Introduction

A 'Black Whirlwind of Emotion': George Wilson's Surgery

In 1856, George Wilson (1818–59), then Professor of Technology at the University of Edinburgh, wrote a letter to the physician James Young Simpson (1811–70) in which he described the amputation of his foot by the surgeon James Syme (1799–1870) in 1842. Wilson composed this letter some ten years after the introduction of surgical anaesthesia about a procedure that had taken place four years prior to it. For Simpson, it therefore provided incontrovertible evidence for the value of anaesthesia 'from the patient's point of view', by describing, in highly eloquent and evocative terms, the experiential terrors of the recent past.[1] In his letter, Wilson recalled that, having been informed of the need for amputation:

> I at once agreed to submit to the operation, but asked a week to prepare for it, not with the slightest expectation that the disease would take a favourable turn in the interval, or that the anticipated horrors of the operation would become less appalling by reflection upon them, but simply because it was so probable that the operation would be followed by a fatal issue, that I wished to prepare for death and what lies beyond it, whilst my faculties were clear and my emotions were comparatively undisturbed.[2]

'Before the days of anaesthetics', he wrote, 'a patient preparing for an amputation was like a condemned criminal preparing for execution'. He 'counted the days' and 'the hours' until the appointed moment arrived. He anxiously awaited the arrival of the surgeon, listening for the 'pull at the door bell', his 'foot on the stair', and 'his step in the room'. He watched in agonised anticipation at the 'production of his dreaded instruments', and attended the surgeon's 'few grave words', before he 'helplessly gave himself up to the cruel knife'.[3] As to the amputation itself:

[1] James Young Simpson, *Acupressure: A New Method of Arresting Surgical Haemorrhage* (Edinburgh: Adam and Charles Black, 1864), p. 566.
[2] Simpson, *Acupressure*, pp. 556–7.
[3] Simpson, *Acupressure*, p. 557.

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Of the agony it occasioned I will say nothing. Suffering so great as I underwent cannot be expressed in words, and thus fortunately cannot be recalled. The particular pangs are now forgotten; but the black whirlwind of emotion, the horror of great darkness, and the sense of desertion by God and man, bordering close upon despair, which swept through my mind and overwhelmed my heart, I can never forget, however gladly I would do so.[4]

Wilson's account of his operation was conditioned by the intervening introduction of anaesthesia, and by the relative painlessness of contemporary operative surgery. Indeed, this was the very point of his letter, the reason that Simpson, who had identified the anaesthetic properties of chloroform in 1847, had solicited it in the first place. Perhaps because of this, Wilson expressed concern that Simpson might think his 'confessions exaggerated'. He assured him that they were not. These were 'not pleasant remembrances', he maintained, and 'For a long time they haunted me'. While they 'cannot bring back the suffering attending the events […], they can occasion a suffering of their own, and be the cause of a disquiet which favours neither bodily nor mental health'. 'From memories of this kind', Wilson observed, 'those subjects of operations who receive chloroform are of course free', and he confessed that if there were 'some Lethean draught' to 'erase the memories I speak of, I would drink it, for they are easily brought back and they are never welcome'.[5]

Rare though such first-hand accounts might be, Wilson's letter can be taken as fairly representative of the experience of pre-anaesthetic surgery from the patient's perspective. After all, while clearly of deep personal significance, his operation, an amputation of the foot at the ankle, was neither the most technically demanding nor the most daunting of early nineteenth-century surgical procedures. In this regard, what is most remarkable about Wilson's letter is its relative lack of emphasis on the pain of the operation when compared to his vivid description of the emotional distress and mental turmoil that it had caused and, indeed, continued to cause. If the physical agonies of the procedure remained ineffable and unrecoverable, then the 'black whirlwind of emotion' that 'swept through' his mind and 'overwhelmed' his heart was, by contrast, indelible.[6]

In many ways, Wilson's recollections of his operation work contrary to our own cultural memory of the pre-anaesthetic era. If for him the emotions of the experience were far more enduring than the pain itself, for us it is the physical agonies of pre-anaesthetic surgery, rather than its emotional dynamics, that haunt our collective memory. This is not to say that the emotional sufferings of the pre-anaesthetic patient are entirely absent from popular consciousness. But, to modern minds habitually accustomed to analgesics, it is that most

[4] Simpson, *Acupressure*, p. 568.
[5] Simpson, *Acupressure*, pp. 568–9.
[6] For more discussion of the historical recollection of pain, see Chapter 3.

inconceivable of sensations, the pain of being sliced open and sawn apart while conscious, that captures the imagination most forcibly.

This book reorientates our cultural, intellectual, and imaginative perspective by putting emotions back at the heart of the history of surgery. It maps the emotional landscape of British surgery from the later eighteenth to the early twentieth centuries, analysing the changing place of emotions within surgical culture, practice, and experience. Although largely concerned with the professional identity and ideology of surgeons, it also seeks to comprehend the patient, not only in terms of experience and agency, but also as regards their shifting ontological status within surgical cosmology.[7] In short, it traces the elaboration of an 'emotional regime' of Romantic sensibility within British surgery, before charting its gradual eclipse, from around the middle of the nineteenth century, by a new emotional regime of scientific modernity.[8] It attributes this shift in emotional regimes to the rise of medical and surgical utilitarianism and the advent of anaesthesia, and locates its ultimate realisation in the aetiological reductionism and techno-scientific rationalism of Joseph Lister's (1827–1912) antisepsis. It demonstrates the profound impact that this shift in emotional regimes had on contemporary surgical culture, and explores the ways in which it reconfigured relations between surgeons and their patients, before ending with a consideration of its legacy for modern-day surgery.

