

6

‘Cannot You Use a Loving Violence?’:
Cancer Surgery

In fury Quintianus ordered them to torture her by crushing her breasts, and when she had suffered in this way for many hours, he finally ordered that her breasts be cut off. ‘Impious, cruel, odious tyrant!’ Agatha cried. ‘How could you do this? Are you not ashamed to take from a woman what your own mother gave you to suck? No matter: I have other breasts you cannot harm, breasts that give spiritual nourishment to all my senses, and them I dedicated long, long ago to God’.¹

Saint Agatha, an early Christian martyr, was popularly believed to have had her breasts removed as a method of torture. The young Christian, living in ancient Sicily around 231 AD, had caught the eye of the ‘idol-atrous’ governor Quintianus, who, angered by her rejection of his sexual advances, had her arrested for her faith and imprisoned in the house of Aphrodisia, a prostitute who attempted to persuade Agatha to welcome Quintianus’s attentions.² Finding that she remained unmoved, Quintianus ordered Agatha to be tortured by having her breasts mutilated and cut off. Then, infuriated by the composure with which Agatha bore this punishment, he had her thrown into a dungeon and left to die. Quintianus’s final revenge, however, was futile, since Saint Peter appeared to the stricken Christian and restored her breasts. She died after later being rolled on hot coals, an avowed martyr of the faith.

Agatha’s story struck a chord in early modern society. She appeared everywhere from Greek and Latin martyrologies to classical poetry and the works of the early Baroque artists, who depicted her undergoing torture or serenely carrying her severed breasts on a platter (Figures 6.1 and 6.2).³ Her story was recounted at length in the influential medieval martyrology *The Golden Legend*, a text that was ‘without doubt one of



Figure 6.1 Lorenzo Lippi, *Saint Agatha*, 1638–44, oil on canvas, 75.7 × 64.1 cm (29 13/16 × 25 1/4 in.). Courtesy of Blanton Museum of Art, The University of Texas at Austin, The Suida-Manning Collection, 1999 (369.1999). Photo credit: Rick Hall. This image is open access under a CC-BY 3.0 licence.

the most widely disseminated books through Europe from ... 1266 until the end of the Middle Ages'.⁴ Most intriguingly, she was, argues Liana de Girolama Cheney, at the centre of resurgence in 'porno-violent hagiography' near the end of the fifteenth century which continued into the sixteenth and seventeenth centuries and was 'augmented by the writings of anatomical science and medical texts'.⁵



Figure 6.2 Sebastiano del Piombo, *The Martyrdom of Saint Agatha* (1520). Courtesy of Polo Museale, Firenze, the Vittoria della Rovere collection.

As the patron saint of breast cancer patients, Agatha later gained an associate of sorts. Born in 1265, Saint Peregrine was the youngest member of a wealthy Italian family active in the antipapal movement of that period.⁶ Upon a visit of the papal ambassador to his locale, it was said that Peregrine joined others in harassing the ambassador and struck him in the face. The ambassador promptly forgave Peregrine and prayed for him, upon which the young man was so moved that he converted to Catholicism and joined the Order of Servants at Siena. Following many years of an ascetic lifestyle in which he never sat or lay down, Peregrine developed a leg ulcer which was pronounced cancerous, and he was told that amputation was the only cure. Peregrine spent the night before the planned operation praying in the chapel, and on falling asleep, dreamed that Christ reached out and touched his leg. Upon waking, the monk found that his leg had healed, and went on to thrive into old age. While his story was a medieval one, Peregrine's beatification took place in 1609. His corpse was repeatedly dug up, and found to be uncorrupted, throughout the seventeenth century, and he was canonized by Pope Benedict XIII in 1726. In early modern Europe, therefore, there was

a great deal of interest in this cancer survivor – some of which, despite widespread anti-papist feeling, must have crossed the seas to England.

What did Peregrine and Agatha have in common, and why did they both become prominent during the early modern period as icons for those facing cancer, despite their radically different experiences? The link between the two figures seems to have been amputation: facing it, suffering it, avoiding it or recovering from it. Agatha remained serene throughout a stylized rendition of a double mastectomy. Peregrine's reprieve from surgery appeared as a powerful example of wish fulfilment. By enduring or avoiding the knife, the two saints reflected the worst fears and most ardent fascinations of their audiences. It is with Peregrine and Agatha in mind, therefore, that this chapter examines representations of surgery to analyse what they reveal about early modern attitudes to cancer, cancer sufferers and medical practitioners. What was cancer surgery? How did it relate to perceptions of cancer, or of the nature of the gendered body? And why would anybody consent to such a 'frightful' course?

My analysis of cancer surgeries, surgeons and patients in this period builds on the contention of Chapter 5: that constructions of cancer as alien to the body encouraged an adversarial therapeutic approach, in which the patient's individuality and subjectivity were often eclipsed. For surgeons, as for physicians, it seems that the intractable, 'rebellious' nature of cancerous disease was felt to justify, and even to demand, the use of radical therapies despite their inherent risk to the patient. For surgeons, however, I argue that the issues raised by dangerous pharmaceutical treatments were amplified. Cancer surgeries – in particular, mastectomies – were among the most dangerous and invasive of the era's medical procedures. Temptingly, they offered a means to remove the perceived interloper from the body, a last resort for patients who believed that they otherwise faced certain death.⁷ However, while this course offered chances for glory, it also supplied disruptions to the narrative of medical progress. Surgeons who carried out cancer operations might find themselves denounced as reckless butchers, or frustrated in their curative efforts. In short, stories of cancer surgery display all the potential and problems of a discourse which sought to divorce patients from their misbehaving bodies.

In the scholarly literature, surgery for cancer has been recognised as an ancient but rare phenomenon. Numerous authors have recognised descriptions of surgical excision of tumours dating back to ancient Egypt and the Edwin Smith papyrus.⁸ For the medieval period, Luke Demaitre notes that several authors listed surgery as among the possible cures for cancer, though they counselled readers to avoid this course.⁹ Marie-Christine Pouchelle's *The Body and Surgery in the Middle Ages* also

identifies Henri de Mondeville, an eminent fourteenth-century surgeon, as having performed a variety of operations to remove cancerous tumours and ulcers.¹⁰ Writing on the more recent past, Marjo Kaartinen argues that the mastectomies for cancer were relatively common during the eighteenth century, and finds the latter half of the century to have been marked by the development of 'radical' forms of mastectomy in which much underlying muscle was removed.¹¹

My own analysis has been influenced by a growing literature on the semiotics and practice of Renaissance surgery, much of which contradicts stereotypes of the 'swashbuckling "sawbones"' heedlessly hacking off limbs and pulling teeth.¹² Lynda Ellen Stephenson Payne's *With Words and Knives: Learning Medical Dispassion in Early Modern England*, for example, provides a thoughtful look at surgeons' attitudes toward patient suffering, reading between the lines of texts which take a brutal approach to those under the knife, and demonstrating that many surgeons were keenly aware of the pain they inflicted.¹³ Taking a broader view of surgical practice, works by Andrew Wear and Philip K. Wilson describe a medical landscape in which surgeons formed an increasingly professionalised and learned body, with ambitions toward the same prestige and rewards enjoyed by members of the Royal College of Physicians.¹⁴ With the translation of many classical anatomical texts into English, an increasing number of surgeons possessed scholarly credentials to match their substantial practical training, and 'English reformers of surgery', argues Wear, 'stressed with great unanimity that both groups [physicians and surgeons] had much in common in terms of medical theory and practice'.¹⁵ Moreover, Wear finds surgery to have been a more dynamic field than physic, open to innovation in procedures and instruments and with 'a craft emphasis on practicality, dexterity and the value of experience'.¹⁶ From 1684 onward, surgeons repeatedly applied for their craft to be divorced from that of the barbers with whom they shared a College, a wish finally granted in 1745.¹⁷ While Wear and Wilson have illuminated surgeons' ambitions for their profession, work on perceptions of surgery among non-medical audiences has been less forthcoming. As I will discuss later in this chapter, however, several scholars investigating the representation of early modern torture, vivisection and anatomy have noted that these crafts were often compared with surgery, such that the surgeon's status as a preserver of life was often tenuous.¹⁸ This aspect of the semiotics of surgery, especially invasive surgery, begs further study, and my examination of the possible affiliation of cancer surgery with these cruel and violent trades aims to contribute to that broader discussion.

This chapter is divided into four sections, focussing first on questions of why and how cancer surgeries were undertaken, and later on the difficulties of representing these operations in medical writings. In the first section, I address two obvious questions – whether cancer operations were taking place, and why patients might consent to them. The second section then looks at methods for some of the most common procedures. Section three considers what motivated some surgeons to carry out cancer operations, and how that motivating narrative came under threat from fellow medical practitioners. Finally, I examine how issues of gender and power were treated in accounts of surgery from the operators themselves.

