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'Not [...] Bodily Illness Merely': Framing Disease and the Physician in the Medical Narratives of Jane Austen and George Eliot

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List of Abbreviations

The following table describes the significance of various abbreviations and acronyms used throughout the thesis.

WORKS BY JANE AUSTEN	
PP	Pride and Prejudice
SS	Sense and Sensibility
NA	Northanger Abbey
EM	Emma
PER	Persuasion
SAN	Sanditon
WORKS BY GEORGE ELIOT	
MM	Middlemarch

Introduction

According to George Rousseau, whose body of research has focused in large part on the relationship between literature and medicine, 'By the late eighteenth century, British literature—especially the prose novel—was quickly absorbing medical content, while medical practice was being transformed to an unprecedented degree' (2011, p. 172).[1] This phenomenon was exacerbated throughout the nineteenth century, when the novel reached a pinnacle in popularity as a literary genre. As Heather Meek has written, reflecting on Rousseau's work on the link between the rise of the medical profession and that of the novel, that

> […] the novel has been seen as a purveyor of medical information: fiction reproduces and reworks conventional medical wisdom as it adopts, challenges, or transforms medical notions […]. Medical ideas and themes are not only disseminated through the novel but also…absorbed and woven into the very fabric of the text, sometimes determining its structure and language (2021, p. 53-54).

In this thesis, I adopt Meek's understanding of the novel as a complex entity functioning as a repository for popularised medical knowledge, a vehicle for its problematisation, and a porous ground easily permeated by the language and structures of scientific disciplines. Moreover, novels need conflict, or tension, for their plots to function. Examining the medical configurations of narrative tension in novels is deeply informative not only about the social and cultural contexts in which a story is inserted, but also about the areas in which the categories of literature and those of medicine are the closest or the furthest apart.

However, as the title of this work already announces, this is not a dissertation that focuses on medicine and novels in general, for my research aims to trace the development of some of the major changes in the medical knowledge and culture of the first half of the nineteenth century by looking at how these transformations are echoed by two prolific and popular authors of that time—Jane Austen and George Eliot. The choice of two "authoresses", as Austen and Eliot would have referred to themselves, is intentional for

[1] For an account of how the origin of the sensationalist novel can be linked to the development of a theory of sensibility and research on the nerves and brain, see George S. Rousseau (2004). Nerves, Spirits and Fibres: Toward the Origins of Sensibility (first published 1975). In: *Nervous Acts* (pp. 157-184). London: Palgrave Macmillan.

two main reasons. Firstly, I wanted to centre my research on women because female bodies are on the front lines of nineteenth-century developments in medicine and medical technologies, as will be seen in the Chapter 2 discussion around how the emergence of gynaecology as a male-dominated medical field further confined women's medical expertise to caregiving roles. In the context of nineteenth century medical science, which showed a growing interest in the pathology of women's bodies and minds, reading women's voices offers important insights into the ways in which they participated in and resisted to the models of knowledge and power that oppressed them.[2] Secondly, I believe that the issue of gender is embedded into the relationship between literature and medicine, or, taking a step back, between the humanities and sciences. As I will discuss in Chapter 1, and as the work of Daston and Galison has made clear (2007), the development of nineteenth-century science is inextricable from the construction of objectivity as a method for suppressing the self in order to achieve scientific truth, (theoretically) uncorrupted by subjective bias. One of the enemies of objectivity thus constructed is the expression of emotions:

> In late nineteenth-century statistics, as in atlas making, objectivity also took on a moral tinge. For example, the British statistician Karl Pearson in 1892 called on enlightened citizens of modern polities to set aside their "own feelings and emotions" for the common good, on the model of the scientist who "has above all things to aim at self-elimination in his judgments, to provide an argument which is as true for each individual mind as for his own." In the making of images, the taking of measurements, the tracing of curves, and many other scientific practices of the latter half of the nineteenth century, self-elimination became an imperative (Daston & Galison, 2007, p. 197).

The openly acknowledged enemy of the scientific will to set aside emotions and feelings was artistic expression, as Daston and Galison remind us: 'The scientific self of the mid-nineteenth century was perceived by contemporaries as diametrically opposed to the artistic self' (2007, p. 37). In *Middlemarch*, for example, the artist Will Ladislaw famously defines the poet as having 'a soul in which knowledge passes instantaneously into feeling, and feeling flashes back as a new organ of knowledge' (*MM,* Ch. 22, p. 155). However, claims of science's untainted objectivity were also used to encode women's

[2] With the important caveat that writers like Austen and Eliot do not challenge many other oppressive structures, such as socio-economic status, being a colonial subject, and experiencing racialisation.

exclusion from scientific training, with the justification that women would be incapable to achieve that self-elimination that was a precondition for scientific thought. As history-of-science scholar Londa Schiebinger has shown in her work *The Mind Has No Sex? Women in the Origins of Modern Science*, the nineteenth century saw the consolidation of a specific flavour of gender essentialism that would become dominant in culture, that of complementarity: 'The doctrine of sexual complementarity developed in the eighteenth century as part of the ideological apparatus associated with the professionalisation of science and the rise of the ideal of motherhood' (Schiebinger, 1989, p. 273). Complementarity and the associated notion of a woman's nature was both the cause and the justification for the exclusion of women from science:

> In 1872, medical professor Theodor von Bischoff argued against the admission of women to medical school, using what he termed the "impartial and certain" methods of science to prove that the "pure and unadulterated feminine nature" was not a scientific one (Schiebinger, 1989, p. 268).

Thus, to read women's accounts of science and scientific culture is to uncover acts of resistance towards a model of knowledge that relegated their gender to specific subjects, and to prioritise an unfolding of the literature and science debate that fundamentally incorporates the issue of gender-based social subordination.

Why Jane Austen and George Eliot, then? Though the pairing might seem unexpected, placing them side by side enables their similarities to emerge. Unlike Eliot, Austen did not set out to write novels about medicine, and yet re-reading Austen during a global pandemic has made the medical content of her later novels much more apparent. As will emerge in my analysis in Chapters 3 and 4, the sick body, illness, and injury, are constant preoccupations for Austen's characters and even affect the romantic plots. The comparison with Eliot's use of medicine and medical knowledge in *Middlemarch*, which is set less than a decade after Austen's later novels, makes Austen's commentary about the 'pathology of everyday life' more apparent (Wiltshire, 1992, p. 155). At the same time, the proximity with Austen emphasises Eliot's exploration of themes of gender. Unlike Austen, whose body of work has been embraced by feminist scholarship, Eliot sits much more ambiguously within feminist criticism, due to the difficulty with reconciling Eliot's own personal success as a novelist (and her scandalous cohabitation with George Henry Lewis) with her tepid engagement with 'the Woman Question' (Ringler, 1983, pp.

55-56).[3] I do not attempt to solve this ambivalence here, but my analysis of women's roles in the medical narratives of Austen and Eliot does highlight both the importance of integrating feminine qualities like empathy, sympathy, and care, within the increasingly professionalised world of (male) medical practitioners. In other words, both Austen and Eliot use medical narratives to reclaim the value of a set of feminine qualities, acquired through socialisation, within the discourse on medicine and the medical profession.

There are two critical frameworks that provide the guiding principles of my analysis: Michel Foucault's notion of the "medical" or "clinical gaze" and Rita Charon's theorisation of "narrative medicine". Ultimately, my argument throughout this thesis is that both Austen and Eliot resist and challenge the growing authority of the nineteenth-century doctor by counteracting the excesses of the (male) clinical gaze with a significant emphasis on narrative power. To unpack this, it is now useful to look at Foucault's and Charon's concepts individually before explaining how their use in tandem is particularly useful for the literary analysis of Austen and Eliot.

Foucault's *The Birth of the Clinic* (1963) has provided an extremely influential theoretical framework for understanding the radical changes in the discourse surrounding disease that have characterised modern Western medicine from the end of the eighteenth century (1973,[4] p. xii). In Foucault's words,

> The space of *configuration* of the disease and the space of *localization* of the illness in the body have been superimposed, in medical experience, for only a relatively short period of time—the period that coincides with nineteenth-century medicine and the privileges accorded to pathological anatomy. This is the period that marks the suzerainty of the gaze, since in the same perceptual field, following the same continuities or the same breaks, experience reads at a glance the visible lesions of the organism and the coherence of pathological forms; the illness is articulated exactly on the body, and its logical distribution is carried out at once in terms of anatomical masses. The 'glance' has simply to exercise its right of origin over truth (1973, pp 3-4).

In the clinic, the patient's body becomes both the site and the structure of disease. Here, the doctor's gaze (often achieved through the mediation of medical instruments) describes

[3] As Ringler reports, though she supported the cause of female education, 'she was at best indifferent, at worst hostile, to the cause of women's suffrage' (1983, p. 55).

[4] The English translation of Foucault's *Birth of the Clinic* first appeared a decade following the publication of the original text, is a footnote so essential here?.

the body with a new grammar that centres pathology and excludes narrative discourses. The doctor's inspection of the diseased body 'silently lets things surface to the observing gaze without disturbing them with discourse' (Foucault, 1973, p. xix).

The significance of Foucault's *Birth of the Clinic* for contemporary criticism of literature and science and for literary criticism more generally is evidently essential, for the notion of the 'clinical gaze' now sits at the convergence of several frameworks that have developed alongside Foucault's or have been influenced by it. The lens of the microscope, one of the key instruments used by the Foucauldian doctor to inspect and frame the body, seamlessly morphs into the lens of the video camera deconstructed by Laura Mulvey's 'Visual Pleasure and Narrative Cinema' (1973), which has introduced the concept of the 'male gaze' in feminist and in media studies discourses. Similarly, postcolonial and decolonial frameworks have been quick to absorb Foucault's concept of the 'speaking eye' (Foucault, 1973, p. 114), to dismantle 'racist-sexist-imperialist constructions of otherness and difference' that are prevalent in societies with historical ties to colonisation and imperialism (Knopf, 2008, p. 7). Though I focus my attention on texts relating the experience of upper-class women, it is important to acknowledge the stratification of discourses built over time onto the Foucauldian concept of 'gaze' as a framework for understanding power and control.

Foucault's theorisation of the clinical gaze has also been easily incorporated into accounts of the history of nineteenth-century medicine because it provides a structure for understanding one of the key changes in the power relationship between the medical practitioner (the subject) looking at the diseased body, and the patient (the object) being looked at. This can be explained as a new power configuration, a disproportionate redistribution of authoritativeness between the narrative of the patient and the narrative of the doctor, the latter being the one prioritised. This is how French and Wear summarise the changes in the relationship between doctor-led and patient-led narratives between the late-eighteenth and the early-nineteenth century:

> Early in the [eighteenth] century, the patient's and the doctor's words are one. […] But over the course of the century, this symmetry fades. Doctors begin to sound like doctors, and patients' voices disappear. Listen, for instance, to this narrative, of a farm labourer, as recounted by a mid-century surgeon. Fifteen years prior to the consultation, 'he got a surfeit (so the country people call any sudden alteration of the blood and juices, by

> drinking cold liquors when they are very hot…).' Already the doctor has distanced himself and his concepts of illness from 'the country people'. […] The doctor has taken over, commandeered the patient's own words, almost unconsciously interpreting them and replacing them with his own medical equivalents. By the 1780s, the patient's narrative was no longer the focus of inquiry in the infirmary (2005, p. 99).

By the early decades of the nineteenth century, descriptive phrases of a patient's illness, such as 'he complained of a slight headach', become formulaic, while doctors' reports from this time show a heavier focus on descriptions originating

> […] from the physical examination of the patient. From such details, doctors adduced the patient's diagnosis. The patient's narrative was replaced by physical diagnosis and post-mortem dissection. The body, the disease, became the focus of the medical gaze, not the patient's version of illness (French & Wear, 2005, p. 100).

What French and Wear mean when they say that 'the doctor has taken over' is that the language of medical case reports, as they show, becomes more "scientific" (French & Wear, 2005, p. 99). A doctor is seen transcribing a farmer's account of chest pain as a 'fluttering in the precordial region', evidently not an expression that could have been used by the patient themselves (French & Wear, 2005, p. 99). Medical reports also become more "objective", relying not on the self but on the "truthful" information provided by medical tools, such as the thermometer and the stethoscope, for 'Living patients were evaluated by respiratory sounds, temperature, pulse, and condition of the oft-drawn blood' (French & Wear, 2005, p. 100). It is a process of convergence between scientific specialisation, new technologies improving accuracy in the measurement of data, the greater role of the hospital versus the home as the *locus* of diagnosis and treatment, and the progressive removal of the patient's narrative authority.

In the novels by Austen and Eliot that are the focus of this thesis there is a continuous tension between the medical gaze of the observer and the narrative authority of the observed. I do not use the words 'doctor' and 'patient', here, because these categories are not fixed in the novels. Austen's *Persuasion* and *Sanditon*, for example, transfer medical authority from the "medical man" to the heroines in whose perspective the narrative voice is immersed, and even Eliot's *Middlemarch* occasionally displaces the medical gaze from the character of Dr Lydgate as a way to problematise it and reflect on its effects on the recipient. Both novelists, I will show, use various configurations of the

medical gaze and narrative authority to challenge traditional power structures and to show the benefits of integrating narrative models (usually women-led ones, characterised by empathy and sympathetic care) within diagnostic and medical practices. Of course, neither Austen nor Eliot explicitly frame their medical narratives in these terms. Therefore, I believe that only an analysis of the moral qualities associated with characters practicing the medical gaze and narrative competence respectively, as well as their various degrees of success within the plots, can shed some light on the systems of values that sustain these novels, and their similarities.

If contemporary discourses on literature and medicine are able to recognise and analyse the importance of narrative, both as a tool for doctor-patient interactions and as a key component of the human experience of illness and disease, it is largely the legacy of the medical humanities research area and of Rita Charon's work on narrative medicine. The medical humanities are, in a sense, the other half of our medicine and literature coin, an effort to show how medicine above all sciences contains both scientific and artistic categories, and how these elements of art should be actively studied and celebrated as an integral part of medical education, with the goal of building a more democratic and inclusive practice of medicine:

> How will medical students make sense of the conundrum that they are simultaneously educated for both sensibility (such as close noticing in anatomy learning and clinical diagnosis) and insensibility (shutting down the 'natural' reactions of aversion and disgust to cadavers, pus, open wounds, vomit, and so forth)? Strangely, it seems hard for medicine to admit that science is not only political (knowledge is power), but also intrinsically aesthetic, where a good rule of thumb is that appreciation precedes explanation: the body is sculptural; chemical formulae are elegant; a pathological specimen may be painterly; and so forth. The aesthetic is inherently challenging as it approaches the sublime, and medical students learn to tolerate the ambiguity that pathology may be for them at once fascinating and repulsive, while for their patients entails suffering. The humanities then are integral to medicine and there is no need to imagine that we must tack them on as added extras (Bleakley, 2019, p. 5).

The medical humanist, then, rejects the construction of objectivity described by Daston and Galison as the removal of the self, recognising that illness can elicit "human" responses such as repulsion (e.g., to bodily fluids) or aesthetic pleasure (e.g., looking at a specimen under the microscope) in the doctor, and that a medical practice that

encompasses both the scientific and the artistic can reach new and expanded areas of knowledge. Having emerged in the 2000s, Rita Charon's *Narrative Medicine* has been one of the catalysts for the medical humanities revolution.

Narrative medicine, in Charon's framework, is

> […] medicine practiced with the narrative competence to recognize, absorb, interpret, and be moved by the stories of illness. […] By telling stories to ourselves and others—in dreams, in diaries, in friendships, in marriages, in therapy sessions—we grow slowly not only to know who we are but also to become who we are. Such fundamental aspects of living as recognizing self and other, connecting with traditions, finding meaning in events, celebrating relationships, and maintaining contact with others are accomplished with the benefit of narrative. A medicine practiced with narrative competence will more ably recognize patients and diseases, convey knowledge and regard, join humbly with colleagues, and accompany patients and their families through the ordeals of illness. These capacities will lead to more humane, more ethical, and perhaps more effective care (Charon, 2006, p.8).

In Charon's approach, I see a spontaneously emerging dialogue with the Foucauldian view of the history of modern medicine, the notion that the authority of science and the doctor was achieved by creating distance, by alienating the patient from their narrative of the (diseased) self. According to Charon, the body is 'self-telling', which means that it 'can and perhaps must speak for its self, despite the drives to separate them, to treat them as unrelated or even antagonistic' (2011, p. 36). Charon illustrates this concept by relating a patient-doctor conversation in which a woman suffering from alcoholism, in describing her experience, hints at a correlation between alcohol use and an unhappy marriage (2011, p. 36). To practice narrative medicine is to accept and welcome the idea that the private dimension of the self often overlaps with the body and might, at times, be made visible (Charon, 2011, p. 36). If Charon sees the body as *self*-telling, I might describe Foucault's conceptualisation of the body under the clinical gaze as self-*telling*, meaning that everything that medicine can reveal is revealed by the body. Under the clinical gaze, the separation between body and self is complete, and only one is the object of medicine, for 'the illness is articulated exactly on the body, and its logical distribution is carried out at once in terms of anatomical masses. The 'glance' has simply to exercise its right of origin over truth' (Foucault, 1973, p. 4).