Historiography and Context

Emotions and Surgery thus provides an analytical account of the history of emotions applied to British surgery in the long nineteenth century. During the last ten to fifteen years, the history of emotions has grown into one of the most flourishing and exciting fields of historical scholarship. The roots of this approach lie in the work of Carol and Peter Stearns in the 1980s, although they can probably be traced back even further to the abortive study of *mentalités* by the French *Annales* school, or to the historical sociology of Norbert Elias.[9] However, the history of emotions really came to fruition in the late 1990s and early 2000s when, building on the Stearns' model of 'emotionology', scholars such as William Reddy and Barbara Rosenwein fabricated a theoretical

[7] This word is chosen to suggest the parallels with Nicholas D. Jewson's landmark article 'The Disappearance of the Sick Man from Medical Cosmology, 1770–1870', *Sociology* 10 (1976), 225–44.

[8] William Reddy, *The Navigation of Feeling: A Framework for the History of the Emotions* (Cambridge, UK: Cambridge University Press, 2001), pp. 124–6.

[9] For example, see Carol Z. Stearns and Peter N. Stearns, *Anger: The Struggle for Emotional Control in America's History* (Chicago: Chicago University Press, 1986); Norbert Elias, *The Civilising Process: Sociogenetic and Psychogenetic Investigations* (Oxford: Blackwell, 1994 [1939]). For a historical account of the history of emotions, see Rob Boddice, *The History of Emotions* (Manchester: Manchester University Press, 2018), ch. 1.

framework for studying the affective cultures of the past with their respective concepts of emotional regimes and 'emotional communities'.[10] Since then, there has been a good deal of theoretical and terminological debate, as scholars have sought to nuance existing models, or develop new ones.[11] This is especially true of recent years, as the history of emotions has gained sufficient intellectual self-confidence to expand into new areas of study and to engage with other disciplines.[12] Meanwhile, beyond the theoretical debates, numerous scholars have sought to 'do' the history of emotions by applying these conceptual frameworks to the archival record, using feeling as an interpretive prism though which to rethink our understanding of past human relations.[13]

The histories of medicine and science have not, perhaps, been shaped by the emotions to the extent that other areas, such as histories of the family and domesticity, have been.[14] Indeed, in his 2009 introduction to a special section of the journal *Isis* on 'The Emotional Economy of Science', Paul White suggested that, far from following the 'emotional turn', historians of modern science were heading in the opposite direction, towards a study of objectivity.[15] White was one of the earliest historians of science and medicine to take the emotions seriously, as was his fellow contributor to this special issue, Fay Bound Alberti. In her article, Bound Alberti analyses the death of the Scottish

[10] Peter N. Stearns and Carol Z. Stearns, 'Emotionology: Clarifying the History of Emotions and Emotional Standards', *American Historical Review* 90:4 (1985), 813–36; Reddy, *Navigation*; Barbara H. Rosenwein, *Emotional Communities in the Early Middle Ages* (Ithaca, NY: Cornell University Press, 2006).

[11] For example, see Thomas Dixon, '"Emotion": The History of a Keyword in Crisis', *Emotion Review* 4:4 (2012), 338–44; Rob Boddice (ed.), *A History of Feelings* (London: Reaktion, 2019); Katie Barclay, *Caritas: Neighbourly Love and the Early Modern Self* (Oxford: Oxford University Press, 2021).

[12] For example, see Stephanie Downes, Sally Holloway, and Sarah Randles (eds), *Feeling Things: Objects and Emotions through History* (Oxford: Oxford University Press, 2018); Dolores Martín-Moruno and Beatriz Pichel (eds), *Emotional Bodies: The Historical Performativity of Emotions* (Urbana: University of Illinois Press, 2019); Mark Smith and Rob Boddice, *Emotions, Sense, Experience* (Cambridge, UK: Cambridge University Press, 2020).

[13] For example, see Nicole Eustace, *Passion Is the Gale: Emotion and the Coming of the American Revolution* (Chapel Hill: University of North Carolina Press, 2008); Joanne Bailey, *Parenting in England, 1760–1850: Emotion, Identity and Generation* (Oxford: Oxford University Press, 2012); Claire Langhamer, *The English in Love: The Intimate Story of an Emotional Revolution* (Oxford: Oxford University Press, 2013); Katie Barclay, *Men on Trial: Performing Emotion, Embodiment and Identity in Ireland, 1800–45* (Manchester: Manchester University Press, 2018); Sally Holloway, *The Game of Love in Georgian England: Courtship, Emotions and Material Culture* (Oxford: Oxford University Press, 2018); Joanne Begiato, *Manliness in Britain, 1760–1900: Bodies, Emotion, and Material Culture* (Manchester: Manchester University Press, 2020).

[14] For example, see Susan Broomhall (ed.), *Emotions in the Household, 1200–1900* (Basingstoke: Palgrave Macmillan, 2008).

[15] Paul White, 'Introduction: The Emotional Economy of Science', *Isis* 100:4 (2009), 792–7, p. 792. White refers here, among other things, to Lorraine Daston and Peter Galison, *Objectivity* (New York: Zone Books, 2007).

surgeon-anatomist John Hunter (1728–93), caused, according to his contemporaries, by heart failure induced by 'affections of the mind', to highlight the intimate relationship between mind and body in pre-modern medicine and to assert the powerful role that emotions played in shaping ideas about health, disease, and embodied experience.[16]