6.1 ‘But is there no other Way, but this frightful one?’¹⁹ **Facing cancer surgery**

Any examination of surgery in the early modern period – an era before antiseptics, antibiotics or anaesthesia – must begin with several obvious questions. Did cancer surgeries actually take place during this period? If so, then why? That is, why would anybody consent to have their body cut into, even to have parts of their body amputated, when doing so ensured agony and potentially death? In this section, I contend that cancer surgeries were an established feature of the early modern medical landscape, and that patients’ decisions to undergo these procedures were based on personal experiences of suffering as well as popular beliefs about cancerous disease.

Accurately quantifying cancer surgeries is an impossible task. Most of the surgical practice actually taking place in this period was never recorded, much less preserved for modern readers, and medical textbooks often provided instructions for an operation without indicating whether the writer had actually carried out that procedure, or how often. In her study of breast cancer, Kaartinen suggests that surgery ‘became more common’ from the late seventeenth century onward, and provides numerous examples of mastectomy from the mid-late eighteenth century.²⁰ In the period 1580–1720, however, the picture is less clear. Cancer operations seemingly remained uncommon, and, as I shall discuss, many medical practitioners and patients refused to countenance the procedure, for a variety of reasons. Nonetheless, anecdotal evidence suggests that cancer surgeries were an established feature of the early modern medical landscape. For instance, in May 1665, Samuel Pepys remarked upon the mastectomy of his ‘poor aunt James’ with sympathy, but without much surprise.²¹ Some medical textbooks, most notably

Wiseman's *Several Chirurgical Treatises*, gave many examples of surgeries the authors had carried out, including dates, locations and names. Most tellingly, numerous newspapers carried advertisements indicating that cancer surgeries were taking place on an infrequent but steady basis during the early eighteenth century. On 8 February 1728, for instance, an announcement in the *London Evening Post* reported that 'the lady of Sir Challenor Ogle' had undergone an operation to remove a cancer in her breast, 'and there is great Hopes of her Recovery'.²² Newspapers' obituary pages also indicated the prevalence of cancer surgery, albeit in unhappier terms: multiple listings record the deaths of cancer patients during or following operations, most often mastectomies.²³

Clearly, some cancer sufferers did opt for surgery, despite its evident perils. Moreover, descriptions of surgery, as seen later, indicate that they were often doing so in a premeditated and considered manner, when it did not seem that their disease was immediately about to kill them. This fact makes cancer surgery particularly interesting. Other amputative or invasive procedures described for the same period tended to take place after accidents or on the battlefield, with death otherwise imminent. The most notable exception to this rule, lithotomy, was usually completed in a matter of minutes, whereas cancer surgeries could take hours or even days.²⁴ Cancer operations, almost uniquely, entailed a patient agreeing, in advance, to lay down their more or less functional body for prolonged cutting and burning knowing that they might never get back up. Estimating just how many such patients did get back up is a fraught undertaking. In his study of the work of surgeon Daniel Turner, however, Wilson has found that tumour patients fared worst of all those whom Turner attended, with 28.9 per cent dying in the practitioner's care.²⁵ Turner was by all accounts a skilful surgeon, and Wilson's analysis does not specify how many of these patients underwent mastectomies or amputations versus the number treated with more conservative lumpectomy or cautery. It thus seems clear that many, perhaps even most, patients undergoing substantial cancer surgeries would die during or soon after their treatment.

Given these appalling odds, what made cancer patients agree to, or even seek out, a surgical cure? Firstly, patients experienced an increasingly poor quality of life as their illnesses progressed, and grasped at any chance, however remote, to end their pain. Secondly, the formulation of cancer as a rebellious, semi-sentient, unstoppable malignant disease impelled patients to remove these seemingly alien growths from their bodies before they took over. Evidence for the first of these considerations was stressed in texts discussing cancer surgery, where surgeons

sought, as I shall discuss, to justify their involvement in such risky cures. Poignant accounts from these surgeons' case records depicted patients often unable to lead any semblance of a normal life, in constant pain and suffering social isolation as a result of their illness's appearance and putrefactive stench. Wiseman, for example, described the following encounter with a patient suffering with mouth cancer:

Coming to the Patient with the [palliative] Prescriptions, he asked what way we had designed to cure him. After some pause (for we, having no hopes of curing him, had not discoursed of that,) Sir *Fra. Pr* answered, the attempt of Cure in such Ulcers had been always unsuccessful and extream painful...and thereby the Disease hath been exasperated, and the Life of the Patient shortned. The same was affirmed by us all. The Patient replied, God's will be done. I pray go and consider of the way: for I had rather die than live thus.²⁶

The patient in this account suffered from a tumour and ulcer that had caused most of his teeth to fall out, and had spread from his jaw to his cheek and the roof of his mouth. Daily life – eating, drinking, talking and sleeping – must have been painful and laborious in the extreme, and it was this loss of function, even more than the attendant pain, that Wiseman later described as the motivation for patients putting 'to trial' a cure 'by Knife or Fire'.²⁷ Given that patients with quite minor tumours were often tempted to undergo surgery, he asked:

How much more then shall these poor creatures, who have Cancers over-spreading their Mouth, eating and gnawing the Flesh, Nerves and Bones? Who, besides the danger they are in every minute of being choaked with a fierce Catarrh, do suffer hunger and thirst; and if they can swallow Broth, Caudle or Drink, yet is it with an unsavoury tast...and their Spirits are infected with the stink, whence Fainting frequently happens; Sleep is a stranger to their eyes, their Slumber very troublesome, and Death is only their desire. At such a time as this it is not to be wondred if they try a doubtful Remedy, though painful.²⁸

Pain and debility were in themselves strong motivators for undergoing surgery. In the case of cancer, however, those pains were felt all the more keenly in light of their relation to the fearsome 'nature' of the disease. In opposition to surgery, as to aggressive pharmaceutical treatments, practitioners repeatedly cited Hippocrates' aphorism 6.38: 'Occult cancers

ought not to be cured; for they that are cured die soon, whereas they that are not cured live longer'.²⁹ However, as the inclusion of cancer remedies in many of those same texts testifies, many patients could not be satisfied with such measures. Moreover, the construction of cancer in zoomorphic terms, with repeated emphasis on its malign, rebellious and 'cruel' characteristics, framed the ideal response to the malady as its physical *removal* from the body, a desire that seemed realisable only by surgery. As Théophile Bonet put it, '[Y]ou must try even with danger to cure a Disease, that would certainly kill'.³⁰ Although many writers gave examples of patients who lived with tumours until their death from some other cause, for those experiencing bodily 'invasion' by cancerous tumours, these examples paled in comparison to the tales of cancer's malignancy reinscribed by both medical and popular literature. In this climate of fear, Dionis bluntly advised one patient that 'she had no other choice, but either that Operation [mastectomy] or Death'. 'She, like all other Patients', he recalled, 'preferring Life to the Loss of a Member, determin'd to undergo it'.³¹

Accounts of the circumstances which led cancer sufferers to consent to, or even demand, surgery offer a vivid picture of patient experiences of this disease. Whilst the noting of cancer operations in newspapers implies that these procedures were uncommon, the way in which they are presented nevertheless shows that they were an established treatment route for cancers, regardless of the risks they posed. The individual decisions which led to these operations – the extraordinary acts of consent to amputation and incision made by patients – were based on prolonged suffering and the belief that that suffering could be ended only by expelling the malign 'alien' from within. In these critical decision-making moments, the thoughts and feelings of the patient are, perhaps unsurprisingly, visible to a greater extent than anywhere else in the surgical process. Their experiences show poignantly the distress they experienced every day, and for most patients, this was the only stage at which their opinions about their surgery, good or bad, would be recorded. As I shall demonstrate, when they came under the knife, cancer sufferers' voices subsided, and they were presented – ideally at least – as passive, silent bodies.

6.2 Operational methods

Diseases which Medicines cure not, the Knife cureth; what the Knife cures not, Fire cureth; what the Fire cures not, they are to be esteemed incurable.³²

Descriptions of what drove patients toward surgery usually foregrounded individual patients' suffering. When the decision was made, however, and the patient came under the knife, the emphasis of surgical texts changed drastically. As in this discussion of 'Knife' and 'Fire', by the German medical practitioner Johannes Scultetus, medical textbooks and casebooks shifted their focus from patients to bodies, and from bodies to tumours. This new perspective was centred on 'extirpating what is superfluous', and there were diverse methods by which surgeons could do just that.³³ Some cancer operations were relatively minor, while others posed a serious risk to the patient's life. Some were the work of minutes, while others took days to complete, and they could be undertaken on parts as diverse as the eyes, breasts, face, legs, and scrotum.³⁴ This section identifies three main operations which constituted the vast majority of cancer surgeries, and which each showed relative homogeneity across the early modern period and the diverse locations in which they were performed. These paradigmatic cancer operations – ordered here in terms of their increasing invasiveness and dangerousness – were simple lumpectomies, facial surgeries, and mastectomies.

