstances have left her in great grief and affliction and I fear have contributed a great deal to a return of the complaint. There is a small lump by the side of the same breast which now and then gives her pain but she dislikes to mention it to Mr Snaith, her apothecary, I therefore cannot allow it to proceed any further without acquainting you of the circumstance and requesting you to give me your excellent advice in what manner we ought to pursue. It has not been of so long standing as the former nor near so large, and it would be a great comfort to us both, if it could possibly be dispersed in preference to another operation, the thoughts of which make her as you may suppose very uneasy and dejected. I shall wait anxiously for your opinion.[31]

Martin Sheath's identification of 'great grief' as a cause of his wife's renewed affliction was, as we have seen, in keeping with Cooper's own views on the aetiology of cancer. Evidently, Cooper took on the case and recommended topical treatments, perhaps given the patient's fear of another operation. Clearly, too, he advised the Sheaths to trust to their local surgeon-apothecary, Frank Snaith, given that the next letter relating to her case, dated September 1834, is written by him and addressed to Cooper's manservant, Charles Balderson:[32]

I address this to you by desire of Mrs Sheath, who supposes Sir Astley has not returned to Town. Mrs S begs me to inform you that there is a sore in that part of the Breast […] formed from the healing of the sore in the first operation; she said she had the same when in Town and that Sir Astley soon healed it principally by the application of a white powder, but Mrs Sheath does not know whether it be the same she is using at present […] She has considerable pain in the fresh Ulceration […] afore mentioned […] Do suggest something if Sir Astley has not returned. Mrs Sheath is miserable about this new Ulceration and the adhesion of the lint, to […] which […] she attributes the new ulceration.[33]

Sheath's profound misery concerning the progress of her complaint and her anxiety to receive Cooper's advice are clearly communicated in this letter and only amplified by the next message from Snaith, some two months later. 'Mrs Sheath is so anxious to hear from you respecting the excoriations I mentioned in my last letter', it reads, 'that she would have me to write again today from Wyberton. She is alarmed lest the excoriations should spread under the arm, which is not improbable they will do if their progress cannot be arrested'.[34] Meanwhile, in one of the last letters in the archive, dated June 1835, Snaith records the alarming state of Sheath's condition and conveys her desperation:

[31] RCSE, MS0008/2/2/4, File of letters and notes of cases sent to Sir Astley Cooper, 1807–36, Letter from Martin Sheath to Astley Cooper, 7 February 1832.

[32] His actual surname was Osbalderson, but he was given this 'cognomen which offered a greater facility of pronunciation'; Bransby Blake Cooper, *The Life of Sir Astley Cooper, Bart.*, vol. 1 (London: John W. Parker, 1843), p. 329.

[33] RCSE, MS0008/2/2/4, Letter from Frank Snaith to Charles Balderson, 23 September 1834.

[34] RCSE, MS0008/2/2/4, Letter from Frank Snaith to Astley Cooper, 11 November 1834.

Our poor patient Mrs Sheath, has again requested me to trouble you with a statement of her present condition; the original sore is much the same it is a little more filled up from the bottom so that it does not look so much like a scooped out cavity, but the small ulceration, which she calls excoriations have spread since I last addressed you. They have extended from the Breast across the axilla to the back part of the arm, but they have extended much further downward along the abdomen, & on the Breast which has never been affected before […] We apply the lotion to the Ulcerations […] but it appears to make no alteration to the parts, she is anxious you should order something else, as she says, that if one thing does not answer, you always try another, now do my Dear Sir, write immediately, she is so anxious, and I was to have written to you two days ago, but was prevented.[35]

It is not known what happened to Mrs Sheath; given the nature of her symptoms, it seems likely that she succumbed to her condition. These letters therefore give voice to the profound anxiety of living with a painful, disfiguring, and almost certainly terminal disease.[36] But they also point to the importance of emotions in soliciting advice and treatment. Clearly Snaith was taking direct instruction from Mrs Sheath in his communications with Cooper. His role was not simply to report his clinical observations, but also to pass on her feelings and to leverage changes in treatment based, to a significant degree, on her state of mind. Perhaps unsurprisingly, given the widespread apprehension of its incurability, such expressions of anxiety and fear on the parts of patients were particularly common in cases of breast cancer. But they were also evident in other conditions too, especially other instances of cancer. Thus, a note delivered to Cooper by one of his male patients states:

Our Patient Mr Stayner the Bearer, has requested us to give you the outline of his Case […] He has during the last two years suffered a considerable pain in the Lumbar Region and the urine has deposited a lateritious sediment. But latterly he has been apprehensive of some Scirrhous affection of the rectum we have not discovered such disease existing but our patient's mind has been strongly impressed with this idea in consequence of his Father and Mother both having died from Cancer of the Rectum and the latter sloughing Mamma [breast cancer].[37]

Sheath's case thus illustrates the apprehension and anxiety that attached to the experience of disease in general, as well as the ways in which those fears were instrumental in shaping therapeutic decision-making. For example, her initial wariness of revealing her condition to her surgeon-apothecary was not uncommon. Whether from fear of an unfavourable diagnosis or from a belief that nothing could be done to alleviate their condition, patients often concealed

[35] RCSE, MS0008/2/2/4, Letter from Frank Snaith to Astley Cooper, 10 June 1835.

[36] On the experience of pain and cancer, see Kaartinen, *Cancer*, pp. 94–101; Javier Moscoso, 'Exquisite and Lingering Pains: Facing Cancer in Early Modern Europe', in Rob Boddice (ed.), *Pain and Emotion in Modern History* (Palgrave: Palgrave Macmillan, 2014), 16–35.

[37] RCSE, MS0008/2/2/3 pt. 1, File of letters and notes on cases sent to Sir Astley Cooper, unpaginated note dated 11 October.

their symptoms, even from loved ones.[38] In 1836, for instance, Frances White of Thatcham in Berkshire wrote to Cooper with a history of her case, which began, aged 28, when she 'discovered a small lump forming about the size of a nutmeg on the top of my left Breast near my duct'. White 'took little notice of it for a year or more', as it gave her little pain. However, she later 'began to have shooting pains in my Breast and the lump gradually increased'. It was only aged 36, when the tumour started to discharge 'something like clear water', that she went to see Cooper, 'something I very much regret not having done in the first beginning of the Disease'. As she explained, 'I never let any Medical Gentleman see it before Sir Astley for as I resided in the country I had not sufficient confidence to think they could do me any good, the doctors in Berkshire having but little experience in such cases'.[39] Meanwhile, in December 1833, Cooper received a letter from the Lancaster physician Edward Denis De Vitré (1806–78) asking his advice in the case of Mrs Mackreth, the 62-year-old wife of a local clergyman who had already undergone a previous operation. 'Unfortunately', De Vitré wrote, 'she has all along observed the strictest secrecy regarding her complaint, and only informed her husband of it a week ago'. As such, her condition was quite advanced and De Vitré told Cooper that 'I have not flattered Mr Mackreth's expectations'.[40] Practitioners were well aware of this inclination to conceal, and another Lancastrian correspondent, the Blackburn surgeon James Barlow, wrote:

> It is lamentable to recount the numerous cases of tumours which I have witnessed and which have either been neglected on the one hand by the supinity of the Patient, or from ignorance and timidity of the surgeon on the other insomuch that the disease has ultimately become exasperated [*sic*] beyond the aid of the scientific surgeon.[41]

In other cases, however, it was the surgeon who might conceal the full reality of a patient's condition from them. This was a matter of some contention within Romantic surgery. As we have heard, surgeons of the period spoke of the necessity of putting the patient's needs and desires at the centre of decision-making. And indeed, at a time when operative surgery required active resolve on the part of the patient, consent and collaboration were absolute necessities. Thus, Frederic Skey proclaimed that 'However, desirable it may be, that the mind of the patient be animated by a full share of hope and confidence in the issue, this desideratum cannot justify his withholding the honest, and unreserved declaration of his thoughts and opinions'.[42] Skey's reference

[38] Kaartinen, *Cancer*, pp. 64–7.
[39] RCSE, MS0008/2/2/4, Letter from Frances White to Astley Cooper, 22 May 1836.
[40] RCSE, MS0008/2/2/3 pt. 3, Letter from Edward D. de Vitré to Astley Cooper, 14 December 1833.
[41] RCSE, MS008/2/2/12, Notebook of notes on a case of the removal of a tumour from the cheek, unpaginated. The notion that women were particularly inclined to conceal their condition was widespread in this period; Kaartinen, *Cancer*, p. 66.
[42] Frederic Skey, *Operative Surgery* (London: John Churchill, 1850), p. 12.

to the patient's state of mind hints at the delicate balancing act inherent to the clinical consultation. In the early part of our period in particular, when, as we have seen, emotions such as anxiety and grief were thought to have a powerful influence on the propagation and exacerbation of physical complaints, presenting the patient with a full account of their predicament might only serve to compound it. Certainly, patients occasionally feared they were not being told the whole truth. For example, in 1832 Maria Wigg of Honiton in Devon wrote to Cooper, stating:

> Could you, Sir think of any thing to afford me relief I should <u>for ever</u> feel extremely thankful, for I must acknowledge that I still feel apprehension of a cancer, and when most troubled with pain am fearful you did not tell me exactly what it really was, therefore dear Sir your <u>candid</u> answer will be very very acceptable to me and greatly ease my mind.[43]

Neither were such fears unfounded, for in 1822 John Rosewarne, a surgeon of Wadebridge in Cornwall, wrote relative to his patient:

> As Miss Best is extremely anxious and agitated on the subject I have endeavoured as much as possible to keep the real nature of the complaint from her until imperious [*sic*] changes in it should oblige me to be more explicit, and I still think that the most cautious manner of proposing an operation would be necessary; I have as yet only ventured to hint at it.[44]

Evidently, the patient's fear of the operation could be as profound as that of the condition itself and had a material effect on their treatment.[45] In 1835 Dr Bowen of Carmarthen wrote to Cooper concerning his patient, Mrs Hughes, from whom Cooper had already removed a tumour and the whole left breast the previous year. Subsequent shooting pains in the region produced 'great despondency' and 'She now has a great drea[d of being] obliged to submit to another [operation]'. 'I have therefore said nothing to her on the [subject]', he wrote, 'but recommended her to consult you personally and thereby have her mind made easy'.[46] As we have seen in the case of Mrs Sheath, her husband's desire that her tumour be 'dispersed' through the use of caustics derived from the fact that the prospect of another operation made her 'very uneasy and dejected'.[47] Likewise, Mrs Mackreth doubtless kept the return of her cancer secret from her husband in part because 'She dreads the idea of another

