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Pain, sympathy and the medical encounter between the mid eighteenth and the mid twentieth centuries

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Abstract

Witnessing people in pain inevitably elicits anxiety in physicians and other caregivers. Physicians are often required to inflict certain types of discomforts in order to alleviate other, more destructive, pains. Accusations that physicians lacked sympathy can be heard throughout the centuries. This article explores the diverse medical responses to such claims between the eighteenth and twentieth centuries. It interrogates changing definitions of clinical sympathy. The concept of sympathy was continually being reworked for each generation of medical professional. Crucially, in this reworking, philosophers (such as Adam Smith) and physicians came into dialogue. Cultures of sympathy were understood in both physiological and metaphorical terms, and were tied to changing notions of professionalization

Pain, observed surgeon René Leriche in 1939, is ‘like a storm ... the patient is beside himself, quite beyond all capability of analysing it, unless, on the contrary, he fixes his attention altogether on his suffering’. Taming this storm was a task fraught with anxiety for physicians as well as patients. Face to face with people writhing in agony, Leriche admitted that he felt intensely miserable. It ‘distressed’ him to be ‘powerless to understand’ the other person’s pain. He described being ‘impressed by something of great severity’ that he ‘would like to be able to alleviate’, but which was both incontrovertibly tangible and yet strangely amorphous. He portrayed surgeons like himself reaching out their hands to their patients, sympathetically touching the ‘region of pain’, only to be ‘surprised that you can feel nothing, and yet at times, by your touch, even exciting dreadful recurrent spasms of pain’. There was simply ‘nothing to be seen’. Even the most intimate knowledge of physiology paired with the liveliest imagination failed to provide clinical observers with a way out of the ‘abyss’ in which the other person languished.¹

Leriche’s *The Surgery of Pain* is a rare example of a surgical textbook that freely confesses to the feelings of despair and impotence experienced by surgeons encountering people in pain. His book was published after nearly a century of remarkable advances in analgesics and anaesthetics. Prior to 1846, surgeons conducted their work without the help of effective anaesthetics such as ether or chloroform. Surgeons and their patients depended on the blunt relief given by laudanum or alcohol. It was no wonder surgeons were required to be ‘men of iron ... and indomitable nerve’.² Even non-surgical treatments were inherently painful, involving blood-letting, emetics, laxatives, enemas and cautery using hot irons or corrosive substances such as sulphur, caustic soda or quicklime. And cure might still remain elusive. As poet Jane Winscom sarcastically remarked in ‘The Head-Ache, Or An Ode to Health’ (1795),

Ye sage Physicians, where’s your wonted skill?

In vain the blister, bolusses and pill ...

The lancet, leech, and cupping swell the train

Of useless efforts, which but give me pain.³

Many physicians and their patients even regarded such painful treatments as necessary if there was to be any hope of recovery. As the vice president of the American Medical Association pronounced in 1849, pain was ‘curative ... The actions of life are maintained by it’. Without ‘the stimulation induced by pain’, surgery would ‘more frequently be followed by dissolution’.⁴ The torturous pains of surgical operations were believed to be necessary to prevent haemorrhage. The deliberate infliction of painful treatments in order to alleviate (other) pains was at the heart of claims that physicians could only win plaudits for their healing skills by losing any fine-tuned susceptibility to sympathize. As one critic sneered in 1854, perhaps some physicians had even acquired a ‘taste for screams and groans’: might they be unable to ‘proceed agreeably in their operations without such a musical accompaniment’?⁵

Accusations that medical practitioners lacked sympathy or, at the very least, needed to be ‘hardened’ to other people’s pain in order to carry out their job were not limited to periods of history where effective analgesics or anaesthetics were unavailable, however. They were also not hurled exclusively at specific medical traditions (such as cautery, bloodletting or experimentation), nor could they be heard only in exceptional contexts (as in wartime, when supplies of analgesics might have run low). Contrary to the assumptions of many researchers in the medical humanities, such accusations did not emerge when narrative-based, domestic traditions of medicine (as in the eighteenth century) were overtaken by more ‘scientific’, hospital-oriented care. Rather, allegations about the insensitivity of medical practitioners were a constant theme throughout the centuries, intrinsic to the relationship between patients in pain and those attempting to alleviate the agonizing ‘storm’. Pain is both absolutely unique and infinitely shareable. The communication of pain – as in the urgent cry ‘It hurts, *here!*’ – is distressing for physicians. Through imagination and identification, observers of a person in pain ‘tremble and shudder at the thought of what he feels’, as Adam Smith put it.⁶ Whether intentionally or not, sufferers *inflict* this trembling and shuddering on their audiences. This article explores the frantic attempts by medical practitioners from the eighteenth century onwards to deal with their fears that pain represented (in the worlds of literary scholar Elaine Scarry in her influential book *The Body in Pain*) an ‘unmaking of the world’, not only of the patient, but also of physicians and surgeons.⁷ By insisting on the underlying humanity of their vocation, medical practitioners sought to reconfigure their worlds, both professionally and personally. The precise grounds for their defence, however, underwent important changes. The related concepts of clinical sympathy and empathy (which only emerged in the English language at the end of the nineteenth century) were constantly being resurrected and redefined for each generation. The ways these concepts have been employed expose important fault-lines in the relationship between medical practitioners and people in pain since the eighteenth century.

Complaints that medical trainees as well as qualified practitioners lacked sympathy – or were even outright sadistic – have been heard throughout the centuries, with many critics harking back to a golden period where a greater harmony of interests between physicians and patients was supposed to have flourished. In the seventeen-eighties, for instance, William Noland’s *An Essay on Humanity; Or a View of Abuses in Hospitals* castigated nurses and doctors for their lack of ‘sensibility’ and ‘compassionate attention’.⁸ Might the ‘inhumanity’ of physicians have been influenced by pecuniary factors? After all, Nolan went on, no patient could buy a state of *total* painlessness, but wealthier ones might be able to afford a physician with a sympathetic demeanour and a greater willingness to prescribe the most effective forms of pain relief. Patients languishing in charitable or public hospitals had no such options. In such institutions, tender-heartedness was in short supply. Nolan indicted these medical practitioners for not giving ‘unhappy patients’ the ‘consolation ... that the nature of their malady demands’. Worse: they actually practised ‘cruelty’. Hospital stewards displayed a total lack of sympathy for patients who, ‘in the acuteness of their pains’, were

‘guilty of the least vehement expressions’. Patients who failed to ‘maintain an equality of tempers in the extremity of pain’ were attacked for acting in an ‘intolerable’ manner, ‘and for no other human reason, than that perhaps their agonies are so!’ Surgeons were as bad as hospital stewards. Nolan scolded them for being too eager to amputate infected limbs, without considering the alternatives. ‘Surely’, he argued, ‘in a matter of such magnitude to human nature’, surgeons should pause before wielding their knives. This was particularly the case given ‘the horrible fears that anticipation [of amputation] unavoidably excites in the patient’s mind’ and the ‘excruciating pain’ of the actual operation. Unsympathetic conduct was incompatible with ‘the dignity of the gentleman, the sensibility of the man, or the profession of a surgeon’, but large sections of the medical profession were thoughtless in their treatment of patients experiencing pain.⁹

It was a theme that continued in later decades. Nineteenth-century physicians were as likely to be accused of emotional aloofness as their predecessors. In 1840, for instance, Thomas Turner informed young medical students attending the Royal School of Medicine and Surgery in Manchester that members of their profession were generally assumed to ‘have little sympathy for the sufferings of others’.¹⁰ Sir Henry Holland made a similar point. In his *Medical Notes and Reflections* (1857), he repeated the ‘just view of Aretæus’ that ‘although it is impossible for the physician to restore health to all who are sick’ (to think otherwise would be to raise physicians ‘above the Divinity’), yet his duty was to ‘procure freedom from pain’ for his patients. This principle of eradicating pain might seem ‘too familiar to need assertion’, Holland went on, but ‘there is reason to think that this principle is not duly inculcated as a precept in medical instruction’. He lamented that the ‘description of diseases according to nosological systems, and of conventional methods of cure, too often supersede those more general rules [to eradicate pain]’.¹¹ Crucially, this statement – indeed, the entire chapter ‘On Pain, as a Symptom of Disease’ – was absent in the first edition in 1839, suggesting that the advent of anaesthetics might have increased patients’ expectations of sympathy from their physicians.

