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Sentimental Tools:
Literary Narrative, Female Bodies, and Medical Identities in France, 1795-1850

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Abstract

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As it did in so many other arenas, the French Revolution of 1789 razed the medical landscape in France. Revolutionaries, pushing for open access to all professions, successfully eradicated the corporate privilege that characterized medical practice in the *ancien régime*; where they failed, however, was in replacing it with any coherent set of professional guidelines. Professional medicine in the early nineteenth century foundered, without a clear course between the statist and laissez-faire models that had so clearly failed by 1803. A new clinical-associative model emerged in the 1820s that placed doctors in a position of establishing social value both through service to the state and through service to individual patients. Case narratives, as the primary link between the individual and the collective, became a discursive category of proof—and an integral component of medical identity—in the early nineteenth century. Doctors consciously sought to establish their place in the social hierarchy through a "scientific" validation of the bourgeois worldview, particularly with regard to questions of gender and class. They further cemented their authority by using literary narratives—sentimental, gothic, and realist—to give their arguments currency by establishing both the social value and the expertise of medical professionals. This dissertation thus argues for a re-conceptualization of the process of medical professionalization as a process of identity construction, based on a performative model of negotiation between creator and audience.

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The Construction of Medical Identities: Rethinking Professionalization in the Nineteenth Century

In 1825, a French doctor named Frédéric Hélie arrived at the bedside of a pregnant woman from the department of Orne. Summoned by Madame Dupuytren, the elderly midwife (*sage-femme)* who was attending Marie-Anne Foucault at the birth of her child, Hélie found the woman in much distress. Upon conferring with the midwife, the doctor learned that she had been shocked during an examination to find the child's right hand in the birth canal. Unsure what to do, the midwife called for a professional *accoucheur* to assume responsibility for this dangerous birth, thereby bringing Hélie into the events of that night. When Hélie examined Foucault, he felt the hand of her baby (who had been motionless for several minutes) and decided on dramatic action. Taking a knife, the doctor used it to remove the baby's right arm in order to maneuver the child into a more suitable position for delivery. After turning the infant in the birth canal, Hélie removed the other arm and delivered the child. Placing the stillborn infant at his feet, he turned his attention to delivering the placenta. While the doctor was tending to Madame Foucault, one of the women attending Foucault directed Hélie's attention to the armless child lying naked on the floor, insisting that she had seen the infant move. Hélie assured her that the child was most certainly dead and that what she had seen was undoubtedly the result of him accidentally nudging the body with his boot. The movements, however, continued as the birth attendants, increasingly alarmed at the doctor's inaction, washed the child in preparation for receiving sacraments. They noted

that he was bleeding heavily from the arms and slowed the flow of blood by applying tight compresses to the wounds, an action that saved the life of the armless child, allowing him to live a further six years.[1]

It was, by its very nature, a dramatic medical affair—a macabre scandal within the local community. But its true importance lay not in what happened on that night in 1825, but rather in the months and years following, specifically the way it highlighted questions of medical authority in early nineteenth-century France. This case—and the firestorm it sparked—suggests much of the complexity involved in how the medical community identified itself and its role in French society and how it portrayed that identity to a broad (and largely bourgeois) public, particularly in the 1830s and 1840s. The lessons of the Hélie Affair therefore ask us to reconceptualize power and professionalization as a cultural process, dependent on the conscious creation and re-creation of public identities by doctors and their detractors.

The Hélie scandal generated a series of letters, reviews, and editorials, written by litigants of this case, their representatives, and various members of the medical community of Paris. The essential question was straightforward: Did Hélie take an appropriate medical course (as defined by precedent and the medical knowledge of the day) or was his decision to remove the infant's arms an act of barbarism? It was, superficially at least, a matter of comparing case history with established protocol. Beneath the surface, however, this case reflected both a display of and a challenge to the

[1]Pierre Foucault to the Royal Academy of Medicine of Paris, Lettre à l'Académie Royale de Médecine de Paris, "Quéstion médico-mégale sur la mutilation des deux bras d'un enfant au sein de la mère, Papers Relating to the Académie Royale de Médecine from 1820-1832," Académie Royale de Médecine (hereafter cited as ARM), Receuil de Pièces, 1820, Box 27615, Bibliothèque Interuniversitaire de Médecine (hereafter cited as BIUM), University of Paris V.

power and authority of medicine, as each side debated the limits and meaning of one doctor's medical decisions.

The Civil Tribunal's appeal to the *Académie royale de médecine* as the ultimate arbiter of all questions medical publicly marked that Academy as a potent force in French society, but it was a force still in the process of defining itself and delineating its own disciplinary boundaries. Consequently, this medical scandal reflected in many ways the myriad strategies used by the medical community on its path to professionalization and power. How did medicine become a recognized and accepted public authority? The answer to that question lies in the multitude of case narratives that the litigants used to influence the outcome of the case, as each side sought to create a compelling narrative that would convince the tribunal of the "rightness" of its version of events. Together, they paint a picture of a collective discourse, delineating the boundaries of proof and purpose within the medical community and revealing how doctors understood their role in post-Revolutionary society.

Let us begin with the family that brought the suit. In 1827, Pierre Foucault wrote a letter to the *Académie royale de médecine*, asking the esteemed members of that group to examine the civil proceedings of this case and to lend their judgment of his wife's medical care. The very nature of this lawsuit reflected a change in the medico-legal process in France, a convergence of two bourgeois institutions (medicine and law) that claimed to have answers to the questions facing the French public in the early nineteenth century. The first chair of Forensic Medicine was established in France in 1794, but it was not until 1803 that reforms in the legal system required expert witnesses to be graduates of medicine and members of the medical community. Before that date, only

minimal medical knowledge (specifically one course taught by the *faculté de médecine*) was necessary for one to be considered a medico-legal expert.[2] The creation of the *Académie royale de médecine* in 1820 placed a new medical body at the forefront of this process, as one of the chief responsibilities outlined by the Academy's charter was offering collective opinions on legal matters.[3] Its power, however, remained new and relatively untested until the Hélie Affair, which is often cited as the first modern malpractice suit.[4] Their opinion would serve as a basis for the tribunal's verdict, a fact that Foucault noted in the opening of his brief:

> A poor peasant from the department of Orne comes with confidence to place in your hands the outcome of his entire family, by presenting for your examination the records of the proceedings and the judgment of the Civil Tribunal of Domfront, which constitutes and outlines the facts that should serve as the foundation for an answer to a question on which the Tribunal wants your wisdom and guidance.[5]

His language in this passage was simple and straightforward, in keeping with many of the rhetorical conventions of the day, as he portrayed himself as a simple man appealing to the proper authorities for help.

In addition, Foucault and his representatives used a highly sentimental language, one that was designed to elicit sympathy from their audience and to create an almost paternalistic relationship between the *Académie royale de médecine* and Foucault. Sentimentalism, as a literary genre, was particularly concerned with using language and imagery that were intended to evoke strong emotional reactions in its readers. Foucault

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[2]Matthew Ramsey, *Professional and Popular Medicine in France, 1770-1830*, (Cambridge: Cambridge University Press, 1988), 106-107.
[3]"Ordonnance portant création de l'Académie royale de médecine," *Annuaire de l'Académie royale de médecine* (Paris: Bechet jeune, 1824), 1-2.
[4]Claude Sureau, *Faillait-il tuer l'enfant foucault*, (Paris: Editions Stock, 2003).
[4]Pierre Foucault, Lettre à l'Académie royale de médecine de Paris, Quéstion médico-légale sur la mutilation des deux bras d'un enfant au sein de la mère, (Rouen: Imprimérie de Francois Marie, 1828), 3. BIUM, MS 46.

adopted similar strategies in order to make his readers empathize with his grief. In Foucault's original letters to the doctors of the *Académie royale de médecine*, he described himself as a "poor father" looking for justice for the "mutilation" of his son.[6] The legal brief prepared by his lawyer, Domfront, however, went even farther:

> The cries of this small, unhappy [infant] announced his existence and the need that he had for medical help. Nature struggled against pain and nothingness. The impassive obstetrician washed his hands, took *eau-de-vie*, and turned to Foucault with a calm air, without seeming to hear or see anything. His heart was not moved by pity in the midst of such an appalling scene. […] Hélie remained mute in the midst of a family in panic, and left without offering a word of consolation to the mother; without looking at the child; without attempting to relieve his suffering; without giving any advice on what could be done. O Humanity! […] and that such an act occurred in the middle of the civilization of the nineteenth century…! And this obstetrician today finds friends to excuse him, colleagues to defend him…" [7]

According to this version of events, Hélie failed not only as a surgeon, but (more fundamentally) as a "civilized" human being. Not only was he unskilled; he was uncaring. It was that perceived lack of compassion that Domfront highlighted in his brief, placing far more emphasis on the indifferent behavior of Hélie after the delivery than on the actual medical procedure. The lawyer focused on the coldness of Hélie's reaction, thereby creating a story wherein the central characters were polar opposites on a moral spectrum—the indifferent doctor who displayed nothing but callous disregard for the overwhelming suffering (both physical and mental) of a poor family helplessly dependent on his knowledge to guide them through a "distressing affair." Domfront's phraseology and his liberal use of exclamation points were indicative of a distinctly sentimental and melodramatic narrative strategy that emphasized the shocking nature of

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[6]Domfront, Speech delivered to the Académie royale de médecine during the Foucault Inquest, which took place between 28 June and 5 July 1826, ARM Receuil de Pièces 1820s, From the Library of Dr. Broca, BIUM, MSS 27615, #46,

[7]*Ibid*.

the incident and the appalling nature of Hélie's reaction, rather than arguing the specific medical facts of the case.[8]

Hélie, on the other hand, used an alternative rhetorical strategy as the heart of his defense. Focusing on the intricacies of the "art" of delivery and delineating clearly between those he felt capable of understanding his actions (the professional medical community) and those not (everyone else), he wrote,

> You, who understand the difficulties of the practice, can alone be the judges of my conduct as an artist […]. I declare, hand on conscience, that, being called in difficult labors, I know, theoretically and practically, all that the art teaches in deliveries with arm-first presentation.[9]

His oath was little more than obfuscation. In 1787, Jean Louis Baudelocque (who in 1806 would become the first chair of obstetrics in France) wrote a text entitled *Principes sur l'art des accouchements, par démandes et réponses, en faveur des sages-femmes de la campagne*, intended to be an encyclopedic compendium of existing knowledge about labor and delivery. In the case of an arm- or shoulder-first presentation, Baudelocque recommended pushing the arm back into the uterus to perform a version [manually turning the infant into a more conducive position] and then delivering the child in a more conventional manner.[10] So why did Hélie lay (false) claim to medical precedent? Why did he profess strict adherence to the standards of the day?

The answer to that question lies in Hélie's desire to overcome the challenges posed to him by Foucault and his representatives. For Hélie, the key to his defense lay in establishing himself as a respected member of the medical community and in stressing

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[8] *Ibid*.
[9] Hélie, Lettre à messieurs les membres de l'Académie royale de médecine de France, 7 March 1829, ARM Receuil de Pièces 1820s, From the Library of Dr. Broca, BIUM, MSS 27615, #37.
[10] Jean-Louis Baudelocque, *Principes sur l'art des accouchements, par démandes et réponses, en faveur des sages-femmes de la campagne* (Paris: Méquignon Ainé, 1787).

the difficulty of the profession he shared with his would-be judges. He depended on that inter-connectedness to lend his story a credence that could compete with Foucault's sentimental tale. Thus, he described his actions as perfectly in keeping with contemporary precepts and defended his actions both during and after the affair.

In constructing his defense and challenging Foucault's accusations, however, Hélie also employed many of the same sentimental and melodramatic strategies that he denounced in Foucault's brief:

> I have been depicted as a cold and barbaric mutilator who bathes in the sewer! If, after much distress, I should be the victim of my zeal to do good, I predict, sirs, that my ruin will bring about the loss of a large number of unhappy women who will remain unhelped. Experience gives weight to my words; since I have been pursued, in the canton I love, two women have died in labors with arm-first presentation without having been delivered by […] practitioners of the art. […]. In the difficult circumstances in which I found myself, I acted with conscience and with understanding of the art; if I committed a diagnostic error concerning the state of the fetus, there were many things that could have led me astray at the moment while I was entirely occupied with the health of the mother.[11]

Hélie ridiculed the charges leveled against him by exaggerating them to ridiculous proportions. He highlighted his own empathetic reactions to the scene, in order to negate the monstrous image of him painted by Domfront. In this way, then, the Hélie Affair reflects a shared belief in the persuasive power of sentimental and melodramatic strategies on both sides. What was it about those strategies that made them so compelling?

The answer to that question lies in the social and cultural uncertainties of the period after the Revolution in France, particularly as it pertained to gender norms. The Revolution had upset gender relations and, at the turn of the nineteenth century, there was tremendous political pressure to restructure those norms—ending women's political

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[11] *Ibid.*

clubs, executing outspoken women, and rejecting the concept of female citizenship. Women had certainly, over the course of the Revolution, taken to demanding a voice in the Revolutionary process. They submitted petitions to the National Assembly for certain rights and even resorted to riots to make their voices heard. It was an ambition that met with a great deal of political and social resistance in France. Many scholars have argued that the closing of women's clubs in 1793 was, in effect, a conclusive silencing of women who had been politically active during the years of the French Revolution.[12] Thus, by that year, "the woman question" that had been the subject of so much debate, referring specifically in this context to the question over what role women would play in the new Republic, was answered. Women's voices were silenced, making the story of gender and the French Revolution a story of the "limits of citizenship" for women.[13] According to this tale of French women's "defeat," then, 1793 offered a "definitive" solution that was codified in 1804 with the official adoption of Napoleon's Civil Code and justified in the latter half of the nineteenth century by the cultural adoption of the Victorian "cult of domesticity." And that, these scholars concluded, was the French path to late nineteenth-century female domesticity.[14]

In the 1990s, however, scholars began to question the neatness of this report, particularly its ability to account for the complexity of contemporary conceptions of

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[12]Joan Landes, *Women and the Public Sphere in the Age of the French Revolution* (Ithaca: Cornell University Press, 1988); Olwen Hufton, *Women and the Limits of Citizenship in the French Revolution* (Toronto: University of Toronto Press, 1992).

[13]The phrase "limits of citizenship" is taken from Olwen Hufton and her book, *Women and the Limits of Citizenship in the French Revolution* (Toronto: University of Toronto Press, 1992).

[14]For other traditional scholars positing these views, see Joan Landes, *Women and the Public Sphere in the Age of the French Revolution* (New York: Cornell University Press, 1988); James McMillan, *France and Women, 1789-1914* (London: Routledge Press, 2000); James McMillan, *Housewife or Harlot: The Place of Women in French Society, 1870-1940* (New York: St. Martin's Press, 1981); and Jane Abray, "Feminism and the French Revolution," in *The French Revolution in Social and Political Perspective*, ed. Peter Jones (London: Hodder Arnold, 1996), 236-252.

gender, which, as a socio-cultural construct, operates on a variety of levels and plays out in a variety of arenas. These scholars argued that "the woman question" in fact remained unanswered and very much at issue well beyond the dissolution of the women's clubs. The year 1793, for these revisionists, was merely one step in a much longer (and far murkier) process of subjugating of women in late eighteenth- and early nineteenth-century France.[15] After all, gender norms went deeper than just the political level. While representatives in the National Assembly thought they had solved the problem by silencing women's legitimate political voices (and gender historians have long accepted it as a truism), it was, in fact, merely a superficial solution. In the last decade, a number of scholars have convincingly demonstrated that the closing and banning of women's clubs did not silence women's political voices. By examining family and civil law in post-1793 France, for example, Suzanne Desan has shown how French women often considered themselves equal to their male counterparts in the legal arena, initiating lawsuits over divorce, inheritance, paternity, and other marital disputes as a claim to autonomy over their own lives as part of a family. These women saw themselves as having powerful rights within the context of the family and family law.[16] Jennifer Ngaire Heuer, on the other hand, has looked at the civil cases of female *émigrées* who contested accusations that they had abandoned the nation and were undeserving of civic rights.

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[15]Dominique Godineau, for example, has argued that women's voices continued to make themselves heard well past 1793 and into the period of the Directory. Focusing on the collective action of women, primarily in the radical clubs, Godineau argues that political rights and complete equality with men were never truly an issue for these revolutionary women. Pointing to the fact that it is impossible to separate the economic (subsistence crises), social (class), and political (citizenship) issues imbedded within the women's movement, Godineau has made a compelling argument that, even after the official banning of the clubs, women's voices were not immediately silenced. After 1793, the movement continued to take the form of more personal protestations, until they were permanently silenced by the victorious Convention for their role in an uprising of *prairial* year III. See Godineau, *The Women of Paris and their French Revolution*, trans. Katherine Streip (Berkeley, CA: University of California Press, 1998).

[16]Suzanne Desan, *The Family on Trial in Revolutionary France* (Berkeley: University of California Press, 2004).

These women, according to Heuer, capitalized on the tension between family and nation and specifically women's roles therein. Because they were subordinated within their own households, the *emigrées* argued, they could not be held responsible for the actions of their fathers or husbands. They used this ambiguity, this loophole, if you will, to apply for amnesty and the right to return to France under the Directory. According to Heuer, questions of citizenship and female rights were not answered by 1793, at least not practically.[17]

Denise Davidson has further complicated the question of the Revolution's impact on women by pointing to the myriad ways in which women of all classes carved out room for themselves in the urban landscapes of Revolutionary France. The Revolutionary project, in Davidson's estimation, blurred traditional social boundaries and created new spaces for the presentation of self and the observation of others. Those boundaries remained permeable until around 1830, when increasing class distinctions under the July Monarchy hardened boundaries and avoided potential disaster by dividing society into fundamentally separate spheres, based not just on gender, but on class as well. Considered collectively, then, these scholars have rethought the concept of public space, and demonstrated that female subordination was not the product of Revolutionary ideology, but rather a conservative response to Revolutionary experimentation.[18] As women repeatedly pushed against the boundaries of their normative identity within the French nation and exploited ambiguities in law, custom, and ritual to make spaces for

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[17]Jennifer Ngaire Heuer, *The Family and the Nation: Gender and Citizenship in Revolutionary France, 1789-1830* (Ithaca: Cornell University Press, 2005).
[18]Robert Nye, "Women, Work and Citizenship in France since 1789," *Gender and History* 18, no 1 (April 2007): 188.

themselves, they revealed the complexities of "the woman question" in France in the late eighteenth and early nineteenth centuries.

There are limitations to such arguments, however. Robert Nye, for example, has criticized both Desan and Heuer for their dismissal of the eighteenth-century biological (or what he called "medico-philosophical") construction of women as inherently procreative and maternal. There was, he argued, a discursive construction of gender patterns that negated any true argument for equality, whether political, ideological, or legal.[19] As such, he questioned whether deeply rooted gender norms were ever *truly* in flux. Susan Foley has agreed, noting that pre-Revolutionary fears of female sexuality and political power (notable in criticisms of Madame de Pompadour and Marie Antoinette) continued to appear throughout the late eighteenth and early nineteenth centuries and consequently limited any attempt by women to gain citizenship and/or political rights.[20] Nye's and Foley's critiques are particularly compelling when placed in the light of the post-Revolutionary turn to science as an arbiter of truth.

In the immediate post-Revolutionary period, different elements of French society exhibited a fascination with what was perceived as the absolute truth inherent in science and math. Marie-Noelle Bourguet has pointed out that the Napoleonic period saw an increasing fascination, bordering on obsession, with statistics and the quantification of all aspects of life and the nation.[21] Moreover, Robert Nye has suggestively argued that, after the Revolution, there was an increase in the use of naturalist discourse and interest

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[19] *Ibid*.
[20] Susan K. Foley, *Women in France since 1789: The Meanings of Difference* (New York: Palgrave Macmillan, 2004).
[21] Marie-Noelle Bourguet, *Dechiffrer la France, la statistique départementale à l'époque napoléonienne* (Paris: Éditions des Archives Contemporaines, 1988).

in those elements of society subject to natural law—like science.[22] After a period of dramatic fluctuations in the political conception of gender, a turn to the naturalized language of medicine and the biological imperative offered a compelling and reassuring answer to the gender question. Nye wrote,

> Because this change [in understandings of gender and sexuality] coincided with the era of revolutions at the end of the eighteenth century, it seems reasonable to conclude that bourgeois political theory required the elaboration of new 'natural' relations in society that would somehow counteract unsettling experiments with political liberty. Indeed, the more radical the political vision, the more conservative the outlook on the proper relations between the sexes, as the example of Rousseau so clearly illustrates.[23]

As they attempted to clear a path out of the Terror, the French sought to reconstitute gender norms that had been in flux during the Revolution, and legislative decrees were hardly sufficient to create a set of gender norms with the power to structure society. Instead, the French turned to a language of natural gender difference, a language that was buttressed by the emergent authority of professional medicine. No longer content with the philosophical debates of Enlightenment thinkers like Rousseau or Condorcet, many in the French nation wanted concrete solutions to the problems of the post-Revolutionary world. They wanted certainty. They wanted science.

In the last decade, a number of scholars have explored the question of what role science played in the post-Revolutionary period. Jean-Luc Chappey, for example, in studying a short-lived social scientific institution known as the *Société des Observateurs de l'homme*, has reconceptualized the process by which scientific groups rose to social prominence. The *Société des Observateurs*, Chappey claimed, emerged not from scientific advances, but rather from a shared desire among many (particularly religious)

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[22]Robert Nye, "Honor, Impotence, and Male Sexuality in Nineteenth-Century French Medicine," *French Historical Studies* 16, no. 1 (Spring 1989): 48-71.
[23]*Ibid*., 49.

counter-Revolutionaries to regain control over public discourse after the upheaval of the Republic. The success of the group (however limited it might have been) was, for Chappey, rooted in the social network that surrounded the *Observateurs*. Indeed, the most compelling aspect of Chappey's work is his recognition of the struggle the *Société* faced in maintaining its cultural currency in post-Revolutionary France. Almost immediately after the group's founding in 1800, questions about its scientific and social relevance emerged. Attempts to bring recognized scientists and scholars into the group (to validate that relevance and make it more "marketable") strained the social dynamics of the group and forced the creation of new regulations to govern their collective work. In recognizing the convergence of science and the marketplace, Chappey has demonstrated that scientific identities have always been defined by social interaction—relations among members, expectations of the audience, and the mundane workings of the publishing community. As a result, what the *Société* studied and published was often less the result of intellectual curiosity than it was about the appetite of an audience for certain material. When the desire disappeared, so too did the *Observateurs*.[24]

This model for understanding the relationship between science and society in the early nineteenth century as the consequence of a rather symbiotic relationship between expert performance and audience expectation has proved compelling. In 2005, Pietro Corsi argued that science occupied a privileged position during the Directory because it offered a discourse of order and reason. When that order was imposed by Napoleon,

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[24]Jean-Luc Chappey, *La Société des Observateurs de l'homme: Des anthropologies au temps de Bonaparte (1799-1804)* (Paris: Société des études robespierristes, 2002). Chappey has also written on what he deems the *vulgarisation* of science in two articles: Jean-Luc Chappey, "Enjeux sociaux et politiques de la 'vulgarisation scientifique' en Révolution (1780-1810)," *Annales historiques de la Révolution française* 338 (October – December 2004): 1-31; Jean-Luc Chappey, "Sciences et politique en Révolution (1792-1802) : Questions autour de 'l'exception française'," in *Révoltes et révolutions de 1773 à 1802*, ed. P. Bourdin, and S. Bianci (Paris: Éditions du Temps, 2004): 251-276.

interest in science faltered.[25] Christelle Rabier has further demonstrated how scientific publications, particularly in the publication of surgical textbooks, became increasingly esoteric over time. Such shifts fostered the creation of a new medical community, distinct from its earlier (more general) audience.[26]

What this means for historical understandings of science in nineteenth-century France is that its rise to prominence was the result not of a separation from social upheaval, but rather of a complex and often symbiotic relationship between the two, defined largely by a mutual quest for stability and security in the post-Revolutionary world. Medicine, built as it was on the foundations of science in the nineteenth century, was part of the same process; early nineteenth-century doctors were subject to the same social and cultural demands as Chappey's *Observateurs* and Rabier's surgeons. By rethinking the changes that took place in French medicine during and after the Revolution, we can begin to see the immeasurable influence that socio-cultural uncertainty had on the professionalization of medicine in the nineteenth century.

French medicine underwent a dramatic transformation at the turn of the nineteenth century.[27] Beginning with the Revolution itself, *ancien régime* patterns of medical organization disappeared. The *cahiers de doléances* of 1789 that called for dramatic changes to the medical profession had the added effect of creating a new

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[25]Pietro Corsi, "After the Revolution: Scientific Language and French Politics, 1795-1802," in *The Practice of Reform in Health, Medicine, and Science, 1500-2000. Essays for Charles Webster*. eds. Margaret Pelling and Scott Mandelbrote (Aldershot: Ashgate, 2005) 223-245.
[26]Christelle Rabier, "Vulgarisation et diffusion de la médecine pendant la Révolution: l'exemple de la chirurgie," *Annales historiques de le Révolution française* 338 (October-December 2004): 75-94. See also Rabier, "Publier le geste chirurgical : la lithotomie en France et en Grande-Bretagne (1720-1820)" in *Formes et significations des gestualités médicale, guerrière et politique*, eds. Anne-Claude Ambroise-Rendu, Fabrice D'Almeida and Nicole Edelman (Paris: Seli Arslan, 2006), 29-41.
[27]Matthew Ramsey, *Professional and Popular Medicine in France*; Dora Weiner, *The Citizen-Patient in Revolutionary and Imperial Paris* (Baltimore : Johns Hopkins University Press, 1993).

discourse of public health for Revolutionaries.[28] Michel Foucault has argued that this discourse, which made public health a concern of state, broke down during the Revolutionary period under the pressure of two competing theories of how best to ensure public health. The first was a utopian (Rousseauist) vision of social rebirth and regeneration that would eliminate disease and render doctors unnecessary. The second was a more practical approach to health that focused on making health care available to all French citizens. This division, Foucault says,

> allowed medicine to 'play' an important role by linking medicine with the destinies of states, they revealed in it a positive significance. Instead of remaining what it was, the dry, sorry analysis of millions of infirmities, the dubious negation of the negative, it was given the splendid task of establishing in men's lives the positive role of health, virtue, and happiness.[29]

Despite, or perhaps because of, this idealism, Revolutionaries were never able to create an institutional program for medical reform to effect their vision.[30]

Medicine was thus, at the turn of the century, caught up in the Revolutionary project to reinvent the social order. When that project ultimately collapsed, medicine too destabilized—the old structures were gone, but new ones had not been created to take their place. Thus, as medicine and nature became a discourse of recovery in the volatile post-Revolutionary period, particularly in the realm of upset gender norms, it did so in a veritable vacuum of medical identity and authority. Nineteenth-century doctors capitalized on this openness by investing the medical project with social significance by offering answers to the "woman question." Doctors' ability to speak for the female body,

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[28]Jean-Pierre Goubert and Dominique Lorillet, *1789: Le Corps Medical et le Changement: Les Cahiers de Doléances des Médecins, Chirurgiens, et Apothocaires* (Toulouse: Editions Private, 1984).
[29]Michel Foucault, *The Birth of the Clinic: An Archeology of Medical Perception*, trans. Sheridan Smith (New York: Vintage Books, 1973), 34.
[30]Ramsey, *Professional and Popular Medicine*, 122-128.

to understand and explain it in the very scientific terminology that was so compelling in post-Revolutionary France, made them experts on this "woman question." They defined and controlled the terms of the debate by supporting an argument that women's bodies (for all their social and cultural complexity) were defined by fundamental biological differences.

By subsuming the social and cultural components of female identity within the biological ones, nineteenth-century French doctors narrowed the field of experts, so to speak, in a way that appealed to many French men (and women) after the upheaval of the Revolution. Women's bodies—and the countless socio-cultural manifestations they entailed (mother, daughter, wife, lover, actress, prostitute, widow)—were placed under the auspices of natural law and the only men trained to understand that law: doctors. The fascination with women's bodies, as exemplified by the rise of obstetrics, was therefore not accidental; it granted doctors a great deal of power over the debate about women's proper place in society, by creating an authority that transcended the parameters of the immediate subject. That medical authority, both in its creation and in its transmission (two closely connected concepts, as we shall see), was central to medical professionalization. Medicine in the nineteenth century operated as a form of cultural authority that guided the restructuring of gender, a question of extreme importance in the post-Revolutionary period. As medicine offered a popular, naturalistic proof of a conservative gender order, it garnered more power in French society. The question is how. Certainly the fact that it *could* offer a compelling answer to the gender question played a role, but it took more than that to establish the authority of medicine. How then did medicine become a cultural authority?

Thomas Laqueur has offered an explanation of the "how" and "why" behind the nineteenth-century medicalization of fears about female sexuality and power in his *Making Sex: Body and Gender from the Greeks to Freud*.[31] Gender, according to Laqueur, has been a remarkably stable force in history; sex, on the other hand, has seen a great shift between two paradigms that seem to correlate only in the fact that each supported contemporary conceptions of gender. This change that was not attributable merely to advances in medical and scientific knowledge, but must rather be examined within the greater context of the intersection of power and knowledge. Sex, in his words, must be analyzed as "a sociological and not an ontological category."[32] One of Laqueur's most significant contributions has therefore been the recognition that the science upon which western medicine was built was a construction that developed in response to specific historical circumstances. As such, this medico-scientific claim to understand women and to provide an answer to "the woman question" imbued medical doctors with a certain degree of social authority, so that, as the authority of science grew in nineteenth-century Europe (and particularly in post-Revolutionary France), so too did the importance of the physical female body in conceptions of women's role in society. Thus, in the early nineteenth century, French doctors were able to build for themselves a sort of professional authority that had not existed prior to that period.

What these observations indicate is the necessity of challenging prevailing scholarly conceptions of medical professionalization. It was born not in the blossoming of medical institutions (clinics, hospitals, medical colleges) of the late nineteenth century, as is generally thought, but rather in the cultural complexity of the previous half century.

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[31]Thomas Laqueur, *Making Sex: Body and Gender from the Greeks to Freud* (Cambridge, MA: Harvard University Press, 1990).
[32]*Ibid*., 8.

It was born not of medical advances and changes in science, but rather in the relationship between the medical profession and society at large—between a doctor-writer and a (largely middle class) audience that was literate and engaged. In many ways, then, professionalization in French medicine was based on a performative model (where professional elitism was defined by the value placed on services rendered and rooted in the relationship between performer and audience), rather than an institutional one. As nineteenth-century French doctors seized the opportunity of the post-Revolutionary period to make their case for indispensability to the general public by offering answers to "the woman question," they used medical texts as a way of demonstrating their authority. Examining medical case studies focused on the female body, both individually and as a collective, will demonstrate how culture and science merged into a new type of medical literature, a new discourse that would serve as the basis of a new medical profession in France.

In the last 75 years, historical approaches to medicine have changed dramatically. Following the call of Henry Sigerist to place medicine within a broader context, there was an increase in social histories of medicine during the 1970s and 1980s, histories that focused methodologically on the institutions and practice of professional medical doctors. This marked a decided shift from the early twentieth-century tendency to consider the history of medicine as an ever-progressive story of scientific and technical advances, of medicine's path to modernity. After all, to quote Sigerist, by the mid-twentieth century, we knew

> much about the history of great medical discoveries, but very little on whether they were applied or to whom they were applied. In every medical action there are always two parties involved, the physician and the patient, or, in a broader sense, the medical corps and society. […].

> Medicine is nothing more than the manifold relations between these two groups.[33]

Under the influence of Sigerist, early understandings of medicine as inexorably progressive gave way to more complex analyses of competing social, institutional, and intellectual sites of uneven medical development. Social historians began to study non-institutional medical practice and practitioners—seeking to place charlatans, religious healers, and female midwifes alongside physicians and surgeons in the medical community. They examined the social dynamics of educational standards, access to doctors, the politicization of medicine, as well as the social perception of medicine. Scholarly understandings of medicine were suddenly much messier, boundaries much less well defined, and the idea of constant and limitless medical advancement almost universally abandoned. Medicine could no longer be seen as the sum of medical discoveries and advancements; rather, in many ways, it became the story of relationships—among doctors, between doctor and patient, between discovery and application, between its popular and professional incarnations. The multi-dimensionality of these relationships is important because it captures what was at the heart of Sigerist's call in 1940: the idea that medicine cannot be separated from the society of which it is a part.

One of the keys to this social history of medicine, therefore, was an understanding of professionalization as the intentional demarcation of those institutions and practitioners that would be considered legitimate, separating them from those that would

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[33]Henry Sigerist, "The Social History of Medicine," *The Western Journal of Obstetrics and Gynecology* 48 (1940): 714.

not.[34] The distinction between professional and popular was therefore built, in this social approach, around a uni-directional process whereby the professional displaced the popular as the accepted form of medical practice. In 1992, Roy Porter attempted to take that recognition of competing medicines in a new direction, noting that "[s]cholars have been recognizing more clearly since the early 1980s that what they study is not so much the history of medicine as histories of medicines. For there has never been a single, homogeneous body of theory and practice answering to the name 'medicine'; the terrain of healing has always been characterized by great diversity."[35] Medicine, then, was not merely what went on in the elite world of professional medicine; there were, outside of that realm, countless alternative approaches to medicine that complicated the professionalization of medicine. Still, this multitude of medicines has, for the most part, remained divided into two consistent categories—medical trends that belonged to professional (scientific) medicine and those that belonged to popular (or folk) medicine.

Several scholars have recently attempted to complicate that view by demonstrating important links between these two categories, spurred in part by Porter's proclamation that "one important aspect seems largely to have remained in the shadows: the development of medical popularization, the process by which regular medicine is diffused to the wider public."[36] Even in opening this new field of inquiry, however, these works have largely replicated the problematic tendency to differentiate somewhat arbitrarily between those elements deemed part of professional medicine and those dismissed as popular.

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[34]Susan M. Reverby and David Rosner, "'Beyond the Great Doctors' Revisited: A Generation of the 'New' Social History of Medicine," in *Locating Medical History: The Stories and their Meanings*, eds. Frank Huisman and John Harley Warner (Baltimore, MD: Johns Hopkins University Press, 2006), 167-193.
[35]Roy Porter, Introduction to *The Popularization of Medicine, 1650-1850* (London: Routledge, 1992), 1.
[36]*Ibid.*

The problem lies in a positivistic understanding of professionalization and popularization that is overly dependent on a model that posits clear and identifiable distinctions between the professional and popular realms. Jacques Poirier, for example, in 1983, was the first to define medical popularization as the re-creation of professional medical concepts in a manner that rendered them accessible to a lay audience. The process by which this occurred, Poirier argued, involved the intentional transformation of an extant medical corpus into something that had a broad-based appeal, built on two important goals: 1) a more general intelligibility; and 2) a more practical applicability. The narrow confines of this definition created a strict distinction between popular medical literature and the professional work from which it was derived, so that while the professional can be made popular, the reverse is inherently impossible.[37]

In so conceptualizing the process of popularization, early social historians of medicine advanced an understanding of the relationship between professional and popular medicine that was uni-directional, proceeding *from* the professional realm *to* the popular one, prompting challenges from a new school of medical historians. Matthew Ramsey, for example, has examined the uneasy overlap between popular and professional medicine, noting the tenacity of popular medicine and the inability of members of the medical profession in France to eradicate folk medicine completely in the period between 1770 and 1830. Yet his argument about the blurred boundaries between professional and popular medicine retains enough of Poirier's model to suppose that professional medicine was built through the "top down" exclusion of popular medicine and culture:

> Recent work in the sociology of science […] has questioned the model of popularization as the one-way diffusion from scientists to laymen of

[37]J-L Poirier, "La vulgarisation médicale: considérations philosophico-historiques," *Revue d'éducation médicale* 6 (1983): 184-190.

> simplified and therefore distorted versions of esoteric knowledge. [..] But the distinction made within modern medical discourse between its 'technical' and 'popularized' forms, and the differences between the rules that govern them, are clear enough to justify retaining the model here.[38]

While this power dynamic is undoubtedly true at the institutional level, Ramsey underestimates the degree to which the professional and the popular (reconceptualized as the *processes* of professionalization and popularization) were interdependent in the nineteenth century.[39] There was no uni-directionality in the relationship between professional and popular medicine. Without popular culture and popular medicine, professional medicine could not have taken the path it did. Rather, the emergent authority of professionalized medicine was dependent on the ability of doctors to convince a broad public of doctors' expertise and value, something that could not happen in a vacuum. Chappey recognized this fact when he penned the following lines: "If specialized scientific publications encountered financial and commercial difficulties as a result of the limited audience for which it was intended, the commercial success of agronomical and technical works demonstrated that there was an audience for science outside the group of professors and their students."[40] For Chappey, acknowledgment of the blurred boundaries between the professional and the popular in early nineteenth-century science was fundamental to the establishment of scientific institutions, forced as they were to grapple with the divide between two seemingly irreconcilable audiences.

Such an approach necessitates a change in our understanding of the professionalization of medicine by recognizing the ways in which the process of

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[38]Matthew Ramsey, "The Popularization of Medicine in France, 1650-1900," in *The Popularization of Medicine, 1650-1850*, ed. Roy Porter (London: Routledge, 1992), 97. Ramsey's work on the overlap of popular and professional medicine is also a central tenet of his monograph, *Professional and Popular Medicine in France, 1770-1830* (Cambridge: Cambridge University Press, 1988).

[40]Chappey, "Enjeux sociaux," 21.

professionalization equally depended on the process of popularization. For guidance, we can turn to sociology. Stephen Hilgartner has argued that, because medical discourse is a site of struggle for control and authority, professionalization cannot depend on the exclusion (however successful or unsuccessful) of popular discourse. Rather, for Hilgartner, it is built on the ability to use elements of each in a manner that best meets its goals.[41] Understanding the rise of modern medicine in this way opens up a new way of viewing the relationship between science and the culture of which it was a part.

Influenced by Michel Foucault's conception of the medical gaze and his ideas about the normativizing role of the medical profession in the nineteenth century, scholars such as Thomas Laqueur and Ludmilla Jordanova began to reveal the culturally constructed nature of physiological understandings of the human body, particularly the *female* human body.[42] These scholars have effectively shown how changes in medical/scientific understandings were tied not just to scientific discovery, but also to issues of political culture, including questions of gender. "Of all the tools with which woman has been named," Marina Benjamin has noted, "science has been invested with privileged authority" because it could claim its roots in nature and ground itself in objectivity.[43] It was an authority that transformed science into a powerful arbiter of "truth," a conflation that was, as Benjamin has argued, flawed because it ignored "the

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[41]Stephen Hilgartner, "The Dominant View of Popularization: Conceptual Problems, Political Uses," *Social Studies of Science* 20, no. 3 (Aug 1990): 519-539. See also Hilgartner, "Science Advice as Public Drama," in *Science on Stage: Expert Advice as Public Drama* (Stanford, CA: Stanford University Press, 2000).

[42]See Ludmilla Jordanova, *Sexual Visions: Images of Gender in Science and Medicine Between the Eighteenth and Twentieth Centuries* (Madison: University of Wisconsin Press, 1989); Thomas Laqueur, *Making Sex: Body and Gender from the Greeks to Freud* (Cambridge, MA: Harvard University Press, 1990).

[43]Marina Benjamin, *A Question of Identity*: Women, Science, and Literature, (New Brunswick, NJ: Rutgers University Press, 1993), 121.

relationship between masculinity and knowledge production."[44] Medicine and science, traditionally controlled by men, have been structured around a patriarchal paradigm (wherein men are subjects and women are objects) that normativized the superiority of the masculine.[45]

Londa Schiebinger has taken it a step further, noting that the Scientific Revolution, which took place in the West during the seventeenth and eighteenth centuries, was ultimately built on the exclusion of women and "the feminine" from science.[46] Combined with Laqueur's conclusions about the determinant quality of gender and other compelling demonstrations that certain mid-century debates were as much concerned with the philosophico-religious questions of medical intervention in childbirth as they were with scientific discovery, this strand of medical historiography has successfully reconceptualized medicine as a site of contested gender relations within a centuries-old cultural struggle over power and knowledge.[47]

What is ultimately missing from this gender-based methodology is a sense of historical specificity. Rather than focusing on how clearly defined social and cultural trends that prompted shifts in the medical model, many of these scholars have posited almost ahistorical paradigmatic shifts, dependent only on maintaining the superiority of "the masculine." If one narrative stopped working, it was replaced with another, regardless of historical precedent. This oversight is problematic, particularly in the late

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[44]*Ibid*., 8.
[45]Evelyn Fox Keller, *Reflections on Gender and Science* (New Haven, CT: Yale University Press, 1985).
[46]Londa Schiebinger, *The Mind has No Sex? Women and the Origins of Modern Science* (Cambridge, MA: Harvard University Press, 1989).
[47]Laqueur, *Making Sex*. Mary Poovey, "'Scenes of an Indelicate Character': The Medical Treatment of Victorian Women," in *The Making of the Modern Body: Sexuality and Society in the Nineteenth* Century, eds. Catherine Gallagher and Thomas Laqueur (Berkeley: University of California Press, 1989) 137-168. See also the other articles in *The Making of the Modern Body*; Ann B. Shteir and Bernard V. Lightman, eds, *Figuring it Out: Science, Gender, and Visual Culture* (Hanover, University Press of New England, 2006); and Joan Huber, *On the Origins of Gender Inequality* (Boulder: Paradigm Publishers, 2007).

eighteenth and early nineteenth centuries (at the crux of both scholars' arguments), because the degree of upheaval and the rapidity of change precludes any sense of inevitability. There were always several competing discursive possibilities at any given moment in the post-Revolutionary period. How did medicine and science emerge from that struggle so privileged? Again, the complexity and uncertainty of the post-Revolutionary period in French history is instructive.

