

Epilogue

New Pasts, New Futures

In September 1879, Joseph Lister arrived in Amsterdam for the International Congress of Medical Science as something like a conquering hero. According to the *British Medical Journal*, the public address he gave there was received ‘with an enthusiasm which knew no bounds’. As Lister approached the lectern, ‘the whole assembly rose to their feet [...] with deafening and repeated rounds of cheers’. After five full minutes, this scene, which the *Journal* thought ‘unprecedented [...] in the history of medical science’, was interrupted by the President of the Congress, Franciscus Donders (1818–89), who announced: “‘Professor Lister, it is not only our admiration which we offer to you; it is our gratitude, and that of the nations to which we belong’”.¹

The adulation did not end there. Three days later, the evening’s entertainment consisted of a series of short theatrical performances, including two ‘artistically dressed tableaux vivants’. The first of these was based upon a ‘well-known print’ of the pioneering sixteenth-century surgeon Ambroise Paré, ‘dressing a wounded man on the field of battle’. However, in place of Paré was ‘a similitude of Lister’, and ‘in the foreground an immense foyer of carbolic acid’.² ‘The idea’, the *British Medical Journal* reported, ‘was immediately seized, and from the whole theatre there rose such an universal acclamation, with continuous ovation to the name of Lister, that it was only after Mr Lister had, under compulsion, bowed his acknowledgments from his place [...] that the enthusiasm subsided’.³

This ‘idea’, it might be imagined, was that Lister had rewritten the history of surgery, that he had supplanted the achievements of the past by his own revolutionary discovery. Paré was said to have been one of Lister’s personal heroes and he would frequently quote the Frenchman’s famous dictum concerning the patient: ‘I dressed him, God cured him’.⁴ Now, however, Lister stood, quite

¹ *British Medical Journal* 2:977 (20 September 1879), p. 453.

² The meaning of the term ‘foyer’ here is uncertain, though it could be taken to imply a visual centrepiece. Either that or it was simply at the front of the stage.

³ *British Medical Journal* 2:977 (20 September 1879), p. 454.

⁴ Rickman John Godlee, *Lord Lister*, 2nd ed. (London: Macmillan, 1918), pp. 91, 566–7.

literally, in Paré's place, usurping his oft-acknowledged position as 'the father of surgery' and suggesting that there was, in essence, no *true* surgery before Lister. As St Clair Thomson wrote nearly sixty years later:

Lister, this genius, created anew the ancient art of healing. He did more for surgery and mankind in his life-time than all the surgeons of all the ages have been able to effect since the time of Hippocrates [...] The history of our world is divided into the two periods, before and since the coming of Christ – BC and AD. The history of Medicine and Surgery, and of human bodily suffering, will always be divided into the time before and after Lister.⁵

As we saw at the beginning of Chapter 1, each generation of surgeons had rehearsed its place in the history of surgery, casting itself as the pinnacle of achievement and presenting those who came before as, at best, stepping stones on the way to greatness or, at worst, unenlightened butchers labouring in darkness. And, in turn, each of these narratives was overwritten by the one that succeeded it.⁶ All generations were guilty of the same presumption in this regard. But what is remarkable about the Listerian myth of the birth of modern surgery is how durable it has been. So much about surgery has changed since Lister's time, yet no surgeon has usurped his place at the summit of the surgical pantheon in the way that he can be said to have displaced those, like Ambroise Paré or John Hunter, who came before him.

The Listerian myth is thus still with us and it has served to shape popular and professional perceptions of the history of surgery in profound ways, not least in terms of its emotional dimensions. Such perceptions are founded upon a fundamental disjuncture in historical continuity established by commentators like Thomson. In the first half of the twentieth century, most surgical history was written by surgeons, and these surgeons were, almost exclusively, supporters of the antiseptic system. Many of them, such as Thomson, Godlee, or John Rudd Leeson, were either relatives or former colleagues of Lister. But even beyond the realm of hagiography and reminiscence, there were attempts to craft a historical narrative that set Listerian surgery apart from all that had preceded it. In the very early twentieth century, the popular science and technology writer F. M. Holmes (b. 1851) penned a paean to surgical modernity entitled *Surgeons and Their Wonderful Discoveries* in which the story of antiseptis was told almost entirely in Lister's own words.⁷ Meanwhile in 1912,

⁵ RCSE, MS0021/1/15, St Clair Thomson, *Lister, 1827–1912: A House Surgeon's Memories* (1937), pp. 27–8.