Concerns about medical cruelty reached almost hysterical levels in the latter decades of the nineteenth century, largely as a consequence of public concern about the practice of vivisection (which was, in itself, a response to shifts in the discourse of sentience more widely).¹² It was self-evident to many critics of the medical profession that scientists trained in vivisection would develop a callous attitude towards other vulnerable life forms. Lesser humans, such as paupers, were at risk. In the poem ‘The Vivisector’, after the physician ‘mangles [the] living flesh’ of a dog, he

Then seeks the hospital,
An oft frequented place,
With knife in hand and knitted brow,
He scans each anguish’d face,
With hopes in some poor waif to find,
An ‘interesting case’!
No pity born of human love,
No sympathy with pain,
... But reader can you – *would* you call,
This *soulless* thing a *Man*?¹³

Within public hospitals, another critic complained, patients were being treated as though they were nothing more than living 'material'. In the midwifery department of a teaching hospital, he continued, there was a 'craving' among trainee doctors to be present during abnormal cases of women giving birth. Students expressed 'disgust ... if the process proceeded naturally'. This was the case even though

chloroform was only given exceptionally, [so] an abnormal and scientifically interesting case meant protracted agony to the patient. The students do not realise how cruel their wish was; they only yielded to a desire for increased knowledge in itself praiseworthy, and overlooked the fact that the patient was not merely what she was often called, 'teaching material' ... but a sentient, suffering, agonised, human creature.

Everything was subordinated to 'science, considered as an end in itself'.¹⁴

Finally, claims about the emotionally blunting impact of nosological systems, professionalization, medical training, experimentation and the relentless pursuit of scientific objectivity continued into the twentieth and early twenty-first centuries. At Harvard Medical School in 1927, Francis Peabody blamed hospitalization, the narrow curriculum in medical schools and the pace of medical practice for failing to nurture a caring attitude towards patients. He emphasized the need 'to extinguish' the 'smoldering [*sic*] distrust' of physicians.¹⁵ Nearly seventy years later, similar comments could still be heard. The authors of an article in the *British Medical Journal* blamed the problem on 'modern medicine', which rendered 'pathological tests and radiography ... speedier than allotting precious time extracting a detailed history from an inarticulate, frightened patient'. Their concern was undermined, however, when they went on to say that 'the lower the patient's social status the less likely is the physician to discuss *his case* with *them*', betraying an implication that the physician owns 'his case' and the patient is a passive, silent 'them'.¹⁶ The accusations continued into the twenty-first century, with Paul West observing that physicians regarded 'the rest of the race as a bunch of whiners'. He noted that

We are all familiar with the professional euphemisms of 'you'll feel a little push' and 'some pressure', after which pain electrifies your skull ... Elements of a secret society here mingle with an Inca-like disdain for the masses. Habitude has engendered hebetude; and familiarity, overfamiliarity.

People, he argued, 'hate the sufferer because we hate pain. So when your M.D. lets you languish and writhe, it is because he or she hates the pain you feel, therefore hates you'.¹⁷

Given the fact that medical practitioners almost always claimed to be inspired by compassionate instincts, as much if not more than the job's intellectual and pecuniary rewards, this long and deep tradition of hostility (or, at the very least, ambivalence) towards their motives is intriguing. As this article argues, practitioners responded to the defamations in ways that changed significantly over the centuries. In the eighteenth and early nineteenth centuries, their defence was framed in terms of an insistence on the gentlemanly sensibilities of physicians, with sympathy being a prominent trait. Crucially, this sympathy was believed to be innate, although not (as we shall see) universal. When this notion of sympathy disintegrated, the 'man of feeling' became the 'man of science', with empathetic detachment being the most appropriate way for physicians to express their humanity.

The insistence that eminent surgeons and physicians were sympathetic men – were, indeed, *gentlemen* – was crucial to the identity of medical practitioners, whether from the landed or professional elites. Sympathy was intrinsic to their identity as 'men of feeling', that is, men who were 'naturally' humane and capable of emotions of irresistible compassion for suffering humanity.

This concept of the ‘man of feeling’ was part of a much broader reworking of class and civilization in the early eighteenth century. It was linked to the cultivation of a new sensibility that emphasized sympathetic identification: increased respect for other people that would both forge and advance a sentimental sympathy for the human lot. Through the power of the imagination, people developed an innately moral, sympathetic disposition towards others.¹⁸ A range of philosophers enlarged upon the concept of sympathy, albeit all introducing different inflections. In *A Treatise of Human Nature* (1739), for instance, David Hume believed that there was ‘no quality of human nature’ that was ‘more remarkable, both in itself and in its consequences, than that propensity we have to sympathise with others, and to receive by communication their inclinations and sentiments, however different from, or even contrary to, our own’.¹⁹ Adam Smith followed on from Hume in his influential *The Theory of Moral Sentiments* (1759). Man may seem selfish, Smith observed in the book’s first sentence, but there were ‘some principles in his nature, which interest him in the fortune of others, and render their happiness necessary to him, though he derives nothing from it except the pleasure of seeing it’. Since people had ‘no immediate experience of what other men feel’, they could only form some idea of ‘the manner in which they are affected ... by conceiving what we ourselves should feel in the like situation’. Through acts of imagination, he went on,

we place ourselves in his situation, we conceive ourselves enduring all the same torments, we enter as it were into his body, and become in some measure the same person with him, and thence form some idea of his sensations, and even feel something which, though weaker in degree, is not altogether unlike them.

In this way, other people’s ‘agonies’ are made manifest, ‘and we then tremble and shudder at the thought of what he feels’.²⁰

Eighteenth-century medical thinkers quickly adopted this rhetoric, appealing to the notion of sympathy and situating it within the broader concept of sensibility. Furthermore, they conceived of sympathy as located within physiology; it was produced by the nervous system itself, both literally and metaphorically.

The blurring of the moral notion of sympathetic understanding with the physiological concept of the sympathetic nervous system was part of a mid eighteenth-century response to questions being raised about Descartes’s mechanistic model of pain. In ‘Meditations on First Philosophy’ (1641), Descartes insisted that ‘I have a body which is adversely affected when I feel pain’. He went on to say that

Nature teaches me by these sensations of pain ... that I am not only lodged in my body as a pilot in a vessel, but that I am very closely united to it, and so to speak so intermingled with it that I seem to compose with it one whole ... For all these sensations of hunger, thirst, pain etc. are in truth none other than certain confused modes of thought which are produced by the union and apparent intermingling of body and mind.