Bound Alberti's earlier collection, *Medicine, Emotion and Disease, 1700–1950* (2006), is often cited as a seminal text for the entwined histories of emotion, medicine, and the body.[17] It certainly serves as a snapshot in time, its list of contributors including scholars, such as Thomas Dixon, Rhodri Hayward, and Bound Alberti herself, who would soon be associated with the Centre for the History of Emotions at Queen Mary University of London. This was founded in 2008 as the first dedicated research centre for the historical study of the emotions in the United Kingdom. While this development certainly helped to drive interest in the history of emotions in this country, it has taken some time for historians of medicine as a whole to pay serious attention to the emotions. This is now beginning to change, and recent years have seen the publication of several important works, such as those by Mark Neuendorf on psychiatric reform or Rob Boddice on the emotional politics of vivisection.[18] Boddice's valuable research on the concept of sympathy within late nineteenth-century medicine and science resonates with some of the arguments developed later in this book, even if my understanding of the earlier period is somewhat at odds with his.[19] Furthermore, the somatic turn in the history of emotions provides ever greater opportunities for historians of medicine to make a significant contribution to the field, while historians from other specialities are increasingly bringing emotions, medicine, and the body together in productive ways.[20] *Emotions and Surgery* pushes this project forward, demonstrating the value of an emotions-orientated approach to the

[16] Fay Bound Alberti, 'Bodies, Hearts, and Minds: Why Emotions Matter to Historians of Science and Medicine', *Isis* 100:4 (2009), 798–810. See also Bound Alberti, *Matters of the Heart: History, Medicine and Emotion* (Oxford: Oxford University Press, 2010), ch. 2.

[17] Fay Bound Alberti (ed.), *Medicine, Emotion and Disease, 1700–1950* (Basingstoke: Palgrave Macmillan, 2006).

[18] Rob Boddice, *The Science of Sympathy: Morality, Evolution and Victorian Civilization* (Urbana: University of Illinois Press, 2016); Boddice, *The Humane Professions: The Defence of Experimental Medicine, 1876–1914* (Cambridge, UK: Cambridge University Press, 2020); Mark Neuendorf, *Emotions and the Making of Psychiatric Reform in Britain, c. 1770–1820* (London: Palgrave Macmillan, 2021).

[19] This is especially true of his characterisation of feeling and gender in the early nineteenth century: Boddice, *Sympathy*, pp. 44–5.

[20] Martín-Moruno and Pichel (eds), *Emotional Bodies*. The latter is particularly true of recent literature on the First World War, e.g. Ana Carden-Coyne, *The Politics of Wounds: Military Patients and Medical Power in the First World War* (Oxford: Oxford University Press, 2014); Jessica Meyer, *An Equal Burden: The Men of the Royal Army Medical Corps in the First World War* (Oxford: Oxford University Press, 2019).

history of surgery by showing how a sensitivity to the emotions enables us to reframe our perspective and question some of our most basic historical assumptions.

The history of pain might be regarded as a cognate of the history of emotions.[21] The intimate connection between the histories of surgery, pain, and the emotions is intuitively understood, especially because surgical treatment, both operative and therapeutic, has historically involved a considerable amount of pain, and because, as Wilson's testimony suggests, the 'conquest' of surgical pain in the form of anaesthesia had profound implications for surgery's emotional dynamics. *Emotions and Surgery* is not conceived as a surgical history of pain, per se. Nonetheless, pain features prominently in our discussion of pre-anaesthetic surgery, and comes into particularly sharp relief in the debates surrounding its prospective elimination. *Emotions and Surgery* also elaborates Joanna Bourke's suggestion that the traditional perception of pre-modern physicians and surgeons as uncaring and indifferent to pain is inaccurate.[22] It shows that sympathy played a far more important practical, social, and rhetorical function within pre-modern surgical practice than has generally been recognised.

As well as drawing on a rich vein of scholarship in the history of emotions, *Emotions and Surgery* is also firmly situated within the history and historiography of surgery. It is not unreasonable to suggest that the history of surgery has traditionally been something of a poor relation to the history of medicine, at least in terms of scale. Like much early work in the history of medicine, the history of surgery was once dominated by heroic accounts of innovation and progress.[23] This is perhaps even more true of surgery than of medicine, given the profession's enduring myth of a meteoric ascent from barbers to brain surgeons. As we shall see, this myth was largely constructed in the nineteenth century, when surgeons pointed to the achievements of pathological anatomy, anaesthesia, and antisepsis, innovations that found few rivals in the world of medicine, as evidence of the intellectual superiority and practical utility of their science. However, if popular histories of surgery still tend towards mythic triumphalism, the scholarly historiography of surgery has developed in sophistication and nuance since the early 1990s. This is due in no small part to the work of Christopher Lawrence, whose publications, including the path-breaking collection *Medical Theory, Surgical Practice:*

[21] For an overlap in terms of concepts and personnel, see Rob Boddice (ed.), *Pain and Emotion in Modern History* (Basingstoke: Palgrave Macmillan, 2014).

[22] Joanna Bourke, *The Story of Pain: From Prayers to Painkillers* (Oxford: Oxford University Press, 2014), ch. 8.

[23] For example, see Owen D. Wangensteen and Sarah D. Wangensteen, *The Rise of Surgery: From Empiric Craft to Scientific Discipline* (Minneapolis: University of Minnesota Press, 1978).

Studies in the History of Surgery (1992), opened up a whole new approach to the subject.[24] In time, this breach in the walls of surgical myth has been exploited by a number of scholars, including Carin Berkowitz, Clare Brock, Sally Frampton, and Thomas Schlich, all of whom have produced important accounts of surgical thought and practice from the late eighteenth to the early twentieth centuries.[25]