[43] RCSE MS0008/2/1/9, Letter from Maria Wigg to Astley Cooper, 24 September 1832.
[44] RCSE, MS0008/2/2/3 pt. 1, Copy of a letter from John Rosewarne to Thomas Stewart, 9 July 1822.
[45] Kaartinen, *Cancer*, pp. 91–4.
[46] RCSE, MS0008 2/2/3 pt. 3, Letter from Dr Bowen to Astley Cooper, 26 November 1835. This page of the letter is badly damaged and the words in square brackets are conjecture.
[47] RCSE, MS0008/2/2/4, Letter from Martin Sheath to Astley Cooper, 7 February 1832.

operation'.[48] All three of these women had endured the agony of surgical excision, and had no desire to repeat the experience, even if that came at the cost of their life. But in any case, surgical removal was well known to be a most uncertain 'cure' and many women were understandably cautious of undergoing the ordeal unless there was a real chance of success. In Chapter 2, we encountered Mrs Palmer of Wellingborough who visited Cooper in 1836 for a tumour of her left breast, caused by the combination of a physical blow and the ill-health of her son. In the accompanying note from her surgeon, Benjamin Dulley (c.1807–88), he observed:

> There does not seem to be any great enlargement of the glands in the axilla but there is a kind of chain of communication from them to the tumour which has deterred me from submitting to her the prospects of an operation until I had had your opinion thereon – for in the few cases in which I have operated there has been the usual tendency to reproduction of the disease which precludes giving so favourable a prospect of real ease as Patients generally require before submitting to a painful operation.[49]

In 1815, Mrs Etchley of Hereford attended Cooper with similar questions as to the efficacy of an operation. The note she bore from her surgeon, Mr Griffiths, stated: 'The principle questions we wish to submit to your decision are […] Whether you think it advisable to remove the Tumour by excision? and in the next, how far you think this Lady a good subject to undergo such an operation, looking forward to permanent advantages?'[50]

As it turned out, Cooper did not think Etchley's case to be a 'true scirrhous', and hence she did not require an operation. Meanwhile, in other instances patients had to be convinced of the imminent risk to their health in order to go under the knife. For example, a note in Cooper's archive gives an account of the case of Mrs Davis of 'Old St Pancras Church', a 34-year-old woman who developed a tumour of the right breast weighing five pounds (her breast as a whole weighed fifteen). 'This immense enlargement was not attended with much pain', the note observes, the main issue being its weight, 'and this inconvenience, added to the apprehension that the patient's health must soon give way under the influence of such a disease, induced her to consent to its removal with the knife in the judicious hands of Sir A Cooper'.[51] However, perhaps the most striking example of a patient being persuaded to consider an operation, by dint of their own experience as much as by surgical advice, is that of Jane Watson, a Quaker from Waterford in Ireland. She began her letter by asking 'perhaps Astley Cooper may recollect being applied to for advice by Jane

[48] RCSE, MS0008/2/2/3 pt. 3, Letter from Edward D. de Vitré to Astley Cooper, 14 December 1833.
[49] RCSE, MS0008/2/2/3 pt. 3, Letter from Benjamin Dulley to Astley Cooper, 28 April 1836.
[50] RCSE, MS0008/2/2/4, Letter from J Griffiths to Astley Cooper, 14 April 1815.
[51] RCSE, MS0008/2/2/3 pt. 1, unpaginated note dated 19 September 1822.

Watson, respecting a tumour in her breast on the 29th of the 5th month (May) in the present year'. '[H]e rather approved an immediate removal', she notes, 'but as she could not at that time submit, he prescribed a plaister, daily aperient pills, and occasional application of leeches'. There follows a detailed account of her complaint, complete with emphatic underlining. She observes that in the 'last three [months], there has been evidently a considerable encrease [*sic*] of size, as well as of pain' in her tumour. She had followed Cooper's instructions, including in the application of the 'plaister' and the daily 'aperient pills', and while the pills operated 'moderately', the leeches did not produce 'the inflammation she feared'. 'Still', she adds, 'she has not been sensible of deriving much, if any benefit from them'. Watson maintained that 'she has not had any medical advice since seeing Sir A C – considering herself his patient, and acting according to his directions'. She therefore 'solicits Sir Astley Cooper's candid opinion, whether from what she has now communicated he thinks there is still a prospect of her being relieved by an opperation [*sic*]'. '[C]rossing the waters at such a late season of the year with the journey to London appears a formidable addition', she concluded, 'but still she might be induced to undertake it, if there appears a probability of success and begs Sir Astley Cooper will kindly favour her with a reply at the earliest period that finds his convenience as she waits it, with considerable anxiety'.[52]

Jane Watson's letter is remarkable in many ways. Here is evidence, if ever it were needed, that the patient's voice was by no means entirely effaced by the advent of clinical medicine. Like many others in her position, she uses the language of emotion, particularly anxiety, to leverage a response. But what is particularly striking about her letter is the fact that it is couched in the third person. While this might be a quirk of Quaker prose, it also served to give her observations a greater degree of clinical authority, as if they had been written by a medical attendant. Indeed, at one point in the letter she acknowledges the oddity of her address, stating that 'if he [Cooper] thinks he could understand her situation better by having it stated by a Surgeon she will have it done'.[53] Watson was clearly an assertive and capable woman, managing her illness to the best of her abilities. Sadly, the records suggest that she died, aged 62, some six years after penning this letter.[54]

If some patients required persuasion about the need for an operation, others were far more readily disposed to submit. In August 1835, for example, Cooper received a letter from his former pupil Henry James Prince (1811–99), surgeon to the General Infirmary at Bath, who would later become notorious

[52] RCSE, MS0008/2/2/3 pt. 1, Letter from Jane Watson to Astley Cooper, 10 July 1839.
[53] RCSE, MS0008/2/2/3 pt. 1, Letter from Jane Watson to Astley Cooper, 10 July 1839.
[54] www.igp-web.com/IGPArchives/ire/waterford/churches/quaker-deaths-w3.html (accessed 01/05/22).

as the founder of the Agapemonite religious sect.[55] Prince wrote that during his medical studies in London, which were attended with 'some degree of mental anxiety, my attention was attracted to a gradual decline of general health by the Enlargement of two or three glands in the right groin', a condition that was exacerbated by his contracting gonorrhoea in 1833. At the time of writing, his right testis had swelled to the 'size of a large hen's egg', which 'acts as a mechanical impediment to my taking exercise so successfully that I am crippled by it'. He therefore requested Cooper to remove it in its entirety, stating:

> The impression upon my own mind is that the presence of the diseased Testis is the only prevention to recovery and that my health will never be restored without the extirpation of the gland. I am 24 years of age, of a nervous and irritable temperament, and extremely susceptible to external impressions of every kind.[56]

The idea that the mental anxiety produced by a tumour could only be remedied by its excision, regardless of its pathological status, can also be found in one of Cooper's casebooks, wherein the entry for a 20-year-old patient by the name of Mrs Hole ends with the resolution: 'To be removed on the ground of anxiety as it prays upon the mind'.[57] For others, however, no amount of persuasion could overcome the fear of an operation. Thus, one of Cooper's patients, who was herself being treated for breast cancer, wrote that she 'had a Sister that was afflicted with a Cancer for many years who had not courage to undergo an operation and had Causticks applied'. She broke out in ulcers, which were healed with 'the juice of Clivers, or Goose Grass, but she Dyed [*sic*] in 2 years apparently of consumption at the age of 47'.[58]

As this correspondent's reference to her sister reminds us, relations between patients and surgeons were often mediated, not only by medical attendants, but also by friends and family. Benjamin Brodie told his students that the 'Medical practitioner necessarily sees more of the interior of the families whom he visits than other persons', while Frederic Skey maintained that family members could play a vital role in the surgical consultation, allowing the surgeon to 'speak more freely and unreservedly to persons only secondarily concerned' and enabling the 'exercise of the calmer and more disinterested judgement of one […] more competent to meet the occasional idiosyncrasies of a patient's mind'.[59] Skey's somewhat idealised representation of familial disinterest neglects the fact that friends and family often brought their own

[55] Timothy C. F. Strutt, 'Prince, Henry James (1811–1899)', *ODNB*.
[56] RCSE, MS0008/2/2/4, Letter from Henry James Prince to Astley Cooper, 10 April 1835.
[57] RCSE, MS0008/2/1/6, Volume of case notes in the hand of Sir Astley Paston Cooper, 1817–20, unpaginated.
[58] RCSE, MS0008/2/2/4, Letter from E. Wood to Astley Cooper, 22 November [no year].
[59] RCSE, MS0470/1/2/5, Benjamin Brodie, 'Introductory lecture of anatomy and physiology' (October 1820), f. 5; Skey, *Surgery*, p. 13.

emotions into the bargain. As we shall see, parents could exert considerable agency in refusing surgical treatment for their children, whereas others were anxious to procure it. In February 1835, for example, the surgeon John Dalton (1771–1844) of Bury St Edmunds sent his daughter Hannah to see Cooper in the company of his son and fellow surgeon John Dalton junior (1803–59). The accompanying letter reveals that she had a 'Serious stricture' in her rectum and a 'malformation of Parts' that had prevented the consummation of her marriage. Dalton apologised to Cooper for having 'troubled you with what all eminent consulting Surgeons hate, a long prosing and to you perhaps ignorant, stupid story', but he begged Cooper's forgiveness and hoped he would 'attribute it to the anxiety I feel as a Parent'.[60] In other instances, family members played a mediating role that was closer to Skey's ideal. Thus, in 1832, the surgeon Caleb Woodyer (1766–1849) of Guildford wrote to Cooper about a patient of his named Miss Hayden, a 70-year-old 'maiden lady' suffering from 'a diseased Breast'. Woodyer noted that 'Her niece, Miss Sophia Hayden will now likely accompany her, who has a strong mind'. This was probably just as well, he claimed, as her aunt 'has the high nervous sensibility, which requires caution in your observations'.[61]

As we have heard, first-hand accounts of operations written by patients themselves are relatively rare. The closest we have to such a thing in Cooper's archive is a letter sent to him in 1823 by the former East India Company surgeon John Cairnie (1769–1842) of Largs. In October 1816, a canister of gunpowder exploded in Cairnie's left hand, 'whereby the muscles of the thumb and palm of the hand were much lacerated, and the bone of the first phalanx of the thumb was broken'. He appeared to be recovering well, but some days later he began to haemorrhage and 'we were unable after repeated attempts and much suffering to me to find from whence it proceeded'. As a result:

> the palmar arch was cut down upon and tied, but to no purpose the bleeding returning at intervals without any warning reduced me extremely – The radial artery was next cut down upon and tied[.] [I]n doing a sheath [of] the nerve had been included, as when the Ligature was tightened, I started involuntarily from my back to my legs and a severe pain struck me from the occiput to the forehead over the right eye.[62]

This operation 'proved also unsuccessful and the thumb was next removed at its junction with the Carpal bones'. Still, the source of the bleeding could not be found and so Cairnie had to undergo an amputation between the elbow and the wrist. However:

[60] RCSE, MS0008/2/2/6, Letter from John Dalton to Astley Cooper, 22 February 1835.
[61] RCSE, MS0008/2/2/4, Letter from Caleb Woodyer to Astley Cooper, 7 February 1832.
[62] RCSE, MS0008/2/2/3 pt. 1, Letter from John Cairnie to Astley Cooper, 8 April 1823.