To be guided by Foucault and Charon in the analysis of the texts by Austen and Eliot, then, is to explore the boundaries and the intersections of the clinical gaze and the use of narrative in how the doctor-patient relationship is represented by these authors, and to notice when gaze is prioritised over narrative, and when narrative power is used to resist the excesses of gaze. An important clarification is needed, here. While Foucault's framework has a historiographical component, as it seeks to provide a set of categories to understand how the concept of the clinic and the disproportionate distribution of power in the doctor-patient encounter developed out of nineteenth-century ideologies and practices, Charon's medicine is projected into the future. This is to say that the practice of narrative medicine envisioned by Charon is not the same as the heightened focus on patient's narrative that preceded the establishment of the clinic and the clinical gaze. In fact, as will be seen in Chapter 1 and Chapter 2, one of the main reasons why eighteenth-century medicine was much more focused on patient's narrative is that chances that medical diagnoses would bring cures were slim. When not projected toward bringing a cure, 'medicine becomes a more amorphous territory than otherwise, extending to many realms of human life' (Rousseau, 2011, p. 172). By contrast, Charon's narrative medicine centres cure, and broadens its definition to include aspects of the human that were overlooked by a hyper-focused attention on healing the body. Still, Charon's categories are useful precisely because they intentionally expand upon inherited definitions of medicine and cure, and because they incorporate elements of listening and care that have long been framed, by "men of science", as incompatible with the scientific method, into successful medical practice. In my analysis of Austen and Eliot, I wish to unearth elements of a similar intentionality in two female authors writing at the dawn of medical professionalisation and the medical gaze.

This is a thesis about systems of knowledge and systems of power. Chapters 1 and 2 endeavour to provide a thorough historical and cultural background for my literary analysis by contextualising the key issues of the literature and science divide, the professionalisation of medicine, and the role of women in nineteenth-century medicine. Chapter 1 retraces the steps that allowed medical science to consolidate its authority during the nineteenth century while discussing the peculiar position that medicine occupies within the debate over the 'Two Cultures' of literature and science popularised by C. P. Snow in the sixties. Chapter 2 turns the focus on the history of women's

experience of medicine as both practitioners and patients. In particular, it draws attention to the way in which the rise of the (male) doctor came at the expense of female nurses and midwives, who eventually lost authority over women's healthcare. A portion of this research is dedicated to the implications of male doctors' encounters with female bodies, analysing the ways in which medicine promoted a pathologized understanding of women's bodies and minds. This chapter, then, introduces the medical narratives of Austen and Eliot, discussing how they fit within this broader historical discourse, and preparing the ground for the specific themes that are the focus of Chapters 3 ad 4. Chapter 3 explores the tension between gaze and narrative by looking at how Austen and Eliot engage with nineteenth-century debates over the relationship between body and mind. As will be seen, a consequence of the growing specialisation of scientific disciplines and the localisation of disease in the body was the gradual separation between disorders of the body and disorders of the mind, the latter eventually being explored almost exclusively by psychology. Set at a time when linkages and mutual influences between body and mind remained part of the dominant medical discourse, Austen and Eliot's narratives use representations of bodily and mental disorders to comment on the limitations of medical science. Further, their exploration of such ailments as biliousness, gout, hypochondria, and mental strain functions as a vehicle for voicing anxieties about the looming social transformations produced by middle-class mobility and the emerging culture of consumerism. Lastly, in Chapter 4 I examine the ways in which Austen and Eliot construct alternative models for authority in their novels, through narrative structures, characterisation, and patterns of success or failure. The final section is dedicated to the various strategies used by Austen and Eliot as novelists, as well as by the characters created by them (be they virtuous, like Austen's heroines, or morally ambiguous like Eliot's Rosamond) to reclaim the cohesion and authoritativeness that only narrative power can grant. Ultimately, each section of the chapters is devoted to unfolding, exploring, and explaining an existing tension. Hierarchies produce tension, and tensions encode hierarchical structures, or systems of power and oppression. This thesis focuses on tensions of gender (bodies socialised as men and women), of disciplines (humanities and sciences), and of methods (gaze and narrative). As I have mentioned at the beginning, tension is the breath of the novel, moving the action and driving the plot. I hope the tensions I consider will function in a similar way, as dynamic forces that move the

research without exhausting it, leaving space for new explorations of systems of power and systems of knowledge.

1 On Medical Authority: Nineteenth-Century Contexts of Literature and Science

1.1 Understanding the Literature and Science Dichotomy

The relationship between literature and science was first described as a dichotomy by C.P. Snow in the 1959 Rede lecture on 'The Two Cultures'.[5] According to Snow, literature and science in post-World-War-II society were two distinct cultures, both 'in an intellectual but also in an anthropological sense' (1959, p. 10). Snow found that literature and science were distinguished by separate interests, attitudes, and approaches, and were permeated by a profound sense of mutual incommunicability. Further, he argued that scientific disciplines were characterised by, yet comfortable with, their internal incommunicability, of the kind existing for example between a biologist and a physicist. The implied message is that literary disciplines tend to be all-encompassing and uncomfortable with the specialisation of knowledge. This idea is reinforced by Snow's claim that, when presented with the two cultures framework, scientists tended to accept his depiction of their "culture", while non-scientists were quick to call his argument an oversimplification (Snow, 1959, p. 8). There are numerous ways to read this claim, but one key is provided by Snow's description of the role of books within scientific culture:

> Of books, though, very little. And of the books which to most literary persons are bread and butter, novels, history, poetry, plays, almost nothing at all. It isn't that they're not interested in the psychological or moral or social life. […] It is much more that the whole literature of the traditional culture doesn't seem to them relevant to those interests. They are, of course, dead wrong. As a result, their imaginative understanding is less than it could be. They are self-impoverished. But what about the other side? They are impoverished too—perhaps more seriously, because they are vainer about it. *They still*

[5] Rede lectures, also known as Barnaby lectures due to being held on St Barnabas' Day (11 June), were a cycle of lectures hosted at Cambridge since the early sixteenth century, and which became an annual appointment from 1858. Originally, the lectures were on the topics of Humanity, Logic, and Philosophy. A full list of Rede Lectures is available from the digitised Archives of the University of Cambridge Library: https://www.lib.cam.ac.uk/university-archives/glossary/rede-lectures, accessed 12 December 2022.

> *like to pretend that the traditional culture is the whole of 'culture'*, as though the natural order didn't exist (1959, pp. 14-15, italics mine).

The divide between literature and science is identified by Snow in the fundamentally different attitudes that scientists and 'literary persons' display toward 'traditional' culture, that is, novels, poetry, history, and plays.

It is difficult to ignore the degree to which Snow's lecture was still imbued in late-Victorian discourses over the legitimacy of scientific education. Snow's lecture was, after all, a response to another debate over the relationship between literature and science that had taken place less than a century earlier in that same lecture hall. In 1882, Matthew Arnold had delivered his own 'Literature and Science*'* lecture, a passionate argument against 'the displacement of humanist by scientific education' (Levine, 1987, p. 12). And who was Arnold feuding with? His ideological opponent was Royal Society Fellow T. H. Huxley, who in 1880 had addressed the first cohort of students enrolled at Birmingham's Mason Science College (now the University of Birmingham). Huxley's main argument was that scientific education could emancipate itself from literary education in the training of future scientists. He indicated languages and sociology as the only other disciplines that could complement a scientist's preparation and relegated the classics to ornamental, rather than fundamental status (Huxley T. H., 1882). Though Arnold and Huxley were both involved in curriculum reforms and collaborated on various occasions, their names would remain permanently enmeshed in their public controversy.[6] As Stefan Collini has observed, 'questions about the proper place of the sciences and the humanities in the nation's educational system appeared to be inextricably entangled with elusive but highly-charged matters of institutional status and social class' (2012, p. XVI). As the son of an elite school's headmaster, Arnold was the embodiment of traditional institutions and education, while Huxley had little formal education and attended a college for surgeons (Collini, 2012, p. xv). This is what the scientific journal *Nature* had to say about Mason College the day before Huxley's opening address:

[6] For an account of the private and public relationship between the two, see D. A. Roos (1977). Matthew Arnold and Thomas Henry Huxley: Two Speeches at the Royal Academy, 1881 and 1883. *Modern Philology*, *74*(3), 316–324.

> By its foundation deed the College is established to provide instruction, as far as possible, in mathematics, abstract and applied; physics, both mathematical and experimental; chemistry, theoretical, practical, and applied; the natural sciences, especially geology and mineralogy, with their application to mines and metallurgy; botany and zoology, with special application to manufactures; physiology, with special reference to the laws of health; the English, French, and German languages; and the scheme may, in the discretion of the trustees, include all such other branches of instruction as will conduce to a sound practical knowledge of scientific subjects, excluding mere literary education ('Mason College', 1880).

The last sentence is a perfect summary of the Arnold v Huxley debate; supporters of Huxley's line of thought believed that 'mere literary education' was not conducive to obtaining a 'sound practical knowledge' of science. As the topic of curriculum reforms in medicine is directly linked to the process of professionalisation, it is useful to introduce some historical context about the rise of the medical profession, although this process will be explored in more depth in later sections of this chapter and in Chapter 4. At present, it is important to note that removing the requirement for the literary education of doctors constituted and implicit attack at the institutions that had for centuries exercised a monopoly over the profession, namely the Royal College of Physicians. In fact, the London-based College of Physicians, which only admitted members educated in Oxford or Cambridge, had the power to prosecute 'non-members who charged for medical advice within a seven-mile radius of the City' (French & Wear, 2005, p. 53). The Medical Act of 1858 was the first major challenge to this institution, for it established and regulated the figure of the general practitioner, ending the guild-based system of apothecaries, surgeons, and physicians, and enabling other schools both within and outside London to provide medical courses and examinations (French & Wear, 2005, p. 187) As reported by Parry & Parry (2018), the Royal College of Physicians had strongly opposed the reform 'on the ground that they expected that the equalisation of entry qualifications to the profession would produce greater homogeneity, but only at the expense of pulling down the status and privileges of the physician' (p. 126). The division between surgeons and physicians, with the previously mentioned barriers preventing access to the College of Physicians, had produced the flourishing of medical universities in Scotland. Edinburgh-educated surgeons received an education differing from that of comparable English institutions for the 'integration of a wide range of medical and allied subjects', including

‘anatomy and surgery, botany, chemistry as applied to pharmacy, and midwifery’ (Waddington 1973, cited in Parry & Parry, 2018, p. 105). It can be seen, therefore, how the removal of the formal distinction between surgeon and physician would result in competing models of education in which educational background and status were unambiguously entrenched.

For the current discussion, I aim to disentangle the historical manifestation of this ideological rift between science and literature, which is represented at least partially by the divergent schools of thought of medical curriculum reformers, from the theoretical structures that produced it. To do so, the first step is to justify why the debate carries ongoing relevance for current criticism. George Levine provides a clear explanation when he states that ‘The divergence of the scientific and literary discourse remains critically important because of the question of authority’ (1987, p. 11). However, Levine identifies scientific authority with the pursuit of truth. The scientist, and I would add the nineteenth- and twentieth-century scientist in particular, ‘will work with an unselfconscious confidence that they are in the business of describing the real’ (1987, p. 15). By contrast, the arts and humanities are not interested in objective truth despite having been traversed by movements such as realism, and can therefore position themselves as both separate from scientific discourse and capable of incorporating it into their own by framing it as narration, or mythology (Levine, 1987). This ability of literary discourse to include scientific theory within its own structures is further exemplified by Levine’s observations about the humanities’ relationship with Thomas Kuhn’s *The Structure of Scientific Revolutions* (1962):

> Thomas Kuhn’s enormously influential theory of scientific revolutions seemed to speak directly to the needs and interests of the literary-critical community and was fairly quickly absorbed into its discourse. “Paradigm” … is part of the critical vocabulary (Levine, 1987, p. 13).

Literary discourse successfully embraces theoretical constructions of the history of science and scientific methods, subsuming them within its own framework. Interpretation is to literature what discovery is to science, and by positioning interpretation above discovery, the humanities seek to retain theoretical control over disciplines whose practical applications have historically grown more and more impenetrable to the non-specialist, to the point of incommunicability. In attempting to shed some light as to why

this is, my argument here is that the tension within the literature and science divide is not caused solely by their competing searches for authority but is also a struggle for power. The power of literature can be said to lie in its ability to include the most diverse discourses within a narrative construction, while science expresses power through its pursuit of data-backed truths and the production of new technologies.

One issue with analysing literature and science in terms of their irreconcilable methods and pursuits and of their battle for theoretical, cultural, and political power, is the risk of erasing the areas where their interests and methods overlap, as well as their long history of coexistence as ways to see the world. In fact, much of literary criticism has been devoted to resolving this apparent chasm by analysing the overlapping areas existing in the specific language, pursuits, and knowledge produced by literature and science. The first notable example was *Literature and Science* (1963) by Aldous Huxley, the grandson of Arnold's ideological opponent. In this volume, Huxley identified the beginning of scientific progress with the pursuit of quantities, and the specialisation of scientific language with the pursuit of clarity (1963, p. 12). Where literary language seeks uniqueness, which allows experimenting with rhetorical devices, scientific language seeks brevity and conciseness (Huxley A., 1963, p. 13). Scientific language becomes 'purified', repetition is favoured over literary uniqueness, and jargonization becomes a stable, positive feature (Huxley A., 1963, pp. 16-17). However, Huxley found in science the ability to both burn and build bridges with the natural world and its representations (1963, p. 110). In terms of burning bridges, Huxley cites how Keats reportedly lamented the way in which Newtonian physics 'de-poeticized man's world and robbed it of its meaning'—a reference to the poem 'Lamia', in which the phrase 'unweave a rainbow' is an apparent reference to Newton's experiments with prisms (Huxley A., 1963, p. 111; Keats, 1820, line 237). Nevertheless, Huxley notes that, ultimately, what this meant for poetry was that the world came to be perceived not as a symbol for something external, but as being an intrinsically meaningful and poetic thing in and of itself. Gillian Beer's *Darwin's Plots* (1983) offers another account of the contaminations between literature and science through a study of the literary language of Charles Darwin followed by an account of evolutionary narratives in the works of late Victorian novelists such as George Eliot and Thomas Hardy. As Beer thoroughly demonstrates through her analysis,

> What is remarkable about the mid- and late nineteenth century is that instead of ignoring or rebutting attempts to set scientific writing and literature side by side, as is sometimes the case in our time, both novelists and scientists were very much aware of the potentiality released by the congruities of their methods and ends (Beer, 2009, p. 84).

While these accounts certainly challenge the notion of a rigid dichotomy between literature and science, I would argue that they do not dismiss the idea that the source of the ambivalence characterising their relationship is an overarching battle for authority and power. The fact that Darwin's *Origin of the Species* (1854) was rooted in literary language and structures can simultaneously confirm that scientific writing and the imagination have not always been incompatible, historically speaking, and reinforce the notion that the decline in the authority of imaginative discourses is the reason why this is no longer the case. Why did Darwin write in the way he did? Matthew Arnold claimed in his lecture that Darwin 'once owned to a friend that for his part he did not experience the necessity for two things which most men find so necessary to them–poetry and religion; science and the domestic affections, he thought, were enough' (cited in Super, 1974, p. 65). Yet his classical education and literary influences show in his writing, which is rich in metaphorical language in addition to contemporary discourses—some have noticed the presence of Malthusian vocabulary, for example (Levine, 1987). What is interesting about Arnold's anecdotal evidence, here, is the fact that Darwin felt that he could emancipate himself from literary discourse—despite it permeating the language of his scientific pursuits—while Arnold was attempting to legitimise the study of his texts as comparable to the *belles lettres* due to their cultural influence. This tension features again in Snow's lecture, in which he describes scientists as having completed the process of emancipation from the humanities. In this tension, I believe, lies a struggle for power as both a way to influence political and economic decisions and as cultural relevance.

It is clear from the way in which the literature and science question has been formulated, by T.H. Huxley, Arnold, and Snow, that the question of power is closely tied to that of knowledge production. As A. Huxley wrote, 'the precondition of any fruitful relationship between literature and science is knowledge' (1963, pp. 70-71). As already discussed, Levine took this idea a step further by describing scientific knowledge as being preoccupied with truth and describing the "real world". Yet there is another important element which Huxley and particularly Levine acknowledge, and that is the

transformative relationship that science has with the natural world. Expanding on the point about the quick absorption of Kuhn's theory into literary criticism, Levine comments on how the humanities have, at times too easily, dismissed the scientific pursuit of truth as a mythology to reject (Levine, 1987, p. 14). He expresses uneasiness about the facile 'rejoicing at our liberation from the authority of science […] as long as it fails to confront our commonsense perception of the power of science to manipulate reality' (ibid.). This is indeed a major trapping of any attempt to analyse the literature and science dichotomy. At core, it is an unfair fight, for where science can exit the ideological battleground at any point to continue experimenting, manipulating, and modifying the physical world, literature is left alone to ponder either the theoretical or, increasingly, the ethical failings of such manipulations. Science's ability to exercise its authority in more than one realm is precisely the reason why it can affirm its independence from literary discourse. Any attempt to reframe scientific thought into purely theoretical terms in order to subsume its underlying principles within an overarching philosophy of the humanities must be flawed. It would be too tempting to label this aspect of the literature and science relationship as a form of envy that literary discourse exercises over the scientific to lament the former's confinement to the realm of representation. What I argue, instead, is that this tension is the product of a conflict with rather more material expressions and repercussions.