In drawing upon the historiography of surgery, this book is specifically indebted to two key studies. The first of these is Peter Stanley's *For Fear of Pain: British Surgery, 1790–1850* (2003). Stanley's book is a peerless general account of British surgery in the early nineteenth century, which uses an impressive range of sources to tell the history of surgeons and their patients in the 'final decades of painful surgery'.[26] However, Stanley's book, rich in content though it is, is a broad historical survey of the period whose approach is more descriptive than analytical, and more synoptic than specific. By contrast, *Emotions and Surgery* is focused on the particular role played by emotion in shaping surgical practice, identity, and experience. Unlike Stanley's book, it moves beyond the advent of anaesthesia to consider how the emotional landscape of surgery was reshaped by the epistemological upheavals of the late nineteenth century. Most importantly, *Emotions and Surgery* provides a rigorously analytical, interpretive, and explicatory account of the rise and fall of one surgical emotional regime and its supersession by another, situating these huge transformations within shifting constellations of social thought and cultural practice. The second book to which *Emotions and Surgery* speaks most directly is Lynda Payne's *With Words and Knives: Learning Medical Dispassion in Early Modern England* (2007). There is no need to say too much about the interpretive differences between our two books here, as these are discussed in detail in Chapter 2. Suffice it to say that whereas Payne emphasises the quality of surgical dispassion, a self-conscious act of emotional distancing from the sufferings of the patient, and presents this as the timeless quality of the surgical operator, I emphasise the historical mutability and contingency of surgical emotions, and put much greater emphasis on the place of emotional intersubjectivity within

[24] Christopher Lawrence (ed.), *Medical Theory, Surgical Practice: Studies in the History of Surgery* (London: Routledge, 1992). See also Roger Cooter, *Surgery and Society in Peace and War: Orthopaedics and the Organization of Modern Medicine, 1880–1948* (Basingstoke: Palgrave Macmillan, 1993).

[25] Thomas Schlich, *The Origins of Transplant Surgery: Surgery and Laboratory Science, 1880–1930* (Rochester, NY: University of Rochester Press, 2010); Carin Berkowitz, *Charles Bell and the Anatomy of Reform* (Chicago: Chicago University Press, 2015); Claire Brock, *British Women Surgeons and Their Patients, 1860–1918* (Cambridge, UK: Cambridge University Press, 2017); Sally Frampton, *Belly-Rippers, Surgical Innovation and the Ovariotomy Controversy* (London: Palgrave Macmillan, 2018).

[26] Peter Stanley, *For Fear of Pain: British Surgery, 1790–1850* (Amsterdam: Rodopi, 2003), p. 8.

the cultures of Romantic surgery.[27] And yet, despite the differences between our two approaches and arguments, and despite the fact that *With Words and Knives* is not a history of the emotions as conventionally conceived, it is important to acknowledge the significance of Payne's work in exploring the role of emotions in surgery, and in demonstrating what it can add to historical understanding.

Chronology and Concepts

Emotions and Surgery covers a period of huge social, cultural, and intellectual transformation. It begins in 1793, the year of John Hunter's death. As we shall see in Chapter 1, Hunter exerted a profound influence on early nineteenth-century surgery and his work was integral to the self-fashioning of surgeons as men of scientific credibility and social respectability. But, while Hunter's legacy lived on, his death also marked a shift in surgical culture. Payne suggests that Hunter cultivated a 'necessary inhumanity' in his emotional relationship with patients.[28] While there is reason to question how common this was among the practitioners of the later eighteenth century, what is certain is that the 1790s saw the rise of a new generation of surgeons who eschewed emotional dispassion, emphasising instead the importance of sympathy and compassion, and the necessity for effecting an emotional engagement with patients.[29] This marked the birth of what I call Romantic surgery. One of its early leading lights, arguably its founder, was the Scottish surgeon John Bell (1763–1820). Bell played a prominent role in constructing surgery as an emotionally 'authentic' science, one defined by its embodied qualities and by the surgeon's routine exposure to the extremes of pain, suffering, and distress.[30] He published his first major surgical text, the *Anatomy of the Bones, Muscles and Joints*, in 1793, which was also the same year as the start of war with France, a conflict that would continue, on and off, for over twenty years, and would cast a long shadow over early nineteenth-century Europe. Although *Emotions and Surgery* is not explicitly concerned with the practice of military surgery, it shows that war shaped the cultures and values of nineteenth-century surgery as a whole, a point that has been expounded in more detail elsewhere.[31]

[27] Lynda Payne, *With Words and Knives: Learning Medical Dispassion in Early Modern England* (Aldershot: Ashgate, 2007), pp. 1–2.

[28] Payne, *Words*, pp. 2, 6–7.

[29] Indeed, Payne suggests a similar model even for eighteenth-century surgeons like Percivall Pott. Lynda Payne, *The Best Surgeon in England: Percivall Pott, 1713–88* (New York: Peter Lang, 2017), p. 2.

[30] Michael Brown, 'Surgery, Identity and Embodied Emotion: John Bell, James Gregory and the Edinburgh "Medical War"', *History* 104:359 (2019), 19–41.

[31] Michael Brown, '"Like a Devoted Army": Medicine, Heroic Masculinity, and the Military Paradigm in Victorian Britain', *Journal of British Studies* 49:3 (2010), 592–622; Brown,

Emotions and Surgery begins by exploring the cultures of Romantic surgery and delineating the figure of the Romantic surgeon (as well as the Romantic patient). It is therefore imperative to clarify what I mean by the term 'Romantic'. Romanticism is a capacious concept that has found greater application in literary studies than in history. Indeed, it is rare to find historians using Romanticism as a chronological signifier at all. At the most general level, Romanticism can be defined as a cultural, intellectual, and artistic movement that originated in the very late eighteenth century and whose influence continued until around the middle of the nineteenth. While it is often seen as a reaction to Enlightenment rationalism, Romanticism displayed many marked continuities with earlier cultural forms, notably sensibility, that openness to the feelings of others that sentimental moral philosophers argued might regulate interpersonal conduct and improve social relations.[32] However, Romanticism reconfigured sensibility in distinct and important ways.[33] For instance, it devoted particular sentimental attention to the 'dependent', including women, children, animals, and the enslaved.[34] It also turned the emotional gaze inwards, lauding emotional introspection and self-reflection, and laying the groundwork for modern notions of psychic interiority.[35] Likewise, it placed great emphasis on emotional *experience*. Whether it be through an encounter with the natural world, the reading of a novel or poem, or an exposure to suffering, experience and introspection enabled the cultivation of a 'heartfelt' emotional authenticity that was held to be a hallmark of personal nobility, and that distinguished Romantic sensibility from the supposedly contrived and mannered artifice of the earlier period.[36]

'Wounds and Wonder: Emotion, Imagination, and War in the Cultures of Romantic Surgery', *Journal for Eighteenth-Century Studies* 43:2 (2020), 239–59; Christopher Lawrence and Michael Brown, 'Quintessentially Modern Heroes: Surgeons, Explorers, and Empire, c.1840–1914', *Journal of Social History* 50:1 (2016), 148–78.