The assistant in charge of the Retractors let them slip during the sawing of the bone and some of the soft parts got into the teeth of the saw when the pain was most excruciating I could compare it to nothing but boiling lead running into a fresh wound, happily it was but momentary or I must have died under it.[63]

In another, not dissimilar instance, William Dann, a 34-year-old shipwright, was admitted to Guy's Hospital in May 1816 and found to have an aneurysm of the popliteal artery. During the operation, which appears to have been performed by the notoriously incompetent William Lucas junior, the femoral sheath was tied up with the ligature and 'as this was done the Patient's cries were deplorable [and] he seemed to suffer in an extreme degree'.[64] Evidently curious about the pain he had caused, the surgeon asked Dann after the operation to describe what he had felt:

He says the first incision into the integuments was a sharp smarting pain, but that produced from the application of the ligature round the sheath was of an exquisite burning nature; he describes it as if the limb was sliced down with an [*sic*] hot lance – the pain shot down to the knee, and was described as tho [*sic*] a lance had passed into the part – then it went down in like manner to the ankle where the same feeling occurred as in the knee – When the artery was properly separated from the sheath he felt it raised distinctly, and was relieved of a stretching pain when it was divided and retracted, he felt it go in, on his word.[65]

These two instances provide a fleeting, yet intensely visceral, insight into the embodied experience of pre-anaesthetic surgery. In her pioneering study, Elaine Scarry argues that the experience of pain ultimately destroys language, rendering it inexpressible.[66] This is because she treats pain as a thing in itself, which stands outside of language. By contrast, scholars such as Javier Moscoso and Joanna Bourke have sought to understand pain as a cultural and linguistic phenomenon, an 'event' that only achieves 'significance' (or meaning) through its expression.[67] Certainly, Carnie and Dann's use of simile and metaphor suggests something of the ineffability of such intense embodied experiences, as does George Wilson's account of his operation in 1842, in which he claims that 'suffering so great as I underwent cannot be expressed in words, and thus fortunately cannot be recalled'.[68] And yet, if Wilson's account supports Adam

[63] RCSE, MS0008/2/2/3 pt. 1, Letter from John Cairnie to Astley Cooper, 8 April 1823.
[64] On Lucas' incompetence, see Cooper, *Life*, vol. 1, p. 302; John Flint South, *Memorials of John Flint South* (London: John Murray, 1884), pp 52–3.
[65] RCSE, MS0008/2/2/3 pt. 1, unpaginated case of 'Popliteal aneurism'.
[66] Elaine Scarry, *The Body in Pain: The Making and the Unmaking of the World* (Oxford: Oxford University Press, 1985), pp. 3–11.
[67] Joanna Bourke, *The Story of Pain: From Prayers to Painkillers* (Oxford: Oxford University Press, 2014), pp. 1–19; Javier Moscoso, *Pain: A Cultural History* (Basingstoke: Palgrave Macmillan, 2014).
[68] James Young Simpson, *Acupressure: A New Method of Arresting Surgical Haemorrhage* (Edinburgh: Adam and Charles Black, 1864), p. 568.

Smith's assertion that 'Nothing is so soon forgot as pain', Carnie's memory of that sensation was clearly alive and well some seven years after the event.[69]

In the relative absence of such first-person testimony, we find that the language used to describe the experience of patients in the operating theatre was often more generic. As we shall see in Chapter 4, where operations went wrong, or where it suited the reformist agenda of journals like *The Lancet* to highlight the sufferings of the patient, that language used could be emotive and expressive. For the most part, however, descriptions of successful operations either make little reference to the bearing of the patient or, if the operation was particularly gruelling, highlight the 'fortitude' of the sufferer. Thus, in the case of Mrs David, noted above, it was said that the operation to remove the tumour from her breast lasted 'about eighteen minutes, without the patients [*sic*] hands (at her own desire) being confined or her eyes darkened and without her uttering one word of complaint'.[70]

Within Cooper's archive, first-hand descriptions of pain most commonly relate to the chronic sensations of illness, or the acute agonies of therapeutic treatment, rather than the experience of operative surgery. In part, this may have something to do with the clinical value of such testimony. Except in such cases as Dann's, where the surgeon's curiosity was piqued, the pain of undergoing an operation was ubiquitous and thus of comparatively little clinical interest or relevance. Let us remember, too, that Wilson's account of his operation only assumed meaning through its contrast with the relative *painlessness* of anaesthetic surgery. By contrast, patients' descriptions of the pain of disease, or of treatment, could serve a diagnostic, prognostic, or therapeutic purpose. Hence, at various points in his casebooks, Cooper records the subjective sensations of his patients, such those of Mrs Smith, a 59-year-old woman with a tumour in her left breast, who described her condition thus: 'The pain is by fits – like a Cork Screw – like a Knife at others – sometimes like [illegible] – sometimes like an aching'.[71] Moreover, for patients themselves, such descriptions had a moral and emotional force. They might generate pathos and encourage a favourable response from their surgeon, or they might leverage a change in treatment. In the case of 'W Davy' from Marlborough, they testified to his diligence in following Cooper's instructions, and provided information by which to determine his future treatment. Davy suffered from a tumour on his cheek and in May 1831 he supplied Cooper with 'a statement of the progress and success of the application of arsenic to my face', in 'compliance with your request'. He describes a pain that the modern reader can hardly begin to imagine:

[69] Adam Smith, *The Theory of Moral Sentiments* (London: A. Miller, 1759), p. 56. On the use of metaphor in descriptions of pain, see Bourke, *Pain*, ch. 3.
[70] RCSE, MS0008/2/2/3 pt. 1, unpaginated note dated 19 September 1822.
[71] RCSE, MS0008/2/1/9, annotation opposite p. 1.

I applied the Pulv: arsenic to the face. The pain was very severe and incessant for the first day and night – The second day the pain was at times, great but not unremitting, During the day, from weakness induced by want of rest and continual pain, I fainted – The third and fourth days were days of suffering, but not excessive. I had but little rest at night. The fourth night was more painful than any, except the first. I conclude, that was occasioned by a disposition to separate, the dead from the live flesh, as after this, it became more easy […] From this time, both pain and swelling gradually subsided. I should observe that the enflamed state and swelling of the cheek were very great. One eye was nearly closed, and the mouth almost shut up by the swelling […] At the end of one month the past portion of the dead flesh sloughed off […] the wound gradually contracting, till at the end of one week, May 10th, it healed completely –

The pain, for the two first days, after the application to the face, was like violent pricking of needles, the thrusting of knives, and often as if something were gnawing the flesh, at times there was a sensation of numbness.[72]

Given such suffering, even in an ostensibly successful case, it is perhaps unsurprising that patients frequently expressed deep despondency about their condition. As we have heard, this was a state of mind that was regarded with grave concern by surgeons, for dejection, especially after an operation, could prove fatal. Thus, in Cooper's casebooks, accounts of patients' aftercare make frequent reference to their mood. In one instance, for example, a 'Stout healthy man was brought into Guys Hospital who had a compound fracture of his leg'. Amputation was immediately performed but, after two days, it was noted that 'his countenance is desponding' and just under a week later he died, 'apparently of weakness'.[73] Occasionally it is possible to hear the patient give voice to feelings of despair or resignation. For example, in 1804, the surgeon John Leadam (1780–1845) of Tooley Street, Southwark, told Cooper of the case of a woman under his care who suffered from a severe stomach complaint and exhibited 'the most distressing symptoms', including vomiting and twitching. Two or three times a day she felt '(to use her own expression) "a Sensation of Half Dying" for which she considered Fainting away would be the happiest relief'. According to Leadam, she had frequent recourse to opium, 'more from her particular watchfulness, than pain [and] … in her latter moments, she loudly called for it, to ease the pangs of death'.[74] Similarly, a description of a woman who suffered from erysipelas following an operation on her face recounts that she was in such pain that she 'could not swallow the bark which was poured gently into her mouth'. Soon afterwards she 'said "she wished the Lord would free her from pain" in a manner scarcely intelligible' and 'at 2 o'clock on the morning of the 22 Dec she died'.[75]

[72] RCSE, MS0008/2/2/3 pt. 1, Letter and case report from W. Davy to Astley Cooper, 30 May 1831.
[73] RCSE, MS0008/2/1/4, Cases in Surgery, Volume 4 (1788), 'Case 28th', ff. 70–2.
[74] RCSE, MS0008/2/2/4, Letter from John Leadam to Astley Cooper, November 1804.
[75] RCSE MS0008/2/2/7, File of letters and notes on cases sent to Sir Astley Cooper, 1813–38, Letter from 'RB' to Astley Cooper, undated.