As Western science started to emerge out of the experimental method of Newton and Galilei in the seventeenth century, and as its transformative properties began to find productive applications in the accumulation of material goods, science's power started to grow (Levine, 1987, p. 7; Collini, 2012, p. x). Its first and most notable adversary was religious power, whose attempts to rein in scientific discoveries were numerous, starting with Galilei's famous abjuration under duress. Upon closer examination, there is a lot of common ground between the religion and science and the literature and science dichotomy—narration is pivotal in both religion and literature, and both have an active power of influencing constructions of society through representation. Where the parallels seemingly end is upon a comparison between the material powers that were historically held by religious as opposed to literary institutions. It is not difficult to identify the political powers and institutions at play in the Catholic Church's attack of Galilei, or even in the Creationists' refusal to abandon dogma for Darwin's scientific argument. Literary

discourse, however, has rarely been identified with political power. The aesthetic movement of realism in the nineteenth century has solidified literature's role as a repository for broader culture, which in its hands is collected, re-elaborated, and transformed into artistic objects. But for centuries, until scientific inquiry began to shift its focus 'from the phenomena presented to consciousness by the senses to their invisible and tangible components' (Huxley A. , 1963, p. 7), male members of the upper classes acquired a literary education prior to embarking on their careers as landowners, lawyers, or politicians. By including, in literary discourse, the material power exercised by political institutions whose members' personal education rested on literature, it is easier to see how the literature and science divide cannot be understood as separate from a divide between two methods of manipulating and influencing the world, each represented by different establishments. As shown by the Arnold v Huxley debate, this divide became visible and urgent, culminating in a public controversy, at the end of the nineteenth century. The manifestations of science in nineteenth-century literary narratives, some of which are the object of this thesis' discussion, are in this view reframed as attempts to halt, challenge, or rethink scientific power in literary terms. I argue that these efforts were rooted in an underlying desire for the reappropriation of a power once possessed by the humanities and which was slipping away, expressed as a reaffirmation of literature's ability to hold life and the human within the unified space of the imagination. In turn, I propose that such desire was born out of a growing and pervasive anxiety surrounding the changing social order brought about by science's ability to physically shape and manipulate matter. To this point, Levine's analysis offers another important examination of the changing relationship that poets and novelists displayed toward science and the scientist throughout the nineteenth century. He paints a picture of the early nineteenth-century author as displaying a 'love-hate' relationship with science (Levine, 1987, p. 22). On the one hand, this author is concerned with the overreaching ambition of science; at face value, Mary Shelley's *Frankenstein* is one such story, with Victor's narrative functioning as Shakesperean-like hamartia (Levine, 1987, p. 22). On the other hand, the nineteenth-century author is attracted by 'the enormous possibilities of science' (ibid.), which led Dickens to fill 'the pages of his weekly journals with popularizations of scientific thought', to use but one example (Levine, 1987, p. 23). Adding fuel to this tension is the issue of professionalisation. Ruskin had 'deep respect for the scientific

enterprise' but 'was fighting the professionalization of science' (Levine, 1987, p. 22). Levine links Ruskin's critique of professionalization to his dissatisfaction with specialised scientific language and how it appeared to him as set on a course to destroy the literary imagination. This was not a novel argument. John Donne's 'An Anatomy of the World' (1611) lamented the 'new philosophy' that in dissecting matter would cause the world to appear like lonely atoms, 'all in pieces, all coherence gone' (2014, p. 838 line 213). And Edgar Allan Poe's 'Sonnet—To Science' (1829) [7] offers a similar perspective on the topic:

> Science! true daughter of Old Time thou art!
> Who alterest all things with thy peering eyes.
> Why preyest thou thus upon the poet's heart,
> Vulture, whose wings are dull realities? (In Otis 2020, lines 1-4).

Underneath these poets' protests, however, is perhaps less of a concern for poetic imagination—which seems to have carried on imagining—and more of a sense that, by appropriating the natural world's phenomena and presenting them in a new language, science was beginning to occupy an authoritative role that used to be literature's own. The only way literature could fight this dispossession was through its own language and structures, that is, by incorporating, analysing, and reframing scientific knowledge into verses and narratives.

At this point, it might be useful to address the role of art and artistic thought, which incorporates but is not exhausted by literary discourse, in the dichotomy that locates 'science' at one end of the spectrum. Having framed scientific power as deriving from the ability of science to manipulate reality, it is worth thinking about where this leaves art, arguably possessing a comparable capacity for both theoretical constructions and practical applications. Moreover, artistic representation has had, historically, a closer and more intertwined relationship with truth.[8] One resolution to this seeming contradiction is given by Daston and Galison's study on *Objectivity* (2007). The authors

[7] The *Oxford English Dictionary* attests the first usage of the word "science" to mean 'The intellectual and practical activity encompassing those branches of study that relate to the phenomena of the physical universe and their laws, sometimes with implied exclusion of pure mathematics' as appearing in the late eighteenth century—specifically, in C. F. X. Millot's Elements General History: Part Second, 1779 "science, n.". OED Online. https://www.oed.com/view/Entry/172672?redirectedFrom=science, accessed 11 December 2022.

[8] I am using "artistic" in the *OED* sense 'Of or relating to visual arts such as painting, design, and sculpture, as distinguished from literature, music, etc.' *OED Online*. https://www.oed.com/view/Entry/11241?redirectedFrom=artistic, accessed 13 December 2022.

of this volume trace the trajectory of self-emancipation followed by scientific disciplines in the long nineteenth-century[9] and locate their source of authority in the emergence, in the 1800s, of a new scientific self on a mission to suppress its own subjectivity in pursuit of 'objective' truth (Daston & Galison, 2007). This new objectivity, a concept derived from Kantian epistemology and expanded in the Romantic period by philosophers like Fichte and Schelling, relied precisely on the scientists' process of distancing themselves from the artists by rejecting the authority of drawing from Nature and seeking complete reliance on mechanical images instead (Daston & Galison, 2007). A key argument is that, up until the Enlightenment, 'Neither artists nor anatomists sensed any tension between the demands of truth and those of beauty; on the contrary, an ugly drawing was more than likely a false one' (Daston & Galison, 2007, p. 102). Thus, the artist's power of material representation continued to serve the scientific method, most notably through the illustrations that botanists and anatomists produced for scientific textbooks. However, with the appearance of photography, scientists became concerned with the idealised perfection of the artistic drawing and sought to remove all traces of human manipulation from their observations of the natural world or human anatomy (Daston & Galison, 2007, p. 123). In rejecting the artistic interpretation of reality, seen as carrying an 'inner temptation to theorize, anthropomorphize, beautify, or interpret nature', nineteenth-century scientists were also rejecting the existence of a unified source of authority (Daston & Galison, 2007, p. 139).[10] This was the age of Comtean positivism, when science and technology became sources of power and authority in themselves, making the fracture with art and literature a permanent rift.

Although several areas of science such as biology and physics have been very successful at attaining the type of objectivity that alienates the subjective self, thus emancipating their language, methods, and pursuits from the humanities while solidifying their authoritativeness, there is one field in which such elements as representation, narrative, and subjective experience continue to play an integral part—medicine. As the

[9] The phrase 'long nineteenth century' was coined by Eric Hobsbawm in *The Age of Revolution: 1789-1848* (2000). London: Phoenix (1st ed. 1962). Hobsbawm focused on what he called a 'dual revolution', the French and Industrial, and their transformations on the political and economic landscapes. For the purpose of this discussion, I am adopting this phrase as a way of connecting the consolidation of scientific authority in the mid-to-late nineteenth century to the ideas of self and rationality emerging from the Enlightenment.

[10] Levine made a similar point by arguing that the role of positivism in the history of science can be explained at least partly with the desire to reject the concept of unified authority as emerged from post-Enlightenment and Romantic discussions (Levine, 1987, p. 8).

following section will explore, medicine can bridge the gap and navigate the tension between scientific and literary discourse due to its holistic focus on the human.

1.2 Medicine: The Science of the Human

> I should never have been happy in any profession that did not call forth the highest intellectual strain, and yet keep me in good warm contact with my neighbours. There is nothing like the medical profession for that: one can have the exclusive scientific life that touches the distance and befriend the old fogies in the parish too (*MM* Ch.16, p. 106).

I begin this section with a quotation from *Middlemarch* (1874), in which Dr Lydgate describes his rationale for choosing the medical profession. According to Lydgate, only the medical profession does successfully merge intellectual activity with human connection and is therefore deemed superior to any other. Despite coming from a fictional doctor, the quotation demonstrates a recognition of the inherent presence, in medicine and medical practice, of both scientific knowledge and human understanding. The role of medicine and care in providing reassurance and comfort to the ill and their families will be explored further in later chapters, along with the relevant intersections of gender and class, but the point of convergence between the scientific and the human I believe is useful to focus upon at present is that of patient narratives.

In the early 2000s, Rita Charon's research and practice originated the field that would become known as narrative medicine. In the seminal text of the same name, *Narrative Medicine* (2008), Charon explores the ways in which plot and narrative inhabit the experience of both patient and healer and provides a blueprint for a type of medical practice that successfully integrates the rigorous application of scientific knowledge with the empathetic awareness of the complex yet 'ordinary human experiences that surround pain, suffering, and dying' (Charon, 2008, p. 6). In Charon's view, 'a medicine practised without a genuine and obligating awareness of what patients go through may fulfil its technical goals, but it is an empty medicine, or, at best, half a medicine' (Charon, 2008, p. 6). In this framework, narrative knowledge is what enables medical practitioners to access the patient's experience. Medicine, she writes,

> […] is itself a more narratively inflected enterprise than it realises. Its practice is suffused with attention to life's temporal horizons, with the commitment to describe the singular, with the urge to uncover plot (even though much of what occurs in its realm is, sadly,

> random and plotless), and with an awareness of the intersubjective and ethical nature of healing (Charon, 2008, p. 39).

I have introduced Charon's framework at this stage because it is particularly useful for analysing the developments of nineteenth-century medicine and their literary implications. Several accounts have shown that, until the early 1800s, medical practitioners relied heavily on patient narratives and family history for diagnosing illness (Caldwell, 2004, p. 6; Penner, 2004, p. 2).[11] As both Caldwell and Penner have noted, it was only with the advent of Romantic medicine that disease was effectively located in the body. Eighteenth-century accounts of illness were still heavily dependent on Galenic humoral theory—the notion that good or ill health is determined by the balance or imbalance of blood, phlegm, and bile, the fundamental bodily fluids (Guerrini, 2000, p. 98). An explanation of disease that followed humoral theory was also reliant on the concept of "constitution", which was seen as a person's 'general health and vitality as integrated with the condition of the mind, disposition, and temperament' (Garden, 2007, p. 559). Some constitutions were considered prone to humoral imbalance and therefore ill health, which effectively meant that disease was thought of and discussed as an individual experience rather than in ontological terms. Humoral theory would remain a widespread and largely dominant discourse used to frame perceptions and accounts of disease well into the nineteenth century, particularly within popular medicine, until it became gradually superseded by germ theory (Garden, 2007, p. 559). A comprehensive overview of the origin and developments of germ theory would require a separate discussion, but it is useful to include here a brief summary of a few crucial events. The scientist most widely and closely associated with the development of the germ theory of disease was Joseph Lister, although recent accounts have challenged the notion that he was single-handedly responsible for the development of this theory (Lawrence & Dixey, 1992, pp. 153-154). Lister's theory of developed from a 'germ theory of putrefaction' that

[11] S.J. Reiser's monograph *Medicine and the Reign of Technology* (1978) offers a more in-depth analysis of historical transformations of the doctor-patient relationship and how new technologies helped shape it, including analysis of medical diaries such as Dr Symcotts' casebooks, reporting on events from as early as 1637 (see Chapter 1, 'Examination of the Patient in the Seventeenth and Eighteenth Centuries'). Reiser's account is particularly useful to avoid the danger of using strict categories to explain the gradual change from patient-led to doctor-led narrative. Reiser shows how, though the patient's own account was indeed the preferred diagnosing method in the seventeenth century, doctors of the era also observed physical manifestations of bodily illness and depending on the case in front of them observation may have included touching the body to check temperature, pulse, and deformations of the skin.

allowed him to explain the 'putrefactive origins of epidemic disease' to 'the new, and quite different, German germ theory of infective disease', developed in the late 1870s and 1880s in collaboration with William Watson Cheyne (Lawrence & Dixey, 1992, p. 154). An article by a Dr E.P. Hurd of Massachusetts, which appeared in an 1879 issue of the *Atlanta Medical and Surgical Journal*, shows the coexistence of humoral theory and notions of germ theory:

> The *materies morbi* of fever in general is unknown. The germ theory lacks inductive proof, and certainly cannot apply to sympathetic fever from wounds or surgical operations etc., or to ephemeral or catarrhal fever (p. 412).

Interestingly, it was the doctor's first-hand experience of the inability to break fevers with the use of antiseptics that reinforced the notion that bodily secretion and excretion—thus, its constitution—should be the key to understanding the progress of illness (Hurd, 1879, p. 412). The author of the article does admit, however, to having limited experience, and the purpose of the piece is not to refute germ theory wholeheartedly, but to invite 'caution and judgment' (Hurd, 1879, p. 414). Further, he defends the practice of disputed methods for counteracting fevers, such as cold baths for children, insisting that 'some of us country physicians…have saved lives by these means' (Hurd, 1879, p. 415). The reason for engaging with a document written by a country doctor from the other side of the Atlantic is to show that the medical practitioner filled the gap within the knowledge of the *materies morbi* by paying closer attention to patients' constitution and their response to various methods of treatment. In this context, having an extensive knowledge of a patient's constitution was fundamental for building trust.

The association of doctor-patient trust with a sound understanding of patients' constitution (in its broader connotation of body and character intertwined) is a motif that features frequently in literary representations of doctors. In *Middlemarch,* the arrival of the new doctor Lydgate is met with scepticism, with one character admitting that, though the old doctor was 'coarse and butcher-like', she 'never knew him wrong' because 'he knew my constitution' (*MM* Ch. 10, p. 59). This attitude is indicative of a value system in which understanding the human went hand in hand with understanding anatomy and pathology. And precisely because the concept of constitution referred to a series of physical and personality traits ascribable to a single individual or, in a broader sense, their immediate family, it is possible to see how patient narratives played a major role in

treating the ailments of a specific constitution. In Austen's later novels, in which main and supporting characters frequently engage in discussions on illness and healing methods, a person's constitution is often mentioned as the ultimate explanation for both ailments and behaviours. In *Emma* (1816), constitution provides a needed explanation for Frank Churchill's ill temper in the presence of hot weather, while in *Sanditon* (1817)[12] the Parker sisters declare that they 'have consulted physician after physician in vain, till we are quite convinced that they can do nothing for us and that we must trust to our own knowledge of our own wretched constitutions for any relief' (*SAN* Ch. 5, p. 28). The latter quotation encapsulates the frustration felt by the characters upon discovering the limits of medical knowledge, which could do no better than a layperson's understanding of medicine in treating their ailments. This is precisely where we find the intersection of constitution, patient narrative, and early nineteenth-century medical practice. A doctor's heavy reliance on patient narratives is to be understood in the context of their limited knowledge on the origin of illnesses (Rousseau, 2011, p. 172). Where doctors and patients establish fruitful relationships, medical practitioners fulfil an important social function beyond healing—they provide empathy (Garden, 2007, p. 552). Empathy toward the sick and their suffering is what helped them bridge what Charon calls the "ill-well" divide between patient and doctor. Reflecting on contemporary practices, Charon notes how today's doctor and patient encounters are also encounters between personifications of health and illness created by 'conflicting delusions about…mortality' (2006, p. 24). It is the doctor's dismissal of their own mortality in the presence of another's disease that, in denying a universal human experience, removes all possibility for communication with the death-facing patient. Further, it is the advantage given to the doctor by their superior knowledge and understanding of illness that creates the gap in the first place, and in applying knowledge without empathy the contemporary doctor exercises authority at the expense of human connection (Charon, 2006, p. 24). In Austen's *Emma,* there is a brief exchange in which Mr. Woodhouse responds to an inquiry about the health of local surgeon and valued community member Mr. Perry:

> "Oh! good Mr. Perry--how is he, sir?"
>
> "Why, pretty well; but not quite well. Poor Perry is bilious, and he has not time to take care of himself--he tells me he has not time to take care of himself--which is very sad--

[12] First published in 1925 as *Fragment of a Novel by Jane Austen January-March 1817* (Sutherland, 2019, p. xxix)

> but he is always wanted all round the country. I suppose there is not a man in such practice anywhere. But then there is not so clever a man any where." (*EM* Vol. I*,* Ch. 12, p. 73)

It is a short, humanising moment in which the doctor is shown as participating in the experience of illness, in addition to being self-sacrificing in nature, and it illustrates a doctor-patient relationship in which there is no evident sign of a disproportionate power balance. And the main positive quality with which the doctor is identified is that of cleverness, which feels more relatable to non-medical people than extensive scientific knowledge. Shared humanity, rather than medical knowledge alone, is what lays the foundation for doctor-patient trust in the Highbury community.