For any operation, certain preparations had to be made and precautions taken before the patient came under the knife. As Wiseman observed, operating in the spring or autumn was preferable, though not always possible.³⁵ In many cases, surgery represented the last resort in a course of treatment, so it was likely that the patient would already have been eating a prescribed diet and perhaps taking medicines aimed at reducing the tumour and strengthening the body. Where mitigating pain was concerned, Kaartinen argues that eighteenth-century surgeons often administered opiates and alcohol before a procedure. Although they showed concern for patients' pain, however, most accounts of cancer surgery prior to 1720 make no reference to any such ministrations. This might have been because surgeons were aware of the possible risks of overdose with opiates in particular: as I shall discuss, records of palliative care show that medical practitioners were happy to prescribe laudanum to patients who were clearly dying, often to help them sleep, but they were conscious of the medicine's potentially lethal side-effects. In addition, it was often necessary that the patient remain conscious so that the operators could gauge his or her physical state. Sudden sensitivity to the knife might indicate that a surgeon had reached the bottom of a necrotic ulcer and touched living flesh; conversely, slipping into unconsciousness was a worrying sign of blood loss as well as a natural reaction to intense agony.

Tumours which appeared on the face, arms and legs often merited relatively minor surgeries (insomuch as any early modern surgery was

'minor') which were designed to bring the malady to a swift conclusion while minimising its physiological and social impact on the patient. As Alexander Read pointed out for 'apostems' (undifferentiated, generally benign, lumps), surgery might be preferable to some medicines, particularly caustics, in such cases: 'First, if Apostems be in the Face, to avoid the filthiness of the Scar, after the Curation. Secondly, in small Tumors: for so they will be the sooner whole'.³⁶ Philip K. Wilson and Olivia Weisser separately note 'the stigma of a marked body': namely, that marks or moles on the face were often taken as signs of bad luck, or worse, symptoms of venereal disease.³⁷ Patients might thus have been tempted to undergo this procedure even where tumours appeared slow growing or benign. Worried sufferers may also have been fearfully aware of cases in which facial tumours ulcerated and 'ate' through the cheeks, nostrils or eyelid.

In the best cases, excision of small tumours could provide a quick, if painful, resolution to the problem. Wiseman, for example, cited the example of 'A Man of about fifty years of age...with a hard unequal Tumour, of the bigness of a large Wall-nut, between the Coronal and Sagittal Suture'.³⁸ This tumour, Wiseman recalled, 'was at that time crusted over with a Scab, and seemed to be a milder sort of Cancer'.³⁹ Wiseman decided to operate:

Therefore providing Dressings ready, I made an Incision round it to the Scull; then raised it off with a *Spatula*, and permitting the blood to flow a while, dressed it up with Astringents. The third day after I took off Dressings, and saw the Lips of the Wound well disposed, and the *Cranium* uncorrupted. I rasped it till the blood appeared under it, then dressed up the Wound with Digestives...and after Digestion incarned and cicatrized it with as little difficulty, and dismissed him cured.⁴⁰

Several factors contributed to this operation's success. The tumour was, as Wiseman noted, 'resting upon the *Cranium*', a hard base from which it could easily be separated. The lump was relatively small, and the patient was acquiescent to Wiseman's method, allowing him to apply medicines and cauterize the wound over several days. Wiseman's description, however, was atypical of the kinds of operation most frequently found in medical textbooks. Whether because they were felt not to merit recounting, or because they were rarely carried out, straightforward excisions of sub-dermal tumours were the exception rather than the rule. Most descriptions of cancer surgery on the face and limbs recorded rather more complicated procedures, often with less positive outcomes.

Despite the distinctive symptoms identified by various medical practitioners as signalling cancer, it is clear that many patients, particularly those travelling from the countryside to seek medical advice in the city, did not identify their tumours as cancerous until they reached an advanced stage. Furthermore, they were understandably reluctant to consent to surgery until it became clear that there was no other option. This state of affairs may explain why most of the facial cancer surgeries described in medical texts (and among cancer operations, facial surgeries far outstripped everything but mastectomies) tended to be lengthy, often complex affairs. Surgeons described operations for tumours which had spread over the face, often involving the gums, nasal cavities, eyelids and even the eye itself. For instance, in another of his many examples of the difficulties of cancer surgery, Wiseman recounted the case of a 'military Captain' whose initially minor mouth cancer had spread to include the salivary glands, both '*Maxilla*' (bones of the upper palate), the lower lip, the gums (causing some teeth to fall out) and some glands under the jaw.⁴¹ On consulting Wiseman, the patient was informed that his tumour was cancerous, and resolved to have it removed by Wiseman with the help of fellow practitioners Thomas Cox, Walter Needham and 'Mr. *Gosling*'.⁴² Wiseman commenced by pulling out the patient's loose teeth, then set to work with a series of 'actual' cauteries or hot irons:

[H]aving his Head held firm, and his lower Lip defended, I passed in a plain Chisel cautery under the *Fungus*, as low as I could, to avoid scorching of the Lip, and thrust it forward towards the Tongue, by which I brought off that *Fungus* and the rotten *Alveoli* at twice or thrice repeating the Cautery; then with Bolt-cauteries dried the *Basis* to a crust. After with a Scoop-cautery I made a thrust at the *Fungus* over-spreading the left Jaw, and made separation of that, and what was rotten of the *Alveoli*: then with Olive and Bolt-cauteries I dried that as well as he would permit.⁴³

This patient's surgery was far lengthier and more dangerous than the simple excision with which Wiseman had removed the cranial tumour. As the limits of the patient's 'permission' indicate, it must also have been excruciatingly painful. Wiseman and his contemporaries recorded more of these kinds of operations – lengthy removals including the use of both knife and cautery – than they did simple lumpectomies, despite the fact that these complex procedures were often unsuccessful. The unfortunate Captain, for example, endured several more days of similar treatment, but eventually died when the tumour spread throughout his

mouth and into the larynx, an outcome which Wiseman attributed in part to reluctance to allow him 'to keep down the *Fungus* afterwards as it arose' by use of further cautery.⁴⁴

Wiseman seems to have been particularly innovative in his cancer surgeries, and assiduous about recording the most interesting examples. Operations for facial tumours, however, were recorded throughout the early modern period. For example, the 1634 collected *Workes* of Ambroise Paré, which had first appeared in French in 1575, recounted a 'new and never formerly tried, or written of way' by which the author had removed a facial tumour in a 50 year-old man.⁴⁵ 'The way is this', instructed Paré:

The Cancer must be thrust through the lips on both sides, above and below with a needle and threed, that so you may rule and governe the Cancer with your left hand, by the benefit of the threed (least any portion thereof should scape the instrument in cutting) and then with your Sizars in the right hand, you cut it off all at once, yet it must be so done, that some substance of the inner...lippe, which is next to the teeth, may remaine, (if so be that the Cancer be not growne quite through) which may serve as it were for a foundation to generate flesh to fill up the hollownesse againe. Then when it hath bled sufficiently, the sides & brinckes of the wound must be scarified on the right and left sides, within, and without, with somewhat a deepe scarification, that so...we may have the flesh more pliant and tractable to the needle and threed. The residue of the cure must be performed just after the same manner as we use in hare-lips'.⁴⁶

Omitting the hot irons later employed by Wiseman, Paré's operation offered the opportunity to 'rule and governe' this most ungovernable disease. Perhaps tellingly, however, the success of his venture was unrecorded: Paré advanced the method as one by which cancers might be cured without cautery and the associated scarring, but gave no details as to the survival or otherwise of his patient in this case. Despite the uncertain outcome of Wiseman and Paré's procedures, versions of the same were employed throughout the late sixteenth, seventeenth and early eighteenth centuries.⁴⁷

While a number of medical practitioners seem to have been aware of, and occasionally practised, operations for facial tumours, in general cancer surgery reflected the disease's status as paradigmatically afflicting the female breast. Despite its invasiveness, the mastectomy operation was by far the most prominent in medical textbooks, casebooks and

advertisements. Most mastectomies followed a similar template: the pulling away of the breast from the body, followed by the removal of the whole breast with a sharp implement. William Beckett's 1711 *New Discoveries Relating to the Cure of Cancers* relates the procedure in brief but excruciating terms:

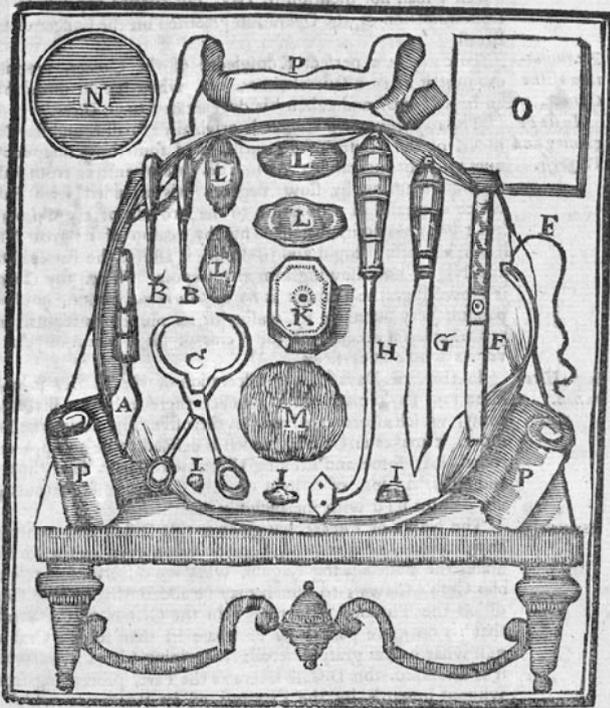
Let the Patient be placed in a clear Light, and held steady; then take hold of the Breast with one hand, and pull it to you; and, with the other, nimbly make Incision, and cut it off as close to the Ribs as possible, that no Parts of it remain behind. But if any *cancerous Gland* should remain, be sure to have actual Cauteries of different sizes, ready hot by you, to consume it, and to stop the Bleeding; or otherwise apply, for restraining the Hemorrhage, Dorsels dipp'd in scalding hot *Ol. Terebinth* [turpentine oil] ... then with good Boulstring and Rolling, conveniently place the Patient in Bed, and at night give her an *anodine Draught*, then the second or third Day open it, digest, deterge, incarn and siccatrize.⁴⁸

Beckett's procedure contained several variables which medical practitioners altered according to their own preferences. He provided no instruction, for example, as to what one should use to 'nimbly make Incision'. Most operators favoured a knife or razor, but the Dutch surgeon Paul Barbette noted that some surgeons used needles or hooks and a 'string'.⁴⁹ In his 1710 *A Course of Chirurgical Operations*, Dionis suggested one used both, helpfully supplying a diagram of his preferred equipment (Figure 6.3).⁵⁰ 'The Chirurgeon', instructed Dionis, 'with Ink traces out the whole Circumference, which is the place where the Incision is to be made':

[T]hen running the crooked Needle D, across the Body of the Tumour; it is threaded with the String E, whose two ends are tied, and with which he makes a Noose which serves to sustain the Tumour, and in drawing it to separate it from the Ribs... then with Razor F, or a large flat Knife G... the Chirurgeon cuts at the marked Place, and takes off the whole Body of the breast in a short time.⁵¹

It seems – though Dionis's explanation is unclear – that the string was passed through the base of the breast using the needle (as shown in Figure 6.4, from Scultetus's *The Chyrurgeon's Store-House*). This served to partially separate the breast from the underlying muscle so that it was more stable and could more easily be excised. Kaartinen argues that the

FIGURE XXVIII. The APPARATUS for the Operation practis'd on the CANCER.



A Cancer is universally agreed to be the most terrible of all Of the Evils which attack Mankind; though Wars and CANCER. Plagues kill in less time, they don't yet, to me, seem so cruel as the Cancer, which as certainly, though more slowly, carries those afflicted with it to the Grave, withal causing such Pains as make them every day wish for Death.

'Tis a Disease which attacks not only the Breast, but several Reason of other Parts, on which it is not less outrageous: It sometimes *its different* assumes Names.

R 4

Figure 6.3 Pierre Dionis, *A Course of Chirurgical Operations, Demonstrated in the Royal Garden at Paris* (p. 247), 1710. Copyright of the University of Manchester. This image is open access under a CC-BY NC-SA 4.0 licence.

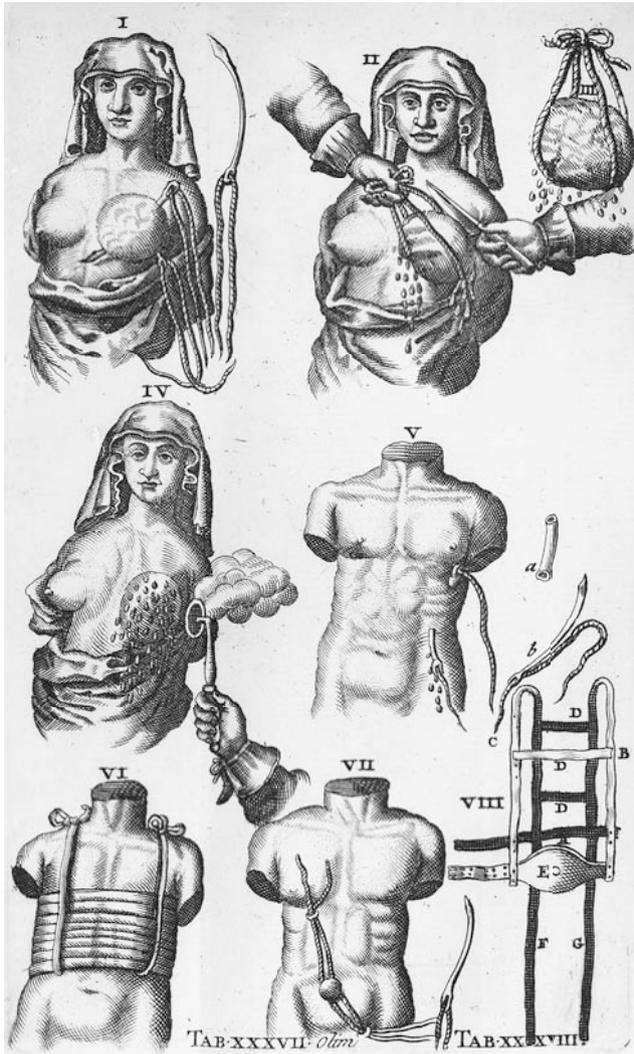


Figure 6.4 Johannes Scultetus, 'Breast cancer operation', from *Het vermeerdeerde wapenhuis der heel-musters*, 1748. Courtesy of Wellcome Library, London. This image is open access under a CC-BY 4.0 licence.

needle and cord technique was 'in vogue' in the late seventeenth and early eighteenth century, after which it gradually disappeared.⁵² In the sources I have examined, however, it seems to have been uncommon.

There were, of course, exceptions to this rule: for example, a surgeon at Saint Bartholomew's hospital, Joseph Binns, took the string method to an extreme. Tying a string around the breast on the morning of 9 August 1648, he 'tied it harder' over the next 13 days until on the 22nd, 'the lower string was through the bigness of a finger, the upper one near to an inch' and he 'with string cut [the whole breast] off in the ligature'.⁵³ Predictably, however, the patient died a week later: the absence of this procedure from other contemporary texts gives the impression that Binns either misunderstood instructions such as those given by Scultetus, or tried this method as an ill-fated experiment.

In a 'typical' mastectomy, therefore, the surgeon would probably use a knife to cut away the breast tissue. In all likelihood, he would have removed virtually the entire breast down to the chest wall. Dionis described a lumpectomy operation to be used when the cancer was small, palpable and movable, but he was in the minority.⁵⁴ Conversely, Beckett recalled observing an operation in which 'a Part of that [pectoral] Muscle was cut away, and the cartilages of Two of the Ribs laid bare, and the patient happen'd to be cur'd'.⁵⁵ This too was uncommon, presumably because it increased mortality rates even further.⁵⁶ While they were wary of removing too much flesh, surgeons remained mindful of the disease's characteristic malignancy, and repeatedly stressed the importance of removing every trace of the cancer. '[I]t must be all taken away', stressed Bonet:

A Canker once cut doth often come again, 1. When all was not cut out, through timorousness, either in the Operatour, or in the Patient. 2. Because the Arteries that emit this vitious blood, by reason the less Arteries are cut away from the part affected, must contain more blood than before, and therefore when they are open, will discharge that blood upon some other part, whence comes a new Canker. 3. Because there is so much malignity latent in the Body, that a Canker will always grow afresh.⁵⁷

Though the operator could do little about cancer 'latent in the body', he could, it was believed, minimise the risk of recurrence by pressing the bad blood out of the nearby veins and making sure to excise every scrap of cancer either with the knife or cautery. Precisely what means were used to complete the operation and stop the wound from bleeding was mostly a matter of individual choice, sometimes influenced by the constitution and temperament of the patient. Dionis, for example, reported that he had stopped using hot cauteries because they 'make the