⁶ See also Christopher Lawrence, 'Democratic, Divine and Heroic: The History and Historiography of Surgery', in Christopher Lawrence (ed.), *Medical Theory, Surgical Practice: Studies in the History of Surgery* (London: Routledge, 1992), 1–47; Lawrence, 'Surgery and Its Histories: Purposes and Contexts', in Thomas Schlich (ed.), *The Palgrave Handbook of the History of Surgery* (London: Palgrave Macmillan, 2018), 27–48.

⁷ F. M. Holmes, *Surgeons and Their Wonderful Discoveries* (London: S. W. Partridge, c.1901).

the year of Lister's death, the eugenicist physician Caleb Williams Saleeby (1878–1940) published *Surgery and Society: A Tribute to Listerism*, which, he claimed, answered the 'lack [...] of any book devoted to the most beneficent achievement in the entire record of science'. While Saleeby acknowledged that 'Surgery of some kind is doubtless almost as old as the human race', he maintained that 'its history, until the second quarter of the nineteenth century, scarcely needs writing'.⁸ Such sentiments were commonplace. In his popular biography of Lister, published in 1948, Hector Charles Cameron (1878–1958), son of Lister's friend Hector Clare Cameron, wrote that 'modern surgery began' in 1865 when Joseph Lister 'stepped from his carriage at the gates of the Royal Infirmary Glasgow' holding 'the first crude sample of carbolic acid'.⁹ For others, however, there was at least some value in a longer historical perspective, if only to better reflect the achievements of techno-scientific modernity. In 1925, for example, a correspondent to *The Lancet* wrote of the challenges involved in 'enabl[ing] the present generation to realise the state of affairs that existed' before Lister. 'Even those who experienced something of the fringe of its horrors are apt sometimes to forget the advantages we enjoy to-day', he opined. He therefore recommended that 'All students ought to read the story of "Rab and His Friends"', by Dr John Brown' wherein 'they will find in beautiful language an accurate description of an old-time operation for removal of the breast'. But, in terms of a general understanding of the pre-Listerian past, 'we require an exact description with some detail as much for educational as for historical purposes'. 'It would', he claimed, 'supply a real want'.¹⁰

These early histories of surgical modernity smoothed out the complexities of the recent past in order to present a seamless narrative of triumphant discovery. Thus, despite the ambiguous relationship between antiseptic and aseptic surgery, many accorded with the view propounded by Lister's closest allies that asepsis, which had become the dominant mode of surgical cleanliness by the early twentieth century, was merely 'Listerism perfected'.¹¹ Meanwhile, other authors sought to subordinate the earlier discovery of anaesthesia to a narrative of Listerian triumph. They did this either by rolling the two together (Lister's presence at the first operation under ether in Britain was useful here, his antagonistic relationship with James Young Simpson, the pioneer of chloroform, less so), or by diminishing the relative importance of anaesthesia when compared to antiseptics. According to Saleeby, anaesthesia did not fully conquer

⁸ C. W. Saleeby, *Surgery and Society: A Tribute to Listerism* (New York: Moffat and Yard, 1912), pp. 1, 28.

⁹ Hector Charles Cameron, *Joseph Lister: The Friend of Man* (London: Heinemann, 1948), p. 1.

¹⁰ *Lancet* 206:5319 (8 August 1925), p. 302.

¹¹ Harvey Graham, *The Story of Surgery* (New York: Doubleday, 1939), p. 365. See also Holmes, *Surgeons*, ch. 3.

surgical pain, for while post-anaesthetic operations may have constituted ‘an utterly different spectacle and an utterly different experience for the patient, [...] surgical fever supervened in practically every case’. Hence, pre-Listerian surgery remained ‘eminently painful surgery, for inflammation was its normal sequel, and though anaesthesia was a mighty boon, the worst was always yet to come’.¹² In a similar vein, the Leeds surgeon Berkeley Moynihan (1865–1936) claimed that ‘Before Lister came’ surgical operations were characterised not only by ‘heavy mortality’, but also by an ‘almost insupportable burden of terror and of suffering’ that even chloroform could not alleviate.¹³

Moynihan’s words highlight perhaps the most important and enduring way in which such early accounts configured the history of surgery, as the physical agonies and emotional terrors of the pre-modern past came to dominate popular representation. Almost all early histories of surgical modernity presented the pre-Listerian and pre-anaesthetic era in deeply emotive terms. In opening his chapter on the origins of antisepsis, for example, F. M. Holmes chose to imagine the following pre-Listerian dialogue:

‘Dead! my brother dead! But you said the amputation was proceeding favourably?’

