



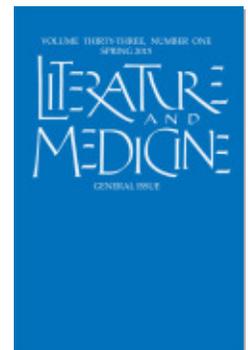
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Literature and Medicine, Volume 32, Number 1, Spring 2014, pp. 105-132
(Article)

Published by Johns Hopkins University Press
DOI: [10.1353/lm.2014.0004](https://doi.org/10.1353/lm.2014.0004)



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“Let Me Die in Your House”: Cardiac Distress and Sympathy in Nineteenth- Century British Medicine

Meegan Kennedy

I happened to answer the door myself, as all my domestics were out looking at some public spectacle. [The man there] appeared to me to be actuated by great terror; and upon my asking him what was the matter, he said, “I have called upon you to request you would let me in, and allow me to die in your house.”¹

This episode, published in 1854, evokes the suspense of a novel by Wilkie Collins or Mary Elizabeth Braddon, where an ordinary protagonist is drawn into some intricate, horrifying plot. We identify with the quotidian narrator, and we shudder with curiosity over the dark story of the mysterious, terrified stranger. However, this scene occurs not in a sensation fiction novel but in William Stokes’s medical treatise on the diseases of the heart; and it describes not a scene of pursuit but the effects of over-imbibing green tea.

How can we account for this singular presentation of a common symptomatology? This essay examines the prevalence of romantic discourse—that usually associated with the genre of romance—in published treatises on heart disease. Both the case histories of individual patients and, more surprisingly, the generic descriptions of disease types presented in these treatises frequently call upon discursive strategies that were traditionally associated with romantic fiction.

I have argued elsewhere that modern British medical and literary authors share three diverse approaches to their challenges of truthful observation and representation: curious “sight” or spectacle, realist observation, and human insight.² During the nineteenth century, a realist narrative of observation becomes a mark of scientific progress

and literary ambition. However, physician authors do not entirely abandon "curious" narratives characterized by affecting sights and romantic discourse. This essay focuses on the published case histories of nineteenth-century British heart patients and argues that these display an increased frequency of three curious elements: sensationalism (exaggerated, dramatic, and shocking events and language), sentimentalism (pathos and melancholy), and imagined experience, where the narrator projects himself imaginatively into the lived experience of his subject. Because these strategies invite an answering emotion from the physician, and implicitly from the reader as well, we might consider them all as sympathetic prose. That responding emotion is, I should stress, not necessarily pity (it might equally be horror). Regardless, the text solicits a common feeling or "feeling along with"—in this case, a "distress"—that strives to bridge the gap separating individuals' bodily experience and asserts the common humanity of these actors as joint participants in the human drama.

Realism and Romance

The case histories I examine here necessarily refer to the project of Victorian realism, which had both literary and scientific manifestations. Both realism and romance had developed conventions governing both the style and the subject matter of a text. The most salient characteristics of realism for my study include a record of the quotidian rather than the extraordinary; an empiricist commitment to the details of experience; a concern with accuracy, precision, reliability, and verisimilitude in representation; an ideal of plain speech; a goal of transparency and reduced mediation; a disinterested stance; and a skeptical, deflationary approach. Physicians came to endorse a medical realism produced by a particular, clinical discourse. This was marked by methodical practice, detailed and accurate (if possible quantified) observation, formal syntax, specialized terminology, an interest in typicality and the establishment of normative categories, and a dispassionate tone declaring a distanced, objective relation to the patient.³ Clinical discourse is associated with the rise of clinical medicine, but—as this essay demonstrates—cases from this period display a range of discursive approaches beyond the clinical, including techniques commonly found in romance.

I use the protean term "romance" here to describe a set of narrative strategies generally set in opposition to realism; the term when describing this literary mode does not refer to the Romantic era but

is instead related to the medieval romance tradition. By the nineteenth century, romances typically demonstrated an interest in unusual actors, settings, and events; a fascination with extremes, the exotic, and the extraordinary, including an exaggerated, emotive, archaic, or ornate style; and a florid expression and solicitation of affect through a sentimental, sensational, or melodramatic discourse.⁴ If romance inflates what it sees, realism, valuing a detached skepticism, seeks to deflate those claims.

Although nineteenth-century medical writers—many literary ones too—considered realism to be superior to, in part because of its rejection of, romantic writing, I am not proposing this kind of hierarchy or purity, even if it were possible. In fact, most nineteenth-century texts, fictional and nonfictional, draw upon both realist and romantic strategies. One mode may predominate depending on context, audience, and other demands; but an author will often turn momentarily to another discursive strategy. Even classic literary realism flirts with romance: consider Elizabeth Gaskell's too-pure, eponymous *Ruth* or the improbable, dramatic conclusions of George Eliot's *Adam Bede* or *Mill on the Floss*. Victorian physicians and novelists share textual strategies under different disciplinary pressures. Attention to these tensions productively complicates our view of the power relations written by and through the medical clinic and engenders a more versatile understanding of genre, as strategic, situational, momentary, and historically contingent. Any text's generic identity is formed in a complex negotiation between the demands of generic tradition, publication context, author, audience, and subject matter. Moreover, the case history requires work across disciplinary boundaries: physicians must be historians as well as clinicians. Finally, the nineteenth-century explosion of print publication meant that physicians and novelists often read and wrote in the same pages.

Thus, while we privilege the physician's rhetorical authority, his text is constructed and consumed under circumstances that challenge a notion of genre as pure or stable. As a result, nineteenth-century case histories reflect their authors' familiarity with a range of generic models, including romantic genres familiar to us from novels, such as sentimental romance, Gothic fiction, the sensation novel, imperial romance, and scientific romance. Each genre has a history that associates it with a particular context, expected audience, plot trajectory, discursive range, tone, and style. Physicians drew upon such generic models to help them negotiate particular strains in their narrative, even in professional contexts.

Romantic Medicine and Interesting Cases

When physicians campaigned for clinical observation and the straightforward, detached, objective, and professional discourse that served as their realist aesthetic, they explicitly rejected some of the more romantic aspects of the medical past, such as eighteenth-century medicine's curious sights and their affective expression in print. Although nineteenth-century case histories still invoke a curious sight to describe rare or spectacular cases, they often turn to the euphemism "interesting," which moderates the romantic appeal of what earlier they would have termed frankly "curious." "Interesting" can mean "worthy of further study," but it can also mean something like "calling forth the emotion (especially the pity and sympathy) of observers." A scene described as "interesting" in sentimental fiction is likely to evoke the narrator's (and reader's) sympathetic identification with the sufferer—exactly what the clinical observer should avoid. The term substitutes for—and to some extent obscures—the sentimental strand of romantic medicine, but it does not eradicate it; in fact, the term "interesting" enables the perpetuation of these affective cues by shielding them under a more professional rubric. It thus complicates the physician-author's claim to a disinterested objectivity even as the term signals the shift to that objectivity. An "interesting" discourse often draws upon conventional romantic characters and plots, and it most often appears in difficult cases as a supplement, not a challenge, to clinical observation. "Interesting" discourse may continue to be useful to physician-authors in the age of clinical medicine because it allows them to tap into a familiar narrative when negotiating the rhetorical challenges of an affecting case. Once germ theory provided an alternate, powerful explanatory narrative for many fatal cases, "interesting" discourse sharply diminished.