[32] Norman S. Fiering, 'Irresistible Compassion: An Aspect of Eighteenth-Century Sympathy and Humanitarianism', *Journal of the History of Ideas* 37:2 (1976), 195–218; G. J. Barker-Benfield, *The Culture of Sensibility: Sex and Society in Eighteenth-Century Britain* (Chicago: Chicago University Press, 1992).

[33] Julie Ellison, 'Sensibility', in Joel Faflak and Julia M. Wright (eds), *A Handbook of Romanticism Studies* (Chichester: Wiley, 2012), 37–53.

[34] Debbie Lee, *Slavery and the Romantic Imagination* (Philadelphia; University of Pennsylvania Press, 2002); David Perkins, *Romanticism and Animal Rights* (Cambridge, UK: Cambridge University Press, 2003); Bailey, *Parenting*.

[35] For the move to an increasingly introspective, 'inwardly turned' self in the later eighteenth century, see Dror Wahrman, *The Making of the Modern Self: Identity and Culture in Eighteenth-Century England* (New Haven: Yale University Press, 2004).

[36] For the importance of emotional authenticity within Romantic sensibility, see Lionel Trilling, *Sincerity and Authenticity* (London: Oxford University Press, 1972); Tim Miles and Kerry Sinanan (eds), *Romanticism, Sincerity and Authenticity* (Basingstoke: Palgrave, 2010). On the issues of sensibility and artifice, see Markman Ellis, *The Politics of Sensibility: Race, Gender and Commerce in the Sentimental Novel* (Cambridge, UK: Cambridge University Press, 1996).

The relationship between Romanticism and science has been widely acknowledged.[37] This is particularly true for gas chemistry.[38] The English chemist Humphry Davy (1778–1829) was perhaps the quintessential Romantic man of science, melding sublime emotional experience and rigorous self-experimentation with a literary sensibility.[39] Likewise, Davy's friend Samuel Taylor Coleridge (1772–1834) combined the writing of Romantic poetry with scientific and philosophical pursuits.[40] Elsewhere, scholars have considered Romanticism in relation to the sciences of life, including debates over vitalism and the development of transcendental anatomy and cell theory.[41] And yet, with remarkably few exceptions, no study has yet addressed the impact of Romanticism on quotidian medical and surgical practice.[42] *Emotions and Surgery* does just this, demonstrating the profoundly important ways in which Romantic sensibility informed surgical practice and shaped surgical culture, both at the level of rhetoric and self-presentation, and at that of experience and identity. It argues that sympathy, compassion, and emotional intersubjectivity were central to an idealised Romantic relationship between surgeon and patient; these qualities were not simply culturally valued, allowing surgeons to shape resonant public identities as men of feeling, but were rooted in the conditions of pre-anaesthetic surgery, facilitating the emotional negotiation of death and distress, and functioning as a vital tool for the therapeutic regulation of bodily and mental health.

Given the centrality of the emotions within the cultures of Romanticism, it is perhaps somewhat strange that they have been subject to so little consideration in relation to contemporary surgery. Indeed, within the public consciousness,

[37] Andrew Cunningham and Nicholas Jardine (eds), *Romanticism and the Sciences* (Cambridge, UK: Cambridge University Press, 1990); Richard Holmes, *The Age of Wonder: How the Romantic Generation Discovered the Beauty and Terror of Science* (London: HarperCollins, 2008); Richard C. Sha, *Imagination and Science in Romanticism* (Baltimore: Johns Hopkins University Press, 2018).

[38] Mike Jay, *The Atmosphere of Heaven: The Unnatural Experiments of Dr Beddoes and His Sons of Genius* (New Haven: Yale University Press, 2009).

[39] Christopher Lawrence, 'The Power and the Glory: Humphry Davy and Romanticism', in Cunningham and Jardine (eds), *Romanticism*, 213–27; Jan Golinski, *The Experimental Self: Humphry Davy and the Making of a Man of Science* (Chicago: Chicago University Press, 2016).

[40] Trevor H. Levere, 'Coleridge and the Sciences', in Cunningham and Jardine (eds), *Romanticism*, 295–306; Nicolas Roe (ed.), *Samuel Taylor Coleridge and the Sciences of Life* (Oxford: Oxford University Press, 2001); Eric G. Wilson, 'Coleridge and Science', in Frederick Burwick (ed.), *The Oxford Handbook of Samuel Taylor Coleridge* (Oxford: Oxford University Press, 2009), 640–59.

[41] L. S. Jacyna, 'The Romantic Programme and the Reception of Cell Theory in Britain', *Journal of the History of Biology* 17:1 (1984), 13–48; Jacyna, 'Romantic Thought and the Origins of Cell Theory', in Cunningham and Jardine (eds), *Romanticism*, 161–68; Philip F. Rehbock, 'Transcendental Anatomy', in Cunningham and Jardine (eds), *Romanticism*, 144–60; Sharon Ruston, *Shelley and Vitality* (Basingstoke: Palgrave Macmillan, 2005).