Despite Descartes’s attempts to show how body and mind ‘intermingled’, he became known for the Cartesian *distinction* between body and mind, arising largely from his famous image of the mechanism of pain (published in *Traité de l’homme*, twelve years after his death). In that image, fast-moving particles of fire rush up a nerve fibre in the foot towards the brain, activating animal spirits which then travel back down the nerves, causing the foot to move away from the flame. In this model, the body was a mechanism that worked ‘just as, pulling on one end of a cord, one simultaneously rings a bell which hangs at the opposite end’.²¹ This became the model of the body propagated by the founder of clinical teaching, Herman Boerhaave.

In the mid eighteenth century, however, influential physicians (mainly in Edinburgh) began challenging this mechanistic model. In particular, Robert Whytt in 'Observations on the Nature, Causes, and Cure of Those Disorders Which are Commonly Called Nervous, Hypochondriac, or Hysteric' (1768) introduced his famous 'sentient principle'. According to this principle, 'nerves are endued with feeling, and ... as there is a general sympathy which prevails through the whole system, so there is a particular and very remarkable *consent* between various parts of the body'. He marvelled at the 'sentient and sympathetic power of the nerves'.²² Every 'sensible part of the body' was in 'sympathy with the whole'. In other words, the body was interconnected; organs were mutually aware.

For physicians of the time, the notion that disease and health were the consequence of 'sympathy' within the body was profoundly productive. James Crawford, for example, made sympathy one of three causes of illness. 'Oftentimes', he claimed, 'the Effects [of disease] appear in one Place, when the Source or real Cause lies in another; for distinct and remote Parts communicating or consenting with one another by the Intervention of long Nerves and Muscles, a Part really whole and sound may be pained'.²³ According to yet another version, Seguin Henry Jackson in *A Treatise on Sympathy in Two Parts* (1781) distinguished between similar and dissimilar kinds of sympathy. In his words,

Sympathy is similar, when a part sympathizes, i.e. has any affection or action and another part, not apparently connected, has an affection or action similar to the other. We then say ... that the sympathizer has the same cause as the sympathant, which had produced the original affection or action.

In contrast, sympathy could be called dissimilar 'when the affection or action in the sympathizer is different to the affection or action in the sympathant'. To make the point clearer, he gave the following examples:

If you strain your ancle [*sic*], or suffer much from the dressing of a wound, either will produce sickness and vomiting. The affection of the ancle from the strain, or wound, is either a sensation, or an affection producing a sensation, to wit, pain, yet this sensation from affection produces action in the stomach, where no morbid condition of affection can be supposed to be then present.

However, he went on, 'Sometimes the action of affection of the sympathizer will be different from that of the sympathant'. For instance,

syncope has occasionally followed the voiding of costive faeces. Their labored expulsion is attended with a sensation producing action from *excitement*, yet this sensation causes an affection of the sensorium from *collapse*. Here, the head sympathizes with the rectum, tho' the two affections are dissimilar.

It was important for Jackson that the sympathetic body responded to *external* as well as internal impressions. When looking at a beautiful woman, a man's 'sympathy of impression' would become excited; when looking at a woman of 'good sense and understanding', his 'sympathy of consciousness' would respond.²⁴

Jackson's merging of sympathy internal to the body and sympathy external to it is crucial to understanding the role of sympathy in eighteenth-century medicine and relationships between physicians and patients. The sympathetic nervous system did not only operate within a person, but was a social system as well. Thus, Whytt claimed a 'still more wonderful sympathy between the nervous systems of different persons, whence various motions and morbid symptoms are often transferred from one to another, without any corporeal contact'.²⁵ Even 'doleful stories, or shocking sights' could bring on fainting or convulsions in 'delicate people'.²⁶ This was what *Encyclopaedia Britannica* alluded to when, in 1797, it defined sympathy as the

quality of being affected by the affection of another; and [it] may subsist either between different persons or bodies, or between different parts of the same body ... Sympathy ... relates to the operations of the affections of the mind, to the operations of the imagination, and to the affections of the external senses.²⁷

The sympathetic nervous system enabled communication not only between organs within a single person but also between people.

In his *Remarks on the Sympathetic Connection Existing Between the Body and Mind, Especially During Disease* (1836), John Walker Ord made the link even more directly. One kind of sympathy, he argued, was that which existed between different parts of the body, that is, 'the disease in one part causing irritation or pain in a part distant'. Another kind, however, was 'that kind which connects us with the actions of others'. These included not only the type of imitative sympathy involved in 'yawning, [and] laughing' (Jackson's 1781 treatise labelled such forms of sympathy 'imitative'): crucially, it also encompassed higher forms of social sympathy, such as 'feeling for the distress of others'.²⁸ He admitted that he did not know the 'causes of these feelings of sympathy', but 'it has been seen how indissolubly, the mind and the body are connected together, how wonderfully the one acts on the diseases of the other, and how peacefully and usefully, that which is immortal and divine, conjoins itself with that which is gross, earthly and sensual'.²⁹

From the middle of the century, then, the relationship between the sympathetic nervous system and the 'man of feeling' drew together. This is perhaps less surprising if we note that the philosophers and physicians developing these ideas moved in similar social and political circles. As historians Chris Lawrence and Catherine Packham have clearly demonstrated, these distinguished physicians were not only supported by landed elites but were also friends and colleagues of leading philosophers of the time, particularly in Edinburgh.³⁰ Many were members of the Edinburgh Philosophical Society, which had emerged from the Edinburgh Medical School and regularly debated issues of medicine alongside those of philosophy. Seguin Henry Jackson even admitted that, when he developed his theory of the sympathetic nervous system, he was drawing on 'the old language' of moral sympathy as used by philosophers: admittedly, he noted, there might be some objections to this usage but he decided to continue to deploy 'the old language, that I may not be misunderstood'.³¹ Although we might observe that this is a classic instance of science's use of metaphor in the development and exposition of new ideas,³² for Jackson the links between the moral category of sympathy and the sympathetic nervous system were not merely metaphorical: the body and the social system shared the same laws of Nature and were, in essence, self-governing.

For these thinkers, the physiological and the social were intimately entwined. This was not the case for later commentators, for whom social sympathy was only *metaphorically* linked to the nervous system and physical sensibility. Leslie Stephen referred explicitly to the metaphorical use of sympathy in *The Science of Ethics* (1882), for example. He began by stating that 'To think about other beings is to stimulate our sympathies' and this enables people to 'open their ears to lamentations which were once interpreted as idle sound'. He continued:

We may say that we think about other men by becoming other men. We appropriate provisionally their circumstances and emotions. Metaphysicians and mystics have expressed this by denying the ultimate validity of individuality, and by saying that in some transcendental sense a man is his neighbour, or that all men are manifestations of one indivisible substance.

He rejected this language – which was the language of vitalists – but accepted that ‘So far as I sympathise with you I annex your consciousness. I act as though my nerves could somehow be made continuous with yours in such a way that a blow which fell upon your frame would convey a sensation to my brain’.³³ The use of sympathy as affecting the nerves of onlookers remained intact, albeit only metaphorically.