As mentioned earlier, by the 1880s it became widely accepted by the scientific community that the origin of fevers resided in 'biological agents', what we now know as viruses and bacteria (Lawrence & Dixey, 2006, p. 154). Lawrence and Dixey attribute the overall low opposition to this theory to the fact that, in addition to the success of Lister's experiments with antiseptic surgery, it fit in well with theories of evolution and the cell (2006, p. 154). With germ theory, the fear of contagion entered the cultural and literary discourse, with important consequences for narratives and plot structures.[13] There is, however, a missing link in the transition from humoral, constitution-focused understandings of disease toward the biology-based theory of germs. The idea that constitution alone could not explain the workings of disease was first challenged by Xavier Bichat's tissue theory at the turn of the eighteenth century. Though the scientific merit of Bichat's ideas has since been largely discredited, the impact of tissue theory can be observed in what Foucault defined as an epistemological shift in the perception of illness (Singy, 2015, p. 565). In *The Birth of the Clinic*, Foucault focused on Bichat's new interpretation of disease as something that starts in the body, as a corruption of the tissues of which it is composed, and which *postmortem* dissection is able to locate and identify (Singy, 2015, p. 565; Caldwell, 2004, p. 5). The 'age of Bichat' is, for Foucault, the turning point for the development of the clinical gaze that will come to define the doctor-patient relationship in the twentieth century (Foucault, 1973, p. 122). Foucault defines the clinical gaze as having both visual and tactile elements, in that it 'records and totalizes'

[13] For an account of how scientific discoveries on the origin and spread of disease influenced Victorian writers' plots see Young Choi, T. (2016). *Anonymous Connections: The Body and Narratives of the Social in Victorian Britain*. University of Michigan Press. Chapter 3 on 'Contagious Narratives' analyses Eliot's use of the multiplot in *Middlemarch* as a narrative extension of its themes of contagion and disease.

bodily signs, but is also 'a gaze of concrete sensibility', for which touch becomes an extension of the eye (pp. 120-121). By moving beyond the external boundaries of the body in search of the origin and progression of disease,

> […] clinical experience sees a new space opening up before it: the tangible space of the body, which at the same time is that opaque mass in which secrets, invisible lesions, and the very mystery of origins lie hidden. The medicine of symptoms will gradually recede, until it finally disappears before the medicine of organs, sites, causes, before a clinic wholly ordered in accordance with pathological anatomy (p. 122).

In other words, Foucault sees a dehumanising push inherent in Bichat's theory, and later embedded into cell theory and the medicine of organs. In creating new bodily boundaries for medical exploration of disease, as well as for its cure, the patient is increasingly identified with the body. And with the development of anaesthesia for surgery in the 1850s (Lawrence, 2006, p. 22), this new patient-body is increasingly silent and passive, while the doctor's gaze becomes totalising. Reduced to a physical being exhibiting symptoms, the patient attracts a lower degree of empathy from the doctor.

Garden's article argues that the alienation of empathy from medical care began in the nineteenth century. Eighteenth-century concepts of sensibility and sympathy, which described physical systems allowing humans to partake in other individuals' experiences of pain and suffering, started experienced criticism from philosophers like Hume and Burke due to preoccupations about 'sharing too completely in another's suffering' (Garden, 2008, p. 560). Incidentally but crucially, both thinkers identified in literature a powerful medium for experiencing sympathy in a filtered, more sustainable way (Garden, 2008, p. 560). The process described by Garden, which begins with the mediation of sympathy and culminates with pitting empathy against objectivity due to 'concerns about overidentification' (Garden, 2008, p. 560), follows the trajectory explained by Daston and Galison. The gradual suppression of empathy can be seen as part of that wider suppression of the subjective self that would allow nineteenth-century scientists to reach 'objective' truths. Eighteenth-century reason, no longer deemed capable of controlling the excesses of imagination and feeling, would give way to the 'the triumph of the will'—the restraint and self-discipline now indispensable to navigate a scientific world of technologies and measurable data without bias (Daston & Galison, 2007, p. 228).

The transition from patient-centred medicine, in which the doctor uses empathy to access and interpret patient narratives, to a doctor-centred medicine in which the body of the patient is to an extent separated from their subjective self for the purposes of diagnosing and treating, did not occur overnight. Caldwell's close readings and analysis of late-eighteenth- and early-nineteenth-century medical case reports shed light on a period of recalibration and negotiation of power balances in which the "history" (patient's narrative) and "physical" (doctor's examination) had equal hermeneutic validity (2004, p. 144). One of the sources cited by Caldwell is a casebook dated 1799 and belonging to Essex surgeon Richard Paxton. Here is how Paxton transcribed an incident of a snake bite involving an adolescent: 'A boy 16 years of age seeking Bird Nests in the Hedges trod upon a Viper wch (*sic*) fastened on his leg on the forepart near the Spine of the Tibia midway between the knee and ankle' (2004, p. 144). There are three notable elements in this report. The first is a mix of medical and colloquial language—"seeking Bird Nests" and "near the Spine of the Tibia" are presented as equally valuable pieces of information in recounting the incident. The second element is Paxton's decision to record the boy's motivation for walking in the area where he was bitten, the seeking of bird nests. As Caldwell notes, this detail is at once the most relevant or irrelevant, depending on whether we consider the point of view of the doctor or the patient as the more authoritative. This is taken as evidence of that ongoing power negotiation between the suffering and the healer, and the narrative authority of each. Lastly, the account of the snakebite is both literary and clinical, for it reads as a cohesive narrative. Here, the boy's motivation for treading in the Hedges provides the plot with a protagonist and an antagonistic viper. And this narrative causality permeates the second part of the doctor's account, which is decidedly more scientific in tone, with the use of the word "fastened" in relation to the behaviour of the snake. Contrasted with a more neutral "crawled", the choice of "fastened" signals the viper's intention of biting, which perhaps affects the listener's perception of the severity of the injury. Therefore, one could say that narration is the web holding together the scientific and the literary elements of a turn-of-the-century medical case report such as Paxton's. In this sense, the Romantic physician/surgeon is a "doctor-writer" who 'often uses the patient's own words, but increasingly notes signs that he has detected from physical examination' (Caldwell, 2004, p.144). Comparing Paxton's case reports with those of Richard Bright, whose first volume of *Reports of Medical Cases*

was published less than two decades later, in 1827, there is already an observable shift in language, and narrative style begins to be supplanted by note-taking and brevity— "pulse 140", "tongue red at the point" (Caldwell, 2004, p. 149). These annotations describe a body being dissected and remove all pronouns, which further creates a sense of detachment between the body and the individual who inhabits it. This process was driven by the development of pathologic anatomy and aided by the advent of technologies such as the stethoscope and microscope. The connection between new medical technologies and the increase in the doctor-patient gap is in line with Daston and Galison's notion of mechanical objectivity, that is, the process of displacing objective observation from the fallible self to the mechanical (and later automatised) registration of data using technology, a process epitomised by the use of photography in the second half of the nineteenth century (Daston and Galison, 2007, p. 42). During auscultation or in looking at diseased tissue through a microscope, the early nineteenth-century doctor begins to view illness as a phenomenon occurring in recognizable patterns, independent of the host (Charon, 2000, p. 25). Humoral theory, constitution, and sympathy increasingly lose authoritativeness and are replaced by a progressively reductionist view of the patient's body, in which disease can be circumscribed to individual organs or tissues (Charon 2000, p. 26). In *Middlemarch*, the old Casaubon is laughed at as he is about to marry the eligible young Dorothea, with one character remarking that 'Somebody put a drop [of his blood] under a magnifying-glass and it was all semicolons and parentheses' (*MM* Ch.8, p. 45). This sentence is a rare giveaway of the temporal gap between the time of publication of the novel (1874) and the period it is set in (1830). Given the precision with which Eliot compiled her timeline of medical advancements in her *Quarry for Middlemarch*[14], the presence of this sightly anachronistic remark in the novel heightens the dehumanising effects of scientific scrutiny. Under the magnifying lens, blood extracted from a person may reveal their state of health, but in this instance the picture of Casaubon's unhealthy blood becomes a proxy for his broader character and suitability for marriage. It is important to note that this remark does not come from a doctor, but from a layperson's own interpretation of the medical knowledge that was trickling down into general culture.

[14] This is the name given by the author to the notebooks containing her research and planning for the novel. Hereafter simply referred to as *Quarry*, it is divided into two parts, one dedicated to 'various scientific and medical matters', including quotes from several *Lancet* articles, the other filled with plot points and chapter outlines (Hornback, 2000, p. 506).

Nevertheless, it is a marker of a cultural change, for disease is no longer deemed mysterious, but can be seen, interpreted, and described to others, making the patient's own account less valuable to the physician than it used to be. The doctor will still request it, as the persistence of the "history and physical" examination in contemporary medicine testifies, but it becomes more easily dismissed when the data clashes with that acquired through mechanical objectivity.[15]

In summary, during the long nineteenth century the medical profession acquired authoritativeness and recognition, not least through a significant expansion of its knowledge and the methods for acquiring it, now involving instruments and tools capable of reading bodily signs more reliably and accurately than the physician's own powers of observation. This comes at the expense of a fundamental shift in the doctor-patient relationship. The space for individual narratives and self-representations of symptoms, personal histories, and experiences of disease is reduced, and so is the opportunity for connecting on a human level with the person administering the cure. According to Bourdieu, this is the beginning of "modern" medicine, 'when physicians asserted their authority as scientists by imposing specialised language on their patients' experiences' (Frank, 1997, p. 6). The doctor's story prevails as the most valid and truthful.

However, although medicine has, to a degree, been successful in distancing itself from the humanities, it cannot emancipate itself completely from narrative and textuality. This is because the acts of curing and caring require intersubjective connection through words, but also because the body, as Charon puts it, cannot (and should not attempted to) be severed from the self (2011, p. 36). According to Charon, the body is 'self-telling', that is, revelatory about the self, for an alcohol consumption-related disease might expose a story about a sad marriage just as a snake bite on the leg reveals a story about seeking bird nests. The degree to which a doctor listens to the self-telling body is variable and has changed throughout history, yet 'even the most robotic surgeon knows that the body alone cannot recover from illness. It needs the motivated agency of the patient's self to do the

[15] It might be useful to provide some more context as to the later trajectory of mechanical objectivity as it pertains to auscultation. In an article that appeared on the *International Journal of Cardiology,* which attempted to reconstruct the various narratives surrounding the 1816 invention of the modern stethoscope by Laënnec, T.O. Cheng includes a few remarks about how the 'use of a stethoscope is an art of medicine that is being lost amid growing reliance on gadgets such as echocardiography, computed tomography, magnetic resonance imaging, cardiac catheterization and angiography.' (2007, p. 284). Compared to contemporary technology, even the instrument that arguably created the conditions for the doctor-patient gap is re-evaluated in a more humanistic light, as a tool that connects the physician to the patient.

physical therapy, take the pills, resist the cholesterol, work out' (Charon, 2011, p. 36). Because of this interdependence of clinical and narrative practices, analysing literary representations of medicine at a crucial time of change in history, namely the 1820s and 1830s, allows us to provide some reconciliation for the literature and science divide. To complete this picture, it is now worth looking at the ways in which the changing attitudes toward medicinal science and the medical profession are reflected in literary narratives. Both the doctor and the novel acquire authoritative status in the first half of the nineteenth century, and this transformation is reflected in plots, characters, and narratives of the period.

1.3 The Doctor in the Novel, from Romantic to Victorian

The discussion surrounding literature and science has so far proceeded under the assumption that literary discourse is built on unified principles, that is, that the ways in which the powers of narrative operate are analogous across the different literary genres. This assumption has been useful to distinguish the specificities of literary versus scientific discourse, yet it omits the fact that the genre of the novel did not always hold the same degree of authoritativeness.

The 1821 edition of the *Quarterly Review* included a piece on *Northanger Abbey* and *Persuasion* by Richard Whateley, which includes the following comments on the emerging genre of novels:

> The times seem to be past when an apology was requisite from reviewers for condescending to notice a novel; […] We are inclined to attribute this change, not so much to an alteration in the public taste, as in [*sic*] the character of the productions in question (Justice, Ed., 2012, p. 208).

At the time of Whateley's review, poetry would have been the genre most readily associated with literature, while prose writing was dedicated primarily to historical or political treatises. According to Whately, then, what allowed novels to be taken seriously was a shift in subject matter, from sensationalism to realism, which consisted in 'presenting to the reader, instead of the splendid scenes of an imaginary world, a correct and striking representation of that which is daily taking place around him' (Justice, Ed., 2012, p. 208). There is a notable overlapping of authority and masculinity in what was defined as 'proper literature', for much of the sensationalist novel production of the late

eighteen century was produced for and by women (Pearson, 1997, p. 636). Austen's *Northanger Abbey* (1817), on which Whateley's review comments, makes explicit reference to the perceived lower status of novels in the cultural landscape, connecting it with the gender of their readers:

> […] there seems almost a general wish of decrying the capacity and undervaluing the labour of the novelist, and of slighting the performances which have only genius, wit, and taste to recommend them. […] "And what are you reading, Miss--?" "Oh! It is only a novel!" replies the young lady, while she lays down her book with affected indifference, or momentary shame (*NA* Ch. 5, p. 23).

In this light, Whateley's previous identification of the reader as unambiguously male feels misplaced and misleading, but it does offer an indication of the type of reader that needed to be impressed by a novel in order not to be ashamed of reading Austen instead of Byron. In praising Austen's novels, both Whateley and Sir Walter Scott,[16] who published a 'Review of *Emma*' in the *Quarterly Review* (1815), compared her works to Flemish paintings for their depictions of subjects 'finished up to nature, and with a precision which delights the reader' (Justice, Ed., 2012, p. 365). Realism would soon dominate the literary landscape of novels and become symbolic of the authoritativeness and legitimacy of the novel as a genre. As reported in Logan, a Victorian physician expressed incredulity, upon reading *Middlemarch*, at the fact that Lydgate's character was not based on a particular individual, a testament to Eliot's imaginative powers (1991). The ability of realist fiction to build upon and integrate reality with the imagination caused important changes in characterisation and subject matter, including the new narrative and moral value given to the doctor in the novel.

I have established by now that the perceived authoritativeness of the medical profession grew exponentially over the nineteenth century, in no small part due to the increased knowledge of anatomy and the origin of fevers—what was known as pathological anatomy. The preceding section focused on the ways in which professionalisation widened the doctor-patient gap by deprioritising empathy as a

[16] One of the most well-known and prolific writers of the time, he published twenty-three novels including *Ivanhoe* (1819) and the *Tales of My Landlord* series (1816;1818; 1819; 1831). He was also a literary critic publishing in the *Edinburgh Review*, *Quarterly Review*, and *Blackwood's Magazine*. Source: Hewitt, D. Scott, Sir Walter (1771–1832), poet and novelist. *Oxford Dictionary of National Biography,* https://doi.org/10.1093/ref:odnb/24928, accessed 30 January 2023.

diagnosing tool, for example by decentring patient-originated narratives. However, it is now worth looking at the areas in which medical professionalisation strengthened the patient's trust in the doctor, albeit under a new set of values, and how this emerging relationship is encapsulated by new characterisations of doctors in the novels of the period.

One of the main threats to the perceived authoritativeness of medical practitioners prior to the regulation of their profession was the danger of quackery. The word 'quack' appeared in Samuel Johnson's *Dictionary* (1755) and included the definition 'a vain boastful pretender to physic, one who proclaims his own Medical abilities in public places' (Porter, 1989, p.4). The lack of regulation and the tough competition within the medicine market meant that the boundaries that separated quack and 'proper' medicine were often extremely blurry (Porter, 1989, p. 4). Further, it has been pointed out that pre-nineteenth-century professionalisation and specialisation, in part due to the limited range of cures available to practitioners as well as the uncertainty surrounding their effectiveness, medical treatments included a stronger performative component (Logan 1991, p. 199). This attitude is reminiscent of the "premodern" experience of illness as described and analysed in anthropological research, which can be summarised as an overwhelming sense of impotence in its presence (Frank, 1997, p. 4)[17]. In other words,

> The old practitioners engage in the broad gestures of treatment, as though playing to the balconies and trying to compensate in appearance for what is lacking in substance. To the patients, those gestures are all-important (Logan, 1991, p. 199).

As a result, literary depictions of doctors had long been driven by the comical-satirical elements of their characterisation. This type of doctor is epitomised by the character of Dr Purgon in baroque playwright Molière's *Le Malade Imaginaire* (1673). Molière chooses a *nomen loquens* to name the doctor of his comedy as to represent the nature of his treatments, which were intended to remove the putrid humours causing ailment in Argan's body. Dr Purgon is a "quack", but the play leaves it up to the audience to interpret

[17] Frank uses the terms "premodern", "modern", and "postmodern" to describe Bourdieu's research in ethnomedicine with a focus on North African practices. In this taxonomy, premodern medicine is overpowered by the lack control over disease, modern medicine prioritises the doctor's narrative, and postmodern medicine is overwhelmed by extreme specialisation (Frank, 1997, pp. 4-8). I make no attempt to discuss the merit of Bourdieu's research or review its problematic aspects relating to the Western gaze, but I believe these categories are useful to explain the changing attitudes with which patients expected and reviewed a doctor's performance.

whether his dishonesty lies in the use of fake medicinal cures or in his choice to exploit Argan's hypochondria to sell expensive remedies, or both. The comedy that ensues in each Argan-Purgon encounter is determined both by the audience's knowledge that none of the prescribed cures are going to heal the protagonist, and by the understanding that Argan's symptoms are more of an indication of his refusal to live than the manifestation of any "real" illness. Although the audience doubts Argan's patient-narrative, the play does not offer any positive, non-caricatural representation of either medicine or doctors. It is impossible to extract medicine from comedy.