In France, early nineteenth-century medical history was dominated by debates over the nature and meaning of medical authority itself. As we have already seen, the Revolutionary medical project collapsed, leaving behind it a plethora of questions concerning the state of professional medicine in France. From public health to medical education, doctors and legislators alike argued over where the boundaries of professional medicine should be drawn. Those debates, originating outside of medicine, spilled over into the practice of medicine itself. What is needed is an exploration of how a blend of socio-cultural debates and medical knowledge merged to create specific discourses that defined the authority of medicine. Still, one of the most significant contributions of this cultural turn in medicine has been a recognition that the medical world was bounded by multiple discourses, which were constitutive, rather than reflective, of medical knowledge, medical experience, and medical identity.

One model for exploration has been provided by scholars Angus McLaren, William Bynum, and Jan Goldstein, who have collectively pointed to the mid and late nineteenth century as a crucial period in the creation of medical identities in the west. Goldstein, for example, has convincingly demonstrated that, in the nineteenth century, a new psychiatric profession arose in France through a struggle over which group

(psychiatrists or the Church) had the moral and social right to diagnose and treat the mentally ill, particularly on the question of hysteria. The victory of the psychiatric community over its rivals, according to Goldstein, reflected its ability to convince an audience that they were the community's members as scientific specialists, were best equipped to "console and classify" mental illness, particularly illnesses such as hysteria and monomania that were popular topics of discussion even outside of the medical community.

Moreover, these scholars have argued that the rise in hysteria diagnoses in the latter half of the nineteenth century afforded doctors in France and Britain an entry into the fabric of the bourgeois family structure.[48] Medical concern over women's nervous maladies provided a path to "respectability," according to McLaren, by sustaining and strengthening "the old myths of female inferiority:"[49]

> In the first half of the nineteenth century, the French doctor's record of triumphing over disease was not itself sufficient to establish the credibility of medical science. Able to offer his patients few tangible benefits, he could only make himself an indispensable fixture of bourgeois society by becoming, in addition to its medical consultant, its moral counselor and confessor.[50]

In other words, mid and late nineteenth-century concern over hysteria (and the rise in such diagnoses) was less the result of changes in bio-medical understandings of the female nervous system and more the result of French doctors' desire to make themselves a more important part of bourgeois society. By inserting themselves into the cultural narratives of the day, doctors carved out a niche in the power dynamics of the period.

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[48]Angus McLaren, "Doctor in the House: Medicine and Private Morality in France, 1800-1850," *Feminist Studies* 2 (1975): 39-54; William Bynum, Roy Porter, and Michael Shepherd, eds, *The Anatomy of Madness: Essays in the History of Psychiatry* (London: Tavistock Publications, 1985).
[49]McLaren, "Doctor in the House," 39.
[50]*Ibid*.

These scholars have offered an intriguing methodology, suggesting that late nineteenth-century doctors used medical literature in a multitude of ways, but always with an eye to a broad audience empowered to determine medicine's role in society. Sociologically, identity is understood not as a state of being, but rather as a complex cultural process whereby the observer and the observed negotiate a shared understanding of one's place in a common world, so that it "encompasses some notion of human agency, an idea that we can have some control in constructing our own identities."[51] Beginning with noted sociologist George Herbert Mead in 1934, this approach has treated identity as a negotiation between the internal and the external, one in which people must constantly imagine and re-imagine how others perceive them.[52] Identity is thus understood to be deeply rooted within the culture or society of which it is a part, so that identity and identity creation are built on a common understanding of symbols and their meaning.[53] Identity, then, is not an ahistorical state of being, but rather an act, the nearly continuous creation and re-creation of a dialectical relationship between actor and audience.

Consequently, in treating medical identities as a dialectical process, the work of medical historians such as McLaren and Goldstein is compelling, but is ultimately limited by an historiographical tendency to equate medical interest in the female body with the hysteria diagnosis in the later nineteenth century. This trend ignores the qualitative and quantitative weight of obstetrical and gynecological cases in the earlier half century and

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[51]Kath Woodward, *Questioning Identity: Gender, Class, and Nation* (London: Routledge, 2000).
[52]George Herbert Mead, *Mind, Self, and Society* (Chicago: University of Chicago Press, 1934). For more on Mead's "social psychology" see David L. Miller, ed., *The Individual and the Social Self: Unpublished Essays by G. H. Mead* (Chicago: University of Chicago Press, 1982) and Alex Gillespie, "G.H. Mead: Theorist of the Social Act," *Journal for the Theory of Social Behavior* 35, no 1 (2005): 19-39.
[53]Judith Williamson, *Consuming Passions: The Dynamics of Popular Culture* (London: M. Boyars, 1986).

instead embeds itself in a belief that there was a veritable split in the middle of the nineteenth century between earlier scientific advances, which "scientized" medicine, and later cultural (discursive) dynamics, through which doctors became an integral part of society, particularly in the gendered field of hysteria diagnosis and treatment. The late nineteenth century did not *invent* a culture of medical power based on writings about the female body; rather such a culture was in fact rooted in both the post-Revolutionary debates over gender and the unquestioned conflation of science and truth.[54]

Michael Francis Brown, in a dissertation entitled "For the Dignity of the Faculty," has challenged the standard chronology of nineteenth-century medical professionalization by looking at the work of doctors in York. Rather than accepting the usual division of the nineteenth century into two halves, he sees one trend developing between 1760 and 1815 and a distinct, though related, trend between 1815 and 1850. Both trends, he has argued, were the result of the self-conscious crafting of a public identity by various members of the medical community (physicians, surgeons, apothecaries, general practitioners) as they attempted to validate what they did. In the earlier period, their justification involved crafting a public image that emphasized what Brown calls "medico-gentility" or a mastery of "polite" knowledge. The latter period, in contrast, highlighted the doctor's role as public servant. What is most compelling here is Brown's strategic manipulation of how doctors portrayed themselves to the general public, an attention that came in response to the shifting needs and expectations of that society. Between 1760 and 1815, doctors stressed their expertise and superiority. Between 1815 and 1850, they pointed to

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[54]For more information on gender and hysteria in the late nineteenth century, see Jan Goldstein, *Console and Classify: The French Psychiatric Profession in the Nineteenth Century* (Chicago: University of Chicago Press, 1987); Janet Beizer, *Ventriloquized Bodies: Narratives of Hysteria in Nineteenth-Century France* (Ithaca, NY: Cornell University Press, 1994); and Evelyne Ender, *Sexing the Mind: Nineteenth-Century Fictions of Hysteria* (Ithaca, NY: Cornell University Press, 1995).

their valuable contributions to public health.[55] As such, Brown has provided an exciting model for medical professionalization, one that locates the origins of English medical professionalization not in the late nineteenth century, but rather in the late eighteenth and early nineteenth centuries.

Medicine in France underwent much the same process, but it was condensed and refocused by the French Revolution. The creation of any recognizably modern professional medical identity did not begin in earnest until after the Revolution had cleared the impediments to medical progress that were institutionalized in the *ancien régime*. Revolutionaries created a new space for change after 1789 that was unthinkable in the corporate world of socio-economic privilege.[56] It was not until the 1790s that changes in medical identity, rooted in cultural concerns defined by the upheaval of the Revolution, began to appear. If we apply Brown's connection of identity formation with the professionalization of medicine in the first half of the nineteenth century to France, however, a new image of the emergence of the medical profession in France emerged. This line of inquiry seeks not to examine specific medical knowledge, but rather to identify and analyze competing cultural discourses concerning the authority of medicine. To make sense of the performative nature of identity creation, we must turn to a line of inquiry that, interestingly enough, originated not in the historical community, but rather in the medical community itself: narrative medicine.[57]

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[55]Michael Francis Brown, "For the Dignity of the Faculty: Fashioning Medical Identities in York, 1760-1850" (Ph.D. diss, University of York, 2004).

[56]Matthew Ramsey, *Professional and Popular Medicine in France, 1770-1830* (Cambridge: Cambridge University Press).

[57]The late 1980s saw the emergence of a new model for understanding the medical profession. Howard Waitzkin, for example, professor of medicine and social science at the University of California at Irvine, has directed scholarly attention to issues of doctor-patient communication as a discourse worth of theoretical consideration. He argued that patients provide their doctors with a language of personal trouble that is deeply rooted in broader social issues. But most doctors ignore the social context in favor of

Scholars have long noted the intersection of literature and medicine, but as G. S. Rousseau pointed out in his 1981 article on the state of the field, that influence was typically seen as moving *from* medicine *to* literature within strict chronological boundaries. It was this assumption that Rousseau challenged, by highlighting a number of new ways in which to explore medicine's influence on literature. First, he noted, doctors have historically used case histories, which are, by their very nature, narrative in form, as their primary form of communication. Stories, even medical ones, are grounded by the culture in which they written. This influence appears in unspoken assumptions and beliefs can be seen in medical case studies, which seek to assign meaning to illness and disease, as Kathryn Montgomery Hunter has noted in *Doctors' Stories: The Narrative Structure of Medical Knowledge*:

> [N]o matter how scientific it may be, medicine is not a science as science is commonly understood: an invariant and predictive account of the

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symptom-based diagnoses. Doctors typically discourage patients from expressing broader concerns about their lives because concerns that do not lend themselves to the technical lexicon of diagnostic possibilities tend to gravitate toward the margins of medical talk."[57] This dismissal of the multitude of stories being sifted through in any medical encounter represents failure of modern medicine that is representative of the authoritative position medicine has taken in society. In 1988, Arthur Kleinman published *The Illness Narratives*, in which he observed that "illness" (the human experience of disease), is quite different from "disease" as a scientific category. Medical practitioners must learn to diagnose pathology from a patient's narrative description of his or her illness. In 1996, Rita Charon instituted a new program in Narrative Medicine at the Columbia University School of Medicine. The goal of this department was to increase the narrative capabilities—that is the ability to hear, understand, and interpret what is being said in a patient's description of his or her symptoms and to analyze the physician's own narrative role in translating illness to disease—in a new generation of medical students. These trends have offered a new theoretical framework from which to approach the study of medicine. Charon and Maura Spiegel also founded the journal *Literature and* Medicine in 1982 as a place for doctors, literary critics, and historians to explore the relationship between literature and medicine in a variety of ways. Rita Charon, "Narrative Medicine," LitSite Alaska, http://litsite.alaska.edu/healing/medicine.html. Accessed 20 July 2006. For more on Charon's work on the theory and practice of narrative medicine, see Rita Charon, "To Build a Case: Medical Histories as Traditions in Conflict," *Literature and Medicine* 11, no. 1 (1992): 93-105; Rita Charon, "Medical Interpretation: Implication of Literary Theory of Narrative for Clinical Work," *Journal of Narrative and Life History* 3, no. 1 (1993): 79-97; Rita Charon, "The Internist's Library: Doctors at the Heart of the Novel," *Annals of Internal* Medicine 121 (1994): 390-1; Rita Charon, "Narrative Accuracy in the Clinical Setting," *Medical Encounter* 11, no. 1 (1994): 20-23.

G.S. Rousseau, "Literature and Medicine: The State of the Field," *Isis* 72, no. 3 (Sept 1981): 407.

> physical world. Medicine's goal is to alleviate present suffering. Although it draws on the principles of the biological sciences and owes much of its success to their application, medicine is (as it always has been) a practical body of knowledge brought to bear on the understanding and treatment of particular cases. We seek more from a visit to the doctor than the classification of our malady. We want our condition to be understood and treated."[58]

Moreover, medicine and literature share a common language, as well as common cultural symbols and signifiers, making similarities inevitable in the way that doctors and writers describe suffering and the body. Thus, doctors, like writers, engage in a fundamentally interpretive activity and look to narrative to organize their inquiries.

The application of narrative theory to the history of medicine has given rise to a group of scholars who have noted the parallels between a culture's dominant literary styles and the writings of its medical community. Anne Vila, for example, has argued that the eighteenth-century preoccupation with sensibility was present in the works of both Samuel-August-André-David Tissot and Jean-Jacques Rousseau during the Enlightenment era. Both the doctor/hygienist and the *philosophe*/novelist related the volatility of the sensible "life force" to the degree of civilization in an individual. Those who were more civilized were also more delicate (they were particularly concerned with people living in cities and with women) and both Tissot and Rousseau feared that sensibility could go beyond refinement of heart and into nervous maladies like melancholia or vapors. As such, Enlightenment medicine (influenced by writers like Rousseau) developed a socio-anthropological slant with an emphasis on healthy

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[58]Kathryn Montgomery Hunter, Introduction to *Doctors' Stories: The Narrative Structure of Medical Knowledge* (Princeton, NJ: Princeton University Press, 1991), xvii-xviii.

sensibility and a program for moral living that, in turn, influenced moral hygienists.[59] In other words, the moral and the medical were inextricably linked in the eighteenth-century notion of sensibility.

The recognition of the fundamental narrativity of the medical experience has therefore opened up a new arena for the study of the medical text, particularly in the context of the construction of medical identities. In 1996, Steven Stowe published an article linking the nineteenth-century case narrative (the most widespread form of medical writing) with American doctors' professional concerns over identity and authority. Until the 1860s in the American South, the medical community's claim to legitimacy lacked popular support. Case narratives became a way to make sense of medical work from a doctor's perspective—to explain the fallibility of medicine, to deal with the internal tensions created by medicine's identity as both knowledge and practice, and to increase the prestige of doctors by emphasizing the pressing urgency of their daily work. The essence of medicine, according to Stowe, was "at the bedside," not in hospitals and laboratories as in twentieth-century medicine.[60]

Twentieth- and twenty-first-century case narratives are formulaic and impersonal, lacking explicit social context. This was not true of nineteenth-century case narratives, which were instead highly personalized, reflecting the tensions of a developing profession that was searching for its place in society's evolving power structure. Rather than teleologically reading into nineteenth-century case studies the shortcomings of a "pre-modern" medicine, Stowe has argued that scholars must note how each style

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[59]Anne Vila, *Enlightenment and Pathology: Sensibility in the Literature and Medicine of Eighteenth-Century France* (Baltimore: Johns Hopkins University Press, 1998).
[60]Steven Stowe, "Seeing Themselves at Work: Physicians and the Case Narrative in the mid-Nineteenth-Century American South, " *American Historical Review* 101, no 1, (February 1996): 41-79.

reflected the role of medicine in society. Twentieth-century medicine intentionally cast out the problematic tension of human fallibility inherent in the practice of medicine by reducing the doctor-patient communication to a formulaic recitation of symptoms, history, diagnosis, and treatment. The "art" of medicine (practice) has been hidden within a discourse of scientific fact (knowledge) in part because medical authority has been well established and the profession is in a position of social prominence. Its nineteenth-century predecessor, however, *depended* on the "story" to establish authority and influence based on both specialized knowledge and interaction with patients.[61] By contextualizing these nineteenth-century case studies, Stowe has given more explanatory weight to the "narrativity of medicine."

In 2003, literary critic Meegan Kennedy attempted to reinsert social context and notion of contingency into analyses of eighteenth- and nineteenth-century English case study. According to Kennedy, the medical case history operated as both a literary genre and a cultural artifact that demonstrated the Victorian concern over the place of science in culture. The nineteenth-century case study linked language to visual observation through two competing discourses: one curious (born of the eighteenth century), which used exotic and sensational rhetoric to create a Romantic vision of medicine; and the other realist (developed in the nineteenth century), which promoted an ideal of objective distance. Though the evolution of the clinical case narrative in the nineteenth century theoretically rejected the personal and emotional (the curious) in favor of a clinical (realist) vision, Kennedy contends that curious narratives persisted throughout the nineteenth century, until they were marginalized by the unapologetic use of the curious gaze in psychoanalysis, a field never fully accepted by the professional medical

[61] *Ibid*.

community. This revised nineteenth-century version of curious narratives gave rise to a new style of medicine—gothic medicine—in which the most spectacular aspects of eighteenth-century medicine were suppressed. And though doctors used diagrams, charts, and statistics to quantify the curious gaze, tropes of sentimental narrative continued to play a role (usually as a way to compensate for the failures of medicine) in nineteenth-century English medicine, even as literature and medicine continued working their way apart.[62]

Both Kennedy and Stowe have thus identified an intriguing source for studying the broader impact of literature's influence on nineteenth-century medicine—the case study. These medical texts are a particularly useful object of study for this project for two distinct reasons: 1) during the nineteenth century, they became one of the primary methods by which doctors shared information, both with each other and with a broader educated audience; and 2) they provided an element of medical literature that was expressly narrative in form, allowing for a more explicit comparison between medical and literary texts. They are captivating discursive spaces for understanding the conscious construction of medical identities.

This brings us back to the ultimate question of medical professionalization in France after the Revolution. Kennedy's work, while theoretically sound, approaches case studies from a literary perspective and often lacks the historical specificity necessary to explain the driving forces behind medical change. One is left wondering how the myriad social interactions among doctors, patients, and a broader audience influenced the discursive choices made in the writing of case studies. What was it about the nineteenth

[62]Margaret Kennedy, "A Curious Literature: Reading the Medical Case History from the Royal Society to Freud " (Ph.D. diss., Brown University, 2000);

century that drove doctors' narrative choices? Stowe's argument, on the other hand, is more contextually grounded, and is thereby suggestive of a new approach to medical professionalization in France in the nineteenth century, one that breaks free of the historiographical tendency to adopt medicine's own discursive tradition of equating professional medicine with scientific medicine. He looks back to a period before medicine laid claim to science to demonstrate how its authority was actually created out of personal narratives. Where Stowe falls short, in contrast to Kennedy, is in his deployment of a concept of literary narrativity. While he clearly outlines commonalities in doctors' usage of "the story," his work lacks recognition of the connection between those stories and the dominant cultural narratives of the day. Stowe's approach can therefore be taken to the next level by looking at the specific trends used by doctors as they constructed narratives and by analyzing how each of those choices aided the building of medical authority. For this, it is necessary to look at the social concerns and cultural narratives of the period in question. As such, we are left searching for a period that exhibits both social uncertainty and dominant cultural narratives, as well as a changing medical world, which leads not to the latter half of the nineteenth century, but rather to the preceding half century, beginning with the post-Revolutionary period.

The Revolution had destroyed the privileged institutions of *ancien régime* medicine, but failed to replace it with a meaningful, cohesive system. Stripped of their corporate privilege, doctors in post-Revolutionary France were left with an identity crisis of sorts. The Revolution had attempted to define medicine as a social and political phenomenon, by subsuming it within a discourse of public health, so that French doctors in the early nineteenth century found themselves caught between an identity defined by

elite privilege and one defined by social value. Doctors in the post-Revolutionary period had to manage two contradictory self-images, and understanding how they did so sheds a new light on French medical professionalization.

Built on a language of science and nature, medicine remained very much an art in the hands of specially trained practitioners who dispensed their knowledge to others in particular ways. Control over that knowledge and its circulation was a source of power for the emergence of a professional medical community.[63] Thus, just as the medical community was in the process of dramatic internal change after the Revolution, it was simultaneously in the process of external change: creating an "audience" for itself, a group of men and women who needed to be convinced that professional doctors were essential to the well-being of post-Revolutionary society. Succeeding at such an important task required the development of a medical language that could bridge the divide between professional doctors and laymen. This new language drew much of its authoritative force from the use of familiar literary narrative and from its re-conceptualization of gender norms that validated the superiority of the masculine, which had been in flux during the Revolution.

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Specifically, this dissertation focuses on early nineteenth-century French doctors' successive use of sentimental, gothic, and realist narratives in case studies that dealt with questions about the female body and the way they used such narratives to take control

[63]Foucault, preface to *The Birth of the Clinic*, xii-xix.

over "the woman question." For the purposes of this dissertation, sentimental narrative will be defined as a literary style that emphasized the physical and mental experiences of emotion and that associated such feelings with virtue. Gothic narrative intensified these emotional experiences by blending them with contemporary aspects of melodrama and by creating a genre that deployed tropes of the monstrous, the mysterious, and the unknown in the pursuit of what was considered the joy of extreme emotions. Realist narrative, on the other hand, can be understood as a literary style that claimed representational authenticity and verisimilitude by eschewing the ornamentation of it sentimental and gothic counterparts. This approach will examine how the (at-times problematic) use of such disparate literary narratives allowed doctors to create an identity that struck a balance between authoritative elitism and necessity to the social good. It was that identity that served as the foundation of professional medicine, when professional medicine is reconsidered as a cultural process, rather than an institutional state.

Chapter Two examines the instability that accompanied the post-Revolutionary period in France, in light of the rise of the bourgeoisie and the liberal professions. It traces the structural changes that characterized medicine between 1795 and 1850, as doctors consciously sought to align themselves with the emergent bourgeoisie by validating their worldview, particularly with regard to questions about gender and class. Chapter Three explores the rise of the case study as a discursive category of proof in the early nineteenth-century medical community, highlighting the case study's role in establishing medical identity and authority. Chapter Four analyzes how the rise of

obstetrics and gynecology allowed doctors to explore the meaning and limits of medical power by exploiting the social dimensions of a naturalized female body. Moreover, it demonstrates how obstetrical case studies effectively produced a clearly gendered relationship of power, wherein male doctors assumed control of the traditionally female realm of childbirth by casting themselves as the narrators of the medical story. This process necessarily transformed the female story of childbirth into a medical narrative, with "woman" as the object of a (male) medical gaze. It consequently validated a male-dominated gender order that had been in flux since the Revolution. The unique blend that was struck in these texts allowed doctors to create a public identity based on mastery of a body of knowledge that was both utterly foreign and absolutely indispensable to the rest of society.

The final section—Chapters 5 and 6—looks at the tools (namely a shifting balance of competing literary styles, including sentimental, gothic, and realist narratives) used by doctors as they constructed medical identities based on both expertise and social value. More specifically, Chapter Five examines how the authors of case studies used sentimental and gothic tropes to emphasize social value of doctors and to create a medical identity that was tied to the social value of doctors—the good that the profession could do for society at large. Chapter Six, on the other hand, explores how doctors balanced that sentimental identity (lest they give too much control to the public) by using the tropes of realist narrative to emphasize the expertise that set doctors apart from the rest of society. This section further traces the reciprocity of those narrative styles, as medicine settled into a far more prominent role in French society during the early nineteenth century—

well before the institutional and scientific changes of the subsequent half-century.

Part I:

Foundations of Post-Revolutionary Medical Identity

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The French (Medical) Revolution: Changing Conceptions of the Liberal Professions

I. Changing Medical Models, from the *Ancien Régime* to the Bourbon Restoration

French medicine in the nineteenth century was profoundly different from what had preceded it in the eighteenth century. The Revolutionary project of re-imagining a world without privilege undermined the very nature of professions—defined as vocations dependent on educational training—as they had existed in the *ancien régime*. This early modern meaning of profession was flexible enough to encompass a wide variety of non-noble occupations—artisan, merchant, theologian, lawyer, and doctor alike—with very different relations to the "profit motive." For while all were compensated for their work (a fact that distinguished them from the nobility), there was a distinction between the market professionals, including artisans and merchants, whose income was directly dependent on productivity and the liberal professionals, including doctors, lawyers, and theologians, whose ranks were necessarily filled with men of independent wealth. Nonetheless, the market professions and the liberal professions shared in the pre-Revolutionary corporate model, in which all matters pertaining to a given profession

were determined by the central *corps* that governed it. The authority to practice was granted by the state, but executed by the *corps*.[1]

In the case of doctors, the governing *corps* was institutionalized in two primary groups—the *facultés de médecine* and the slightly less powerful *collèges de médecine*. These two *corps*, rooted in the early modern university, drew their power primarily from a monopoly over education and training. The *facultés* developed and implemented the curriculum, oversaw testing, and awarded the degrees that permitted entry into the medical profession. Truly, the only path to a medical career in pre-Revolutionary France went through the *facultés*, since everything from licensing to publishing fell under the purview of education and training. Even in areas without a faculty, where licensing was overseen by the local *collèges*, education and training remained in the hands of the *facultés* in other cities. Aspiring doctors from the smaller provinces would travel to a larger city (often Paris or Montpellier) for the four years of university training required to sit for exams.[2] Upon passing the exams, the doctors would be granted licenses to practice in the region controlled by the degree-granted faculty. Upon returning, they had to apply to the local *collèges* to have the license approved. Only then would they be accepted as doctors in their native province. This explains why doctors often chose not to return, if work within the city of their training was possible; the corporate maneuvering necessary just to practice was, at best, intimidating and, at worst, prohibitive.[3] What this model dictated was therefore three-fold: 1) it was limited to those with some degree of independent wealth, who could afford to pursue the long (and expensive) training

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[1]Jan Goldstein, *Console and Classify: The French Psychiatric Profession in the Nineteenth Century* (London: Cambridge University Press, 1987), 15-16; Ramsey, *Professional and Popular Medicine*.
[2]Goldstein, 8-40.
[3]Laurence Brockliss and Colin Jones, *The Medical World of Early Modern France* (Oxford: Oxford University Press, 1997).

necessary to become a doctor, without the guarantee of a lucrative career; 2) it was centered in the cities, particularly those like Paris and Montpellier, with strong *facultés*; and 3) it closed the ranks of the medical profession to outsiders by assigning the *corps* a monopoly that "protected" the sanctity of the profession.

The absolute control that the *facultés* and *collèges* exercised over the medical profession was therefore understood as fundamental to the profession itself. Its adherents believed that, if even the slightest deviation from this exclusivity were allowed, it would mean the end of the healing arts themselves. "Conflict of jurisdiction," the Paris faculty cautioned in the decade before the Revolution, would lead to "anarchy," which would inexorably "plunge the important art of healing into a disastrous quackery."[4] Monopoly guarded the purity of medicine. During this period, "true" medicine (meaning that governed by the *facultés*) was divided into three categories—physicians, surgeons, and apothecaries—all of whom were trained as generalists. Doctors proudly used their knowledge of the entire human body to distinguish themselves from outsiders who specialized in one body part or another: dentists, *sages femmes*, oculists, and barber-surgeons, in particular.[5] The medical *faculté* was granted the ability to distinguish, categorically and unconditionally, those who belonged from those who did not, and they jealously guarded the privileges that accompanied their autonomy. For though the authority of the *facultés* came essentially from the state, in the form of the patent letters that served as their charter, the *facultés* were largely self-regulating.

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[4] *Commentaires de la faculté de Médecine de l'Université de Paris, 1777-1786*, ed. E. Wickersheimer (Paris: Imperies Nationale, 1915), 339; Qtd in. Goldstein, *Console and Classify*, 17.
[5] *French Medical Culture in the Nineteenth Century*, eds. Ann La Berge and Mordechai Feingold (Amsterdam: Rodopi, 1994), 154-155.

In spite of this independence, the connection between the medical *corps* and the French state actually increased in the twenty years before the Revolution. In 1776, Anne-Robert-Jacques Turgot, controller-general and chief advisor to Louis XVI, founded an investigatory commission in the tradition of the great scientific academies of the seventeenth century. That group would, in 1778, become the *Société royale de médecine*. The new medical association marked a break with the strictly corporate model ruled so completely by the *facultés* by erasing the boundaries between state and *corps*. Charged with a joint research and advisory role, particularly in matters, such as epidemics, that affected the French state, this society, under the leadership of two notable doctors, Joseph-Marie-François de Lassone and Félix Vicq-d'Azyr, was expected to be more progressive than the medical *facultés*, whose contributions to the advancement of medicine, critics charged, were hindered by their conservatism. In that way, then, the society offered a new way of thinking about the medical profession, one that was directly tied to the state, thus creating two models of medicine in France—one corporate, the other statist—that vied for supremacy. Nonetheless, they collectively followed a hierarchical pattern that elevated those who belonged and marginalized those who did not.

The Revolution changed all of that. Castigating the institutions of *ancien régime* medicine as pillars of tyrannical privilege, revolutionaries eliminated professional *corps* of all types, from artisanal and merchant guilds to professional societies, when the d'Allarde law of 1791 declared it "free to every citizen to engage in whatever commerce, or to exercise whatever professions, art, or trade he may wish."[6] The intentionally broad

[6]*Les Archives parlementaires, 1787 à 1860*, eds. Jerome Madival and Emile Laurent (Paris: Dupont, 1867-1913), vol. 23: 202.

scope of this law meant that the *facultés*, the *colleges*, and the *Société royale* that governed French medicine were dismantled. They were instead replaced with a more general group of medical practitioners: the *officiers de santé* (members of the *comité de santé*, an association open to all who purchased a *patente* or license to practice). Under this new law, medicine was subject to the same laws that governed shopkeepers and shoemakers.[7]

The Revolutionary *comité de santé* was a fluid category, indistinct enough to make it nearly impossible to distinguish between those with the requisite training and experience to be called legitimate doctors and those who, under the old system, would have been considered "quacks."[8] As Antoine-François de Fourcroy observed in 1803, the problem with a notion of health officers was that "those who have learned their art are put on the same level with those who have not the slightest notion of it."[9] The deregulation by the Revolution had destroyed both the corporate and the statist model, only to replace them both with an approach that encompassed nothing so much as a complete absence of oversight. Though successful in destroying pre-Revolutionary medicine, the years after 1791 were filled with contentious disputes over the best way to restructure the profession. Proposals ranged the political spectrum, from the sans-culottes' call for "a popular medicine," free of corruptive privilege, to a state-sponsored (and -supported) medical program that would be carefully trained and charged with the public health.[10] The debate raged for more than a decade, but legislators in the Convention and the Directory were so

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[7]Maurice Crosland, "The *Officiers de Santé* of the French Revolution: A Case Study in the Changing Language of Medicine," *Medical History* 48, no. 2 (April 2004)
[8]*Ibid*.
[9]R. Roland, *Les médecins et la loi du 19 Ventôse an XI* (Paris, 1883) 11; Qtd in Edward H. Ackerknecht, *Medicine at the Paris hospital, 1794–1848* (Baltimore, Johns Hopkins Press, 1967) 38.
[10]Archives Nationales: F-17, A 1146, d. 4, "Pétition à la convention nationale," by Cardon, citoyen de la section Poissonière (Impr. Franklin, n.d.), 2; Qtd. in Goldstein, 33.

bitterly divided that no functional replacement was ever adopted. French medicine stagnated.

Under Napoleon's rule, there was a concerted effort, organized by Fourcroy, to restructure medicine with the law of 19 *Ventôse an* XI (March 10, 1803). This statute standardized educational requirements for doctors and required all practitioners of medicine (except in extreme cases) to be accepted into the ranks of "doctor" before they could exercise their skills. All regulation was under the aegis of the state. Admittance to medical school required both completion of a secondary program at a *lycée* and a *baccalaureate*. Doctors of medicine and surgery were further expected to pursue three years of medical education that combined university- and hospital-based training, with university-based exams to prove competency before licensing, which was placed in the hands of *jurys médicaux*.[11] As a regulatory model, it depended heavily on the state for its governing principles, but remained relatively open to newcomers and social advancement. This 1803 law provided the standard that would guide the practice of medicine for most of the nineteenth century, though it would be 17 years before a new professional pattern—the clinical-associative model—would emerge in France.

The early nineteenth century in France has often been described as the "age of the clinic," and this was, in large part, due to the changes that took place in Paris between 1803 and 1820. During this period, a number of developments (institutional, technical, pedagogical) pushed French medicine into the hospital and provided the basis for a new medical identity that emphasized clinical experience. The architect of the clinical school, centered in Paris, was Marie-François-Xavier Bichat, a prominent physician who had

[11]L.W. B. Brockliss, "Before the Clinic: French Medical Teaching in the Eighteenth Century," in *Constructing Paris Medicine*, eds. Caroline Hannaway and Ann La Berge (Amsterdam: Rodopi, 1998), 71-115.

studied in both Lyon and Paris during the Revolution. Bichat is most famous for identifying 21 different types of body tissue and, through countless autopsies, demonstrating the various (observable) effects of disease on those tissues.[12] But it was the larger implications of his research that changed the way doctors in Paris approached their art. According to Bichat, physical changes in tissue were the direct consequence of disease; this necessitated a new way of thinking about pathology based on external indicators. Bichat's theory placed an overwhelming emphasis on an individual doctor's ability to read (and interpret) the signs his patient's body was exhibiting. As a method, it depended not on the esoteric knowledge that had been the core of the *ancien régime* medical curriculum, but rather on practical experience—experience gained at the bedside. It was a theory further supported by François-Joseph-Victor Broussais (one of the most significant medical reformers in France at the beginning of the nineteenth century), when he described the two types of "animal matter." The first, he wrote, was "fixed animal matter, constituting the tissue of the organs"; the second was "mobile animal matter," or humor. Disease affected these types differently.[13] To understand disease, then, and to know how to treat it, doctors needed to practice on real patients in real hospital settings.

In the first two decades of the nineteenth century, there were 28 hospitals in Paris alone. Within those hospitals, there were more than 6,000 patient bedsides at which medical students could learn, establishing conditions that were ideal for clinical practice (particularly clinical research).[14] Between 1800 and 1820, physicians and surgeons in

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[12]John G. Simmons, *Doctors and Discoveries: Lives that Created Today's Medicine* (New York: Houghton Mifflin, 2002), 58-62; Anita Guerrini, *Experimenting with Humans and Animals: From Galen to Animal Rights* (Baltimore: Johns Hopkins University, 2003), 65-80.
[13]François-Joseph-Victor Boussais, *Traité de physiologies appliqué à la pathologie* (Paris: Chez Delaunay, 1822), 7.
[14]W.F. Bynum, *Science and the Practice of Medicine in the Nineteenth Century* (Cambridge: Cambridge University Press, 1994), 26.

French hospitals were responsible for several inventions that advanced the cause of experiential medicine. Jean-Nicolas Corvisart, for example, perfected his mentor Leopold von Auenbrugg's use of chest percussion to diagnose cardiovascular pathology. Percussion allowed doctors to examine a patient's heart and lungs for inflammation without opening the chest cavity, a technique that facilitated the earlier diagnosis of heart and lung problems.[15] In 1816, five years before Corvisart's death, physician René-Théophile-Hyancinthe Laennec invented the monaural (one-ear) stethoscope to facilitate indirect auscultation (listening), which was infinitely superior to the direct auscultation (laying the ear upon a patient's chest) that was used at the time. Doctors in early nineteenth-century France were developing a standardized routine to aid their examination of the human body in a hospital setting.

In spite of the growth of hospitals and clinical medicine in Paris, and in spite of the fact that Paris was quickly becoming the center of Western medicine, many within the larger French population remained distrustful of medical practitioners. The individualism of the medical market under Napoleon and the Bourbon Restoration (wherein doctors were trained and licensed under a state system, but left to practice independently) did little to reassure its potential patients of their expertise and value to the community. The emergence of "scientific medicine" in Paris was largely removed from the quotidian experience of the individual doctor and his patients, leaving the advances primarily in the field of research, rather than in patient care or institutions.

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[15]P.R. Fleming, *A Short History of Cardiology* (Amsterdan: Rodopi, 1997), 74-76; Goldstein, *Console and Classify*, 103-104; Russell Maulitz, *Morbid Appearances: The Anatomy of Pathology in the Early Nineteenth Century* (Cambridge: Cambridge University Press, 1997), 66-69. For a cogent (and infinitely readable) summary of the emergence of the clinical school, see Roy Porter, *The Greatest Benefit to Mankind: A Medical History of Humanity* (New York: Norton, 1997), 306-314.

This pattern changed, yet again, with the establishment of the *Académie royale de médecine* in 1820. The establishment of this group under Louis XVIII initiated the return of an associative model, though with significant differences from the regulatory power of the *facultés and collèges* of the *ancien régime*.[16] Though Matthew Ramsey has rightly noted the limits of the Academy as a professional body of oversight, its importance as a professional learned society cannot be denied. As the pre-eminent site for professional sociability in nineteenth-century medicine, the *Académie* served as a platform for debating practical and theoretical advances in the field.[17] According to an 1835 edition of *L'Annuaire de l'Académie royale de médecine*, the purpose of the *Académie* was two-fold: 1) to respond to the government's questions about issues of public health; and 2) to discuss all contemporary research that could further the progress of the art of healing.[18] To serve both of these ends, this group of Paris-based doctors (and associated members in the provinces) met regularly and established several journals—some, such as the *Annuaire* and *Bulletin*, were published directly by *Académie*; others, such as *La Lancette Française*, merely featured articles written by prominent members of the *Académie*.

II. Class, Politics, and Medicine under the July Monarchy

The *Académie royale de médecine*, as the first new professional medical association in France since the Revolution, was in many ways reminiscent of the *corps* that had controlled French medicine for so long. Though membership in this new

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[16]"Liste des membres, Académie royale de médecine, 18 October 1829," *L'Annuaire de l'Académie Nationale de Médecine* (1835): 101-108.
[17]Ramsey, 106-107.
[18]"Rapport au roi sur l'Académie royale de médecine," *L'Annuaire de l'Académie Nationale de Médecine* (1835): 16.

academy was theoretically open to all doctors, it was not automatically extended to every practitioner in France. Members were chosen carefully. As in the *facultés*, *collèges* and *Société royale* of the *ancien régime*, this selectivity conferred on *Académie* members a great deal of prestige. Unlike that of the earlier *corps*, however, this influence was not rooted in arbitrary privilege, but rather in the recognition of merit that emerged from the medical marketplace. There was a veritable, albeit limited, democratizing of the liberal professions (as has already been demonstrated with lawyers and, more recently, with librarians and archivists in the July Monarchy) that was further reflected in the increasing political prominence of the men who engaged in these occupations.[19]

France under Louis-Philippe was, in a word, unstable. The constitutional limitations on monarchy and the expansion of the electorate that were outlined by the Charter of 1830 altered the political dynamic in France. The Charter lowered the voting age from 30 to 25 and the tax qualification from 300 francs to 200, consequently doubling the number of enfranchised voters.[20] The franchise in France remained limited to the wealthiest 2.8% of the total French population (about 240,000 men in 1846, just two years before the monarchy collapsed), so the vast majority of the French population still did not have a political voice.[21] Still, the emergence of so many new players in the political realm brought new, competing ideologies to the forefront. As the "King of the French," Louis-Philippe often found himself charting a course between opposing factions. The most obvious threats to the Citizen-King came from the Republicans

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[19]Lucien Karpik, *French Lawyers: A Study in Collective Action, 1274-1994* (Oxford: Oxford University Press, 1999); Peter Gay, *Schnitzler's Century: The Making of Middle-Class Culture, 1815-1914* (New York: Norton, 2002); Lara Jennifer More, *Restoring Order: The École des Chartes and the Organization of Archives and Libraries in France, 1820-1870* (Duluth, MN: Litwin Books, 2008).
[20]Murray Bookchin, *The Third Revolution: Popular Movements in the Revolutionary Era* (New York: Cassell, 1998), 60
[21]William Simpson, *Europe: 1783-1914* (London: Routledge, 2000), 130.

calling for the destruction of the monarchy itself and the Legitimists who demanded the restoration of the Bourbon monarchy. Even closer to the center (amongst Louis-Philippe's nominal supporters), though, there were potent divisions between the left-leaning Movement Party and the right-leaning Resistance Party (which itself would split into factions under the more conservative Guizot and the more liberal Thiers). Add in the Utopian Socialists and the occasional ultra-Royalist, and the July Monarchy faced near-constant threats to its authority, as evidenced by uprisings in 1831, 1832, 1834, and 1836.[22]

The streets of Paris in the 1830s were thus filled with political disorder; barricades were erected eight times between 1827 and 1849. But political insurrections were not the only problems that destabilized the city. In the 1830s, Paris was a maze of narrow, filthy, and often dangerous passages. The sewage system was an outdated amalgam of aboveground and underground, covered and (more often) uncovered channels that, in some cases, dated back to the thirteenth century. Cesspools, designed to contain waste, overflowed and contaminated the surrounding soil. The streets were filled with sludge. Rats and fleas were a way of life.[23] It is unsurprising, then, that these grimy streets served as the backdrop of a cholera epidemic that killed more than 20,000 of Paris's 650,000 inhabitants in 1832.[24]

The epidemic itself, which lasted approximately seven months, was devastating. The sick and the dead were everywhere in Paris. Affected areas were quarantined, cesspools and sewers closed. Hospitals overflowed with the sick and morgues with the

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[22]Cartlon Joseph Huntley Hayes, *A Political and Social History of Modern Europe* (New York: Macmillan1939), 94-95.
[23]David Pinkney, *Napoleon III and the Rebuilding of Paris* (Princeton: Princeton University Press, 1958).
[24]Alfred Werner, et al., *Les Épidémies*: *un sursis permanent* (Neuilly-sur-Seine, France: Atlande, 1999).

dead. The Bureau of Vital Statistics could not keep up with requests for death certificates, while cemeteries ran out of graves. And it was disproportionately worse in the poor, working-class areas of Paris than it was in the middle-class areas.[25] This socio-economic difference was well noted in the period, as when German poet Heinrich Heine described how the poor "murmured bitterly when it saw how the rich fled away, and, well packed with doctors and drugs, took refuge in healthier climes. The poor man saw with discontent that money had become a protection also against death."[26]

As cholera raged on in France (and particularly in Paris), state officials looked desperately for a solution to the problem that was ravaging the French people. The epidemic moved the question of "public health" to the forefront. Studies were commissioned to ascertain the causes of cholera, the conditions that bred it, and the most effective means of containment. The most significant of these studies were those performed under the direction of Louis-René Villermé, whose findings highlighted the connection between poverty and increased mortality. Again and again, Villermé used statistical analysis to demonstrate how the poorer districts of a city (and, by extension, the poorer cities of a nation) suffered much higher rates of death, particularly in times of crisis such as the cholera epidemic, than did wealthier areas.[27] His studies gave statistical weight to the connection between status and disease and to the public health movement designed to mitigate it.