Even in less acute cases, patients could experience profound despair. One of the most notable examples of this in Cooper's archive concerns the Reverend Dr Michael Burke (1789–1866), Catholic Rector of the Parish of St Peter and Paul in Clonmel, Ireland. Burke fractured his left thigh in a fall from a coach travelling from Boulogne to Paris. According to the case report:

> Dr Burke was to all appearance a very healthy man, but suffered intense anxiety of mind owing principally to an apprehension of the result of his accident being fatal, an idea which seemed to occupy his mind incessantly, almost to the exclusion of every other thought, and partly to his absence from home in a foreign country away from his friends and his parish.[76]

The celebrated surgeon Philibert Joseph Roux (1780–1854) declared that it 'required only time for nature' to heal the fracture, but Burke expressed 'the utmost desire to get home'. Indeed, another surgeon, M. Durand, 'attributed the tardiness of the union to the patient's state of mind which he alleged to be […] distracted by nostalgia, and apprehension of a fatal result'. As Thomas Dodman has shown, Romantic conceptions of nostalgia were intimately tied to absence from home, and the 1820s and 1830s constituted its 'golden age' as a clinical condition, especially in its spiritual homeland of France.[77] Even after his return to Clonmel, however, Burke's mind was 'still in a state of the greatest despondency […] his fears of a fatal result have continued' and 'his depression of spirits is such that he is often affected even to tears'. Indeed, his despondency was so persistent and unyielding that his attendants began to lose their patience, for his case concludes with the observation that due to 'his peculiar temperament […] his complaints are supposed to be often much greater than in proportion to any actual pain or annoyance suffered'.[78]

In a number of instances, despondent patients contacted Cooper because they believed him to be their last hope of relief. In March 1817, for example, Charles Jamieson of Inverness wrote to Alex Mackenzie in London, repeating his 'earnest wish that you would once more lay my case before Dr [*sic*] Cooper' for 'if he will or cannot do any thing for me there is no help'. Included with the letter was an account of his 'long distressing state', which involved a sore on his penis that prevented him from urinating without intense pain and putting his 'whole frame […] in a kind of stupefied state'. 'The medical men here when they call

[76] RCSE, MS0008/2/2/3 pt. 1, unsigned, undated case notes.

[77] Thomas Dodman, *What Nostalgia Was: War, Empire, and the Time of a Deadly Emotion* (Chicago: University of Chicago Press, 2018), pp. 128–30. See also Philip Shaw, 'Longing for Home: Robert Hamilton, Nostalgia and the Emotional Life of the Eighteenth-Century Soldier', *Journal for Eighteenth-Century Studies* 39:1 (2016), 25–40; Joanne Begiato, 'Selfhood and "Nostalgia": Sensory and Material Memories of the Childhood Home in Late Georgian Britain', *Journal for Eighteenth-Century Studies* 42:2 (2019), 229–46.

[78] RCSE, MS0008/2/2/3 pt. 1, unsigned, undated case notes.

say "how do you do" and promise to call [again] in the evening', he wrote, but while 'they are my real friends and would do me good if they could', they availed him nothing. As such, he sought to procure Cooper's advice, 'as may either relieve me or that I may conclude nothing can be done for me' and that 'I must struggle with my distress and meet the consequences'.[79]

Jamieson's letter brings us to the final set of emotions that are given expression by patients in Cooper's archive. Perhaps unsurprisingly, given the limited power of early nineteenth-century surgery to cure many of the most serious conditions that came under its purview, expressions of relief, joy, and gratitude are somewhat less common than those of anxiety, fear, and despondency. Nevertheless, there are a number of instances in which patients either wrote to Cooper themselves, or had their recovery communicated to him by third parties. Cooper's breast cancer patients were especially expressive on this point, and particularly indebted to him as an individual. Thus, in reply to Cooper's enquiry after her health, a woman from West Burton in the Yorkshire Dales, signing herself 'E Wood', wrote 'You tell me you have not forgot me, I should be a most ungrateful person if I ever forget my obligation to you, as, under providence, you were the means of saving my life when Mr Hay of Leeds told my Son that I could not survive 6 weeks, and that all the Surgeons in England could not save my life'.[80] Meanwhile, Frances White, whom we encountered earlier, claimed that 'I must always consider my life has been prolonged owing to my going to Sir Astley and the kind attentions of his worthy assistant Mr Balderson'.[81] As we saw at the beginning of Chapter 2, in the introduction to his *Illustrations of the Diseases of the Breast* (1829) Cooper imagined telling one of his patients that her breast was not cancerous and seeing her face brightened 'with the smile of gratitude'. These letters clearly show that such imaginings were grounded in reality and, indeed, in his casebooks Cooper recounts an even more powerful, affective response on the part of 'Mrs Stuart', who 'consulted a medical gentleman respecting a tumour which she had in her breast and immediately as he told her it was not cancerous or ever would be she fainted'.[82] However, as Hannah Newton's work has shown, recovery from illness was not simply an occasion for joy and gratitude, or even overwhelming relief, but also for religious reflection and praise.[83] Hence,

[79] RCSE, MS0008/2/2/4, Letter from Charles Jamieson to Alex Mackenzie, 24 March 1817.
[80] RCSE, MS0008/2/2/4, Letter from E. Wood to Astley Cooper, 22 November [no year].
[81] RCSE, MS0008/2/2/4, Letter from Frances White to Astley Cooper, 22 May 1836.
[82] RCSE, MS0008/2/1/7, Casebook in the hand of Sir Astley Paston Cooper, 1793–1823, unpaginated.
[83] Hannah Newton, *From Misery to Mirth: Recovery from Illness in Early Modern England* (Oxford: Oxford University Press, 2018), ch. 4.

while Wood referred to Cooper as a tool of providence, in 1837 George Chamberlaine, the Rector of Wyke Regis and Weymouth in Dorset, told him that 'By the blessing of God, I have every reason to believe that the whole of the stone which tormented me for four years is dissolved' and that 'my heart is filled with gratitude to the almighty disposer of all events; I consider myself a most fortunate Man for being in mercy, reprieved for a short period, and for being permitted at my advanced age to enjoy my life, free from pain and disease'.[84] Sadly for Chamberlaine this reprieve was indeed short, for records suggest that he died four months later.[85]

Thus far in this chapter we have mostly heard from Cooper's private patients. Even if their interactions with him were mediated by others, the letters sent on their behalf nonetheless suggest a certain intimacy. This quality of intimacy was, no doubt, dependent upon an equivalence of social status, combined with the security and confidence of the patron. However, it also had complex emotional dimensions. This was especially pronounced in the case of Cooper's female patients, notably those undergoing treatment for breast cancer. As we have just seen, these women were particularly expressive of their gratitude to Cooper and often projected onto him the identity of a saviour. This derived, in part, from the severity of their condition, and the relatively low chances of a successful cure, which made the joy of deliverance all the more intense. But it also stemmed, as we suggested in Chapter 2, from Cooper's identity as a man of feeling with an especial attachment to the opposite sex. This emotional dynamic is clearly evident in his correspondence. For example, in reporting on the satisfactory state of his patient Mrs Barratt, the surgeon Thomas Plum of Bath wrote that 'she bids me say (with her best Compliments) that if you would address the other side of the letter a few lines to herself, she should feel most happy'.[86] Cooper's other patients, namely those whom he treated in his capacity as surgeon to Guy's Hospital, no doubt had somewhat less latitude in their dealings with him. Moreover, those dealings have left far fainter traces in the historical register. In the next section we shall therefore turn our focus to the relationships between Romantic surgeons and their poorer patients, demonstrating that, while the latter's voices are certainly less distinct than those of wealthy clients, we can nonetheless unearth evidence of an emotional agency and, even, of a resistance to clinical authority.

[84] RCSE, MS0008/2/2/7, Letter from George Chamberlaine to Astley Cooper, 27 June 1837.
[85] NA, PROB 11/1885/81, Will of Reverend George Chamberlaine, Clerk, Rector of Wyke Regis and Weymouth, Dorset (31 October 1837).
[86] RCSE, MS0008/2/1/9, Letter from Thomas Plum to Astley Cooper, 10 June 1832.

'Wilful and Bad to Manage': Agency and Resistance in the Hospital

Historians have long been conscious of the links between the growth of the hospital system in the eighteenth century and that of contemporary disciplinary institutions, such as the workhouse and prison.[87] Traditionally, they have characterised the relationship between hospital patient and practitioner as one of dependence and subordination. At the same time, however, they have been sensitive to the reciprocity of medical charity and to the fact that patients had something to gain from admittance to a hospital, even if it came at the price of obedience and gratitude.[88] Indeed, in keeping with the historiography on the Poor Law, historians of medicine have increasingly recognised that such institutions might be 'resources strategically deployed by the poor, rather than oppressive regimes imposed on them'.[89] These ambivalences are neatly encapsulated in a quote from John Abernethy, who told his students that 'I am certain that people are saved in a Hospital who would have died in a palace from the fear of having recourse to [a] decisive plan of treatment'.[90] For Abernethy, therapeutic efficacy was, in part, the consequence of an abnegation of autonomy. This is not to say that hospital patients could be operated on without their consent. Rather, it implied that clinical *decisiveness* was a function of clinical *authority*, and that the patient who could be more easily persuaded might also be more easily saved.

Of course, we might see in Abernethy's remarks a kind of wry commentary on exactly the forms of emotional autonomy and agency that we have seen at work with Cooper's private patients. But this is not to say that hospital patients, and poorer patients generally, did not exercise their own agency when it came to negotiating surgical authority. For one thing, while admittance to a hospital like Guy's generally required the personal recommendation of a governor (except, that is, in the case of accidents, when patients were brought in off the street), many patients came into the hospital with a very distinct sense of what they wanted and expected from their treatment.[91] When Joseph Townend arrived at the Manchester Infirmary, for example, he managed to convince the

[87] Lee Davison, Tim Hitchcock, Tim Keirn, and Robert Shoemaker (eds), *Stilling the Grumbling Hive: The Response to Social and Economic Problems in England, 1689–1750* (New York: St Martin's Press, 1992); Donna Andrew, *Philanthropy and Police: London Charity in the Eighteenth Century* (Princeton: Princeton University Press, 1989).

[88] For example, see Roy Porter, 'The Gift Relation: Philanthropy and Provincial Hospitals in Eighteenth-Century England', in Roy Porter and Lindsay Granshaw (eds), *The Hospital in History* (London: Routledge, 1989), 149–78.

[89] Hogarth, 'Joseph Townend', p. 96. See Hitchcock, King, and Sharpe (eds), *Chronicling Poverty*.