While Georgian-era representations of doctors were centred on satire, things began to shift during the Romantic period. Doctors began to appear in novels as 'minor professional archetypes' (Sparks, 2016, p. 13). This means that, though they did not yet participate fully in the narrative, they started to possess sufficient authoritativeness as to exonerate them from satirical portrayals. Austen's novels offer the perfect example of this type of characterisation. With the exception of *Emma*, where Mr Perry is a participating member of the Highbury community and is nominated throughout the novel, Austen's doctors usually offer brief appearances at pivotal plot points. The doctor in *Sense and Sensibility* (1811) is called to treat Marianne's illness, and similarly a doctor is summoned to look at Louisa's head injury in *Persuasion*. However, as Sparks notes, 'the doctor's significance to [the] fictional plot is checked by his relative inability to control nature' (2016, p. 15). As I will explore in more detail in Chapter 4, the practice of nursing (usually carried out by a loving character, either a relative or a romantic interest) is portrayed as equally, if not more, effective for the recovery of the ill characters as the doctor's intervention. Despite such limitations to the trust displayed by the plot and narrator toward doctors, the fact that none of the doctors appearing in Austen's works are cartoonish or comically "quack" cannot be underestimated. Austen's satire rarely spares any subjects, as her ridicule of clergymen shows. One possible explanation for this would be the seriousness of the situations in which doctors appear in her novels. This fits the narratives in *Sense and Sensibility* and *Persuasion*, but fails to explain the dynamic in *Emma*, where Mr Perry is frequently represented in comedic situations, yet the readers do not laugh at him, but rather at Mr Woodhouse's anxious interpretations of his medical recommendations. I believe that neither respect for the profession nor issues of note and narration alone explain the absence of a Purgon-inspired character in Austen's novels. I

would argue that is it precisely the uncertainty, both economical and of social status, in which medical practitioners still operated in the late Georgian era that relegated them within an ambiguous character space. The Austenian doctor eschews one-dimensionality but is not admitted into full development either. In *Emma*, the lower point in the protagonist's character arc occurs when she mocks Miss Bates, an act of transgression which is promptly condemned by Mr Knightley. In the argument that ensues, he says:

> Were she a woman of fortune, I would leave every harmless absurdity to take its chance, I would not quarrel with you for any liberties of manner. Were she your equal in situation—but, […] She is poor; (*EM* Vol. III, Ch. 7, p. 259).

To use a current expression, Austen never punches down on characters belonging to the lower classes; her pungent satire is reserved to the ridiculous manners displayed by members of the gentry or those admitted into their social circles, for example the Bingley sisters in *Pride and Prejudice*. As Sparks reports,

> Until the mid-nineteenth century, doctors overwhelmingly belonged to the lower-middle class, and most received their training in hospital schools or through apprenticeships; […] As a young man, Sir James Paget (1814–99), a middle-class man who later became physician extraordinaire to the Queen, writes about skipping meals and "learning the value of dates and raisins for averting hunger," and about delaying his engagement for eight years until he could afford to marry his fiancée (2016, p. 12).

Sparks' monograph *The Doctor in the Novel* addresses the cultural changes that led medical professionals from existing at the margins of literary narratives to influencing the structure of the marriage plot in the Victorian era, where a physician like Dr Lydgate is not only central to the representation of the life of the town, but is bound to a 'marital plot that uniquely represents his professional orientation' (2016, p. 3).[18]

Before expanding on how the characterisation of Lydgate in *Middlemarch* embodies a new type of doctor representation, that of the doctor-hero, it is useful to follow

[18] It should be noted that the Victorian era witnessed the rise of the middle classes more generally, and many other professions that would have been denigrated a few decades earlier reached new and stronger authoritative status (Sparks, 2016, p. 14). Lizzie Bennett's uncle Mr Gardiner, a lawyer living in London, is laughed at or disdained by several upper-class characters in *Pride and Prejudice*, whereas Victorian literature has numerous examples of successful and wealthy lawyers, from Mr Jennings in Dickens' *Great Expectations* (1861) to Mr Standish in *Middlemarch.* However, the argument here is that doctors did not simply become worthy of literary representation, but that their appearance in the novel fundamentally affected plots and narratives.

the somewhat tangential route that is the portrayal of doctors in novels with a supernatural element. A year after Austen's premature death, the literary landscape was once again transformed by the publication of *Frankenstein* (1818) by Mary Shelley. In this novel, the doctor's god-like ability to manipulate nature is met with ethical and moral concerns. In the novel, Victor Frankenstein builds a lot of his knowledge and expertise in medicine and science outside of the main institutional channels, so much so that one of the professors at Ingolstadt university where he enrolled expresses appalment upon learning about his research—'Have you…really spent your time in studying such nonsense?' (Shelley, 2008, p. 45). This alone may function as a commentary about the dangers of the absence of clear educational paths for the medical profession. Where the social commentary is more explicit, however, is in the treatment of popular fears around dissection.

According to Sparks, one of the reasons for the relative social marginality of doctors prior to professionalisation was their association with the practice of dissection (2016, p. 13). Dr Frankenstein himself admits that 'often did my human nature turn with loathing from my occupation', referring to the time he spends in the dissecting room (Shelley, 2008, p. 55). Dissection was by no means a new practice—Rembrandt painted the famous *Anatomy Lesson of Dr. Nicolaes Tulp* in 1632. However, its diffusion and perceived importance for medical education was consolidated in the early nineteenth century in tandem with new discoveries in pathological anatomy (Sparks, 2016, p. 13). The moral panic that surrounded the discourse around its ethicality and legitimacy was fuelled by the lack of regulation on the sourcing of bodies and the related issue of grave-robbing (Marshall, 1995, p. 43). The regulation of dissection in the UK can be observed through two important pieces of legislation. These were the 1752 Murder Act, which made dissecting the corpses of murderers compulsory, as an additional form of punishment, and the 1832 Anatomy Act, which granted anatomists access to the unclaimed bodies of destitute factory workers (Marshall, 1995, p. 43).[19] Marshall has reported a link between the establishment of the Royal College of Surgeons in Edinburgh in 1800 and the notable increase in graverobbing cases that year (Marshall, 1995, p. xiii).

[19] Analysing the history of dissection through a class lens would require a separate, lengthy discussion, but it is worth mentioning here that, unsurprisingly, this controversial piece of legislation more than chipped away at poor people's trust in doctors, for it equated poverty with crime. For a fuller account of this history see Ruth Richardson (2001). *Death, Dissection and the Destitute.* London: Phoenix.

The ongoing horrors of the resurrectionists' activity in Edinburgh—the popular name for grave robbers—reached their peak with the Burke and Hare scandal of 1827-28, in which the men were found guilty of a series of murders for the purpose of selling the bodies to a well-known anatomist (Marshall, 1995, pp. 1-2). The Anatomy Act received royal assent only a few years later and, according to Marshall, was a watershed moment defining the beginning of a change in the public perception of dissection, and the cultural importance of the debate is reflected in the publication of *Frankenstein* and its two revised editions of 1823 and 1831 (Marshall, 1995, p. 14). Shelley presents Dr Frankenstein as the true monster of the novel, but within the tale of scientific hubris and immorality, the horrors of grave-robbing gave fuel to contemporary calls for legislation that would give dignity to the anatomist's profession (Coyer, 2017, p. 90). Despite the self-loathing that comes from the pursuit of an activity with strong immoral connotations, the passage describing Victor's visits to the graveyard declares to the reader that 'To examine the causes of life, we must first have recourse to death. I became acquainted with the science of anatomy, but this was not sufficient; I must also observe the natural decay and corruption of the human body' (Shelley, 2008, p. 51).

In the post-*Frankenstein* literary landscape, Victorian-era explorations of the social anxieties surrounding the ethical boundaries of medicine included Stevenson's *The Strange Case of Dr Jekyll and Mr Hyde* (1886) and H.G. Wells' *The Island of Dr Moreau* (1896). These novels appeared at the fin-de siècle, a time when fears of reverse evolution, or degeneration, had entered the social discourse through such writings as those of Cesare Lombroso and Max Nordau. Wells replaces dissection with the horrors of vivisection, but ultimately it is the role of science and of the scientist in society that is at stake in all these novels, as well as the boundaries of scientific research. This type of representation of the medical practitioner is both in contrast with and an extreme stretch of the 'doctor-hero' archetype, the prevalent mode of representation of the doctor in the Victorian novel (Sparks, 2016, p. 15). The doctor-hero is intelligent, armed with high ideals of scientific discovery, and one step away from failure or social and moral fall. *Middlemarch's* Dr Lydgate, as will be discussed, is perhaps the Victorian doctor-hero par excellence, but even his character arc is indebted to *Frankenstein* and its legacy. Like Dr Frankenstein, his ambition rests on the discovery of something that would revolutionise the perception of life and the body—finding the 'primordial tissue' is to Lydgate what the 'principle of

life' is to Victor. Moreover, Lydgate's research and practice is halted by the ethical concerns around dissection practices exhibited by the inhabitants of Middlemarch, which include one Mrs Dollop fearing he 'meant to let the people die in the Hospital, if not to poison them, for the sake of cutting them up' (*MM* Ch. 45, p. 274). Writing retrospectively, the narrator frames these fears as ignorant and unfounded, but the fact remains that the reader never does find out how far Lydgate might have gone in his pursuits had he been enabled by his environment.

Notwithstanding some superficial similarities between Lydgate and Frankenstein, Lydgate's story is that of a failed, rather than fallen, doctor-hero. Eliot's *Quarry* includes excerpts from surgeon diaries, editorial pieces, and reports (sourced primarily from the medical journal *The Lancet*) that together create the image of medical professionalisation in 1830 as an obstacle course. Among the issues that filled the journal that year were the fact that the Royal College of Physicians excluded Edinburgh-trained practitioners from practicing in the London area, and fixed scales of fees for visits, which penalised the poor and were financially damaging to new practitioners (Eliot, 2000, pp. 550-553). Though well-connected, Lydgate struggles in the novel due to a conflict between his ambition to create a new fever hospital that would treat people and research disease on a larger scale—the early 1830s saw several cholera outbreaks across Europe—and his inability to live up to the expensive lifestyle he inadvertently enters after marrying the most eligible of Middlemarch's *nouveau riche*. As will be discussed in the chapters that follow, there are various elements that demand a more nuanced reading of both Lydgate's ambition and his subsequent failure. Nevertheless, his storyline cements the doctor in the Victorian novel as capable of holding protagonist status and eliciting empathy in the reader toward both his personal situation and his medical undertakings.

The appearance of the doctor as a fully-fledged character in the novel, at a time when both the genre of novels and the medical profession were establishing their respective authority within the literary and scientific fields, can also be read as an attempt to reassert literature's cultural hegemony in society. The literary imagination is capable of recreating life-like situations and characters, and of building interactions that lead to a deeper understanding of the origins, purposes, and applications of scientific knowledge. However, by pointing the magnifying lens at the interactions of literature and medicine in the writing of Jane Austen and George Eliot, this dissertation will not attempt to resolve

the power struggle between literature and science, but rather examine the complexities of power and its representations. A deeper look at the ramifications of medicine, doctoring, and the politics of care in these authors' works will allow to disentangle nineteenth-centuries anxieties surrounding power relations from wider phenomena of social class and gender mobility. In the following chapter, I will introduce the role played by gender in shaping the changing perceptions of scientific and medical authoritativeness before discussing the ways in which Austen and Eliot incorporate gender, medicine, and power in their writing.

2 The Medical Narratives of Jane Austen and George Eliot

2.1 Medicine and Nineteenth-Century Women

In Chapter 1 I have described two pivotal changes in nineteenth-century medical science, and how they shaped the relationship with the humanities and the human. The first change was the increase in authoritativeness achieved by medicine. In the process of achieving higher authoritative status, medical science distanced itself from more subjective ways of knowing, for example by placing patient-led narratives below doctor-led observations when diagnosing illness. The second change consisted in the codification and regulation of the medical profession in Britain, which unified—on paper, at least—the different classes of medical practitioners (physicians, surgeons, and apothecaries), and conferred them a higher degree of authority and influence over the diagnosis and treatment of disease. Aided by new technologies including the stethoscope and microscope, as well as by the innovations brought by surgical anaesthesia and a more rigorous and regulated practice of dissection for training and research, the nineteenth-century doctor increasingly locates and treats disease by directing the clinical gaze toward a body that is silent and still. This is not to suggest that nineteenth-century medicine considered the body as the sole or primary location of disease. Quite the contrary, for the interplay of body and mind permeated both scientific and literary culture. The eighteenth-century interest in nervous disorders, from hypochondria to dyspepsia and hysteria, was amplified in the nineteenth century, through the rise and development of psychology (Hare, 1991, p. 43). By the *fin de siècle,* nervous disorders were understood in conjunction with unsanitary living conditions, excessive physical and mental labour, and new technologies, as is unfolded in the collection of essays *Anxious Times* edited by Bonea et al. (2019). Chapter 3 of this

dissertation will be devoted to exploring the mind-body connection and how it relates to medical practice in Austen and Eliot. However, despite being unable to isolate disease in the body alone, the nineteenth-century doctor isolates its bodily symptoms and prioritises his own observations over interactions with the patient and their internal experience of illness. Thus, the patient is increasingly treated as an unreliable narrator, and their experiences are reframed and reformulated by the medical practitioner's gaze. This section explores the impact of these scientific and cultural changes on the relationship between (male) doctors and female patients in the nineteenth century. Specifically, I will look at the construction of the clinical gaze as an expression of masculine authority, and at pathologized representations of the female body.

Starting with the equation between masculinity and authoritativeness, it is perhaps more useful to begin with the deconstruction of objectivity operated by feminist thinkers. Daston and Galison's account of objectivity acknowledges feminist critiques of objectivity as a masculinist framework in passing, along with debates occurring within political and philosophical circles that pondered 'over the existence, desirability, or both of objectivity in science' (2007, p. 52). However, they make the conscious decision not to engage with these debates, which are deemed to be purely conceptual and 'an unpromising tool for the task of understanding what objectivity is, much less how it came to be what it is' (Daston & Galison, 2007, p. 52). While I see the merit of their methodology and the results it produced, it seems to me that by refusing to engage with feminist analyses of objectivity as a concept and as part of the history of science, they miss an opportunity to explain some societal repercussions of objectivity, for example in the gendered division of labour.

Donna Haraway's 'Situated Knowledges' (1988), which is referenced in Daston and Galison's *Objectivity*, offers an overview of the problem of reconciling objectivity, science, and feminism. This essay appeared at a time when second-wave feminism had long entered cultural discourse and reflects on the intricacies and contradictions that emerged in 1970s feminist re-interpretations of the notion of objectivity. Haraway criticises early feminist accounts of the notion of objectivity, which she finds lacking in complexity and resting on a 'them versus us' explanation of objectivity in science (1988, p. 575). According to this view, objectivity is a patriarchal construction historically employed as scientific justification for gender oppression. Haraway, however, rejects

such a linear interpretation, arguing that science is but rhetoric, and that 'all knowledge is a condensed node in an agonistic power field' (1988, p. 577). And though objectivity in science may have historically been theorised and enforced by men, she questions whether its epistemological principles may be abstracted and reworked into feminist discourse, just as Marxism was (Haraway, 1988, p. 578). In doing so, she attempts to separate the theory of knowledge from its application, and envisions 'feminist accounts of objectivity and embodiment' as requiring

> […] that the object of knowledge be pictured as an actor and an agent, not as a screen or a ground or resource, never finally as a slave to the master that closes off the dialectic in his unique agency and his authorship of "objective" knowledge (Haraway, 1988, p.592).

Put simply, feminist objectivity is not hierarchical, it operates horizontally and has the ability to hold both the knower and what is being known within a space of equal authoritativeness. However abstract Haraway's theorisation might appear, it nonetheless provides a useful tool for analysing the role played by gender in power dynamics involving medical objectivity, where viewing the female body as 'a screen or a ground or resource' can and has led to stripping women of their agency and bodily autonomy. It also offers another framework for reading literary representations of objectivity in medicine. As I will show in the following sections of this chapter, the representation of medicine and medical knowledge in Austen and Eliot is underscored by the question of women's authoritativeness in their doctor-adjacent roles of nursing and caregivers. Characters like Anne Elliot and Dorothea Brooke eschew simple categorisation by being both constrained by their social environment and by being allowed to emerge as authoritative figures in key narrative places. Before delving into the medical narratives of Austen and Eliot, with an emphasis on issues of gender, it is useful to paint a clearer picture of what being a woman in need of medical care entailed in the nineteenth century.

In piecing together some key context regarding women's interactions with medical professionals in nineteenth-century England, it must first be acknowledged that there are several factors that would have affected their experience of medical care, such as socio-economic conditions and personal characteristics like age and race.[20] Most of the

[20] In *The Age of Hypochondria* (2010), G. C. Grinnell dedicates a chapter to the medical history of Mary Prince. Prince was born an enslaved woman in Bermuda who, upon abolition, was brought to England as a servant and was able to run away from her master and dictate her life's memory, published in 1831 as *The*

sources and first-hand accounts that have survived the test of history come from middle- and upper-class women, despite recent efforts to recover marginalised voices.[21] In acknowledging that this is a skewed perspective, I nonetheless endeavour to provide an overview of how issues of gender and gender-based oppression intersected with the previously discussed changes in medical professionalism and the doctor-patient gap.

Recounting René Laënnec's 1816 invention of the stethoscope, Reiser notes that the doctor was persuaded by his colleague Gaspard Bayle's efforts to detect acoustic phenomena in the diseased body by applying his ear to the patient's chest, having previously dismissed the Hippocratic theory of sound in disease (1978, p. 25). However, he 'used it sparingly because he found it inconvenient and distasteful to move his ear over the patient's chest, and the procedure often embarrassed the patient' (Reiser, 1978, p. 25). The apex of discomfort occurred when Laënnec

> […] examined a young woman who had a baffling heart disorder. To diagnose her illness he tried to use percussion and palpitation (pressing the hand upon the body to detect internal abnormalities): the patient's obesity thwarted both techniques. He then thought of placing his ear to her chest to listen to her heart, but the patient's youth and sex restrained him. Then a fact in acoustics flashed through Laennec's mind. He remembered that sound travelling through solid bodies becomes augmented (Reiser, 1978, p. 25).