‘So it was, but erysipelas set in, and, I am sorry to say, it has proved fatal.’

To this sorrowful announcement no more could be added, and sick and faint with the sudden news of death, instead of the cheering intelligence of progress, the inquirer staggered away to bear the crushing blow as best he might.¹⁴

As this passage suggests, such emotive qualities were most closely attached to the experiences of patients and their loved ones. These experiences were often condensed into endlessly recycled parables. For example, Thomson wrote of how, in the days before Lister, the public ‘shrank and shuddered at the suggestion of entering a hospital’, the surgical ward being perceived as little more than ‘the entrance to the valley of the shadow of death’. To exemplify his point, he recounted an anecdote from Frederick Treves who, as a house surgeon at Whitechapel’s London Hospital in the mid-1870s, was called upon to secure the consent of ‘an East-End mother’ for ‘some trifling operation’ on her daughter. “‘That’s all right’” said the patient, “‘it’s easy enough to give my consent, but what I want to know is: who’s going to pay for the poor girl’s funeral?’”¹⁵

This emphasis upon the emotional, mental, and physical trials of the pre-modern patient served to communicate the misery from which humankind had been delivered by the heroic triumphs of modern surgery. There was an element of truth in this, of course, for the pre-anaesthetic past was indeed

¹² Saleeby, *Surgery*, pp. 31, 37. ¹³ *Lancet* 209:5406 (9 April 1927), p. 746.

¹⁴ Holmes, *Surgeons*, p. 35.

¹⁵ RCSE, MS0021/1/15, pp. 18–19. This story appears in a number of histories, including Graham, *Story*, p. 336.

characterised by great suffering and profound anxiety on the part of surgical patients. However, what such accounts also did was to establish a stereotype of the pre-anaesthetic *practitioner* that was fundamentally at odds with the image that Romantic surgeons had sought to craft of themselves. To be sure, popular satires of the late eighteenth and early nineteenth centuries had often caricatured surgeons as heartless butchers, just as they had depicted medical practitioners more generally as self-interested and lacking in compassion.¹⁶ But, as we have seen in Chapters 1 and 2, Romantic surgeons challenged this cliché by emphasising their heartfelt sensibility, commitment to care, and deep emotional connection to their patients. By contrast, in consigning the pre-modern past to a dark age of ignorance and agony, and by presenting modern surgery as both uniquely curative *and* uniquely compassionate, early twentieth-century commentators overemphasised pre-anaesthetic surgical dispassion, often to the extent of alleging a passive cruelty in their forebears. As Frederick Treves claimed in 1900:

It is little wonder if the older surgeon became rough and stern, if his sense of feeling became dulled, and if the sympathetic side of his nature suffered some suppression. Indeed, contemporary accounts are apt to represent the operator of pre-anaesthetic times as rough almost to brutality and as coarse both in his conduct and in his utterances.

Compressing anaesthesia and antisepsis into a simultaneous surgical revolution, he continued:

Within the compass of some thirty years the whole state of affairs has changed. Consideration for the patient and for the patient's sensibilities have become a matter of the first moment and the operator has learnt that his work is best done if done with gentleness and tact, and that haste and bluster, coarseness and coarse handling are out of place around the operating table.¹⁷

It is hardly surprising, perhaps, that the nuance and complexity of the pre-anaesthetic past were obscured by the shining light of surgical modernity. And it is important to note that such accounts often acknowledged the achievements of surgeons like John Hunter, Astley Cooper, and Charles Bell. Even so, by emphasising the professional beneficence of their own era, early twentieth-century surgeons and surgical historians levelled the emotional landscape of the period that had immediately preceded them. Indeed, they rendered the emotional regime of Romantic surgery virtually unintelligible. Some commentators acknowledged the emotions experienced and expressed by surgeons of the earlier era, but these served merely to exemplify what Berkeley Moynihan

¹⁶ Fiona Haslam, *From Hogarth to Rowlandson: Medicine in Art in Eighteenth-Century Britain* (Liverpool: Liverpool University Press, 1996); Roy Porter, *Bodies Politic: Death, Disease and the Doctors in Britain, 1650–1900* (London: Reaktion, 2001).