Patient tremble' and he could achieve the same result by skilful use of the knife, followed by 'Pledgets' (material pads) and 'astringent powders' to stop the bleeding.⁵⁸ In line with contemporary wisdom that closing a wound was dangerous, surgeons generally did not stitch the site of mastectomies or other substantial cancer operations until later in the eighteenth century.⁵⁹

Post-operation, the patient was at high risk of infection, as well as remaining in considerable pain. Occasionally, surgeons would return to treat the wound with hot cauteries again.⁶⁰ Whether because this course was intolerable to the patient, however, or because it was ineffective, such extended treatment was fairly uncommon.⁶¹ Instead, surgical texts often recorded either the authors or their colleagues administering prescriptions with soothing and anti-inflammatory properties, as well as some potent analgesics. Wiseman, for example, prescribed one mastectomy patient a 'Pearl-Julep' 'to refresh her fainting spirits', and the next day she was given 'distilled milk', containing, among other ingredients, gentian, rose, agrimony, cinnamon and veronica.⁶² In 'extremity of pain', he recorded, she was to be given a drink made with theriac, a concoction which usually contained opium and snake venom.⁶³ In many cases, it appears that surgeons monitored their patients closely in the days after surgery, and remained aware of the potential for infection or a recurrence of the cancer for months, even years. For their part, patients were advised to be constantly on the lookout for new tumours, and told they 'must not discontinue the use of internal Remedies for some Years, lest a Fresh tumour should break out in some other Part, and produce a new Cancer'.⁶⁴

Descriptions of early modern cancer surgery showed a relative homogeneity, pointing to the existence of established operative conventions, and to a steady stream of patients who were willing to put those conventions to the test. Despite their exceptional invasiveness, such operations were broadly intuitive, aiming for a golden mean between extirpating the cancer thoroughly and minimising dangerous blood loss. Interestingly, they were also united in the way in which they described the process of operation. Surgeons, as we have seen, vividly portrayed the sufferings of their patients prior to surgery. They also, to a lesser extent, showed empathy with the pain and shock experienced by patients after a major cancer operation. Descriptions of the operation taking place, however, showed no such personal attention. Rather, they were characterised by an anatomical emphasis in which the person under the knife was consistently reduced to the sum of his or her parts. The reasons for, and effects of, this phenomenon are the subject of the remainder of this chapter.

6.3 'What then can we think of this shameful Undertaker [?]'⁶⁵ Competing narratives of cancer surgery

Reading early modern instructions for and accounts of cancer surgery is a stark reminder of just how dangerous and painful these operations must have been. Clearly, some patients summoned the strength to undergo such procedures because they believed surgery was the only option left to relieve their sufferings, and prevent their premature deaths. As we have seen in the previous chapter, however, the recourse of desperate patients to such extreme measures may in fact be less remarkable than the willingness of medical practitioners to administer them. For surgeons, as for physicians, undertaking invasive and bloody procedures was a course often fraught with doubt and difficulty. Many surgical texts show that operators were traumatised by the screams and struggles of patients in agony under the knife. Moreover, when they attempted anything but the most superficial excisions, surgeons risked killing or maiming the patient, incurring serious and lasting damage to their reputations and hence their livelihoods.

In these grim circumstances, several of the factors which motivated early modern surgeons to conduct cancer operations were clearly linked with those which compelled sufferers to consent to this course. Firstly, operators were all too aware of patients' often chronic and unremitting pains. Cancer sufferers' pleas for relief at any cost clearly rang loudly in the ears of many medical practitioners. Secondly, cancer in some senses 'invited' surgical intervention by dint of its seemingly evil and rebellious nature. To the early modern mind, cancer was hostile and malign: an alien to the body repeatedly imagined as deliberately resistant to cure, and aligned with evil influences in the world at large. For medical practitioners as well as patients, surgery offered a chance to reach into the body and remove the interloper, and the language of surgical textbooks often represented (and reinforced) an adversarial relationship between medical practitioners and cancer. In his 1583 *The Method of Physick*, for example, Philip Barrough counselled medical practitioners to 'devide the good from the evill' when excising cancers.⁶⁶ A text by Jacques Guillemeau and 'A.H.' similarly advised that the 'reliques' of the disease be 'abolish[ed]' – language that must have echoed particularly loudly in post-Reformation English ears.⁶⁷ Repeated injunctions to remove all the cancer not only advised on clinical practice, but reflected and reinforced appealingly tangible and symmetrical ideas of cure: that the body could be restored by cutting into it, and the disease of burned humours could be quelled with burning iron.

Surgeons thus responded to both the physical reality and the rhetorical construction of cancer as a fearsome, evil disease. Furthermore, in many surgical texts, it is clear that discussions about cancer operations constructed those surgeries as not only compassionate, but contributing to medical knowledge and the 'progress' of surgery more broadly. In the adversarial drama played out between surgeons and the cancers they sought to eliminate, there was a distinct sense of intra-professional (and largely homosocial) cooperation as well as competition. This was partly a matter of necessity – surgeons needed assistance to keep the patient held steady, pass instruments, heat iron cauteries and apply 'pledgets' or pads to stem bleeding. To a greater extent than physic, surgery was a trade learned through apprenticeship, and many operators could have expected to have one or more such charges in attendance.⁶⁸ In a broader sense, surgeons were 'apprenticed' to the ancient and medieval medical writers whose advice they often cited. Demaitre notes the influence of Rhazes (Muhammad ibn Zakariyā Rāzī, 865–925 AD) and Galen on medieval discussions of cancer surgery by Avicenna and Lanfranco, who were in turn frequently cited by seventeenth-century writers.⁶⁹ Surgeons undertaking such operations could therefore feel that they were contributing in their turn to a patrilineal development of knowledge.

Even when they were not required for practical purposes, it is clear that many experienced surgeons and other medical practitioners attended and assisted at cancer surgeries, particularly mastectomies and invasive facial operations, out of professional curiosity or camaraderie. Wiseman, for example, recorded that he had examined and operated on cancers in conjunction with, or in the presence of, other medical practitioners including Walter Needham, 'Mr. Nurse', Doctor Bate, Doctor Thomas Cox, Doctor Micklethwaite, Jacques Wiseman (his 'kinsman'), and Mr. Hollier, Mr. Arris, Edward Molin, Mr. Troutbeck and Mr. Shunbub (all surgeons).⁷⁰ Likewise, at the mastectomy observed by Reverend John Ward, which took place over several days, two surgeons, 'Clerk, of Bridgnorth' and 'Leach, of Sturbridg[e]' operated, while Walter Needham arrived too late on the first day, but 'staid...to see it opened' again the next day, and 'Dr. Edwards' marked with ink 'the way how and where it should be cut'.⁷¹ That surgeons were seemingly so keen to be involved with cancer surgeries, despite the risks to their reputations in the event of a patient's death, shows how fascinated they were by these procedures. Their attendance at and detailed recording of operations with a novel pathological or methodological element also suggests that they saw cancer operations as potentially perfectible: a coup which, if achieved, would undoubtedly bolster the claims of many surgeons

that their craft should be considered a noble profession, equal to that practised by university-educated physicians.

Surgeons who dwelt on the technical improvement of cancer surgeries clearly believed that in the long term, operative advancements could benefit both practitioners and patients. For the individual sufferer, however, this 'long view' could reach unsettling extremes, allowing surgeons to ignore the suffering of individual patients in the service of curiosity, learning or fame. Notably, in scholarship on early modern dissection and vivisection, Sawday, French and Egmond have all noted an imaginative connection between these occupations and that of the surgeon. Concomitant with the intense interest in dissection and anatomy during the early modern period, they argue, was a suspicion that living humans might be next under the curious anatomist's hand.⁷² For instance, citing Edward Ravenscroft's *The Anatomist* (1697) and Thomas Nashe's *The Unfortunate Traveller* (1594) as examples, Sawday contends that the idea of a *living* anatomy possessed a peculiarly compelling horror for early modern dramatists, and that '[i]magining one's own dissection was a device unique to early-modern culture'.⁷³ It is by no means certain that this fear was unfounded. Egmond mentions 'some evidence of vivisection on human beings', while French notes that '[r]umour...had it that at least two Renaissance anatomists succumbed to temptation and ventured into human vivisection'.⁷⁴ As Richard Sugg observes: 'Available data indicates that almost no one was prepared to advocate human vivisection during the Renaissance. By contrast, however...various figures seemed ready to believe that the practice might be carried out by their contemporaries'.⁷⁵ Moreover, it was seemingly accepted that if anyone was to venture into vivisection, it would be surgeons, rather than physicians. First published in 1605, Michael Drayton's 'Sonnet 50' vividly imagined that 'in some countries, far remote from hence', condemned criminals might be used as experimental subjects by surgeons, who would