Such metaphorical appeals to the sympathetic nervous system were prominent in a vast range of more popular literatures focusing on social sympathy, often drawing on an elaborate vocabulary of nerves, veins and the circulation of blood. For instance, the Reverend Andrew Stone wrote eloquently in 1861 about the ‘sympathetic sorrows’ that ‘fall across our hearts from the trouble of another, when we make that trouble our own’. He argued that such ‘knowledge of suffering and the sympathy it awakes’ enriches character: in this way, ‘new veins are struck that run down with golden seams into their ... unexplored depths’.³⁴ An article in *The Lady's Newspaper* in 1860 also paid homage, metaphorically, to the power of the sympathetic nervous system in alleviating the pain of neuralgia. In this article, an unnamed physician treated a ‘lady’ who complained of neuralgia, exacerbated by melancholy produced by suffering many years of unrelieved pain. He ‘advised her to seek out some fellow-being who was suffering more than herself’ and to ‘go forth daily for the purpose of administering aid and comfort’. The woman followed his prescription and, rapidly, her own symptoms vanished. The explanation for this miracle echoed eighteenth-century treatises on the sympathetic nervous system. In the physician’s words,

On each visit her nerves were thrilled by expressions of gratitude from the sufferer – her active emotions were startled into healthful exercise – her blood increased in circulation. Her chilly sensations ceased. She is now no longer in need of medical treatment.

The physician called this cure the ‘therapeutics of the New Testament’, but the restoration of his patient’s natural order could equally have been dubbed the ‘therapeutics of Sympathy’.³⁵

There were four main reasons for the shift of sympathy from the physiological to a metaphorical realm. The first reason was due to changing ideas about the body, with increased elaboration of the mechanisms of physiology. The (largely) Edinburgh-based physicians were always in conflict with their contemporaries in London, particularly members of the more conservative College of Physicians. Second, there was increased dismay over the ‘loose’ and unscientific way the term ‘sympathy’ was being used. Even Dugald Stewart registered his concerns over this in *The Philosophy of the Active and Moral Powers of Man* (1855). He complained that the ‘same word *sympathy* is applied in a loose and popular sense’, including everything from ‘the connexion which exists between different organs of the body, in respect of health, or of disease’ to ‘those contagious bodily affections which one person is apt to catch from another; such as yawning, stammering, squinting, sore eyes, and the disorders commonly distinguished by the name of Hysterical’. He admitted that ‘in all these different instances there is, no doubt, a certain degree of analogy’, but he warned against using the concept in ‘scientific discussion’ where ‘philosophical precision is aimed at’. Even that great ‘Systematic Moralist’, Adam Smith, was guilty of imprecision, he argued. The concept of ‘sympathy’, Stewart claimed, ‘appeared to Mr. Smith so important and so curiously connected, that he has been led to attempt an explanation, from this single principle, of all the phenomenon of moral perception’. This was a great mistake. Smith had been

misled ... by an excessive love of simplicity; mistaking a subordinate principle in our moral constitution ... for that Faculty which distinguishes Right from Wrong; and which (by what name soever we may choose to distinguish it) recurs on us

constantly, in all our ethical disquisitions [*sic*], as an ultimate fact in the nature of man.³⁶

The mechanism by which the sympathetic nervous systems of people 'intermingled' was not clear and increasingly seemed unscientific.

Third, concerns about the imprecise and unscientific usages of sympathy were exacerbated by its association with 'quackery', including mesmerism. Around the same time as Stewart's critique, for instance, Joseph Buchanan was explaining animal magnetism in 'sympathetic' terms. In his *Outlines of Lectures on the Neurological System of Anthropology*, he claimed that the

relief of pain and disease by the operations of animal magnetism, is mainly dependent upon the sympathetic relations between the operator and the subject. If the former be of vigorous health, he is continually elevating the subject to his own condition, and also receiving a morbid influence from his patient; in other words, an equilibrium is establishing between them. Hence operators generally suffer from the contact even more than they are aware, and patients are benefited in proportion to the character of the constitution with which they come into contact.³⁷

Misuses of the concept of the sympathetic nervous system were also common in other 'sciences' that many in the medical profession regarded as 'quackery', including homeopathy, phrenology, physiognomy, Perkinism, hypnosis, electro-biology, clairvoyance and spiritualism.

Finally, some commentators worried that sympathy was not necessarily benign. Of course, this had long been recognized but it took on a greater prominence after the French Revolution and widespread plebeian unrest in Britain. Through sympathy people might 'catch the contagion of [other people's] complex sentiments', but this might result in gaining 'a purely pleasant excitement from the narrative of others' suffering', concluded Henry Sidgwick in 1882.³⁸ While Shaftesbury, Hume, Smith and others had regarded sympathy as a moral force, later commentators either downgraded it to the 'imitative' forms or emphasized its ruder, 'contagious' forms in inciting mob action, for instance.

Being a 'man of feeling' was indistinguishable from being a man of high repute within eighteenth-century society. A culture of sympathy was assigned to physicians in their attempts to maintain their social status and improve their professional one. In 1784, for instance, James Moore (a member of the Surgeons of London) launched an attack against critics who claimed that physicians and surgeons possessed a 'want of feeling for the distresses of human nature' and might even be 'cruel'. Quite the contrary, Moore exclaimed, men who entered the profession were motivated by a desire to alleviate pain. If this was not the case, then 'men of benevolent dispositions' and 'even men of common humanity' would be deterred from taking up the profession, since 'the natural wish of the truly benevolent is, to cherish and cultivate, within their own breasts every sentiment and feeling of humanity'. It was those to whom 'distressing objects are less familiar' who were 'exceedingly apt to lose' their sense of humanity. Indeed, he continued, if the accusation that exposure to suffering diminished 'the sentiments of compassion in the breasts of the humane' were true, then

it would go to prove, that those people in general ... who make it a duty to visit prisons and hospitals, and search in the cells of poverty for proper objects for the exercise of compassion and charity, gradually become hard-hearted; while genuine sensibility dwells only in the breasts of those who fly from scenes of misery, shut their ears against the cry of anguish, and, at the accidental sight of every object of wretchedness, show no emotions but those of horror and disgust.

Of course, such an idea was 'so contrary to experience' that it was 'not worth the trouble of a refutation'. It was clear that surgeons were better at their task if they were compassionate.³⁹

Distinguished physician Worthington Hooker went even further. In *Physician and Patient* (1849), Hooker maintained that a doctor had to treat his patients as though they were family members or friends. He must feel sympathy 'in their seasons of suffering, anxiety, and affliction'. 'Familiarity with scenes of distress' would not make such a physician 'incapable of sympathizing with others', unless he was only viewing patients as a 'source of emolument'. The good physician would not do 'violence to his natural sympathies' but would allow his sympathy to 'flow out, as he goes forth on his daily errands of relief and mercy to high and low'. In this way, the physician's 'natural' sympathies would actually 'become more tender and active, instead of being blunted and repressed'. Of course, Hooker continued, the physician's sympathies were not 'mawkish sensibility which vents itself in tears, and sighs, and expressions of pity', but were 'active sympathy'. In Hooker's words, the good physician may appear

to have surrendered his humanity to the cold and stern demands of science. He may seem to be devoid of sympathy, as he goes to work midst scenes of suffering, without a tear, or even a sigh, performing his duties with an unblanched face, a cool and collected air, and a steady hand, while all around him are full of fear, and trembling, and pity. Yet there *is* sympathy in his bosom, but it is *active*.