¹⁷ *Lancet* 156:4014 (4 August 1900), p. 314.

called 'the full horror of the old days'. Speaking to the Royal College of Surgeons on the centenary of Lister's birth in 1927, he stated:

It is startling to read that when in the year 1821 Astley Cooper operated upon George IV for a small sebaceous cyst on the head, so tortured was he by anxiety lest erysipelas or pyaemia might develop that he sought to put upon others the responsibility of the operation, on Cline, on Everard Home, on anybody but himself. He speaks of the operation in terms which to us now appear absurd, fearing that 'it might by possibility be followed by fatal consequences'. He says, 'I saw that the operation if it were followed by erysipelas would destroy all my happiness and blast my reputation', and 'I felt giddy at the idea of my fate hanging upon such an event' [...] It is hard to believe that a surgeon eminent enough to be chosen for service to the King should be so deeply moved at the prospect of what was to him, as to us, technically the simplest of operations. The exercise of the art of surgery brought terror then where it now brings joy, to surgeon no less than to patient.¹⁸

Cooper's expression of intense emotion, once so culturally resonant, was, by the early twentieth century, merely an 'absurd' relic of pre-modern misery and professional impotence.

This emphasis on the horrors of the past, on its capricious and callous cruelties, continues to structure popular perceptions of the pre-anaesthetic era. The bifurcation of surgical history into a glorious modernity and a benighted past is perhaps most neatly exemplified by Guy Williams' two-volume popular history of medicine and surgery, *The Age of Agony* (1975) and *The Age of Miracles* (1981). Chronology plays a somewhat confused, yet highly suggestive, role in Williams' account. The *Age of Agony* is ostensibly concerned with the 'Art of Healing' between 1700 and 1800, whereas the *Age of Miracles* explores the period from 1800 to 1900. But in reality, the late eighteenth and early nineteenth centuries are fractured across both books. When used to illustrate the horrors of the pre-modern, early nineteenth-century surgeons like Astley Cooper are consigned to the 'age of agony'.¹⁹ When harnessed to a narrative of progress, meanwhile, eighteenth-century practitioners like John Hunter find themselves alongside anaesthesia and antiseptics in the 'age of miracles'.²⁰ The message is clear. As Williams writes in his brief introduction to the first book: 'Do we realize sufficiently what we have escaped by being alive in the twentieth century, not the eighteenth century? The following pages will tell'.²¹

¹⁸ *Lancet* 209:5406 (9 April 1927), pp. 746–7. The original account is taken from Bransby Blake Cooper, *The Life of Sir Astley Cooper, Bart.*, vol. 2 (London: John W. Parker, 1843), pp. 229, 233.

¹⁹ Guy Williams, *The Age of Agony: The Art of Healing, c.1700–1800* (Chicago: Academy Chicago Publishers, 1986 [1975]), pp. 113–14.

²⁰ Guy Williams, *The Age of Miracles: Medicine and Surgery in the Nineteenth Century* (Chicago: Academy Chicago Publishers, 1987 [1981]), ch. 2.

²¹ Williams, *Agony*, p. 2.

For much of the twentieth century, Astley Cooper served as the touchstone for the ‘old world’ of surgery, something that doubtless owed much to the legacy of his nephew’s biography. Since the late 1970s and early 1980s, however, it has been Robert Liston, conceived as a muscular mixture of bravura and brutality, who has come to most powerfully embody the supposed contradictions of the pre-anaesthetic age. As we saw in Chapter 1, Lister’s modern reputation is founded, at least in part, on factually unstable ground. Thus, in his curiously influential book *Great Medical Disasters* (1983), Richard Gordon alleges that Liston amputated a leg in two-and-a-half minutes ‘but in his enthusiasm [removed] the patient’s testicles as well’. Meanwhile in another instance, Gordon maintains that Liston amputated the leg of a patient (who later died of gangrene) and, in his haste, severed two fingers from his ‘young assistant’ (who likewise died of gangrene), as well as slicing the coattails of a ‘distinguished surgical spectator, who was so terrified that the knife had pierced his vitals he dropped dead from fright’. It was, Gordon claims, a ‘triple knock-out’, ‘the only operation in history with a 300 percent mortality’.²²