In nineteenth-century British medicine, an "interesting" discourse typically combines exaggeration with an emotional appeal to affective response. It foregrounds what is most romantic about the case, which might be rare, extreme, exotic, sexual, pathetic, fatal, or challenging. The case might be unusual (a "zebra") or it might consider exaggerated aspects of otherwise common elements (extreme pain, body temperature, tumor size); the case might derive from an exotic context, often with an Orientalizing frame, or discuss the process of generation; it might depict pathetic subjects such as sick children or young women, or any dying patient; it might indicate the limits of medical knowledge and practice. Cases that combine these triggers, such as puerperal fever, are

most likely to challenge professional competency and to draw upon the strategies of an interesting discourse.⁵

Scholars such as Jane Thrailkill and Jill Matus have demonstrated how nineteenth-century obstetrics and psychology sometimes use nonclinical language. These medical fields may tolerate such language due to their special status, associated as they are with sexuality and the privileged site of maternity or with the seat of the mind and emotions. However, we also find an “interesting” romantic discourse in nineteenth-century British cardiology, for the study of the human heart also held special status.⁶ The medicine of the heart retained—as Kirstie Blair and Fay Bound Alberti have shown—a unique significance, given the heart’s identity as the seat of the passions and an exquisitely sensitive nervous organ. The complex mix of affecting symptomatology in cardiac medicine also probably encouraged the discursive hybridity that characterizes nineteenth-century commentators’ imaginative, sympathetic presentations of heart disease.

British cardiac case histories during these professionalizing decades foreground a variant of “interesting” discourse characterized by the term “distressing.” These cases repeatedly use the ambiguous term “distress” to describe the symptoms of heart disorders. For example, Thomas Davies explains in 1835, “I have seen instances of sudden death occurring in the midst of the most agonizing distress.”⁷ Walter Walshe notes of syncope, “The sensations are, on the whole, painful and distressing.”⁸ O’Byren Bellingham says of angina in 1853, “I cannot ... imagine any state more likely to be attended by intense distress, anxiety, and suffering” and notes the “distressing feeling of oppression” in dyspnoea.⁹ At the end of the century, W. H. Broadbent remarks, “When [the dropsical patient] speaks it is in fragmentary sentences, and with evident effort and aggravation of the respiratory distress.... One of the most distressing symptoms is sleeplessness, and when, after hours of weary shifting of position, the sufferer is overcome by fatigue and drops off, he has painful dreams, and wakes suddenly in affright and suffocation.”¹⁰ Similarly, James Little (1894) notes, “Restlessness, breathlessness at night, and sleeplessness are symptoms which at times inconceivably distress the subjects of chronic heart disease.... [Patients] dread to fall asleep.”¹¹ Again, “Mr. W. ... [upon kneeling at church] felt such distress about his heart that he was obliged to leave the building.... He had a distressing consciousness of heart-beat.... He had distressing fluttering and trembling of the heart.”¹²

These case histories use the term “distress” or “distressing” to denote physical suffering, but the term also acknowledges an affective

state. "Distress" can describe numerous symptoms of heart disease, primarily pain of various sorts, dyspnoea ("air-hunger"), and the anxiety and fear of feeling death is near. Physician-authors seem especially likely to use this term when the case elicits interesting discourse, especially sensationalism (where "distress" suggests suspense, fear, disgust, shock, or horror) or sentimentalism (where "distress" signals anxiety, pity, regret, poignancy, sorrow, or pathos).

Many cases describing the patient's distress also document the physician-author's imaginative projection into his patient's experience. This sympathetic bridge could be depicted in either romantic or realist discourse. Literary authors like George Eliot argued that sympathy was necessary in classic realism, but it had usually been considered an unwelcome complication in the disinterested, clinical realism that nineteenth-century physicians increasingly valued. Blair, for example, discusses the stethoscope as part of a trend in nineteenth-century medicine in which "the possibility of affective communication between doctor and patient is denied" in part through the material intervention of technology connecting but also dividing them.¹³ That shift toward a detached, realist narrative mode in medical recordkeeping has come increasingly under scrutiny. Kathryn Montgomery Hunter differentiates the patient's subjective account of illness from the physician's narrative, which aims to be "strictly ordered ... narrowly descriptive and toneless in order to sort out the patient's subjective report of discomfort ... from the physician's more objective view of the case."¹⁴ She continues, "This flatness aids the emotional detachment felt necessary to the continued ... care of the ill," but argues that physicians need to recognize the narrative structures of their work.

Recently, medical humanists have been arguing that empathy is a useful tool within the clinical encounter, but many define it as a cognitive, not affective, response: the observer does not share the patient's feelings.¹⁵ Rae Greiner, a literary scholar, similarly argues that Victorian "sympathy and feeling are not the same," and that "sympathy is an operation of mind, fundamentally a cognitive process [that] usually results in feeling but is not equivalent to it."¹⁶ Jodi Halpern, however, counters, "If the physician relies strictly on detached observation ... she will miss important features of the patient's individual experience."¹⁷ Instead, she argues, "empathy requires experiential, not just theoretical, knowing, [wherein] the physician experiences emotional shifts while listening to the patient."¹⁸ These case histories demonstrate how nineteenth-century British physicians narrativized their sympathy and distress during a period we associate with the distancing of the

patient-physician relationship. These physicians experience emotional shifts in response to patient suffering and record those shifts using a romantic discourse traditionally used to express and solicit affective response—even as they honed new diagnostic technologies that increased objectification of the patient. In short, during the same decades when clinical medicine, the clinical case history, and the dispassionate mode of realism were established as the professional norm, British treatises on heart disease provided a site where the romantic language of distress conveyed patient suffering in a way that declared the physician-author to be at once detached from and connected to his patient.

Sensation

The renowned Peter “Heart” Latham begins his 1846 treatise on the heart by commenting, “Observation has traced back, with fearful fidelity, a long line of formidable and fatal diseases to their pathological parentage in the heart.”¹⁹ The parade of alliterative elements frames cardiac disease as a horrific juggernaut of human suffering and death. With romantic descriptors like “fearful ... formidable ... fatal,” the phrase a “pathological parentage” echoes Gothic family romances by Horace Walpole, Ann Radcliffe, James Hogg, and the Brontës, where the monstrous sins of the past haunt the present.