As such, the physician's sensibilities became 'more deep and more tender'.⁴⁰

As is implied in Hooker's insistence that the physician's sympathies were not 'mawkish sensibility', this model of sympathy was coded 'masculine' and was increasingly infused with a mentality that was self-consciously rational and scientific. The 'insinuation that a compassionate and feeling heart' was 'commonly accompanied with a weak understanding and a feeble mind' was patently 'malignant and false', insisted John Gregory, author of *Lectures on the Duties and Qualifications of a Physician* (1772). Indeed, sympathy was one of the 'moral qualities peculiarly required in the character of a physician'.⁴¹ The author of *Lecture on Sympathy* (1907) made a similar point, deriding those who assumed that sympathy was 'a weak quality' that 'goes usually with a feeble character'. Admittedly, there were some 'weak characters who, chameleon-like seem to have no colour of their own, but to reflect the hues of those by whom they happen for the moment to be surrounded'. Drawing on the distinction made by physiologists between 'imitative' sympathy of the nervous system (such as that resulting in simultaneous laughing or yawning) and the higher forms of sympathy, the author insisted that the 'weak' form of social sympathy was 'not the sympathy of the human being; it is rather the imitative propensity of the ape'.⁴²

The sympathy that physicians possessed was neither feminine nor apeish: it was masculine. As late as 1925, in a speech at the Charing Cross Hospital Medical School, Sir Herbert Waterhouse warned students against sympathy that 'degenerate[d] into sentimentalism': sympathy had to be 'blended with firmness and decision'.⁴³ The peculiarly masculine quality of sympathy was also what Sir John Williams meant in his 1900 speech to medical students. Drawing on the idea that sympathy was contagious – albeit in a metaphorical way – he informed the students that it was not possible to do ward-rounds 'without becoming infected with the contagion of sympathy', but that sympathy was

not of that variety which evaporates in sentimental speeches on platforms and finds its reward in publicity. It is of more lasting stuff. It is not the sort which shows itself in cries of impotence in the presence of difficulties and flees from the presence of suffering. These serve but to strengthen it.

This was a virile, not impotent, sympathy. It was 'not of the frothy sentimental variety'. It was steadfast and masculine.⁴⁴

Accordingly, sympathy had to be actively protected against its feminine imitators. It was common knowledge (at least according to the physician to the Westminster General Dispensary in 1781) that women were 'most readily influenced by tender and sympathetic feelings'. Everyone knew, he claimed, that 'pregnant women, when they are witnesses to the pangs of labour in another woman, very commonly will complain of feeling these pains'. But, he claimed, this was nothing more than '*imitative sympathy*' – a distinctly lower branch of sympathy than the manly one possessed by medical practitioners.⁴⁵

'True' versus 'imitative' sympathetic systems were only one distinguishing feature. The allegedly innate character of human sympathy turned out to be less universal than implied as well. Although theories about sympathy were based on notions of a 'sympathetic' physiology or bodily sensitivity, it was taken for granted that lesser humans did not possess the same measure of bodily sympathy as did their superiors. In his pioneering article 'The nervous system and society in the Scottish enlightenment', Chris Lawrence has argued that

Through a theory of sensibility, physiology served to sanction the introduction of new economic and associated cultural forms by identifying the [Scottish] landed minority as the custodians of civilization, and therefore the natural governors, in a backward society. A related theory of sympathy expressed and moulded their social solidarity.⁴⁶

Lawrence is correct in drawing attention to the role that these physiological ideas played in nurturing a sense of social superiority and social cohesion among the Scottish elite. The sympathetic body belonged to elites. In *A Treatise of Human Nature* (1739), for example, Hume maintained that the 'skin, pores, muscles and nerves of the day-labourer' were 'different from those of a man of quality' and 'so are his sentiments, actions and manners. The different stations of life influence the whole fabric, external and internal'.⁴⁷ Or, as Adam Smith observed twenty years later, 'savages and barbarians' could not expect much sympathy from their comrades. 'Before we can feel much for others', Smith went on, 'we must in some measure be at ease ourselves'.⁴⁸

Other physicians and moralists agreed. John Gregory linked sympathy with imaginative faculties, noting that 'taste' was dependent upon 'the improvement of the powers of the Imagination'. However, the

advantages derived to Mankind from Taste ... are confined to a very small number. The servile condition of the bulk of Mankind requires constant labour for their daily subsistence. This of necessity deprives them of the means of improving the powers either of Imagination or Reason.⁴⁹

Seguin Henry Jackson, author of *A Treatise on Sympathy in Two Parts* (1781), discussed earlier, also insisted that the man most susceptible to the 'sympathy of impression' and 'sympathy of consciousness' was the one who was 'in perfect health and vigor, who lives well', in contrast to the man who was 'lean, starving'. In his words, 'unless the body is properly nourished', a person's mind would not be 'in full possession of all her powers, by which she is rendered susceptible of these stimuli'.⁵⁰ So when Adam Smith extolled the moral excellence of sympathy, in which the onlooker was able to 'enter as it were into his [the sufferer's] body, and become in some measure the same person with him', it was a move infused throughout with relations of superiority and inferiority, the powerful and the powerless. As literary critic Stephen Greenblatt put it, albeit in the context of the Renaissance, the 'imagined self-loss' of empathy in effect conceals its opposite: a ruthless displacement and absorption of the other. Empathy, as the German *Einfühlung* suggests, may

be a feeling of oneself into an object, but that object may have to be drained of its own substance before it will serve as an appropriate vessel.⁵¹

The restrictive nature of sympathy based on physiological sensitivity was further emphasized by scientists, physicians and philosophers interested in evolutionary principles. Their starting point was not the sympathetic nervous system as conceived of by their eighteenth-century predecessors, but was based on a notion of sympathy rooted in the body as imitative and instinctive. For them, sympathy was a biologically determined instinct that developed as the infant matured. Like earlier theorists, they also made a distinction between 'true' sympathy and mere impulsivity. Thus, according to Herbert Spencer in 'The comparative psychology of man' (1876), sympathetic feelings required a 'social environment for their development' and involved 'imaginings of consequences'. In contrast, impulsivity was characteristic of children and 'Bushmen'. It was nothing more than a simple 'reflex action', a fleeting emotion.⁵² Alexander Bain made a similar argument in 'Is there such a thing as pure malevolence?' (1883), tracing the rise of sympathy with that of civilization: primitive peoples take 'delight' in scenes of suffering.⁵³ In *The Science of Ethics* (1882), Leslie Stephen elaborated. In his words,

Much cruelty ... means simple insensibility. The defect of sympathy is also an intellectual defect. The child tormenting an insect or the savage abandoning his infant is simply not entering into the feelings of his victim ... Cruelty of this kind is therefore nothing but intellectual torpor, an incapacity for projecting oneself into the circumstances of others ... The dulness [*sic*] which incapacitates a boor for appreciating the feelings of the refined nature is so far a disqualification for all the more complex social activities.

The more civilized a people, the greater their sensibilities.⁵⁴

At a popular level, such hierarchical models of sympathy (whether understood physiologically or figuratively, or based on nervous or instinctual systems) had practical implications for those in the medical profession: they justified the superior status of some practitioners over others. For instance, in women's struggles to be admitted to medical school, the accusation that they were 'utter[ly] heartless and without pity or sense of care and gentleness' – they were not *gentlemen* – was as prominent as claims of intellectual incapacity.⁵⁵ Of course, class mattered. Women of 'higher' social class were assumed to be more 'sympathetic' as nurses than their working-class sisters. Thus, on 28 June 1902, *The Nursing Record and Hospital World* published an article entitled 'A question of "class"', which argued that 'the finer the organism the more acute the sensations'. This was why, the author explained, 'in the matter of pain', a 'well-born woman will more easily enter into the feelings of her patients than a woman who belongs to the lower orders'.⁵⁶ The hierarchical nature of models of sympathy also excused violence against denigrated groups. In the 'great chain of feeling', vast numbers of people were thought to lag significantly behind. Most obviously, 'Negroes', the 'uncivilized' and 'savages' lacked a sufficiently 'sympathetic' nervous system fully to feel pain.⁵⁷ The poor and manual labourers were also deficient in pain-sensitivity, as were 'imbeciles'.⁵⁸ Lacking a sufficiently 'sympathetic' physiology, these groups were less capable of feeling sympathy for others.