First make incision on each mastering vein
Then staunch the bleeding, then transpierce the corse,
And with their balms recure the wounds again
Then poison, and with physic him restore
Not that they fear the hopeless man to kill
But their experience to increase the more. (l. 6–11)⁷⁶

As Sugg observes, Drayton's fears might have been founded, in part, upon his observation of surgeons' 'necessary, temporary detachment from

human suffering', a trait which 'threatened to harden into a permanent and dominant identity in the perception of the lay public'.⁷⁷

Even if they were not explicitly associated with anatomists, surgeons undertaking invasive operations were bound to find their narratives of progress interrupted by the uncomfortable fact of patients' suffering under the knife. The problematic nature of the surgeon's craft, which both healed and hurt, has been noted by several historians of early modern and medieval medicine. Andrew Wear's 'Medical Ethics in Early Modern England', for instance, describes the difficulty of drawing a line between treatments which harmed and those which helped patients, while in her reading of Henri de Mondeville's medieval surgical works, Pouchelle notes that Mondeville himself admitted that 'surgeons have a reputation for cruelty' and 'the surgeon who refuses to be considered as an executioner or public tormentor would become a laughing-stock among "ordinary uneducated people"'.⁷⁸ One common concern among surgeons was that they might be perceived as over-eager to employ the knife, and hence, as one ship's-surgeon cautioned, be 'esteemed Butcher-like and hateful'.⁷⁹ Cancer surgeons were, it seems, particularly vulnerable to accusations of cruel, callous or incompetent conduct which allied them with the anatomist, torturer or butcher. The operations they carried out were some of the most lengthy and dangerous undertaken during the early modern period, particularly in the case of mastectomy. Furthermore, these operations were not always immediately and visibly necessary. It was easier to decry a surgeon removing a superficially healthy breast which contained palpable tumours than it was to quibble with an operator who caused similar pain while removing a bullet or amputating a mangled limb.

In this suspicious climate, the language with which some surgeons chose to describe their operations suggests that they, too, were uncomfortable with the pain they inflicted. In some cases, it is clear that cancer operators preferred, or perhaps needed, to view the person under the knife as a specimen rather than a thinking, feeling patient. Many accounts of surgery show operators focussed on their relationship with other practitioners or with the 'rebellious' cancer, to the exclusion of the patient as subject. Wiseman's description of a mastectomy performed on a 'Country-maid', for example, contains no details about the patient other than her occupation, age and the initial appearance of her breast.⁸⁰ It does, however, give a detailed account of 'the experimenting of the Royal Stiptick liquor' (designed to stop bleeding), the arrival and involvement of Needham and Jacques Wiseman, and Richard Wiseman's attendance on some 'friends' who wished to see the new stiptick.⁸¹ From the time the operation is resolved upon, to when it is completed, the whole

body of the patient is never referred to, but is only manifest through the breast, the tumour and the blood issuing out. This erasure of the patient was by no means confined to Wiseman. Looking again at Figure 6.4, for example, one sees in Scultetus's diagram the depersonalization of the woman under the knife. In the top left-hand image, we view the patient, looking oddly serene as the needle is passed through her breast, her hair covered and seemingly armless. The accompanying text describes 'a *Breast* affected with an ulcerated Canker', effacing the subject attached to that breast.⁸² In the next picture, the hands of the surgeon[s] descend as if from the heavens to remove the breast, and in the third, the (literal) dissociation of patient from cancer is complete as the amputated breast hangs, detached, 'weighing six physical pounds'.⁸³ The pictures marked V, VI and VII on the same page are meant, according to the text, to represent treatment for a fistula, bandaging of the thorax and correction of a hernia.⁸⁴ Their continuous numbering with the mastectomy pictures, however, rather implies a continued improvement – that the ideal or corrected body is one in which both subjectivity (the face) and femininity (both the breasts) are absent.

The uneasy relationship between femininity and cancer surgery is discussed later in this chapter. In relation to surgeons' self-construction as compassionate and progressive, however, it is evident that taking patient subjectivity out of the equation in texts on cancer surgery served several purposes. First, while surgeons acknowledged the pain of surgery when discussing the decision to operate and the proper provision of aftercare, excluding the patient at the moment of greatest suffering – under the knife – made it easier for surgeons to construct themselves and their activities in their own, flattering, language, rather than the fearful or suspicious terms in which they were often criticised. Furthermore, the exclusion of a patient's thoughts, feelings and personality from textual representations of surgery mimicked the detachment which was deemed necessary in order for surgeons to do their job. In her work on medical dispassion in early modern England, Payne describes at length the trauma and difficulty inherent in operating upon conscious patients.⁸⁵ Lengthy cancer operations were particularly distressing for all involved; as one *Medical Dictionary* advised, women undergoing mastectomy might 'shriek and cry in a manner so terrible, as is sufficient to shock and confuse the most intrepid surgeon, and disconcert him in his operation.'⁸⁶ Under such circumstances, the surgeon had to 'equip himself in all the steps of his operation, in such a manner, as if he was deaf to the moving groans, and piercing shrieks, of the tortur'd patient.'⁸⁷ In fact, as the *Dictionary* implied, the best sort of patient

would be a silent, unfeeling carcase, such as young surgeons sometimes practised upon.⁸⁸ Confirming this fantasy, and relaying instructions for mastectomy, Dionis informed young surgeons that '[t]his Operation is easier than is imagined before 'tis performed; for the Breast separates as easily from the Ribs, as when we divide the Shoulder from a Quarter of Lamb'.⁸⁹ His statement, seemingly meant to reassure, tacitly acknowledged the dread with which some operators must have approached this procedure, and the mental tactics employed to overcome it.

Representations of cancer surgery thus consistently engaged with the potential of that operation both to help and harm. Where cancer surgeons might try to efface the dangerous and painful nature of their interventions, however, other medical practitioners had no such qualms. For every author who provided accounts of or instructions for cancer operations, there were many more writers – often physicians, but sometimes lay onlookers or surgeons writing against their perceived inferiors – who accused cancer surgeons of conduct which was at best careless and at worst positively evil. In a 1703 publication from 'T.D.' on the 'Abuses' committed under the name of chirurgery, for example, the author singled out one surgeon's cancer operations for particular attention.⁹⁰ This operator was, it seems, moderately famous for mastectomy operations in particular: T.D. stated that 'I make no question but you have hear'd of one who calls himself the un-born Dr'.⁹¹ The doctor's practice, wrote T.D., was 'monstrous': 'The Number of Womens Breasts, which this man has cut off within these few Years is scarce to be believ'd: And yet... he cannot produce One, where there was a true ulcerated Cancer, that is now living to tell Tales of Him'.⁹² Given that cancer was widely acknowledged to be difficult if not impossible to cure, 'what then can we think', asked the author,

of this shameful Undertaker, who makes no more of taking off a Breast (altho' no otherwise than a Butcher might do the same) than some Persons do to pair [pare] their Nails, so that scarce any thing of a distemper'd Breast is presented, but the poor Woman is frighten'd out of her Wits, with the dismal Sentence pronounc'd of its being Cancerous.⁹³

For T.D., the activities of the 'unborn Dr.' could not be viewed as compassionate or progressive. Instead, the casting of the surgeon as 'Undertaker' in this account explicitly opposed the operator's self-construction as a preserver of life. Moreover, naming the doctor as a 'Butcher' who cut up women as readily as he cut his nails subverted surgeons' emphasis on the

professionalism of their craft and prefigured, in distorted form, Dionis's assertion that mastectomy might be as easy as dividing up a shoulder of lamb. Undoubtedly, there were foolish or unscrupulous practitioners to be found in every kind of surgery. However, T.D. implied that cancer surgery was an area in which unscrupulous practitioners could make their mark particularly easily, because women were so afraid of the disease that they could easily be manipulated into undergoing unnecessary operations. As someone who apparently grew his own coffers by doing physical harm to his patients, this 'Dr.' might even be viewed as malignant in his own right.

These accusations were damning and imaginatively compelling ones, calculated to strike a chord with contemporary fears about the motivation and competency of surgeons. Even 'T.D.' did not argue that surgeons actually enjoyed inflicting pain. However, the obvious agony of the cancer operation, combined with surgeons' reluctance to acknowledge that pain in their medical writings, inevitably led to accusations that those who carried out these procedures were more interested in personal gain and professional advancement than in the humanity of their endeavours. As a profession, surgery could not escape the fact that only the intent to heal definitively separated the surgeon from the torturer, and only a successful result distinguished him from the anatomist. That cancer surgery came in for particular scrutiny in this regard was a product of several factors. These operations were, as I have shown, unique in their invasiveness and the fact that they were undertaken at the patient's behest or with their pre-obtained consent. Furthermore, belief in the evil, quasi-ontological nature of cancer fostered the desire to extract this interloper from the body in a way unmatched for other diseases. Even contemporary surgeons identified cancer as a disease particularly likely to provoke dangerous 'experiment' with 'bold and rash' pharmaceutical and surgical methods, precisely because it was such a mysterious and fascinating malady to medical practitioners.⁹⁴ Throughout the early modern period, it seems, both surgeons and those who observed their activities knew that therapeutic encounters with cancer and the preservation of humanity – in both patient and operator – could not easily coexist.