Such sensational rhetoric is not uncommon in nineteenth-century case histories of heart disorders. The case in my epigraph (the man in “great terror” wishing to “die in your house”), related by Stokes, is no outlier. We also find John Williams (1852) musing on the “terrible cause of this tumult” or Robert Semple (1875) on “an infinity of suffering.”²⁰ Arthur Sansom (1876) warns that the pain of angina pectoris is “of terrible significance,” explaining,

... if you have once seen a pronounced example of it, you will never forget it. The patient suddenly sits up in his bed, and with a cry of horror indicates his sense of pain at the praecordium. It has great intensity, but is of a cold and sickening character; the chest is fixed, the breathing not quickened, and your hand, placed over the epigastrium, finds that the heart’s action is slow and laboured. The face wears a look of horror, the hue is pale or slightly leaden, and a cold sweat breaks out upon the forehead. Worse than the pain is the feeling of fearful sinking and depression; the poor patient gasps, “I shall die!” and, sometimes, as in a case which it

was once my lot to witness, his short, but concentrated sufferings in a few minutes end in death.²¹

Similarly, in Edwards Crisp's report of a death from dissected aorta (1847), the patient "called for assistance, being seized with violent pain in the cardiac region.... He exclaimed, "I am a dead man!" and he gradually sunk in an hour and a half from the first appearance of the symptoms."²² When these cases record the patient's last words, it is often in this dramatic manner, especially when the patient (as often happens) senses his approaching death. When the patient is reduced to gestures and moans, his extremity is evident; with dyspnoea, even his final words are lost to us as the last bridge between the living and the dying is severed.

Sansom frames a sensational vignette illustrating the unbearable predicament of the breathless patient. He explains,

the patient gasps restlessly, there is an instinctive craving for more air to oxygenate the sluggish blood in the lung; there is *air-hunger* as the Germans expressively term it.... [I]n the later stages ... the patient cannot lie down; perhaps can scarcely recline from the perfectly upright position: the whole mental energies seem bent upon the one task of getting air into the chest.... I will quote the graphic words of Hope ... "With eyes widely expanding and starting, eyebrows raised, nostrils dilated, a ghastly and haggard countenance, and the head thrown back at every inspiration, [the patient] casts around a hurried distracted look of horror, of anguish, and of supplication; now imploring in plaintive moans or quick, broken accents and half-stifled voice, the assistance already often lavished in vain; now upbraiding the impotency of medicine, and now, in an agony of despair, dropping his head on his chest, and muttering a fervent invocation for death to put a period to his sufferings."²³

James Hope, the originator of this description, continues:

For a few hours—perhaps only for a few moments—he tastes an interval of delicious respite, which cheers him with the hope that the worst is over, and that his recovery is at hand. Soon that hope vanishes. From a slumber fraught with the horrors of a hideous dream, he starts up with a wild exclamation that "it is returning." At length ... the muscles of respiration ... refuse to perform their function. The patient gasps, sinks, and expires.²⁴

Hope's scripting here could not be more dramatic, in a scene offering what Austin Flint terms "a fearful intensity of suffering," from the false hope on the deathbed (a common trope of romantic medicine and a powerful source of dramatic irony) to the final curtain: "The patient gasps, sinks, and expires."²⁵ Hope presses every wrenching detail upon us in a classic example of romantic prose, emphasizing the drama of the scene using excessive, inflationary language as he expresses and solicits an affective response. No melodrama could be more exciting, horrifying, astonishing, or pitiful. Hope's romantic portrait of angina demonstrates clinical physicians' acceptance of sympathetic prose; Edinburgh- and Paris-trained, a pioneer of heart sound research, and a former president of the Royal Medical Society of Edinburgh, he boasted superb credentials and commanded respect.²⁶

Sensational descriptions continue to animate cardiac treatises throughout the nineteenth century, even dislodging the physician's detachment. Thomas Shapter (1874) writes,

[The patient] awoke suddenly, hastened out of bed, seized the back of a chair, and leaned over it, gazed about wildly, stamped, moaned, the perspiration streamed from him, the heart's action was violent and irregular, the murmurs indistinct, the pulse bounding, breathing oppressed, pain across the chest intense.... So intense was the pectoral pain, and the fear of impending death, that he dreaded sleep lest spasm and death should then overtake him. The last and fatal attack had only commenced; in some two minutes he was dead.²⁷

Shapter's dramatic description accumulates intensity with the hastening cascade of phrases depicting the patient's increasingly desperate actions. Shapter even loses control of his prose briefly when his own comments ("the heart's action was violent and irregular") are ungrammatically run into the list of the patient's movements, and even the physician's observations ("the murmurs indistinct, the pulse bounding, breathing oppressed, pain across the chest intense") temporarily take on the quality of that agonized train of motions by which the patient unsuccessfully seeks relief. That last, bald statement—"in some two minutes he was dead"—provides an ironic contrast, as the seemingly endless, inescapable tortures of the patient abruptly give way to the silence of death.

Sentiment

If sensation often dramatizes the struggle for oxygen as the heart fails, sentiment is equally at home in cardiac cases. Sentimentality is said to be "the discourse of the heart." It is thought to be, as Judith Stoddart puts it, "a natural, emotional response, a reflex of universal human nature instead of a particular form of cultural competence."²⁸ In fact it's cultural, a learned response. And because of its constitutive link to sympathy, which philosophers have long grounded in an observer's relation to the suffering body, sentiment is intimately related to medicine: any medical text needs to negotiate its rhetorical relation to patient suffering and thus also to sentimental discourse.

Sentimentalism in cardiac treatises can be discerned in the frequent reference to the patient as "the sufferer" or in the use of euphemistic or pathetic language as when Crisp says "the poor patient sunk on the following day" or (quoting a colleague), "he sank under the disease in a few days, presenting one of the most distressing spectacles that can well be imagined."²⁹ Flint recalls a patient "who experienced the excruciating torture of daily attacks for several months before he found relief in death."³⁰ Williams decries the heart palpitation caused by debauchery, which "cast[s] a baleful influence over the brightest prospects of youth, and send[s] to a premature grave the loveliness of woman, and the strength of manhood."³¹ Francis Hawkins offers an overtly affecting scene: "Unable to bear any but an upright posture, or one slightly reclining forward, his consciousness seldom impaired, the patient sits with the cup of death constantly before him, which he longs at once to drain. At length, upon some slight exertion or motion of the body, the labouring heart appears to stop, exhausted, and the patient's sufferings are suddenly at an end."³² Hawkins here deftly sketches the suffering patient as pitifully restless with pain, and he presses us to imagine the tense stillness of the man facing death, which he both dreads and longs for. With a pathetically slight exertion, the heart (no longer "his" heart) stops and the description, like the patient, is "suddenly at an end."

Surprisingly, romantic discourse can occur even when a cardiac case does not produce great suffering or when the case ends well, as in a difficult case reported by George Balfour in 1876: "Thus this poor dying creature was, after nine months' treatment, dismissed in a comparatively active condition, and both looking and feeling well."³³ The anticlimactic descent from the sentimentalism of "poor dying creature" to the matter-of-fact phrase "looking and feeling well" marks a

remove from romantic to realist discourse. A similar anticlimax characterizes Stokes's angina patient with three pages of "unprecedented" suffering; he was temporarily relieved by eighteen tumblers of punch and "the best opium," although he succumbed eventually.³⁴ The case of the mysterious stranger in my epigraph also combines sensation and anticlimax. The patient (a colleague of Harvey's) is dosed with cherry brandy and bed; he awakes feeling "quite relieved from all his disagreeable feelings."³⁵

Integration and Circulation of "Distressing" Cases

Some physicians, Latham and Elliotson for example, describe suffering without sensationalizing their descriptions of heart disorders; but many do turn to romantic discourse despite clinical norms. Indeed, many British cardiology texts re-circulate cases from other physicians, although generally Victorian medicine values individual empirical observation over book authorities.