The accusation that physicians lacked sympathy or were at risk of becoming 'emotionally hardened' by their job was one that could be heard throughout the centuries. Physicians and other medical practitioners fought powerfully against this stigmatization: sometimes, on the grounds that they were gentlemen; at other times, on the grounds of their professional, scientific standing. Theirs was a benevolent and compassionate profession – this they all agreed upon. Time and again, physicians insisted on their sympathetic identification with those in pain: in the words of a doctor who trained in the nineteen-tens, they felt a

‘passionate sympathy for the sick’, had a ‘special urge to be able to do something for those in pain’, and could even ‘feel the hurt they felt’.⁵⁹

There was a problem, however. Faced with people in pain, what exactly constituted the correct ‘sympathetic manner’? This article will argue that there was a profound shift in how medical practitioners believed they could best achieve their benevolent objectives. The ‘men of feeling’ of the eighteenth century, who approached patients with hearts swollen with compassion (albeit infused also with a sense of superiority and power), embodied a different conception of what was the best way to display sympathy than that of the ‘men of science’ of later centuries. Increasingly, the perceived value of emotional closeness between physician and patient was disrupted. This is not to imply that physicians actually became less caring of their patients: rather, what changed were ideas about what constituted a sympathetic or caring comportment. In histories of clinical sympathy, the narrative-based manner of eighteenth-century physicians has been, first, generalized to apply to all relations between physicians and their patients in the past (as opposed to only *some* patients) and, second, valorized over the evidence-based, quantitative and technologically driven demeanour adopted by later physicians. Late twentieth-century assumptions about the value of narrative have meant that many historians have evaluated the more detached caring behaviours of ‘scientific’ practitioners negatively. However, just as the ‘men of feeling’ of the eighteenth century were highly dependent upon the articulate statements of their elite patients (rather than pauper ones), the narrative medicine promoted by many concerned commentators in the medical humanities was also infused with a particular class-based ideology that assumes that speech is redemptive. This emphasis on the centrality of narrative in the construction of identity emanates from a very narrow class base (that is, highly educated white professionals).

One of the central explanations for shifts in the theatre of clinical sympathy is related to the perceived value of affect in the healing process. Prior to the biomedical revolution of the late nineteenth and early twentieth centuries, sympathy was not only important because it was a sign of gentlemanliness and professionalism: in fact, the alleviation of pain itself depended upon a physician convincingly acting out his sympathy. In other words, prior to the development of effective drug regimes, the profound influence of the mind over the body was central to the alleviation of pain. John Gregory alluded to this effect in his *Lectures on the Duties and Qualifications of a Physician* (1772). He admitted that an ‘excess of sympathy’ by the physician might ‘cloud his understanding, depress his spirit, and prevent him from acting with that steadiness and vigour, upon which perhaps the life of his patient in a great measure depends’. Nevertheless, a high level of sympathy was an indispensable quality for a physician, since it ‘naturally engages the affection and confidence of a patient, which, in many cases, is of the utmost consequence to his recovery ... the patient feels his approach like that of a guardian angel ministering to his relief’.⁶⁰ As in the discussions about the sympathetic nervous system, Gregory made a distinction between ‘true’ sympathy (that is, deliberative, ‘natural’ and conscious) and the ‘imitative’ variety (such as when a physician mirrored the patient’s pain by becoming ill or ‘depressed’ himself).

Benjamin Rush also emphasized the importance of sympathy as a healing quality. In his 1805 lecture ‘On the utility of a knowledge of the faculties and operations of the human mind, to a physician’, he recalled returning to his childhood home to visit an old friend who was dying of typhus fever. On entering her room, he ‘caught her eye, and, with a cheerful tone of voice, said only “the eagle’s nest”’, a reference to a nest that they used to watch when children. The dying woman ‘seized my hand without being able to speak, and [I] discovered strong emotions of pleasure in her countenance, probably from a sudden association of all her early domestic connexions and enjoyments with the words I had uttered. From that time she began to recover’.⁶¹ For Rush, this was evidence of the effect of

the imagination on the body: the desperately ill woman was cured by recalling the happiness of her youth, reinforced by the fact that the words had been uttered 'from the mouth of one whom she had known then, and who had partaken with her of those early emotions'.⁶² In other words, the sympathetic connection between the dying woman and her physician-friend was curative. Rush went on to argue that not all physicians possessed this sympathetic trait: it was an attribute of men hailing from the more civilized ranks in society. He castigated 'members of the Medical Profession, especially in remote districts', who were

too often mere impudent pretenders, persons of no education or birth, and ignorant of the merest element of the philosophy of the mind, or how vastly useful it might be in all cases, to trace accurately the influence of the mind over bodily disease. They go coarsely to work like mere empirics and imposters, when they ought to probe deeper for the wound; and see that it is not the physical but the mental character.⁶³

Rush instructed the listener to gain knowledge of the 'faculties and operations of the mind in the study and practice of medicine' because this would 'teach him, that in feeling the pulse, inspecting the eyes and tongue, examining the state of the excretions, and afterwards prescribing according to their different conditions, he performs but half his duty in a sick room'. In order to cure, the physician must 'pry into the state of his patient's mind, and so regulate his conduct and conversation, as to aid the operation of his physical remedies'.⁶⁴ In other words, as Rush put it, knowledge about the mind was nothing less than a 'branch of physiology'.⁶⁵

However, the development of diagnostic classification systems and new medical technologies increasingly reduced the perceived importance of sympathy in alleviating pain. This was a long drawn-out process, beginning in the seventeenth century with Thomas Sydenham's classification of diseases and culminating in magnetic resonance imaging and C.T. scans in the twenty-first century. As Stanley Joel Reiser explained in 'Science, pedagogy, and the transformation of empathy in medicine', codification

elevat[ed] the pathognomonic above the idiosyncratic symptoms. The goal of evaluating illness has become the classification of people into delimited categories of diseases. Thus the symptoms that combine patients into populations have become more significant to physicians than the symptoms that separate patients as individuals.

This led to a 'growing detachment from the unique traits of their patients'⁶⁶ and a shift of emphasis from healing (a process involving interaction between patients and physicians) to treating (an action carried out by physicians *to* patients).

Technologies also encouraged physicians to bypass the emotional contagion that could characterize doctor-patient relationships. The invention of the stethoscope in 1819 redirected attention (in the words of Reiser) 'from a focus on the patient's experiences to a focus on the body's structures'.⁶⁷ The intimacy of pressing an ear against the sweaty or clammy skin of a person in pain was disrupted: the heartbeat could be heard, literally, from a distance. Technologies removed the 'inaccuracies and uncertainties' introduced by patients' subjective accounts.⁶⁸ Even more important was the vast array of chemical tests that were being introduced. This was illustrated by historian Joel Howell, based on his meticulous research using hospital case records in the New York City Hospital (940 records) and the Pennsylvania Hospital (1,622 records). In 1900, he found, few clinical tests were used, while within quarter of a century they were ubiquitous, routinely carried out on nearly all patients.⁶⁹ Microbiology, chemistry and physiology enabled physicians to bypass patient narratives in their search for an 'objective diagnosis'. These knowledges encouraged physicians to focus more on the disease than the patient, on 'cases' rather than 'suffering

people'. Patient narratives were not dismissed ('it hurts, *here!*'), but accurate diagnosis was increasingly perceived to take place far from the bedside.