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[25]Sean Quinlan, *The Great Nation in Decline*: *Sex, Modernity, and Health Crises in Revolutionary France, 1750-1850* (Aldershot: Ashgate, 2007), 180.
[26]Heinrich Heine, "The Cholera," *Heinrich Heine's Life Told in his Own Words* (New York: Holt, 1893), 209.
[27]Joshua Cole, *The Power of Large Numbers: Population, Politics, and Gender in Nineteenth-Century France* (Ithaca: Cornell University Press, 2000), 85.

The conclusions of studies such as Villermé's reflected the reality of a class struggle that was very much a part of life under the July Monarchy. Catherine Kudlick has demonstrated how the French bourgeoisie, while on the rise in the 1830s, remained uncertain about its position in French society. The cholera epidemic of 1832 became a way for the bourgeois citizens of France to distinguish themselves from the lower classes. Cholera, and the myriad meanings assigned to it (filth, sin, a nation in decline), were laid at the doorsteps of the lower classes. The disease became synonymous with disorder and revolution, as the bourgeois fear of infection merged with a disdain for the lower classes.[28] As a result, the public health movement that emerged so prominently in the 1830s (characterized by commissions, reports, and advisory agencies that reported to king and assembly on medical issues—including epidemics—affecting large numbers of people) reinforced the categories of early industrial political economy. It offered bio-medical statistics as *proof* of the differences between rich and poor, worker and bourgeois, lower class and middle class.

III. Specialization and the Clinical-Associative Model

By integrating extant notions of socio-economic class and the authority of the state, the public health movement of the 1830s grounded medical identity by imbuing the associative model with a "social middle" that was based in clinical practice. From 1803 to 1820, there existed two distinct conceptions of "medicine" in France. The first revolved around the image of the individual doctor practicing in the countryside. Daily contact with people allowed him to establish his reputation in a medical marketplace.

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[28]Catherine Kudlick, *Cholera in Post-Revolutionary France: A Cultural History* (Berkeley: University of California Press, 1996).

The second was rooted in urban regulatory bodies: the medical colleges that educated students, the clinics where interns practiced, the *jurys médicaux* who tested and licensed aspiring doctors. In the day-to-day practice of medicine, there was little overlap between the state and the individual in this medical model. The creation of the *Académie royale de médecine* in 1820 changed that. This new medical assembly provided a middle ground, a way of drawing individual doctors into the larger world of medicine. Their meetings fostered professional sociability; their journals facilitated the sharing of new ideas. Their advisory role in matters of public concern drew them ever closer to the state. The *Académie royale* (and the provincial academies that followed) had thereby established an associative model that set doctors apart from the rest of society by connecting individual doctors to a collective of their peers.

The 1830s public health movement completed that connection by taking the collective and assigning it social value. The advisory role played by public hygienists, while clearly intent on direct connection between the medical community and the state, was ultimately aimed at establishing social value, the movement's contribution to improving the lives of French citizens. The practice of medicine, as with the other liberal professions of the 1830s (law in particular), was therefore simultaneously individualistic and communal, bound up in the same socio-political and economic categories that underscored the upheaval of the July Monarchy.[29] The professional medical community's quest for status was nearly indistinguishable from the larger political and social quest for stability.

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[29]For more on the associative space between the individual and the state in law, see chapters 6 and 7 of Karpik, *French Lawyers*.

Until the nineteenth century, specialization was eschewed in medical practice; doctors instead fell into one of three categories—physican, surgeon, or apothecary—that emphasized general knowledge of the human body (understood to include anatomy, physiology, pathology, and pharmacology).[30] Focusing on a specific body part or system was marginalized, a disparaged consolation prize for those on the outside. It would remain this way until the nineteenth century, when medical specialties began to emerge, beginning with the field of *accouchements*.[31] In 1835, membership in the *Académie royale de médecine* included 11 members claiming obstetrics and gynecology as their specialty. That was 7% of the total membership, a significant number, given the narrow parameters of their field of specialization. As a comparison, consider the fact that obstetricians and gynecologists made up approximately 5% of the total number of doctors in the US in 2007.[32] These numbers are striking, particularly given how new the specialty was in the 1830s. They further reflect the importance of the specialty, whose weight as a percentage of the whole remained steady at around 7% during the first half of the nineteenth century.

The debate over specialization was, in many ways, a debate over privilege and control, particularly in the realm of childbirth, as the professional (male) *accoucheur* displaced the *sage-femme*. Traditionally, women (in the forms of both the midwife and the pregnant woman) exercised substantial agency within the reproductive realm. The professionalization of that world (which began with the *accoucheur* and climaxed with

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[30]George Weisz, *Divide and Conquer: A Comparative History of Medical Specialization*, (Oxford: Oxford University Press, 2005) 3-5.
[31]George Weisz, "The Development of Medical Specialization in Nineteenth-Century Paris," *French Medical Culture in the Nineteenth Century*, ed. Ann LaBerge and Mordechai Feingold (Amsterdam: Rodopi, 1994), 149-188.
[32]The American College of Obstetricians and Gynecologists < www.acog.com> 3 January 2008.

the advent of the use of anesthesia for childbirth) eliminated such agency, placing women fully under the authority of male doctors. It pushed midwives aside, to make room for the expertise of medicine.[33]

Inasmuch as midwifery care was even mentioned in medical texts in the nineteenth century (and such mentions were generally quite brief), midwives were usually depicted as a conduit between doctors and patients. The typical reference to a midwife in an obstetrical case study emphasized her recognition that the situation went beyond her capacity as a medical practitioner, as when Civatte described one such midwife's decision, upon "determining that the delivery would be laborious," to call "for the resident doctor."[34] Or when Villeneuve described a Marseilles midwife's escort of a woman in labor to *Maternité*. When the two women arrived, the midwife recited a number of pertinent facts about the case (including the patient's history of pregnancies and when and how this labor had begun). The doctor allowed the midwife's narrative to establish the seriousness of the case ("labor had commenced three days ago and her water had been broken for 48 hours"); then, without further mention, she was gone.[35] These doctors portrayed midwives as non-entities, useful as repositories of background information, but "ignorant," "useless," or "dangerous" as true medical practitioners.[36]

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[33]Mary Poovey, "Scenes of an Indelicate Character: The 'Medical' Treatment of Women" *The Making of the Modern Body*, eds. Thomas Laqueur and Catherine Gallagher (Berkeley and Los Angeles: University of California Press, 1987), 137-168.

[34]Louis Civatte, "Accouchement laborieux chez une femme dont le basin est vicié; presentation de l'épaule droite en seconde position avec issue du bras; version, application du forceps; mort de l'enfant, rétablissement de mere," *La Lancette Française* 24 (21 July 1831): 95. Interestingly, he uses the term *accoucheuse* rather than *sage-femme* here, perhaps as a limited show of respect for the woman who recognized her own limitations in the situation.

[35]E. P. F. Villeneuve "Rupture de l'utérus dans un accouchement laborieux causé par un vice de conformation du basin," *Archives générales de médecine* 1, no. 26 (1831): 563. Available from BIUM <www.bium.univ-paris5.fr> (accessed 18 December 2008).

[36] *Ibid*., iij.

Not all members of the medical community dismissed the work of midwives. Some, such as Aloïs Delacoux, validated midwifery's contribution to the medical world, depicting their work as "worthy of our consideration and […] a profession that merits our respect."[37] Still, even Delacoux, in his relative praise of midwifery, relegated midwives to cases where male doctors were either unnecessary or unavailable. Never would a midwife displace a doctor in a case of true need. There was a fundamental hierarchy of status in the practice of medical arts, accepted even by some midwives, as when madame Vion described her principal role as an "*intermediary* between doctor and patient."[38]

It was decidedly circular reasoning: because women were incapable of understanding and controlling their own bodies, it was necessary for medical professionals to step in; as a result of this intervention, doctors stripped women of an agency that had belonged to them for centuries, rendering them less and less capable of comprehending their bodies. In this way, doctors in the early nineteenth century assumed full control over the process of childbirth. Their hegemony in this matter was so complete that even the definition of "*accouchement*" was affected. In 1767, the *Dictionnaire de chirurgie* defined "*accouchement*" as the way "nature rids itself of the fetus and placenta that it contains during pregnancy."[39] All focus was on childbirth as a natural phenomenon, and there was little change in the 1787 *Encyclopédie méthodique de medicine* or in the 1790 *Encyclopédie méthodique de chirurgie*.[40] By 1812, medical authors were beginning to emphasize the role of medical intervention in childbirth. The

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[37]Aloïs Delacoux, *Biographies des sage-femmes célèbres, anciennes, modernes, et contemporaines* (Paris: Trinquart, 1834), i-ivj

[38]M. H. Vion, *Maladies de la matrice, ou exposé succinct des signes qui font reconnaître les diverses affections qui attaquent cet organe* (Paris: Chez l'Auteur, 1837), 6.

[39]Thomas Levacher de la Feutrie, "Accouchement," *Dictionnaire de chirurgie*, vol. 1 (Paris: Chez Lacombe, 1767), 13.

[40]"Accouchement," *Encyclopédie méthodique de medicine* (Paris: Panckoucke, 1787) 76; "Accouchement," *Encyclopédie méthodique de chirurgie* (Paris: Panckoucke, 1790) 20.

Dictionnaire des sciences médicales published that year defined "*accouchement*" as the "the natural expulsion, or *extraction by art*, of the baby and its dependents from the uterus."[41]

Then, in 1837, *accouchement* became a medical science, according to the *Dictionnaire de médecine usuelle*:

> This important part of medicine is composed of great knowledge borrowed from all other branches of the art of healing, and it is this chain of borrowing that has made it a specialty shared by few, whose precepts are based in anatomy, on the study of the functions of life, no less, so that knowledge of these maladies is exclusive to these doctors who must possess it in abundance.[42]

Although later in the entry he admitted that most pregnancies ended happily with no need for intervention, the author, a doctor named Jean-Pierre Beaude, continued to emphasize the necessity of a doctor's role in the process, arguing that "the presence of a doctor is *always* useful [as] it inspires confidence and courage."[43] Moreover, this entry devoted eight pages to defining the medical process of *accouchement*. Of those eight pages, roughly 10% (76 / 822 lines) was dedicated to "natural childbirth" that required no intervention. The remaining 90% (746 / 822 lines) was devoted to descriptions, pictures, and recommendations for situations that necessitated medical intervention.[44] In this way, doctors claimed a traditionally female realm for themselves and positioned themselves as an authority on the female body.

As part of this new influence, doctors elaborated a new "medicine of women" defined by an absolute difference between the sexes. The period between 1800 and 1850

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[41]"Accouchement," *Dictionnaire des sciences médicales par une société de médecins et de chirurgiens* (Paris; Packoucke, 1812), 64.
[42]J. P. Beaude, "Accouchement," *Dictionnaire de médecine usuelle*, vol 1 (Paris: Imprimérie Bonaventure, 1837), 30.
[43]*Ibid*., 51.
[44]Eugène Bouchet, "Accouchements," *Dictionnaire de therapeutique médicale et chirurgicale* (Paris: Germer Baillière, 1867), 16-23.

produced hundreds of monographs pertaining to the female body. Most of these works focused on the same types of questions and themes—vestiges of the humoral theory of the body, the importance of the sexual life cycle in women's health, the essential differences between men and women, and, finally, the significance of sexual complementarity—which helped to create a medical construction of women that was capable of answering many of the gender questions that had been so prevalent earlier in the century.

IV. **The New Medicine of Women**

From the time of Galen in the second century, western medicine had rested on a one-sex model, understanding the female anatomy as merely the inverse (and inferior) of the male. Countless illustrations emphasized similarity; medical nomenclature offered no unique names for female organs; the humoral theory of bodily matter illuminated a shared corporeal economy. It was a model that was difficult to displace because of its flexibility (it was illustrative, not determinant, of greater truths) and the fact that it validated the male as the standard. In fact, it had such appeal that even evidence to the contrary was either ignored or co-opted in some way. Then, sometime near the end of the eighteenth century, the paradigm shifted not as a result of advancing scientific knowledge, but rather because of two distinct shifts: 1) an epistemological one in which the allegorical link between the body and the greater social order was replaced by a notion of science as the determining basis of knowledge; and 2) its political counterpart, which centered on a struggle for power within an enlarged public sphere. As a result, a

new two-sex system emerged, in which the difference between women and men was one of kind, rather than degree as it had been in the past.[45]

The conversion to the two-sex model, however, did not mark a complete break with the past. Rather, the nineteenth-century understanding of the female body blended elements of the old Galenic concept with new understandings of the female life cycle. What this entailed, in practice, was a merging of physical and social categories designed to emphasize difference. As such, in 1830, there were five primary characteristics thought to define the female body: age, temperament, constitution, pregnancies, and marital status. Of those, three (age, temperament, and constitution) were purely physical, one (marriage) was purely social, and one (pregnancy) displayed qualities of both.

Constitution and Temperament

The humoral theory that organized medical knowledge prior to the nineteenth century posited the existence of four humors, or fluids, that co-existed in a tenuous balance in the human body. That balance, however, was not the same for every individual. In fact, that inevitable abundance of one humor over another in a single body, defined as "constitution," was a determinant force in that person's health. A person's constitution, whether defined by blood, phlegm, or yellow or black bile, was his or her natural state of humoral balance. It came to be, by the nineteenth century, a kind of shorthand for "healthy" and "unhealthy." People with "strong constitutions," were considered to be generally healthy. Likewise, a person of "weak constitution" was prone to health problems. As a result, the goal of medical practice was primarily to restore

[45] *Ibid.*

balance among the humors, typically by bleeding, blistering, sweating, purging, or vomiting.[46]

It was this understanding of health as a delicate balance that governed the nineteenth-century understanding of the female body (ruled as it was by the cool humors—black bile and phlegm). Overexertion, which changed the body's temperature, could upset that already-delicate balance and lead to medical complications. Female heat was linked to an excess of passion—passion that women lacked the ability to control. Men, on the other hand, were governed by the warm humors (yellow bile and blood), which made them more capable of withstanding exertion.

Accordingly, doctors often paid close attention to lists of activities that were appropriate for women, categorizing them in terms of their constructive or destructive properties for female health. It was not merely that women and men had different talents or different interests that defined those activities in which they could participate; it was a biological imperative.[47] This was certainly true in Antoine Martin Bureaud-Riofrey's *Education physique des jeunes filles, ou hygiène de la femme avant le mariage*, which argued that there were certain exercises that must be added, for medical purposes, to the education of women. These included "walking, dance, graded exercises of the arms and legs, inclination of the torso, different exercises of the baton, those of balance, climbing or descending on different ladders," though he went on to assure the reader that none of

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[46]John Duffy, *From Humors to Medical Science*: *The History of American Medicine* (Urbana: University of Illinois Press, 1993).

[47]Antoine Martin Bureaud-Riofrey, *Education physique des jeunes filles, ou, hygiène de la femme avant le mariage* (Paris: Librarie des sciences medicales, 1835), 171; Found in "The History of Women", Microfilm, #992; Claude Lachaise, *Hygiène physiologique de la femme; ou de la femme considerée dans son système physique et morale, sous la rapport de son education et des soins qui réclame sa santé à toutes les époques de sa vie* (Paris: Chex M. Marvis, 1825), 299-326.; Found in "The History of Women", Microfilm, #180; Adam Raciborski, *De la puberté et de l'age critique chez la femme, au point de vue physiologique. hygienique, et medical., et de la ponte periodique chez la femme et les mammifères* (Paris: J.B. Balliere, 1844), 484-487.

these exercises should actually exhaust the young lady in question; walking should be done slowly, as women could easily lose control of their physical bodies and fall down. The same held true for any of the above listed exercises—in moderation, they were useful for releasing extra passion in women before marriage; in excess, they increased a woman's temperature and compromised her health. Also important for a woman's natural balance was a commensurate amount of rest to recover from even minimal exertion.[48] The female humors were arranged in such a delicate balance that any upset would have profound ramifications for a woman's health.

The humoral constitution of a body did more than determine its possesser's relative health; it also determined his or her temperament, or emotional character. Traditionally, for example, someone with a surplus of yellow bile was considered to be choleric, or disagreeable. Someone with an abundance of blood was described as sanguine, or strong and courageous. Women, who were typically dominated by the cool humors, were most often melancholic (despondent and irritable) or phlegmatic (stolid and unemotional), depending on whether they had a surfeit of black bile or phlegm.[49] In the eighteenth century, understandings of temperament developed a new dimension within moral sense theory and came to incorporate sensibility, or the physical experience of emotion.[50] Within this eighteenth-century understanding, women were "dominated by their cerebro-nervous system," and men "by their vascular fiber system."[51] This physiology left women vulnerable to emotional excess and to disruptions in their health.

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[48]Bureaud-Riofrey, 171-173, 212.
[49]Duffy, 85-90.
[50]Lawrence Rothfield, *Vital Signs* (Princeton: Princeton University Press, 1992), 25; Lindsay Wilson, *Women and Medicine in the French Enlightenment: The Debate over "Maladies des Femmes* (Baltimore: Johns Hopkins University Press, 1993)
[51]*Ibid*., 73.

Age and the Life Cycle

The new medicine of women that emerged in the nineteenth century was built around the notion that diseases were caused when the body was out of its natural state of equilibrium, particularly for women, whose balance was understood to have important sexual undertones. Women were more sensitive to emotional stimuli and were therefore considered to be more passionate than men. This sexual fervor had the ability to "stir the blood," so to speak, and upset the desired consistency between blood and nerves.[52] This was offered as an explanation for the delicacy of women's health at particular stages in their lives:

> During the puberty of a woman, the efforts of life fall successively on different organs; there are undulations of liquids and nervous fluids which run through the economy and search (for a way to) settle themselves; these physical phenomena admirably explain the inequalities in the character of young girls; these continual and nevertheless fleeting maladies change places at each instance, like the fluids which move ceaselessly […].[53]

In other words, both women's temperaments and their actual physical well-being depended on keeping their nervous and vascular fluids in a state of equilibrium—something that proved particularly difficult when women's bodies went through sexual changes.

While women (as individuals) largely continued to be depicted as "women" (a category), that tendency was supplemented in the late eighteenth century by a more nuanced recognition of the importance of the life cycle for women. Instead of prescribing advice for "women" (category), doctor-authors began to take into account the

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[52]Suzanne LeMay-Sheffield, *Women and Science: Social Impact and Interaction* (Santa Barbara: ABC-CLIO, 2004).
[53]Bureaud-Riofrey, 304.

changes that a woman's body went through during the course of her life. There were not just differences between men and women; there were differences among individual women as well. According to this new understanding, women's lives were divided into four segments, each defined by a specific change in sexuality and in reproductive function: 1) *enfance* (childhood); 2) *puberté* (adolescence); 3) *grossesse* (pregnancy); 4) *åge critique* (menopause). Between *puberté* and *grossesse*, there could be added the category of *le mariage* (marriage), but, since that did not center on an identifiable bodily transformation, these authors tended to treat marriage as a solution to or treatment for the physical "malaise" that accompanied adolescence.[54]

The various stages of a woman's life cycle, defined as they were by the critical moments in female sexuality, were assumed to be crucial to understanding the female body. As one doctor described it, "[…] the moment when a woman, ceasing to exist for herself, acquires the generative faculty, by the great influence that it has on her future health, should be, for the physiologist doctor, a profound subject of meditation."[55] For these doctors, then, in order to comprehend "woman", one must begin by understanding her body and, essentially, her sexuality. Women became intrinsically linked to their sexual function and hence detached from their rational faculty. Since women were so tightly enmeshed with their physicality, the idea that they had no self-control adopted a new validity, imposed by the authority of science and medicine. Being linked to their bodies, which worked independently of their reason and intelligence, meant that women needed to be controlled by external factors, namely marriage and pregnancy.

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[54]LeMay-Sheffield, 35-37.
[55]Lachaise, 110.

Marriage and Pregnancy

These medical theorists began to look at the bodily structure of human males and females in an attempt to prove physiological difference. Men and women were born essentially the same, but as their bodies began to assert themselves (around the age of six), they became incommensurate. First, as has already been demonstrated, men and women were seen to be dominated by two completely different kinds of fluids in this quasi-humoral system of the nineteenth century. Yet beyond that, doctors began to examine the skeletal, muscular, and functional systems of the female body in order to prove, tangibly, the differences between men and women. They concluded that men and women are born the same, but that they grow differently. As Schiebinger has pointed out, medical theorists focused on specific body parts in order to prove women's difference and inferiority.[56] Such incommensurability, they claimed, was not the result of education, but rather of innate differences: "[…the] delicacy [of a woman] is not only the effect of education, it is the particular constitution of woman."[57] Her muscles are weaker, her skin paler, and her frame smaller. Her sexual organs were even considered completely different. Even in terms of temperament, women and men were completely different. Women, more emotional and sensitive, were thought to be inferior, biologically and morally, to men: they needed someone to take care of them, someone to control them when they could not control themselves.

That "someone" found its personification in the form of a man, who, although different, was thought to be complementary to women in that both sexes were

[56] Schiebinger, 42.
[57] Bureaud-Riofrey, 19-20.

"incomplete" without the other. Male and female sexual function, while inherently different, began to assume a certain degree of complementarity characterized by an active/passive dichotomy. The male organ gives, the female receives. Again, this reiterates the idea that women cannot be in control of their *passive* bodies—they must always exist in relation to another (male) body. Strikingly, this idea of the passivity of women was often joined to the idea of women's more passionate natures. Though it seems contradictory for contemporaries to have joined these two opposing ideas, when put together in a medical context, they became a strong argument for the external control of women's bodies. Enter marriage with its regular intercourse as a medical solution. Male sexuality assumes an active role and works to contain female sexuality by instituting the natural human desire for monogamy. Women's sexuality is thus calmed and controlled by men—and they are once again dismissed as the weaker sex.[58]

Marriage was thought to restrain the uncontrolled passions that flooded a young woman's body during puberty because it regularized and institutionalized sexual intercourse. One doctor even went so far as to describe puberty as the "springtime of life" and to argue that the female body "responds in its entirety to the act of reproduction, of which the uterus is one of the principal instruments."[59] This was followed by an account of the importance of marriage to the health of women because it prevented the sexual impetuousness that could result in a variety of maladies, such as hysteria and nymphomania. The weaker sex was thought to have the strongest desires and thus

[58] Lachaise, 9-15, 79, 171-190; Renaud-Riofrey, 18-22
[59] Lachaise, 74-75.

needed to be controlled by the institution of marriage.[60] In other words, if women failed to marry, they would suffer not only socially and morally, but physically as well.

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If we are to understand medical professionalization as the result of the self-conscious construction of public identities, then it becomes necessary to recognize the fundamental characteristics of those identities. The changes that took place in French medicine (and French society at large) between 1789 and 1850 brought two particular characteristics to the forefront: 1) the rise of the individual case, defined as it was by the rule of experience, within the clinical tradition; and 2) the predominance of "the woman question" and the rise of obstetrics and gynecology as the first medical specialty. Both of these issues were bound up in the questions of authority, status, value, and expertise that structured the emergence of the modern medical profession in France during the first half of the nineteenth century.

[60] Raciborski, *De la Puberté,* 484-487.

3

A Category of Proof:
The Case Study in Nineteenth-Century Medicine

What emerged from the reforms in the first fifty years of the nineteenth century was the undeniable importance of experience—experience that was gained one patient at a time. The significance of the individual case for illustrative purposes was not particularly new. Consider, for example, an unpublished manuscript written by a Parisian doctor at the end of the eighteenth century. Setting out to undermine Revolutionary theories about human nature, Nicholas Chambon de Montaux offered a pointed critique of the widely read works of Jean-Jacques Rousseau. Rousseau, Chambon de Montaux claimed, seduced his readers with the passion and heat of his writing style—*not* with the power of his proof. Through charismatic narrative, Rousseau convinced many of his readers of the innate goodness of man—an idea that the experience of the French Revolution had led Chambon de Montaux (a Revolutionary himself, who served as the mayor of Paris from December 1792 to February 1793) to question.

The doctor instead believed that not all humans were born with the same moral leanings and set out to prove his conclusions by "testing" Rousseau's "theories" (as he dismissively deemed them) through an examination of multiple subjects in situations that had left them relatively free of societal influence.[1] His tests involved not the inductive method of contemporary science, but rather a series of unconnected stories that he had

[1]According to Chambon de Montaux's description of his method, he observed children of various ages abandoned by their families and living in relative isolation, well outside of the urban spheres of influence.

accumulated during his time as a doctor in France. For example, one of his most compelling "cases" was that of a young murderer in the south of France:

> A young man of 21, who had already killed ten undeserving people, all on the road that leads to the market at Neufchâteau; he was traveling with a certain person unknown to him. A storm passed with large claps of thunder: at each flash that preceded the noise of the lightning, the traveler winced and made the sign of the cross. The murderer was indifferent, he fired a pistol into his chest. Taking nothing, he left this man on the ground, continued his route, arrived at an inn in Neufchâteau, where he said coldly to the innkeeper, 'a man has been killed by the thunder along the road […]. Alert the magistrate to have the body moved.' The rest of this declaration has nothing to do with my subject, but how does one characterize such an atrocious action, committed with such indifference, with no apparent motive, if one cannot say that this murderer was born with the most abominable inclinations?[2]

Chambon de Montaux used an individual case to illustrate his primary (pre-determined) point, which was that Rousseau (and by extension the Revolutionaries who agreed with him) was misguided in his understanding of human nature. In this situation, the case played what was primarily an illustrative role.

Changes in medical education and organization in the first four decades of the nineteenth century pushed the individual case to the forefront, away from illustrative and towards constitutive purposes. In essence, the case came to define the way that doctors saw themselves and their work. According to a report dated 26 September 1837, the *Académie royale de médecine*, after much deliberation at royal request, recommended a new set of guidelines for medical instruction. Article 2 of these "*dispositions*" concerned the division of medical education into four years with two semesters each. The curriculum within those eight semesters demonstrated the emphasis placed on clinical experience. The first year was largely devoted to establishing a fundamental knowledge base—anatomy, chemistry, medical history, physiology—but even as early as the second

[2] Chambon de Montaux, Chapter 33.

semester of medical school, students were expected to make regular visits to hospitals in order "to familiarize themselves with the objects that are the resort of surgery."[3] The second year continued the study of anatomy, physiology, and pathology, but also introduced "clinicals" where medical students learned through observation of actual procedures performed at hospitals. The third and fourth years introduced more intense and specialized clinicals (including a "*clinique des accouchements*" in the fourth year), so that students gained the necessary experience before they were ever granted the title of "doctor."[4] In this way, the acceptance of clinical training—rooted as it was in observation and experience—transformed the individual case into an essential component of medical identity.

I. Rise of the Case Study in the Early Decades of the Nineteenth Century

From its inception, the first (and predominant) French medical academy after the Revolution, the *Académie royale de médecine*, was charged with a double role: advising the crown on issues of medicine and public health and protecting patients and practitioners from innovations considered hazardous or ineffective. In that way, the *Académie* institutionalized the world of professional medicine and created an exclusive arena for control over the dissemination of knowledge about the medical world, including issues of health (such as epidemics and venereal disease) that clearly intersected with the public domain. As such, the *Académie Royale* became a site of sociability that occupied both the private and the public (the professional and the popular) domains.[5] The

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[3]"Enseignement médical: délibérations du conseil royal approuvées par le ministre" *La Lancette Française: Gazette des Hôpitaux* 122 (17 October 1837): 485-488. Qtn. on 488.
[4]*Ibid*., 488.
[5]Pierre Guillaume, *Le Rôle Social du medecine depuis deux siècles (1800-1945)* (Paris: Association pour l'Étude de l'Histoire de la Sécurité Sociale, 1996), 39-42.

aforementioned journals consequently occupied a liminal space, wherein the boundaries between public and private were blurred quite consciously and in such a way that the individual case came to have significant implications on a more general level.

The significance of the individual experience was reflected in the rise of the medical case study, or *observation* as it was labeled most often in the early nineteenth century. Even the word choice is instructive. While the general sense of the term "*observations*" in an early nineteenth-century context might be equated with "remarks" or "comments," contemporary doctors' use of the term was quite a bit different. They deployed the term in a scientific context, understanding it as a defining principle in contemporary scientific methodology, which included observation, hypothesis, and experimentation.[6] The term "*observation*" was thus meant to connote a precise examination with a goal of edification.

Though the case study was not unknown prior to the nineteenth century, the prevalence with it appeared in early nineteenth-century French texts (particularly obstetrical and gynecological texts) is striking. Between 1823 (the journal's founding) and 1850, for example, the *Archives generales de médecine* published 1098 cases studies over the course of 86 published issues, or an average of 12.77 case studies per issue.[7] In fact, a thorough perusal of the issues of three medical journals—*La Lancette Française*, *Archives générales de médecine*, and *Gazette médicale de Paris*--published between 1830

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[6]"Observation," *Dictionnaire des sciences médicales, par une société de médecins et de chirurgiens*, vol. 37 (Paris: Pancoucke, 1819), 29-48. The underpinnings of the scientific method as it was understood in the nineteenth century were observation, hypothesis, prediction, and experimentation. See Ronald N. Giere, *Foundations of the Scientific Method: The Nineteenth Century* (Bloomington: Indiana University Press, 1973).

[7]*Archives génerales de médecine* (Paris: Béchet Jeune, 1823-1850).

and 1850 demonstrates that it was exceedingly rare for an edition of any of these medical journals not to include several *observations*.

Again, statistics are helpful; delving into one particular issue of a medical journal can help to illuminate the relative weight of the case in the first half of the nineteenth century. For this purpose, we will examine the individual elements of the October 1826 issue of the *Archives générales de médecine*. In the 163 pages that comprised this edition of the journal, there were 15 distinct articles (with the 4 book reviews in the *Bibliographie* section counted as one article). Of those 15 articles, 11 included case studies, leaving only 4 without any *observations* at all. Within the aforementioned 11 articles, there were 49 separate case studies cited. Statistically, this means that there were 4.45 case studies per article that cited such cases. More generally, there were 3.26 case studies per article in this issue of the journal, or roughly one case study per 3.33 pages. If we exclude the *bibliographie* (book review) portion of the journal (which necessarily did not use case studies as proof), those numbers change to 3.5 case studies per article, or roughly one case study per 3.24 pages.[8] In other words, case studies were, without a doubt, statistically significant by the end of the first quarter of the nineteenth century in France, offering further proof for the overwhelming importance of the case study or *observation* in medical writing by the 1830s.

Nowhere was this rise of "the case" model more apparent than in the five editions of an immensely popular work on childbirth by Jean-Louis Baudelocque. This book, entitled *L'Art des accouchements*, was published for the first of five times in 1781, but it was between the 1796 and 1815 editions that a most profound shift occurred. It was not that his argument changed dramatically; on the contrary, his conclusions remained

[8] *Archives génerales de médecine* 1, no. 12 (Paris: Béchet Jeune, 1826) : 169-331

relatively unaltered in all five versions. What did change was the *structure* of the argument: the presentation that Baudelocque thought would be most convincing for his intended audience (primarily other doctors, but also a small percentage of the educated public) shifted during the early years of the nineteenth century.[9]

The first structural variation that appeared in the 1806 version was a general shift throughout the work that brought case studies from the footnotes to the text itself. Baudelocque divided his work into three sections: an introduction; a discussion of physiology; and a discussion of pathology. It was in this third section that this new style took shape between 1796 and 1806. Rather than using case studies as a brief addendum to a point already made (and relegating them to the footnotes) as had been his practice in 1796, by 1806 Baudelocque recognized their significance and power as proof and chose to move them from the margins to the center. In some cases, he merely repositioned the footnote in its entirety within the text with no significant changes. For example, in the 1796 text of Tome I, section 3 at the bottom of page 417 was a footnote detailing the history of a pregnant woman who, though perfectly at term, had experienced profuse bleeding during her 1787 labor. Baudelocque wrote,

> The feeble state in which I found this woman, upon arriving at her home, the small amount of blood she had lost, and the growth of her uterus since the first loss [of blood], left me no doubt that there was internal bleeding. I explained things to the woman's husband; I did not underestimate the danger facing her.[10]

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[9]Jean Louis Baudelocque, *L'Art des accouchements* (Paris: Chez Méquignon, 1796); Jean Louis Baudelocque, *L'Art des accouchements* (Paris: Chez Méquignon, 1806); Jean Louis Baudelocque, *L'Art des accouchements* (Paris: Chez Méquignon, 1815).
[10]Baudelocque, *L'Art des Accouchements* (1796), 417.

In the 1806 version, this footnote was moved verbatim into the full text of the book.[11] The same was true of the subsequent two footnotes.[12] In fact, in this section of the book, Baudelocque moved no fewer than twenty observations or case studies from footnotes to text.[13]

The second structural change, which appeared between 1806 and 1815, was the addition of a preface, adopted from a paper read at a meeting of the doctors of the *Maternité* hospital just a month after Baudelocque's death, which highlighted the significance of observations and the power of the doctor-observer:

> To arrive more surely at the goal that [Baudelocque] is proposing, to give his students a truly solid instruction, he does not limit teaching to simple speech; but, after having exposed in a clear, but concise manner, the particular object that he is treating, he further develops it by clarifying different points through questions that he addresses to one or more students. […]. Each day one or two students are charged with giving him a verbal or written account of particular cases which were presented in hospital practicals; and the examination and discussion of these facts becomes a new, even better, source of instruction, feeling that the precept is derived immediately from the example. Each lesson is thus like a conversation between a good father and his children; it is not lecture alone, but the intelligence and the judgment that one expends; nothing escapes attention. […]. Along with his talent of observing, Baudelocque also had that of explaining, of transmitting his observations. Abundant and creative in his lessons, he did not seek to dazzle by some pompous discourse; he wanted to teach. He was simple, methodical, grave, and commanded attention and respect.[14]

The evolution of Baudelocque's *L'Art des accouchements* clearly demonstrates the increasing discursive significance of observations, experience, and the medical case study during the first thirty years of the century. The use of case studies was not mere habit or happenstance—it was a rhetorically deliberate move, designed to convince an audience of

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[11]Baudelocque, *L'Art des Accouchements* (1806), 470.
[12]Baudelocque, *L'Art des Accouchements* (1796), 418-425; Baudelocque, *L'Art des Accouchements* (1806), 472-480.
[13]Baudelocque, *L'Art des accouchements* (1806), 458-694.
[14]Baudelocque, *L'Art des accouchements* (1815), 10-15.

doctors' authority to speak on a particular subject by marking him as an integral part of a community defined by shared knowledge. Case studies themselves became a currency of proof in the medical world and, as such, came to distinguish the medical community.

II. The Meaning and Value of the "Individual Case" in the Late 1820s

Though clearly the predominant form of medical writing by the nineteenth century, case histories were by no means unproblematic. Emerging from two distinct philosophical traditions—one that used the case to test the boundaries of categorical knowledge (the case as exception) and one that perceived it as a representative illustration of that category (the case as example)—the nineteenth-century case study was subject to unique demands. Case narratives operated as both fact and story, while being compelled to incorporate both disease and person simultaneously.[15] In the late 1820s and early 1830s, theoretical challenges to the perceived reliance on case studies in medicine emerged. Two issues of *La Lancette Française*, dated 8 and 10 April 1830, illuminate a heated debate concerning the utility of a single (isolated) observation. The debate was sparked by a lecture delivered on 1 April 1830 by Guillaume Dupuytren, a highly regarded member of the surgical division of the *Académie*. During the lecture, Dupuytren dismissed the usefulness of isolated observations, which he claimed were dangerous and inhibitive to the advancement of medicine. Such observations, he was reported as saying, were, more often than not, manipulated to fit preconceived ideas and

[15]Kennedy, 9-11.

biases, thereby contributing little (if anything) to the progress of medical science, which was best served by the accumulation of a "mass of facts."[16]

The rapidity and vehemence with which Dupuytren's argument was rebutted is indicative of how controversial his remarks were. Just two days after *La Lancette Française* published this article, an anonymous author (or group of authors) argued that, far from being useless, individual cases were in fact the building blocks of medicine—without them, doctors would know nothing practical. This doctor wrote, "the particular fact that you gather today, that you publish tomorrow, that you have seen, is a fact that, though isolated today, can be grouped with others tomorrow."[17] For where else, the article questioned, could one find Dupuytren's revered "mass of facts" but in the slow accumulation of numerous "isolated observations"? Observations, he countered, were not inherently untrustworthy; in fact, without them, there would be no medical knowledge to speak of. Taking it a step further, the author argued that all facts (not just observations) could be manipulated to fit pre-established ideas or conclusions. It was the responsibility of the observer (both the original observer of the event and the observing audience of the case history) to develop and maintain a standard of proof for these observations. If a doctor was vigilant, precise, and convincing, so too would his case study be. If he was careless or imprecise, his case study would have no value to others in medicine. The value of a case study was bound up in the value of doctors themselves.

Moreover, in a slightly backhanded blow to Dupuytren's public denunciation of observations, the article noted that a bigger problem came from the "great men" of a field, who could silence a debate with a single declaration. The accusation was clear—

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[16]"Utilité des observations isolées," *La Lancette Française: Gazette des Hôpitaux* 25 (8 April 1830): 99.
[17]*Ibid*., 100.

this was precisely what Dupuytren was trying to do in this debate and the author could not accept that. Such suppression of debate, he wrote, was far more detrimental to the progress of medicine than the undirected compilation of individual case studies. It was up to all members of the profession to resist the manipulation of facts by relating the stories of their practice, comparing them with others, and drawing conclusions from all the evidence available.[18]

In this particular debate, the majority of doctors agreed with the anonymous critics of Dupuytren. Two days after the initial exchange (with the next publication of *La Lancette Française*), an article entitled "Explanation of the Errors into which Monsieur Dupuytren has Fallen, in our Consideration" was inserted into the discussion. Its authors too disagreed fundamentally with Dupuytren. In fact, they argued that Dupuytren had made an egregious error— his fundamental belief that facts could ever straightforwardly form the basis of physiological and pathological principles and that facts never contradict themselves—which caused him to draw inaccurate conclusions. In contrast to Dupuytren, these doctors claimed that medical facts often contradicted themselves because medicine was as much an art as a science. Inconsistencies had nothing to do with a superficial analysis or bias on the part of the researcher, as Dupuytren had argued. Rather, they resulted from the intricacies and complexities involved in the practice of medicine, of taking theoretical knowledge and putting it to work in a variety of contexts. As proof, they cited several of their own cases of post-amputation deaths, in which autopsies found no evidence of infection or internal injuries (*lésions*). These deaths could not be explained by existing knowledge—yet still they occurred. For the authors of this

[18]*Ibid*., 100-101.

article, there was no need to dismiss as useless these cases or facts merely because they contradicted other findings:

> For us, we accept the two things; one does not bother us more than the other; to find disorders of the viscera after the death of an amputee, it is a typical thing. Not to find anything is much less common, but we are not the first to signal it […][19]

For these authors, then, the fact that these two observations (one where infection was present, the other where it was not) did not directly support each other was not a justifiable reason to embrace one as right, and the other as wrong. Rather, both were part of the "mass of facts" that would make for a more nuanced, useful, and accurate conclusion in the end.

Similar debates over the validity of the individual case were raised with the advent of evidence-based medicine in the 1830s, as doctors increasingly attempted to define medicine as a science. In 1835, the Academy of Science commissioned a broad study of the work of Dr. Jean Civiale, who had used statistics to argue for a change in the medical approach to gall stones. Civiale won the 1836 *Prix Montyon* from the Academy for this work and is widely considered one of the founders of evidence-based medicine. The commission, while lauding his work, nonetheless raised serious questions about the validity of his method, rooted primarily in the concept of the individual case. Using a statistical method, the group noted, required the observer to "lose sight of the individual seen in isolation, to consider him only as a fraction of the species.[20] Again, medicine is

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[19]"Explication de l'erreur dans laquelle est tombé à notre égard M. Dupuytren," *La Lancette Française: Gazette des Hôpitaux* 26 (10 April 1830): 103.

[20]J. Rosser Matthews, "Commentary: The Paris Academy of Science Report on Jean Civiale's Statistical Research and the 19th Century Background to Evidence-Based Medicine," *International Journal of Epidemiology* 30 (2001): 1249-1250. Qtn. from S.D. Poisson, F.J. Double *et al*. "Rapports: Recherches de Statistique sur l'affection calculeuse, par M. Le docteur Civiale," *Comptes Rendus Hebdomadaires des Séances de l'Académie des Sciences* 1 (1835): 173. Cited in Matthews, 1250.

tied to a fundamental individualist imperative. Each case was different, each patient distinct. The medical project remained rooted in the individual case. Challenges to that concept, while intriguing, were met with fierce resistance in the early nineteenth-century medical world.

This debate over the usefulness of individual case studies was linked in part to a broader concern over clarity and specificity in medical knowledge. The doctors who wrote case studies in nineteenth-century France were very well aware of the importance of the words they chose to describe their observations. This emphasis on the "case in isolation" placed the burden of proof on the doctors who wrote case studies, leaving them quite aware of the importance of the words they chose. It was an idea promoted by Dr. Sebastien Guillié, the director of the *Institut royal des aveugles-travailleurs*, when he claimed in 1819 that "[m]ost men observe nothing, do not even know how useful observation is, judge in haste, and think they are acquiring knowledge when they are only learning words empty of meaning." It was thus imperative for Guillié that doctors "rectify their language" and "give themselves better habits."[21] Language, he argued, could be manipulated if it were not subjected to intense scrutiny and rooted in careful observation; after all, shifts in language could mean the difference between truth and error.