I do not find evidence that the language of distress is entered under suspicion in this context. It is often tightly integrated with the most correct clinical discourse, as in Davies, above, or Flint, who shifts smoothly from "paroxysms of pain in the praecordia ... never into the left upper extremity" to "heart-pang."³⁶ Shapter, similarly, moves easily from "a male, aet. 38, florid complexion, well nourished, with antecedent regurgitant disease of the aortic valves" to "He awoke suddenly, hastened out of bed, seized the back of a chair ... gazed about wildly, stamped, moaned."³⁷

We might look to authors who demonstrate a more restrained diction for markers that a romantic discourse like the language of distress is discouraged or devalued in clinical medicine. However, this does not appear to be the case. The cases of Stokes and Crisp adhere to norms of clinical discourse, but both men include romantic cases from other physicians, including the dramatic "die in your house" case, which Stokes passed along from a Dr. Harvey. Neither author distances himself from these cases by framing them any differently other than giving credit to the attending physician. Indeed, the quoting physician does not use quotation marks, so the authorship of the actual history is ambiguous, permitting a slippage of narration between the narrator and the more emotive attending physician whose case he is recirculating.

Despite the supposed development of a hegemony of clinical discourse in nineteenth-century medicine, then, the use of romantic discourse does not appear to discourage the publication and circulation of cases in new textual contexts even into the last quarter of the century. In fact, quite the contrary: a number of the "distressing" cases I've quoted above originated with physicians other than those quoting them in publication (see notes). Most impressively, Hope's sensational, iconic case ("With eyes widely expanding and starting") originally appears in his own treatise, published in 1832 with several later editions; and then it also appears as his contribution to the *Cyclopaedia of Practical Medicine*, edited by the eminent trio of John Forbes, Alexander Tweedie, and John Connolly, and published in 1835. It then reappears in a series of lectures given by Bellingham at St. Vincent's Hospital in 1849 that he published in the *London Medical Gazette* in 1850 and again in Bellingham's 1853 *Treatise on Diseases of the Heart*; in Flint's 1859 *Practical Treatise on the Diagnosis, Pathology, and Treatment of Diseases of the Heart*; and, as we have seen, in Sansom's 1876 *Lectures on the Physical Diagnosis of Diseases of the Heart*. In half a dozen different publication contexts to a range of audiences across nearly five decades of British medicine, Hope's patient gasping for breath repeatedly symbolizes not just the facts but the drama of the heart for Victorian physicians. The extended circulation of such cases demonstrates that sympathetic prose is not restricted to the pre-clinical era.

Contrast with Other Diseases

Written representations of other illnesses do not often evoke the same effort to address the patient's suffering.³⁸ Consider the description of "hooping cough" in Walshe (1851). We might expect whooping cough to be sentimentalized: it was a disease with terrible, wracking symptoms that produced great anxiety; it attacked and frequently killed young children; its treatments were unsatisfactory; it swept through in epidemic form; and its victims were innocents, in no way complicit (as heart patients were understood to be) in their fate. Whooping cough involves fits during which "both inspiration and expiration are ... laborious,—the former prolonged, and accompanied with a loud, cooing noise ... the latter consisting of a number of successive forcible puffs ... performed with almost convulsive energy.... [T]he minor phenomena of asphyxia become apparent.... [B]lood may issue from the mouth, ears, and nose; the conjunctiva become ecchymosed;

slight convulsions occur, and involuntary ... discharge of the faeces and urine take place."³⁹ Such symptoms might certainly be "distressing," but Walshe hews to a strict clinical line. He chooses sentence subjects that are generalized symptoms ("inspiration and expiration," "the minor phenomena of asphyxia") or bodily fluids related to isolated body parts. The patient as person is not visible here. Walshe's diction is careful and clinical (expirations are "almost" convulsive) and his syntax is calm, methodical, judicious, balanced; he eschews inflationary language. Finally, he neither acknowledges nor solicits an affective response; he doesn't even acknowledge that the patient may display an emotional response to these terrifying symptoms.

In contrast, he describes the pangs of heart disease with a much wider range of discourse: with a more various vocabulary and more responsive prose rhythms, with the characteristic momentum accrued through accumulating lists of words and phrases, and with more dramatic delivery. The pain is "dull, aching in character, lancinating, tearing, or indescribable,—an exquisite torture, grasping, constrictive, and suffocative, producing, or certainly coupled with, a dread of impending dissolution."⁴⁰ Furthermore, "Feeble, fluttering, distressing palpitation, increased by the slightest movement ... is a standing source of misery to those sufferers. So, too, is uneasiness in the cardiac region, of characters most difficult to describe,—of an intensity varying between a mere sensation which constantly reminds patients that (as they often express themselves) 'they have a heart,' and the agony of angina,—paroxysms of which may actually occur and put an end to existence."⁴¹ Here the physical symptoms collapse into the emotional ones and are conveyed in terms equally passionate. Finally, in extremity, "rupture of the heart—itsself complete and instantaneous—kills instantaneously. The hand is suddenly carried to the front of the chest; a piercing shriek uttered; some convulsive twitches occur, and the patient expires."⁴² What a contrast this offers to the death from whooping cough, which Walshe describes in exemplary clinical prose.

Why Cardiac Cases

What is it about heart disease that compels these efforts to convey indescribable suffering, in language not generally welcome in the increasingly formal, realist medical record? While the pain and despair of angina reliably evoke the language of distress, other kinds of heart-related illnesses also do so: aneurysm, dilatation of the heart, fatty

degeneration of the heart. For example, in discussing "cardiac asthma" (congestive heart failure), Hope calls it "perhaps the most distressing in the whole catalogue of human maladies."⁴³ What elements of cardiac medicine can account for this persistent use of romantic discourse even when the cases are not particularly complex or dangerous, or when they are relieved by the deflationary forces of anticlimax?

1. The heart has particular symbolic resonance in Western culture. Blair argues that the heart took on metaphorical significance in British culture akin to that of consumption or cancer.⁴⁴ Daldy (1866) poetically muses about how "Nature ... foresaw how, in the vicissitudes of man's life his life-organ, his prime mover of life, would be the chief participator in, and sympathiser with, the varied strains which must be constantly exerted upon his circulation."⁴⁵ Other organs, like the brain or the generative organs, also have an augmented symbolic status; cases involving these organs also frequently turn to the language of distress.