[90] RCSE, MS0232/1/5, John Flint South, 'Lectures on Natural and Morbid Anatomy and Physiology, delivered by John Abernethy Esq. FRS in the Anatomical Theatre at St Bartholomew's Hospital in the years 1819 & 1820, Vol. 4th', f. 211.

[91] Roy Porter, 'Accidents in the Eighteenth Century', in Roger Cooter and Bill Luckin (eds), *Accidents in History: Injuries, Fatalities and Social Relations* (Amsterdam: Rodopi, 1997), 90–106.

surgeons to attend to his injured wrist, as well as attempt a 'risky and untested surgical procedure' to remedy the consequences of a childhood accident and sever the web of skin that attached his right arm to his side.[92] Astley Cooper's archive reveals similar examples of patient assertiveness. Thus, one of his casebooks notes that 'Mr Dixon of Newington Butts sent a young woman into the Hospital with a tumour in her breast which was unaccompanied with any signs of ill health and altho [*sic*] she was anxious for an operation I refused to perform it and she quitted the Hospital'. However, the woman returned a few months later 'with the swelling increased and I then made an opening into it and discharged several ounces of clear serum'.[93]

Leaving the hospital, either under treatment or in the face of an unsatisfactory response, constituted the most basic, and most extreme, exercise of patient agency. In 1819, for example, Cooper received an extensive report from the York surgeon James Atkinson (1759–1839) on the case of a young man with aneurysmal varix whose arm had to be amputated. Atkinson reported that his patient was 'detained rather longer in York than he would have wished, to keep him under subjection (being a sort of sailor) and to insure the firm cicatrisation of the wound'. The man had spent nearly two weeks in York County Hospital and, while his identity as free-roaming, free-living Jack Tar evidently required him to be kept under especially close observation, it also militated against him staying put. Hence, he 'was very desirous (in his own terms) "to slip his cable" some days before he was permitted' and he 'left York in good plight on the 27th of the month'.[94]

Atkinson remarked that this patient left hospital 'with more grateful feelings upon the occasion, than might have been expected from the discipline he had received from his doctors'.[95] As such comments suggest, this case provides a revealing insight into the dynamics of patient agency. This young man had fallen 'near twenty feet from the top of a Vessel that was going to be launched, and injured his head and back'. After the accident he was bled by a surgeon but 'in a very inconvenient situation, in a bad light, and with the left hand'.[96] Thereafter his arm began to swell and he was taken to the County Hospital, where it was determined that he had developed an aneurysm and that 'an operation appeared to be the only recourse'. As Atkinson explained:

> It became necessary now, as a crisis drew nigh, to enter into some explanation with the patient and his mother, as to the nature, consequence and relief of the complaint. They had been taught to apprehend that it was possible an operation might be required.

[92] Hogarth, 'Joseph Townend', pp. 97–8. [93] RCSE, MS0008/2/1/7, unpaginated.
[94] RCSE, MS0008/2/2/3 pt. 2, James Atkinson, 'Case of Aneurysmal Varix, operation and subsequent amputation', f. 25.
[95] RCSE, MS0008/2/2/3 pt. 2, Atkinson, 'Aneurysmal Varix', f. 26.
[96] RCSE, MS0008/2/2/3 pt. 2, Atkinson, 'Aneurysmal Varix', f. 1.

And to this expedient, they were not much averse; but they had somehow attached the idea, that it could be performed on one day, and entire recovery take place on the next. Our prospects however were by no means so flattering. And Mr Saunders and myself endeavoured to set them right in this particular. A very sensible and a very firm question was put to us, whether, after the operation, there might not possibly be still a necessity for amputation. We replied that it was an event intended to be prevented, but that we could not pledge ourselves to answer for the success.[97]

Clearly, then, even within the context of hospital treatment, such procedures were subject to serious negotiation, with the patient and his mother making 'very firm', yet also 'very sensible', inquiries as to the nature of the operation and its chance of success. It was, as Atkinson explained, 'On these grounds [that] we started'. Unfortunately, the operation proved problematic. 'Those parts under the skin were very irritable' and the pain was such that it was 'scarcely supportable by the patient', even though he was 'a hardy man and bred up in pitch and tar'. After the operation, he suffered restless nights and was 'flushed, hot and feverish, with a pulse above one hundred'. Subsequently, ecchymosis appeared on his elbow and gangrene began to set in. During this time, Atkinson notes:

We had frequent occasion to chide him, for removing the arm out of the favourable position, in which we left it after the dressing. He was ill nursed by his mother, and was wilful and bad to manage, and would suffer his arm to get laid under him or in a descending posture, notwithstanding he was requested to avoid it.[98]

Eventually it was decided that, because of the spread of gangrene, 'all chance of saving his limb was over', and 'with his consent it was agreed to amputate'. His recovery, however, was good; his arm 'healed very well' and he was eventually able to leave the hospital, albeit somewhat earlier than his attendants would have liked.[99] Atkinson's patient was evidently a 'wilful' man and, on occasion, 'bad to manage'. He entered hospital as an object of charity, but was by no means entirely submissive to surgical 'discipline'. Indeed, he appears to have given full expression to his feelings, including irritation, despondency, and impatience. Having said that, even if he was a less compliant and agreeable patient than Townend, he likewise left hospital in accordance with the social expectation of gratitude for his treatment.

This case provides a point of entry into a number of issues relating to the agency of poorer patients, both within and without the walls of the hospital. For one thing, the involvement of the patient's mother (by whom he was apparently 'ill-nursed') suggests that parents and other relatives could exert as much

[97] RCSE, MS0008/2/2/3 pt. 2, Atkinson, 'Aneurysmal Varix', ff. 6–7.
[98] RCSE, MS0008/2/2/3 pt. 2, Atkinson, 'Aneurysmal Varix', ff. 7, 11, 12, 15.
[99] RCSE, MS0008/2/2/3 pt. 2, Atkinson, 'Aneurysmal Varix', ff. 16, 23, 25.

influence in these cases as in those of wealthier, fee-paying patients. Henry Robert Oswald's diary records his interaction with the 'poor father' of a 'boy with a Diseased Leg'. '[W]hen I told him the probability of its being necessary to amputate the leg', Oswald recounts, 'he was very averse to such a thing and said it was shocking to do so and that he would rather see the boy go to the grave'. In response, Oswald told him it was 'more shocking to see a fine boy die for want of assistance and that many a man and these great men were alive and well after the operation useful to themselves and Society'. However, while he apparently 'saw the force of Reason […] prejudice prevailed' and the father, who claimed that 'he had never used a dose of medicine in his life', refused the operation, leaving the boy to an uncertain fate.[100]

Relatives could also resist surgical authority in other ways. For example, Abernethy told his students about one of his former hospital patients at St Bartholomew's who had a sore on his leg and whose 'nervous system was extremely wrong'. When the patient eventually died, Abernethy was 'very anxious to examine the body'. As we shall see in Chapter 5, at the time of this lecture (1818), British surgeons had no legal right to the bodies of those who died under their care, and yet they were acutely aware of the system that had been established in France, whereby pathological anatomy had become routinised in hospitals, something that, they argued, had enabled Paris to become the leading centre for clinical education in the world.[101] By contrast, men like Abernethy were reliant upon the compliance of relatives in order to gain access to such bodies for the purpose of post-mortem dissection. In this case, he claimed 'a little turn against who called herself his relation would not allow me', adding 'A very wrath I was in with her'.[102] Abernethy's frustration was shared by Thomas Paget junior (1796–1875), Honorary Surgeon to Leicester Royal Infirmary, who, in October 1832, wrote to Cooper to provide an 'unsatisfactory account of the late Mrs Slater' who 'sank rapidly on her return to Leicester and died suddenly' of breast cancer. '[O]f the internal appearances I could not prevail upon the friends to allow me examination', he lamented, for 'there is much contradict [*sic*] feeling and of course obstinacy in these parts'.[103]

[100] NLS, MS9003, Diary of H. R. Oswald Snr, describing his first six months as surgeon to the 4th Duke of Atholl, Governor General of the Isle of Man (1812–13), ff. 65v–66r.

[101] John Harley Warner, 'The Idea of Science in English Medicine: The "Decline of Science" and the Rhetoric of Reform, 1815–45', in French and Wear (eds), *British Medicine*, 136–64.

[102] RCSE, MS0232/1/1, John Flint South, 'Lectures on the Principles of Surgery delivered by John Abernethy Esq. FRS in the Anatomical Theatre at St Bartholomew's Hospital in the years 1818 and 1819', ff. 153–5.

[103] RCSE, MS0008/2/19, Letter from Thomas Paget junior to Astley Cooper, 25 October 1832. This was just after the passage of the Anatomy Act, but even so the relatives still had the right to retain the body. It may, however, have contributed to public 'obstinacy' on the subject of anatomical dissection. See Chapter 5.

In addition to demanding treatment or leaving the hospital, another form of patient agency was to refuse particular forms of treatment. This was not an uncommon occurrence. As we have heard, the disciplinary cultures of the hospital, as well as the paucity of other options available to them, may have encouraged poor patients to acquiesce to an operation that, had they more money and more autonomy, they might have declined. Nonetheless, as we have also heard, therapeutic treatment within the hospital still required a degree of negotiation, and patients were at liberty to determine their treatment, albeit within more limited parameters than were available to private patrons within the 'medical marketplace'.[104] Thus, one of Cooper's casebooks records that a man named 'Goodfellow was admitted into Guys with a bad compound fracture of the Elbow Joint […] He was strongly urged to submit to the Operation of Amputation but positively refused'. In this case the patient's decision seems to have paid off, as 'The most simple treatment was pursued […] The wound healed kindly and the man recovered'.[105] In another instance, the patient's reticence to submit met with a more ambivalent response. The surgeon Robert Cook of Gainsborough, Lincolnshire, wrote to Cooper in May 1831 informing him that 'At length I [will] send you the Tumour from Miss Davenport's breast – it is a good deal shrivelled from having become dry before it was put in spirit'. Its excision, he observed, 'left a large Chasm which it was impossible to bring together either by sutures or straps'. However, he did not specify how Davenport was persuaded to agree to the procedure, saying only that 'she would not have it removed' and that 'she bore the operation very ill although it was of short duration not 2 minutes'.[106]

Even if patients did not directly refuse treatment, they might nonetheless prove challenging to surgical authority, particularly by means of their behaviour on the wards. In Cooper's casebooks this seems to have been an especial problem for those patients who were brought into the hospital having suffered an accident, many of whom were drunk, disruptive, or otherwise 'bad to manage'. Early in his career, for example, he attended a 'young man' who was admitted to St Thomas' Hospital having 'received a violent blow from another on the left side of his head'. 'There was a wildness & irrationality about the Patient', Cooper notes, 'wh[ich] Mr C[line] suspected arose from his having been intoxicated & wh[ich] was proved to have been the case afterwards for

[104] On the concept of medical patronage, see Nicholas D. Jewson, 'Medical Knowledge and the Patronage System in 18th Century England', *Sociology* 8:3 (1974), 369–85. For its ambivalent relation to the social historical concept of the 'medical marketplace', see Mark S. R. Jenner and Patrick Wallis, 'Introduction', in Jenner and Wallis (eds), *Medicine and the Market in England and Its Colonies, c.1450–c.1850* (Basingstoke: Palgrave Macmillan, 2007), 1–23.