This concern for linguistic precision was part of a larger cultural trend in late eighteenth- and early nineteenth-century Europe (most notably in France), when rhetorical emphasis moved away from flamboyant public speaking and toward a more

[21]Sebastien Guillié, "De l'Abus des Mots en Médécine," Journal de Médécine Pratique (1819), 34.

staid textual mode of communication.[22] Though doctors recognized that this meticulousness could be at times tedious, it was necessary because it eradicated uncertainty. One "should not see in this precaution, superfluous without a doubt, merely an artifice of language," they cautioned, for "[w]ithout it, we could not give our ideas all the lucidity necessary."[23] The rhetoric of writing, then, was of the utmost significance for doctors in the nineteenth century because it defined the medium by which they communicated ideas, challenged beliefs, and established a medical profession that distinguished itself by its control over a specialized body of knowledge.

III. Case as a Category of Proof in the 1830s and 1840s

What was it about the case that made it such a powerful encapsulation of the medical experience? The practice of medicine has always been built around an inherently problematic dichotomy between disease—a pathological category—and illness—the human experience of that category. The modern medical process is fundamentally based on a transformation of illness (the symptomatic experience of a malady) into disease (a diagnostic category).[24] Any representation of that process would therefore necessarily blur the boundary between objectivity and subjectivity, science and art, scientist and healer. By linking language to visual culture, giving words to corporeal experience,

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[22]Michael Cahn, "The Rhetoric of Rhetoric: Six Tropes of Disciplinary Self-Constitution," in *The Recovery of Rhetoric: Persuasive Discourse and Disciplinarity in the Human Sciences* eds. Richard Roberts and James Good (Charlottesville: University of Virginia Press, 1993) 87-100

[23]Paul Dubois, "Rapport à l'Académie sur 2 Cas de Monstruosités," *Mémoires de l'Académie Royale de Médecine* 4, no. 1 (1835), 481.

[24]Arthur Kleinman, *The Illness Narratives: Suffering, Healing, and the Human Condition* (New York: Basic Books, 1988).

nineteenth-century case studies existed in that liminal space between the physical and the linguistic, consequently offering "the appearance of a 'curious discourse' that insists upon the unknown and the subjective in the midst of the ostensibly disinterested, knowledge-producing project of experimentalist medicine."[25] The uneasy juxtaposition of a language of unbiased scientific terminology with the inherent subjectivity of narrative imbued *observations* with a flexibility that allowed them to adapt to the changing pressures of nineteenth-century French society, particularly in the realm of class and gender norms.

Narratives have power because they tell stories and stories are fundamental to the modern world. As Lyotard described, "little narratives" (as opposed to grand or meta-narratives) constitute a fundamental principle of modern society because of the discursive and performative restrictions they place on those who operate within that milieu.[26] Everyone is subject to the rules imposed by narrative, a universality that gives it "both its local authority and its heterodox socio-political power. Throughout the culture, unofficial small stories are told, listened to, retold, affirmed, disconfirmed, reissued, dropped, all this occurring alongside of other stories circulating in the same manner, in sometimes intersecting paths."[27]

Let us reconsider the Hélie Affair that captured French attention in the 1820s and 1830s. Not only did those who were directly involved rely on deliberately constructed narratives of the case in question, but many other members of the medical audience for these *causes célèbres* used case studies to describe and affirm their own positions on the

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[25]Kennedy, 4.
[26]Jean-François Lyotard, *The Postmodern Condition: A Report on Knowledge* (Minneapolis : University of Minnesota Press, 1984.).
[27]Martin Kreisworth, "Trusting the Tale: The Narrativist Turn in the Human Sciences," *New Literary History* 23, no. 3 (Summer 1992): 642-643.

medical drama and the larger issues that drama raised. For example, in constructing a defense of Hélie (laid out in a series of letters to the editor of *La Lancette Française* between 1827 and 1828), one provincial doctor, Auguste-Charles Leroux, cited a number of cases described by Hélie's chief detractor, a Parisian doctor named Jean Capuron. For Leroux, Hélie's defense lay mainly in the fact that medicine was an art rather than a science and, as such, was inherently fallible. To illustrate this point, Leroux pointed first to mistakes and reversals of opinion made by Capuron himself in the course of his career. He derisively cited an instance in one of Capuron's books on the art of childbirth in which the renowned doctor reversed an earlier stance on the issue of opium as an anti-spasmodic: "I do not know who is right or wrong, the reverend-father Jean Capuron of 1827, stripping opium of its calming and anti-spasmodic virtues, or the reverend-father Jean Capuron of 1823, exalting this virtue and saying to us 'Anti-spasmodics such as laudanum […] are the most appropriate course for dissipating general spasms."[28]

Leroux pointed to this reversal of opinion as justification for his own plea for latitude in the professional judgment of Dr. Hélie. The rhetorical strategy allowed him to dismiss, if not the doctor's mistakes, at least the accusation of negligence or willful malpractice. Every doctor, he suggested, made mistakes and if Hélie's detractors looked over their own records, they would find instances that, while not as public as Hélie's, were just as troublesome. What was most revealing, however, was the structure of the his argument, in trying to prove that Hélie made a reasonable and understandable mistake in his evaluation of the situation, Leroux harnessed the power of "the case"—the specific

[28]F. M. Leroux, "Petit essai d'une petite lettre provinciale philosophico-médicale," *La Lancette Française: Gazette des Hôpitaux* 24 (18 December 1828): 96.

instantiation of a medical practice designed to illustrate and explain its basic precepts. Leroux put that *observation* to work within this heated debate by subjecting one of the leading experts in the field of French obstetrics to the same type of intense scrutiny and criticism that Hélie's infamous story had prompted.[29] He pitted case against case; the individual *observation* had become a category of debate and a discourse of proof.

Reaction to the debate between Capuron and Leroux was mixed. Some doctors supported Leroux (and by extension, Hélie), as when a doctor from Turin named Malvani offered a sympathetic description of a similar case he had observed. "If four practitioners, one after another, could not succeed," Malvani challenged Hélie's critics, "it is not surprising that Dr. Hélie was unsuccessful in circumstances where he found himself all alone; one must not believe, as is the pretense of Dr. Flammant, that one can always conduct the maneuvers of childbirth as one wants."[30] There was not always a "right" and "wrong" in medicine, particularly in the realm of *accouchements*: doctors had to make the best decision they could, based on the specifics of the case before them. At times, they would make inevitable mistakes; at others, they would not. Regardless, all doctors should recognize the fact that they too could fall prey to the uncertainty of medicine and be empathetic to their fellow doctor's plight. His proof? Case narrative. Neither Malvani nor the doctors involved in the Hélie Affair listed facts or used textbook knowledge to make their cases; they did not debate physiological assumptions. Instead, they depended on the power of the story and the validity of firsthand experience to serve as proof in a heated and very public debate. The case had become a war of words, words that took the form of the case narrative. Treated as exceptionally instructive and

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[29]*Ibid*., 93-96.
[30]Malvani, "Accouchement avec sortie du bras: lettre adressé à M. le docteur Leroux (de Rennes)," *La Lancette Française: Gazette des Hôpitaux* 92 (2 June 1829): 365-368.

compelling, the case narrative possessed a unique ability to capture the reader's attention by bringing a sense of immediacy and applicability to the general lessons of physiological medicine.

The influence of the story was equally apparent in an 1829 "*fait curieux*" published by Erasme de Caignou. It was a case of an extra-uterine pregnancy, in a thirty-two-year-old Parisian woman, for which Dr. Caignou was consulted approximately six and a half months into the gestation, when the midwife found a large tumor or growth outside of the uterus. "I recognized," Caignou remembered, "in the diverse symptoms and in the extreme sensitivity of her stomach, a very intense peritonitis [abdominal infection], and, having determined that the birth could not be completed without the help of my art, I sought to fight" these problems. His "methods did not procure the desired end, and the state of the patient was becoming more and more desperate," so he consulted several doctors about his " decision to make an incision into the tumor in order to extract the child," claiming that it was the woman's only chance at survival.[31] Disagreement generated even more consultation (the total number of medical professionals involved in the case reached fourteen, excluding the midwife); consultation bred debate. And so it was that, once they agreed on Malvani's suggested operation, too much time had passed. The surgery, performed 53 hours after Caignou made the official diagnosis and recommendation, was too late.[32]

The editors who published his *observation* were appalled at the doctors' collective

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[31]Erasme de Caignou, "Grossesse extra-uterine: Foetus dévelopé dans le pavillon de la trompe gauche; Opération particulière, foetus de 6 ½ mois, extrait vivant," *La Lancette Française: Gazette des Hôpitaux* 39 (19 September 1830): 153-156. Qtn. on pp. 154-155.
[32]*Ibid*., 155.

indecision, writing, "It is deplorable that anyone would have first opposed this operation […] as it gave time for all the symptoms of peritonitis to develop. Performed several hours earlier, [the surgery] might have saved this woman." The shamefulness of the actions did not, in these writers' estimation, "diminish at all the merits of the observation," but rather stood as validation of the importance of acting with haste.[33] In this validation of even the least successful case, the editors' words reflected the weight of the case study in nineteenth-century medicine, based in large part on its capacity for instruction, as did a slightly later manuscript collection assembled by Pierre Nicolas Gerdy, a member of the Paris *faculté* and one of the most renowned surgeons of his day. Though ultimately left unpublished, these manuscripts reflected a rhetorical approach based on the value of the individual case, using three distinct case narratives as a discourse of proof about the most appropriate course of action in shoulder-first fetal presentations during labor and delivery.

To make his case, Gerdy highlighted the dangers of this type of delivery and noted several issues that made the transverse presentation (wherein babies lie sideways in the uterus) far more dangerous than other modes of delivery: 1) uterine contractions were ineffective in forcing the infant out of the vaginal opening; 2) the labor was extended and non-productive; 3) the shoulder could not settle in the pelvic basin; and 4) when the water broke, it became possible for the uterus to empty its amniotic fluid completely, creating a strong probability of infection.[34] Gerdy used three cases as proof for his claim that doctors must pay particular attention to cases like these (though relatively uncommon compared to the number of uncomplicated deliveries performed by nineteenth-century

[33] *Ibid*.
[34] *Ibid*.

French doctors every year) and that they must master a technique that he called a "simple adduction."[35] This suggestion signaled, in a self-conscious challenge to the status quo, a shift from earlier practices that used a complete manual [external cephalic] version for all types of mal-presentation. His rhetoric had to be persuasive, and what did he find to be the most compelling and persuasive option? Case studies.

Structurally, Gerdy's argument allotted considerably more time and space to the case studies than to either the introduction or the conclusion, a structure that underscored the primacy of cases studies in nineteenth-century medicine. This structure was mirrored by his contemporary Joseph Capuron in a more general critique of the state of obstetrics in nineteenth-century France.[36] Capuron emphasized the importance of more intensive study in the field of obstetrics. "Obstetrical therapeutics," he wrote, "have been designed to help a woman in labor, when she cannot give birth alone."[37] His understanding of the role of obstetrics rested on both a recognition of the superiority of natural (physiological) birth *and* a belief that certain (pathological) conditions rendered such a natural birth impossible. It was those cases that necessitated the intervention of a professional *accoucheur*. In such situations, it was the duty of the *accoucheur* to attempt manual interventions that repositioned the infant to ensure that a natural delivery was possible first, saving surgical and mechanical interventions as a last resort.[38]

Capuron composed his argument out of the cases he had attended in which an

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[35]An **adduction** is a procedure that pushes the protruding limb back to the midline of the body, in such a manner as to encourage rotation in direction or another to bring the baby into a more productive position.
[36] *Ibid*.
[37]Joseph Capuron, "Reflexions sur la thérapeutique obstétricale, sur la division de l'accouchement manuel en genres et en espèces ou positions, et sur le choix de la main pour opérer la version de l'enfant," *Extrait du Bulletin Général de Thérapeutique, Tome XIII* (Paris: Imprimerie d'Everat, 1837), 1.
[38]*Ibid*., 1-4.

infant presented with something other than his or her head because these were the types of cases that could most often be facilitated through a manual aid (version or adduction), unlike other problems (malformations of the uterus, extreme weakness, cessation of productive contractions), which typically required mechanical or surgical aid. "In order to appreciate these divisions and these minutia, in order to help us emerge from inutility and ridicule," he challenged, "let us consult experience and practice. They respond with more decisive facts than the clearest reasoning or the wisest lessons."[39] From three separate observations, Capuron ultimately crafted a defense of his belief that women in childbirth often required the help of a well trained—and well grounded—obstetrician to bring their pregnancies to a successful conclusion.[40] Arrogance bred mistakes; experience bred knowledge. It was the key to becoming a good doctor. As such, the medical case was intertwined with the value of the medical professional because it evolved as a central element in how doctors learned and practiced their art.

IV. The "Observation" and the Oppositional Elements of Medical Identity

This centrality of the case study, and its role as a fundamental category of proof, joined to create a common discourse that structured the often-contentious world of early nineteenth-century French medicine. Cases always had the potential to become fuel to the fire of an extremely impassioned debate, as becomes clear with an examination of a particularly heated discussion that captured French medical attention in the 1830s. The value of the case narrative as an argumentative tactic was manifest in the ongoing debate concerning the use of *seigle ergoté* in deliveries directed by an *accoucheur*.

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[39] *Ibid*.
[40] *Ibid.*, 1-4.

Pharmaceutical *seigle ergoté* was made from a fungus that grew on rye plants and was used to precipitate childbirth and halt post-partum hemorrhage as early as 1582 in Frankfurt. It was dispensed widely by midwives in early modern France, long before its tenuous acceptance by the professional medical community in 1808. But its side effects were always problematic (*seigle ergoté* or ergot is the root ingredient of modern-day LSD), and dosages were tricky. There were a number of incidents involving uterine spasms and fetal distress that caused concern among practitioners.[41]

The members of the *Académie royale de médecine* invested a great deal of energy in the early 1830s into debating the utility of this drug in the obstetrical field. One of the first justifications of the ergot method was published Dr. Louis Benoit Guersent in 1830. In his defense, Guersent used three *observations*, which he believed enough "to convince people that this method, employed in opportune circumstances, has brought success, without any sort of subsequent problems.[42] The first case, that of a woman named Mme. Dupressoire, took place in December 1828. The 23-year-old woman had begun labor at midnight and progressed quickly to a cervical dilation equivalent to a five-franc piece (approximately two centimeters) before her labor stalled.[43] She was given a dose of *seigle ergoté* and, fifteen minutes later, her cervix was completely dilated and contractions had fully commenced again. A healthy baby was born two hours later with no complications. Mother and child left the hospital nine days later in perfect health

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[41]C. DeCosta, "St. Anthony's Fire and Living Ligatures: A Short History of Ergometrie," *The Lancet* 359:: 9319 (18 May 2002): 1768-1770.
[42]Louis Benoit Guersent, fils, "Clinique de la ville: Observations sur l'emploi du seigle ergoté dans les accouchements" *La Lancette Française: Gazette des Hôpitaux* 2 (7 October 1830): 6.
[43]In the mid-nineteenth century, the five-franc piece had a diameter approximately equal to 3.2 centimeters, according to William Stanley Jevons. *Money and the Mechanism of Exchange*. New York: D.Appleton & Co, 1875. http://www.econlib.org/LIBRARY/YPDBooks/jevons/jvnmme13.html.

(they were required to stay because the woman developed a condition called milk fever, which the doctor attributed to her decision not to nurse). None of these problems, Guersent assured his readers, had anything to do with the use of *seigle ergoté*. A similar situation occurred in the second observation. With this narrative, Guersent related the story of a 26-year-old woman who went into labor and progressed quickly to a dilation equivalent to a two-franc piece (approximately two and a half centimeters) before her labor stalled.[44] The administration of a small dose of *seigle ergoté* caused her labor to recommence within an hour, and she delivered a healthy boy with no complications. It was much the same situation in the third observation: Guersent used *seigle ergoté* to treat a woman whose labor had stalled. Within an hour, labor had progressed and the woman delivered a healthy baby "in the normal way."[45]

As in other medical articles from the period, Guersent's argument consisted of just two parts: 1) a brief introductory paragraph, in which he introduced the topic and stated what he was attempting to prove (the utility of *seigle ergoté* in obstetrics); and 2) a lengthy discussion of three different case studies.[46] He spent a significant amount of time and effort developing all three case studies according to a specific pattern emphasizing the elements of each case best suited to his findings, constructing a persuasive rhetorical strategy that depended less on a discussion of the physiological and pathological issues being debated than on the narrative of clinical experience.

While there were several doctors who agreed with Guersent's analysis (including a renowned surgeon named Villeneuve), there were many who did not, and the debate

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[44]In the mid-ninteenth century, the French two-franc piece had a diameter of 2.5 centimeters according to J.Laurence Laughlin. "Appendix III," *The History of Bimetallism in the US* (New York: D.Appleton & Co., 1895), 247.
[45]Guersent, 6.
[46]*Ibid*., 6-8.

between the two sides became rather intense. In late summer 1831, Jean Capuron (of Hélie Affair fame, not to be confused with Joseph Capuron, whose defense of manual intervention has already been examined) delivered a lecture to the *Académie royale de médecine* deriding the use of *seigle ergoté*. According to Capuron, this drug was too unreliable and too unstable to be helpful at all in obstetrics, whether it be used to accelerate labor or to staunch hemorrhages before, during, or after the delivery process. Interestingly enough, although Capuron had no personal ergot case studies on which to draw, he maintained a medical formula that highlighted the case study. He just had to look outside of his own medical experience to find them.

Analyzing the work of the most "heated" participants of the debate, he argued, allowed him to conclude that the dangers of *seigle ergoté* outweighed the potential benefits. He was careful to declare that his opinion was founded on the unbiased review of anti-*seigle ergoté* observations offered by "the most skillful doctors of Europe and of one unequaled midwife."[47] Even the work of pro-*seigle ergoté* doctors (like Guersent) did little to convince Capuron of the value of the drug in obstetrics. "Even the contradictions that have struck me in the writings of ergotists," he wrote, "have done nothing to make me an apostle of their false obstetrical and hemostatic remedy."[48]

The reaction to Capuron was swift. His was clearly a charged argument, in spite of his claim to be a disinterested observer in the ongoing debate. Referring to the non-ergotists as "the most skillful doctors" and to ergotists as "heated dissidents" was certain

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[47]Joseph Capuron, *Examen des remarques et reflexions de M. Villeneuve sur un mémoire de M. le docteur Capuron concernant du seigle ergoté* (Paris: L'Imprimerie de Crapelet, 1832), 4.
[48]*Ibid*.

to cause a stir, no matter how balanced he claimed his language and judgment to be.[49] Capuron was (unsurprisingly) challenged several months later by a memoir published by André-Charles-Louis de Villeneuve, a Parisian doctor who argued in favor of the use of *seigle ergoté* in certain cases. He based his conclusions on the observations of several doctors—including three separate observations from Dr. Goupil, one from Dr. Prowse, and one from Dr. Michel—combining them with other scientific treatises, such as Marie-Alexandre Desormaux's *De Abortu* and *Précis de doctrine sur l'accouchement par les pieds, pour servir à un acte publié*.[50] According to Villeneuve, it was surprising that Capuron would challenge a practice like the use of *seigle ergoté* when so many facts and observations verified its utility. By ignoring them, Villeneuve claimed, Capuron had undermined his own position as an unbiased commentator on the issue at hand.[51]

Capuron's subsequent response to Villeneuve was equally heated. He began with a brief statement ostensibly meant to appease his opponent (yet another indication of how heated the debate had in fact become):

> Always, I declare that they [my doubts and incredulity about *seigle ergoté*] have not diminished the esteem and affection that he [Villeneuve] inspired in me long ago and which are quite inalterable. If science and the arts are the domain of intelligence or the wit, affection is also the life of the soul or heart. I thus believe that one can have a battle of opinions without upsetting peace among men. […]. If I lose my way, if I am in error and someone points it out, he has done me a great service. […]. It is with these ideas that I return to this discussion.[52]

If Capuron's word choice was exceedingly careful in his introductory remarks, it was because he was setting the stage for a scathing attack on Villeneuve's carefully built

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[49] *Ibid*.
[50] Marie-Alexandre Desormaux, *De Abortu* (Paris: Imprimeur Fain, 1811); Marie-Alexandre Desormaux, *Précis de doctrine sur l'accouchement par les pieds, pour servir à un acte publié* (Paris: Imprimeur Didot Jeune, 1804).
[51] A. C. L. Villeneuve, *Mémoire historique sur l'emploi du seigle ergoté pour accélérer ou déterminer l'accouchement: ou la délivrance dans le cas d'inertie de la matrice* (Paris: Gabon, 1827).
[52] Capuron, "Examen", 8.

defense of *seigle ergoté*. To challenge Villeneuve's statement that there were thousands of cases that should convince doubters (particularly Capuron himself) was to challenge the validity of the case studies themselves. Certainly, Capuron did not doubt the importance of experience in medicine. On the contrary, he noted that experience was often rightly seen as sacrosanct in medicine, and he recognized the value that case narratives had in contributing to the knowledge base of medicine. But he also wrote, "There is no other science where one speaks so much of observation and experience and where observations are less infallible," thus suggesting that case narratives could be (and often were) manufactured and manipulated to fit better with preconceived ideas.[53] Thus, he claimed, observations must be balanced by research and statistics and held to a higher standard than those at the time. Case studies could not be vague (as Capuron felt those cited by Villeneuve to be) or they became worthless. Utility lay in precision and specificity.[54]

Capuron pointed out that in all of the case studies (particularly those of Dr. Goupil) there was no mention of the circumstances surrounding the use of *seigle ergoté*. Goupil neglected to mention the patients' temperature, constitution, medical history, and labor progression—all elements that Guersent and Capuron had self-consciously highlighted in their narratives on the subject. In his first observation, for example, Goupil did not attempt to distinguish between intestinal colic and uterine contractions, lumping both into the general category of abdominal pain. There was no description of how the patients' labors had progressed—at what rate, with what complications—or why

[53] *Ibid*., 11.
[54] *Ibid*., 12-16.

the *seigle ergoté* would be beneficial. The doctor had only mentioned the women's suffering (which he described as quite great) as foundation for the use of *seigle ergoté* and, according to Capuron, mentioned nothing of any efforts to facilitate labor manually or to encourage the woman to push through the pain and labor on her own, naturally, before taking any further medical steps. In other words, there were no specifics given about the obstetrical case cited, only that *seigle ergoté* was given to ease the suffering of the mother, thus leaving the reader with no justification for the need to use *seigle ergoté* in this case. The case offered no proof as to the utility of *seigle ergoté* in the obstetrical field. And the other narratives cited by Villeneuve were, according to Capuron, equally imprecise and therefore unusable.[55]

Capuron himself offered an alternative case study, one that he presented as the epitome of useful case narratives. It was an extremely detailed account of a forty-year-old woman at the end of her third pregnancy. After beginning labor, she called a local doctor (Borel) who arrived just before her water broke. Labor stalled after twenty-four hours and a small dose (thirty grains) of *seigle ergoté* was administered in a sucrose-water suspension. There was little effect. At 7:00 the next morning, Capuron was called in for a consultation. He tried several different approaches before finally using forceps to remove the infant. A tumor on the scalp had caused the cessation of labor and prevented a natural delivery. The child was born with some signs of life, making an effort to breathe on his own, but, in spite of attempts to help him, died an hour later, leading Capuron to conclude that *seigle ergoté* did nothing to effect a happy outcome. In fact, he went so far as to suggest that the ergot perhaps poisoned the infant, noting that his neonatal physical condition was comparable to that of several sailors poisoned by a plant

[55] *Ibid*.

extract [*substances venéneuses végétales*] similar in composition to *seigle ergoté*. It was unclear to Capuron whether the baby's death was caused by the length of the labor, the amount of time the head was stuck in the pelvic basin, or the ill effects of *seigle ergoté*. In any event, Capuron said, this observation did not lend itself to "a high idea of *seigle ergoté*."[56]

Thus, the debate about *seigle ergoté*, outlined here through the most prominent (though by no means the only) articles published on the topic, illuminates the clinical-associative model of medicine in 1830s France. At the center of professional sociability—how doctors learned, how they taught, how they interacted with each other as peers—was the individual case. It was at the locus of communication, whether unemotional (as in Caignou's description of an extra-uterine pregnancy) or heated (as in the debate over *seigle ergoté*). It was, by the early nineteenth-century in France, the key referent in the medical world, appearing in journals, memoirs, lectures, and letters shared by professional doctors. In any type of medical discussion, the case narrative was nearly sacrosanct as evidence. As Capuron put it, blithely paraphrasing Hippocrates, "experience trumps all."[57] Even criticisms of case narratives were merely calls for improvement; they did not question the value of experience related through stories. Rather, these doctors encouraged all medical practitioners to be more specific, more detailed, and more precise in the stories that they told. They urged their peers to be better storytellers.

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[56] *Ibid*., 30-32. Qtn. on 32.
[57] *Ibid*.

IV. Rethinking the Individual Case as a Category of Medical Identity

Case studies, as part of the medical discourse, became a site of contention about what constituted valid medical knowledge and valid medical practice. As such, they became, in many ways, a tool for doctors to define themselves and their profession, a way to distinguish medicine from and bind it to the rest of society simultaneously. The early nineteenth-century increase in the value of the case study was directly related to that genre's unique ability to make medicine meaningful to a broad public, to offer "a narrative structure which makes available to the culture at large the notion of a coherent subjectivity accumulated through experience."[58] The value of the case in nineteenth-century medicine was, accordingly, two-fold. First, it served a medically illustrative purpose, as examples of larger themes and theories.[59] Second, its status as a discourse of proof in the medical community, a conscious rhetorical strategy intended to persuade, transformed its primary characteristic—namely, narrativity—into a genre of medical identity.

The first category—the instructive worth of a case—appeared in doctors' writing in a variety of ways. Often, it was through the use of the case as an example, as when Dr. François Mélier criticized the findings of his colleague, Charles Dronsart, by pointing to some of his own cases that had yielded a different conclusion. "This doctor's assertions," he wrote, "are contradicted by observations that I have published. […]. I will cite a new case to prove it."[60] And so he did. It was equally apparent when a colleague,

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[58]Meegan Kennedy, "A Curious Literature: Reading the Medical Case History from the Royal Society to Freud" (Ph.D. diss., Brown University, 2000), 31.
[59]*Ibid*., 6-9
[60]François Melier, "Réponse de M. Mélier a la letter de M. le docteur Dronsart," *Archives générales de médecine* 1, no. 15 (September 1827): 148-150.

Dr. Le Sauvage, decried the pitiful state of knowledge about the nervous system, particularly with regard to the pain center. He attempted to add his voice to the physiological discussion with a series of case studies, declaring that "[t]he observations of this type that I am going to communicate to you, though small in number, clearly indicate that its faculties [those of the encephalon, or central nervous system] are quite isolated."[61] Or in a doctor named Malle's gentle rebuff of his compatriot, a Dr. Piorry: "He based his conclusions on a limited number of cases and a good number of anatomical, physiological, and pathological considerations. This question, as with almost every question belonging to medicine, being among those that require the sanction of experience, I feel compelled to add some *faits* [cases] to those published by M. Piorry."[62] In all three of these articles (and countless others like them), individual cases were used to exemplify larger points that their authors were making.

At other times, the pedagogical value of the case was highlighted. "Acknowledging, once again, that peritonitis often occurs," Louis-Auguste Baudelocque wrote in 1823, "we must ask if it always leads to death. To prove the contrary, is there *anything stronger* than the following observation?"[63] He continued, "I would ask that someone cite for me an example of an operation that is without any danger,"[64] thereby assuring his readers that he was open to other options, wanting only to find the best possible solution for women in difficult births. If someone wanted to disagree with him,

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[61]Malle, "Nouveaux Observations sur les accidens cérébraux," *Gazette médicale* 2, no. 1 (11 May 1833): 346.
[62]Le Sauvage, "Hémiplégie du sentiment sand lesion du mouvement," *Archives générales de médecine* 1, no. 21 (November 1829): 428-429.
[63]Louis Auguste Baudelocque, "Nouveau moyen pour délivrer les femmes contrefaites à terme et en travail, substitué à l'opération appelée césarienne" (Paris: Chez l'Auteur, 1823), 28-29.
[64]*Ibid*., 29.

the critic would need to couch his argument in a language of the *observation* because the terms and parameters of the medical debate were defined by firsthand experience.

The performative nature of medicine in the nineteenth-century meant that doctors' stories had an audience that was larger than merely the professional elite to which medical professionals belonged. Midwives and local practitioners often showed a keen interest in the writings of professional doctors, as did many members of the literate (largely educated middle-class) population. Thus, medical writers had to write for two audiences—one expert and one lay—and it was this dichotomy that guided the process by which medicine professionalized in nineteenth-century France. In many ways, then, the individual case became, over the course of the 1820s and early 1830s, a genre of medical identity.

Case studies had their origin in the medical writings of Hippocrates, whose perception of illness was essentially narrative in nature because it relied on the causal links among past, present, and future.[65] Each action engendered a specific result, which in turn prompted a clearly defined reaction. In other words, disease caused symptom, symptom prompted treatment, and treatment resulted in convalescence. From its very inception, then, medicine depended on the unidirectional chronology of the story. The inherent narrativity of the case study helped doctors make sense of the inexplicable by re-contextualizing the unfamiliar, rendering it more approachable and understandable.[66]

The significance of narrative could therefore never be truly hidden in the

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[65]Harriet Nowell-Smith, "Nineteenth-Century Narrative Case Histories: An Inquiry into Stylistics and History," *Canadian Bulletin of Medical History* 12, no. 1 (1995): 49.
[66]Robert Nye, *Masculinity and Male Codes of Honor in Modern France* (New York : Oxford University Press, 1993).

"disinterested" language of science and the natural world, even as early as 1831, when *La Lancette Française* published a case study written by Dr. Civatte, concerning the difficult labor of a woman whose child presented shoulder first. The story began when Civatte was alerted to an arduous birth by a local midwife who had discovered the shoulder-first presentation after intentionally rupturing the pregnant woman's amniotic sac. When she recognized the danger, this midwife called immediately for a doctor. Further examination by the doctor revealed that the right hand of the infant had nearly exited the birth canal and that the cervical opening was blocked by part of the spinal column. The *accoucheur's* forearm could not extend into the birth canal more than half its length, making it impossible to effect an obstetrical [external cephalic] version. A second doctor was deemed necessary, and Civatte was called.

Upon examination, Civatte realized that something had to be done immediately because any delay would be fatal. He placed the woman on her bed and, confirming her condition, began the process of turning the infant for a feet-first delivery. With much difficulty, he pushed the baby's arm back into the uterus, found both feet, and maneuvered them through the birth canal. The shoulders engaged with some difficulty, but did eventually pass through the cervical opening. The doctor rested long enough to allow the baby's head to engage before guiding his final descent.[67] The child (a boy) gave no signs of life despite what Civatte deemed the "prodigious care" he was given, but the mother recovered nicely. Civatte left, he wrote, the next day with the hope of an easy

[67]Civatte, "Accouchement Laborieux chez une Femme Dont le Bassin est Vicié ; Présentation de l'Épaule Droite en Seconde Position, avec Issue du Bras" *La Lancette Française: Gazette des Hôpitaux* Tome 5 (1831-1832): 93-96. **Engagement**, in the obstetrical sense, refers to a shift in fetal movement where the presenting body part (usually, but not always, the head) drops into the pelvic basin in preparation for birth.

recovery for the mother."[68] Clearly, then, this doctor structured his case along narrative lines, telling the story from beginning to end and highlighting the principal events in a manner that moved from symptom to diagnosis to outcome.

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In the early nineteenth century, medical discourse came to depend on the case narrative or case history, which took a patient's description of his or her symptomology as the foundation for an interpretation of what those symptoms meant. In the words of Nancy Theriot, "Much of this literature can be read as a double narrative, as the physician's interpretation of the symptoms and examination results and as a physician-shaped account of the patient's story."[69] After all, though allowing for some patient autonomy in the shaping of narrative presentation, the case history was, in the end, inherently structured by the physician's sense of what was significant.[70] Members of the medical community by and large used the case narrative as a means of telling the story from their own perspective. What this meant was that doctors had a great deal of control over medical stories. It was the very act of interpretation that defined the stories and rendered them significant. It was this control over the medical experience that became a defining characteristic of professional French medicine in the first half of the nineteenth century. Case studies were thus more than just an extension of a pre-existing emphasis on clinical medicine. In their inherent narrativity, they were exceptionally flexible. They

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[68] *Ibid*., 95.
[69] Nancy Theriot, "Negotiating Illness: Doctors, Patients, and Families in the Nineteenth Century," *Journal of the History of Behavioral Sciences* 37, no. 4 (2001): 351.
[70] *Ibid*., 352.

could be instructive; they could be illustrative; they could be controversial. One thing they could not be was ignored.

4

The Rise of Obstetrics: Gender, Authority, and Medical Specialization

I. Specialization as Identity: Obstetrics in France in the 1830s

The rise of obstetrics and gynecology as the first medical specialty in France profoundly changed the profession. As the only sub-discipline to gain official recognition by the *Académie*, obstetrics received unusual attention amongst the medical community in the nineteenth century. The changes began in the universities of the late eighteenth century, with the emergence of professional chairs of obstetrics among the medical *facultés*; by 1830, each of the three dominant *facultés* in France—Paris, Montpellier, and Strasbourg—had one.[1] The educational curriculum expanded after 1804 to include a *cours des accouchements* and clinical training within the maternity hospitals.[2] According to student notes from the early nineteenth century, numerous lectures addressed the differences between the sexes, as did one on comparative reproduction, in which noted zoologist Georges Cuvier emphasized the differences between the testicles and what he called their analogous female counterpart, the ovary. While there were similarities in structure, he noted, in function the ovary "differed completely," as did the uterus, fallopian tubes, vagina, and vulva.[3] For two days, Cuvier demonstrated the value placed on questions of gender by the medical community, as he

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[1]Weisz, 6.
[2]Florent Palluault, "Medical Students in England and France, 1815-1858" (Ph.D. diss, Oxford University, 2003)
[3]Pierre-Nicolas Gerdy, "Extrait des leçons de Cuvier sur la génération comparée," Papiers Divers, Boite 2, BIUM, MSS 5159.

lectured on the organs, fluids, and vesicles that differentiated men from women, clearly. After all, nowhere are the key issues in any field more apparent than in the education and training of future practitioners.

As a result of this increased training, the number of doctors who were licensed as "*accoucheurs*" increased, as did the frequency of publication on topics pertaining to the female reproductive system. An examination of all issues of *Archives générales de médecine* published between 1823 and 1850, for example, reveals 259 case studies concerned specifically with obstetrics and gynecology. This was 24% of the total number of case studies published during this period [See Figure 4.1].

	OB-GYN Case Studies	**Total Case Studies**	**Percentage**
1823-1829	70	285	25%
1830-1839	101	402	25%
1840-1850	88	411	21%
Total	**259**	**1098**	**24%**

Figure 4.1: Case Studies in *Archives générales de medicine* (1823-1850)

It was a significance that was reflected in other realms of the medical world, as well, most notably the field of research.

Unlike in the German states, there were no "research universities" in early to mid-nineteenth-century France, meaning that the concept of medical research grew slowly out of traditions that were tied to the university, the *faculté*, and the *Académie royale*. One of the most significant collective examinations of the female body took place in the 1830s

(published in 1841), under the watchful eyes of some of the most prominent and respected members of the Parisian *faculté de médecine.* The researchers behind the project were among the most influential men in the early nineteenth-century medical world—Guillaume Dupuytren (head surgeon at the Hôtel-Dieu), Pierre Fouquier (royal physician to Charles X and Louis-Philippe), Jacques Lisfranc (pioneer in the field of gynecology), Alexandre-Jacques-Francois Brière de Boismont (who—in 1833—had been awarded a prize for his work on the cholera epidemic in Poland), and at least ten others.[4] Over the course of ten years, these 14 doctors examined 1200 women from a variety of backgrounds, in order to understand the influence of menstruation on the female body, particularly through the female life cycle. "It seems that a function as old as the world," wrote Brière de Boismont, speaking for himself and the other doctors, "should hold little interest for observers […], but if we can give to this study the precision that modern scholars have introduced in the sciences, some new results can still be noted."[5] Even something as fundamental as the physiological process of menstruation could actually have profound implications, particularly on women's health. In the context of the widely accepted humoral theory, curiosities such as atypical onset, cessation, abnormal flow, and continuation during pregnancy could upset a woman's delicate balance and cause her distress.[6] For these eminent scholars, a variety of circumstances played a significant role in the health of women; if those circumstances could be manipulated and controlled, then

[4]The article explicitly names fifteen doctors involved in the study, but indirectly references the existence of "others named by Dr. Menière.." Alexandre-Jacques-Francois Brierre de Boismont, "De La Menstruation; Faire connaitre l'influence que cette fonction exerce sur les maladies et celle qu'elle en reçoit" *Mémoires de l'Académie Royale de Médecine* (Paris: Ballière, 1841), 104-233.
[5]*Ibid*., 104.
[6]*Ibid*., 104-125.

the lives of women, and hence the larger population, could be improved.

During that same period, the *faculté* of Paris commissioned the study of another bodily fluid that was unique to females. In 1838 and 1839, Alphonse Devergie designed and performed an experiment intended to analyze the quality of breast milk produced by wet nurses. He microscopically examined the properties of 172 milk samples, charting them according to several criteria: name; age; temperament; constitution; color of hair and skin; volume of breasts; size of chest; and age of milk (time since the baby's birth). Devergie wanted to use this chart to determine which elements and characteristics made for the most effective wet nurse.[7] His investigation (and similar experiments performed by Becquerel and Vernois) became the foundation of *Hygiène de la premiere enfance* in 1845, in which Eugene Bouchut explored the idea of wet nursing, including what to look for in a wet nurse and what to avoid, and concluded, as had Devergie that the ideal candidate for this most feminine of duties was "a young woman between the ages of 25 and 30, with a strong constitution, a large chest, sanguine-lymphatic temperament, brown hair, healthy white teeth, and breast with large nipples and areolas."[8]

The aforementioned research programs, and other like them, developed in French medicine in the 1830s as part of the larger social-scientific program promoted by men such as Villermé. The *Statistique Générale de France*, originally commissioned by Napoleon in 1800 but abandoned with the fall of the First Empire in 1814, was resumed in 1833 for the purpose of conducting a national census every five years. On the local level, as part of the statistical project that developed in that year after the cholera

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[7]Alphonse Devergie, "Sur la valeur de l'examen microscopique du lait dans les choix d'une nourrice," *Mémoires de l'Académie Royale de Médecine*, Tome 10 (Paris: J. Ballière, 1843), 202-222.
[8]Eugène Bouchut, *Hygiène de la première enfance* (Paris: J. Ballière, 1845), 201-221

epidemic, census bureaus also accumulated mortality statistics. Their work served as the foundation for the efforts of Villermé and other public hygienists, charged with improving the overall health of France. Questions of health and mortality were intertwined with issues of state control, class, and public wellbeing, a combination that also came to influence the health practitioners at the clinical (and not just state) level. It was a concept called "evidence-based medicine," chartered by the work of Jean Civiale in the 1830s. At issue was the question of how doctors accumulated knowledge, thereby establishing expertise.[9] They grappled with finding the right balance between individual cases (so much a part of their identity, as we have already seen) and "the power of large numbers."[10]

This understanding of medical research, bound up as it was in questions of medical knowledge and status (on both the state and the institutional level), left members of the French medical community (namely, the *facultés* and *Académie*) to explore those issues that they considered to be of deep significance. One of those issues was the female body. The question is: why? Why was *accouchement* the first medical specialty? Why did 7% of French doctors choose to reject a centuries-old tradition of generalism? Why did medical instruction and research expand to include (and indeed, in the case of pedagogy, require) the "new medicine of women," when it disdained the very existence of other specialties? Why was such significance placed on understanding women's bodies?

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[9]Daniel J. Friedman, et al., *Health Statistics: Shaping Policy and Practice to Improve the Population's Health* (Oxford: Oxford University Press, 2005), 27-29.

[10]The phrase "the power of large numbers" is borrowed from Joshua Cole's study of statistics and demography by the same name.

II. **The Woman Question in Post-Revolutionary France**

Pierre Roussel, author of one of the most celebrated books of the late eighteenth and early nineteenth centuries, described the astounding proliferation of writings on women as the result of "general preoccupation of which 'woman' is the object, even amongst the most austere thinkers. It would be difficult," he continued, "to give any idea of all the published genres of which she is the subject. Poets have exalted her qualities; moralists have laid bare her faults; public figures have discussed her rights; doctors have described her maladies; physiologists have revealed the most intimate secrets of her organization."[11] According to Roussel, women in the late eighteenth century were understood to have their own distinct understandings of the world, defined by biology, so much so that the physiological similarities between men and women were clearly less important than the differences, an idea that (unsurprisingly) appealed to many during the upheavals of the late eighteenth century.

Roussel's popularity was largely the result of the *way* that his writing organized the world around him, the way it "resolved the naggingly paradoxical nature of sensibility itself [which had] come dangerously close to meaning too many things at once."[12] By defining a heightened state of emotional awareness (which facilitated useful contributions to society) as male and its hysterical counterpart (overwrought passions that limited productivity) as female, Roussel revived a popular cultural concept that was threatening

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[11]Pierre Roussel, *Système physique et morale de la femme, ou Tableau philosophique de la constitution, de l'état organique, du tempérament, des moeurs, et des functions propres au sexe* (Paris: Chez Vincent, 1775); Found in "Les Archives de la Révolution Française" (Oxford: Maxwell Press), microfilm.
[12]*Ibid*., 77.

to lose its potency. He did so by shifting the debate to a question of natural difference. Biology, after all, was constant, unchanging and indisputable. Science could succeed where moralists, philosophers, and legislators had failed. The medicine of women could provide stability.