The introduction of anaesthetics, to take another example, also promoted a certain kind of detachment. This was what James Miller was alluding to in *Surgical Experience of Chloroform* (1848) when he noted that, in the days before anaesthetics, '[medical] students, dressers, and even surgeons grew pale and sickened, and even fell, in witnessing operations' – not because of the 'mere sight of blood, or of wound' but 'from the manifestation of pain and agony emitted by the patient'. In contrast, he continued, after the invention of anaesthetics these medical practitioners were spared the need emotionally to engage (or, indeed, attempt to disengage) with patients since 'a snort is the worst sound' they made.⁷⁰ In the words of the author of *Painless Tooth-Extraction without Chloroform* (1854), with chloroform

The accustomed groans and shrieks of sufferers beneath the surgeons' knives and saws, were all hushed ... Like placid sleeping infants, smiling at some image in their dreams, men and women lost their useless limbs. The sting of surgery was plucked out. The sharpened steel and grating saw lost their cruel power. The surgeon's nerve was now all strung: calmly, deliberately, he could do his work among human tissue. Unimpeded by muscular contractions – unembarrassed by the sufferer's violent contortions – unharassed [*sic*] in his mind by the sensitive cries of woe, he pursued his manipulations as on breathless, lifeless forms.⁷¹

Valentine Mott, writing in *Pain and Anaesthetics* (1863), put an even more positive gloss on it, claiming that the

insensibility of the patient is a *great convenience to the surgeon*. How often, when operating in some deep, dark wound, along the course of some great vein, with thin walls, alternately distended and flaccid with the vital current – how often have I dreaded that some unfortunate struggle of the patient would deviate the knife a little from its proper course, and that I, who fain would be the deliverer should involuntarily become the executioner.

By silencing 'the shrieks and cries of the patient', the surgeon no longer needed to 'nerve himself to a very unpleasant task'. Surgery became 'slow dissection', a term generally used about corpses, not living patients.⁷² David Cheever put it bluntly in 'What has anaesthesia done for surgery?' (1897): as a result of anaesthetics, he observed, the surgeon 'need not hurry; he need not sympathize; he need not worry; he can calmly dissect, as on a dead body'.⁷³

Of course, technologies only operate within social contexts. The mores of scientific medicine were increasingly hostile to displays of emotion in medical practice, seeing them as working against scientific objectivity. While earlier medical practice paid great attention to what Thomas Smith Rowe in 1850 called the 'intermingled relational & mutual dependence existing between the mind & body' and their 'exquisite harmony', in the biomedical model, this intermingling acquired a pejorative connotation, as in 'psychosomatic'.⁷⁴ From the early twentieth century, a more detached kind of medical comportment was also being encouraged by medical education in universities and academic medical centres, with its 'time constraints, difficult patient populations, and acute-care orientation'.⁷⁵ Increased specialization fragmented the individual's body into specific organs and fluids; team work fractured individual responsibility and concern. Expensive training and an emphasis on specialisms encouraged physicians to assume that their training equipped them for interpreting test results rather than for engaging in face-to-face discussions with patients. It also seemed to make better economic sense. In contrast to literature addressed to (male) doctors, writings addressed to nurses were much more likely

to emphasize the need to 'put yourself in your patient's place, think how you would feel if you were afflicted as he or she is, or even as afflicted as they think they are'.⁷⁶ Sympathy – which eighteenth-century physicians had been keen to insist was a 'manly' sentiment – was feminized.

Sir William Osler famously captured the increasing need for physicians to practice detachment in his lecture to graduating medical students at the University of Pennsylvania at the start of the twentieth century. He advised the students that 'imperturbability' was an 'essential *bodily* virtue' and 'a blessing to the possessor'. Although some physicians ('owing to congenital defects', he lamented) may never acquire it, with education and practice many could attain this virtue. It made the patient confident and calmed their fears. In his words, a

certain measure of insensibility is not only an advantage, but a positive necessity in the exercise of calm judgment, and in carrying out delicate operations. Keen sensibility is doubtless a virtue of high order, when it does not interfere with steadiness of hand or coolness of nerve; but for the practitioner in his working-day world, a callousness which thinks only of the good to be effected, and goes ahead regardless of smaller considerations, is the preferable quality.⁷⁷

This was a far cry from his predecessors in the previous century who lauded the cult of sensibility.

According to his biographer, Osler 'wasted no time when seeing patients, and he intensely disliked having to listen to their irrelevant reminiscences'.⁷⁸ However, this did not require a rejection of sympathetic identification. 'Imperturbability' did not result in physicians jettisoning personal concerns for the emotional lives of patients. In the inter-war years, concern about patients and their stories was encouraged by the rising popularity among elite British, American and European clinicians of holistic medicine. Chris Lawrence described the movement as giving

conditional approval of laboratory-generated knowledge, a celebration of bedside diagnostic skills, a cautious attitude to instrumentation, and the holding of specialization in disdain ... Observation at the bedside was a form of natural history that could generate medical knowledge of a unique and most valuable kind.⁷⁹

Articles with titles such as 'The art of medicine' (1923) lamented the fact that

too little do we teach that the patient is not made up alone of tissue structures but is a personality functioning in a given environment. Too often, hospital, outpatient and even office practice becomes a mere routine, and the attending physician fails to remember that every case represents a human heart, crushed to the point of despair by sickness and resultant poverty.

The author issued a hearty plea for a return to the 'art' of medicine.⁸⁰ As Francis Peabody told students at the Harvard Medical School in 1927, the 'art of medicine and the science of medicine' were 'not antagonistic but supplementary to each other'. Indeed, treating the whole person was crucial if the patient was to be cured. To illustrate his point, Peabody conjured up a patient called 'Henry Jones' who had been diagnosed with mitral stenosis. 'The disease is treated', Peabody conceded,

but Henry Jones, lying awake nights while he worries about his wife and children, represents a problem that is much more complex than the pathologic physiology of mitral stenosis, and he is apt to improve very slowly unless a discerning intern

happens to discover why it is that even large doses of digitalis fail to slow his heart beat.

Any doctor who ignores emotional factors 'is as unscientific as the investigator who neglects to control all the conditions that may affect his experiment'.⁸¹

René Leriche's *The Surgery of Pain* (1939), which introduced this article, was perhaps one of the most eloquent pleas to the diagnostic and healing power of listening to patients. In one of many charming vignettes, he mentioned a friend who carried out a gastrectomy under local anaesthetic. At one point in the operation, the patient began complaining and 'at each thrust of the needle, he moaned'. Annoyed, the surgeon said, 'I can't possibly be hurting you with what I am doing'. The patient simply replied, 'Which nevertheless does not prevent me from feeling pain'. For Leriche, this was a telling message: by listening to patients when they complained of pain, surgeons would be forced to change their opinions about the insensibility of the viscera. He acknowledged that patient reports of pain might be 'long and tedious' and the patient 'nearly always appear to us to enlarge too complacently on the mosaic details of his subjective sensations' while physicians wanted to 'go straight to the facts'. But 'much may be learned by listening more attentively to our patients'. He continued:

There are, in fact, both in disease and in the patient, many more things than we generally realise. There are, first of all, many secondary functional disorders which may be full of meaning; for the least serious kind of disease may have wider repercussions in us than we are aware; and, quite apart from the cause of the disease, there is also the part played by temperament in its production ... We ought, therefore, all the more to try to study the sick man and his disease at one and the same time.