[42] Robert Allard, 'Medicine', in Faflak and Wright (eds), *Handbook*, 375–90.

this era is typically reduced to caricature, a world of misery, gore, pain, and death in which patients reluctantly placed their lives in the callous(ed) hands of semi-literate butchers who were indifferent to their sufferings.[43] Even within the academic literature, the early nineteenth century is often conceived as little more than the prelude to surgical modernity, the last days of darkness before the dawn of anaesthesia and antisepsis. It would, of course, be disingenuous in the extreme to claim that surgery in this period did *not* involve a great deal of suffering, pain, and death. But, as this book demonstrates, it was precisely because of these conditions that surgeons shaped an extraordinarily rich and expressive emotional culture.

Having explored the emotional regime of Romantic surgery, *Emotions and Surgery* examines the transition to a new emotional regime between the second quarter of the nineteenth century and the first decade of the twentieth. In this period, I argue, emotion, both as a form of expression and as a way of conceptualising the patient, was increasingly marginalised within surgical culture. This process was facilitated by the emergence of new ways of talking and thinking about feeling within surgery, and the transformation of subjectivity and pain wrought by the introduction of inhalation anaesthesia. This transition from the Romantic to the techno-scientific, the pre-modern to the modern, was capped by Joseph Lister's application of germ theory to surgical practice in the mid-1860s, something that saw the patient, as an emotionally agentive presence, effectively disappear from surgery by the 1880s.[44] While I am cautious of giving the impression that this book adheres to a 'great man' view of history, the importance of Lister and antisepsis within this cultural transformation cannot be denied, and so the end date for the study is given as 1912, the year of Lister's death, and the moment at which modern techno-scientific surgery can be said to have come of age.

This book utilises a number of concepts and terms that are specific to the history of emotions and thus require some explanation. Perhaps the most important of these is emotional regimes. William Reddy defines an emotional regime as a 'set of normative emotions and the official rituals, practices, and emotives that express and inculcate them'.[45] Reddy's notion of the emotional regime is predicated on the theory of the 'emotive', which is the understanding that emotion is a 'speech act' (and also a gestural one) that not only gives expression to a feeling but also induces its sensation.[46] In other words, what it is possible to feel is, in large part, determined by one's ability to give

[43] For example, see Lindsey Fitzharris, *The Butchering Art: Joseph Lister's Quest to Transform the Grisly World of Victorian Medicine* (London: Allen Lane, 2017), prologue.
[44] As we shall hear, this has parallels with Jewson, 'Disappearance'.
[45] Reddy, *Navigation*, p. 129.
[46] Reddy, *Navigation*, p. 128.

expression to it. Emotional regimes, broadly speaking, constitute a culture within which certain emotions are expressible and meaningful, while others are less so. They are not fixed but mutable, and subject to change over time. Reddy's original formulation of emotional regimes was rather prescriptive, and his sense of their operation somewhat oppressive. This book therefore employs the concept in more of a heuristic than a purist way, to describe the historically contingent normativity of particular forms of emotional sensation and expression, and to distinguish the emotional cultures and practices of Romantic sensibility from those of scientific modernity. For this reason, while *Emotions and Surgery* generally employs Reddy's ideas, it occasionally references the work of other scholars, such as Barbara Rosenwein, whose concept of the emotional community allows for a more relational understanding of emotions as a system of feeling, connecting or defining a particular social or vocational group, such as surgeons.[47]

There has been a great deal of debate within the field about the role played by language in structuring our understanding of past emotions, and a suggestion that the terms we use might occlude, as much as enhance, our analysis. This is true even of the word 'emotion' itself, which, as Thomas Dixon has shown, has a particular intellectual history.[48] According to Dixon, emotion was not firmly established as 'a category of mental states that might be systematically studied' until the middle of the nineteenth century.[49] Nonetheless, he acknowledges that the word entered the English language in the eighteenth century, and was certainly in use by the early nineteenth to talk about sensations of feeling and mood. For example, in describing the effects of nitrous oxide in 1800, Humphry Davy wrote: 'My emotions were enthusiastic and sublime; and for a minute I walked around the room perfectly regardless of what was said to me'.[50] Moreover, Dixon credits Charles Bell (1774–1842), the younger brother of John Bell and one of the key figures in the early chapters of this book, with being the 'coinventor' of the modern concept of the emotions.[51] For this reason, and for the sake of terminological convenience, I have judged it appropriate to employ emotion as a descriptive shorthand for various sensations and expressions of mood, even if the sources do not always use precisely those terms. At the same time, however, I am sensitive to the historically contingent quality of emotion words, and I therefore avoid the term 'empathy', which is an early

[47] Rosenwein, *Emotional Communities*.
[48] Thomas Dixon, *From Passions to Emotions: The Creation of a Secular Psychological Category* (Cambridge, UK: Cambridge University Press, 2003); Dixon, '"Emotion"'.
[49] Dixon, '"Emotion"', p. 338.
[50] Humphry Davy, *Researches Chemical and Philosophical, Chiefly Concerning Nitrous Oxide or Dephlogisticated Nitrous Air and Its Respiration* (London: J. Johnson, 1800), p. 488.
[51] Dixon, '"Emotion"', p. 341.

twentieth-century neologism, using instead the actors' categories of sympathy and compassion. And yet, as we shall see, sympathy, which means 'suffering with', does not, in its modern sense at least, quite communicate the extent of imaginative projection into the other described by Romantic surgeons, and thus, when discussing the surgeon–patient relationship, I employ the modern concept of 'intersubjectivity', a term with less conceptual and moral baggage than empathy.