Doctors in the immediate post-Revolutionary period continued to make this connection between the instability of the Revolution and the instability of gender norms:

> We have seen in the troubles of our unhappy country, young women eager to satisfy their cruelty through the spectacle of the unfortunate people who were the victims of the mob's furor, excited, through word and action, by the ferocity of cannibals who rip their fellow citizen to bits, to have the audacity to separate the bloody tatters; hideous but incontestable signs of the atrocity of their hearts.[13]

For this doctor, then, the fundamental nature of women had been corrupted by the fury of the French Revolution, particularly the fury of the Terror. Nicholas Chambon de Montaux, an eminent physician and former mayor in Revolutionary Paris, was clearly horrified by the actions of these women. Chambon de Montaux's critique of the damage done to gender relations by the Revolution was by no means new. On the contrary, it was part of a tradition that dated back to the Revolution itself, when the Convention had to grapple with the issue of women's political clubs. While some members (and the radical women who supported them) advocated extending the vote to women as matter of fulfilling the promises of the National Assembly, the Declaration of the Rights of Man and Citizen, and the Constitution of 1791, others felt that allowing women a political voice was inviting disaster. It was a fact that "Marie Antoinette, the wife of the last tyrant," one sans-culotte complained, "was the ruin of France, that Corday had

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[13]Nicolas Chambon de Montaux, "De l'influence de l'organisation de l'homme et de celle des choses placées hors de lui sur l'éxercise de ses facultés intellectuelles," Papers and Notes of Nicolas Chambon de Montaux, Tome X, BIUM, MSS 5142.

assassinated the friend of the people, and that many other things were women's responsibility."[14] Opponents of women's political clubs offered images of radical women as pike-bearing harpies, intent on nothing more than death and destruction, in stark contrast to the Revolutionary ideal of Republican motherhood, with its presumption of women's natural and virtuous domesticity.[15] It is unsurprising, then, that a number of writers, including those in the medical community, emphasized the need for a return to normalcy in gender relations during the early nineteenth century.

Doctors in particular touted their unique ability to restore harmony because of what Jean Houdaille—a medical student applying to the Paris Faculty in 1820—described as the close connection between the female body and the social order, particularly in the realm of reproduction. "The art of delivering a child," he exulted, "bound by an infinite wealth of contact with the sweetest sentiments of nature, is of the dearest interest of society."[16] Medicine—especially the emergent sub-field of obstetrics—was well equipped to undo the destruction left behind by the Revolution.

Notions of childbirth have always been influenced by a variety of cultural discourses (including, but not limited to, literature, medicine, and oral traditions) so that the word itself has myriad symbolic meanings in a given culture, meanings that shape and

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[14]Quoted in Dominique Godineau, *The Women of Paris and their French Revolution* (Berkeley: University of California Press, 1998), 272.
[15]Lynn Hunt, *Politics, Culture, and Class in the French Revolution* (Berkeley: University of California Press, 1986); James McMillan, *France and Women, 1789-1914: Gender, Society, and Politics* (London: Routledge, 2000); Joan Landes, *Women and the Public Sphere in the Age of the French Revolution* (Ithaca: Cornell University Press, 1988).
[16]Jean Houdaille, "Essai Physiologique sur la Femme, et les Causes de l'Accouchement Difficile" in *Collection des Thèses Soutenues à la faculté de Médecine de Paris, An 1820ˆ (*Paris: Imprimerie de Didot Jeune, 1820).

re-shape each other.[17] For example, during the Revolution, parturition was emblematic of Republican motherhood and "birthing a new nation." Amidst the natalism of the 1870s in France, childbirth stood in for a restoration of national health and vitality. In the early nineteenth century, childbirth proved to be an apt metaphor for concerns of social and political order, as "the problem became one of how political form could reproduce itself predictably in the wake of the 1790 legal collapse of primogeniture. […]. How the family reproduced itself had everything to do with the distribution of wealth," status, and, finally, power.[18] Assuming control over a powerful (and adaptable) narrative that equated childbirth with a broader concept of "genesis" gave doctors a foothold in bourgeois society. Medicalizing the very act of parturition offered the promise of certainty—in the guise of science—in a fundamentally uncertain world. The emergence of obstetrics as the first true specialty in French medicine was therefore as much the result of societal confusion about gender norms after the Revolution as it was about institutional and pedagogical debates within medicine itself. The subject mattered as much as the structure.

Assuming the identity of *accoucheur* placed doctors squarely in the middle of a far-reaching debate over public health, civic responsibility, and gender relations. The more control a doctor had over childbirth, the more authority he garnered within the scope of that debate. Accordingly, in the majority of early nineteenth-century cases where a doctor was consulted during parturition, his (typically self-described) role was not as facilitator and guide, but rather as the architect of a happy outcome. This was

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[17]Tess Coslett, *Women Writing Childbirth: Modern Discourses of Motherhood* (New York: Manchester University Press, 1994), 3.
[18]Carol Mossman, *Politics and Narratives of Birth: Gynocolonization from Rousseau to Zola* (Cambridge: Cambridge University Press, 1993), 14-15.

particularly true as the techniques and tools of medical *accouchement*—forceps, cephalotribe, caesarean section, anaesthesia—were refined. Each technological and surgical advance took agency out of the hands of women (patients and midwives alike) and placed it instead in the hands of doctors, who, embracing their new role, claimed that their presence "gave women the courage and confidence" necessary to effect a happy outcome.[19]

III. The Question of Agency in the Medical Relationship

On 14 November, a doctor by the name of Morère was called to the bedside of a middle-aged woman who had been sick for several years. Because that meeting was their first, Morère began the medical examination by asking her about the course of her malady, from beginning to end. What he learned he reported as such: a 41-year-old woman began to exhibit signs of pregnancy in 1833 (at the age of 34). The woman, named Lamoureux, reported nausea, frequent heartburn, breast tenderness, and syncope (loss of consciousness), among other worrisome signs. But the continuation of her regular menstrual period made her (and others around her, including several doctors) doubtful that a pregnancy was truly the cause. Within a few months, she began to feel, or think she felt, fetal movements, but still she remained uncertain, convinced by numerous doctors who had all told her it was impossible for her to be pregnant and continue menstruating.[20]

Six or eight months after Lamoureux began exhibiting the aforementioned signs, she experienced what Morère described as "very serious neurological trouble"—

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[19]Beaude, 31.
[20]Morère, *Grossesse extrautérine, extrait du Gazette des Hôpitaux* (Paris: Imprimérie de Pommeret et Guenot, 1841), 1-2.

trembling, pain, loss of appetite, insomnia—and abdominal distension, particularly on the right side. The doctor she consulted used treatments, such as blood-letting and frictions (intense rubbing on her abdomen), which were incompatible with pregnancy. The treatments did nothing to alleviate her symptoms; within a week, in fact, the pain on her right side had increased. Doctor and patient were equally confounded. As weeks passed, and she felt "neither labor pain nor water breaking" to indicate that birth was imminent, Lamoureux's hope faded. The pain did not. Over the next several years, she saw a number of local doctors to no avail. None, Morère related, "alleviated even momentarily her suffering."[21]

Then, in the spring of 1839, Lamoureux began to experience a bloody and purulent discharge from the anus—a situation that, again, proved beyond the expertise of local doctors. It was then that she consulted Morère, who worked hard to overcome Lamoureux's initial reluctance to submit to an examination. His scrutiny yielded surprising results—the existence of a small tumor-like obstruction in Lamoureux's intestine, similar in size and shape to a fetal head—but his diagnosis was equally surprising. Morère told Lamoureux that, seven years earlier (in 1833), her understanding of her symptoms had been correct. Unfortunately, the pregnancy she had suspected developed outside the uterus (most likely in the fallopian tubes), a potentially dangerous situation that caused rapid swelling in her abdomen. Her fallopian tubes ruptured and the fetal sac subsequently adhered to the intestines (rather than the uterine wall), increasing pressure on the rectal wall until the wall itself was perforated. The fetal sac entered the

[21] *Ibid*., 2.

rectum and remained there for the next seven years, obstructing her digestive system and causing Lamoureux tremendous suffering.

The treatment Morère prescribed was built around a central surgical procedure—the manual removal of the fetus through the rectum. Any other method, according to the doctor, would be futile, as evidenced by nearly a decade's worth of doctor visits providing no relief for Lamoureux. Upon hearing this news, Lamoureux burst into tears, according to Morère, and began pleading with the doctor to find another way:

> [she] kept repeating that it was impossible, that she would rather die than consent to letting me resume my examination; she believed that if people in her country should learn that she had given birth to a child via her rectum, they would suppose her guilty of vicious and immoral habits that she assured me (unnecessarily) she had never done. Her husband was crying and making the same protestations.[22]

In the end, Lamoureux and her husband acquiesced to the doctor's recommendations and allowed him to use medical instruments to remove (piece by piece) the putrefied fetus.[23] By January of the next year, Lamoureux was convalescing nicely, though she still complained of occasional pain in her rectum. Dr. Morère continued to treat her until August 1841, when she had regained most of her health and vigor. On the last day of that month, Morère brought his mentor, Jean Zuléma Amussat, to examine Lamoureux, and it was Dr. Amussat who presented this case study to the *Académie royale de médecine* a week later, on 7 September 1841.[24]

The enthusiasm with which members of the Academy greeted this case

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[22]*Ibid*., 5.
[23]According to Morere's description, he used curettes and tenettes, which are surgical instruments used to dilate small vessels and remove diseased tissue. "D and C," Medline Plus, National Library of Medicine and National Institute of Health, <http://www.nlm.nih.gov/medlineplus/ency/article/002914.htm>.
[24]Morère, 5-8.

demonstrates the currency that the unexpected held in the medical community of early nineteenth-century France. Morère, after treating Lamoureux, found her story interesting enough to relay to his friend and mentor. Amussat, for his part, was suitably enthralled; he wanted to see it (and therefore her) for himself. His experience apparently did not disappoint, since he presented the case to the rest of the *Académie royale de médècine* shortly thereafter. Thus, a number of different medical professionals (veritable strangers from Lamoureux's perspective) took turns poking and prodding, debating and discussing the unfortunate woman's "situation."

The clearly gendered assignment of roles played by patient and doctor in this case reveals an inherently unequal power structure organized around the belief that a female patient must be examined and understood by a male doctor (often against her wishes) before she could get better. Morère, for example, challenged those doctors who had merely listened to Lamoureux's story without doing any exploration of their own. Those doctors had "abandoned her," he wrote, "and exploited her credulity to the detriment of her purse and her health," leaving her helpless and suffering.[25] The first doctors she consulted erroneously denied the possibility of pregnancy without intensive examination because her description of her "symptoms" did not match their expectations. They denied her assessment as naïve, but then failed to examine her fully to uncover the truth. Latter doctors were misled by the original diagnosis. All failed her by not looking deeply enough.

It was a difficulty Morère could appreciate, for he too ran into problems convincing Lamoureux to submit to an examination. It was her embarrassed resistance,

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[25] *Ibid*., 3.

not the doctors' ignorance or apathy, that hindered medical discovery. The problem, according to Morère, was that this division of power was inappropriate in a medical relationship. The male doctor could not allow his female patient to determine the extent of the examination and the evidence he could find. So this case study also raised some important questions about the relationship between cultural norms and the emerging medical world. In his construction of this case study, Morère chose to focus on his role as the "authority" in this relationship; a crucial part of the responsibility that accompanied such power was overcoming resistance, or making the patient understand the need for such physical contact. How did he do that? It was not by explaining his thinking or rationally convincing her that his diagnosis was correct; rather, he used an uncompromising, unflinching declaration that he was her only hope. This emphasis subtly shifted control over life and death to the medical realm and thus to him.

Morère's case was only one example of a larger trend in which the male and female subjects of medical case studies were treated very differently with regard to agency and control over the experience of disease. In one observation, a young man's reactions to his treatment were recorded: "At around two minutes, I perceived, said the young man, a diminution of the cold, which in the last three minutes, further diminished to some light shivers, which I felt come back intermittently for about ten minutes."[26] The medical process in this instance was given voice by the patient himself, as he described the sensations he was feeling in the first person and in his own words. By contrast, the same doctors' presentation of observations concerning female patients was quite different. Just two pages later, there was a discussion of a young woman also suffering

[26]"Maladies Regnantes," *Journal de Médecine Pratique* (February 1809): 82

from intermittent and unexplained fever. Nowhere in this observation was the woman allowed to speak for herself. Her words were instead given voice by the doctor, who described her as having "strong pains" and "intermittent fever" for several days, which "he set out to cure."[27] In fact, the *only* use of the first person was the doctor's brief narrative of what he did in order to heal her.

Quantitatively, there was a clear distinction between the two case presentations. In the example of the young man, first-person pronouns (*je* or *me*) were split equally between the patient and the doctor. In the three paragraphs devoted to this case, the author-doctor referred to himself in the first person twice and quoted the patient's use of the first person twice. In the five paragraphs devoted to the young woman, however, there were three instances where the doctor used the first person and none at all for the patient.[28]

Clearly, then, for this doctor, there was a difference in how the genders were allowed to represent themselves in the medical contest. But how pervasive was it? Was it merely the misogyny of a single doctor or was it more representative of a general trend in nineteenth-century French medicine? Again, statistical analysis is instructive. A examination of 218 obstetrical-gynecological case studies published over the course of the first half of the nineteenth century reveals that 76 (35%) include at least one usage of the first person on the part of the doctor, peaking as high as 46% in the decade between 1830 and 1840 [See Figure 4.2].

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[27] *Ibid*., 83.
[28] Ibid., 82-83.

	1800-1820	1820-1830	1830-1840	1840-1850	Total
First Person (Doctor)	**17**	**23**	**24**	**12**	**76**
	23%	46%	46%	30%	35%
First Person (Patient)	**0**	**2**	**0**	**0**	**2**
	0%	4%	0%	0%	.9%
Total	**76**	**50**	**52**	**40**	

Figure 4.2: Stylistic Conventions in 218 French Gynecological Case Studies, 1795-1850

In those same case studies, the female patient's "voice" appeared precisely two times: once in a letter praising the doctor who saved her life; and once in a letter denouncing the doctors who could not help her.[29] This was fewer than 1% of the case studies examined. The voices of women were rarely heard. Instead, their sensations became symptoms and their lives became observations, as the patient's narrative became the doctor's narrative.

IV. The Debate over Patients' Rights in the 1830s

The gendered and uneven nature of the medical relationship suggests the emergence of a new paradigm for medical professionalization, one in which agency (specifically the ability to control the medical experience) passed to the male doctor based on his ability to save his female patient and, more broadly, society. The fascination with women's bodies, then, was not merely a curiosity, but rather a complex interchange between medicine and the larger culture of which it was a part. As a result, the rapid growth of a medicine of women was matched by an increase in *intensity* within

[29]Launay, 46; Audin-Rouvière, 215.

discussions of the "medicine of women," as evidenced by two debates that commanded the attention of doctors in the 1830s and 1840s. The first was a debate over patients' rights, through the lens of female refusal to submit to physical examinations. The second was a debate over doctors' rights within a discussion of "artificially induced abortions."

Let us begin with the first debate—the one ultimately concerned with patients' rights, specifically the limits of a female patient's right to refuse medical intervention. The discussion began in earnest during the 16 March 1832 meeting of the *Académie royale de médecine* when the topic turned to the issue of caring for difficult patients. "Women under police surveillance," Philipppe Ricord wrote of his patients at the *Hôpital des Vénériens*, treat "venereal disease […] with an insouciance that comes from the fact that three-quarters of the symptoms do not produce pain or even disturbance."[30] The familiarity that women in the sex trade had with sexually transmitted disease left them indifferent to its effects; they ignored symptoms, rejected treatment, and detested hospitals, consequently becoming "*foyers d'infection*."[31] They then criticized the doctors who tried to help them. Ricord used this report to challenge existing standards of examination for these women because so many of them were prone to concealing or dismissing any symptoms. On the other hand, he noted, there was a parallel group that emphasized even minor ailments, hoping to extend their stay in the hospital. They manipulated their tales of pain and suffering, in order to gain a desired outcome. For Ricord, the stories of these prostitutes were not entirely trustworthy. Listening to women's stories and looking over their bodies was not enough, according to Ricord, who

[30]Philippe Ricord, "Mémoire sue quelques faits observes à l'hôpital des vénériens, lu en séance de 16 mars 1832," *Mémoires de l'Académie Royal de Médecine*, vol 2. (Paris: Baillière, 1833), 160.
[31]*Ibid*.

instead argued for the absolute necessity of external *and* internal exploration.

The use of pelvic (or internal) examinations had been used in midwifery care for centuries, but with an increase in the number of male *accoucheurs* in the late eighteenth and early nineteenth centuries, its use clashed with contemporary notions of modesty. In 1801, when Joseph Recamier tried to reintroduce the use of the speculum (which had been around since the time of Gaul) in French medicine, the whole question of an internal exam met with a great deal of resistance. The controversy was two-fold. First, a situation in which a male was viewing the genitalia of a woman who was not his wife was considered to be disgraceful. Second, the insertion of a foreign object into the vagina was thought to be arousing (for the female patient) and therefore indecent. It was not until the 1820s and 1830s that internal examinations—strategically designed to allow doctors to avert their eyes as much as possible (as seen in Maygrier's 1822 sketch below)—became more widely used in France, but even then it was not without its detractors.[32] Modesty, then, was an impediment to careful medical scrutiny.

[32]Lana Thompson, "Speculum," in *Encyclopedia of Prostitution and Sex Work* (), 456-458

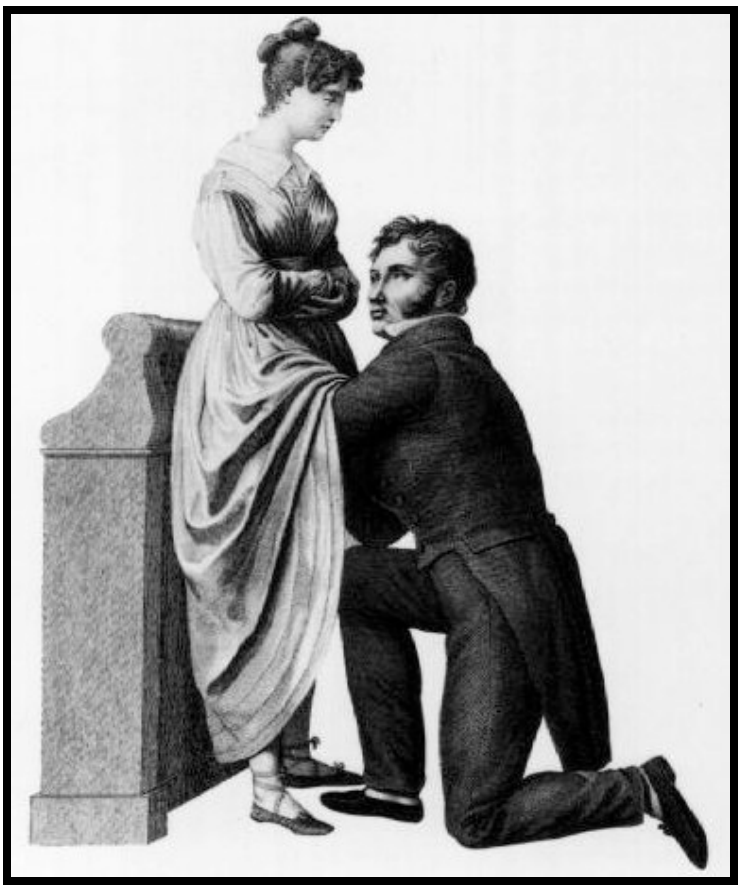

Figure 4.3: Doctor performing a vaginal exam
Jacques-Pierre Maygrier[33]

Eight months later, the question of patients' right was revived in another debate over difficult female patients. The first issue of *La Lancette Française* in 1833 (dated January 1), opened with a letter to the editor written by a young, relatively unknown, doctor named Gendron in response to an article published in the same journal two weeks earlier. The original article traced a number of cases at the *Hôtel-Dieu* and highlighted complaints from a number of female patients about rough or inadequate care there.[34] The editors of *La Lancette Française* used the accusations as a springboard for discussing the

[33]*Nouvelles démonstrations d'accouchement* (Paris: Béchet, 1822). BIUM Coté 000614, Planche 29
[34]A. Gendron, Letter to the Editor, *La Lancette Française: Gazette des hôpitaux civils et militaires* (1 January 1833): 8.

problems in the medical education and experience of interns. The undercurrent of disapproval incensed the doctors at *Hôtel-Dieu*, with Gendron at the helm, and they formulated a response to what they called "a number of injurious insinuations" in the original article.[35]

At the heart of this issue was the criticism levied at the doctors of the *Hôtel-Dieu* that they were not taking the time to examine their patients adequately and appropriately (a charge quite reminiscent of Morère's dismissive critique of rural doctors' inability to help Madame Lamoureux). According to the article, these young doctors were failing their patients in a variety of ways, particularly in a lack of both concern for their patients and order in their hospital. The result was that women who were "close to delivery [had stopped] coming to *la maternité*." It was a charge that Gendron found laughable. "We find it hard to believe," he wrote derisively, "that some of these complaints come from women in labor. Each of us has remarked, while on duty, about the reluctance shown for leaving the maternity ward; it often happens that some women return to their homes only to come back later to the Hôtel Dieu."[36]

Gendron, for his part, shifted responsibility for this state of affairs squarely onto the shoulders of the patients, who "far from refusing the care given by the students, employ[ed] almost any ruse to obtain it."[37] The night in question (December 18-19, 1832), he remembered, was unusual. The first patient arrived around midnight to deliver her child and was refused entrance until the intern (a medical student undergoing clinical training) on duty could be consulted. Around 2:00 am, despite protests from some in the administration, the intern admitted her and she delivered her child an hour later. The

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[35] *Ibid.*
[36] *Ibid.*
[37] *Ibid.*

second woman arrived just after 3:00 am, having already given birth; the intern, ready to admit her, realized that the rules expressly forbade entrance to both mother and child. Not wanting to separate mother and child, the administration admitted her to Maternity against the advice of the intern on duty.[38] Gendron dismissed the complaints of the two because neither was supposed to have been there. Far from abusing these women, he opined, the doctors at *Hôtel-Dieu* had broken the rules, challenged the administration, and jeopardized their own careers, in order to help them. The interns' defense, then, lay primarily in undermining their accusers' right to stand in judgment by emphasizing the extraordinary nature of the circumstances. It was an indirect repudiation of patient subjectivity within the confines of medical experience.

At times, however, the repudiation of patient agency was far more direct, as when Jacques Lisfranc dismissively wrote, "[t]his patient seemed to us to be greatly exaggerating her suffering. We all noted that, except when we visited, it seemed that her pain was far from troubling her repose."[39] Or when another doctor denounced his patient's reaction to his efforts to save her life, describing her as "ignorant" enough to believe the miraculous power of medicine to be "the work of sorcerers and priests."[40] Again and again, the medical record is filled with accounts of doctors who scorned their patients' accounts as naïve, uninformed, or just plain ignorant. Such doctors eschewed the subjectivity of illness for the certainty of disease, particularly in cases involving the new "medicine of women." Beliefs about modesty and propriety clashed with beliefs about truth and certainty. Whether the women involved were modest mothers, deceptive

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[38]*Ibid*.
[39]Jacques Lisfranc, "Inspection générales des cols de l'utérus," *La Lancette Française* 15 (4 December 1828): 58.
[40]*Ibid*.

criminals, or hypochondriacs, the end result was the same. Patients—women—could not be trusted with their own medical story.

V. The Debate over Doctors' Rights in the 1840s

The second (though not unrelated) debate that shook the nineteenth-century medical world concerned doctors' rights, specifically the extent to which doctors had the authority to make decisions that countered a patient's wishes, accepted practice, or social expectations. At the heart of the debate was a medical scandal involving artificially provoked abortion (or induced miscarriage, as it was sometimes called) and its legal implications. It began with the inauspicious publication of a small serial publication entitled *Revue Générale des Journaux de Médecine*. Republished in the 9 March 1843 edition of *La Lancette Française*, the article introduced the French medical community to the "Grand Affair," a controversial medico-legal case from Switzerland that became the talk of medical communities across Europe in the late 1830s and early 1840s.[41]

It all began innocently enough, with the fourth pregnancy of Marie-Judith Grand, a 32-year-old woman from the Swiss canton of Vaud. Grand's first three pregnancies were uncomplicated, the latter two attended only by her mother-in-law, a woman "without instruction in the art of childbirth."[42] Her fourth (and last) pregnancy in 1838, on the other hand, was quite a bit different. As early as the third month of her pregnancy, Madame Grand began to feel abdominal pain so intense that she told her husband "*that*

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[41]Paul Dubois and Alphonse Devergie, "Affaire Grand: Avortement, rupture du vagin; Renversement de la matrice; Sortie du corps de l'utérus à travers les parties génitales," *Annales d'hygiène publique et de médicine légale* 1, no. 19 (1838): 425-428.

[42]Paul Dubois, "Observation: Affaire Grand," *Annales d'hygiène publique et de medicine légale* 1, no. 19 (1838) 426-428.

she could be dead the next day [emphasis in text]."[43] She retired to her room early that evening, periodically crying out in pain. Her agony became "so unbearable" that Monsieur Grand sent a messenger to the village midwife asking, indeed begging, for her assistance. The local midwife refused, so Grand went to the neighboring village to find a midwife, who came within the hour. Upon seeing Marie-Judith, the concerned midwife instructed Monsieur Grand to call for a trained *accoucheur* (*accoucheur instruite*). Dr. Campiche arrived at 3:30 in the morning. The surgeon examined Grand and noted a uterine retroversion (twisting) with a vaginal stricture (narrowing) that was causing her pain, swelling, and hemorrhage. Campiche tried in vain to reposition Grand's uterus, but the patient succumbed at 4:30 in the morning, an hour after the doctor arrived.[44]

It was certainly not an uncommon end to a nineteenth-century pregnancy, particularly not one with physiological complications. It could easily have faded into the background, as many such cases had before. But this case was destined for something more. "This death might have passed unnoticed," the celebrated *accoucheur* Paul Dubois wrote, "as one of those events that often follows a miscarriage […] if public rumors had not attributed it to criminal actions."[45] But gossip persisted, and the case became a medico-legal *cause célèbre* in the Swiss and French medical communities.

Médecine légale is a term that emerged in France in the late eighteenth and early nineteenth centuries to describe a subfield of medicine that was concerned with both matters of criminal evidence (i.e., explaining the significance of medical matters in a legal case) and areas of medicine with legal significance (such as insanity or

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[43]*Ibid*., 427.
[44]Retroversion in the uterus occurs when a woman's uterus is tipped to the back, instead of the front. Vaginal stricture refers to a pinching of the vaginal walls that results in blockage of that orifice.

rehabilitation).[46] Official medical jurisprudence first emerged as a discipline in France in the seventeenth century, with university courses dedicated to teaching forensics. Jurists often called on doctors to give testimony on questions of infanticide, sexual violence, or inheritance. By the latter half of that century, and well into the eighteenth, however, legal medicine stagnated. Nearly anyone claiming medical knowledge could stand as an "expert witness" because the only requirement was sitting for one lecture in forensics. It was not until the Revolution that the modern practice of legal medicine in France re-emerged (this time under the purview of the university). The first professional chairs of legal medicine were established by the French state in 1794, and, in 1803, Napoleonic legislation mandated that expert medical witnesses be licensed doctors, take a course in forensics, and pass an examination in legal medicine. By the middle of the nineteenth century, legal medicine had become an accepted sub-specialty, with associations and journals dedicated to issues of concern for these doctors. As a group, they were expected to be familiar with both medicine and law, and to speak with the authority of experience in matters where the two coincided.[47]

As in the nineteenth-century public health movement, legal medicine was a way of connecting doctors to the French state. And, also like the public health movement, it was rooted in the class struggle of the late Restoration and July Monarchy. On one level, the medico-legal community addressed many of the concerns of the bourgeoisie: legitimacy; inheritance; patrimony; abortion; and sexuality. If a woman gave birth after the death of her husband, how long did she have before the child was deemed illegitimate? If a child died three days after birth, was that considered stillbirth or death?

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[46]Shafeek Sanbar, *Legal Medicine* (St. Louis: Elsevier Health Sciences, 2007), 3.
[47]Chaille SE: Origin and progress of medical jurisprudence. J Crim Law Criminol 40:397–402, 1949

In this way, doctors made themselves indispensable to the rising bourgeoisie by using their expertise to "clarify domestic disputes." On a second level, the medico-legal community also worked with public hygienists to police the lower classes, advising jurists on matters such as criminal insanity. "The diminution and, above all, the degradation of the human species," wrote Paul Mahon, a leading proponent of *la médecine légale* in Paris, "have finally forced [the state] to encourage the study of the proper measures of remedying such a terrible affliction."[48] Consequently, medico-legal practice often acted as a conservative force in French society, charged with validating the status quo in France. As a result, medico-legal inquests, such as the one initiated by the Grand case, were as much about the stability of the bourgeois state as they were about the specific issues in question.

The question at the heart of this particular controversy was whether or not the fatal injuries and complications sustained by Judith-Marie Grand were caused intentionally, either by Madame Grand herself or by another party, or whether her death was merely an unavoidable consequence of a birth gone terribly wrong. Campiche and another doctor named Mayor performed an autopsy three days after her death. Campiche and Mayor stated that Marie-Judith Grand's death was the result of injuries she sustained (including contusions on her abdomen, retroverted uterus, vaginal stricture, and spontaneous abortion) and that it was impossible for her to have inflicted such injuries on herself. They even hinted at the possibility of foul play.[49] That prompted the village of Rolle to convene a legal inquest into the matter. Having several questions about the

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[48]Paul Mahon, *Médecine légale et police médicale* (Paris: Bertrand, 1807), 3.
[49]Campiche and Mayor, "Procès-Verbal: Affaire Grand," *Annales d'hygiène publique et de médicine légale* 1, no. 19 (1838): 428-431.

medical issues involved, the tribunal commissioned a *conseil de santé* to offer some conclusions about the case. This is where things got heated. The *conseil de santé*, under the leadership of a doctor named Verdeil, came to a conclusion that was markedly different from that of Campiche's and Mayor's autopsy report. The majority of the council found that it was quite possible for Judith-Marie Grand to have suffered from self-inflicted injuries, most likely sustained in an intentional and arduous effort to induce a miscarriage.[50]

The implications of this legal case for the medical community in the 1830s fall into two basic categories: 1) the relative balance of authority between the individual and the collective in the clinical-associative model; and 2) the convergence of the medical and legal communities in the validation of the bourgeois state.

1. The Individual and the Collective

The first issue at the heart of this legal battle over one woman's death was a struggle between the individual and the collective as it pertained to medical authority. As doctors struggled to establish what had happened to Marie-Judith Grand, they were, in many ways, using her body as a battleground for determining where the ultimate power lay—with the individual doctor who was familiar with the intricacies of the case in question or with the medical collective acting as a repository of all accumulated medical knowledge. In January 1837, the contradictory findings of the *conseil de santé* and the doctors who had performed the autopsy were sent to the Tribunal, which immediately

[50]The minority opinion was that there was not enough information to make any determination whatsoever; it explicitly criticized the autopsy report of Campiche and Mayor as "lacking", a statement the majority agreed with as well. Conseil de Santé, Letter to Inquest Commission, *Annales d'hygiène publique et de medicine légale* 1, no. 19 (1838): 431-436.

sent letters to both parties asking for more information to help it resolve the differences. Neither side backed down. The *conseil de santé* was particularly scathing in its censure of the two rural doctors, claiming that the report contained "ambiguities" that could not be resolved "because of the corpse's state of putrefaction." For that reason, the "council could therefore only offer opinions on *possibilities* [emphasis in text].[51] The *conseil de santé* considered its job done; if they had failed to agree with Campiche's and Mayor's findings, it was because said doctors had failed to create a convincing case.

The two rural doctors reacted in kind, sending the case to a French *accoucheur*, Paul Dubois, for comment, an act that introduced the French medical community to the case. For his part, Dubois, a renowned scholar in the field of obstetrics, agreed almost immediately with the *conseil de santé*, prompting Campiche to appeal to Marie-Guillaume-Alphonse Devergie (often considered the father of forensic medicine in France) with two personal letters that provided some additional background to the case.[52] Campiche noted, for example, that Monsieur Grand (Marie-Judith's husband) had twice tried to kill his wife with the help of his parents. While in prison on suspicion of his wife's death, Grand guiltily admitted to slipping poison in his wife's drink on two separate occasions. "The first words Grand's mother said to her daughter-in-law upon entering the room, the night of the event" Campiche continued, "was that she was going to have a miscarriage."[53] The clear implication, of course, was that the Grand family had been trying to kill Marie-Judith for some time and that this case was merely the

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[51]François Verdeil, et al. Statement to Tribunal de Rolle, *Annales d'hygiène publique et de medicine légale* 1, no. 19 (1838) , 466.
[52]Paul Dubois, "Avis Motivé," *Annales d'hygiène publique et de medicine légale*, 1, no. 19 (1838). 436-447
[53]Campiche, letter to Alphonse Devergie, 17 March 1837, *Annales d'hygiène publique et de medicine légale* 1, no. 19 (1838): 448-451.

culmination of that process. The French doctor was convinced. Devergie's opinions carried a great deal of weight in the European medico-legal community, and the Tribunal de Rolle was no exception. The members agreed with Devergie (and hence with the original autopsy findings), leading Campiche to express his gratitude for the Frenchman's "benevolent and powerful support" when the young Swiss doctor was "left alone to struggle against all the notable surgeons of [his] country."[54]

The Grand Affair revealed fundamental uncertainties about nineteenth-century medical identity. Where were the limits of the individual doctor's autonomy drawn? And how were those limits determined by the complex interaction of the broad network of medical institutions in France in the 1830s? Within the university system, for example, there were the *facultés* in charge of the educational canon and the *jurys medicaux* responsible for licensing. Together, they controlled the composition of the medical community from the top down. What they did not do was serve as a functional site of professional sociability, an association designed to merge a collection of individual doctors into a group. The creation of the *Académie royale de médecine* in 1820 attempted to bridge that gap between practice and oversight. It was expected, as part of the Academy mission, to be on the cutting edge of research, advising the state on whatever matters might be deemed necessary, but, at times, its members clashed with the extant university institutions that controlled the medical canon. Finally, in the 1830s, this convergence of state and medical interests was furthered by the growth of the public health and medico-legal movements, which co-opted doctors into service to the state. The doctors who debated the Grand Affair, as a matter of medical jurisprudence, did so

[54]Alphonse Devergie, "Avis Motivé," *Annales d'hygiène publique et de medicine légale* 1, no. 19 (1838): 469-475; Tribunal de Rolle, letter to Conseil de Santé de Vaud, *Annales d'hygiène publique et de medicine légale* 1, no. 19 (1838): 456-460.

within the context of those competing institutions. In the end, then, the struggle over who would be allowed to "speak" for Grand's body in this case was equally concerned with the question of who would "speak" for medicine and, by extension, for the bourgeois state.[55]

2. Medicine, Law, and the Bourgeois State

The effects of the Grand Affair continued into the 1840s, though the parameters of the debate had shifted beyond the individual case. The convergence of the lawyers and doctors in legal medicine had created a new realm of civil service that was both distinct from the state and an integral part of its expansion. The history of lawyers in the nineteenth century was a volatile one. Though lawyers in the *ancien régime* stubbornly resisted labeling the bar as a corporation, insisting instead that they were an order or free association, the Revolution (as it had with the medicine) disbanded the privileged institutions (that had governed the practice of medicine). They would not be reconstituted in full until 1822 (though steps to require a law degree and permit professional associations were taken as early as 1804), but as the profession was rebuilding itself, it became the "voice of liberal public opinion" with a "flamboyant style of political pleading."[56] Doctors began to participate directly in government, and no single group benefited from the July Revolution of 1830 more than lawyers, who posted the largest numerical gain within the Chamber of Deputies that year as a result of the expansion of the electorate to include the wealthy bourgeoisie.[57] Lawyers and doctors, then, acted in the 1830s to represent the French bourgeoisie in different ways. One group

[55]Ramsey, *Professional and Popular Medicine in France*
[56]Karpik, 1, 101-102.
[57]Gay, *Schnitzler's Century*, 19-20.

validated the liberal political agenda through legislative debates; the other naturalized an understanding of the human body that fit with bourgeois beliefs about gender and class. Still, compellingly enough, both professions understood themselves to be integral parts of the larger process of re-ordering a state in disarray.

In legal medicine, those two worlds coincided. Consequently, debates over individual cases often had broader meaning, as was the case in the Grand Affair. In March 1843, Dubois published another article—this time in the *Gazette Médicale*—defended the usefulness of provoked miscarriage in cases of uterine retroversion or pelvic stenosis (the same pathological issues faced by Marie-Judith Grand during her ordeal). The very next week, the editors of *La Lancette Française* responded with an open letter to the medical community on the issue of provoked miscarriage in these specific instances. The long-term significance of the scandal, according to these editors, looking back on the affair five years later, had little to do with Madame Grand herself. Rather, it was about whether or not provoked abortion in the case of pelvic stenosis or stricture (the defining characteristics of Grand's medical condition) should become part of general obstetrical practice or relegated to the ranks of other so-called immoral and illegal procedures.

Within five years, the debate had transformed from a discussion of an individual medico-legal case (an attempt to determine the actions of a very few people) to a discussion about the limits of a doctor's authority (what doctors could and could not, should and should not, do), with all its social and cultural ramifications. One side espoused the belief that inducing a miscarriage in the case of pelvic stenosis could save women's lives. All doctors must realize, they argued, that such a malformation almost

always negates any possibility of a live, healthy birth, and puts the mother herself in grave danger. For doctors on that side of the debate, the risk was not worthwhile. On the other side was a belief that doctors did not have the moral right to choose between the fetus and the mother: "[t]o cause the death of a fetus at its mother's breast, or to expel it before the time intended by Nature, is a crime."[58] And it was, at least according to the editors of *La Lancette Française*, a heated debate. Jean-Louis Baudelocque, for example, repeatedly espoused the virtues of the caesarean section as an alternative that would save both mother and child.[59]

Somewhere in the middle fell Dubois and the editors of *La Lancette Française*. Laennec's invention of the monaural stethoscope in 1818 allowed doctors, for the first time, to determine pregnancy before maternal reports of quickening. Quickening, or the moment at which fetal movement could be felt by the mother, was the point at which a pregnancy could be officially declared because it was, according to legal (and some religious) traditions, the beginning of life. By the 1840s, however, physicians were able to hear a fetal heartbeat four months into the pregnancy, often before the mother was able to feel any movements at all. Moreover, medical research out of England definitively proved (by the 1840s) that fetal development was incremental, implying that there was no "one moment of quickening" at which the soul entered the fetus and endowed it with life. Critics used this as evidence that life began much earlier than generally thought, demanding protection for the fetus from at least the beginning of a heartbeat (though some, especially in the Church, argued from conception). This pressure led to legislative

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[58]*Ibid*., 115.
[59]Angus McLaren, "Abortion in France: Women and the Regulation of Family Size, 1800-1914," *French Historical Studies* 10, no 3 (Spring 1978): 461-462, 471-473.

change, so that, by mid-century, doctors who knowingly induced abortion in pregnant women had broken the law. [60]

It was in this context that the question of "induced miscarriage" or abortion in the case of uterine malformations emerged. As a legal matter, this situation was particularly complicated because it normally meant choosing between the life of the mother and that of the child. Legislators, the editors of *La Lancette Française* wrote, must distinguish between provoked miscarriage intended to save women's lives and criminal abortion. One was a legitimate, life-saving medical practice, the other a moral disaster. That distinction, they continued, should be left to the discretion of doctors. After all, they were the only ones who could know the appropriate response to any given medical situation. Anything else would be downright dangerous for the medical profession and the people they serve, with the potential for non-experts to pass laws that would hinder the at-times urgent practices of medical doctors.[61] It was nothing short of an infringement on doctors' right to practice their art.

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As for the Grand Affair, it did not end the way that the young Swiss doctor who had steadfastly pursued the charge of foul play wanted. In spite of Campiche's best efforts, he and Devergie were unable to convince the Tribunal of the veracity of their account. Even indisputable proof that Grand's husband and parents-in-law had tried on two separate occasions to poison the young woman was not compelling enough for the legal panel. Marie-Judith Grand's mother-in-law was acquitted in full. Her father-in-law was convicted of trying to poison her in 1832, while her husband was found guilty of

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[60] John Riddle, *Eve's Herbs:* (Cambridge, MA: Harvard University Press, 1999), 206-227.
[61] *Ibid*., 116.

trying the same in 1834. For the injuries and "provoked miscarriage" that ended her life, however, all were set free. Campiche was appalled. "The whole process," he wrote, "pointed to such a sequence of atrocities, such villainy in the Grands […], that it is difficult not to attribute the death of Madame J. Grand to the cruel maneuvers performed in the pursuit of her death."[62] This, despite the fact that Devergie's support had, according to Campiche, "brought nearly all opinions back to [his] own." Thus, in the struggle between law and medicine over who would assign the ultimate meaning to this particular case, it was the lawyers who won (though admittedly with the help of a split within the medical community). The jurists had requested, heard, and then dismissed certain expert medical testimony.