Gordon’s account is a specious mélange of half-truths and outright fiction. There is no evidence for the death of a surgical spectator in this manner (and hence no basis to the 300 per cent mortality claim). Likewise, his story about Liston accidentally severing the fingers of his assistant, as well as the testes of his patient, can be traced back no more than five years to *The Rise of Surgery* (1978) by Owen and Sarah Wangenstein.²³ In this book, Owen Wangenstein recalls a ‘Very likely apocryphal [...] anecdote’ told to him by his ‘former physiology professor, Frederick H. Scott, who as a student of [Ernest Henry] Starling in London heard that a surgeon of the *Liston era* [note: not Liston himself], in his hurry to amputate a thigh “included two fingers of his assistant and both testes of his patient”’.²⁴

Regardless of their dubious veracity, these stories about Liston have worked their way into countless popular histories and have served to underscore the horrors of the surgical past. For example, Richard Hollingham’s *Blood and Guts* (2008), produced as a tie-in to a BBC television series of the same name, features Liston prominently in its first chapter, tellingly entitled ‘Bloody Beginnings’. Alongside a number of questionable statements and outright

²² Richard Gordon, *Great Medical Disasters* (New York: Stein and Day, 1983), pp. 19–21.

²³ At least two other near-contemporary texts contain a version of this story: Elisabeth Bennion, *Antique Medical Instruments* (London: Sotheby Parke Bernet, 1979), p. 55; Steven Lehrer, *Explorers of the Body: Dramatic Breakthroughs in Medicine from Ancient Times to Modern Science* (New York: Doubleday, 1979), p. 92.

²⁴ Owen D. Wangenstein and Sarah D. Wangenstein, *The Rise of Surgery: From Empiric Craft to Scientific Discipline* (Minneapolis: University of Minnesota Press, 1978), pp. 36, 38. Emphasis added. The fact that, in his version of this story, Gordon separates the severing of the testes from the severing of the fingers raises further questions about its historical veracity.

factual errors (including the bizarre suggestion that Liston died in a sailing accident), Hollingham repeats the claim about Liston's 300 per cent operative mortality.²⁵ He constructs Liston as a man approaching the cusp of modernity, yet one who remained firmly rooted in the 'messy, bloody and traumatic' world of the pre-modern, an operator who prioritised skill over sympathy but who, because he washed his hands and wore a clean apron, somehow perceived, albeit dimly, the distant light of surgical redemption.²⁶ As with Williams, there is a clear moral to the story: 'If you need an operation, just be grateful that you are alive today and not 170 years ago – the next patient on Robert Liston's operating schedule'.²⁷

Liston also appears in the early pages of Lindsey Fitzharris' best-selling popular history of surgery, *The Butchering Art* (2017). Fitzharris' book is a good place to conclude this synopsis of surgical myth-making, not only because it constitutes the apotheosis of the literary genre, but also because it is functionally indistinguishable from the Listerian hagiographies of the early twentieth century, thus bringing us full circle. Fitzharris' book is a lively, if oddly truncated, biography of Joseph Lister that draws heavily, and uncritically, on earlier accounts written by his relatives, friends, and associates. As such, it recounts a tale of heroic individualism in which, as Christopher Lawrence notes, the 'mythic aspects of Lister's work' reach 'Arthurian dimensions'.²⁸ Like so much of its source material, Fitzharris' book glosses over the complexities of contemporary germ theory and avoids substantive reference to Lister's vociferous support for vivisection, or his vehement opposition to female medical education. It likewise presents the history of antiseptic surgery as a near-miraculous redemption from suffering. Pre-antiseptic and pre-anaesthetic surgery are, as ever, the straw man of history, an 'age of agony' in which 'savagery, sawing and gangrene' rule the day.²⁹ Fitzharris deploys the customary clichés about Liston, 'one of the profession's last great butchers', and even suggests that the social status of early nineteenth-century surgeons was so low that 'many were illiterate' and that they were viewed 'much like a key cutter or a plumber today', something that would, no doubt, have come as a surprise to Sir Astley Cooper, Sir Everard Home, or Sir Charles Bell.³⁰

²⁵ Richard Hollingham, *Blood and Guts: A History of Surgery* (New York: Thomas Dunne Books, 2008), pp. 41–2, 65.

²⁶ Hollingham, *Blood*, pp. 40, 42. ²⁷ Hollingham, *Blood*, p. 298.

²⁸ Christopher Lawrence, 'Blood and Guts: Victorian Achievements in Surgery', *Times Literary Supplement* (4 May 2018), 28–9.