2. Heart disorders bring on severe symptoms (pain, dyspnoea, anxiety, conviction of approaching death) that are indeed extremely distressing. Latham, in his description of endocarditis, even imitates the frantic respirations of disease: "Praecordial pain, and anguish, and fluttering, and gasping for breath, and pallor, and delirium, and nervous exhaustion, and threatened syncope, all in their extreme degrees, made death the apprehension of almost every hour."⁴⁶ The symptoms impress "all in their extreme degrees."

3. Angina in particular was thought to be characterized by a feeling of dread and impending death. Semple explains, "A feeling still more characteristic and more distressing than pain is that of choking or suffocation, with an apprehension of impending death, and this sensation is so distinct, and is so fully impressed upon the mind of the patient, that a repetition of the attack is regarded as almost a certain prelude to dissolution."⁴⁷ Here the dreadful conviction of "impending death" is considered even "more distressing" than the actual pain of the attack. This symptom presents not only another form of extremity—the patient feels himself literally *in extremis*—but also poignant drama, as a man faces his own mortality, and occasionally irony, when the attack does not (yet) prove fatal.

4. The heart is itself "sympathetic," closely linked to the sympathetic nervous system, which means that it responds to mental and emotional stimulus as much as to physical stimulus. Victorian physicians were fascinated by this connection; John Williams focused his work on it. Broadbent explains, in 1891, "Nothing is more certain than the influence of prolonged mental depression upon the heart, and

the sensation of aching, oppression, and weight which attends grief and anxiety ... is indicative of an injurious effect upon this organ. It is almost literally true that people die of a broken heart."⁴⁸ This connection allows the cardiac treatise to feature dramatic scenes. James Wardrop (1837) recalls, "A lady apparently in perfect health, on receiving unexpectedly the account of her mother's approaching dissolution, fell on the ground lifeless!... [T]he wife of a criminal dropped down dead, after bidding her husband a last adieu!"⁴⁹ He acknowledges that such dramatic scenes are imitated by theatrical performers. Even as late as 1884, Alonzo Clark comments, "The heart bounds with joy, it sinks in great disappointments, at sights of horror."⁵⁰

But this connection remained unexplained. Thomas Mee Daldy muses, "Why emotional disturbance, apparently the same, should produce in one person excited and frequent heart-action, and in another slower, and as we call it, 'depressed' heart-action, is a problem not easily solved."⁵¹ Williams terms it a "mysterious" and "remarkable influence" that "we cannot attempt to explain."⁵²

This sympathy between the heart and the mind or emotions meant that cardiac symptoms could be referred to either a structural (organic) or functional (psychogenic) cause; in the latter case it was assumed that no physiological changes or lesions would be found to account for the symptoms. Other organs, such as the brain or stomach, were understood to be affected by the emotions as well. If no physiological derangement was found, the ailment must be functional; often treatment was limited to mitigating the symptoms, regardless of etiology. Further muddying the landscape for diagnosticians, Williams and others feared that chronic functional disease could eventually damage the heart and vessels.

5. Indeed, heart disorders as a whole were considered particularly difficult to understand, to diagnose, to predict the course of, and to treat. For example, Shapter admits that the cause of angina was unknown, having (as of 1874) been "attributed to spasm, cramp, neuralgia, epilepsy, specific disintegration of the heart's structure, ossification of the coronary arteries, to a heart loaded with blood, to enlarged liver, to gout, and latterly, to paralysis."⁵³ Physicians noted that the intense pain and fear of impending death associated with angina might or might not reflect organic disease of the heart and might or might not correlate with a dangerous condition.⁵⁴ Some heart disorders were well established, but the very category of angina was relatively new, having been identified by William Heberden in 1768. While other diseases were often presented as deceptive or difficult—hysteria, syphilis, and

consumption, for instance—heart disease was considered a challenge by physicians from Latham, who lamented in 1845 that “the diagnosis of disease is often easy, often difficult, and often impossible,” to Broadbent in 1881, who remarked, “The question [of prognosis] is one of such difficulty and complexity that I have never felt to have obtained so complete a grasp of it as to be in a position to place my conclusions before the profession.”⁵⁵ This uncertainty surrounding disorders of the heart, considered to be the center of the body’s physiological and emotional life, may have contributed to physicians’ being more likely to use sympathetic prose in recording their cardiac cases, and in particular to breach the code of disinterest in order to acknowledge and share their understanding of the patient experience.

6. Finally, physicians may have been more likely to present cardiac disorders via sympathetic prose because they were thought to be especially likely to “have a heart” themselves. The case of the famous John Hunter frequently appears, the irony often commented upon, that the great surgeon himself was felled at a relatively early age from his own vulnerability to this exquisitely sensitive organ. Although Hunter’s well-known irascibility was thought to have contributed to his death, Williams (1852) suggests that the studious years required for a medical degree might also make physicians especially likely to suffer from weak hearts themselves. “Where is the zealous student,” he asks, “whose nervous system is finely and delicately woven, who has not experienced some such affection in a greater or less degree? Who has not endeavoured to shake off the depression which palpitation brings and leaves, which comes unbidden in the earnestness of study...?”⁵⁶

Technology and Treatment

Sympathetic prose persists in cardiac cases despite immense changes in cardiac medicine, which was perhaps more than any other specialty affected by new diagnostic technologies distancing the physician from the patient. Early nineteenth-century physicians debated the advances in auscultation and percussion, used Laennec’s stethoscope, and studied the pulse. Mid-century physicians disseminated standardized methods for measuring, observing, and recording the movements of the chest, in Sansom’s system and Marey’s cardiograph. At the same time, physicians could consider the development of the sphygmomanometer and sphygmograph for measuring blood pressure. By 1900, a physician could know much more than his Romantic-era counterpart had about what was going on inside his patient’s chest.

However, this wave of heart-tracking technology increased an ironic gap between Victorian physicians' knowledge of cardiac disease and their ability to do something about it. Despite promising developments like the effect of amyl nitrate in arresting paroxysms of angina, nineteenth-century physicians were able to do little more than observe the progress of disease and attempt to mitigate the patient's distress.⁵⁷ Blair notes that, despite developments in cardiac theory since Hunter's death in 1793 and the growing acceptance of digitalis as a cardiac stimulant over the early decades of the nineteenth century, the treatment of Thomas Arnold's angina in 1842 still in many respects reflected an eighteenth-century therapeutics: brandy, mustard plaster, hot flannels, massage, laudanum and camphor for pain. These primarily offered a symptomatic treatment.⁵⁸ In fact, nineteenth-century physicians seem to have used less digitalis than their predecessors.⁵⁹

Physicians' inaction becomes especially pronounced in cases of angina, where patients are desperate not to move or be moved for fear of bringing on an attack or exacerbating the pain. As Broadbent says, "I have known a patient sit in the same position almost through an entire night, not venturing to make the slightest movement and scarcely seeming to breathe, while the perspiration rolled off his forehead and came through his clothes."⁶⁰ Milner Fothergill notes that the patient in a paroxysm of angina "preserves the same position ... and dares not be moved, the suggestion to move him being pain to him and causing terror," and that, in fact, he "appear[s] rather to not dare to breathe than to have difficulty in doing so."⁶¹ Fothergill frames the physician's position as one of doubt and limited options: "Narcotics and antispasmodics ... are not very desirable agents to administer in a condition, whose pathology is enveloped in doubt. Chloroform or other inhalations are not very safe agents, as their action on the heart is not known."⁶² Sympathetic prose, with its expression of connection and investment in the patient's experience, addresses the physician's essential *inability* in this situation—his medical inability to alleviate or cure the disorder; his imaginative inability to truly know the patient's pain; his linguistic inability to convey the reality of that pain—and insists on the physician's commitment to the patient nevertheless.