[105] RCSE, MS0008/2/1/7, unpaginated.

[106] RCSE, MS0008/2/2/3 pt. 3, Letter from Robert Cook to Astley Cooper, 28 May 1831.

soon after he became sick & vomited up a considerable quantity of superfluous liquor of some kind'.[107] As this example suggests, cases of intoxication were particularly problematic when accompanied by injuries to the head, as the symptoms were often hard to distinguish from delirium. John Abernethy told his students of the case of a woman who had her 'skull knocked in with a cane on Blackfriars Bridge'. 'I closed the scalp as well as I could', he claimed, 'and laid on a compress to give support to the Dura Mater – but I could not make out whether the symptoms were those of Concussion, Compression or Drunkenness'. '[S]he was stupid enough', he continued, 'but did not appear insensible for she howled at the operation very much'. The next day she refused to let the dresser touch her head, but did consent to Abernethy inspecting her wound. Thus, he concluded, she 'had been nothing more than drunk for she had a perfect recollection of my having performed the operation upon her'.[108] If this patient's drunkenness made her more expressive in the operating theatre, Cooper gives an account where the opposite was the case. 'A Woman was brought into Guys Hospital completely intoxicated', he notes, 'and with much injury done to her leg by a compound fracture [so] that an amputation was deemed necessary and was performed':

> She was totally insensible to pain during its performance – but the following day when she was expected to be recovered from her intoxication her senses seemed imperfect her memory had failed her and it was with great difficulty she could be made to believe that her Leg was removed – She continued in a sort of Stupor for several weeks – her stump looked well yet her wit was disturbed – she had much pain & at length death ensued.[109]

This case raises the question of how much consent was involved in the decision to amputate her leg. Clearly, Cooper determined that her injuries were life threatening and that an operation could not wait for her to regain her sobriety. Such issues of consent and coercion were especially difficult to navigate in the case of patients who, through either illness or injury, were deemed to be 'deranged'. In one case, for example, Cooper attended a man who was injured in the collapse of a house, which had fractured his leg and left him disordered in his senses. 'When I saw him […] he was extremely restless and talked incessantly, yet he knew his Wife', Cooper noted: 'He layed [*sic*] for 4 or 5 minutes as if dead and would then suddenly start and commit the greatest violence'.[110] In another instance, a 37-year-old patient called John Smith was admitted to Guy's Hospital with a tumour in his elbow. He 'suffered great pain' after the operation, Cooper recorded, and at six in the evening he 'suddenly rose from

[107] RCSE, MS0008/2/1/1, Cases in Surgery, Volume 1 (1788), 'Case 4th', ff. 6–7.
[108] RCSE, MS0232/1/5, f. 107. [109] RCSE, MS0008/2/1/4, 'Case 24th', f. 63.
[110] RCSE, MS0008/2/1/3, Cases in Surgery, Volume 3 (1790–1), 'Case 4th', f. 6.

his bed, to quit as he said the hospital, and return home. He earnestly desired the removal of the ligatures, convinced that the blood was obstructed in its course, talked in an unconnected manner about his family and appeared to labour under mental aberration'. Four hours later he was 'much the same' and refused a request 'to remove to another ward'. Eventually he 'was removed by force to Isaac's [ward] and an opiate draft given by Compulsion'. According to 'The person who accompanied him to Town', he was deranged, and thus required 'Coercion'. For the next few days he continued to be as 'bad as ever, calling aloud, sitting up in bed, and using the arm used [*sic*] in the operation roughly'. However, his mind was soon 'reconciled' by a visit from his brother and he remained in Guy's for another month, until he 'Went away, his Intentions being unknown'.[111]

Lest it appear that patient agency and subjectivity on the wards of the hospital merely involved resistance to surgical authority, or disruptive and challenging forms of behaviour, it is important to note that the archive also provides evidence of emotional communion and tenderness between hospital patients and their attendants. Although less evident than in the extensive and often expressive correspondence between surgeons and their private patients, such feelings were also an important aspect of the dynamic of institutional care. In Stuart Hogarth's account of Joseph Townend's stay at the Manchester Infirmary, for example, he points out the deep affection that Townend had for a number of the practitioners and students who attended him and 'whose unmistakable tokens of real kindness I shall never forget'.[112] Meanwhile, in reference to the St Bartholomew's patient whose body he was 'anxious' to examine, Abernethy remarked that he was 'a very good hearted and good tempered man, for when I had done dressing him, I used to sit down and we told one another stories'.[113] Moreover, in an especially poignant instance, the young Astley Cooper recorded the case of a 13- or 14-year-old boy who fell from a scaffold, fracturing his skull and driving pieces of bone 'into the substance of the brain'. He lost all sense and movement in his right side, accompanied by 'very painful sensations'. In his distress, 'He was often supplicating the nurse to rub his arm with her hand'. Sadly, he was to die less than five weeks after the accident.[114]

Resistance to surgical authority was not always a conscious or calculated act. Even in those instances where patients acquiesced to the surgeon's directions and were, to all intents and purposes, a model of good behaviour, the nature of pre-anaesthetic surgery meant that willpower alone did not necessarily make

[111] RCSE, MS0008/2/2/3 pt. 1, unpaginated case, 'Aneurism from Bleeding'.
[112] Hogarth, 'Joseph Townend', p. 99. [113] RCSE, MS0232/1/1, f. 154.
[114] RCSE, MS0008/2/1/1, 'Case 8th', ff. 15–17.

one a good operative subject. In the final section of this chapter, we shall therefore explore the issue of nervous irritability and its role in shaping the concept of the 'obstreperous' surgical patient.

'Obstreperous' Patients and 'Bad Stumps': Irritability and Unconscious Resistance

The title of this chapter makes a distinction between conscious and unconscious forms of patient agency. It is important to acknowledge, however, that Romantic conceptions of the unconscious differed somewhat from modern ones. The notion of the unconscious as a constituent of the psyche that is inaccessible to the conscious mind and is the seat of various mental processes, including phobias, desires, and drives, is largely, though not exclusively, the product of Sigmund Freud (1856–1939).[115] However, in the Romantic period, idealist philosophers such as Friedrich Schelling (1775–1854) and Samuel Taylor Coleridge were developing notions of the transcendent mind that would shape later concepts of the unconscious, while by the 1830s and 1840s, physiologists such as Marshall Hall (1790–1857) and Thomas Laycock (1812–76) had established the basis for the autonomic nervous system, whereby bodily processes, even bodily actions, might take place without wilful intent.[116] For the earlier part of the Romantic period, namely 1790–1830, the term unconscious, though often used in the same manner as 'insensible' (and implying a *loss* of consciousness), is less frequently used to describe actions outside of conscious volition. Nonetheless, such meanings were clearly inchoate, for one of the earliest uses of the term in *The Lancet* concerns a man suffering from a severe injury to the head who is described as having 'unconsciously pass[ed] his evacuations'.[117]

Moreover, by invoking the concept of unconscious agency (or resistance), I want to suggest more than merely unwilled actions; I want to approach something closer to Bruno Latour's reading of object agency. For Latour, everything within the network of relations has agency, including non-humans and inanimate objects. These objects have agency because they interact with humans

[115] For a classic account of the 'discovery' of the modern unconscious, and of the contribution of individuals other than Freud, see Henri F. Ellenberger, *The Discovery of the Unconscious: The History and Evolution of Dynamic Psychiatry* (New York: Basic Books, 1970).

[116] Sean J. McGrath, *The Dark Ground of Spirit: Schelling and the Unconscious* (London: Routledge, 2013); Alan Richardson, *British Romanticism and the Science of the Mind* (Cambridge, UK: Cambridge University Press, 2001); Edwin Clarke and L. S. Jacyna, *Nineteenth-Century Origins of Neuroscientific Concepts* (Berkeley: University of California Press, 1987). Laycock was himself heavily influenced by German idealist philosophy, particularly that of Johann Gottlieb Fichte (1762–1814). See Michael Brown, *Performing Medicine: Medical Culture and Identity in Provincial England, c.1760–1850* (Manchester: Manchester University Press, 2011), pp. 193–4.

[117] *Lancet* 6:137 (15 April 1826), p. 93.

and can often frustrate, obstruct, or otherwise shape their actions.[118] While, of course, surgical patients were not merely objects, their agency did transcend the level of conscious action and wilful intent. Surgical bodies are always, in a sense, sites of resistance, in that they can defy cure, or 'behave' in ways that confound the wishes of both the surgeon and the patient. In the pre-modern and pre-anaesthetic period, these tendencies were all the more marked, and surgical bodies frequently proved extremely difficult to manage, both inside and outside of the operating theatre.