In the broader medico-legal discussion of induced abortion, however, the doctors were more successful in their pursuit of an autonomous sphere of influence. While the Napoleonic Penal Code of 1810 outlawed abortion, making it punishable by prison or forced labor for both doctor and patient, it was notoriously difficult to enforce in the nineteenth century.[63] By 1850, in fact, cultural narratives of abortion had changed from an unwed mother's "last resort" to a "back-up method of birth control" for married women.[64] Induced abortion—whether medical (with pharmacological herbs), surgical (forced rupture of the uterus), or manual (intense pressure on or sharp blows to the abdomen)—became an accepted, even advertised, form of birth control. This was the

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[62]Campiche, Letter to Alphonse Devergie, *Annales d'hygiène publique et de medicine légale* 1, no. 19 (1838): 469-475; Tribunal de Rolle, letter to Conseil de Santé de Vaud, *Annales d'hygiène publique et de medicine légale* 1, no. 19 (1838): 476-477.
[63]Peter De Cruz, *Comparative Healthcare Law* (), 437;
[64]Angus McLaren, "Abortion in France: Women and the Regulation of Family Size, 1800-1914," *French Historical Studies* 10, no 3 (Spring 1978): 461-462, 471-473.

result of a number of trends, not the least of which was the systematic closing of other options, including abandonment.

Under the July Monarchy, in particular, the bourgeois campaign against working-class immorality led to the closing of foundling hospitals, which, in the words of one reformer, left "the working-class girl" with "no other recourse than abortion or infanticide."[65] Indeed, in areas where foundling hospitals were closed, rates of abortion (and its acceptance) increased. References to abortion (in literary, medical, and journalistic texts alike) placed it alongside withdrawal, the rhythm method, and the sheath as legitimate forms of birth control. It was no longer relegated, to paraphrase Angus McLaren, to use by a single girl looking to end her first pregnancy; it was also actively sought by married women looking to control family size. Legally, abortion was banned unless a mother's life was in danger. Practically, however, it remained murky through the nineteenth century, since abortions largely private (and hence notoriously difficult to enforce), so it was not until the 1920s that stronger laws against abortion could be imposed and enforced amidst the post-war demographic crisis.[66]

Early nineteenth-century obstetrical and gynecological case studies thus served as a site of some of the most volatile and significant discussions in the emergent medical profession in France. More than anything, members of the medical community used obstetrics and gynecology to explore the limitations of the power of doctors (individually and as a collective) at a time when those boundaries were not yet fixed. Pregnancy and childbirth were evocative metaphors for the revival and continuation of the French state within the post-Revolutionary upheavals of the early nineteenth century. In this way,

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[65]François Vidal, *De la répartition des richesses* (Paris:, n.p. 1846), 285, Cited in McLaren, "Abortion in France," 465.
[66]McLaren, "Abortion in France," 470-485.

then, the gender order that was imbedded within the "medicine of women" and the medicalization of childbirth became central to professional medical identity, to doctors' claims to "speak"—for their patients, for society, and for the bourgeois state—with the authority of "scientific truth."

Part II:

The Poetics of Professionalization

5

Sentimental Medicine: Establishing the Social Utility of Medicine in the 1830s

I. Literary Sentimentalism

The rise of the novel as a predominant literary form in the eighteenth and nineteenth centuries had profound implications for the practice of reading, particularly with respect to the relationship between text and reader. It created an autonomous discursive realm, distinct from the stories told in a primarily oral culture, because there was no "context" through which to interpret the story, no gestures or inflection to indicate or qualify meaning. It was only through the act of reading itself that an audience could "know" and understand a story. The novel therefore provoked a paradigmatic literary shift, one in which reception replaced intention as the source of meaning and authors were forced to adapt new writing conventions that were consciously designed to elicit a desired reaction.[1] Sentimentalism in particular embraced this concept fully, devoting itself to the goal of evoking intense emotions in its readers.

Sentimentalism, as a literary genre, was born out of the eighteenth-century philosophical tradition of moral sense theory, best espoused by British philosophers Francis Hutcheson and David Hume. According to moral sense theory, morality—or the ability to distinguish between right and wrong—can be understood to operate in a manner analogous to the other senses. In such a theory, morality (in direct contrast to rational

[1]Peter Brooks, *Body Work: Objects of Desire in Modern Narrative* (Cambridge, MA: Harvard University Press, 1993).

ethics) is understood not by reason, but rather by *feeling* or *sensation*. If writers (in particular) could compel strong feelings or sensations in audiences, then they could guide virtue or morality. The moral philosopher Adam Smith, whose work would become one of the foundations of later literary sentimentalism, was in many ways the natural heir, as a student of Hutcheson and friend of Hume, to this line of philosophical inquiry. Smith, however, challenged the idea of a moral sense as outlined by Hutcheson and Hume, taking issue with the idea that there exists a singular *sense* for moral perception and positing instead a far more complex vision of moral understanding, claiming that there are multiple "moral sentiments" which people could share.[2] According to Smith, human behavior was constantly torn between two opposing impulses—self-love (or self preservation) and benevolence. Both inclinations provoked strong emotional reactions to stimuli, but they were often at odds with each other, which undermined the innate usefulness of sentiment as a guiding force. Instead, Smith argued, this conflict necessitated a "disinterested viewer" who could take a much broader view of the ethics of a situation. The value of sensibility, then, rested in modeling one's choices on what the disinterested viewer would do. In the words of historian David Bell, "it was less a movement of individual feeling and rather an imagined arena in which the subjectivities of all human others, and of the self, are reconstructed in a manner which has to be both emotional and judgmental at once."[3] Sensibility, then, as an imaginative undertaking, lent itself nicely to the fictional arena and prompted a new literary genre that "showed

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[2]James Bonar, *Moral Sense* (New York: Routledge, 2004), 168-199; G.abriela Remow, "General Theories in the Moral Theories of Smith and Hume," *Journal of Scottish Philosophy* 5, no.2 (September 2007): 119-134; Introduction to "Moral Philosophy," *Late Modern Philosophy: Essential Readings with Commentary*, eds. Elizabeth Schmidt Radcliffe, et al (Malden, MA: Blackwell Publishing, 2007), 257-260.

[3]David Bell, *Sentimentalism, Ethics, and the Culture of Feeling* (New York: Macmillan, 2000), 43-49.

people how to behave, how to express themselves in friendship and how to respond decently to life's experiences."[4]

By focusing on distress that was rarely deserved (using archetypal victims—defenseless women, aged men, children, long-suffering heroes) and by describing that distress with words such as virtue, delicacy, tenderness, and melancholy, sentimental narrative presented readers with a situation for which they were expected to feel pity or sympathy. Suffering drew readers into the story, encouraging them to feel certain emotions (pity, anger, jubilation) for certain (recognizable) characters and situations. Sentimental literature was therefore, to some extent, dependent on the reader for its meaning. Accordingly, sentimental writers strove to create situations that necessitated moral judgment on the part of the reader, and then guided the reader to the "correct" judgment, allowing sentimental narrative to be both optimistic (assuming that people would be moved by their own natural sentiment) and Manichean (positing an absolutely correct response and leaving no room for doubt).

It was a literature specifically designed to cause tears and other demonstrations of emotional excess. This tendency to focus on emotion and outburst was often buttressed by the (mis-) use of exclamation points, dashes, and other punctuation marks, which interrupted the flow of the sentence, so as to illustrate the immediacy of emotional reaction: it could interrupt one's train of thought with little or no notice. In such works, readers were to be moved to literal tears, so overwhelmed by their own moral judgment (their moral sense, in philosophical terms) that they experienced it physically, making the private body public. Failure to evoke this reaction could be seen as a failure on the part

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[4]Janet Todd, *Sensibility: An Introduction* (London: Metheun , 1986), 4.

of the author or, alternatively, on the part of the reader. In either case, sentimental narrative was judged by its ability to evoke emotional and thus virtuous reactions.[5]

Because the novel inherently created a polarity between subject and audience, one in which the reader was simultaneously displaced from the story and immersed within it, it necessarily re-imagined the reader as voyeur to the most private of all realms, the human body. The novel's emphasis on physicality operated on some level as a story of invasion, with the reader peering into a private realm of which he or she was not a part.[6] Sentimental narrative in particular publicized what should have been a private experience—emotion. Readers became intimate observers of the human psyche and the human condition through the physical body. This allowed authors of sentimental novels to explore questions of particular concern to contemporary society (notably questions of sexual origin and identity), as the instinctive "desire to see" and "desire to know" that were intrinsic to voyeurism in general created a powerful cultural narrative that defined and enforced social norms.[7]

The voyeuristic gaze was particularly conspicuous in medical narratives, since both doctor and reader necessarily crossed the boundaries of privacy by delving into the recesses of the human body. Nineteenth-century literature was fascinated with doctors and medicine, and the character of "the doctor" appeared in numerous novels during the first half of the century, from *Le Médecin de Campagne* in 1833, to *Le Père Goriot* in 1835, to *Madame Bovary* in 1857. The doctor was considered an exceptionally astute

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[5]David Denby, *Sentimental Narrative and Social Order in France, 1760-1820* (New York: Cambridge University Press, 1994); William Reddy, *The Navigation of Feeling: A Framework for the History of Emotions* (Cambridge: Cambridge University Press, 2001); Ann Jessie Van Sant, *Eighteenth-Century Sensibility and the Novel: The Sense in Social Context* (Cambridge: Cambridge University Press, 1993.
[6]Brooks, 1-26.
[7]Dorothy Kelly, *Telling Glances: Voyeurism in the French Novel* (New Brunwick, NJ: Rutgers University Press, 1992).

observer, so, as (an often progressive) character, he was deployed as a literary device for making observations about society and social mores in general.[8] "The doctor is the confessor of the modern age," one French writer explained, "and he is obligated to the secrecy of confession, just like the priest," thereby associating doctors with observation not just of the human body, but of the human psyche and human condition as well.[9] Nowhere could this voyeuristic medicine be seen more clearly than in the realm of obstetrics and gynecology, since "the physician's invasion of the womb" opens a private realm to public scrutiny and "rescues the fetus from the oblivion of its union with mother."[10] This made the *accoucheur* the ultimate voyeur, looking into the most private and mysterious of spaces—a female body in the process of creating life—making medical texts an ideal site for a style of writing (sentimental narrative) that did the same.

II. Social Connectedness

Sentimental narrative was predicated on the basic principle of social connectedness, setting the individual in the context of broad human relationships.[11] In the novel, such associations were often represented by friends and family—husbands, wives, children, parents, loved ones of all sorts—who placed characters in a broad social spectrum, wherein the experiences and emotions of one impacted the experiences and emotions of others. In medical texts, however, French doctor-writers also emphasized the importance

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[8]Michele Respaut, "The Doctor's Discourse: Emblems of Science, Sexual Fantasy, and Myth in Barbey d'Aurévilly's 'Le Bonheur dans le Crime'," *The French Review* 73, no.1 (Oct. 1999) : 71-72.
[9]Jules Barbey d'Aurévilly, "Le bonheur dans le crime," *Oeuvres romanesques completes* Vol. 2 (Paris: Gallimard, Bibliotheque de la Pléiade, 1966), 89; cited in Respaut, 72.
[10]Alice Gaine Adams, *Reproducing the Womb: Images of Childbirth in Science, Feminist Theory, and Literature* (Ithaca: Cornell University Press, 1994), 157.
[11]Leo Braudy, "The Form of the Sentimental Novel," *Novel: A Forum on Fiction* 7, no. 1 (Autumn, 1973): 5-13; Joanne Dobson, "Reclaiming Sentimental Literature," *American Literature* 69, no. 2 (June 1997): 265-269.

of social relationships—the idea that the pain and suffering of the patient had much larger repercussions for his or her social circle—as a way of validating the significance of doctors' work in ways that owed much to the sentimental literature of the day.

First, French doctors highlighted the social bonds within the larger community of medical practitioners. This strategy was aimed at a relatively small audience of doctors, colleagues, and peers. They used the social to imagine an individual identity predicated on the idea of the "self-in-relation"—where doctors filtered their own authority and power through that of the larger society of similar experts.[12] Consider, for example, the "*Reflexions*" section of an article in the March 1809 issue of the *Journal de Médecine Pratique*. After devoting nine pages to the case at hand (violent hiccups), the editors ended with this admonition: "We can all see, through this observation, how important it is to return to the origins of a malady in order to be able to treat it successfully. The author would no doubt have combated it differently had he been better informed [about its origins]."[13] Case studies were understood, then, to serve the instructive and socially constrictive purposes of a cautionary tale for their readers, making them intrinsically social phenomena.

The importance of the medical community in the clinical-associative model established after the Revolution was undeniable, and early nineteenth-century doctors were committed to its protection, as when the *Académie royale de médecine* condemned its own too-rapid growth between 1820 and 1829 (when members were asked to give an accounting of the "state of the field.") Academy members urged an immediate reduction in the numbers of doctors in the Academy, including an end to all honorary and

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[12]The term "self-in-relation" is borrowed from Dobson, "Reclaiming Sentimental Literature."
[13]"Observations sur un hoquet violent," *Journal de medicine pratique* (March 1809): 55.

associated titles. The significance of social connection was not about quantity; it was about quality. Doctors were joined in a community whose elite status came from its limited membership. Too great an increase in the numbers of that community, they worried, could only diminish its prestige. [14] What this report made clear was a shared desire to maintain a closely connected, and strictly limited, professional world, where those who belonged were elevated above those who did not. It was a world that doctors consciously developed in their case studies, as they appealed to an audience of their peers.

Looking back at the Hélie Affair of the 1820s, we can recall how Hélie appealed to his fellow doctors as the only people who could truly appreciate his actions.[15] No one else, he claimed, could possibly understand the choices he had to make. His defenders further urged the medical community to be kind to their colleague, as only providence stood between them and the fate that had befallen Hélie.[16] In the Grand Affair, doctors depended on their professional connections—even as they debated them—during the six years of discussions that were prompted by the death of Marie-Judith Grand.[17] In this way, early nineteenth-century doctors consciously recognized and emphasized the importance of social connection amongst "the aggregate of educated men, enlightened practitioners, and the masters themselves." Scientific and medical societies, such as the *Académie royale* or various provincial *Sociétés médicales d'émulation,* would allow doctors to establish "relationships amongst themselves that are founded on a common

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[14]"Rapport au Roi sur l'Académie Royale de Médecine: 10 octobre 1829," *L'Annuaire de l'Académie Royale de Médecine*, (1835): 17.
[15]Hélie, Lettre à Messieurs les Membres de l'Académie Royale de Médecine de France.
[16]F.M Leroux, "Petit Essai d'une Petite Lettre Provinciale Philosophico-Médicale," *La Lancette Francaise: Gazette des Hôpitaux* 24 (25 December 1828): 95-96.
[17]For the numerous sources cited in this affair, see chapter 3.

need to multiply, extend, and exchange the knowledge" that was at the foundation of medical practice.[18]

Doctors, however, were not the only observers of medical practice. Every French man and woman was a potential patient, a fact that greatly expanded (and complicated) the intended audience of medical writing. Medical stories were not only found in medical texts, but were instead a popular part of the culture of the day, as in the case of novelist Jules Sandeau's story of a sickly young woman whose ultimate happiness was guided by her doctor's advice, or in the character of Emma's husband in Flaubert's celebrated *Madame Bovary*, or the case of the title character of Balzac's *Le médecin de campagne*.[19] Advertisements for medical treatments were essential components of newspapers and journals beginning on the late eighteenth century. Disease operated as a metaphor for social problems, borrowing from the language of medicine to describe "social ills," "degeneration," and "the diseased city of Paris," and effectively medicalized the way the culture talked about not only gender and class, but society as a whole.[20]

Medicine was thus moving beyond the preserve of an educated elite. For that reason, early nineteenth-century French doctors had to recognize and embrace the fractious nature of their audience. One group was specially trained and educated in the functioning of the human body; the other group was not. One was familiar with discipline-specific terminology; the other was not. One was generally receptive to medical change; the other was not. The two segments of the case study's audience

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[18]*Dictionnaire des Sciences Médicales*, vol. 51, s.v. "sociétés savantes," 419.
[19]Ramsey, *Professional and Popular Medicine in France*; Mary Donaldson-Evans, *Medical Examinations: Dissecting the Doctor in French Narrative Prose, 1857-1894* (Lincoln, NE: University of Nebraska Press, 2000); Colin Jones, "The Great Chain of Buying: Medical Advertisement, the Bourgeois Public Sphere, and the Origins of the French Revolution," *The American Historical Review* 101, no. 1 (February 1996): 13-40.
[20]Introduction to *French Medical Culture in the Nineteenth Century*, eds. Ann La Berge and Mordechai Feingold (Amsterdam: Rodopi, 1994), 1-24.

required a different approach, a different vocabulary, and a different focus, but because they made up a singular audience, nineteenth-century doctors had to contend with these differences in a unitary fashion. They did so by constructing a style that emphasized the inter-connectedness of all the members of this broadly conceived audience—doctor, patient, interested reader—through strategies borrowed from the sentimentalist writers of the day.

Often they struck this balance by highlighting the glories that medicine and medical doctors offered society at large, as when Pierre Thiaudière praised the intricacies of the art of medicine. "Medicine demands so much study," the young doctor opined,

> so much courage and perseverance, that it requires nothing less than everything that is beautiful and honorable, to relieve the pain of our fellow man, to dedicate to it one's evenings, one's freedom, and one's entire life: to succeed in the practice of delivery, therefore it is necessary to have great knowledge, patience, a self-possession that nothing can shake, and ironclad discretion and probity.[21]

For the doctors, it was a discourse of sacrifice and dedication, with the doctor in the role of self-sacrificing hero, denying his own needs to help others. For the doctor's female patients, however, it was a discourse of salvation in which "the humanity of doctors w[ould] bring them to the rescue of these poor women who think only of thrift when they choose a midwife." The social connection between doctors and patients was fundamental to the intrinsic value of medicine as a profession.

Doctors exploited that connection in their writing, by including their patients' social circles—friends and family—in their descriptions of cases. Some highlighted the husband's reaction to complications in his wife's pregnancy or labor. Others peppered their narrative with the concern of friends and family members, as when Joseph Marie

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[21]P.N. Thiaudière, "Observations sur deux cas rémarquables d'accouchemens laborieux," Archives de la Société d'Émulation, Box 5, BIUM, MSS 2197.

Audin-Rouvière's included in his text a letter from a young man who had been in love with one of Audin-Rouvière's patients. The young man writes,

> The young woman who inspired in me this dangerous passion had been dead for fifteen months, and my melancholy had not faded at all since the unhappy event. I constantly thought of the cherished traits of that young woman. My love, having lost all hope, […] found new force by the eternal denial of its object. I became insensitive to all; nothing pleased me […].[22]

It was clearly a story of the physical damage that emotional yearning could do, a story lifted from the sentimental genre. What the inclusion of this letter allowed Audin-Rouvière to do was to put his patient in a broader social context of suffering. Her illness and death were not isolated events; she was not the only person who suffered. Rather, the pain extended into the larger community of which she was an apparently beloved part. The impact of medical doctors (as the people who treated illness) thus extended beyond the patient as well, since the outcome of their actions affected so many people beyond the immediate patient.

The same broad strokes of social interaction and shared concern were equally apparent in a young doctor named Congrain's description of a "most curious case." At the heart of the story was a sixteen-year-old girl named Victorine. Victorine was small for her age, with black hair, dark eyes, and pale skin. She had a relatively strong constitution, never having suffered from a serious illness, though she did have what Congrain called a nervous temperament. The doctor described her as being extremely impressionable and surprisingly empathetic to others' pain. There was, however, absolutely no history of nervous episodes within her family, so it came as a surprise when, upon the death of a close friend, she fell into an extreme state of depression. At

[22]Audin-Rouvière, 165.

8:00 one evening, while preparing for bed, she suddenly became catatonic, completely unaware of her surroundings. She was later seized by convulsions and tremors, punctuating the air with what the doctor described as "piercing cries and heart-rending sobs."[23]

Her friends and family, Congrain noted condescendingly, believed it to be the work of evil spirits and malicious sorcerers, so they staged an elaborate ritual to exorcise the demons causing her such pain. When that did not work, her companions were themselves overwhelmed with grief and sorrow: "There were, in that house, more than fifteen people who were crying and distressed; one of them, believing that the woman was dying and not wanting to abandon her to her sad end, suggested that someone find a doctor." It was then, Congrain continued, that a number of the woman's friends came to his home a little after 12:00 in the afternoon, almost 18 hours after the beginning of the episode. [24]

Upon examining her, Congrain remarked that Victorine appeared to be in immense pain, to the point where the lightest touch drew "cries that were said to be grating on those nearby." After several hours of painful examinations and treatments, many of which found her close to death and begging for a priest-confessor to administer last rites, Congrain was at long last able to bring an end to the woman's suffering.[25] What is most striking about his choices, however, lies in the dramatic way in which his blend of the personal and impersonal assigned an almost fictional quality to his reconstruction of the medical story. Consider, for example, the following paragraph:

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[23]Congrain, "Observation Renvoyée à MM. Brieu & Belhomme," Archives de la Société Médicale d'Emulation, Box 6, BIUM, MSS 2197.
[24]*Ibid*.
[25]*Ibid*.

> There was an interval of around 8 minutes between attacks that lasted 5 minutes each. Victorine cried out so piercingly, so heart-rendingly that everyone hurt for her; she curled her body to the front, then to the back; she lifted her arms and began flexing her fingers convulsively; she rolled to the right and then to the left, pressed the skin under her ears, […]; her eyes remained sharp and crazed. The attack stopped, the patient let out a sigh, complained of some pain, and demanded her confessor before dying; she begged us to let her go, so that she could cover her face with her hands; she called for her parents and when they were brought to her, she did not see them, did not recognize them at all.[26]

In this paragraph, Congrain combined impersonal descriptions of her symptoms—convulsions of the arms and hands, rolling from side to side, pressing on her head—with far more personal descriptions of her suffering—the heart-rending cries, her desire to be comforted by her parents—in order to paint a broad picture of the "shared devastation of affectional loss."[27]

The social dimensions of the medical relationship were also evident in the frequent practice of including what might be labeled a "back story"—a narrative of a patient's life that might or might not directly influence the medical narrative. In 1833, Guillaume Dupuytren published his observation of a fifteen-year-old girl suffering from tremendous pain in her abdominal cavity. "The girl," he wrote, had been "exposed on several occasions to the shameful brutality of a drunken man, a worker at the factory where she also worked. He cornered her in a room and, standing in front of her, exposed his naked and erect sexual parts. She was seized by indignation and struck by terror, so much so that she ran to a nearby apartment to remain close to her mother."[28] The young

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[26]*Ibid*.
[27]The phrase is borrowed is from Joanne Dobson, "Reclaiming Sentimental Literature," 266.
[28]Guillaume Dupuytren, "Clinique chirurgicale de l'Hôtel Dieu: Affection nerveuse accidentelle (danse de St. Guy), guérie par les bains tièdes," *La Lancette Française*, (9 February 1833): 71.

girl, according to Dupuytren, began experiencing symptoms (tremors, malaise, fever, stomach upset) very soon after the event.[29] In addition to explaining her medical condition, which could have been accomplished with a description of just her symptoms, his portrayal of her run-in with the drunken man, her terror, her flight to the security of her mother's arms, were all pieces of information that endeared the young woman to her audience and rendered her situation more relatable.

This "socializing back story" also appeared in Pierre Nicolas Gerdy's description of the emotional state, or *bonheur,* of a patient who had consulted him to determine whether or not she was pregnant. Her abdomen was expanding, and she had been experiencing nausea, loss of appetite, and some "mental disturbances," but she was not certain of pregnancy. When Gerdy examined her, he could neither hear a fetal heartbeat nor see the usual quickening. Instead, he noted a regular, pendulum-like movement, unlike anything he had ever seen or felt before. In a parenthetical aside, Gerdy noted that she had twice tried to commit suicide, the consequence of "several episodes of [mental] alienation, caused by a guilty fear that she had caused the death of her first husband. But she was not unhappy in her second marriage, so she had no real reason for despair."[30] As background, this information was only loosely connected to the immediate case. Perhaps Gerdy was laying the framework of mental disturbance, should the "pregnancy" proved false. But given the outcome (the patient gave birth to a healthy, and uniquely large, child), its inclusion in the final version of the case study is surprising. Her "mental alienation" does nothing to explain the irregularities of what proved to be a legitimate pregnancy; what it did do was ground the patient in a much larger social landscape.

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[29]*Ibid*.

[30]Pierre Nicolas Gerdy, "Premier cas: Présentation de l'épaule, sortie du bras reduction, accouchement par adduction de la tête," *Receuil de mémoires: 1834-1836*, Manuscrits Gerdy, BIUM, MSS 2185.

At times, the back story was not completely removed from the case at hand, as when Pierre Fouquier noted that his hysterical patient had spent most of her life in a convent, "where her circumstances had brought her." This fact was significant, he explained, because the intensity of the patient's religious experience had fostered within her a deeply rooted nervous condition, which, on prior occasions, had manifested itself in hysterical episodes, menstrual irregularity, heart palpitations, and abdominal pain.[31] In addition, after examining her lower abdomen and pelvis, he noted that the patient's sexual organs displayed a "vicious tendency that appeared to be the result of the abuse of emmenagogues."[32] On the surface, emmenagogues merely referred to herbs thought to stimulate menstruation and restore humoral balance, but the term was also used in the nineteenth century to describe drugs that were intended to induce miscarriage.[33] Though the suggestion of an unwanted pregnancy was never made explicit in the text, the mention of hysteria (understood to originate from the uterus), emmenagogues (as abortifacients), and a sheltered (religious) past, would certainly have called it to mind, for the nineteenth-century doctor. And though this socializing of the patient was relevant to the case (at least to some extent), its impact on the reader was surely more profound than merely the accumulation of data intended to justify the diagnosis. It reaffirmed contemporary notions of female behavior and the danger of impropriety, and, consequently, made the case infinitely more meaningful for Fouquier's readers.

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[31]Pierre Fouquier, "Maladies Regnantes, Chez l'Homme, on a Observé Aussi Presque Tous les Phenomènes qui Produit Habituellement l'Influence de Printemps," *Journal de Médecine Pratique* (February 1809): 34-48.
[32]*Ibid*.
[33]John M. Riddle, *Eve's Herbs: A History of Contraception and Abortion in the West* (Cambridge, MA: Harvard University Press, 1997).

III. The Maternal

This broad inclusion of patients' backgrounds meant that case studies often incorporated social themes, characters, or tropes that had widespread appeal in early nineteenth-century France. This was particularly true in obstetrical and gynecological case studies, where the issues' ties to the genesis of life meant that they were well suited to stories of renewal, salvation, and sacrifice in the name of love.[34] Women in the nineteenth century, after all, were considered to be created "by nature for a sole purpose: to give birth to man and to nourish him with her precious milk during the first months of his frail existence. […]. Of all her functions, childbirth, so indispensable to propagation and to the continuation of the species, is doubtless the most beautiful and also the most painful."[35]

Nowhere was "the social" more clearly epitomized than in images of maternity. The idea of motherhood provided a powerful social and political category in France under the July Monarchy. Traditionally, gender in the nineteenth century has been subsumed within a model of separate spheres, in which men played a political, public role and women were relegated to the private, domestic realm. More recently, that understanding has been challenged by a recognition that the social significance of "the maternal" occasionally offered women a public role, as when women formed public groups such as the Society for Maternal Charity or when officials used maternalist rhetoric as the basis of nursery school reform. For the most part, women filled the ranks of nursery schools and charities because both groups were understood to be substitutes

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[34]Paul Dubois, "Rapport à l'académie sur 2 cas de monstruosité," *Mémoires de l'Académie Royale de Médecine*, Tome IV (Paris: Ballière, 1835), 482.

[35]"Mémoire pratique sur les soins qui réclame la femme en couche," Document XXXV, Archives de la Société Médicale d'Emulation de Paris: Rapports et Mémoires, Box 3, BIUM, MSS 2196.

for a bourgeois conception of the warm and protective family that was missing from the working class.[36]

Motherhood, then, became the quintessence of social connection, built as it was on the category of what Julie Kipp has called the "self in non-self" or the "self in other." The maternal body—whether pre- or post-partum—was defined by the existence of an "other" (the baby), and the performance of that maternal relationship was consequently a performance of the individual and the social.[37] The culturally laden image of maternity was powerful, allowing medical case studies to transcend the boundaries between the biological and the cultural experiences of becoming/being a mother, as in the case of a "laborious birth" presented to the Academy in 1840.

It was the story of a woman who was giving birth when several doctors noticed a tumor that they could not identify. After much discussion, the doctors decided it was a blood tumor, the consequence of a difficult pregnancy, and proposed a course of action that included rupturing the tumor in order to allow for the birth of her baby. As they attempted to lance the tumor, however, the mother screamed in pain, surprising the doctors, who had assumed the process would cause little or no physical response in the mother. They halted their efforts and concentrated on delivering the baby. After the birth was successfully completed, the doctors learned that the tumor they had been trying to lance was in fact the baby's scrotum, resulting from a frank breech presentation. If it was surprising that the mother felt pain from a supposed blood blister, it was downright

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[36]Christine Adams, "Maternal Societies in France: Private Charity Before the Welfare State," *Journal of Women's History* 17, no. 1 (Spring 2005): 87-111; Linda L. Clark, *The Rise of Professional Women in France: Gender and Public Administration since 1830* (Cambridge: Cambridge University Press, 2000), 11-39.

[37]Julie Kipp, *Romanticism, Maternity, and the Body Politic* (Cambridge: Cambridge University Press, 2003), 4.

shocking that she felt pain from damage done to her unborn baby's body, which led Piedagnel to conclude that his patient had been screaming in reaction to the pain endured by her son.

Though the other doctors at the Academy's *séance* disagreed with Piedagnel's conclusions as presented to them (Piedagnel's colleagues decided that he was inexperienced with the process of childbirth and that he therefore did not truly understand the situation), the validity of his findings is not necessarily what is most important here. Instead, what is crucial is how Piedagnel constructed images of a pregnant woman so closely connected to her unborn child that his pain literally became hers. Her agonized screams and convulsions were the ultimate manifestation of "the maternal", and, as such, was recognizable to a large audience that might not otherwise grasp the intricacies of obstetrical practice.

The link between the maternal, medicine, and the social good was described explicitly in an 1803 book entitled *Médecine Maternelle ou l'Art de Conserver les Enfans*, which opened with these lines:

> An ancient proverb says: *The doctor of a child is a woman*. Does this adage mean that affectionate sentiments, that the instincts and tenderness of women makes them alone capable of giving care to the youngest children? It is an incontestable truth. But should we thus say that medicine is useless to children? This would be a grave error; because there is no time in life when medicine is more powerful, and often more necessary, than when one is in maternal care. […].[38]

In this passage, Leroy harnessed the power of maternal sentiment in order to make an argument for the necessity of medical care, in a conscious effort to extend the reach of doctors into a realm—the care of newborns—that had traditionally not fallen within their

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[38]Alphonse Leroy, *Médecine Maternelle ou l'Art de Conserver les Enfans*, (Paris: Chez Méquignon, 1803), v.

purview. Moreover, in introducing the argument, he did not reach immediately for statistics or physiology; instead, he alluded to the inherent desire of a mother to care for her children, finding in it a compelling metaphor for the medical care of society at large.[39]

In a letter written from Louis-Auguste Baudelocque to the editor of *La Lancette Française* in April 1839, the famous *accoucheur* debated the relative merits of a new procedure known as cephalotripsy (use of forceps-cephalotribe), in which the skull of a fetus is crushed in order to facilitate a natural delivery. These specific forceps (so much more gruesome than others) were theoretically used only in cases where the fetus was dead or had a diagnosis inconsistent with life.[40]

Figure 5.1: Baudelocque's Cephalotribe, 1829

The motivation behind the letter was a caesarean section performed by Dubois on March 30. Baudelocque's issue was not with Dubois's medical skills, but rather with his colleague's decision not to give the woman all relevant information (particularly about the risks). He questioned Dubois's decision to tell her only that it was absolutely

[39]*Ibid.,* vii..
[40]Fleetwood Churchill, *On the Theory and Practice of Midwifery* (London: Henry Renshaw, 1842), 298.

necessary to save her child, arguing that that choice "to expose her life to great danger to save that of her child" or to "let her child die to save herself" belonged not with the doctor, but with the mother.[41] Instead, Baudelocque promoted the cephalotripsy.

Rather than using statistics or dry analysis to make his argument in favor of cephalotripsy, then, Baudelocque channeled the culturally potent image of maternity. Dubois had used maternal rhetoric to justify his decision not to outline all of the surgical risks that his patient was facing, assumed that any mother would do whatever was necessary, including risking her own life, to save that of her child. Baudelocque maintained that rhetoric, even as he challenged Dubois's conclusion. Both doctors therefore manipulated a sentimental discourse of "the maternal"—the connection between mother and child—to explain the woman's choice between her own health and that of her unborn child. The decision, Baudelocque insisted, was not for doctors to make; it belonged to the mother. Yet he later noted that he had never seen a mother who, being made aware of the dangers by her doctor, chose the caesarean section over cephalotripsy. The results, he pointed out, were very impressive—of the eleven women he had performed a cephalotripsy on, only one died, and that one he excused by pointing out that he was called to the scene late. Compared to the use of the scalpel in three caesarean sections that he performed prior to his invention (which resulted in three maternal and two fetal death), the use of forceps-cephalotribe was clearly superior.

Thus, Baudelocque made an interesting discursive transition in this argument, with his assertion of a mother's natural right to choose what is best for herself and her baby. On the surface, this would seem incongruous with the aforementioned tendency to

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[41]Louis Baudelocque, "Opération césarienne – réflexions," *La Lancette Française* 43 (7 April 1839): 171.

medicalize childbirth and shift it away from the domain of women. Baudelocque, however, maintained that there was a "correct" choice. Statistics left no question about which a mother should choose. It was the doctor's duty, he noted, to guide desperate mothers-to-be (in the depths of a stalled and potentially fatal labor) to that *right* decision by giving them the information they needed.[42]

IV. **Shared Suffering**

Part of what made the theme of "the maternal" so compelling in both literature and medicine, then, was its ability to appeal to the emotion of its reader. But it was not the only way that writers—whether medical or otherwise—did so. They often relied on a discourse of suffering to elicit sympathy from their audience. Even in the nineteenth century, childbirth "entailed risks that scared women."[43] Statistically, in the first half of the nineteenth century, the maternal death rate in France was high, higher than in many other European countries. In 1866, Leon Le Fort, a noted anatomist and surgeon, compiled a statistical study of maternal mortality in and around France. Le Fort shows that, between 1802 and 1864, four French cities (Paris, Rouen, Lyon, and Bordeaux) had an average maternal death rate of 3.6%, or almost 1 out of every 25 births. There were places, however, where that rate was much higher, so that, in the worst years at *Maternité*, about one woman in ten died in childbirth, compared to an average of 1 in 200 or 250 in England and Wales during the same period.[44]

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[42]*Ibid*.
[43]Christine Theré, "Women and Birth Control in the Eighteenth-Century France," *Eighteenth-Century Studies* 32.4 (1999): 558.
[44]Leon LeFort, *Des Maternité* (Paris, 1866), 14-31; cited in Irvine Loudon, *Death in Childbirth: An International Study of Maternal Care and Maternal Mortality, 1800-1950* (Oxford: Oxford University Press, 1992), 431-432.

Early nineteenth-century doctors capitalized on that fear, emphasizing the dangers of pregnancy and childbirth, which were frightening prospects for many women, particularly poor women in Paris. One case study from March 1834 highlighted the trauma experienced by Elisabeth Guerin, a thirty-year-old woman from Paris, who suffered from a tubal pregnancy: "tremors, pain, and stomach distension that drew sharp cries from the sick woman with the slightest movement or the least pressure on her abdomen."[45] Women were often described as being "seized by" disorders, a linguistic construction that emphasized the unexpected and unavoidable nature of such maladies and made the medical experience almost frightening in its immediacy.[46] This fear of the unknown and unexpected was exaggerated by language that emphasized the intensity of the pain. To this end, doctor-writers used words like "agony," "desperation," and "extraordinary pain" to highlight what their patients were going through.[47] Over and over the term "suffering" appears in these case studies, highlighting the patient's *experience* of the pain that was endured, rather than the medical *classification* of it.[48]

Pregnancy and childbirth, then, were often described as an ordeal to be survived. One of the primary motivations behind the decision to use such terminology was a desire to rouse certain emotions within the readers of such texts, for the purpose of drawing them into the social matrix of the medical experience. Doctors did so for two primary purposes: 1) to help audiences connect with the patient, so that they cared what happened

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[45]Émile Clement, "Grossesse tubaire," *La Lancette Francaise: Gazette des Hôpitaux civils et militaires* (6 March, 1834): 109.
[46]"Maladies Regnantes," *Journal de Médecine Pratique* (February 1809): 48; Guersent, 6; M. Radford, "Hôpital Obstetrical de Manchester, Extrait de The Dublin Journal of the Medical Sciences, September 1837" *La Lancette Francaise: Gazette des Hopitaux* Tome XI (30 Nov. 1837): 557-560.
[47]Civatte, 95; Nicolas Chambon de Montaux, "Obervations sur les ulcers de l'utérus," Papers and Notes of Nicolas Chambon de Montaux, Tome XI, BIUM, MSS 5143.
[48]A. Jobert, "De la cystocèle vaginale opérée par un procédé nouveau," *Mémoire de l'Académie Royale de Médecine*, Tome 6, (Paris: Ballière, 1837), 697 ; "Maladies Regnantes," *Journal de Medecine Pratique* (Paris: Chez Gabon, 1809): 34-71.

to her; and 2) to illuminate the inequitable distribution of power in the medical relationship by portraying the patient as a victim whose only hope lay in her doctor. "What was I to do in such dangerous circumstances?" asked one doctor rhetorically. "The woman was despairing; her strength was depleted, her courage failing. I proposed a caesarean section as the *only hope* for saving her life."[49] In such a description, references to physical pain and suffering cast the patient as a victim modeled after the "damsels in distress" of sentimental (and later gothic) literature. It was a characterization evidently designed to evoke—in participant and reader—an empathetic desire to help. That help would come in the form of the medical doctor.[50]

V. Doctor as Hero

The hero-victim dichotomy was equally powerful in literature and in medicine, though it was by no means static. **T**here was a split in late eighteenth- and early nineteenth-century sentimental literature, in which two types of sentimental heroes emerged. In early sentimental works, the hero or heroine was typified as an object of compassion or pity. In this model, the feeling or emotion was far more important than the individual. Later exemplars, on the other hand, offered a secondary trend wherein focus shifted to a new type of character, typically male, whose role required that he interpret sensibility and pass it on to the reader. As a character, this new hero was not the one suffering, but was rather the one observing someone else's suffering. "The customary perspective of the sentimental hero," Carol McGuirk had written, was "a

[49]"Note sur un accouchement," Document XXI, Archives de la Société Médicale d'Emulation de Paris: Rapports et Mémoires, Box 3, BIUM, MSS 2196.
[50]Braudy, 5.

downward view of pathetic objects. This process of condescension [was] essential to sentimental rhetoric."[51]

This late eighteenth- and early nineteenth-century sentimental hero was an outsider, a witness to suffering, whose position as an external observer invited affinity on the part of readers. Audiences began to see themselves operating in the same narrative space as the hero, sharing in his role as the arbiter of suffering. This conflation of audience and character was essential to the evolution of sentimentalism from literary trope to cultural narrative, because it allowed the hero to operate as a reflection of self for the reader and thereby involved the audience more deeply in the story.[52]

Doctor-writers in early nineteenth-century France modeled this same concept of the heroic character in their depictions of the role of doctor, as in Victor Szokalski's description of a birth that he attended (using that word quite literally, since the doctor did nothing to aid in the birth itself) in one of the streets of Paris. The case, Szokalski wrote, began at 7:30 in the evening of 26 March 1839, when he was called to an extraordinary scene in the rue Hautefeuille in Paris. Upon arrival, he determined "at a glance" that it was the child, not the mother, who most needed his immediate assistance. The baby was still enveloped in the amniotic (fetal) sac and presented no signs of life. According to a witness, the sac (encasing the baby) had been expelled from the mother's body quite suddenly, as she was walking down the street. It had all happened so quickly that no one had a chance to do anything to help.

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[51]Carol McGuirk, "Sentimental Encounters in Sterne, McKenzie, and Burns," *Studies in English Literature, 1500-1900*, Vol. 20, no. 3 (Summer 1980): 507

[52]Roma Chatterji, "The Voyage of the Hero: The Self and the Other in One Narrative Tradition of Purulia," *Contributions to Indian Sociology*, 19, no. 1 (1985): 95-114.

From these reports, Szokalski knew that he needed to hurry as he turned his attention to the child. "Full of hope," he explained, "I hastened to clean out the child's mouth, and to rub his chest briskly with a piece of flannel; I washed his body with warm water and had the pleasure of seeing, within several minutes, that his breathing had resumed. […]. The mother [was] joyous upon hearing her child cry so loudly."[53] Luckily for mother and child, there was a doctor nearby who could step in and save both of their lives. It was, in the end, a story of triumph. What this narrative did, then, was to create an air of interest, uncertainty, and danger against which the doctor's work could be measured. After all, it certainly was not every day that a woman gave birth to a fully intact amniotic sac, with the baby still inside. It was unprecedented, meaning that Szokalski had to improvise a method for saving the child, using his hard-earned knowledge to improvise a method to deal with an unforeseen and unexpected circumstance.