Imagined Experience, Figuration, and the Ineffable

Sensational and sentimental language express and invite an emotional response, a potentially dangerous endeavor; romantic fiction during the nineteenth century was damned for rousing emotions

in vulnerable populations like women, children, and the working classes.⁶³ In cardiac medicine, sensational and sentimental language often demonstrate that the physician is imaginatively mirroring the patient's distress. By investing so fully in the language of distress, the physician-author strives to imaginatively inhabit the lived experience of the patient and marks his emotional response to the patient's suffering. Clinical discourse cannot meet this rhetorical need, because the clinical realist aesthetic explicitly excludes it.

One telling symptom of imaginative projection is physicians' remarkable investment in describing the unique quality of cardiac distress, especially as they must rely upon the patient's reported experience.⁶⁴ A remarkable proportion of cardiac cases is given over to elaborately detailed, figurative depictions of pain. Physician-authors, following patients' lead, reach for similes and other forms of figurative language in an effort to know and communicate the suffering peculiar to heart disease. Davies laces a clinical report with metaphors, reporting,

In severe cases, the patient feels as if the heart were violently squeezed.... As the fit continues, the dyspnoea often becomes extreme; sanguineous congestions are formed towards the head and face; occasionally syncope or convulsions supervene, and the patient manifests the most unceasing jactitation and apprehension of imminent suffocation. I have seen instances of sudden death occurring in the midst of the most agonising distress.... The increase of the sensibility of the skin and mammae is often so great, that the slightest pressure is excessively painful. I have met with patients whose torments have been so great, that they described their flesh to feel as if torn by the talons of an animal.⁶⁵

Davies carefully delineates the space where he will permit imaginative description, but the nature of this disorder spurs him to juxtapose the calm assessment of a term like "jactitation" (extreme restlessness) with the sentimental acknowledgement of "the most agonizing distress."

Sansom feels the "recital" of symptoms "should be recorded ... in the patient's own words" and illustrates the "most distressing" form of irregular heartbeat with figurative expressions: "the heart's action is said to be 'tumultuous,' ... 'rolling over' and 'tumbling,' as it were; actions described in various terms by various patients, and attended with much distress.... Sometimes the expressions are still more precise, as, for example, 'the fluttering of two pigeons.'"⁶⁶ Similarly, Flint reports one patient's coining of the term "heart-pang" to describe "a sensation

as if the heart were compressed," and he goes on to use the term himself.⁶⁷ Most suggestive, in reporting his own experience of angina pectoris, W. Herries Madden turns to figurative and subjective description only when he describes the feeling that a dose of amyl nitrate effectively "strangled" the spasm in the chest.⁶⁸ He draws attention to this descriptive element: "In speaking of my first experiment with the amyl, I said the spasm was as it were strangled; this word accurately expresses the sensation. I felt as if a new power was suddenly called into play, which seized hold of and by a violent effort crushed out the force previously in action."⁶⁹ His report suggests that the unique and peculiar nature of cardiac distress not only excuses but also requires extraordinary strategies of description.

Significantly, these authors turn to affective language not, generally, when describing symptoms that can be externally assessed but when they must consider the patient's own internal experience of illness; that is, when—other than in the few cases where the physician is himself ill—he must either rely upon the patient's narrative or imaginatively project himself into the patient's role in order to describe particular symptoms. This attempt to acknowledge and comprehend the patient's experience of distress can only, it seems, find expression in the case history as long as imaginative, affective discourse is also permitted. The nature of cardiac distress—in particular the tendency of its anguished patients to evoke an affective response in an observer—makes it difficult if not impossible to convey in dispassionate clinical terms.

This association between the patient's experience of distress and the use of affective discourse persists even when the narrators assert the inadequacy of language to impart the experience of cardiac distress. Flint explains, "The pain [in angina pectoris] is by no means the sole element of the distress. A sense of suffocation and of impending dissolution occasions hardly less suffering. There is, in addition, a feeling of anguish which patients find it impossible to describe."⁷⁰ Elsewhere he terms this "that intense, undefinable anguish and feeling of approaching death."⁷¹ The patient is not the only one struggling to describe this experience. Flint notes, in a case where the patient was afraid to sleep for fear of a recurrence of the paroxysm, "The suffering in this case was beyond description."⁷² Yet physicians seem compelled to try to describe it anyway. Hope refers to dilatation of the heart as "an indescribably distressing ... sensation" and immediately goes on to attempt description: "as if he were dying ... accompanied by palpitation and gasping."⁷³

Stokes spends three pages on a detailed description of an angina patient "with an amount and intensity of suffering probably unprecedented," offering a series of memorable figures that ask us to imagine and inhabit this distress:

a sensation of aching down the arms and legs, with a feeling of lassitude and a desire to sit down, which, however, the patient dare not do ... a sense of constriction referred to the sternum, as if that bone and the spine were being forcibly approximated, and a sensation of the heart being torn from the thorax ... the aching pains in the arms were replaced by a sensation as if red-hot wires extended along the course, ... the carotids appeared impatient of the restraint of the integuments.... [A]t each stroke of the heart, the whole person appeared to undergo a general dilatation, as if it were one great aneurism.⁷⁴

Stokes concludes that the patient's experience is ultimately ineffable. He asserts that the "position of the patient, his dark, wild, staring eyes, and pallid face; the intensity of his agony, the perspiration, which at first stood in large drops, and then ran down his neck, altogether embodied a scene which baffles description, presenting a picture of suffering which could not be imagined or described."⁷⁵ Stokes heaps phrase upon phrase in an effort to convey the intensity of the patient's distress but finally claims even to abdicate the sacred work of observing and reporting, although he is, in fact, imagining and describing what "could not be imagined or described."

The Paradox of the Suffering Heart

Pain is often considered unsharable. Elaine Scarry famously declares, "Physical pain does not simply resist language but actively destroys it."⁷⁶ Lucy Bender, however, has argued that Scarry does not account for degrees of pain nor for sufferers' attempts to express pain metaphorically. While pain certainly presents obstacles to communication, Bender argues, it is a "shared cultural phenomenon."⁷⁷ However, she also argues that the meaning of pain was shifting between the 1840s and 1880s and that it was not a given but rather "part of a complex and unstable system of signification."⁷⁸ Indeed, she argues, no one knew exactly what pain was. In such a context, pain may be expressed and described without truly being communicated.