In this regard, one of the most important concepts in early nineteenth-century surgical thought was that of 'irritability'. This idea originated in the mid-eighteenth-century work of the vitalist physician Albrecht von Haller, who regarded irritability in reaction to stimuli to be one of the defining characteristics of muscular fibres (as opposed to nervous fibres, whose key characteristic was sensibility). Haller's conception of irritability thus provided a rationale (prior to the autonomic nervous system) for why the muscles of the heart functioned without direct conscious input.[119] But for surgeons of the early nineteenth century, the language of irritability expanded to encompass a range of other concepts, notably *irritation*, characterised by inflammation and caused by disease or operative intervention, as well as the influence of the nervous system and the patient's state of mind.[120] As we saw in Chapter 2, these concepts were linked by another of Haller's ideas, namely sympathy, so that each could affect the other. Thus, Astley Cooper spoke of irritability (mediated by sympathy) in terms of a 'stone in the bladder' causing 'pain in the extremity of the penis', or a 'disease of the liver' causing 'pain the shoulder'.[121] Likewise, he claimed that 'Persons affected by cancerous or fungous complaints are of exceedingly anxious minds (at least nine times in ten)' and that 'this anxiety occasions a sort of irritable fever, that invariably proves detrimental'.[122] In this way, irritability shaped the patient as a deeply unstable entity, composed of complex and interdependent bodily and mental relations that always threatened to confound the best efforts of the surgeon. At the same time, however, and as Cooper's reference to cancer patients suggests, irritability (or irritation) also came to describe a kind of constitutional state or personal idiosyncrasy. Thus, as he told his students, 'Constitutional irritation will be very different; that is, much greater in some persons than in others, so that a wound, which in

[118] Bruno Latour, *Reassembling the Social: An Introduction to Actor-Network Theory* (Oxford: Oxford University Press, 2005), pp. 63–86.

[119] Hubert Steinke, *Irritating Experiments: Haller's Concept and the European Controversy on Irritability and Sensibility, 1750–90* (Amsterdam: Rodopi, 2005).

[120] For example, see Benjamin Travers, *An Inquiry Concerning That Disturbed State of the Vital Functions Usually Denominated Constitutional Irritation* (London: Longman, Rees, Orme, Brown, and Green, 1827).

[121] *Lancet* 1:2 (12 October 1823), p. 37.

[122] *Lancet* 1:3 (19 October 1823), p. 75.

one man would be attended by the most dangerous consequences, would not probably in another […] diminish a single ordinary function'.[123]

In this way, patients, through no fault of their own, could be denominated as more or less easy to manage in terms of treatment and operative intervention. Cooper's archive provides an insight into this process, as well as into the complex relationship between concepts. In his notes, for example, he opined that 'Irritability is greatest in the young' before adding that 'it is the power of being excited to action – Irritation is the effect of Irritants on the Irritability'.[124] Elsewhere we can see the ways in which the concept of irritability shaped perceptions of patients. For example, concerning one of his male hospital patients he wrote that '32 hours after his admission he became extremely irritable, restless and quick in all his motions'.[125] In reference to a female patient, he observed that 'She keeps her bed generally. The least noise or talking excites pain, so does agitation of mind. She is very irritable'.[126] Likewise, in the case of another female patient, Cooper recorded that one of his colleagues 'amputated the Leg of a Girl who possessed wonderful Irritability both of body and mind particularly the latter'.[127]

It would be a mistake to infer from these examples that there was a starkly gendered aspect to the concept of irritability, for men were just as likely to be regarded as irritable as women. What is clear, however, is the link between irritability, mental states, and occasionally obstreperous behaviour. When taken together, the concepts of irritability and anxiety can be said to have provided the fundamental logic for the ontological and epistemological 'messiness' of the pre-anaesthetic operative subject, accounting for the uncertainties that surrounded the success or failure of a procedure. But irritability also took on a kind of moral aspect, determining the forms of treatment a patient might receive and defining certain individuals as difficult or troublesome. This is particularly evident in descriptions of operative practice. For example, in 1824, *The Lancet* reported on the case of William Rose, an 18-year-old man of 'scrophulous [*sic*] habit' with 'dark hair, dark grey eyes and a saturnine complexion'. Since childhood, he had been afflicted with a disease of the knee joint, which had ultimately required amputation. However, the procedure had not been a total success and, even after the passage of eight years, 'the patient […] loudly complains of the result of the operation'. The stump was extremely irritable and 'the least touch, however slight, [was] sufficient to excite the most excruciating sensation'. A second operation was therefore carried out, but not, according to the report,

[123] *Lancet* 1:2 (12 October 1823), p. 40. [124] RCSE, MS0008/2/1/7, unpaginated.
[125] RCSE, MS0008/2/1/3, 'Case 5th', f. 9.
[126] RCSE, MS0008/2/2/3 pt. 1, unpaginated case of 'Internal Aneurism'.
[127] RCSE, MS0008/2/1/3, unpaginated case notes.

without some difficulty, in consequence of the extreme irritability of the stump […] and partly from the obstreperous conduct of the patient […] that fortitude which induced him to solicit an operation, and which supported him when placed on the table, forsook him in an instant, on the first touch of the knife. His motions, which were almost convulsive at this period, seriously endangered the fingers of the operator.[128]

In this case, the author of the report stated that the patient's conduct in the operating theatre 'may be readily excused', perhaps because of the extreme constitutional upheaval occasioned by his previous amputation.[129] Even so, his irritability still served to construct him as difficult, the kind of patient to 'loudly complain'. Moreover, in other instances, the links between obstreperous conduct and moral judgement were even more explicit. For example, in 1829 *The Lancet* reported on the case of Michael Graeme, a 31-year-old man who had injured himself falling from scaffolding and who was brought into Westminster Hospital. Drawing on a set of established ethnic stereotypes about over-emotionality and ungovernability, the report noted that 'The patient was an Irishman, obstreperous in his complaints, and very much impeded by his cries and struggles, the diagnostic examination'.[130]

It is within the context of such *misbehaviour* that we might gain a greater understanding of the concept of operative fortitude that we highlighted earlier in this chapter. As we suggested, the language of fortitude was positively ubiquitous in those cases reported in *The Lancet* where the severity of the procedure was matched by the stoicism of the patient. This language not only served as a shorthand for myriad instances of personal resolve, it also shaped a vision of the idealised operative patient, one who was both bodily acquiescent and emotionally self-controlled, the opposite of William Rose, or John Abernethy's patient who, when undergoing a lithotomy, 'exhibited great degrees of nervous irritation crying out "damn my hearties, now you have pull away my hearties"'.[131] In a mirroring of the expectation of calm resolve to which the surgeon himself was beholden, the patient who displayed the requisite degree of fortitude not only set a moral example, they also stood a better chance of recovery. Appearances could be deceptive, of course. In 1832, the surgeon John Scott (1799–1846) of the London Hospital excised a tumour from the face of a 45-year-old man, removing the whole superior maxillary bone. According to the report, 'The patient throughout behaved with the most stoical fortitude'. On being asked by the surgeon 'whether he suffered much during the operation', he smiled, saying that he would 'tell [him] another time', before 'cheerfully' walking to his bed unaided, a display of sangfroid that was 'greeted with the hearty plaudits of all the spectators'. Despite such

[128] *Lancet* 1:19 (8 February 1824), pp. 190–1.
[129] *Lancet* 1:19 (8 February 1824), p. 191.
[130] *Lancet* 11:283 (31 January 1829), p. 575.
[131] RCSE, MS0232/1/5, f. 226.

positive indications, the author of the report noted that 'the patient is dead, having expired in convulsions'.[132] Such cases notwithstanding, the display of fortitude continued to be seen as both a moral and a practical good, with clear, though not unambiguous, links to gender and racial ideologies. Thus, an 1830 report from the Glasgow Royal Infirmary, published in *The Lancet*, warned against using 'the patient's feelings or manifestations of pain' as a measure for the appropriate amount of force necessary to reduce dislocations, observing:

> In this hospital we often see hardy mountaineers, whether exposed to the lacerating extension by pulleys, or to the agonizing march of the knife through the living fibre, display a fortitude and composure, from a confidence in the surgeon and a command over their feelings, that, to a unreflecting spectator, would seem to augur deficient sensation […] But it is equally true, that another and a numerous class of patients, yell with apparent agony, on the slightest interference, even sometimes before it has commenced, or after it has terminated, clearly proving it to be the result of mental trepidation, or a deficiency of that animal *forte* or *bottom*, that so conspicuously characterises the former class of individuals.[133]

While this author clearly associated fortitude with the rugged masculinity of the Scottish Highlander, and while terms such as 'bottom' were often used to describe hyper-masculine figures like boxers, such gender associations were not uncomplicated, for just as men might prove as irritable as women, so too might women display as much resolve as men.[134] Indeed, according to some commentators, fortitude was a positively feminine trait; in 1834, the report of an operation undertaken at Guy's Hospital to remove the greater portion of the lower jaw of a 25-year-old servant named Maria Laler commented that the 'fortitude displayed by the patient was very great, and tended further to confirm the impression that females nearly always bear painful operations with greater courage and patience than men'.[135] And yet, as the century wore on, the discourse surrounding fortitude increasingly emphasised masculine values above all others. In 1843, for example, just three years before the first use of inhalation anaesthesia in Britain, the naval surgeon Richard Dobson (1773–1847) wrote to *The Lancet* stating that 'the fortitude of mind which is necessary to enable a patient to bear a surgical operation without making any exclamations of suffering can be produced through the mind only, without having recourse to either mesmerism or opium'. He then proceeded to provide examples of what James Kennaway has shown to be the cult of operative nonchalance

[132] *Lancet* 17:438 (21 January 1832), p. 604. [133] *Lancet* 13:343 (27 March 1830), p. 927.
[134] David Day, '"Science", "Wind" and "Bottom": Eighteenth-Century Boxing Manuals', *International Journal of the History of Sport* 29:10 (2012), 1446–1465.
[135] *Lancet* 22:559 (17 May 1834), p. 285. For more on women and pain, see Bourke, *Pain*, pp. 206–14.

that attached to military personnel in this period.[136] As Kennaway argues, this military conception of fortitude had a significant racial dimension, with commentators establishing a moral hierarchy that placed either Anglo-Saxons or Highland Scots at the top, with the Irish below and non-white races occupying the lower tiers of the scale.[137] As the examples cited here suggest, such hierarchies also seem to have informed the perceptions of civilian surgeons.