It was also an overtly emotional scene because the child's life hung in the balance at precisely the moment of his birth.[54] Szokalski's descriptions of his hope and the mother's joy reflected the degree to which the participants—doctor and patient alike—were invested in the scene. Szokalski established an emotionality within the event by highlighting the high stakes—the uncertainty and the unfamiliarity of the occurrence, the number of people affected by the poignant scene, and the degree of that effect—of the situation into which he stepped. Then, as he involved himself in this woman's medical emergency, he transformed his role into that of a savior —the hero who brought her

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[53]Victor Szokalski, "Accouchements dans la rue; sortie de l'enfant envelopé de ses membranes intactes," *La Lancette Française* 38 (28 March 1839): 151.
[54]*Ibid*.

limitless joy in the face of such potential devastation by saving her child. As such, Szokalski's description of his actions mirrored many of the characterizations found in sentimental literature.

A second "heroic" tendency that appeared often in early nineteenth-century case studies was the use of the first person. By shifting attention to the doctor's decisions and actions, the use of the first person by doctors (found in 35% of 218 case studies published between 1795 and 1815) allowed the doctor to place himself at the center of the story and to control how the story was told [See Figure 4.2]. For example, Dr. Caignou's use of the first person in an 1829 case study of an extra-uterine pregnancy was quite effective at highlighting the significance of his role in the event. After describing how much pain the mother was in and how desperate she seemed for help, Caignou wrote, "the birth could not happen without the help of *our art*, [thus] I was obliged to penetrate the cyst to grab the infant's head, which I brought out alive."[55]

The third discursive tool that doctors used in constructing themselves as heroic characters in nineteenth-century case studies was an emphasis on the adversity they faced. In this strategy, doctors emphasized the fact that the art of saving lives required doctors to overcome rather significant obstacles. In the case of the woman giving birth in the street, for example, Szokalski faced a scene of uncertainty. There was no textbook, no precedent to tell him what to do. Rather, he had to improvise, based on his expert knowledge and experience, in order to accomplish something very few people of the time could have done. Without those skills, *his* skills, the baby would have died.[56] It was the

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[55]Caignou, Grossesse Extra-Utérine; Foetus développé dans le pavillon de la trompe gauche," *La Lancette Françcaise* 39 (19 September 1929): 154-155.
[56]Szokalski, 151.

height of a hero's triumph over adversity. A similar emphasis on the ability of doctors to conquer problems could be seen in a Neapolitan doctor named Petrunti's description in 1835 of the numerous problems encountered by a pregnant woman with intense abdominal pain. Several doctors tried different approaches, to no avail, until Petrunti, after an intensive exploration of her rectum, suggested a risky operation to remove "skeletal debris" from her rectum, piece by piece over the course of an arduous two-day procedue, during which the woman hovered "near death." At last, the skeleton was removed and the woman recovered, slowly, but with much gratitude for the doctor who saved her.[57]

Even when the outcome was less than favorable (which was often the case in early nineteenth-century French medicine), the doctors consciously separated their heroic behaviors from the unfortunate outcome. This heroic narrative was mirrored in another case found in Gerdy's memoir collection. He wrote,

> The birth appeared to me to require a simple reduction which I first attempted to do myself, later calling my brother, chief of the [obstetrical] service, who verified my observation and attempted a version by feet. This operation was quickly terminated; with the head stuck in the lower channel, we rushed to extract him via forceps, so as to preserve his days, if possible; but we found him dead, and no matter what was tried, we could not bring him back to life [*rappeler à la vie*]. The mother met an end no less unhappy. Even though the labor was not too long and we took every possible precaution with our maneuvers, she was taken by peritonitis [infection of the peritoneum] that left her in a desperate state. There was nothing we could do. She succumbed a few days later.[58]

In this passage, Gerdy emphasized repeatedly the fact that he and his brother tried everything they could, proceeding with caution, respect, and a desire to save both

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[57]Petrunti, "Grossesse extraordinaire, accouchement par le rectum," *La Lancette Française* 43 (9 April 1835): 169-172.
[58]Gerdy, "Accouchement," Manuscrits Gerdy, Receuil de Mémoires, 1834-1836 BIUM, MSS 2185.

patients, but to no avail. Note how the death of the mother was described as the result of a post-natal infection, not the birth itself. This further distanced the doctors from the unfavorable outcome.

The case of the infant was a bit more complicated, as death *did* occur during the birthing process, which was overseen by Gerdy and his brother. But that too is explained away as something beyond his control, the result of a presentation that was "first among the causes of fatality."[59] This sleight of hand allowed him to maintain the heroic doctor façade, in spite of a failure to save five out of the six lives involved in these three cases. First, he emphasized the danger inherent in the situation at hand. There was something intrinsically dangerous in the mere existence of a shoulder-first presentation during childbirth. This allowed Gerdy to portray his actions as a valiant struggle against near inevitability. Second, he emphasized that, even in direst of circumstances, medicine offered the only possibility of hope. So, even in cases where medicine failed in its ultimate goal of preserving life, doctors struggled to maintain an heroic image.

VI. Reflections of Sentimental Medicine

This highly emotional discourse was not intended merely for the enjoyment of medical professionals, who would certainly have been partial to the self-aggrandizement that accompanied such writing. They were also writing to convince others of this fact as well, and there is evidence that it worked:

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[59] *Ibid*.

> Monsieur,
>
> Thousands and thousands of thanks are due you! At last I have come back to life and to happiness, and it is your advice that has performed this miracle. You know that for more than ten years, I was tormented by migraine that, at the time, made me want to die. At the age of 32, no more pleasure for me; no season, no spectacle, no party could provide diversion from my torture; everywhere I carried with me my suffering and trouble. Oh! If I had an enemy, I would not wish on him that which deprived me of my happiness during the best years of my life. When I consulted you, you could not stop yourself from telling me about the pain that my sad situation caused you. The care that you appeared to take gave me hope that I would be cured by your medicine. I used it as you prescribed, I was cured and in less than eight days, my free head made me cherish this existence that I had hated. My husband and two daughters are filled with joy to see, for one, his wife, and for the others, their mother, tranquil, happy, and always ready to share in their pleasures.
>
> Josephine Darette, femme Muratoir[60]

This letter was a bit of a curiosity in the medical literature of the early nineteenth century, since it was one of the few times that a woman was allowed to speak for herself. As we have seen, in the majority of medical texts, use of the first person was reserved for males (generally doctors, but also extending to the occasional male patient). So what made this one of those rare instances in which a female voice came through? I would argue that it was included because it reproduced many of the same themes that doctors themselves espoused, made even more poignant because it is written from the perspective of a narrative of gratitude. The patient had almost given up hope, only to be "given back life and happiness" by her doctor.[61] He likewise restored that of her husband and two daughters by giving them back their wife and mother. This woman's story was clearly a

[60]Audin-Rouvière, 215.
[61]*Ibid*.

blend of the same sentimental tropes—social connection, suffering, the maternal—that structured the early nineteenth-century medical tradition of which it was a part.

Thus, doctors successfully used sentimental tropes to establish themselves as the protagonists in situations that mattered to society at large. They rooted themselves and their endeavors in a narrative that appealed to a wide audience, in order to create for themselves an air of authority based on social value. At every turn, medicine cast itself as a source of stability in insecure times, a tendency bolstered by the use of another popular literary genre of the day—the closely related, though slightly darker, style known as gothic. Gothic narrative provided doctors with another way to emphasize their social utility—this time by emphasizing medicine's ability to provide answers to the problematic questions lurking at the margins of society. From gothic narrative, doctors borrowed tropes that allowed them to draw attention to those elements of society that were in disarray, so that they could be the ones to set it right.

VII. The Gothic Extreme: Medicine at the Margins

Because gothic literature concerned itself with supernatural characters and situations, it has often been dismissed as fantastical and escapist by literary critics and almost entirely ignored by historians. In fact, it is often written off as merely a sensationalistic adaptation of sentimentalism, but if we focus on the overall goal of gothic writing, rather than the *devices* used to accomplish those goals, we can rehabilitate the genre as a means of understanding nineteenth-century France. It was a style of literature that deployed tropes such as the damsel-in-distress, the monster, and the haunted house to create an atmosphere of suspense and horror that engaged the reader's imagination in a

new way. In so doing, gothic writers invested their works with psychological interest and emotional complexity by exposing the reader to sensationalistic themes (and an intentional confusion of good and evil) that were, while removed from the real world, still measurable against extant moral standards. It was a way of restoring order in the midst of disorder, meaning that gothic narrative, like its sentimental counterpart, emphasized the internal, mental processes of emotion and sensation, as a means of enforcing moral norms.[62]

Eve Sedgwick, a pioneer in the field of post-structural gothic criticism, has demonstrated quite compellingly that the gothic emphasis on images of seclusion, such as the veiled woman, went beyond just providing a jejune atmosphere of mystery. Instead, these images highlighted the distinction between the surface and the interior, the uncertainty lurking "beneath the veil," even as those distinctions repeatedly collapsed in gothic tales. Metaphors of disguise privileged the surface and hinted at a more authentic interior that, in the final analysis, never really developed. Gothic identity, then, lay precisely in the superficiality of the surface because it was "social and relational rather than original and private."[63] Similarly, the project of medical writing necessitated a bridging of the gap between the internal and the external, making what was unknown known, and what was unseen seen. Using the structural conventions of gothic narrative (particularly in cases such as infanticide, severe birth defects, or "hearing voices") that operated at the margins of what was considered acceptable in society, doctors invoked the gothic implications of a self that blurred the boundaries between authenticity and

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[62]Robert Hume, "Gothic versus Romantic: A Revaluation of the Gothic Novel," *PMLA* 84, no.2 (March 1969): 282-290.
[63]Eve Kosofsky Sedgwick, "The Character in the Veil: Imagery of the Surface in the Gothic Novel," *PMLA* 96, no.2 (March 1981): 255-270.

superficiality. Such a construction allowed doctors to create an image of disorder that they could then re-order through the power of rational, scientific medicine.

Gothic tropes were often used to dramatize the effects of sentimentalism in medical case studies. Gothic elements were particularly useful for adding a sense of mystery to otherwise ordinary scenes, as when Pierre Paul Broca described an incident " so strange and so surprising" that it was difficult to believe it was true. The midwife who presented the case, Broca recalled with a belittling air,

> begged me not to mock her for what she was going to tell me. So, with a stupefied air, she told me that while she was caring for a pregnant woman, she heard the cries of a fetus inside the stomach of the mother. I coldly told her that this type of thing, while very rare, nevertheless happens sometimes.[64]

He continued this train of thought later in the case study, after he had aided the woman in giving birth to a son:

> This woman [the patient], during my visit, was plunged into the most profound despair; she shed tears, her face was shattered [*decomposé*] by terror. I asked her if she felt any pain, she responded negatively and assured me that her greatest pain was the fear that she had been possessed by the devil or a sorcerer. She swore to me that she had already consulted a priest and a doctors, and the answer she was given was believable only in her extreme naïveté. He [the priest] said that she was evidently a ventriloquist. I consoled her as best I could, trying to persuade her that she was not a witch.[65]

For Broca, then, the value of this case study lay precisely in how extraordinary and shocking it was, because it allowed him to overstep the social boundaries of medicine and speak instead to questions of faith, superstition, and ignorance. Gothic descriptions, with their inherent irrationality, offered doctors a perfect counter to the antiseptic rationality of modern medicine.

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[64]Pierre Paul Broca, "Vagissemens Intra-Utérins," *La Lancette Française* 110 (15 September 1835), 438.
[65]*Ibid*.

Thus, Broca set out to emphasize the extraordinarity of his case in a number of ways. First, he merged a sentimental image of the woman's tears with a far more chilling description of her face being broken up (with the word *decomposé* hinting at an even darker image) by terror. He mentioned sorcerers and devils not only to emphasize his patient's naiveté, but also because they served as foils to his clear and rational thinking. Sorcerers in particular were liminal characters in gothic tradition, belonging to a critical category labeled by Robert Miles as "ghosts and their cognates." These characters existed at (and often beyond) the boundaries of accepted society and therefore represented a collective social anxiety about those who transcended the norm.[66] For doctors, then it was an intriguing way of adding social detail to a case narrative, one that created interest, but ultimately failed to be convincing. Instead, the rational scientism of modern medicine—and the doctor who had mastered it—found the answers the patient had been seeking.

The value of gothic excess as a literary style offered doctors a metaphor for exploring the disordered margins of society in a variety of cases, even those in which its use was less explicit. Images of monstrosity, for example, were often used as categories for understanding the atrocities of medico-legal cases of infanticide. After one particularly appalling case in Cambrai, in which a man murdered three of his four children before killing himself, the doctor described the man as "a monster" who "in a frenzy, took out his anger on his three children," after the true object of his anger (his eldest son) had escaped into the darkness of night.[67] The understanding of infanticide as a "horror" often colored the way the issue was described, as in the case of a woman

[66]Robert Miles, "The 1790s: The Effulgence of Gothic," *The Cambridge Companion to Gothic Fiction*, ed. Jerrod E. Hogle (Cambridge: Cambridge University Press, 2002), 41.
[67]"Triple infanticide – Suicide du meurtrier," *Annales medico-philosophiques*, 11 (1848): 108.

accused of murdering her fifteen-month-old son while her husband was away on business. Upon returning home, the man asked his wife where their son was; her answer was that he was resting. After several minutes, the husband went to look for his young son and found him, dead, wrapped in a sheet, hidden in the deep recesses of a cabinet near the kitchen. His wife's face, this young man despaired, was blank, as though she were unaffected by the events of the night. She was accused of infanticide and tried before a special inquest convened by the mayor of a small hamlet near Alsace. Just as in the Grand case, the question of culpability was left to the medical community. It was doctors' job to explain the unexplainable:

> This was the result of a remarkable criminal process, not only in the enormity of the loss, but also in the difficulty of establishing culpability […]. It is difficult to find even the slightest reason for this crime in the revolting propensities of the human flesh, of which civilized people can offer only a small number of examples […].[68]

The accused woman explained her actions as the consequence of desperate poverty. Her son, hungry to the point of near starvation ("the torments of hunger, taken to the extreme," in her words), would not stop crying and, in a fit of anxiety, she took a blade and cut her son three times on the leg. He died from the blood loss.

This case was the epitome of "the maternal" turned upside down. As the title of the article ("An Extraordinary Case of Infanticide") indicates, the idea of a mother killing her baby was nearly unthinkable in early nineteenth-century France, though even a quick look at the medico-legal cases of the day reveal them to be relatively common. The doctors writing this case study repeatedly indicated their strong surprise at the events of the case and used the words "revolting" and "horrifying" to describe her actions—actions

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[68]Reisseisen, "Examen Médico-Légale d'un Cas Extraordinaire d'Infanticide," *Annales d'Hygiène Publiqueet de Médecine Légale* 1, no 8 (1832): 398

that were in direct contrast to the cultural expectations of "the maternal" already discussed. On some level, then, when the court turned to the medical community to explain and assess blame for her actions, they expected medicine to right this wrong, to restore the cultural tranquility. The doctors rose to the challenge, explaining that this violation of maternal tenderness was the result of mental illness:

> When, in melancholy, disgust with life has become a fixed idea, creating a propensity towards suicide, the unfortunate person searches…either he kills himself immediately by whatever means available, or, if he does not have enough courage for that, or if the instinct for self-preservation is too strong, he seeks to bring death to another person who is his enemy; sometimes even to a friend; more often still to a child. […]. One is thus forced to consider the incriminating act as the product of *aliénation mentale*, despair, and an instinctive compulsion. Now, since the law allows only *aliénation mentale* as an excuse for this crime, it is necessary that the [medico-legal specialist], however lacking […] in scientific characteristics that can serve to determine the manner of intellectual affliction, declare that, at the moment of action, the accused was suffering under a delirium, and the magistrates must reject, for the honor of humanity, the attribution of such an enormous crime.[69]

Problem solved. Question answered. These early nineteenth-century doctors dismissed a potent challenge (infanticide) to the power of "the maternal" by pushing that challenge to the margins of society, categorizing it as a (rare) medical condition for which the accused should not be held responsible. They separated what this woman had done from the idea of motherhood. In fact, it is interesting to note that, while the accused's husband was referred to as "*le père,*" and the dead child as "*le fils,*" on several occasions, this woman was never addressed as "*la mère*" or anything that directly acknowledged her maternal role. In so doing, they validated the cultural norm of "the maternal" and its accompanying social order, thereby returning stability and security to a community that

[69]*Ibid.*, 406, 411.

had been in upheaval since the case first became public knowledge. These types of case studies, reflecting as they did the influence of gothic themes, allowed doctors to emphasize their own contributions to the social good by highlighting their compelling ability to marginalize that which was potentially destructive.

Even the types of medical issues presented in case studies reflected the influence of gothic themes and the anxiety caused by those at the social margins. There were, for example, numerous cases of "medical monstrosities" published in the first half of the nineteenth century. Such monstrosities included the two-headed fetus examined by the Société Médicale d'Emulation de Montpellier in 1805 and Siamese twins connected at the chest, which were presented to the *Académie Nationale de Médecine* in 1822.[70] Both cases were described "monstrous" and "against nature." What such cases did was allow doctors (and their readers) to explore the boundaries of social norms and impose social order through a rhetoric of fear and difference. As Edward J. Ingebretsen points out,

> The trope of monstrosity turns upon anxieties of generation and reproduction, drawing attention to the potentially unnatural consequences of those natural actions […]. The word [monster]'s hex-like power to condemn, alienate, and dehumanize is heightened by its elaborate reinforcement within a 'culture of horror.'[71]

Just as with questions of female sexuality, the use of medical monstrosities placed doctors in a position to provide answers to questions that unsettled society. There were also cases that would have seemed shocking to any reader, such as the case of the woman

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[70]"Déscription d'un foetus monstrueux, communiquée à la société de médecine-pratique de Montpellier," *Annales de la société de médecine pratique de Montpellier* (Montpellier: Imprimériede Jean-Germain Tournel, 1805), 5-7; "Jumeaux réunis par le thorax et le haut de abdomen," *Mémoires de l'Académie Royale de Médecine* (Paris: Ballière, 1828), 363-364.

[71]Edward J. Ingebretsen, *At Stake: Monsters and the Rhetoric of Fear in Public Culture* (Chicago: University of Chicago Press, 2003), 21.

who had a fetus removed from her rectum or the case of the woman who was pregnant for seven years before finally delivering a stillborn.[72] "Monstrosity" even became an analogy for social ills, as expressed in an 1832 letter concerning the spread of cholera. This letter, written from a Viennese official to a French doctor, described the spread of cholera as "a monster," even though "up close, it was a bit less scary."[73] Gothic tropes served as a way for doctors to preserve a "natural" social order in a society that wanted it desperately. So the use of gothic tropes was another way of locating medicine within a social nexus by emphasizing medicine's value to society as a whole.

* * * * *

Case studies in early nineteenth-century France were thus constitutive (rather than reflective) of medical authority because they allowed doctors to assume narrative control over medical stories, giving them the ability to structure those stories in ways that emphasized their own authority, while validating the social and political rise of the bourgeoisie. For this, doctors turned to many of the literary conventions of sentimental and gothic narrative to structure the personal elements of their case studies. More specifically, they built on the social implications of both sentimental and gothic tropes (an emphasis on human connection, intense emotionality, shared empathy, situations that existed on the boundaries of the "normal," and the hero who sought to restore order in the midst of all of this) to establish both themselves and their art as something that was beneficial to social as a whole. Doctors used literary narrative in obstetrical case studies

[72]Petrunti; Sylvestre Rinsi, "Médecine étrangère: Histoire singulière d'une grossesse de 7 ans et 3 mois," *La Lancette Française* 7 (19 October 1830): 25.
[73]"Correspondance Medicale," *Gazettte Médicale de Paris: Journal de Médecine et des Sciences Accessoires*, 1, no. 3 (1832): 155.

as a means of identifying disorder, so that they could re-order it according to bourgeois ideals of gender and class. By naturalizing the inherently maternal character of women, and marginalizing cases that challenged it, doctors demonstrated the ability of medicine to offer stability amidst the insecurity of the July Monarchy.

6

Realist Medicine:
Privileging Medical Authority in the 1840s

The monarchy of Louis-Philippe was born out of the violent upheaval of "three glorious days" in July 1830, when a group of Parisian radicals, incensed by the ultra-conservative Ordinances of Saint-Cloud, rose up and overthrew Charles X. The dramatic events of those three days left France—and the resulting July Monarchy—in an inherently precarious position. It was a monarchy born out of popular action, a contradiction in terms that required an acknowledgment and a denial of that revolutionary heritage. For the July Monarchy to stabilize and legitimize its position, it had to find a way to balance itself between contradictory legacies that Sandy Petrey has labeled "revolution and non-revolution."[1] The 1830s and 1840s in France were therefore characterized by the dominance of dichotomies, or the uneasy juxtaposition of competing ideologies. Monarchy co-existed with republicanism, free trade with protectionism; Catholicism competed with Protestants, and the bourgeoisie with the working class. Though the struggle for hegemony during this period has often been seen as a sort of zero-sum equation, in reality the competing dichotomies were essential to each other.[2] The bourgeoisie, for example, used images of "an other" (populated by the working class) to define itself, a project that was largely intertwined, as we have already seen, with the emergence of professional medicine.

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[1] Sandy Petrey, *In the Court of the Pear King: French Culture and the Rise of Realism* (Ithaca: Cornell University Press, 2005), 37-69.
[2] Jack Ernest Shalom Hayward, *Fragmented France* (Oxford: Oxford University Press, 2007), 91-118

Medical identity, as it was constructed in the first half of the nineteenth century, mirrored this duality of the larger culture in several of its constituent parts: audience (expert and lay); tone (personal and impersonal); and overall purpose (establishing social value and expertise). It is unsurprising, then, that the writing styles doctors adopted for their case studies also reflected the significance of seeming contradictions. They used the tropes of sentimental and gothic narrative to make the case for the social value of medicine. Yet the emergence of professional medicine was not just rooted in the social usefulness of medicine. It was equally dependent on the expertise of doctors, that level of knowledge and experience that set them apart form the rest of society. For this, doctors turned to realism, a literary style that embraced the fractious nature of French society at mid-century and that offered as a "fundamental insight" the belief "that 'everything' and 'nothing' are not opposites but complements."[3] Realism, as a genre, created the real by stipulating the unreal, so that, whenever social reality (or appearances) and physical reality were in conflict, it was social reality that won out. Realism, to paraphrase Lawrence Schehr, assumed both representability and unrepresentability in its project of verisimilitude, or constructing the real.[4]

I. Literary Realism

Scholarly understandings of realism have undergone significant changes in the last twenty years. Traditionally, realism was understood as a genre primarily concerned with the reality of a given time or place. According to this view, realism aimed to provide true-to-life portrayals, depicting everyday, banal activities, without any of the escapism

[3]Petrey, 51.
[4]Lawrence R. Schehr *Rendering French Realism*, (Stanford: Stanford University Press, 1997), 12-15.

that other literary genres of the day provided. In essence, according to these older views, realist (and to a lesser degree, naturalist) narratives attempted to create a mimetic representation devoid of symbolism and room for interpretation:

> At the heart of the realist's conscious agenda is a desire and an expectation to communicate effectively using the shared markers of materiality. Realism cannot begin if it has its back up; rather, it must assume a willing and competent audience that will know at the opening gambit the rules of this most everyday of language games […]. Realism, like life, depends on the kindness of strangers, or, to appropriate Donald Davidson's term, it embraces the 'principle of charity' by which a reasonable understanding is achieved and translation is more or less successfully effected.[5]

From this perspective, French writers such as Flaubert and Zola offered simple, common linguistic constructions because they were closer to "truth," unencumbered by the ostentation of other literary genres. This made simplicity, directness, and precision the hallmarks of a tradition in which writers strove to act as mirrors of reality.

The last twenty years, however, have seen a number of challenges to existing perceptions of realism. Rather than seeing realism as a straightforward attempt to mirror an external reality directly, this new line of criticism maintains that such literature was in fact "not so much the correspondence of a literary discourse to a naturalized and continuous world as it [was] the correspondence with other discourses of verisimilitude, such as science, philosophy, and history."[6] Realism borrowed from the conventions of non-fiction to create a new type of fiction that shared the believability and legitimacy of non-fiction, suggesting that realism never truly *reflected* society, but was rather one of the constitutive forces behind a given culture's concept of truth.[7] The accuracy and self-

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[5]Katherine Kearns, *Nineteenth-Century Literary Realism: Through the Looking Glass* (Cambridge: Cambridge University Press, 1996), 5.
[6]Schehr, 17.
[7]Mack Smith, *Literary Realism and the Ekphrastic Tradition* (University Park, PA: University of Pennsylvania Press, 1995) 2-5.

conscious authenticity that was implicit in the realist narrative was appealing to a medical community claiming a rational, scientific understanding of the physical body. Specifically, there were three different categories of realist strategies from which French doctors writing in the 1840s borrowed heavily.

The first was an idealized concept of "narrative distance," built on the idea of a distinct separation between the narrator and the narrative. In this model, the storyteller "disowned" the story by assuming an outside position wherein he or she, like the reader, observed (but was not attached to) the story.[8] It was a form of detachment intended to correlate with objectivity, or an ability to describe things accurately and without literary pretension, as when Emile Zola described the wedding party's trip to the Louvre in his novel *L'Assommoir*. Teresa Bridgman has described how Zola established narrative distance by differentiating between the artistic aesthetic and reality:

> [N]o aesthetic awareness enters the protagonists' experience of this visit to the column. Fear of heights, concentration on the sky as a means to avoid vertigo, interest in where they are to eat, and a pressing desire to return to ground-level are their only concerns. They are not only unable to respond appropriately to the pictures in the Louvre, they are equally unable to respond (whether through lack of education or for other reasons) to the picture which Zola has painted in words. This passage exposes the techniques of the realist illusion. For the cards are weighted most unfairly. This sky exists for the reader through Zola's aestheticizing language. But it exists for the protagonists as part of a TAW [the actual world] not mediated by language. […]. This description separates the perceptions of the narrator and protagonists.[9]

Realism equated the separation between the narrator and the story as fundamental to constructing an accurate representation of reality. As a result, narrators typically

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[8]Pam Morris, *Realism*, (London: Routledge, 2003) 4-9. See also James H. Reid, *Narration and Description in the French Realist Novel: The Temporality of Lying and Forgetting* (Cambridge: Cambridge University Press, 1993).

[9]Teresa Bridgeman, *Negotiating the New in the French Novel*: *Building Contexts for Fictional Worlds* (London: Routledge, 1998) 113.

assumed a position that situated themselves outside of the immediate action, where they could, theoretically, observe without prejudice or limitations. This claim to objectivity through remoteness was replicated in case studies during the 1840s in a number of ways, including a decrease in the use of the first person and a corresponding rise in use of the passive voice.

The second category of realist conventions that appealed to early nineteenth-century doctors involved an appeal to "the tribunal of experience."[10] Writers in the realist tradition repeatedly emphasized the idea that readers could compare their reading of a text to their experience of the material world and find a direct correspondence between the two. Honoré de Balzac's *Le Père Goriot* explores the intersecting lives of three boarders at the *Maison Vauqueur* in Paris, and opened with a detailed description, drawing a very clear referent for the reader, who could take what he or she knew about the area and compare it with the fictional description. The geography of the novel thereby became a referendum on truth, a way to judge the veracity of Balzac's account. If his descriptions were in keeping with the "tribunal of experience," his novel would be a success; if they were not, it would be a failure, making the "tribunal of experience" the basis of realist credibility, as Balzac himself was well aware:

> Though the word *drama* has been recklessly ill-used and misapplied in our degenerate modern literature, it is necessary to imply it here; not that this story is dramatic in the true sense of the word, but that when it ends some reader may perchance have dropped a tear *intra muros et extra*. Will it be comprehended beyond the walls of Paris? I doubt it. Its minute points of personal observation and local color can be caught only by the inhabitants of that valley which lies between the hills of Montmartre and the higher elevations of Montrouge—a valley full of plastered architecture crumbling

[10]Donald Davidson, *Essays on Actions and Events* (Oxford: Oxford University Press). For insightful analysis of Davidson's rationalist philosophy, see Reed Way Dasenbrock, *Literary Theory after Davidson* (University Park: University of Pennsylvania Press, 1993) and Ernest Lepore and Kirk Ludwig, *Donald Davidson: Meaning, Truth, Language, and Reality* (Oxford: Oxford University Pres, 2005).

> to swift decay, its gutters black with foulest mud; a valley teeming with sufferings cruelly real, and with joys often as cruelly false; a place so full of terrible agitation that only some abnormal event occurring there can give rise to more than a passing sensation. And yet, here and there, even in Paris, we encounter griefs to which attendant circumstances of vice or virtue lend a solemn dignity.[11]

In this paragraph, Balzac wrote to his audience directly, breaking away from the fictional story and encouraging its members to use their own experience to explore the novel. He even went so far as to suggest that the story could be appreciated fully only by Parisians—people who walked the same streets and lived in the same area inhabited by his characters. It was this direct correspondence of the literary to the material world that was the ultimate goal of realist narrative, a goal adopted by the authors of French medical case studies in the 1840s as a means of validating their work.

The final category of realist strategies can be defined as a fundamental rejection of idealism, as realist writers remained deeply suspicious of the ornamentation of sentimental, gothic, and melodramatic narrative. Realist writers' dependence on narrative elements such as repetition and incremental clarification (whereby complicated information is offered slowly and in a strict progression from basic to complex) and their use of extremely precise language were a reaction to what realist writers considered the excesses of earlier literary styles. Perhaps the best example of this process of clarification and precision can be found in Gustave Flaubert's satirical short novel *Bouvard et Pécuchet*, the story of two Parisian clerks on a quest to study as many different intellectual subjects as they can. With each new topic they embraced, they followed a systematic path, beginning with enthusiasm and ending with disillusionment (as every book they read failed to reflect reality in some way), so that, "by the end of the

[11]Honoré de Balzac, *Le Père Goriot*, translated by Burton Raffel, (New York: W.W. Norton, 1997), 1-2.

book, their home has become a kind of burial ground for deceased values."[12] There was a certain patterned repetition to the clerks' arbitrary choices, which allowed Flaubert to construct a challenge to the "reality," or truth-value, of language. He worried that, in the wrong hands, language failed to reflect reality, even as he maintained a fundamental exaltation of "*le mot juste.*" Without "the right word," language, according to Flaubert, failed to reveal truth, and one of the goals of realist literature was to avoid the kind of excess that hindered clear and direct prose.[13]

II. Case Studies in Transition

Near the end of the 1830s, medical case studies began to exhibit signs of the same dichotomies that characterized France under the July Monarchy. The sentimental style that was so popular in the late 1820s and early 1830s, as medicine tried to weave itself into the fabric of the emergent bourgeois state by demonstrating its value to society, was countered in the late 1830s and early 1840s by a new style that borrowed heavily from realism in order to establish doctors as the epitome of dispassionate medical expertise. Near the end of the 1830s, there is evidence that these two styles co-existed, often within the same case study. P.N. Thiaudière, for example, in discussing two "remarkable" cases of laborious birth, struck a compelling (though not unproblematic) balance between sentimental and realist narrative styles.

His early descriptions of the first woman's condition depended heavily on emotion and empathy reminiscent of the sentimental literature of the day. "Her face was

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[12]Charles Bernheimer, "Linguistic Realism in Flaubert's 'Bouvard et Pecuchet,'" *Novel: A Forum on Fiction* 7, no 2 (Winter 1974): 150.
[13]*Ibid*., 151.

pale, her pulse practically nothing, her skin cold," the doctor described vividly, and "blood clots were continually being passed within the hemorrhage, filling her vulva and the area between her thighs. The danger was imminent." Drawing on sentimental strategies, namely an emphasis on the immediacy and intensity of the patient's suffering in an attempt to evoke sympathy within the reader, Thiaudière painted a frightening picture of the pain faced by his patient. The image of all those blood clots coursing between her thighs was enough to concern even the most untrained reader.[14] Harnessing the power of the most devastating potential outcome of the case—death for both mother and child—allowed Thiaudière to assign social significance to his own actions.

At the end of that paragraph (and throughout the next two), however, Thiaudière adopted a very different tone, shifting away from his attempts to evoke sympathy and a desire to help from his audience. Instead of appealing to emotion, he consciously highlighted dispassion through the use of technical language. He was emphasizing his role as one of the few people in society who had the knowledge necessary to help her:

> As soon as I was in the presence of one of my colleagues, I pushed aside the placenta with my right hand, finding a second position of the head. I pushed it back in order to grab the two feet, and I performed a version, terminating the birth in the first position of the feet. I reintroduced my right hand and easily delivered the baby and the umbilical cord, whose placental attachment I had not destroyed. […]. The child was born dead; it was suspected in advance, but the mother, whose suffering was luckily short-lived, was brought back to life.[15]

Here Thiaudière was far more precise in describing the steps he took to treat this woman, down to the details of which hand performed which task. His use of the first-person heroic strategy was tempered by medical terminology (*matrice, cordon omibilicale,*

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[14]P.N. Thiaudière, "Observations sur deux cas rémarquables d'accouchemens laborieux," Archives de la Société médicale d'émulation, Box 5, BIUM, MSS 2197.
[15]*Ibid*.

seconde position) that would have been clear and unambiguous to those who shared his training and indecipherable to those who did not. This medico-linguistic precision placed comprehension of this part of the text beyond the reach of a majority of its readership, emphasizing how Thiaudière and other doctors were members of an exclusive club. Thus, Thiaudière, writing at the end of the 1830s, struck an unlikely balance between two styles—one that highlighted emotion, passion, and social connection, and one that emphasized precision and detachment—because he was writing on the edge of a crucial turning point in the medical construction of self.

Nor was Thiaudère alone in this merging of sentimental and realist strategies. An 1838 observation of a miscarriage complicated by a vaginal tumor paired an evocative description of the woman's suffering with a precise description of the "tumor" that had caused the problems. After sustaining a sharp blow to her abdomen, the patient, with what the doctor described as "courage," made "the long walk back to her, where she felt a considerable loss of blood." Fifteen days later, she experienced "a long and painful labor" that was complicated by her refusal to submit to the use of forceps "for fear that it might be harmful to her child." These lines were reminiscent of the sentimental strategies that emphasized maternal affection and shared suffering, while putting the doctor in a position to act as savior. In contrast, just two paragraphs later, the doctor described the patient's reproductive organs with a disinterest that did not quite match his earlier tone: "in the center of vulvar orifice was found the cervix opened wider than normal; it was purplish and strongly hypertrophied," and "beneath the cervix of the uterus

a fold, formed by the vagina and the opening of the ureter [*l'orifice de l'urètre*] whose direction was changed by […] the pressure of the tumor."[16]

III. Language of Distance

In the 1840s, the realist style, which had emerged less than a decade prior, began to displace the sentimental style more fully in medicine. Increasingly, doctors used the tropes of realist writing—narrative distance, the tribunal of experience, and a rejection of idealism—to establish their own expertise, distinct from an appeal to social value. Let us begin with the realist ideal of distance, which proved compelling for French doctors in the 1830s and 1840s, who were intent on separating themselves from the rest of society. One strategy for achieving this distance involved depicting the narrator from an "outside" position, as though he was observing, but not part of, the scene being described. They did this in a number of distinct ways, but all shared an emphasis on the impartiality of the doctor relating the case.

In an article in the January 1845 edition of *La Lancette Française*, for example, the doctor-author (a man named Bergmann) referred to himself in the third person throughout the article, offering lines such as, "M. Bergmann then prescribed emollient poultices and dressed the wound, first with a zinc-oxide pomade, then with basilicum ointment [salve made from the leaf of a basil plant]; and, under the influence of such a simple treatment, [the patient] was cured in the span of several days."[17] Rather than using the first person "*je*" that had appeared in 46% of the case studies examined from

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[16]A. Jobert, "De la cystocèle vaginale opérée par un procédé nouveau application de ce procédé au traitement du prolapsus de la paroi postérieure du vagin," *Mémoires de l'Académie royale de médecine* (28 January 1840) Tome 6 (Paris: Baillière, 1837), 716.

[17]M. Bergmann, "Revue Thérapeutique: Cas d'existence fe larves de mouches dans le vagin et dans la cavité des narines," *La Lancette Françcaise* 4 (11 January 1845): 16.

the 1830s, this narrator dissociated himself totally from the case, referring himself as "M. Bergmann" and "he," as though the narrator and the protagonist were different people.[18]

An article from February 1845 achieved this distancing in a slightly different way. Rather than referring to himself in the third person, the doctor-author (Velpeau) attempted to avoid referring to himself at all. For example, in describing the malady (a pregnancy complicated by a tumor in his patient's lower back) he wrote the following: "This tumor presented itself without changing the color of her skin; it was quite clearly fluctuating; it is useless to discuss its nature in great detail; it was evident, from the first examination made, that it was filled with pus."[19] Later he described his decision-making process by alluding to current accepted medical knowledge, using the phrase "one knows […]" and "it is indisputable that […]."[20] Only once did Velpeau reference himself at all, and even then it was in the third person. An 1845 observation of "artificial, premature birth" revealed yet another strategy to imply distance and objectivity, as the doctor-narrator referred to himself only as "*l'auteur*."[21] French doctors in the 1840s were clearly trying to avoid personalizing their case studies.

Statistically, this shift towards a more distanced, objective style of language was quite apparent by the 1840s. Examining 218 case studies published between 1795 and 1850 reveals an increasing trend towards the use of what can be categorized as "disinterested language." For these purposes, "disinterested language" has been defined to include either the use of the either the third person to refer to the narrator or the

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[18]See Chapter 5 (Figure VI).
[19]Velpeau, "Grossesse compliquée d'une tumeur occupant le flanc et la portion externe de la region lombaire droite *La Lancette Française* 14 (4 February 1845): 53.
[20]*Ibid*., 54.
[21]Seulen, "Observations de l'accouchement artificial premature—pratiqué avec success," *Archives générales de médecine* 4, no. 9 (December 1845): 488.

exclusion of any reference at all. In the 1840s, a full 58% of the cases examined used some form of disinterested language when describing the relationship between the doctor and the scene.

	1800-1820	1820-1830	1830-1840	1840-1850	Total
Disinterested Lang.	**25**	**16**	**22**	**23**	**86**
	33%	32%	42%	58%	39%
Total	**75**	**50**	**52**	**40**	**218**

Figure 6.1 : Stylistic Conventions in 218 French Gynecological Case Studies, 1795-1850

This means that, by the 1840s (and even the late 1830s, since 42% of the cases examined from the 1830s also used disinterested language), there was a definitive preference for discursive strategies that distanced the narrator from the medical story, in spite of the fact that the doctor had been an integral part of that story.

This distancing of the doctor from the story was further reflected in a change in the use of social context between the 1830s and 1840s. In the sentimental tradition of 1830s medicine, the use of social context was primarily concerned with the patient's world and experiences. Mentioning family and friends, describing lurid details of the case, and demonstrating the shared nature of suffering were all strategies employed by doctors to "socialize" the medical story—to make it broader or more compelling--by situating the patient within a context that was meaningful to a broad audience. Thus, the focus was on the patient's social context, which was something that the average reader could understand and appreciate.

In the 1840s, contextualization changed. Rather than being primarily concerned with the patient, it shifted to the doctor and specifically to the doctor's privileged medical world. References to events or facts outside of the immediate health problem were increasingly limited to medical precedent or the advice of an outside expert, as reflected in the Grand Affair's repeated use of the "outside expert" at the end of the 1830s. References to this larger medical community—its members and its knowledge base—served as a way of asserting the primacy of doctors in the illness experience.

In 1844, for example, a doctor named Pellegrini offered an observation of a 30-year-old woman whose labor had been stalled by the presence of a tumor that was blocking the infant's exit. Called by the local midwife, after the woman had been in labor for 24 hours, Pellegrini first considered a surgical intervention, but was able to use forceps to facilitate the birth with "minimal difficulty." After following the case to its happy outcome (including an unproblematic birth a year and a half later), Pellegrini continued:

> The majority of doctors have made mention of small varicose veins that they have encountered near the uterine orifice, but none has mentioned, that we know of, varicose veins that grow without breaking and swell in such a way as to block the head's passage. In Puchelt's remarkable report, one finds a complete review of all tumors that have been seen to impede childbirth: *exostoses* [bone tumors], *osteo-stéatomes* [bone cysts], and *sarcomes* [tumors of the connective tissue], etc. But in the middle of this long series of tumors, one finds no trace of varicose tumors of the cervix. […]. This observation is a new example of the prudence necessary in obstetrical observations. What would have happened if doctor Pellegrini, obeying his first instinct, had cut the first part of that tumor? Quite probably, a fatal hemorrhage would have been the result. It is therefore always necessary to observe that wise precept of obstetrics: do whatever is possible by hand, then by blunt instruments; but use sharp, cutting instruments only as a last resort, and only when the diagnosis is firmly established.[22]

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[22]G. Pellegrini, "Observations des tumeurs qui ont mis obstacle à l'accouchement," *Archives générales de médecine* 4, no. 5 (August 1844): 503-504.

In this case, there was no mention of the woman's husband or her circle of friends. There was no suggestion of imprudent behavior that might have caused the tumor. In fact, the only thing Pellegrini referenced, outside of the immediate facts of the case, was the state of professional medical knowledge. He cited a very specific medical text (Pechult's) and specialized knowledge (intractable tumors of the pelvic cavity) and, in so doing, narrowed the social world of the case study. In so doing, doctors took the final step in medicalizing the experience of illness and effectively limited his audience to true medical professionals. No one else could have understood it without help, making this text, at lease in one respect, intimidating. The social context in this case was the medical community, a conversation for professionals.