²⁹ Lindsey Fitzharris, *The Butchering Art: Joseph Lister's Quest to Transform the Grisly World of Victorian Medicine* (London: Allen Lane, 2017), prologue. The line about 'savagery, sawing and gangrene' appears on the front flap of the dust jacket of this edition.

³⁰ Fitzharris, *Butchering*, pp. 9, 10, 18, 22. She does, however, acknowledge that the 'triple-knockout' story might be apocryphal.

The Butchering Art is a conventionally Whiggish tale of the triumphs of scientific modernity. But it is also part of a broader culture of contemporary popular history that mines the pre-anaesthetic past for gruesome stories and gory ‘thrills’. Indeed, the period even finds itself the subject of grisly humour, as evidenced by numerous blogs, podcasts, and the BBC television comedy series *Quacks* (2017). One cannot help but think that such ghoulish frisson motivates a not insignificant number of visitors to sites such as the Old Operating Theatre of St Thomas’ Hospital, or to the museums of the Royal Colleges of Surgeons in Edinburgh and London. Of course, public history is a vital, perhaps *the* vital, mechanism for enhancing our understanding of, and engagement with, the past, and museums in particular do an immensely valuable job in this regard. However, public preconceptions are hard to shift, especially when many popular histories tend to reiterate the myths of surgical modernity rather than challenge them.

A question could be posed as to why any of this matters. Why is it important that, within the popular mythology of scientific modernity, the pre-anaesthetic past seems destined to remain an age of ignorance, butchery, and brutality, dominated by caricature and cliché? Well, at the most obvious level, it matters historiographically, for such narratives present us with a flatly two-dimensional picture of surgery in the pre-anaesthetic period, one that diminishes that era’s emotional richness and complexity. It is not simply a question of refuting the idea that all early nineteenth-century surgeons were rough saw-bones or heartless butchers, any more than it is a matter of proposing that they were uniformly men of deep and heartfelt sensibility. Rather, by simplifying or stereotyping the place of emotions within pre-modern surgery, we miss the opportunity to explore the vitally important cultural and political work that emotions performed, in surgery as much as in any other area of human history. My experience with the Surgery & Emotion project has convinced me that the public are open to having their preconceptions challenged by new insights. I remember when, having delivered a paper on the place of emotions in the life and work of John and Charles Bell, a member of the audience told me that they had previously thought that all surgeons in the past were ignorant and cruel, or words to that effect. It was one of those moments that seemed almost calculated to answer the ‘impact agenda’ of modern historical research.

Yet there is, I would propose, even more at stake than this, for the myths that underwrite the narrative of surgical modernity not only condition public perceptions, but also sustain an emotional regime that continues to shape *surgical* practice and identity to this day. This book has presented something of a history in reverse. Whereas most conventional accounts of nineteenth-century surgery tell a story of unalloyed progress, a journey from darkness into light, this book has been concerned with the ways in which emotions

and emotional expression were marginalised within surgical culture. This is not to suggest that it is an anti-progressive narrative *per se*, for it would be ludicrous to claim that being a surgeon or a patient in the pre-anaesthetic era was, in any conceivable way, *better* than being a surgeon or a patient today. But it is, perhaps, a counterintuitive narrative, one that provokes us to think about what has been lost as much as what has been gained. As we have seen, emotions played an important role in early nineteenth-century surgery, in part because the practical conditions of that period meant there was more occasion for the experience and expression of such feelings as anxiety, dread, pity, and sympathy. But their presence in surgery also owed a great deal to the fact that the sensation and expression of feeling were valued within the cultural conventions of Romantic sensibility. By the same token, the relative decline in the importance of emotions within later nineteenth-century surgery, in terms of ontology, intersubjectivity, and reflexivity, derived from the fact that patients and surgeons were increasingly relieved of the emotional burdens of operative surgery, as well as from the fact that modern surgeons were shaping new professional identities that emphasised techno-scientific rationality and biopolitical authority over reflective introspection, affective engagement, or emotional self-fashioning.