Only by listening carefully to the patient could a physician 'succeed in discovering the individual in the disease'. He castigated the field of medicine for being too quick to 'despise the subjective'.⁸²

It is wrong, however, to see the 'holistic' perspective of these practitioners in total contrast to the more aloof comportment of physicians who emphasized 'detached concern'. In fact, Francis Peabody claimed that 'the establishment of an intimate personal relationship' between physicians and patient was crucial in the healing process; that paying attention to emotions was a truly 'scientific' practice; that 'emotional vomiting is just as real as the vomiting due to phloric obstruction'; and that the 'personal bond' provides 'the greatest satisfaction in the practice of medicine'.⁸³ Charles Aring's article in the *Journal of the American Medical Association* in 1958 was equally concerned with promoting professional empathy. Admittedly, he had a negative view about what he called 'sympathy', regarding it as unconstructive and moralistic ('people called malingerers are still people, and it is our duty to find out why and what might be done towards remedy, and nothing more'). Sympathy also risked confusing the physician's problems with those of the patient. However, Aring insisted that the good physician should practise empathy, or 'feeling into' the pains of other people, while retaining a respectful 'awareness of one's separateness from the observed'. An attitude of 'reticence' or 'withdrawal' was detrimental to the relationship. While avoiding getting caught up in the 'enervating morass of the patient's problems', the effective physician had to draw upon 'the richness of one's own emotional experiences', including 'intuition'. It is 'hardly possible to overstate the importance of the uses of empathy in the practice of medicine', he insisted.⁸⁴

This was also what psychiatrist Harold Leif and sociologist Renée Fox meant in their 'Training for "detached concern" in medical students' (1963), another work denigrated by

Halpern. The first part of their definition of empathy was not surprising. It involved ‘an emotional understanding of the patient, “feeling into” and being on the same “affective wave length” as the patient’. However, they then went on to state that ‘at the same time’, empathy

connotes an awareness of enough separateness from the patient so that expert medical skills can be rationally applied to the patient’s problems. The empathetic physician is sufficiently detached or objective in his attitude toward the patient to exercise sound medical judgment and keep his equanimity, yet he also has enough concern for the patient to give him sensitive, understanding care.

Getting the balance right required most students to acquire ‘more detachment and less concern’.⁸⁵

The crucial requirement, then, was ‘balance’. In other words, as students and faculty of the Harvard Medical School were informed in 1964, ‘caring for the patient’ required knowledges taken from *both* the science and art of medicine. In this lecture, Hermann Blumgart disputed the view that the ‘milk of human kindness’ had been ‘curdled by molecular biology’. If sympathy for the patient was defined as ‘entering into and sharing the feelings of another’, it was not constructive: ‘To do so involves a loss of objectivity and perspective and leads to “feedback” mechanisms that may serve to aggravate the fears, the sorrows and the perplexities of the patient’. Physicians must practice ‘equanimity’. Rather, he advocated ‘compassionate detachment’, which included ‘emotional appreciation of the patient’s feelings without becoming engulfed by them’. It was all a matter of entering ‘Into the feelings of one’s patient without losing an awareness of one’s own separateness. *Appreciation* of another’s feelings and his problems is quite different from *joining* in them and is different from *ignoring* them’. Blumgart was firm in the belief that recovery was dependent on emotional as well as physical factors, so doctors must be ‘equally concerned’ with patients ‘as persons’. The patient ‘transfers’ her anxieties onto the shoulders of doctors. As a ‘wise clinician’ advised him: ‘Listen to the patient’s story – he is telling you the diagnosis’.⁸⁶

Training medical students in ‘detached concern’, in other words, was not seen as a substitute for sympathy, but was rather the *prerequisite* for true ‘concern’. Like the ‘men of feeling’ of the eighteenth century, with their carefully honed sympathetic attention to the needs of their elite patients, the ‘men of science’ of the twentieth century were required to express sympathy for patients by judiciously balancing emotional engagement (without which it would be impossible correctly to identify what needed to be done to help the patient) and a scientific demeanour (which would encourage the confidence of patients, and thus serve to hasten the healing process). This is not to romanticize the caring strategies of either the eighteenth-, nineteenth- or mid twentieth-century physicians. Callow, idealistic young medical students in all periods had to be exposed to the bloody practicalities of medicine and surgery if they were to turn into ‘men of feeling’ and ‘men of science’: this took place as effectively in the earlier period in the ‘theatres’ of surgery as it did in the later period in the large public hospitals.⁸⁷ The ‘sympathy’ of eighteenth-century physicians was as infused with power relations as was the detached concern of the latter period: in both cases, ‘caring’ was applied more easily towards some people in pain than others.

In the nineteen-thirties, Leriche depicted pain as being ‘like a storm’, pitching both patients and their physicians into an ‘abyss’ of distress. Medical practitioners, desperate to tame the tempest, found that even their lightest touch might simply provoke yet more ‘dreadful recurrent spasms of pain’.⁸⁸ It was thus doubly distressing for practitioners like Leriche that, despite their profound desire to alleviate suffering, a ‘smoldering distrust’ of physicians reverberated throughout the centuries.⁸⁹ Elite physicians in the eighteenth century sought to rebut suggestions of insensitivity by emphasizing their innate sensibilities, of which

sympathy for people in pain came naturally. Later practitioners recognized that the healing art was also a science, and that emotions had to be harnessed within a different milieu if they were to be effective. In each instance, however, there was a limited economy of sympathy. In medical encounters, sympathy always involved the enactment of inequality, either because hierarchies were built into the concept (as in the idea that different persons possessed varying degrees of innate sensibility and thus responded with greater or lesser sympathetic identification), or were simply assumed for reasons that concerned the differential social and scientific positioning of the protagonists. As later commentators recognized, even the word 'empathy' was problematic. As a translation of the German word *Einfühlung*, it was first used in English in 1909 in the context of art criticism, rather than human-to-human interactions. In the words of Saul Weiner and Simon Auster in the *Yale Journal of Biology and Medicine*,

It is one thing to 'feel into' an inanimate work of art – in the original meaning of empathy – where no direct information is available and error (if such a concept could apply) would have no more significance than perhaps a diminished appreciation of the work. It is an entirely different matter to think one is experiencing or feeling what another is experiencing or feeling; that is an ungrounded assumption, and ungrounded assumptions can lead to error, compromising patient care.⁹⁰

Sympathy 'produces the very inequalities it decries and seeks to bridge', as Amit Rai correctly observed in *Rule of Sympathy*.⁹¹

Despite these problems, the need to insist on the finely-honed sensitivities of physicians has been a constant theme. In each generation prominent physicians reiterated time and again the need to pay attention to patient narratives of pain: even in the highly specialized context of modern medicine, at crucial stages physicians appeal to 'the importance of telling and listening to the stories of illness', in the words of the author of an article in the *Journal of the American Medical Association* in 2011.⁹² The great eighteenth-century anatomist, William Hunter, identified the chief dilemma. In his *Two Introductory Lectures*, published after his death, he argued that dissection (or, as he put it more vividly, 'the use of cutting instruments upon our fellow-creatures') 'informs the *head*, gives dexterity to the *hand*, and familiarizes the *heart* with a sort of necessary Inhumanity'.⁹³ The strategies for dealing with the incommensurate worlds of the physician and the person in pain changed over time, while the fundamental desire to alleviate suffering remained at the core of medical identities.

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