6.4 'And in such searching wounds the surgeon is / As we, when we embrace, or touch, or kiss': cancer surgery and gender relations⁹⁵

All kinds of cancer operation were controversial. The dangerous and invasive nature of such procedures led to much criticism of those who

dared to undertake them – mostly from other surgeons and medical practitioners convinced of the futility of such interventions. Occasionally, however, those surgeons who carried out cancer operations tacitly revealed their own anxieties about opening up the body. These anxieties related, to a striking degree, to female patients, and mastectomy operations. Moreover, they cut both ways, involving the possible subjugation of female patients and emasculation of male operators.

Early modern medicine in general was often imagined as a sexually charged pursuit. The fact that male medical practitioners possessed intimate knowledge of the female body made their craft, as Roy Porter observes, ‘inescapably associated in the public imagination with carnal knowledge’.⁹⁶ Erotic prints and poems, he notes, commonly ‘exploited “medicine” as a double entendre, cover, or euphemism for sexual opportunism’.⁹⁷ Physicians and apothecaries, however, were generally employed in diagnosing complaints and prescribing medicines rather than physically manipulating their patients. It seems evident that surgery, which was necessarily a tactile and intimate encounter, should be even more vulnerable to accusations of sexual misconduct, and tensions ran particularly high when (usually male) surgeons operated on female patients. As a paying customer, any patient, male or female, possessed a high degree of agency over their treatment. Kaartinen has shown that for cancer in particular, many women had substantial knowledge of the surgical and medical treatments available to them, and readily asserted their own opinions as to their treatment.⁹⁸ Conversely, however, Laura Gowing notes that simply being touched could undermine an early modern woman’s social status.⁹⁹ When exposed to touch in inappropriate ways – touched by too many people, or the wrong sorts of people – women’s bodies risked being deemed ‘common’, and compared to the ultimate ‘common’ body, that of the prostitute.¹⁰⁰ Male surgeons touching female patients (and likewise, patients being touched) were, therefore, precariously positioned. Surgeons exercised a peculiarly acute power of touch capable of inflicting not only social but mortal physical damage. At the same time, their access to the body was, as I shall demonstrate, contingent and uncertain.

As described in the first section of this chapter, many cancer patients chose, even demanded surgery, in full knowledge of the likely pain and danger to their life. Some surgeons consented only reluctantly in view of the traumatic nature of the procedure and the attendant danger to their reputations. However, this was not always the case. Several accounts from medical casebooks and instructional texts recall situations in which surgeons tried, unsuccessfully, to persuade patients to

undergo surgery. These situations related almost exclusively to women, and were frequently framed in gendered or sexualised terms. In 1698, for example, *The Compleat Midwife's Practice* recounted the story of an unnamed woman with breast cancer, which was becoming gradually worse.¹⁰¹ '[A] skilful Surgeon', recalled the authors,

refused to open it, but advised the best he could to give her ease, and promised to come to her, if after it brake she would send for him. Some Months after she sent for him, and shew'd him a great quantity of curdled matter newly burst forth; the Breast was lank, but very hard *Glands* lay within, and ... there were some *tubercles* that required to be eradicated; to which purpose, he design'd to have slit open the *abscess*, and to have pull'd away the Cancerated *Glands*, but she would not permit him so much as to enlarge the orifice; upon which consideration he left her, and she died within half a year after.¹⁰²

The authors' sympathies clearly lay with the 'skilful' surgeon in this bizarre tale. As well as an exhortation to readers to submit to the advice of their surgeon, however, the account reads as a gendered power struggle centred upon the surgeon's thwarted desire to penetrate the unnamed 'orifice'. Stressing the anatomical terms in the story – '*tubercles*', '*Glands*' and '*abscess*' – the author tries to emphasise clinical details of the case, but his narrative, like the unnamed surgeon's plan, is continually disrupted by a female who gives her opinions clout by denying access to her body. In certain lights, a woman's reluctance to have her breasts examined or treated by a male practitioner could be construed positively, as an instance of proper feminine modesty. This was, for instance, the case for the writer Mary Astell, whose reluctance to seek treatment for her cancer was represented in a posthumous biography as exemplifying her patience and fortitude.¹⁰³ However, in late sixteenth-, seventeenth- and early-eighteenth-century texts, reluctance to undergo surgery which had been recommended by a medical practitioner was more likely to be depicted as an example of womanly foolishness and obstinacy. Despite the power they wielded during an operation, surgeons were service providers, and were not, in principle at least, allowed to coerce or bully their customers into a procedure. Their opinions were automatically overruled by those of their customer, the reluctant patient, and this clearly sat uncomfortably with some surgeons in a society which traditionally privileged the voices and judgements of men.

The refusal of 'permission' by the female patient in *The Compleat Midwife's* account was elsewhere formulated as a failure to 'submit', a

term which was used in texts on cancer exclusively to describe women who were uncooperative with their medical practitioners.¹⁰⁴ For instance, Daniel Turner recalled in 1714 that encountering a patient with facial cancer, 'I told her if she would submit to the hot Iron, I would serve her so far as I was able, believing that the most likely Remedy for so obstinate a Disease'.¹⁰⁵ The patient was, understandably, frightened by the prospect of the 'fiery Tryal' and refused Turner's intervention in favour of remedies from an 'Empirick'; predictably, it was reported that the cancer had now spread over her face.¹⁰⁶ Once again, the encounter was framed in loosely sexual terms, as to 'serve' a woman could also mean to act as her lover or impregnate her.¹⁰⁷ This aspect of the surgeon-patient relationship was even more prominent in an account by Dionis of the treatment of Madam de Montreuil, a lady who sought his advice whilst he was travelling around France with some colleagues.¹⁰⁸ This lady, unlike Turner's patient, was easily persuaded that surgery was necessary for her breast cancer. However, circumstances meant that Dionis was unable to operate. He recorded: 'She would have desir'd me to have perform'd the Operation; but that she had then her Terms, and having no more than two days to stay at *Marseilles*, I could not satisfie her'.¹⁰⁹ It was not unusual to delay an operation until after a patient's menses. However, the language of 'desire' and 'satisfaction' here connected surgical and sexual performance, particularly as sex during menstruation was commonly believed to be unhealthy.

In scenarios like these, the access of a male surgeon to a female patient's body was implicitly framed in sexual terms. The narratives presented by medical practitioners depicted any resistance to their desires, therapeutic or otherwise, as foolish misjudgements – perhaps characteristic of ignorant and fearful women – which ended badly for the intractable patient. It should be noted that there was no suggestion in early modern texts, medical or non-medical, that surgeons actually experienced sexual gratification from operating on women's breasts. Nonetheless, violence, sexual gratification and surgery were somehow allied, and mastectomy – a dangerous, body-altering operation – was naturally susceptible to such associations. For example, when painting Saint Agatha's tortures, numerous sixteenth- and seventeenth-century artists depicted her tormentors using the surgical instruments of the period.¹¹⁰ Perhaps this is unsurprising: after all, questions of power and violence attached to mastectomy have long been a focus of modern cancer studies such as the tellingly titled *A Darker Ribbon* and *The Breast Cancer Wars*.¹¹¹ Examining a nineteenth-century image of mastectomy, Bridget L. Goodbody makes a similar link between different forms of

power over the female body. In *The Agnew Clinic* (Figure 6.5), she argues, one can trace an 'erotics of sadism', in which the 'supine and helpless position' of the patient 'creates the sense of her willing submission [to the doctors] ...even to the point of willingly placing herself in a violent circumstance from which she cannot escape'.¹¹² Crucially, the semiotics of the situation are not diminished by the operators' good intentions:

[T]he surgeons knew that the patient's fragile life rested very precariously and tenuously in their hands. Taken to the extreme, this thought prompts the question: How far could they rationally and almost ritualistically violate her body to establish their power over her and her cancer without killing her? Such questioning is not intended to imply that the doctors derived pleasure from her pain.¹¹³

As such analyses highlight, where a gathering of men takes place over a female body, questions of 'violation' may arise even where it is clear that the surgeons involved did not purposely exploit that body or gain pleasure from the scenario. Moreover, in a heteronormative society, the