As we saw Chapter 6, modern surgeons like Joseph Lister laid the groundwork for a professional surgical ideal in which claims to compassion were mediated through a scientific and intellectual authority, as well as through forms of social, cultural, and political prestige, that rendered them increasingly remote and ‘god-like’. These tendencies would only be exacerbated as the twentieth century progressed and as surgery, like medicine in general, became increasingly bound up with the political functions of the nation state. This was especially true of the United Kingdom, where, from 1948 onwards, the bulk of healthcare provision was assimilated into the state-run National Health Service (NHS), a body that, as much as it is threatened by the forces of neoliberalism, currently enjoys a mythic status within the British popular consciousness. And yet, however much the NHS may generate profound expressions of popular emotion, notably gratitude, and however much, like Lister’s patients, we may feel (or think we feel) the operations of a detached yet inherently compassionate largesse, the practice of surgery itself, in its idealised forms at least, is an emotions-free zone. Within contemporary surgical culture, emotions are generally seen as something dangerous, a contaminant of the professional persona and a threat to rational decision-making.³¹ Anthropological and medical studies have shown that surgeons, the vast

³¹ Jodi Halpern, *From Detached Concern to Empathy: Humanizing Medical Practice* (Oxford: Oxford University Press, 2001); Daniel Ofri, *What Doctors Feel: How Emotions Affect the Practice of Medicine* (Boston: Beacon Press, 2013).

majority of whom are male, tend to internalise a model of heroic individualism, seeing themselves as ‘problem-fixers’ rather than as caring for patients as whole human entities.³² And in so doing, they have little space, or cause, for intersubjective engagement or emotional introspection. The high-profile former cardiac surgeon Stephen Westaby may have framed his 2019 memoir *The Knife’s Edge: The Heart and Mind of a Cardiac Surgeon* largely in terms of emotions, but it is notable that, in a 2017 interview with the *Financial Times*, he claimed: ‘You’ve got to have the characteristics of a psychopath to make a good surgeon’.³³

It should be noted that Westaby’s fellow interviewee in this instance, the former neurosurgeon Henry Marsh, disagreed with his colleague’s assessment, claiming instead that ‘when surgeons talk about themselves as psychopaths, what they’re talking about is this awkward problem of how you are both compassionate and professionally detached at the same time’.³⁴ Psychopathy might seem an odd balance to strike between compassion and detachment, but even so, it is remarkable that two eminent surgeons should be talking about emotions at all, let alone making them the structuring device for their memoirs, as both Marsh and Westaby have done.³⁵ It could be argued that Marsh and Westaby, as retired, white, male consultants, are in a peculiarly privileged position to reflect on their careers with apparent emotional honesty, and that such licence is unlikely to be granted to more junior practitioners, or those of a different gender or ethnicity, especially in a profession where clinical detachment remains the norm. But in my work with the Surgery & Emotion project I have been struck by the extent to which surgeons, or a distinct sub-set of them at least, are increasingly prepared to talk about the place of emotions in their work. In my experience, this increased sensitivity to the importance of emotion is generally practitioner centred, focusing on such issues as stress, burnout,

³² Joan Cassell, ‘Dismembering the Image of God: Surgeons, Heroes, Wimps and Miracles’, *Anthropology Today* 2:2 (April 1986), 13–15; Pearl Katz, *The Scalpel’s Edge: The Culture of Surgeons* (Needham Heights, MA: Allyn & Bacon, 1999); Rachel Prentice, *Bodies in Formation: An Ethnography of Anatomy and Surgery Education* (Durham, NC: Duke University Press, 2013); Kim Peters and Michelle Ryan, ‘Machismo in Surgery Is Harming the Specialty’, *BMJ* 348 (2014), g3034, <https://doi.org/10.1136/bmj.g3034> (accessed 26/08/21); Kirsty Foster and Chris Roberts, ‘The Heroic and the Villainous: A Qualitative Study Characterising the Role Models That Shaped Senior Doctors’ Professional Identity’, *BMC Medical Education* 16:206 (2016), <https://bmcomeduc.biomedcentral.com/articles/10.1186/s12909-016-0731-0> (accessed 18/10/2021).

³³ *Financial Times* 8 September 2017, www.ft.com/content/d53f2422-9314-11e7-a9e6-11d2f0ebb7f0 (accessed 26/08/21).

³⁴ *Financial Times* 8 September 2017.