According to Reiser's account, the awkwardness of touching another's body was felt by Laënnec regardless of gender, yet it is not until the encounter with a young female patient in need of manual auscultation that Laënnec is prompted to create a tool allowing him to mediate and overcome this physical and social boundary. In this instance, it is implied that the doctor would not have resorted to ear-on-chest auscultation had he not found an alternative method. Laënnec's attitude reveals the complex negotiations and public performance of the social roles of medical practitioner and man. As I have described, early-nineteenth-century medical practitioners treated their patients as clients, thereby

History of Mary Prince. Grinnell explores Prince's own account of her health as displaying both evidence of severe mistreatment and adherence to the conventions of a type of performative hypochondria that characterised the Romantic era.

[21] See, for example, F. Boos (2017). *Memoirs of Victorian Working-Class Women: The Hard Way Up*. Basingstoke: Palgrave. Boos historicises the memoirs discussed, including analyses of the degree of editorial manipulation that working-class women received in telling their own story. Chapter 3 on the autobiographical account of Mary Prince, a formerly enslaved person born in 1788 Bermuda who dictated her life story to her editor, is particularly noteworthy.

standing on a more equal footing in their interaction with them and behaving in accordance with their prescribed social roles. It is easier to understand, then, how the rules of propriety interfered with medical duties when a male surgeon or physician would interact with female patients, even more so if they were young and unmarried. This additional social distance was heightened by the perception of female anatomy as mysterious. The restrictions imposed on bodies available for dissection—which, pre-1832 Anatomy act, were limited to those convicted of murder—meant that 'female bodies were prized as rare commodities; pregnant female cadavers were doubly rare' (McGrath, 2002, p. 63). That is why the 1774 treatise *Anatomy of the Human Gravid Uterus* by British anatomist William Hunter was so remarkable (Daston & Galison, 2007, p. 75).[22] Hunter dissected and analysed thirteen different subjects, at various stages in their pregnancy, and included thirty-four large plates depicting the corpses (Daston & Galison, 2007, p.75). Despite these efforts, knowledge of the female body remained extremely limited. If, to this scarcity of information, we add the rigid social norms that governed interactions between men and women, it is easy to see how the doctor-patient gap for women was already a considerable one. Under-researched and often misunderstood, the pathology of the female body was readily misattributed to women's weak constitution, or to nervous disorders.

Reflecting on how the stethoscope ignited a chain reaction in the development of the clinical gaze, Foucault has the following to say:

> Instrumental mediation outside the body authorizes a withdrawal that measures the moral distance involved; the prohibition of physical contact makes it possible to fix the virtual image of what is occurring well below the visible area. For the hidden, the distance of shame is a projection screen. What one *cannot* see is shown in the distance from what one *must not* see. Thus armed, the medical gaze embraces more than is said by the word 'gaze' alone. It contains within a single structure different sensorial fields (1973, p. 164).

In other words, medical instruments allowed to bridge the physical boundary that previously separated the doctor from the patient. The medical gaze extends beyond what

[22] Hunter was one of the first male midwives at a time when men started to be preferred to women in the birthing chamber of middle and upper-class families, as will be discussed later. See W. Bynum & R. Porter (Eds.), (1985). *William Hunter and the Eighteenth-Century Medical World*. Cambridge: Cambridge University Press. This volume offers a comprehensive account of his medical education and career in the field of obstetrics, as well as on the impact of his work.

is accessible visually and incorporates tactile information, and the patient's body becomes 'a screen or a ground or resource', to use Haraway's words, on which the doctor reads and interprets signs of disease (Haraway, 1988, p. 592). At the same time, as explained by Foucault, the space between the instrument and the body is also a type of screen, but what is projected onto it are the social norms and morals that prohibit physical contact, expressed as shame. Medical tools provided medical professionals with a mediated eye that crossed the physical boundary separating the clinical gaze from the body being analysed while simultaneously increasing the doctor's detachment from their patients. The stronger the reliance on mechanical instruments to examine the body, the bigger the medical distance separating doctor and patient, which in turn makes it possible to cross what would otherwise be perceived as inviolable moral boundaries. Nineteenth-century developments in the diagnosis and treatment of diseases affecting women and women's bodies best exemplify this process.

The increasing specialisation of the medical profession that occurred during the nineteenth century had important consequences for the diagnosis and treatment of "women's" illnesses, as well as for the relationship between medicine and female anatomy. As reported by Emma Rees, toward the half of the century there was a transfer of authority and control over medicalised female bodies from midwifery to the emerging (and male-dominated) field of gynaecology (2011, p. 120). Ornella Moscucci notes that, just as men's pathology was interpreted as a closely dependent on their environment and lifestyle, women's pathology was analysed and interpreted within the framing of women's social role in the marriage and family (1990, p. 106). However, as this social role was inextricably linked to women's reproductive ability and functions, the field of gynaecology was constructed from the very beginning as a 'science that could explain woman's nature in its various physiological, moral, and social aspects' (1990, p. 107). At the same time, the second half of the nineteenth century witnessed the development of an interventionist approach to the treatment of women's disease (Moscucci, 1990, p. 109). Interventionists advocated for viewing women's reproductive system no longer as 'quasi-sacred' and mysterious, but as a collection of organs that, not unlike other areas of the body, could be affected by corruptions like 'tumours and malformations' that 'had to be treated by surgery' (Moscucci, 1990, p. 110). However, the over-identification of women's body and morality created a barrier for male gynaecologists wishing to establish

the physical examination of the genitalia as an important aspect of medical care. Once again, it was the diffusion of a medical instrument that permanently changed the development of gynaecology and became associated with the field—the speculum. The history of this device, however, is particularly telling of how certain categories, namely Black enslaved women, were exempt from the identification of body and morality and were therefore exploited by medical researchers who would then go on to have successful careers treating members of the upper classes. This was exactly the career trajectory of J. M. Sims, the American surgeon who is now commonly associated with the design of the speculum in its present-day shape (Bankole, 1998, p. 115). Sims developed the speculum as an aid for a specific surgical procedure to repair vesicovaginal fistulas, which caused significant discomfort and incontinence (Bankole, 1998, p. 115).[23] He perfected his technique by practicing on enslaved women in Louisiana, including seventeen-year-old Anarcha, who 'suffered through thirty procedures before closure of the fistula' (Bankole, 1998, p.116). After years of experiments on enslaved women, Sims moved to France where he spent much of his working life (Rees, 2011, p. 120). The authority of the gynaecologist and his practices, then, was built on the oppression and control of marginalised bodies such as racialised ones. Stemming from such a foundation, the doctor-patient gap is not only alienating for the patient, but contains an active, violent principle seeking to maintain oppressive hierarchical structures.

As for the White, upper- and middle-class women's bodies that were elevated as the representation of ideal femininity, they remained somewhat caught between the increased authoritativeness of male gynaecologists and midwives, and resistance from socially established norms of propriety. Sheena Sommers' essay on the debates over male midwifery elucidates this tension and how it was navigated by the medical community (2011, p. 90). In tracing the history of how male midwives came to be preferred by upper-class women during birth, Sommers addresses the merits of the 'fashion and forceps' argument that many historians have advanced (Sommers, 2011, p. 90). According to this view, having a male midwife became fashionable during the the eighteenth and early-nineteenth century due to the specific skills and increased professionalism of male

[23] A vesicovaginal fistula or VVF is 'an abnormal opening between the bladder and the vagina that results in continuous and unremitting urinary incontinence. The entity is one among the most distressing complications of gynecologic and obstetric procedures. The existence of VVF is believed to have been known to the physicians of ancient Egypt, with examples present in mummies before 2,000 years BC.' (Stamatakos et al., 2014, p. 131).

practitioners, which included the ability to use forceps (Sommers, 2011). Forceps had been used by male surgeons in cases of difficult births from as early as the 1700s, but in the mid-eighteenth century their design became publicly available (Sommers, 2011, p. 90). However, only male practitioners were trained in how to use forceps (Sommers, 2011, p. 91). This educational disadvantage prevented midwives from being able to perform the same tasks as their male peers, who were increasingly preferred in the birthing chamber. Despite being more highly skilled, male midwives still had to overcome ideas of impropriety, such as the notion that they would pose a sexual danger to women (Sommers, 2011, p. 97). To counteract these claims, male midwives presented the doctor-patient encounter as the interaction between pure intellect and unsexed bodies (Sommers, 2011, p. 98). Among those proclaiming men's ability to transcend their bodies was a surgeon Louis Lapeyre, who published an 'Enquiry' discussing whether pregnant women 'ought to prefer the assistance of their own sex to that of men-midwives' and whether the assistance of the latter 'is contrary to decency' (1772, p. 3). His principal argument in favour of male-midwifery was that male practitioners were pure intellect, unmoved at the sight of female nudity, which was described as a collection of nerves and tissues (Sommers, 2011, p, 100). As Sommers put it,

> […] Lapeyre and his ilk represented the new mechanical universe engaged in the pursuit of reproductive truths, while the female patients he attended to were contrarily portrayed in more organic metaphors as bodies or body parts. […] As a collection of organs and body parts, the female patient possessed neither sex nor subjectivity (2011, p.100-101).

Reading Lapeyre's enquiry and the types of arguments he presented, it seems clear that constructions of gender played a crucial role in constructions of objectivity in (medical) science. Within the historical creation of objectivity in science through the perfected act of suppressing the self is the belief in the male scientist's exclusive ability to suppress his sexuality when interacting with female bodies. This ensured that, for a many decades, women would be excluded from both the emerging corpus of medical knowledge concerning their biological functions and the related professional fields—in 1890s Providence, Rhode Island, Helen Putnam was one of the first women practicing gynaecology (Rees, 2011, p. 120). The rise of gynaecology in the late-eighteenth and early-nineteenth century, which can be seen as a progression from the popularisation of male midwifery to the authority of the (self-proclaimed) unsexed, intellectual, clinical

gaze, adds another layer to the issue of the widening doctor-patient gap. Efforts to discredit the competence and objectivity displayed by midwives and to reduce women's bodies to nerve bundles detached from a thinking subjectivity made the clinical gaze significantly more othering when directed at women's bodies.[24] Women's bodies and functions, especially reproductive functions, became extremely scrutinised and pathologized, while the medical care available was more and more frequently provided by male doctors presenting themselves as the embodiment of objective thinking. The binary opposition of masculine thinking and feminine feeling was most noticeable in the diagnosis and treatment of nervous disorders, as will be seen in more detail in Chapter 4.

In presenting and addressing the systemic inequalities that have affected women's lives and participation in society throughout history, it is important to provide successful examples of resilience and resistance, to avoid depicting entire generations of women as voiceless or passive. Despite considerable efforts to exclude them from the medical profession, many women continued to train alongside men. One of the most famous women medical professionals of the Victorian period was Florence Nightingale. In the essay-letter 'Midwifery as a Career for Educated Women' (1871), Nightingale envisaged that women could make better midwives than men, and would be preferred in the birthing chamber, at the same time lamenting the state of available training for female midwives and putting forward a proposal for its reform (McDonald, 2005, p. 327). Although, as twenty-first-century observers, we might flinch at the rigid separation of genders in the educational paths she envisioned, her goal was a powerful one even by modern standards. The relevance of her message is certainly not to be found in the way she appeared to circumscribe women's expertise to pregnancy and birth—she herself acknowledged the larger question of 'whether *all* branches of medical and surgical practice shall be exercised by women, even upon women' (McDonald, 2005, p. 326). Despite these limitations, the strength of her message lies in challenging the idea that men's medical knowledge could extend seamlessly and without question to include bodies and experiences so unlike their own. Instead, she made the case for a reclaiming of that knowledge:

[24] Though not all women's bodies were subjected to the same degree or modality of medical scrutiny, as it has been noted.

> But why should the midwives be ignorant? And why (in the great movement that there is now to make women into medical men) should not this branch, midwifery, which they will find no one to contest against them—not at least in the estimation of the patients—be the first ambition of cultivated women? (McDonald, 2005, p. 327).

I have introduced Florence Nightingale in this section not only because she was a successful and influential medically trained woman of her time, but also to problematise the interpretation of writings and testimonies from categories experiencing both marginalisation and power, to varying degrees. Like her contemporary George Eliot, whom she had met as editor of the *Westminster Review* Marian Evans, Nightingale's often ambivalent or outright negative opinions on the brewing first-wave feminist movement has left contemporary critics puzzled (Showalter, 1981, pp. 395-396). However, I agree with Elaine Showalter's reading of Nightingale's (and Eliot's) scepticism towards the Women's Movement as resulting from unconfronted privileges in her life, that 'she was relentlessly upper class' and 'intellectually arrogant in the rejection of the emotions and values of ordinary women' (1981, p. 396). Nightingale's complaints about her perceived laziness of women, which are present in numerous writings by her including the letter cited above, are very much reminiscent of George Eliot's dissatisfaction with the plots and subjects of female novelists, which she attacked in the famous essay 'Silly Novels by Lady Novelists' (1856). Yet, as Showalter explains, Eliot and Nightingale 'represented a "feminine" generation which had internalized many of the precepts of the Victorian sexual code' (1981, p. 406). Despite their 'self-imposed limitations' (ibidem), their often-problematic views did not prevent them from issuing their own challenges to gender roles and masculine authority, whether in medical practice or representation. In the sections that follow, I aim not to paint a definitive picture of the women writers I discuss as feminist or reactionary, using contemporary categories. Rather, I endeavour to recover the ways in which the portrayal of medical knowledge and practice is, in the writings of Jane Austen and George Eliot, a vehicle for critiquing and challenging normative views of gender, power, and authority.

2.2 Illness and Medicine in Jane Austen's Later Novels

When it comes to the representation of illness in Jane Austen's writing, the most immediate interpretation available to readers is biographical. Austen died prematurely in 1817, and as her health conditions started to worsen around a year prior, she began to

work on the posthumously published *Persuasion* and *Sanditon*, leaving the latter unfinished. The fact that these novels also happen to be the ones most deeply infused with themes of illness and cure has not escaped the notice of critics, and in choosing to focus on Austen's treatment of medicine in her later novels I am perhaps guilty of perpetuating an easy association between the author's own experience of illness and the choice to include it more preponderantly in her plots. Therefore, it is necessary to start by deconstructing Jane Austen's relationship with illness, medicine, and doctors, and to separate her biographical experiences from the works of fiction she created.

In *Life of Jane Austen* (1890), British historian Goldwin Smith wrote that Austen penned *Persuasion* with 'the hand of death' hovering above her, of which he saw a symbol in the novel's descriptive indulgence over 'the melancholy charms of autumn' (Meyer Spacks, 2013, p. 223). In her introduction to the text of the novel, Patricia Meyer Spacks has noted that this same attitude towards the declining season can also be interpreted as a symptom of the author's absorption of Romantic aesthetics (Meyer Spacks, 2013, p. 223). In fact, *Persuasion* displays a higher degree of earnestness in portraying self-delusions, inner thoughts, and languid feelings, for Anne's interpretation of the other characters' feelings and actions is not always accurate, but the narrator empathises with her point of view, rather than mocking her for it as it did Emma Woodhouse. Still, the heroine of *Persuasion* is sceptical about excessive displays of feelings, as demonstrated by the way in which she cautions heartbroken Captain Benwick against only reading poetry, an art she deems 'seldom safely enjoyed by those who enjoyed it completely' (*PER* Ch. 11, p.73). Irony, wit, and satire are used to mitigate Romantic aesthetics in *Persuasion*, even though the necessity for tonal coherence within a story permeated by melancholy and loss does not allow them to dominate the narrative, as was the case in Austen's earlier work. *Persuasion* explores the psychology of a main character who, at the beginning of the narration, is unmarried, isolated from her family, forced away from her home, and whose only friend and parental figure Lady Russell is the same person who had insisted Anne end her engagement to then-penniless Frederick Wentworth. Additionally, Anne is older than the heroines that preceded her, and her existence on the edge of spinsterhood is what gives a heavier weight to her choices. As John Wiltshire has noted, all kinds of loss and 'human adjustment' to it occupy a central place in the novel (1992, p. 157), and while the theme of loss can be seen as a shorthand

for illness and death, loss of health, chronic pain, and death are equally reframed as among the many existing variations on the universally human experience of loss.