This medical community played an equally important role in an 1845 case study of a young woman who died while giving birth to a child who presented with both head and foot simultaneously. Before launching into the facts of the case, the author, a doctor Roberty, contextualized that case with statistical information from both the United Kingdom and France to demonstrate its rarity:

> In effect, out of 18,387 births that have taken place, in the span of six and a half years, at the Maternity Hospital in Dublin, Dr. J. Clarke has not seen even one example. […]. It was the same for Merriman, who had delivered 1800 women, and of Dr. Janson, from Ghent, who, in 44 years, had seen 13,365 births. On the other side, madame Lachapelle, in 15, 380 births, and madame Boivin, in 20,357, signaled only 3 examples. That makes 3 examples of this sort out of 75,903 or 1 in 25,301.[23]

Again, there was no mention of the young woman's life outside of this medical event; the social connection came from the medical community and its shared body of knowledge. Thus, the 1840s in French medicine saw a distinct change in the use of social context, as

[23]R. Roberty, "Présentation simultané de la tête et d'un pied, dans un cas d'accouchement," *Archives generales des médecine* 4, no. 11 (May 1846): 109.

doctors adopted and adapted realist concepts of externality and distance in the creation of a medical identity based on shared expertise and restricted access—the ability of doctors to know and do what others could not.

We have already seen how nineteenth-century medical identities were bound up in the empirical ideal of the individual experience. In the 1840s, however, the understanding of the case as a genre of medical identity changed, not dramatically, but enough to reflect a change in the medical community's sense of self. Experience remained paramount, but the focus on the individual case changed to reflect the increasing significance of the medical collective. The idea was there, as early as the late 1820s, in the prevalence of statistical studies of the social order. The debate over evidence-based medicine that preoccupied the French medical community in the 1820s was essentially a question about the nature of medical identity. The new approach to social context in realist medicine allowed doctors to merge those two identities in a coherent manner. By shifting social context from the patient's world to the doctor's, the authors of medical case studies were able to ground their individual treatments in the "mass of facts" that Dupuytren had demanded two decades earlier.

IV. Tribunal of Experience

While the individual case repeatedly asserted its primacy in the dispute, the power of statistics remained a recurring undertone, as when a doctor named François-Gabriel Boisseau outlined a number of obstacles to the progress of medicine. For Boisseau, medical advances lay in careful observation (at the individual level) *and* in the equally careful reporting of those observations (at the collective level). Without either of these

elements, medicine would fail. Medicine, he argued, was effective only when reason and observation came together under the banner of "empiricism" and all the "enlightenment" that accompanied experiential certainty. Medicine, then, required both theory and practice; only together could there be progress.[24] Medicine found its purpose in certainty, simplicity, and practicality.

French doctors in the 1840s embraced this dual purpose and the changed view of empirical experience that it implied. Education, observation, and application were bound up in concepts of impersonal detachment and distance, which were expected to promote rational, unbiased consideration. To ensure that ideal, doctors (following Boisseau's advice) promoted an ideal of linguistic transparency, in which descriptors were absolute, expected to describe the material world in a manner that was the same for every reader. It was a model borrowed from realist traditions, rooted as they were in a strong belief in the descriptive value of the material world. Unlike the realist tradition, however, transparent precision in medicine was not intended to be meaningful to everyone. Where realist authors attempted to use language that could be understood by as many people as possible (essential to accurate representation), medical realism (or linguistic precision) was intended for initiates, people who shared a common knowledge base. It was meant for other doctors. Consequently, medical texts of the 1840s began to embrace official terminology and increasingly complex descriptions of the conditions they were treating.

Sharp focus and technical exactitude in language reference a knowledge base that was shared between reader and author, as exemplified in an 1844 observation of a uterine rupture during childbirth published by doctor Velpeau. The patient, a 24-year-old

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[24]François-Gabriel Boisseau, " Memoire sur certain obstacles au progres de la médecine," AME, Box 3, MS 2196

woman, was brought to the *Hôpital de la Charité* after a lengthy labor had failed to produce a child, even after the local doctor tried to use forceps. Her pathology was extensive:

> The child presented with his upper extremity; the head was strongly lodged in the pelvis; the uterus had in its left posterior portion, near the cervical region, a tear several centimeters in length; the uterine tissue seemed to have been shredded, bruised by the forceps; but, as the instrument had not, at that point, been pressed into the belly [*ventre*], it seemed probable that the tear had not been completely caused by the use of the [forceps'] arm, which produced only one serious scratch, but that perforation was complete only once the woman fell. The discharge of liquids and dead fetal matter into the belly followed immediately afterwards. The tissues were gangrenous, emphysematic; there was pus in the abdomen.[25]

Terms like "superior extremity" and "emphysematic" would have been meaningful only to readers with a particular set of experiences, namely other doctors. Though an educated reader might have been able to grasp the terminology on some level, comprehension would have been, at best, rudimentary. For it is one thing to understand the meaning of the term "gangrenous" and another thing entirely to understand the impact that gangrenous tissue would have had upon contact with this woman's interior abdominal cavity. Note also how the doctor did not expand on those meanings, but rather assumed an understanding from his readers. For that reason, he moved quickly to a discussion, not of the impact of the gangrenous tissue, but of the exact dimensions of the uterus before and after rupture.

Doctors' technical linguistic choices were deliberate and directly connected to their professional status. For comparative purposes, it is instructive to examine a different case study (also of a complicated birth) published in the same journal seven months later, but this time written by a respected midwife rather than by a doctor.

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[25]Velpeau, "Rupture de l'utéruse pendant le travail," *La Lancette Française* 8 (January 1844): 30.

Though it was not a case of uterine rupture, it did involve a premature rupture of the amniotic sac, putrefaction of the placenta, and infection in the uterine cavity (a combination that could be just as dangerous to a pregnant woman as uterine rupture). The language used by the midwife to describe the placenta was significantly less technical than that offered by Velpeau:

> Today, August 1, I learned that [the baby's] health is perfect and that is what made me decide to published this observation, which appears to me to be quite interesting. I will try later to bring out the most salient facts. Delivery [of the placenta] occurred a few moments after the expulsion of the child. The placenta, as well as the membranes, presented with a remarkable degree of advanced putrefaction; they released the nauseating odor of putrefaction; the tissue of these organs was in tatters and crepitation due to the release of gas occurred. The odor was strong and repulsive […].[26]

Mercier's description of the birth she facilitated was significantly different from Velpeau's, in spite of the fact that they were both primarily concerned with explaining the complications that had arisen during their respective deliveries by examining the physical markers of said complications. Velpau was concerned with explaining the tear in his patient's uterine wall, while Mercier focused on the putrefied placenta that had been at the root of infection.

Mercier's description was far more focused on her sensory experience of the scene, describing the "repulsive" smell of the placenta and the "tattered" appearance of the amniotic sac. Hers was a description that was easily comprehensible to any educated reader, particularly when compared with Velpeau's technical language, intended only for

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[26]Mercier, "Accouchement, rupture des membranes 4 heures avant l'expulsion du foetus, écoulement des eaux, putrefaction du placenta et de ses membranes, possibilité de l'introduction de l'air dans la cavité de l'amnios," *La Lancette Française* 97 (August 1844): 388. **Crepitation**, according to the *McGraw-Hill Concise Dictionary of Modern Medicine* is "a 'crunching' of tissue caused by presence of gas, which may occur in Lung disease; Spontaneous rupture of small pulmonary blebs–most common in young men, which causes mediastinal or apical emphysema of little clinical significance

experts. That Mercier, as a midwife, was not truly part of the same medical community is clearly reflected in these distinctions in writing style. It therefore becomes equally clear that realist strategies in the 1840s were tied to a dichotomous medical sense of self-in-collective. Technical, specialized language was used to delineate those who belonged to a realm privileged by its knowledge and skills from those who did not. The individual doctor, working with his patients each day, derived his power from his association with a much larger, much more elite community.

V. Stripping Away the Adornment

The final category of realist tropes from which French doctors borrowed in the 1840s was a rejection of the embellishment that was common in earlier medical writings. While writers in the later 1820s and early 1830s embraced the emotionality of sentimental writing (the heated passages exchanged between Hélie and Domfront, so rife with insults and outrage, serve as a clear example), their successors in the late 1830s and 1840s used technical jargon and concise language as a direct repudiation of earlier excesses. In one case study, published in 1847 by a doctor named Pluskal, technical language was used to describe a particularly difficult birth.

The local doctor (unnamed) was called to the bedside of a woman who had been in labor for fourteen difficult hours before it was determined that her difficulty was being caused by a shoulder-first presentation (as in the Hélie case 20 years earlier). After verifying that the child was dead, that doctor decided that the best course of action was to remove the child's arm and subsequently to effect a version in order to remove the child safely, again, almost exactly mirroring the events of the Hélie Affair. The two

descriptions of the events that followed, however, could not have been more different. Pluskal described those actions and those that came later in this way:

> After assuring himself of the death of the fetus, he resolved to perform a disarticulation of the arm; the operation was performed easily and successfully; but the remaining [labor] pains proved an insurmountable obstacle to changing the position of the child. It was then that Dr. Pluskal was called. Examining the woman, he found that the right shoulder of the child, who had a wound up to his neck and part of the chest, was engaged and stuck in the entry to the pelvis. The head was in the mother's left iliac space and the bottom was in the right iliac space. Since the pains were very strong and continuous and since the uterus was pushing strongly against the child, it appeared useless and impossible for M. Puskal to attempt a version by the feet, which is why he resolved to try another maneuver. He pushed a *perforateur* between the two sides that he could most easily reach, widened the wound, and, with his hand, removed the viscera inside the chest; then he pushed one of his hands in the interior of the thorax and, pressing strongly on it and guiding it up and to the left, he managed, after about a quarter-hour, to raise the head and lower the bottom into the entrance of the pelvis, with the help of the labor pains that had not stopped. It was then rapidly expelled […].[27]

Where were the protestations of innocence, the claims that, "hand on conscience," the doctor knew everything that the medical literature had to say about shoulder-first presentations? Puskal offered none of these. Instead, he chose to outline (precisely and without ornamentation) the steps taken in deciding on and pursuing a particular course of action. The description of the removal of the child (removing the abdominal contents, reaching into the chest, and maneuvering it from left to right until the child began to budge) was certainly more graphic than anything produced by Hélie, yet it still managed to remain more dispassionate and technical. Puskal was not concerned with the emotional state of his audience or with convincing them of his empathy; he was merely interested in demonstrating his mastery of the knowledge and skills he had needed to use

[27]Pluskal, "Embryotomie et nouvelle méthode de version dans un case d'accouchement," *Archives générales de médecine* 4, no. 13 (January 1847): 121.

in this case. Puskal and Hélie were writing with different audiences and different goals in mind.

Simple, unadorned language was also apparent in an 1848 case study concerning a young woman pregnant again after a caesarean section four years earlier. In the eighth month of this subsequent pregnancy, she went to doctor Behm for help. An exploration revealed the following:

> Instead of considerable narrowing of the pelvis, estimated at *2p* at its smallest point, which had necessitated the prior gastrotomy, he found an almost normal constitution. There was nothing of interest but a considerable angling of the uterus. Nevertheless, the vagina offered a very small expanse; it was hardly *1p* ½ in diameter, and ended in a *cul-de-sac*, at the base of which was a small opening that was hardly the diameter of a crow's feather, and which his finger, in spite of all efforts, could not enlarge. As birth was not expected for another three weeks or a month, M. Behm applied a dilator on that vaginal stricture. Each day, he introduced into the vagina a prepared spongy cylinder, which was changed each morning and evening. By the third application, the narrowing [at the back of the vagina] was sufficiently enlarged to allow a more complete exploration than she had had to that point. […][28]

Behm then continued to describe his successful treatment of the woman, focusing on the fact that his continued application of this sponge widened the cervical opening enough that the woman could have her second baby naturally, without any need of a caesarean section. What is most interesting about this was the straightforward and dispassionate nature of his presentation. There was no sentimental allusion to the maternal bond, no exaggerated description of the patient's suffering, no mystery to solve. There were merely symptoms, diagnoses, and treatments. It was, at its heart, an outright rejection of the type of adornment that characterized earlier case studies. The doctor was still the hero, managing through his actions to help this woman achieve a positive outcome, but

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[28]Behm, "Observation d'accouchement par les voies naturelles chez une femmequi, dans une grossesse anterieure, avait subi l'opération césarienne," *Archives générales de médecine* (): 103 - 104.

his heroism did not come from overcoming adversity or alleviating a patient's torment. It came from a mastery of medical knowledge. Consequently, it was that medical knowledge (shared by a relative few) that became central to the medical identity.

Thus, the unembellished nature of the realist writing style reflected a different kind of medical identity than was emphasized just a decade earlier. Whereas the sentimental style of the late 1820s and 1830s was designed to showcase the connections between doctors and everyone else by demonstrating the social usefulness of medicine, the realist style of the late 1830 and early 1840s reflected a new sense of identity:

> A medical doctor is not only a practitioner; he is, one cannot say this enough, a scholar who should contribute to the progress of the sciences on which his practice is based, so that, little by little, the practice itself is better. I am also speaking of pharmacists of the first class, from our three superior pharmacy schools. Though I find it useless and impossible to require a baccaalureate of letters for general practitioners and pharmacists of a lower order, I must recommend five years of study for anyone who aspires to the title of 'doctor.'[29]

Doctors were consciously creating an elite identity, a privilege that was rooted not in birth, but in expertise. In the very first line, the author, a doctor named Cousin, crafted a dualistic image of the medical doctor in which the individual doctors were both distinct from the collective (as *practitioners* who interacted primarily with patients) and an important part of it (as *scholars* who contributed to the shared pool of knowledge on which practice was based). It was this dual role that set them apart from everyone else in society, even those who claimed a certain level of medical experience. The technical jargon, unadorned language, and dispassionate style, because they were meaningful only to initiates, were intended to demonstrate membership in an exclusive club, as did the

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[29]"M. Cousin, le Comte de Montalembert, Séance des Chambres du Paris," *La Lancette Française* 77 (1 July 1847): 332.

*Gastrotomy is defined by *Merriam-Webster's Dictionary* as "a surgical incision in the stomach."

increasingly stringent licensing and degree requirements being negotiated during the first half of the nineteenth century.

VI. Evaluating Changes over Time

This study began with an examination of one of the most controversial medical cases of the nineteenth century. The descriptions and observations that were traded back and forth in the Hélie Affair of the late 1820s were laden with emotion and sentiment, as the case repeatedly left the realm of the straightforwardly scientific in order to deal in the realm of emotion—grief, anger, and empathy—thus demonstrating a blatant convergence of science and emotion in medical texts of the day. The Hélie Affair therefore introduced us to the idea that medical texts in the first half of the nineteenth century were full of imagery and language that were often more literary than scientific in outlook. Their texts were clearly not the disinterested, dispassionate scientific treatises that one associates with modern medical case studies. Rather, doctors drew from popular culture as they strove to construct narratives that resounded with their audiences. This, in and of itself, is not surprising. In an eighteenth-century age of *corps*, doctors wrote of privilege and distinction. In the Revolutionary clamor over citizenship, doctors wrote of medical rights and responsibilities in a discourse of public health. In the post-Revolutionary quest for recovery and stability, doctors wrote of social value and expertise. That doctors were men of their age is to be expected. That this blurring of boundaries between the literary and the scientific realms was central to the process of medical professionalization is far more surprising.

Specifically, professionalization in early nineteenth-century France depended on doctors' ability to establish both their social value (what made them an indispensable part of society) and their expertise (what set them apart from that same society). As such, nineteenth-century doctors struggled to negotiate the appropriate balance between a discourse of social sentimentalism and a discourse of scientific realism. Both borrowed heavily from the literary trends of the day, but were combined in an ever-shifting balance that reflected the relationship between medicine and society at large, so that the emphasis on a sentimental narrative of social value decreased, while the emphasis on a realist narrative of expertise and unmitigated truth increased. It is only fitting, therefore, that we conclude with a case study from the end of the period in question. What did case studies look like in 1850, on the eve of the scientific and institutional boom so often identified as the birth of professional medicine?

In February 1850, *La Lancette Française* published a case study of childbirth that ended in a spontaneous uterine rupture. The doctor, a man named Church, was able to remove the fetus successfully and to save the mother's life, so he chose to publish this (rare) happy ending in both the British journal *The Lancet* and its French counterpart *La Lancette Française*. Rather than launching immediately into a description of the patient, leaving general considerations for later, as was typical just twenty-five years before, Church began with a discussion of the generalized category of "uterine rupture," suggesting how his individual case study fit into that category:

> The rupture of the uterus is a truly grave accident that is almost always considered fatal. There are therefore in science few cases in which recovery took place after the extraction of the fetus, either by natural means or by caesarean operation. This is an observation in that genre.[30]

With this introduction, Church established the significance of his work in a manner that was unique, when compared to the style of earlier doctors. Whereas doctors writing between 1795 and 1850 had tended to introduce the patient and her background first, a convention designed to ground their patients in their social surroundings, Church placed his emphasis directly on the annals of medicine, a narrowly circumscribed body of knowledge mastered by few. Only after establishing that expertise did he mention *his* case. The emphasis was clearly on the existing medical framework rather than on any specific doctor.

From there, Church proceeded to describe the patient, listing her age, constitution, pregnancies, and general health, in keeping with the general structure of nineteenth-century case studies. He avoided, however, the tendency to emphasize the shocking or mysterious qualities of the case, prevalent in so many earlier cases:

> The birthing labor began on 8 September [1849], at which point the author was called to this woman, during the night; the bag of waters was ruptured; the labor progressed slowly, with strong pains occurring at long intervals; three hours later, the cervix was mostly dilated, and the child's head almost touched the perineum. A half dozen pains completed the labor, at which point the patient cried, 'What a pain I just felt in my stomach! If this continues, I am surely going to die.' Believing, because of the uterine pains, that this [malady] was the result some abnormality around the uterus, the author gave 30 drops of an opium sedative. Soon after, the patient was seized by nausea and vomiting, difficulty breathing; her skin was covered with a cold sweat, and she continued to complain of cramps in her stomach. […] Putting his hand in [her uterus] Mr. Church found a slanting tear extending from the near the base of her uterus to the left side of that organ, the tear through which the fetus has passed into the

[30]J. Church, "Rupture spontanée de l'utérus, survenue pendant le travail de l'accouchement; extraction de l'enfant par les voies naturelles," *La Lancette Française: Gazette des Hopitaux* 21 (16 February 1850): 84.

> peritoneal cavity. Aided by a colleague, Mr. Church went to find the baby, easily able to accomplish it by natural means.[31]

While there were a number of similarities between this case narrative and others we have studied—a surprising discovery in the middle of childbirth, intense pain and suffering for the mother, danger for mother and child—the descriptive lexicon is quite a bit different.

First, it lacked any use of the first person, except in a direct quotation from the patient. The references that Church made to himself were made not using the self-important "I" of so many earlier cases, where doctors highlighted their own role in making decisions that affected the case, but rather in the third person, emphasizing instead procedural and diagnostic methodology (symptom—precedent-based-diagnosis—application). In fact, the only use of the first person in this case study was also the only use of explicit sentimentalism (appearing in Church's description of the patient's fear that she was going to die from her pain). Both were therefore safely compartmentalized within quotation marks that ascribed those emotions to the patient, rather than to the doctor. Second, there was a great deal of emphasis on precise and realistic representation. His descriptions were exact when he outlined his findings and procedures, describing the nature, length, and position of the rupture in detail. Moreover, the remaining six paragraphs in this case study were dedicated to detailed explanation of what Church did, over the course of twenty days, to save this woman (including step-by-step descriptions of all the ingredients in the potions he used, as well as the patient's physical response to his actions).[32]

Compared to the case narratives that emerged from the Hélie Affair, which had highlighted the intense emotionality of the scene, this 1850 case narrative was decidedly

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[31] *Ibid*.
[32] *Ibid*., 83-84.

dispassionate. Whereas Hélie was defending his professional status through emotional pleas to his colleagues, Church's narrative was straightforward. He shifted attention away from himself as an individual doctor, choosing instead to focus on the methodology of his practice. Why, then, were these two case studies, separated by only two and a half decades, so markedly different? Why did one rely on passion and the other on its complete opposite?

The immediate response is to suggest that the answer to this question lay in the extreme circumstances of Hélie's professional crisis, which invalidated the comparison. The Hélie Affair was, after all, a *cause célèbre* of the medical world. The threat of professional destruction and the debilitation of a child were certainly enough to increase emotionality on both sides. Moreover, the raw emotion of the Foucault parents (and their representatives) contributed to the sentimental rhetoric used by Hélie (and *his* representatives) in his medical recounting of the case. So perhaps the overt sentimentalism was an anomaly, the result of unusual circumstances.

To test this, we must compare the Church case with another obstetrical case—a case of uterine rupture—that was contemporaneous with, but not directly connected to, the Hélie Affair. Such a case (sharing the topic, but lacking the scandal of the Hélie Affair) allows for a more accurate comparison by reducing the number of variables in play. Let us examine, therefore, an 1825 observation concerning a 26-year-old woman by whose arduous pregnancy and labor ended in a fatal uterine rupture. In this case narrative, published by Théodore Guibert and Etienne Moulin (both members of the Academy) 25 years before Church's (at the peak of a more passionate, emotional style of medical writing and merely three years before the Hélie Affair), there emerged a

sentimentalist tone that was far more reminiscent of Hélie's writing style than that of of Church.

In describing the causes of her problematic pregnancy, for example, Moulin and Guibert pointed an accusatory finger at the woman's propensity for dancing. In fact, they claimed that the night of her accident (7 August 1825), after a warm bath and a light dinner, she attended a ball, spending a large portion of the night there. It was this imprudence, they wrote, that caused her to faint in the middle of a waltz. Her friends, terrified by her already alarming state, forced her to return home and take to her bed, while they went to get a doctor. The doctor found this woman in a pitiable condition.[33] In contrast to Church, then, Moulin and Guibert painted a very social picture of the patient, placing her in the context of friends, dancing, and even the imprudence of youth. Church, on the other hand, kept a strict focus on the symptom-diagnosis-treatment paradigm that has been characteristic of more modern medical case studies, revealing nothing more than the symptoms his patient displayed when he first saw her.

The authors of the 1825 case study also emphasized the intensity of the suffering that the woman experienced, calling her symptoms "most grave" and her anxiety "inexpressible."[34] At one point, they even mentioned her husband, who came to them in tears, afraid that his wife was dying. All of these elements served to impress upon the reader just how dangerous and painful (for the patient and her loved ones) the situation was. The authors clearly painted a picture of a woman in desperate need of help, following the sentimental model of victimized (female) patient and heroic (male) doctor. For though the doctors tried everything they could—Moulin and Guibert took great pains

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[33]Moulin and Guibert, "Observation d'une rupture de l'utérus à deux mois et demi de grossesse," *Archives générales de médecine* 1, no. 9 (1825): 382-383.
[34]*Ibid*., 383.

to emphasize that fact—the unfortunate woman "died in the most indescribable agony."[35] It was a story designed to evoke pity and empathy within the audience, who, though unsurprised at the death from a medical point of view (uterine rupture was, after all, almost universally fatal in the nineteenth century), would still have felt sympathy for her friends and family, as well as pity for her suffering. By contrast, Church's depiction of the woman's experience was limited to a brief mention of her pain and fear, when she described her belief that she was going to die if the pain did not stop.[36]

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It was not just the extraordinary circumstances surrounding the 1828 Hélie case that set it apart from Church's 1850 version of a similar problematic pregnancy. A relatively unknown (and certainly not controversial) case of uterine rupture published in 1825 had far more in common stylistically with Hélie's writing than with Church's. The direct comparison yields a recognizable change in the way that obstetrical and gynecological *observations* were presented by mid century, as a result of evolving medical identities in the first half of the nineteenth century. Doctors during this period were trying to establish themselves as a stabilizing force in an insecure world, and they did so by validating the rise of the bourgeoisie in France. As the bourgeoisie became increasingly enmeshed in the political power structure of the July Monarchy, the pillars of their rise—the liberal professions—shifted away from a language of social value and moved instead towards a language of expertise, or knowledge that distinguished doctors from others in the French social framework. They used the tropes of literary realism (as a

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[35]*Ibid*., 385.
[36]Church, 84.

complement to, and later replacement of, a the sentimental emphasis on social value of doctors) to portray an elite, disinterested, *expert* medical community in which doctors functioned. This adjustment was ultimately a consequence of the inherent dualism of the medical project; in audience, tone, and purpose, the medical community responded to competing demands with a certain fluidity in the way it presented itself to the public.

7

Conclusion:
Rethinking Professionalization

French medicine in the latter half of the nineteenth century looked much different than it had a mere half-century earlier. It had experienced tremendous growth, over the course of those fifty years, and was increasing finding acceptance within the upper bourgeoisie of which it was unapologetically a part. By 1850, there were approximately 22,000 licensed medical practitioners operating in France, or roughly one doctor for every 1700 people living in the nation at that time.[1] There were 3 *facultés*, 22 *écoles sécondaires,* and 9 *écoles militaires* dedicated to the clinical training of future medical practitioners, with more than 126,000 beds (in thousands of teaching hospitals throughout Paris and the provinces) to aid in that model of experiential learning.[2] Dozens of medical periodicals (both official association journals, generally published once or twice per month, and the smaller hospital gazettes, which appeared as often as three times per week) circulated in the 1850s.[3] Doctors became central figures in the popular literature of the day, appearing in novels, serials, and periodicals, with medicine itself becoming a metaphor for various public "disorders."[4] By the 1870s, doctors were second only to lawyers as the liberal professionals most represented in the Third Republic Parliament.

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[1]Steven Cherry, "Medicine and Rural Health Care in Nineteenth-Century Europe," in *Health and Medicine in Rural Europe (1850-1945)*, ed. Josep Lluis Barona (València: Universitat de València, 2005), 19-62.
[2]Thomas Neville Bonner, *Becoming a Physician: Medical Education in Britain, France, Germany, and the United States, 1750-1945* (Baltimore: Johns Hopkins University Press, 2000)
[3]Joy Harvey, "Faithful to Old Traditions? Paris Clinical Medicine from the Second Empire to the Third Republic (1848-1872)" in *Constructing Paris Medicine* (Amsterdam: Rodopi, 1998), 313-336.
[4]Kathleen Comfort, "Divine Images of Hysteria in Emile Zola's Lourdes," *Nineteenth-Century French Studies* 30, no. 3 (Spring-Summer 2002): 330-346.

So, by the dawn of the second half of the nineteenth century, doctors had become an integral part of the bourgeois French state by the last half of the nineteenth century. Why?

The answer to that question lies in the complicated process of medical professionalization in France. For far too long, history has understood the emergence of modern medicine in France as primarily a function of institutional changes. According to this explanation, modern medicine began when the Revolution cleared out the *ancien régime* hurdles of privilege and allowed for the re-imagining of the medical world, including training and licensing. The overwhelming abundance of (charity and military) hospitals in France offered an unparalleled opportunity for training "at the bedside," which fostered the growth of an approach to medicine that emphasized clinical experience. The prestige of the three *facultés de medicine* (internationally recognized as the first post-graduate medical schools) made France, the clinical model of medicine, and the hospital the center of medical learning in the early nineteenth century. The dominance of these institutions—the clinic and the university, in particular—thus established physical boundaries between those who did and those who did not belong in the medical profession; they excluded popular practitioners, such as midwives and folk healers, by denying them access to medical institutions. Consequently, modern medicine has been understood to be synonymous with the hospital and, later, with the laboratory.

Where this approach breaks down, ultimately, is in its understanding of the complexities of professionalization as a process. To rely too heavily on an institutional model is to miss what truly gives professions like medicine their power to elevate some groupings of people (defined by knowledge and methodology) above others. By contrast,

a cultural understanding of professionalization recognizes the intricacies of negotiating a relationship between the individual and the collective, broadly conceived. I have suggested, therefore, that medical authority in France was not constructed by doctors within the strict confines of institutions, but was rather *given* to them by an audience made up of two distinct, and often contradictory, elements: 1) other doctors; and 2) a bourgeois audience that looked to medicine and science to provide stability after the French Revolution. The path to professionalization was built, therefore, on the *relationship* between intent and reception, between performer and audience, between the elite and the masses.

Generally speaking, professionalization in the nineteenth century occurred when a very specific, clearly delineated body of knowledge (and those who have mastered that knowledge) developed a self-conscious discourse of public value. As a model, this explanation works for lawyers (who described themselves as defenders of liberty), archivists (preservers of the past), teachers (creators of future—and better—citizens) and doctors (savers of lives and health). The establishment of modern medicine was thus built on a blend of social value and expertise, which both broadened its appeal and limited its practice. Accordingly, professionalization must be re-conceptualized as a cultural process, involving not just institutions, training, and licensing, but the self-conscious managing of public identities as well. Professional identity was not imposed; it was negotiated.

In the twenty-first century, medicine purports to be a science, or, at the very least, to conduct itself according to a scientific methodology. Case descriptions follow a precise formula, beginning with the presentation of symptoms, moving through a

diagnostic process to the course of treatment, and then ending with the patient's response to the aforementioned treatment.[5] Language is precise and unemotional, creating a discursive dependence on detachment and disinterest that is, according to Byron Good, reflective of a (mistaken) belief that scientific language can (and should) be "a mirror of nature."[6] Such language promises the elimination of uncertainty and offers the medical profession a standard for unimpeachable service to state and society. This modern expectation of detachment is misleading, however, because, in the words of Good, discourse is a "rich *cultural language* [emphasis in text] linked to a highly specialized version of reality and system of social relations, and when employed in medical care, it joins deep moral concerns with its more obvious technical functions."[7] The value of modern medicine is therefore rooted not in its *actual* functioning as a science, but rather in its ability to *portray itself* as such. Professional medical identity is a discursive negotiation and, for that very reason, is neither straightforward nor transparent. Instead, it is bound up in a series of cultural interactions whereby the patient communicates his or her suffering to a doctor, who then translates it into something bio-medically meaningful. Such interaction, intended as it is to assign objective meaning to a subjective experience, is therefore necessarily constrained by existing cultural narratives of power and control.

The same was true of the medical world in France during the early nineteenth century, as doctors used elements of literary narrative to structure their case studies, particularly those related to the first specialization to emerge in French medicine: obstetrics and gynecology. Two distinct, and often contradictory, styles of writing

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[5]Mark C. Stuart, *The Complete Guide to Medical Writing* (London: Pharmaceutical Press, 2007) 102-103.
[6] Byron Good, *Medicine, Rationality, and Experience: An Anthropological Perspective*, (Cambridge: Cambridge University Press, 1994), 4.
[7]*Ibid*., 5.

emerged in early nineteenth-century French medical texts and were reflective of doctors' struggles to situate themselves within a society that was characterized primarily by the disputed, but nonetheless relentless, rise of the bourgeoisie. The *Académie royale de médecine*, created in 1820, served as a liaison between the state-controlled licensing and training institutions and the individual doctors who interacted with the public. This new clinical-associative model placed doctors in a position of establishing social value both through service to the state and through service to individual patients. As a result, doctors turned to the excessive conventions of sentimental and gothic traditions to bring readers into the story through the use of empathy. Readers were expected to sympathize with a patient's suffering and to want her to find the help she so desperately needed. It was help that came from the doctor. By drawing the reader in this way, doctors assigned value to their own work.

On the other hand, interest, emotion, and social value were not enough to establish medicine as a viable profession amidst the upheaval of the July Monarchy. Between 1830 and 1848, class struggle in the political and social arenas provided near-constant challenges to the growing power of the bourgeoisie. Hence, the emotional excess of the late 1820s and 1830s was balanced by a style of medical writing built around a dispassionate discourse of precision, specificity, and distance borrowed from literary realism. Technical language allowed doctors to craft a discourse that was materially exact, unencumbered by interpretation or symbolism, and to cast themselves as the elite masters of "truth." This rejection of emotionalism allowed doctors to reject their own revolutionary history and to play a far more conservative role in society.

Managing this dichotomy allowed doctor-writers in early nineteenth-century France to emphasize two ideas that were essential to modern professional medicine: 1) that it provided a valuable service to society; and 2) that its membership was elite, comprised of the rare few able to understand it. Medical professionalization, then, was primarily the result of complex interactions between doctors, the state, and society in the first half of the nineteenth century, particularly as the July Monarchy attempted to re-order France in a way that was both progressive (allowing a political voice to the upper bourgeoisie) and conservative (denying that same voice to the lower classes). Medical professionals increasingly associated themselves with the bourgeoisie, not only in composition, but also in subject matter and rhetoric.

The years after the Revolution in France were full of turmoil, with Revolutionaries having displaced many of the old pillars of social authority, but, for the most part, also having failed to replace them with anything meaningful. This was particularly true in the realm of gender and sexuality. Changes in the understanding of citizenship forced revolutionaries to grapple with the question of women and the demands of (and for) female citizenship. And though the Jacobins attempted to answer "the woman question" by outlawing female political clubs in 1793, we have also seen that their solutions were far from universally effective. Well into the Directory and Napoleonic periods, women challenged and exploited the meanings and limits of female citizenship. As a result, people began to look beyond the legislative arena in their effort to find stability in gender relations.

Answers came from a variety of different places, but the most compelling was the realm of science and medicine. Science had, by the early nineteenth century, developed

around itself an aura of truth—a widely accepted notion that "the scientific" was precise and unimpeachable in its empiricism. It is unsurprising, therefore, that some of the most appealing answers to "the woman question" came from medical doctors, a group of people claiming scientific objectivity. Early nineteenth-century French doctors developed a "medicine of women" that emphasized the physiological differences between men and women and, in the process, undermined radical demands for female participation in the political realm. Doctors therefore constituted a powerfully conservative force in an unstable political world precisely because their work rejected all outward signs of politics. Biology, medical professional insisted, had destined the two genders for very different roles; any transgression of those roles caused medical problems. Normative and deviant behaviors were biologized.

In the process, medicine positioned itself as a site of stability in France during the post-Revolutionary period and capitalized on the authority that position granted to doctors. This was particularly reflected in the rise of obstetrics and gynecology as a recognized specialty (and for awhile the only recognized specialty) in early nineteenth-century France. *Accouchement*, and the underlying "medicine of women" that was rooted in a belief that women were defined by their reproductive systems, became a fundamental category of medical identity in post-Revolutionary France, based on the ability of doctors to provide acceptable answers to "the woman question" in post-Revolutionary France.

It was not, however, merely the *subject* that contributed to the rise of medicine in early nineteenth-century France. Its growth was also predicated upon the *form* that the medical study of the female body took in the first half of the nineteenth century, namely the centrality of the case study. Medicine, as a practice, has always lent itself to a

particularly narrative form of communication—individual cases were nothing more or less than the stories of individual patients, after all—and doctors, as practitioners, came in the nineteenth century to rely on the power of the individual case as a category of identity in an often-contentious discipline. Doctors disagreed about everything from the causes of suppressed menstruation to the appropriate treatment for a difficult birth. When it came to the *hows* and *whys* of pathology, the answer was rarely clear-cut and almost never unchallenged, meaning that medicine, as a discipline, was heavily dependent on the art of persuasion. The clinical-associative model of medicine, born of the 1820s, transformed the individual case into a category of proof because it transcended the boundaries erected between the individual and the collective.

Case studies thus evolved as a discourse of proof in early nineteenth-century medicine, as evidenced by the overwhelming number of case studies that appeared in a variety of texts—journals, books, lecture notes, manuscripts. As we have seen, some of the most contentious debates of the day (the Hélie Affair, the Grand Affair, the issue of using *seigle ergoté* to induce labor, the question of caesarean sections in obstetrics, provoked abortions) involved the exchange of individual observations as evidence for their respective arguments. The case became a category of proof, a way to define the expert knowledge that constituted the base of medical practice and, as such, became a key tool in the determination of medical authority and value.

Case studies, then, served an extremely useful purpose in nineteenth-century France, particularly in the realm of obstetrics, where doctors used gender to structure a power dynamic in which the male doctor was in control of the medical story. By translating the female experience into medical terms, these doctors were able to transform

that experience into something meaningful for medicine and the larger society. As such, doctors devoted an inordinate amount of time to ensuring that their cases studies were the most compelling and persuasive elements of their medical writing. Publications that went through multiple revisions reveal that ongoing effort to increase persuasive effectiveness. Trial and error allowed doctors, over the course of the first two decades of the nineteenth century, to develop a distinctive style by the late 1820s.

In relating the events of the case in question, French doctors relied on a number of narrative conventions to help them achieve their goals in their *observations*. Above all, these obstetrical and gynecological narratives were styled in a manner that emphasized the doctor's ultimate control over the medical experience. No longer did the experience of a physical malady belong to a suffering patient; rather, it was medicalized by the case study and given over to the purview of the doctor. Suffering became symptom, and illness became disease, as female physical maladies were transformed into something that could only be identified, understood, and treated by a trained doctor.

Medical identity in early nineteenth-century France, as depicted by case narratives, shifted agency away from female patients and towards male doctors, particularly in the realm of obstetrics, where doctors exploited cultural conceptions of childbirth to take control over something that had been, for centuries, a natural phenomenon. The medicalization of childbirth, then, was central to the professionalization of medicine because it allowed doctors to assume control over an experience that had previously belonged to others (women). Use of the first person, impugning and/or circumscribing the work of other medical practitioners (namely midwives), and highlighting the submissiveness of the patient were all carefully deployed

to create a version of events where doctors became the narrators of medical stories. This control over the story also gave them control over the experience itself. Authority, however, does not exist in a vacuum; its creation involves both intention and reception, so that doctors needed not only to take control over the medical narrative, but also to ensure that such control was accepted and legitimized by their audience. For this, they turned to popular literary narrative.

Borrowing from the conventions of literature meant that doctors could make use of elements of popular culture to construct a story that would be acceptable (even appealing) to an audience divided between experts and non-experts. They looked specifically to three genres of literature—sentimental, gothic, and realist narrative—that were popular in early nineteenth-century France. Each served a distinct purpose in the creation of medical authority. In the late 1820s and early 1830s, sentimental and gothic narrative offered doctors a way to socialize their work, to establish an emotional connection between patient and reader that evoked an empathetic reaction from the reader. The reader was expected to *care* about what happened to the patient. Doctors borrowed from sentimental and gothic narrative to create this empathy in a number of ways, from mentioning the patient's friends and family in order to emphasize the shared suffering of physical malady, to painting the female patient as the victim, while the doctor operated as a sentimental hero. They highlighted the immediacy and intensity of the pain in order to set up the heroic nature of their own intervention. All of this served to draw the reader—expert and lay alike—into a social web of suffering, through the evocation of a desire to help (or at least a desire to see the patient get help) and consequently gave social value to the work of medicine.

Interest and social value were not, however, enough to establish professional medicine in early nineteenth-century France. As the social value of medicine became increasingly accepted by the late 1830s, doctors equally needed to emphasize what set them apart from the rest of society, what made them elite, making it absolutely clear that not everyone could belong to their community. For this, they turned, in the late 1830s and 1840s, to the realist literary tradition and its emphasis on precision and material exactitude. Doctors balanced their use of sentimental and gothic passion with the far more dispassionate style of realist writing and its claim to act as a mirror on reality. Using technical descriptors, unadorned language, and a careful distancing of the narrator from the events being described and other phrases that proclaimed truth, doctors emphasized their ability to understand something few others could, which set them apart from the rest of society.

Doctors in the early nineteenth century thus attempted to strike a balance between a writing style that emphasized social connection and social value and one that emphasized social division and hierarchy. Together, these two concepts formed a foundation for the professionalization of medicine and the authority that accompanied it, with the balance struck between each changing over time. Over the course of the first half of the nineteenth century, as the medical profession grappled with a fluctuating set of demands—coming from both the state and society—its members maintained a certain fluidity to their identity construction. Their emphasis on the social value of medicine, so crucial in the late 1820s and 1830s slowly gave way to a more distanced style of writing that emphasized mastery of a unique knowledge base. The late 1830s and 1840s therefore saw a decrease in the use of sentimental and gothic narrative and an increase in

the use of realist narrative, so that case studies published after 1850 were thus significantly different from those published two or three decades earlier.

What this period in French medical history indicates is that the process of professionalization was equally a process of popularization. The construction of medical identity was as dependent on the audience as it was on the performer. Professionalization required doctors to transform ideas understood and accepted by few into ideas embraced by many. To convince an audience that this constructed authority and value were legitimate, doctors needed to make a case—a compelling one, a *popular* one—that resounded with their audience.

This shift in understanding the process of professionalization likewise necessitates a reconsideration of the interaction between gender, science, and culture as they guided the rise of the bourgeoisie (and the liberal professions) in post-Revolutionary France. All three of these elements blended to create a new type of authority for doctors in modern France, an authority that validated bourgeois norms. The power and prestige of modern medicine in France was thus built on the stability that it was able to offer with regard to questions of gender in the post-Revolutionary period, particularly during the class struggles that characterized the July Monarchy. Medicine offered answers to the woman question that were imbued with a sense of absolute truth—the absolute, unequivocal truth of science. Medicine, though not itself a science in the truest sense of the word, capitalized on the power of science by basing its answers to "the woman question" on biology. As a result of this pseudo-scientific base, in which medical authority firmly placed women within the domestic sphere of marriage and family by defining them as a function of their reproductive capacity, female sexuality was redirected in a way that

validated the normative bourgeois concept of a proper social order. Thus, modern medicine, as it emerged in France after the Revolution, was bound up in questions of gender, just as gender was bound up in questions of modern medicine.

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