³⁵ Henry Marsh, *Do No Harm: Stories of Life, Death and Brain Surgery* (London: Weidenfeld & Nicolson, 2014); Stephen Westaby, *The Knife’s Edge: The Heart and Mind of a Cardiac Surgeon* (London: HarperCollins, 2019).

responses to grief, and relations with colleagues.³⁶ In general, it is less overtly concerned with the intersubjective emotional relations between surgeons and their patients and the ways in which better emotional interactions and more emotionally sensitive communication might improve healthcare outcomes. Many surgeons still tend to assume that *care* is a natural function of their work, rather than something that needs to be cultivated.³⁷

History, I would argue, has a vital role to play in this process of professional self-reflection. The persistence of emotional detachment as a professional ideal is the result of socialisation and education rather than the inherent nature of surgical practice.³⁸ Surgeons structure their emotional relationships with patients and with each other in ways that are expected of them, and these expectations are often predicated on historical assumptions about the way it has ‘always been’. Both the stereotypes of surgical modernity, with the surgeon as hyper-rational fixer of bodies, and those of surgical pre-modernity, with the surgeon as hardened butcher, sustain the idea that emotional detachment or dispassion is the timeless quality of the practitioner confronted by difficult decisions and emotionally challenging experiences. However, as this book has shown, this is not the way it has ‘always been’. Detachment is not the eternal emotional disposition of the surgical operator. Quite the contrary, in fact. At a time when surgery was perhaps at its most dangerous and challenging, in the decades immediately preceding the introduction of anaesthesia, surgeons shaped professional identities that placed emotions at the heart of the doctor–patient relationship and that took them seriously as a vital element in the regulation of health and well-being. Likewise, if the emotional regime of scientific modernity provides few spaces of ‘emotional refuge’ for surgeons to divest themselves of the onerous burden of professional responsibility and to ward off burnout or ‘compassion fatigue’ (short of resorting to psychopathy), then the relative emotional introspection and freedom of emotional expression experienced by Romantic surgeons confronted

³⁶ For example, see Uttam Shiralkar, *Surgeon Heal Thyself: Optimising Surgical Performance by Managing Stress* (Boca Raton, FL: CRC Press, 2017); A. Pinto, O. Faiz, C. Bicknell, and C. Vincent, ‘Surgical Complications and Their Implications for Surgeons’ Well-being’, *British Journal of Surgery*, 100:13 (2013), 1748–55; S. C. Zambrano, A. Chur-Hansen, and G. B. Crawford, ‘How Do Surgeons Experience and Cope with the Death and Dying of Their Patients? A Qualitative Study in the Context of Life-Limiting Illnesses’, *World Journal of Surgery*, 37:5 (2013), 935–4; M. Orri, A. Revah-Lévy, and O. Farges, ‘Surgeons’ Emotional Experience of Their Everyday Practice – a Qualitative Study’, *PLoS ONE*, 10:11 (2015), <https://doi.org/10.1371/journal.pone.0143763> (accessed 7/5/2022); Erin Dean, ‘Burnout and Surgeons’, *Bulletin* [Royal College of Surgeons of England] 101:4 (May 2019), 134–6.

³⁷ Much of the impetus to think about the role of emotions in improving care comes from non-professional bodies like the Point of Care Foundation: www.pointofcarefoundation.org.uk (accessed 26/08/21).

³⁸ Prentice, *Bodies*; Foster and Roberts, ‘Heroic’.

by equally profound challenges might provide an interesting counterpoint.³⁹ This is not to argue for a naïvely instrumentalist approach to medical history where, as in the early days of the discipline, the past functions as little more than a storehouse for professional instruction or inspiration.⁴⁰ As we have seen in this book, emotions also played a deeply political role in shaping the identity of an inchoate and aspirational professional body. And yet, the very existence of such an identity allows us to challenge both historical preconceptions and professional ones, and forces us to think not only about how we do history, but also about how we might do surgery.

³⁹ For the concept of ‘emotional refuge’, see William Reddy, *The Navigation of Feeling: A Framework for the History of Emotions* (Cambridge, UK: Cambridge University Press, 2001), pp. 128–9. For an excellent discussion of the concept of ‘compassion fatigue’, see Bertrand Taithe, ‘Compassion Fatigue: The Changing Nature of Humanitarian Emotions’, in Dolores Martín Moruno and Beatriz Pichel (eds), *Emotional Bodies: The Historical Performativity of Emotions* (Urbana: University of Illinois Press, 2019), 242–62.

⁴⁰ Elisabeth Fee and Theodore M. Brown, ‘Using Medical History to Shape a Profession: The Ideals of William Osler and Henry E. Sigerist’, in Frank Huisman and John Harley Warner (eds), *Locating Medical History: The Stories and Their Meanings* (Baltimore: Johns Hopkins University Press, 2004), 139–65.