'Affect' is another contested term. For much of its history it communicated a variety of meanings related to mental sensation, including what we might call the cognitive aspects of feeling. Since the development of 'affect theory' in the 1960s, however, it has come to refer specifically to the physiological and pre-cognitive dimensions of emotional sensation and expression, such as a raised heart rate, sweating, or a flushed face. This technical use has increasingly moved out of psychology into the humanities. While some scholars, such as Barbara Rosenwein, reject the distinction, I generally use affect to describe the embodied aspects of feeling. At the same time, given that the concepts of emotion and affect are so inextricably intertwined, as are the mental and physical manifestations of feeling, they often function synonymously.[52]

As a last word on the topic of emotions, I should say that that, while this book mostly deals with emotions as conventionally understood, things such as anxiety, regret, anger, and joy, it also considers other, less easily categorisable, mental states and forms of bodily sensation and expression. Indeed, given that it is conceived, in large part, to trace the changing place of the patient within the cultures and practices of British surgery, *Emotions and Surgery* deals on occasion with much broader ideas of subjectivity and agency, including the embodied sensations of operative practice, the hallucinations of anaesthetised patients, or the unconscious movements of amputated limbs. These might not customarily be regarded as emotions strictly speaking, but they are nonetheless an essential element to consider in a phenomenologically sensitive account of surgical experience and embodiment.[53]

Having established the conceptual parameters of the term 'emotions', it is also necessary to define exactly what I mean by 'surgery'. This book is almost exclusively concerned with the practice of *operative* surgery, or with therapeutic practice of an explicitly surgical kind, often in anticipation of, as an alternative to, or in recovery from, operative intervention. As such, it focuses overwhelmingly on a group of men, sometimes called 'pure' surgeons, who were typically attached to large teaching hospitals, and who

[52] Barbara H. Rosenwein, *Generations of Feeling: A History of Emotions, 600–1700* (Cambridge, UK: Cambridge University Press, 2015), p. 7.
[53] Smith and Boddice, *Emotions*.

therefore performed surgical operations on a regular basis. Because of this, the story told here is one centred on the twin medical metropolises of London and Edinburgh. Outside of these and other major cities, the majority of men trained as surgeons actually practised as surgeon-apothecaries or, as they were increasingly known in the early nineteenth century, general practitioners. These men did not generally undertake a large number of operations, at least not 'capital' ones, the name given to major procedures such as amputations, lithotomies, or the excision of tumours. Much of their day-to-day work consisted of treating conditions that were essentially *medical* – that is, they were rooted in internal, constitutional complaints – or of performing minor surgical procedures like bleeding veins or removing superficial growths. In 1817, for example, a recently licensed surgeon by the name of John Wallace from Carshalton in Surrey wrote a letter to John Flint South (1797–1882), then a student at St Thomas' Hospital in London, in which he discussed his practice in 'the Country'.[54] He had seen two cases of hernia, he explained: 'two broken thighs and a broken arm the only other surgical cases of importance which have fallen to my lot'. For 'every surgical case', he remarked ruefully, 'there are 50 medical'.[55] While I am deeply sensitive to the importance of non-metropolitan medical cultures, and have written extensively about the role of the surgeon-apothecary and provincial practitioner in the ideological elaboration of the medical profession, when it comes to the cultures of operative surgery, there is ample justification for focusing on metropolitan surgeons.[56] After all, not only have they left behind the greatest volume of archival material, but they were also the principal operators, authors, and lecturers of the day, playing a prominent role in the shaping of surgical practice, culture, and identity. Of course, it could be suggested that this focus on metropolitan surgeons risks limiting the generalisability of the emotional regimes I reconstruct in this book. For example, in 1830, the Somerset surgeon Mr Valentine told Astley Cooper (1768–1841), one of the leading practitioners of the day, that 'It has fallen to my lot to perform many operations for a country practitioner amongst them fourteen for the stone 13 of which were successful'. Still, he claimed, 'I do it as a painful duty not with the indifference acquired by the extensive field of London practice'.[57] Here

[54] Carshalton is actually less than ten miles from central London.

[55] RCSE, MS0232/9, Letters to John Flint South and notes on his family, Letter from George Wallace to John Flint South, 8 February 1817.

[56] For example, Michael Brown, *Performing Medicine: Medical Culture and Identity in Provincial England* (Manchester: Manchester University Press, 2011); Brown, 'Medicine, Reform and the "End" of Charity in Early Nineteenth-Century England', *English Historical Review* 124:511 (2009), 1353–88.

[57] RCSE, MS0008/2/2/5, File of correspondence concerning cases including breast cancer and tumour, 1813–47, Letter from Mr Valentine to Astley Cooper, 24 August 1830.

we have a provincial surgeon articulating the idea that the routinisation of operative experience characteristic of London hospital surgery might induce a kind of emotional insensibility. As we shall see, however, the reality was that metropolitan surgeons in London and Edinburgh spoke just as openly about the emotional challenges of their work, suggesting that the values of Romantic surgical culture were widely shared.

I should perhaps add that, while this book adopts an emotions-centred approach, it is sensitive to the ways in which emotions intersect with categories of identity such as class, gender, and race. Gender plays a particularly prominent role in the story, though I have not engaged in any great depth with the entry of women into the medical and surgical professions in the late nineteenth and early twentieth centuries, both because this has been done so well elsewhere, and because the evidence suggests that women's impact on the emotional regime of surgery was, and in many ways continues to be, limited.[58] Likewise, while ideas about race and, more especially, ethnicity do feature in *Emotions and Surgery*, they are not employed as a framing device, in large part because another strand of the Surgery & Emotion project, and its resultant outputs, was conceived to address precisely these concerns.[59]

Sources and Structure

Emotions and Surgery is founded upon an extraordinarily rich body of primary source material. This includes thousands of pages of manuscript casebooks, letters, diaries, notes, and lectures, drawn from the personal papers of various nineteenth-century surgeons. As a case in point, the archive of Astley Cooper, the largest single collection of manuscript material consulted for this book, encompasses more than sixteen boxes of documents, and yielded nearly 3,500 digital images. This material alone took over six months to sort, transcribe, and code into an NVivo database. The majority of the archival materials consulted for this book are held by the Royal College of Surgeons of England, but *Emotions and Surgery* also makes use of material from other archives, including the Royal College of Surgeons of Edinburgh, the Wellcome Library, the National Library of Scotland, and the Cumbrian Archives Service. Moreover, *Emotions and Surgery* utilises a vast quantity of published texts, including medical journals, books, pamphlets, and newspapers. The richness, depth,

[58] See Brock, *British Women Surgeons*; Kim Peters and Michelle Ryan, 'Machismo in Surgery Is Harming the Specialty', *BMJ* 348 (2014), g3034 https://doi.org/10.1136/bmj.g3034 (accessed 06/10/21).