Cardiac treatises of the nineteenth century offer support for both Scarry's and Bender's views. We see repeated attempts by physician-authors to convey unutterable suffering on behalf of the patient, whether by repeating his anguished words or by imagining and describing the pain that keeps him from speaking. The patient is frequently described as suffering ineffable pain—pain that can't be described, that in fact often prevents him from speaking. Yet physician-authors are drawn repeatedly to reporting the patient's words, and—when that is impossible—attempting to imaginatively inhabit (and report) the patient's experience. Broadbent acknowledges both the difficulty and the insistent necessity of description with a remarkable series of metaphors:

The patient stands still, not daring to move or breathe, and feels as if he were in the act of dying. He will say afterwards that if the pain had lasted another moment he must have died.... Some sufferers will say it is indescribable—nothing in their previous experience suggests even a comparison; others speak of the pain as severe cramp in the heart, or as if the heart were gripped by an iron claw.... Another description of the pain is that it feels as if ... the whole chest were being held in a vice. In other cases the pain is compared to a bar of iron across the upper part of the chest; in others, again, to a ton weight upon the lower part of the chest.⁷⁹

The anxious stillness of the terrified patient appears in a series of eloquent figurations, as if his pain is insistently transfiguring him or accelerating through a series of imagined objects outside his body. The patient, "as if ... in the act of dying," "must have died," in what is "indescribable" and without comparison, yet which is also like a cramp or iron claw or vice or bar of iron or ton weight. It is evident in Broadbent's description that this turn to figurative language stands as a trace of the patient encounter. The physician often echoes what must have been the patient's own words here, in terms that attempt to limn the quality of the patient's interior experience even as he admits their incommensurability to that experience.

The suffering that animates these cases demands yet exceeds, refuses, and indeed eludes description. The narrating physician seems compelled to describe his patient's experience. He describes it in detail, often at length, and with some violence to the ideal of clinical dispassion. Yet often the impression left is of a kind of restlessness of the narrative voice, like the terrified anxiety of the patient who can neither sleep nor move.

The physician, called to describe the ineffable, must imagine it for us. However, any nineteenth-century physician would be well aware that the heart's sympathetic susceptibilities make imagination dangerous, and a medical imagination doubly so. Furthermore, the organ most likely to be disordered by an overactive imagination was the observer's heart. Flint comments on "the frequency with which [medical students] imagine themselves to be affected with disease of the heart. The study of the diseases of this organ tends to direct attention to the subject and excite their fears ... and the dread of these diseases seems ... to induce disturbed action of the organ."⁸⁰ The physician who projects himself imaginatively into his patient's distress not only seeks to share that distress but also, it seems, endangers his own health.

Whose Distress?

The language of distress should not be accepted uncritically as a marker of sympathy; the genre of the medical case can objectify whether using realist or romantic techniques. Sensational discourse, despite its claim of shocked common feeling, makes the patient into a terrible spectacle. And while the patient himself probably feels horror at his predicament, the physician's horror cannot be quite the same.

Indeed, sometimes it is not clear, even late in the century, whether a narrative ultimately conveys the "distress" of the patient or of his physician. Hope mentions "the most difficult and distressing cases" and that "class of symptoms, of the most distressing kind."⁸¹ Stokes talks about "that assemblage of distressing symptoms noticed by all authors."⁸² The "distress" here hovers between patient and physician. Hawkins clarifies, "There is scarcely any state of suffering which it is more painful, more appalling to witness."⁸³ Flint, too, terms the "extreme suffering from so-called cardiac asthma" a "painful spectacle."⁸⁴ Fothergill includes, as a symptom of angina, the way that the "patient's condition excites the greatest alarm and sympathy in onlookers."⁸⁵ If the suffering patient is already "distressed" by his pain, given that "to distress" means "to cause pain, suffering, agony, or anxiety to" someone, to whom, then, can his pain now be "distressing" but the onlooker?⁸⁶

Sansom warns his colleagues that "if you have once seen a pronounced example of [angina], you will never forget it.... [T]he hand, placed over the epigastrium, finds that the heart's action is slow and laboured.... [S]ometimes, as in a case which it was once my lot to

witness, his short, but concentrated sufferings in a few minutes end in death."⁸⁷ Sansom clearly registers not only the patient's but also his own distress. Indeed, in revising the passage five years later, he personalizes the scene even more; he replaces the clinical phrase "the hand" with "your hand, placed over the epigastrium."⁸⁸ It is not uncommon for physicians to remark upon their own pain in this way. Broadbent says, in describing cardiac suffering, "The least movement brings on shortness of breath, which is often painful, even to witness."⁸⁹

What does it mean that the physician's suffering claims space on the page here as well? We could dismiss this as yet another example of how the patient's narrative is eclipsed in clinical medicine by the physician's narrative of his own experience and attempts to claim his own suffering. And this reading, I must say, can be justified. It is not unlikely that physicians' sensitivity to patients' pain reflects their own reduced agency in the face of heart disease and their sense of their own vulnerability to a cardiac disorder. The author in many of these cases finds himself helpless to arrest the paroxysm he witnesses; as many of these men admit, they can do little even in the long run except to counsel the patient to avoid precipitating factors, and to alleviate the symptoms—symptoms they may eventually share—as best they can.

But these physician-authors are also clearly striving to understand, to inhabit, to communicate, and even in some respects to take on some of the pain and suffering they witness. In this way, the cardiac case history of the nineteenth century represents a kind of intensification or condensation of Thomas Laqueur's "humanitarian narrative," in that these texts record a constitutive link between the disinterested attention to detail in modern clinical realism and the affective (that is, interested) gesture of reaching out.⁹⁰ These physicians show us two humans alone together in a room—for all other observers fade away in the narratives of these encounters—facing the terrible incommensurability of experience and struggling to overcome it. In such a situation, it is no surprise that the physician-author turns to a range of narrative tools. It is no accident that some of those tools are generic models common to literature rather than the clinical mode of disinterest. These vignettes are not innocent of the author's concern for his own reputation and authority, but they offer meaning beyond this. A patient who asks to "die in your house" is asking for the assistance not just of medical authority but of sheer human commonality, and these texts reflect their authors' awareness not only of this commonality but also of the forms of textuality—literary forms—that often address it.

These texts demonstrate that the suffering of heart disease is terrible for the patient. They also demonstrate that witnessing suffering you cannot alleviate can be traumatic for the witness, even if—perhaps especially if—that witness is a physician who feels himself helpless, trained to a distanced observation he cannot sustain, and terribly aware of both his human bond with the patient and his inability to bridge the chasm of pain that separates them. Indeed, these treatises demonstrate that the physicians observing the suffering heart prove as prone to sympathy—that is, to pain referred from an unrelated organ—as the heart itself. These observers, like the heart, respond to another's pain by experiencing it—or at least a form of it—themselves. In these cases, pain can be understood only by communication from one organ to another, from one suffering body to another, implicitly tying patient and physician together in a common structure in which observation can engender knowledge only by way of vulnerability and suffering. And if the patient's pain is thus communicated to his physician, the physician-author does his best to communicate it to the reader as well. In the decades during which cardiology was becoming a modern specialty, these physicians draw upon both clinical and "distressing" discourse to articulate both the structures of the heart and of its sympathy.