For some commentators of this period, the moral force of emotional self-control was such that it was held to suppress symptoms that might otherwise be regarded as innate to a particular condition. In one remarkable instance, the Worcester physician and later founder of the Provincial Medical and Surgical Association (1832), Charles Hastings (1794–1866), told his colleagues of a case of rabies 'without parallel' in which 'the manly bearing and fortitude' of the patient 'raised his mind above fear and excluded the influence of prejudice'. According to Hastings, the case 'exhibits the action of the rabid poison on *a man* in its true colours, without the mimicry of feigned symptoms, or those aggravations of terror which too often lash and goad the unhappy patient into frenzy and madness'.[138]

Though by no means as extreme, the language surrounding the limbs of amputees likewise exhibits a somewhat moralistic tone. For the most part, patients were not held personally responsible for the irritability of their stumps. Certainly, there is little evidence of a discourse similar to that identified by Erin O'Connor in the aftermath of the American Civil War (1861–5), wherein the 'hysterical' irritability of the stump or the 'neurotic' delusions of the phantom limb actively feminised the male amputee.[139] Indeed, in his lecture on 'Bad and Irritable Stump[s]' delivered to the students of the North London Hospital in 1836, Robert Liston, like many of his contemporaries, expressed pity and sympathy for those patients whose stumps were the source of extreme pain and irritation. Liston was quite clear that the responsibility for this state of affairs lay with the surgeon, for it was his duty to 'proceed in a manner as to do away with all chance of these painful and distressing circumstances'. In particular, he urged his students to ensure that the bone was properly bisected and that the nerves did not 'become entangled in the scar'.[140] At the same time, however, the language of the 'bad stump' still served to cast some patients'

[136] *Lancet* 39:1012 (21 January 1843), p. 623; James Kennaway, 'Military Surgery as National Romance: The Memory of British Heroic Fortitude at Waterloo', *War & Society* 39:2 (2020), 77–92.

[137] James Kennaway, 'Celts under the Knife: Surgical Fortitude, Racial Theory and the British Army, 1800–1914', *Cultural and Social History* 17:2 (2020), 227–44.

[138] *Lancet* 14:363 (14 August 1830), p. 783.

[139] Erin O'Connor, *Raw Material: Producing Pathology in Victorian Culture* (Durham, NC: Duke University Press, 2000), pp. 106–11.

[140] *Lancet* 26:660 (23 April 1836), pp. 133–5.

bodies as obstructive and difficult. This was especially so because an irritable or 'bad' stump was often accompanied by mental despondency, so that the patient became complicit in their own decline. In one case this was almost literally true. Abernethy told his students of a patient who broke his leg while riding in Hyde Park and had to have it amputated. '[S]oon after the operation', he remarked, 'his Stomach and Bowels got wrong – his head became affected and he was delirious':

> [O]n the third day, whilst the nurse was gone down stairs, she heard something go thump thump thump about the drawing room which was on the same floor, with that in which he slept, and in running up stairs found that he had got out of bed and was hopping about, and she was just in time to catch him by his shirt to prevent his jumping out of [the] window.[141]

According to Abernethy, such delirium was not uncommon because hectic fever was a marked feature of this condition, for which 'nothing can be done because the cause cannot be removed'; the fever was 'but a violent exertion of the Constitution' itself. Abernethy informed his students that 'Mr [John] Hunter […] called this "a state of dissolution" […] implying that all hope of relief is at an end'.[142] Indeed, while he maintained that patients could, in principle, recover, the prognosis was generally not good. This was particularly true of those who had suffered from a compound fracture. 'There have been a number of cases of compound fracture since I have been in this Hospital', he claimed, 'but they have all done well except where amputation has been performed, not a single case had a good stump and many died but God knows why'.[143]

Abernethy's confusion is suggestive. With no concept of post-operative infection in which the extruded bone of the compound fracture might introduce microbes into the body, surgeons like Abernethy were only able to account for the success or failure of such amputations by reference to constitutional irritability and mental anxiety. But we must not frame our explanations in such presentist terms. Rather, we must have recourse to what we have called the ontological 'messiness' of the pre-modern operative subject, in which a complex melding of constitutional, nervous, and emotional factors combined to determine a patient's fate. Within this framework, the concept of irritability provided a powerful way of thinking about the patient's capacities and susceptibilities and served to distinguish difficult patients from easier ones. While the discourse surrounding the notion of fortitude suggests that such ideas had a strong moral component, the patient could not always be held fully responsible for their failure to conform to the ideal. Sometimes their bodies simply resisted all attempts to save them. After all, even a 'good' patient might have a 'bad' stump.

[141] RCSE, MS0232/1/1, f. 242.
[142] RCSE, MS0232/1/1, f. 11. [143] RCSE, MS0232/1/1, f. 241.

Conclusion

This chapter has been concerned to recover the patient's voice in the articulation of experience, demonstrating how emotions played a vital role in their dealings with surgeons. At the same time, it has shown how patients, like surgeons, were often expected to conform to certain idealised forms of behaviour, be that the gratitude of the hospital patient or the stoic fortitude of the operative subject. While manuscript archives such as those of Astley Cooper provide an extremely valuable insight into the patient's account of their own condition, the fact remains that their experience of disease, injury, and operative surgery was often mediated by the representations of others, be that medical attendants, family members, medical journalists, or surgeons themselves. In this sense, it is often difficult, not to say futile, to attempt to disentangle lived experience from cultural and representational conventions. This ambiguity is powerfully evident in the case of a Chinese labourer by the name of Hoo Loo, who came to London in 1831 to have a large tumour removed from his groin (Figure 3.1). As Peter Stanley observes, Hoo Loo's case is 'unusually well-documented'.[144] This was in large part because of his exotic appeal at a time of heightened Orientalist interest in China, as well as the sheer size of his growth. The operation to remove Hoo Loo's tumour was undertaken by Charles Aston Key (1793–1849), Astley Cooper, and Thomas Callaway (1791–1848) at Guy's Hospital in front of some 680 spectators, and was reported in *The Lancet*. Initially, the surgical team had proposed to retain the patient's genitals but, after complications arising from the length of the procedure (it lasted over an hour and three-quarters), it was decided that they should be 'sacrificed'. By this time, however, it was too late and 'the depressing effects of the operation' had begun to 'exhibit themselves'. Hoo Loo experienced serious blood loss and syncope, dying shortly after being removed from the table.[145]

What is remarkable about *The Lancet*'s description of Hoo Loo is the way in which it cast him as a model patient and an object of great pity and sympathy. It consistently described him as a man of 'amiable' character, his countenance occasionally melancholic but mostly 'very cheerful and good-tempered'. It reported that he had become a 'great favourite' with the Guy's Hospital nurses and that his death 'elicited the utmost commiseration' and 'perhaps a few tears'. Moreover, in its description of the operation itself, Hoo Loo was cast as a model of moral fortitude and, ultimately, Romantic sublimity:

> The fortitude with which this great operation was approached, and throughout undergone, by Hoo Loo, was, if not unexampled, at all events never exceeded in the annals of surgery. A groan now and then escaped him, and now and then a slight exclamation, and

[144] Stanley, *Pain*, pp. 262–3. [145] *Lancet* 16:398 (16 April 1831), pp. 86–8.

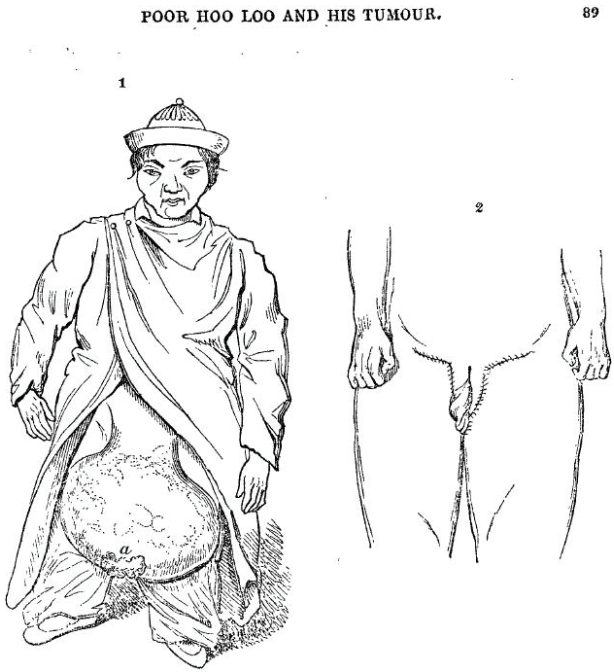

Figure 3.1 'Poor Hoo Loo and His Tumour', *The Lancet* 16:398 (16 April 1831), p. 89. Public Domain Mark

we thought we could trace in his tones a plaintive acknowledgement of the hopelessness of his case. Expression of regret too, that he had not rather borne with his affliction than suffered the operation, seemed softly but rapidly to vibrate from his lips as he closed his eyes, firmly set his teeth and resignedly strung every nerve in obedience to the determination with which he had first submitted to the knife.[146]

There is only one problem with this account. Hoo Loo did not speak any English; neither did *The Lancet*'s reporter, nor any of the surgical attendants, understand a word of his native Cantonese. In the absence of an intelligible voice, *The Lancet* therefore created one for him. The reality of his situation was, however, somewhat more complex, and certainly less picturesque, than *The Lancet*'s report suggested. As Stanley points out, nearly two weeks after the operation *The Times* carried a report from an eyewitness to the event who understood 'the Chinese language' and claimed that what Ho Loo had actually said during the course of the procedure was '"Unloose me,

[146] *Lancet* 16:398 (16 April 1831), pp. 86–8.

unloose me! Water! Help! Water! Let me go!"', and that the 'last articulate sounds he was heard to utter were, "Let it be – let it remain! I can bear no more! Unloose me!"'[147]

The Times therefore gave a very different account of Hoo Loo's experience, suggesting, perhaps, that operative fortitude might function as a means by which the patient was culturally contained and by which their sufferings were rendered more palatable by being refracted through the familiar cultural tropes of pathos and personal self-control. Indeed, so powerful was this vision of the Romantic patient that even while *The Times* acknowledged the agony and terror of Hoo Loo's final minutes, it could hardly present him in any other way than that which had been established by the reporting of *The Lancet*. Hence, it concluded its distressing account by reaffirming his 'mild and gentle manners'. Moreover, while *The Lancet*'s reporter had merely speculated about the possibility of the nurses crying after his death, *The Times* stated it as a positive fact that the 'nurses and patients in the ward shed tears at the fatal termination of the operation'.[148] Clearly, when considering the emotional cultures of Romantic surgery, it is essential to consider the politics of representation. In Chapter 4, we shall therefore explore the ways in which the language of emotion shaped, sustained, and ultimately complicated *The Lancet*'s reporting of London hospital surgery in the 1820s and 1830s.

[147] *Times* 19 April 1831, p. 3. [148] *Times* 19 April 1831, p. 3.