[59] 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.

and variety of this source material allow for an unprecedented insight into nineteenth-century surgical culture, practice, and identity, as well as the relationships between surgeons and their patients. Different sources offer different perspectives. Letters from patients and their medical representatives facilitate a unique understanding of their experience of surgical treatment, while casebooks can illuminate the place of emotion within hospital practice. Surgeons' diaries and correspondence allow us to explore the fashioning of surgical subjectivity, while lectures in both manuscript and printed form provide a useful way to gauge the cultural values and professional norms that surgeons sought to inculcate in their students. Likewise, journals provide a broad insight into the cultural politics of surgery, while surgical biographies and memoirs are highly suggestive of the image and identity that surgeons sought to construct of themselves and their profession.

A wide range of sources are employed throughout *Emotions and Surgery*, but different bodies of material are used to highlight particular issues. Chapter 1 lays the groundwork for our understanding of Romantic surgery as an avowedly 'scientific' practice, grounded in anatomy, but also as an embodied and performative one, in which the qualities of speed, dexterity, and decisiveness were balanced against an emotional assessment of the patient's needs. Using letters, lectures, journals, and books, it reconstructs the Romantic surgeon as an operative man of feeling, but also explores the contradictions and ambiguities of that persona in the form of perhaps the era's most contested figure, Robert Liston (1794–1847).

Chapter 2 focuses on the emotional interiorities and intersubjectivities of Romantic surgery. Drawing on diaries, letters, biographies, and other publications, it explores the cultures of Romantic emotional expression and introspection, countering the caricature of the early nineteenth-century surgeon as a callous or dispassionate butcher. It demonstrates the centrality of emotions not only in the shaping of the surgical self, but also in the affective management of the patient, and the regulation of bodily health and operative outcomes. Hence, it uses the extensive manuscript casebooks of Astley Cooper to open up the relationship between breast cancer and the 'emotion work' of gender within Romantic surgery.

Chapter 3 considers Romantic surgery from the patient's perspective. Using Cooper's rich archive of personal correspondence as well as his casebooks, it illuminates the importance of emotions as a form of agency both in the context of the private surgical relationship and within what, following Michel Foucault, we might consider the 'disciplinary' space of the hospital. Beyond the role of conscious emotional agency, it also demonstrates how this agency might be expressed through embodied acts, figuring the amputee's 'irritable' constitution and 'bad stump' as a site of ontological 'messiness' and as a form of unconscious resistance to surgical authority.

Chapter 4 uses a close reading of *The Lancet*, and its radical, charismatic editor Thomas Wakley (1795–1862), to delineate the 'high water mark' of Romantic sensibility as an emotional regime. It explores the ways in which Wakley and *The Lancet* leveraged the emotional politics of contemporary melodrama to attack the alleged nepotism and corruption of the London surgical elites. More especially, it analyses their campaign to expose instances of surgical incompetence at the city's leading teaching hospitals, demonstrating the ways in which this strategy weaponised the emotions of anger, pity, and sympathy, and considering its implications both for the cultural norms of an inchoate profession and for the ultimate stability of the emotional regime of Romantic sensibility.

Chapter 5 explores the beginning of the end of Romantic sensibility and the origins of surgical scientific modernity. Using a close reading of a wide range of published books, journals, pamphlets, and lectures, it elucidates the role of utilitarian thought in rendering the surgical body emotionally quiescent. It focuses on two distinct but interrelated historical episodes, namely the debates around anatomical dissection that preceded the passage of the Anatomy Act in 1832, and the introduction and early reception of inhalation anaesthesia in the mid to late 1840s. In the first instance, it demonstrates how an ultra-rationalist understanding of sentiment was set in opposition to popular 'sentimentalism' in order to divest the dead bodies of the poor of emotional value. Meanwhile, in the second, it considers how the subjectivity of the newly anaesthetised patient was swiftly tamed by the operations of a techno-scientific rationale.

Chapter 6 charts the ultimate triumph of the emotional regime of scientific modernity in the form of antisepsis, Joseph Lister's application of germ theory to surgical practice. Through an in-depth analysis of journal articles, reports, lectures, biographies, and visual images, it shows how antisepsis effectively eliminated the patient as an emotional presence in surgery. At the same time, however, it demonstrates how this 'new world of surgery' was configured in highly sentimentalised terms, constructing Lister, the ultimate scientific surgeon and the emotional template for surgical modernity, as a quasi-divine saviour.

Finally, the Epilogue builds on these collective insights to highlight the ways in which historical accounts of the Listerian 'revolution' have shaped our perception not only of surgical modernity, but also of the pre-antiseptic and pre-anaesthetic past, flattening the emotional landscape of the Romantic era and consigning it to a surgical 'dark age'. It suggests that these misunderstandings of the past have, in turn, shaped contemporary surgical culture, and it therefore considers how a more nuanced history might inform surgical practice today. As such, *Emotions and Surgery* will hopefully be of interest to a wide range of different readers, including students of the history of emotions and surgery,

as well as those of nineteenth-century Britain more generally. Moreover, by challenging simplistic narratives of triumphant surgical progress, and by subverting much of the mythology that has grown up around this subject, it also speaks to a popular audience interested in the past in all of its complexity, as well as to current surgical practitioners, who may learn something new, unexpected, and possibly even provocative, about the historical origins of their profession and its cultures.