NOTES

My thanks to staff at the Bedford Collection at the Royal College of Physicians, the Wellcome Library, and the Wood Institute at the College of Physicians in Philadelphia; and to the participants in the Medical Case Histories as Genre symposium at King's College London, especially Monika Class and Brian Hurwitz.

1. Stokes, *Diseases*, 519.

2. Brief segments here on clinical realism and the "interesting" derive from Kennedy, *Revising the Clinic*, with the kind permission of Ohio State University Press.

3. On disinterestedness, see Daston and Galison, *Objectivity*, and Levine, *Dying to Know*. For the changes in scientific writing, see Gross, Harmon, and Reidy, *Communicating Science*. For clinical realism, see especially Rothfield, *Vital Signs*.

4. A narrative with an exaggerated interest in historicity and documents (translation, transcription, editing) is likely to verge on the romantic in its overt attention to the mediation of representation. Although literary romances share characteristics with medieval romance (noble protagonist, social class as an innate quality, and plot structure where the social order is disrupted and eventually restored), these elements are less applicable to medical texts.

5. See Thrailkill, "Killing Them"; Kennedy, "'Poor Hoo Loo.'"

6. The study of heart disease was not fully specialized as "cardiology" until the turn of the twentieth century, but I shall use the terms "cardiac" and "cardiology" for ease of reference. See Lawrence, 3.

7. Davies, *Lectures*, 492.

8. Walshe, *Practical Treatise*, 430.
9. Bellingham, *Treatise*, 182, 209.
10. Broadbent, *Structural Diseases*, 18.
11. Little, *Lecture*, 39.
12. *Ibid.*, 60–67.
13. Blair, *Victorian Poetry*, 24.
14. Montgomery Hunter, *Doctors' Stories*, 6.
15. Conventionally, empathy “feels with” while sympathy “feels pity for.” However, the term “empathy” did not exist during the nineteenth century; many Victorians use “sympathy” where we would say “empathy.” On cognition and empathy, see Halpern, “Clinical Empathy,” 670.
16. Greiner, *Sympathetic Realism*, 16. Greiner persuasively argues that a sympathetic but abstracted “fellow-feeling” enables nineteenth-century literary realism (18–20). However, cardiac texts express distress in a romantic manner closer to Hume’s than Smith’s theory of sympathy; the expression may be inadequate, but the attempt is made.
17. Halpern, *Detached*, 70.
18. *Ibid.*, 72.
19. Latham, *Lectures*, x.
20. Stokes is quoting a Dr. Harvey; Williams is quoting a Dr. Baillie; Semple, *Manual*, 4.
21. Sansom, *Lectures*, 5.
22. Crisp, *Treatise*, 169.
23. Sansom, *Lectures*, 27–28.
24. Hope, *Treatise*, 401.
25. Flint, *Treatise*, 192; Hope, *Treatise*, 401. Flint was American, but he was internationally known as an authority on heart-sounds, frequently cited by British sources, and was invited to address the BMA in 1886.
26. See for example Semple, *Manual*, 4.
27. Shapter, *Notes*, 205–06.
28. Stoddart, 195–96.
29. Crisp, *Treatise*, 27, 147.
30. Flint, *Treatise*, 289.
31. Williams, *Practical Observations*, 137.
32. Hawkins, *Rheumatism*, 109.
33. Balfour, *Clinical Lectures*, 386.
34. Stokes, *Diseases*, 220.
35. Stokes, *Diseases*, 519.
36. Flint, *Treatise*, 294.
37. Shapter, *Notes and Observations*, 205.
38. For one exception, see Brian Hurwitz’s essay on Parkinson and *Essay on the Shaking Palsy* in this issue.
39. Walshe, *Practical Treatise*, 418.
40. Walshe, *Practical Treatise*, 433.
41. *Ibid.*, 483.
42. *Ibid.*, 523.
43. Hope, *Treatise*, 394.
44. Blair, *Victorian Poetry*, 28, 30–31.
45. Daldy, *On Disease*, 9.
46. Latham, *Lectures*, 311.
47. Semple, *Manual*, 275.
48. Broadbent, *Structural Diseases*, 11.
49. Wardrop, *On the Nature*, 67–68.
50. Clark, *Lectures*, 239.
51. Daldy, *On Disease*, 4.

52. Williams, *Practical Observations*, 44, 51, 55.
53. Shapter, *Notes*, 207.
54. See Flint, 296–300; Semple, 274–75; Hope, 94–95. See Wooley, 65–67, 75–76; Bound Alberti, 96–98.
55. Latham, *Lectures*, 286; Broadbent, *Structural Diseases*, 1.
56. Williams, *Practical Observations*, 5–6.
57. Bynum, Lawrence, and Nutton note that Thomas Lauder Brunton had published his experiments on amyl nitrate in the *Lancet* in 1867.
58. Blair, *Victorian Poetry*, 100–02.
59. Wray, Eisner, and Allen, "Two Hundred Years," 137–39.
60. Broadbent, *Structural Diseases*, 35.
61. Fothergill, *The Heart*, 251.
62. *Ibid.*, 255.
63. Fothergill warns, for example, "The excitement of modern fiction is not without an effect on the emotional nature of its votaries, who become as abandoned to this form of intemperance as others are to the use or abuse of other stimulants" (262).
64. Dr. Clifford Allbutt records his own case of heart strain while Alpine walking, reporting "a strange and peculiar *besoin de respirer*, accompanied by a very distressing sense of distension, and pulsation in the epigastrium" (quoted in Fothergill [273] and elsewhere).
65. Davies, *Lectures*, 492–93.
66. Sansom, *Diagnosis*, 1, 6.
67. Flint, *Treatise*, 294, 301.
68. Madden, "Nitrate of Amyl," 333.
69. *Ibid.*
70. Flint, *Treatise*, 289.
71. *Ibid.*, 302.
72. *Ibid.*, 291.
73. Hope, *Treatise*, 513.
74. Stokes, 218–19. He attributes this case to "Dr. C. [Charles] Croker King."
75. Stokes, 219.
76. Scarry, *Body in Pain*, 4.
77. Bender, *Representation*, 89.
78. *Ibid.*, 5. See also 56–57.
79. Broadbent, *Structural Diseases*, 34.
80. Flint, *Treatise*, 462–63. Williams considers that actual bedside experience diminishes such anxieties: "no persons are more liable to [nervous palpitations] than those who are dabblers in physic ... having no knowledge of the science of medicine" (*Practical Observations*, 101). I have not found others who make this distinction.
81. Hope, *Treatise*, 214.
82. Quoted in Hope, *Treatise*, 160.
83. Hawkins, *Rheumatism*, 109.
84. Flint, *Treatise*, 191.
85. Fothergill, *The Heart*, 173.
86. "distress, v." *OED Online*, Oxford University Press.
87. Sansom, *Lectures*, 5.
88. Sansom, *Manual*, 5–6.
89. Broadbent, *Structural Diseases*, 18.
90. See Laqueur, "Bodies, Details, and the Humanitarian Narrative."

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