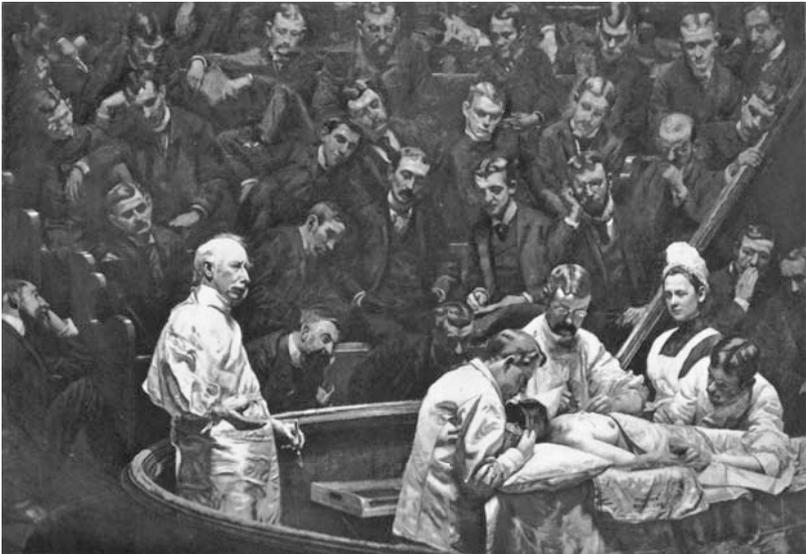


Figure 6.5 The Agnew Clinic. Artist/maker unknown, After Thomas Eakins. Photogravure, c. 1889. Image: 7 7/8 × 11 in. (20.0 × 27.9 cm). Courtesy of Philadelphia Museum of Art: Gift of Samuel B. Sturgis, 1973. This image is open access under a CC-BY 3.0 licence.

'dynamics of inequality' created by such a scenario were readily sexualised.¹¹⁴ The very fact of a female patient placing her life quite literally in the hands of a person of the opposite sex carried an erotic charge in a culture in which – as was true of early modern English society – submission and subordination were indexed to good 'femaleness'.

The peculiarly intimate access to the female body and breasts afforded by cancer surgery might thus be read as connoting sexual desire or domination even though it was never suggested that operators actually viewed their work in this light. Tales of women who refused to comply with surgeons' advice were more common than the equivalent for men both because females made up the bulk of cancer diagnoses and thus surgical cases, and because their assertion of bodily agency was particularly significant in a broadly patriarchal society. This is not to say, however, that cancer surgeries on women were experienced as unproblematic exercises of male power. Cancer was, as we have seen, a disease known for its malignancy, secrecy and resistance to cure. In surgical encounters with the female body, these characteristics could play out in ways that highlighted issues of gender and power, and this was emphatically the case in one unusual but instructive tale, that of London surgeon Samuel Smith.

Cited at length in Chapter 4, Samuel Smith's story epitomises the double danger posed to male surgeons from involvement with the 'cruel' malignancy of cancer, and the troublingly illimitable female body. '[A]t the cutting off of a large Cancerated Breast', it was reported, Smith, a surgeon at St. Thomas Hospital in Southwark, 'had (after the Breast was off) a Curiosity to taste the Juice, or Matter contain'd... which he did by touching it with one of his Fingers, and then tasting it from the same with his Tongue'.¹¹⁵ Tasting a patient's bodily fluids was not unknown in early modern diagnostics, and F. David Hoeniger notes that 'sour and sharp' tastes in blood were thought to indicate an excess of melancholy humours therein, consistent with the outcome in this case.¹¹⁶ Nonetheless, tasting amputated tissue was unusual, and the fact that the 'large' breast belonged to a patient who may have been conscious under the surgeon's hands once more highlights the uncomfortable proximity between medical and sexual touching.

The most dramatic part of this story, however, was still to come. Immediately upon tasting the breast, the surgeon complained that the matter had a persistent and permeating acrid taste. Within 'a few months' the surgeon found himself in 'a Consumption, or wasting pining Condition' and died soon afterward.¹¹⁷ Smith's misfortune was taken by the anonymous author as an indication of the quasi-poisonous malignancy

of cancers. However, it was also clearly gendered. The cancerous matter, for instance, 'pierce[d] through the whole substance of his Tongue, and passed down his Throat', rendering this 'very strong Man' as weak as the woman upon whom he had operated. Moreover, the author's emphasis on this transformation pointed to the corrupting potential of the similarly illimitable female body. As Paster has argued at length in *The Body Embarrassed*, the female body was thought to be characterised by superfluity, leaking and disorder, expressed through the involuntary and incontinent shedding of bodily fluids including tears, milk, urine and blood.¹¹⁸ Smith's plight, which rendered him 'wasting' and 'pining', realised the possible dangers of coming into contact with female excreta, compounded by the noxious and malignant substance of the cancer.

While Smith's subsequent illness was understood to result from his ingestion of the cancerous 'juice', the story also gestured to less obvious kinds of contamination by the female body. In *The Body Emblazoned*, Sawday notes that anatomists risked emasculation as they opened up women's bodies. 'Once the body has been partitioned and its interior dimensions laid open to scrutiny', he writes, 'the very categories "male" and "female" become fluid, even interchangeable'.¹¹⁹ This concern accorded with broader discourses of the period which were concerned with infection and contagion, including through the air or by sight.¹²⁰ Writing on 'contagious sympathy' in Shakespeare, for instance, Eric Langley notes the mingling of science and rhetoric which fostered belief in infection by sight, 'a material thread of connection or contagion between viewer and viewed'.¹²¹ Barbara M. Benedict similarly identifies curiosity – the trait which caused so much trouble for Smith – as 'a perceptible violation of species and categories', which might include violation of proper gender attributes.¹²² Once again, these concerns were emphasised by cancer's well-known tendency to spread and resist medical intervention, as well as remaining 'hidden' prior to ulceration. Like cancers, women's bodies might be viewed as hazardous when they remained 'secret', and even more dangerous when opened up to the medical practitioner's view.

Cancer surgery, and mastectomy in particular, was difficult and dangerous. In such circumstances, it is easy to see how female patients might be dominated, even inadvertently, by male surgeons. These stories, however, demonstrate that the gender relations attendant on cancer surgery were often more complex than one might expect. As we have seen, male surgeons carefully constructed their craft as compassionate, progressive and professional. Real-life women, with their garrulous voices and unbounded, unfathomable bodies, threatened to bring that edifice tumbling down.

Conclusion

Cancer surgeries were undoubtedly perilous operations, potentially lethal for the patient and professionally damaging for the surgeon. In addition, they were clearly intensely traumatic procedures, causing almost unimaginable pain of which medical practitioners were uncomfortably aware. The fact that such surgeries were nonetheless undertaken throughout the early modern period serves as testament to the agony and debility generated by growing tumours or ulcers. Looking at the language in which surgeons described cancer operations also reveals how far they imagined these procedures as part of a new, professionalised kind of surgery, in which collaboration and competition fostered improvement and innovation. Cancer surgeries served as a focus for these narratives for several reasons. There was a steady demand for tumour removals and mastectomies, such that a relatively standardised method could be established, a common ground for medical discussion. Cancer surgeries were, in a loose sense, elective surgeries, not undertaken on an emergency basis. This meant that surgeons could more readily go to view or participate in complex operations, and patients entrusted surgeons with their lives in an explicit and premeditated sense. Perhaps most significantly, the 'nature' of cancer – its status as malign, rebellious and alien to the body – encouraged an adversarial approach to the disease in which surgery offered the alluring prospect of extirpating the intruder.

These factors combined to ensure that cancer surgeries continued, and steadily increased, throughout the eighteenth century and beyond. Behind these larger narratives, however, individual patients and practitioners experienced surgery in ways that were terrifying, confusing and sometimes frustrating. One of the most curious aspects of early modern cancer surgery is the fact that not a single text I have examined mentions the change in bodily appearance effected by mastectomy, even obscurely. For those who survived this perilous operation, it seems that surgeons were reluctant to confront the possible costs of their success, or to undo the detachment from their patients which allowed them to carry out, and construct as progressive, such risky procedures. Of fables of Amazonian mastectomy in the early modern period, Paster speculates that

Mastectomy...implies the Amazon's crucial bodily heresy at least by comparison with the many claims, material and symbolic, on womb and breast in early modern culture – the heresy visibly to control their own bodies, to regulate their own reproductivity, and to offer

a model of self-government in which reproduction and nurture are only two of several forms of service and productive activity.¹²³

For the early modern woman, whose mastectomy was a forced choice, one-breasted existence was unlikely to represent a rejection of contemporary gender roles. Nonetheless, her altered body perhaps signalled to others the courage with which she had decided to assert control over her diseased body – even if that agency came at a high price.



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