That Austen was not simply overpowered by a sense of impending death while she was writing her last novels is corroborated by a comparison between the narrative style of *Persuasion* with that of *Sanditon*. The twelve chapters Austen completed are filled with pungent satire and dramatic characters reminiscent of the ones that populated *Pride and Prejudice* or *Emma*. And yet it is impossible to deny that her later novels are more intensely and intently preoccupied with themes of illness, decay, and suffering. *Sanditon* has been described by many as a novel of illness (Darcy, 2018; Wiltshire 1992, p. 155), which is unsurprising considering its entire plot is set at a sea bathing resort for recovering invalids, whose daily struggles with diseases of both grounded and dubious nature fill most of the action. What is more important, in Austen's later explorations of these themes, health and illness evolve from existing as plot points whose resolution pushes the narrative forward to becoming qualities adding complexity to the psychology and actions of central and secondary characters. In *Sense and Sensibility* and *Pride and Prejudice*, illness is used to drive the plot forward. Critic Erika Wright has defined plot-driving illness as the 'cure model of narrative', in which '[n]arrative arises when we get sick; closure happens because we get well' (2016, p. 25). For example, Marianne Dashwood's illness is the catalyst for her marriage with Colonel Brandon, and Jane Bennett's convalescence at the Netherfield estate brings Lizzie and Mr Darcy within the same space, setting up the attraction, conflict, and misunderstandings between them. Starting with *Emma* and growing in intensity in *Persuasion* and *Sanditon*, illness is treated less as something that happens to characters and more as a key part of their characterisation—Mr Woodhouse is a hypochondriac, Admiral Croft is gouty, Mrs Smith is confined to her lodgings. Nevertheless, the boundaries of this change are porous. One area where the earlier novels do display uses of illness as characterisation is in their treatment of women's nervous disorders, the most egregious example being found in the character of Mrs Bennett. Though her pathology and its cause are shown to derive from her stressful condition as a mother of five daughters with no inheritance ('The business of her life was to get her daughters married' *PP* Ch.1, p. 5), both the other characters and the narrator stop short of sincere compassion toward her, primarily relying on her outbursts for comedic purposes. The one character who is unmistakably and somewhat

empathetically defined by her lack of health in the novel is the intended fiancée of Mr Darcy, Lady Catherine's daughter, yet she appears briefly and silently in the story. Things begin to shift in *Emma*, where illness-cure narrative exists alongside invalid characterisation. Harriet Smith catches a cold and is prevented from attending the Christmas dinner party at the Weston estate, which allows Mr Elton to misguidedly propose to Emma—here, someone else's illness affects the protagonist's narrative. Jane Fairfax uses illness as an excuse to return to Highbury and see her secret fiancé Frank Churchill, only to become 'wearied in spirits' when circumstances render the pretence difficult to maintain (*EM* Vol. III, Ch. 6, p. 250). However, illness is also a gateway into character exploration. Throughout the novel, Mr Woodhouse's complaints and health-related anxieties are manifestations of his deeper fears of abandonment even as they make for comedic moments and affect the plot by acting as a restraining force to Emma's independence of will and economic means. For example, he regularly falls into an argument about health when confronted with the separation from a loved one: he tries to convince others of the dangers of cake when Emma's former governess leaves to marry Mr Weston; he argues with his daughter Isabella about her choice to take the children to South End for healthier air during one of her sporadic visits as a married woman with a family. His own complaints are never serious but always present, affecting others. His hypochondria differs from Mrs Bennett's nervous symptoms in that it is taken seriously by the local apothecary and by the other characters, even marginal ones like the former traders Mr and Mrs Cole, who appear to have ordered a folding-screen from London for the sole purpose of making Mr Woodhouse comfortable at their property. The fact that Mr Woodhouse's complaints do not disappear or improve by the end of the novel ultimately means that they must be managed, rather than cured. Austen's *Emma* appears to be kinder toward women's nervous symptoms, too. In this novel, they fall primarily on the character of Jane Fairfax, with whom the reader is made to sympathise, and are more explicitly linked to the overwhelming pressures she experiences as an unmarried woman without the ability to support herself financially. 'I am fatigued; but it is not the sort of fatigue--quick walking will refresh me.--Miss Woodhouse, we all know at times what it is to be wearied in spirits. Mine, I confess, are exhausted', she declares (*EM* Vol. III, Ch. 6, p. 250). Though the reader will learn that her struggles are complicated by the matter of her secret engagement to Mr Churchill, at the time in which the exchange occurs in the

novel the fatigue appears to be linked to the necessity for Jane to find employment as a governess. *Persuasion* does once again lean into the comedy of female nervousness through the satirical representation of Anne's sister Mary (the word 'hysterical' is used four times in the novel)[25], I would argue that there is a higher degree of empathy afforded to her than there was for Mrs Bennett, not least because of the seriousness of the events that cause her "hysterical fits"—her son's and sister-in-law's life-threatening injuries.[26]

In *Emma*, but especially in *Persuasion* and *Sanditon*, Austen appears to move away from depictions of illness that are primarily there to move the story forward, resolve a conflict, or, in the case of nervous disorders, provide comic relief. Though these elements may be present in later novels in varying degrees, Austen's writing shows a deepened interest in what Wiltshire has referred to as the 'pathology of everyday life'. Illness is no longer confined within a single scene or recurring motif but is embedded within characterisation—Admiral Croft is gouty, the Parker siblings are afflicted by several complaints—thus making the experience of illness at once ordinary and shared. Perhaps it was Austen's own deterioration of health and first-hand experience of prolonged pain that turned illness a more preponderant aspect of her character's lives. No matter the origin, illness, medicine, and doctoring take on a more layered role in Austen's later novels, on which my analysis will focus.

Having introduced the role of illness in Austen's novels, it is useful to address the novelist's depiction of medical practitioners and medical knowledge. Although the portrayal of illness and medical care is prevalent in all her works, the figure of the doctor—in its nineteenth-century declinations of apothecary, surgeon, and physician—is remarkably absent in Austen's narrations. One critic commented on this aspect as early as 1917, expressing dissatisfaction at how 'one expects to meet the doctor, and to learn something about him and his circumstances, but somehow or other one is disappointed. One hears of him, feels his influence, but one rarely meets him face to face' (Adams 1917, p. 375). As John Wiltshire puts it, the absence of doctors is counterbalanced by the ever-

[25] This is the highest frequency of the word in a Jane Austen novel. *PP* and *SAN* contain the word "hysterics", but not "hysterical". The only other novel where "hysterical" appears is *SS*, being used twice by the narrator. Interestingly, *PER* is the only novel where the word is used within dialogue, including by Mary Musgrove referring to herself, which is perhaps a sign of its diffusion as an ordinary descriptor of women's behaviour.

[26] Significantly, in *PER* it is "active" injuries that create Wright's crisis-cure model of narrative, rather that illness, though both illness and injury are situated 'within and against narratives of prevention' (Wright, 2016, p.25).

present practice of 'doctoring' (2005, p. 306). Writing about everyday ailments, Austen's novels are less interested in exploring the reach of medical science and the way in which disease is treated, and more in the everyday management of bodily complaints, as well as how they affect the lives of the suffering and those around them. This continuous assistance provided to the characters in need is what the term "doctoring" encompasses, and is overwhelmingly the domain of women. In *Persuasion*, when Anne's nephew dislocates his collarbone, we are informed that the apothecary was sent for and visited the child, that he replaced the collarbone, that he 'felt and felt, and rubbed, and looked grave, and spoke low words' (*PER* Ch. 7, p. 39). The medical practitioner leaves the page as quickly as he appeared, and what the reader is left with are the difficulties of managing the aftermath of the injury. It appears that Mr Robinson, the apothecary, has left instructions as to how to attend to the child, but interestingly one of the first things the narrator tells us, through the perspective of the child's father, is that 'the child was to be kept in bed and amused as quietly as possible' (*PER* Ch. 7, p. 40). Recuperating after injury or illness involves managing temper and spirits, in other words, is a holistic human experience that cannot be reduced to medical treatment alone. Women are the ones filling the gaps of professional medical care by nursing and comforting the sick, mixing scientific notions with lay medical knowledge and treatments. Women's doctoring can take many forms, from Emma's attempts to soothe her father's distress with reassurance, to Anne's visits to her childhood friend in Bath, who is sick and in dire economic conditions, despite her family's opposition. And while these women do not outwardly challenge or question their social roles as carers, they are vocal about both the complexity and difficulty of care, and the perspective it gives, of which their male counterparts are deprived. 'You do not know what it is to have tempers to manage', Emma says to Mr Knightley (*EM* Vol. I, Ch. 18, p. 103). The line is delivered in an attempt to sympathise with Frank Churchill's inability to attend his father's wedding on account of his aunt's ill health, but the way the plot unfolds makes it clear that Mr Churchill's responsibilities are not equal to Emma's when it comes to dependency.

Though nursing mostly features in Austen's novels as one of many forms of unpaid labour inherently allocated to those socialised as women—'Nursing does not belong to a man; it is not his province', says Anne Elliot—a 'nurse by profession' makes a significant contribution to the plot of *Persuasion* (*PER* Ch. 17, p. 109). This is Nurse

Rooke, rewarded for her medical education with a professional title to accompany her name. Nurse Rooke is the sister of the landlady lodging Anne's invalid friend at Westgate Buildings in Bath, and who in her spare time not only nursed Mrs Smith 'admirably', but also taught her the amusing pastime of knitting, and regularly provided news and gossip observed while working for the families that pay her for her services. Once again, within the women's sphere medical treatment is not limited to survival but is comprehensive of emotional and mental health.

The importance of women's politics of care in Austen's novels is further demarcated by the notable absence of doctor's words. For example, *Persuasion* readers are not privy to any of the words pronounced by the surgeon who examines Luisa's head injury, nor to the other characters' opinion of his abilities as surgeon. On the one hand, the omission strengthens the authoritative presence of the doctor in the narrative, for the narrator turns the focus onto the surrounding characters eagerly awaiting permission to hope:

> They were sick with horror, while he examined; but he was not hopeless. […] That he did not regard it as a desperate case, that he did not say a few hours must end it, was at first felt, beyond the hope of most; (*PER* Ch. 12, p. 81)

On the other hand, this muted presence of apothecaries and surgeons allows lay medicine, particularly women's medicine, to take centre stage within the narrative. Of course, this is not an unusual attitude in a novel by Austen, as her representation of the inherent dignity and relevance of the lives, worries, and aspirations of the women of the landed class is a defining feature of her works. Still, when it comes to the representation of medical knowledge and practice, the choice to amplify representations of medicine administered by women, which combines lay and "proper" medical knowledge with a notion of health that comprises all aspects of the human, offers a challenge to masculine authority that extends beyond the women's sphere. Rebecca Spear has analysed the depiction of lavender water as a remedy for female nervous disorders in Austen's early writing and in Elinor's treatment of Marianne's nervous distress in *Sense and Sensibility* (Spear, 2020, p. 230). In this novel, Elinor fills the role of the female healer, which is given dignity and authoritativeness by the efficacy of her lavender-based treatments (Spear, 2020). Elinor's actions cement her as 'the rational, learned woman Mary Wollstonecraft promoted in *A Vindication of the Rights of Woman* (1792)' and who

'combined pre-existing nursing skills with scientific, rational medicine' (Spear, 2020, p. 231). *Persuasion*'s Anne Elliot takes the rational approach to the next level. She cures her sister's nervousness not with lavender but with rational arguments, and more significantly her authoritative self-collectedness and rationality is validated by other male characters, most egregiously with Captain Wentworth's line 'no one so proper, so capable as Anne' (*PER* Ch. 12, p. 81). In *Sanditon*, the character of Charlotte has been described as representing a (female) clinical gaze, whose sensible viewpoint replaces that of male medical practitioners, and whose diagnoses combine 'medical objectivity with a subjective investment in the feelings and concerns of others' (Mallory-Kani, 2007, p. 315). As Chapter 4 will explore in more detail, Austen's later novels not only reclaim the authoritativeness and validity of women's clinical knowledge as a mix of lay medicine, "sense", and practices acquired through nursing, but also showcase its potential for a transformative relationship between doctors and patients. As I am going to explore in the next section, George Eliot's *Middlemarch* is indebted to Austen's medical plots when it comes to challenging masculine forms of authority. Despite differing from Austen in many respects, not least the centrality given to the character of a professional physician, Eliot's novel combines rigorous scientific knowledge with a holistic, organicist approach in which physical health does not exist in a scientific vacuum, but must be integrated with emotional wellbeing and social inclusion.

2.3 *Middlemarch* and Medical Knowledge

If Austen's representation of medicine is somewhat dependent on her representation of suffering—which triggers the need for compassionate nursing along with professional medical treatment—the same consideration does not apply to George Eliot's *Middlemarch*. Some of the uses of medicine in the novel admittedly resemble Austen's patters. For example, there is the illness-cure narrative of Fred Vincy, whose near-death experience with typhoid fever leads to his sister's marriage with the physician that visited and diagnosed him, Dr Lydgate. Readers can also find examples of illness as characterisation, most notably with the character of Casaubon, whose eventual death of heart disease—the popular Victorian diagnosis of 'fatty degeneration of the heart' (*MM* Ch. 42, p. 263)—is implied to have been caused 'from an inability to love as much as from organic causes' (Blair, 2003, p. 288). However, medicine is given its most prominent role in the development of Dr Lydgate's background and character arc.

Through Lydgate's thwarted efforts to build a medical career centred on 'public health and the scientific advancement of medicine' (Bosserhof, 2020, p. 267), the novel offers a commentary on the state of the medical profession and the role of scientific research at the beginning of the reforms of 1830s.

In *Middlemarch*, Dr Lydgate's medical expertise, education, aspirations, and interactions with the lay medical knowledge of his patients are given strong authoritative status within the multiplot. The construction of Lydgate's character was so realistic that Sir James Paget, a renowned physician who had Eliot herself and her partner G. H. Lewes among his patients,[27] is quoted to have expressed astonishment at the vivid detail with which Eliot built her fictional doctor (Logan, 1991, p. 197). Over the decades that followed the novel's publication, the author's accomplishment appeared even more extraordinary. Garrison's *Introduction to the History of Medicine* declared *Middlemarch* 'a novel which, on the whole, affords the most effective side-light on English medicine in the late Georgian and early Victorian periods' (1914, p. 754). Logan has pointed out that Eliot's contemporaries expressed astonishment at the creative accomplishment of the author, that is, the life-like vividness of her imagination, rather than her ability to incorporate historical facts and details (1991, p. 197-198). Writing in the 1940s, medical historian Frank Halstead, building on Garrison's opinion, had nonetheless some criticism toward Eliot's late-Victorian perspective on medical figures and theories of the early 1800s (Halstead, 1946, p. 420). One element that Halstead found difficult to reconcile is the inclusion of Bichat's tissue theory as the catalyst for Lydgate's scientific ambition:

> I do not feel that there is anything particularly remarkable in George Eliot's detailed account of Xavier Bichat. It is simply a highly realistic touch in a study of Country Life that would not have been complete without touching upon the state of medicine of that period. […] I confess, however, that I was startled to find Bichat in *Middlemarch*. I think that selection was deliberate because Bichat was a foreigner, Bichat was an innovator, and Bichat was in 1829 long dead and it was fitting that he should inspire an enthusiasm in Lydgate' (1946, p. 420).

[27] Paget built his career at Bartholomew's Hospital in London and was later appointed surgeon-extraordinary to Queen Victoria (Peterson, M. Paget, Sir James, first baronet (1814–1899), surgeon. *Oxford Dictionary of National Biography*. Retrieved 3 Mar. 2023, from https://www.oxforddnb.com/view/10.1093/ref:odnb/9780198614128.001.0001/odnb-9780198614128-e-21113.

According to Halstead, the use of Bichat as a formative figure in Dr Lydgate's professional education is dictated primarily by the needs of the novel's historical setting, and he goes as far as saying that the inclusion of Bichatian medicine and concepts is superficial in *Middlemarch*, exposing Eliot's knowledge gaps—'I believe that George Eliot has the words but doesn't know the music' (Halstead, 1946, p. 416). In this section, I would like to analyse Eliot's use of Bichat as a case study of the novel's overall relationship with medicine and medical knowledge. My argument, here, is that the influence of Bichat's theories over the career aspirations of country physician Dr Lydgate, and over the plot structure and philosophical concepts of the novel, can offer a condensed exposition of the novel's overall relationship with medicine. Halstead's criticism may seem superficial but, in emphasising Eliot's focus on 'words' over 'music', he noticed an important feature of her storytelling, which is rhetoric. In *Vital Signs* (1994), Lawrence Rothfield makes a significant attempt to review Eliot's use of Bichat's scientific concepts in terms of their rhetorical value. Rothfield argues that nineteenth-century medicine, because of its lack of formalisation, is among the sciences that 'are prone…to accept, and even participate in, the epistemological distortions of their work by popularizers and philosophers' (1994, p. 11). These disciplines, which include geography, biology, and psychology,

> […] mobilize their techniques, concepts, and metaphors to represent a putatively real object, such as life, territory, disease, or labor, rather than a theoretically constituted object, such as a center of gravity or a magnetic moment (Rothfield, 1994, p. 11)

The best example of the process described by Rothfield would be the use of popularised formulations of Darwinism to represent fashionable Victorian epistemological debates such as free will and determinism.[28] According to Rothfield, Eliot's inclusion of Bichatian pathology does not reduce his theories to popularised epistemologies but does nonetheless display an intricate mix of scientific concepts and rhetoric. In order to assess the merit of this claim, it is useful to look at some key moments in the chapter of the novel in which Bichat makes his short but impactful appearance. Lydgate's character has, at this point, been introduced through the opinions of other characters, but this is the moment where

[28] Thomas Hardy's *Tess of the D'Urbervilles* (1891), for example, is permeated with the language of Darwinism, but evolutionary biology (along with pseudo-scientific ideas of degeneration) is used in the narration not as a scientific theory, but as an overarching epistemological debate over the prevalence of determinism or free will in human life.

the narrator brings the audience into the physician's past and inner life ('I have to make the new settler Lydgate better known' (*MM* Ch. 15, p. 91). After recounting his upbringing as an orphan and the development of his passion for medicine, the focus switches to the "attractiveness" of the medical profession—'it wanted reform' (*MM* Ch. 15, p. 93). The type of reform sought by Lydgate is twofold: he yearns to 'work out the proof of an anatomical conception and make a link in the chain of discovery', but he 'meant to innovate in his treatment also', by way of prescribing medicines 'without dispensing drugs or taking percentage from druggists' (*MM* Ch. 15, pp. 94-95). He believes the latter innovation to be 'quite certainly within his reach' (*MM* Ch. 15, p. 94). This context should tell the reader that Lydgate's ambition is driven by ethical, as well as scientific concerns. He wants to be 'good' while pursuing greatness. However,

> Lydgate was ambitious above all to contribute towards enlarging the scientific, rational basis of his profession. The more he became interested in special questions of disease, such as the nature of fever or fevers, the more keenly he felt the need for that fundamental knowledge of structure which just at the beginning of the century had been illuminated by the brief and glorious career of Bichat, who died when he was only one-and-thirty, but, like another Alexander, left a realm large enough for many heirs.[29] That great Frenchman first carried out the conception that living bodies, fundamentally considered, are not associations of organs which can be understood by studying them first apart, and then as it were federally; but must be regarded as consisting of certain primary webs or tissues, out of which the various organs—brain, heart, lungs, and so on—are compacted…No man, one sees, can understand and estimate the entire structure or its parts—what are its frailties and what its repairs, without knowing the nature of the materials (*MM* Ch. 15, p. 95).

Lydgate's scientific interest lies in the pathology of fevers but, like Bichat, he is interested in structure rather than classification. Foucault has pointed out how Bichat's work was incompatible with the work of contemporary nosographers, differentiating between circulatory, inflammatory, and putrid fevers (1973, pp. 177, 180). Bichat believed that

[29] There is an interesting parallel between Lydgate's act of settling in Middlemarch and the settler-colonial and imperialist language utilised to describe his scientific pursuits. Pathology is called 'a fine America', Bichat is likened to an emperor. In *The Postcolonial George Eliot*, Oliver Lovesey notes that Lydgate's character came close to participating in the colonial enterprise. In fact, later in this chapter he is revealed to have almost joined the Saint-Simonians, a group that created utopian colonies in North Africa (2017, p.175). Lovesey demonstrates several similarities between Lydgate and the Saint-Simonians, including the belief in society's transformation through science (p. 178).

‘fever is merely a locally individualized phenomenon with a general pathological structure’, which meant that his primary focus ‘remained that of finding an organic base for general diseases: hence his search for organic universalities’ (Foucault, 1973, p. 186). This universal organic principle is, according to Lydgate, to be found not in tissues themselves, but in the underlying structure out of which tissues are formed:

> This great seer [Bichat] did not go beyond the consideration of the tissues as ultimate facts in the living organism, marking the limit of anatomical analysis; but it was open to another mind to say, have not these structures some common basis from which they have all started, as your sarsnet, gauze, net, satin, and velvet from the raw cocoon? Here would be another light, as of oxy-hydrogen, showing the very grain of things, and revising all former explanations. Of this sequence to Bichat's work, already vibrating along many currents of the European mind, Lydgate was enamoured; he longed to demonstrate the more intimate relations of living structure, and help to define men's thought more accurately after the true order (*MM* Ch. 15, p. 95).

Lydgate is not the only character seeking structural order in the novel. As Sally Shuttleworth has noted, the ‘quest for an organising principle’ is a signature feature of multiple storylines within the multiplot (2009, p. 146). Casaubon devoted his life to completing a ‘Key to All Mythologies’, a comparative study on theology that is already obsolete before it can be finished, due to Casaubon’s lack of engagement with German-language sources (*MM* Ch. 7, p. 40). Dorothea herself is interested in the past and yearns for a ‘binding theory which could bring her own life and doctrine into strict connection’ with that of her predecessors in history (*MM* Ch. 10, p. 55). Within this context, Lydgate’s scientific enterprise becomes an attempt to create meaning from observations placed ‘in an ideally constructed framework.’ (Shuttleworth, 1984, p.144). What emerges, here, is the way in which Eliot integrates Lydgate’s hermeneutic efforts within organic interconnectedness. Shuttleworth identifies Eliot’s ‘organic ideal’ as ‘a form of personal fulfilment which should transcend egoism and integrate individual desire with social demands’ (1984, p. 142). Shuttleworth quite rightly names the character of Dorothea as the novel’s incarnation of the organic ideal, but the principle underscores Dr Lydgate’s scientific inquiry, too. Lydgate places medical care above his research, for which he ‘counted on quiet intervals to be watchfully seized, for taking up the threads of investigation’, and sees his vocation of furthering Bichat’s discoveries within a positive

moral framework, as doing 'good small work for Middlemarch, and great work for the world' (*MM* Ch. 15, pp. 95-96).

As it turns out, both Lydgate's and Dorothea's aspirations to a hermeneutic ideal are destined to fail (Shuttleworth, 1984, p.160). Lydgate's failure, however, is dictated both by his inability to manage his social relationships (Shuttleworth, 1984, p. 160), and by a problem with the formulation of his research question: 'What was the primitive tissue? In that way Lydgate put the question—not quite in the way required by the awaiting answer; but such missing of the right word befalls many seekers' (*MM* Ch. 15, p. 95). Rothfield's *Vital Signs* chooses to engage with the rhetorical aspect of Lydgate's unsuccessful hermeneutic quest. Eliot presents Lydgate as someone who is both qualified and motivated to advance Bichat's theory, showing that he is able to offer both continuity—his scientific enquiry is modelled after Bichat's—and innovation, represented by his willingness to use the microscope, which Bichat famously refused to employ (Rothfield, 1994, p. 88; Foucault, 1973, p. 166).[30] However, Lydgate is also shown as grounding scientific knowledge in a discourse too specialised to produce an overarching structure—Lydgate's 'primitive tissue' was, in fact, the cell.[31] Rothfield puts the emphasis on this moment as a rhetorical event, placing medicine and its relationship with mimesis at the centre of the realist novel's creation (1994, p. 93). In other words, both medicine and the novel are concerned with issues of the imagination and its subsequent representation. While the parallels between narrator, scientist, and historian are apparent, and at times explicit ('we belated historians' *MM* Ch. 15, p. 91), I would caution against interpreting Lydgate's failed research in purely rhetoric terms. Ian Duncan offers a possible alternative reading for Lydgate's failure; he compares the scientific and intellectual goals of Lydgate and Casaubon, reaching the conclusion that, 'the mistake lies not in the identification of the primitive tissue (or the key to all mythologies), but in the idea that a complex system, developing over time in interaction with its environment, can be contained in a unitary origin' (Duncan, 2013, p. 479). Within this interpretation, Duncan argues that the novelist presents her own synthetic view of events, pursuits, and outcomes as the only successful attempt at resolving complex interrelatedness. This

[30] Bichat is quoted to have rejected microscope-assisted research saying that 'when one looks into darkness everyone sees in his own way' (Foucault, 1973, p. 166).

[31] T. H. Huxley's influential 'The Cell Theory' (1853) is a known source used by Eliot in preparation for writing *Middlemarch* (Duncan, 2013, p. 479)

interpretation is significant because it addresses the 'conflict of interpretations' which has afflicted criticism of Eliot's novel for a long time (Carroll, 1992, p. 234). Carroll sees a healthy tension between conservative interpretations of *Middlemarch'*s multiplot as an organic vision that foregrounds wholeness, and a more subversive reading that focuses on its unfulfilled plots and character arcs to point to the novel's emphasis on fragmentation (Carroll, 1992, pp. 234-236). Carroll writes about the narrator's function as a form of 'double hermeneutics', that is, the ability to simultaneously represent and interpret (1992, p. 240). This duplicity, along with a carefully distanced historical vantage point, allows the narrator to navigate fragmentation in mimesis, and unity in synthesis.

I wish to return to the beginning of Lydgate's career and character arc to illustrate another possible interpretation of the novel's tension between conservative collective forces and progressive individuality (Duncan, 2013, p. 476). In explaining the Bichatian medical organicism embraced by Lydgate, the narrator uses a construction metaphor to illustrate how knowing the nature of its parts is essential for understanding the structure as a whole. I would argue that the novel's events add another element to this equation, namely that to understand a structure, one must understand the self. As I have shown in the previous chapter, Bichat's theories revolutionised pathology by locating disease in the body, which in turn gave rise to the Foucauldian clinical gaze separating the objective and truth-telling doctor from the unreliable, subjective patient. Further, Lydgate's propensity toward using the microscope can be seen as a step toward mechanical objectivity, which again requires the suppression of the self. Yet in suppressing the self, Lydgate is blinded to both scientific and social truths. Here, I use the term 'self' as a shorthand for all the elements that describe one's place in the world, such as socio-economic position, gender, and education. For example, being transplanted from Parisian life to English country society, Lydgate ignores or underestimates his social role as a single man during his interactions with Rosamond, which leads to his proposal to Rosamond carried out of a mix of obligation and momentary feeling—'In half an hour he left the house an engaged man' (*MM* Ch. 31, p. 191). Similarly, as a medical practitioner, he fails to recognise his positions on doctors dispensing drugs as something that could lead to clashing or distrust in the inhabitants of the town, judging his proposed change as within easy reach due to it having legal backing. Even in approaching the study of tissues and fevers, he does not question his methodology and Bichatian *forma mentis*, thus failing

to see the mistake inherent in his research question. There comes, however, a point in the novel when Lydgate is finally able to see his actions projected back at him and assigns new meaning to them, questioning his former interpretation. When an unwell Mr Bulstrode is publicly confronted about his financial affairs and scandalous past, Lydgate finds himself reaching out to support him physically as he attempts to walk away, and is struck by a sudden epiphany. As Eliot writes,

> He rose and gave his arm to Bulstrode, and in that way led him out of the room; yet this act, which might have been one of gentle duty and pure compassion, was at this moment unspeakably bitter to him. It seemed as if he were putting his sign-manual to that association of himself with Bulstrode, of which he now saw the full meaning as it must have presented itself to other minds. He now felt the conviction that this man who was leaning tremblingly on his arm, had given him the thousand pounds as a bribe, and that somehow the treatment of Raffles had been tampered with from an evil motive.[32] The inferences were closely linked enough; the town knew of the loan, believed it to be a bribe, and believed that he took it as a bribe (*MM* Ch. 71, pp. 450-451).

At this pivotal moment, Lydgate is suddenly aware of his position in the town, and what brought him there. Significantly, the realisation stems from an act of compassionate care, which forces him to step outside of the 'clinical gaze' and allows him to feel and comprehend the unified reactions of the people of Middlemarch. David Carroll has identified Lydgate's actions in the aftermath of Raffles' death—namely, accepting Bulstrode's explanation that it occurred naturally and viewing his offer of money as an innocent loan toward his struggling hospital—as the biggest crisis of scientific objectivity in the novel (Carroll, 2006). Lydgate questions whether 'he allowed his indebtedness to Bulstrode to influence his interpretation' of Raffles' symptoms (Carroll, 2006, p. 270). Indeed, despite Lydgate's attempts to reframe his actions as a mistake in 'etiquette', rather than complicity in crime, he cannot shake the impression that for the first time in his medical career he had allowed pathological doubt to become moral doubt (*MM* Ch. 73, p. 457). The narrator explains that he had believed the scientific method to be inherently ethical and free from the questions of morality pertaining to dogma. The incident with

[32] The town believed that Raffles, a dubious old man who knew that Bulstrode had prevented his widow's fortune from being passed on to its legitimate heir and was using the information to blackmail him, had been poisoned by Bulstrode with Lydgate's complicity.

Bulstrode reveals to Lydgate that a vulnerability of the scientific self must taint the application of the method.

Medical science, in *Middlemarch*, is a thematic access point both for wider considerations of organic interdependence, and for reflections on objectivity and authoritativeness. Bichat's tissue theory provides the language and visual imagery necessary to understand how each fragment of life fits within the larger web of human history, while Lydgate's professional mistakes and disappointments question the authority of the scientific method in creating social change. Sally Shuttleworth calls Dorothea the 'novel's true physician', for she 'breaks through the narrowing egoism of Lydgate's vision to suggest order where he perceives only chaos' (1984, pp. 169-170). I would argue that, at the beginning of the novel, Dorothea too suffers from an inability to project her gaze inward. She marries Casaubon out of her hope of being useful to his research, but she fails to see how the limitations imposed on her gender by societal norms and expectations would relegate her into a narrow, unsatisfactory role. Unlike Lydgate, however, she is able to find her place in the 'involuntary, palpitating life' (*MM* Ch. 80, p. 486). After her confrontation with Rosamond over the latter's relationship with Will Ladislaw, Dorothea gives a name to an attitude that has guided her throughout the novel but especially since Casaubon's death, which is her ability to recognise within 'sympathetic experience' the power to acquire knowledge (*MM* Ch. 80, p. 486). Like Anne Elliot, Dorothea Brooke ultimately challenges the objective, clinical gaze embodied by Lydgate's *modus operandi* and provides an alternative model for authoritative knowledge, one that successfully combines observation and learning with qualities culturally constructed as feminine such as instinct and empathy.

In the next chapter, I will explore the points of convergence and divergence in Austen's and Eliot's exploration of the mind-body connection, and how it intersects with questions of gender and medical authority. Through an investigation of Regency biliousness and hypochondria in Austen, and of psychosomatic symptoms and their organicist interpretation in Eliot, I aim to show the different ways in which these authors use the language of narration to comment on the social implications of illness as both a physiological and cultural entity.

3 Coats of the Stomach and Nervous Complaints: Examining the Body-Mind Relationship in Austen and Eliot

3.1 Austen, Biliousness, and the Looming Threat of Middle-Class Mobility

No discourse around medical authority, gender, and the body can be complete without an exploration of nineteenth-century conceptualisations of the relationship between body and mind. The first half of the nineteenth century witnessed an important transformation in how the body-mind connection was understood, with significant implications for the gendered development of medicine and medical care (Hare, 1991, pp. 41-43). As Hare has reported, the eighteenth century was dominated by the sympathetic theory of disease, which was applied to both bodily and mental illness:

> The doctrine of sympathy was the earliest attempt to explain what seemed, within the confines of the body, to be 'action at a distance'. It was believed, for instance, that a wound would be healed by applying a secret remedy to a cloth stained with its blood or to the weapon which caused the wound. […] As an explanation of 'nervous disorders', 'sympathy' was replaced by hypotheses based on the new discoveries in physiology and anatomy (Hare, 1991, p. 38).

Sympathetic interactions allowed symptoms originating in a specific part of the body to spread across the nerves and affect the entire system, as was thought to be the case with hypochondria (Hare, 1991, p. 40). According to Hare, 'the belief that hypochondriacal disorders were related to indigestion […] was still fashionable during the 17th and 18th centuries' (Hare, 1991, p. 40). However, 'The continued failure during the 19th century to find any bodily cause of "nervous disorders" left the way open for new psychological theories, the most acclaimed of which was psychoanalysis' (Hare, 1991, p. 44). What Hare has described is an important movement away from the interconnected framing of the body-mind relationship toward a sharper distinction between disorders of the body and disorders of the mind, the latter requiring a separate medical field devoted to them. In this chapter, I will look at the late-1810s and 1820s culture portrayed by Austen and Eliot and trace the contaminations of eighteenth- and nineteenth-century ideas about body and mind (interconnectedness and emerging separation), and their implications for the authors' medical narratives, maintaining a focus on issues of authority and gender. The current section will be focused on Austen and one nineteenth-century pathology derived from humoral theory, which underwent some important changes at the beginning of the nineteenth century—biliousness. Hisao Ishizuka has written a seminal chapter on this

fashionable malady of the Regency era and its cultural relevance as a 'gateway into a range of other physical disorders' as well as mental illnesses (Ishizuka, 2021, p. 113). I will use his analysis as a starting point for a reading of biliousness in Austen's plots and the ways in which the narrative representation of this complaint intersects with cultural fears around social mobility.

Austen completed *Persuasion* in September of 1816, after a year of ill health that prompted her to visit a renowned physician in London—perhaps the famous Dr Matthew Baillie, one of the physicians of the Prince Regent who was also treating Henry Austen (Upfal, 2005, p. 8). Her illness seemed to improve for a while, and

> On 23 January 1817, Jane noted that she was ''getting stronger than I was half a year ago,'' and a letter to a close friend the following day is just as optimistic. She added, ''I am more and more convinced that Bile is at the bottom of all I have suffered, which makes it easy to know how to treat myself.'' Three days later, in this spirit of optimism, she began work on a new novel, the fragment now known as *Sanditon*, and worked steadily through February and into March (Upfal, 2005, p. 8).

These words contain the key to understanding the Regency notion of bile and biliousness as reported by Ishizuka, that is, the shift in understanding that caused for it to be viewed no longer as a putrid humour to be expelled via 'emetics and purgatives', but as a vital component of one's constitution, a neutral substance to be controlled and managed (Ishizuka, 2021, p. 115). Upon identifying her lifelong issues with bile, in her letter Austen expressed confidence in her ability to maintain the newfound stability of her health, following a doctor-mandated regimen that may have included 'blue pills or calomel and […] inspection of the faeces'. (Upfal, 2005, p. 8; Ishizuka, 2021, p. 123). By the 1820s, biliousness was a 'general watch-word', and bile started to be seen as the cause of an array of disorders, some of which had psychosomatic symptoms, such as nervousness and insanity (Ishizuka, 2021, p. 120). One of the professional figures responsible for this shift in perspective was Dr Abernethy, nicknamed 'Dr. My Book' for his tendency to recommend that his patients read his volume *Surgical Observations* (1806), in which he 'set the golden rule that all diseases were largely determined by the state of the digestive organs: the stomach, the liver, and the bowels' (Ishizuka, 2021, p. 121). As Ishizuka points out, this notion of a sympathetic connection between the digestive and the nervous system was not a novel idea, for 'every surgeon was acquainted

with the reciprocal action of the local and the general, and the universal sympathy between the nervous system and digestive organs' (2021, p. 121). Hare reports that early notions of a connection between indigestion and hypochondria can be traced back to Aetius and transcribes eighteenth-century sources declaring dyspepsia as occurring in tandem with disorders of the mind (1991, p. 40). However, the strength and impact of Abernethy's book lay in his ability to provide straightforward, actionable advice on how to self-diagnose and self-medicate, as well as to popularise explanations of disease centred on the digestive organs:

> The real strength of [Dr Abernethy's] 'My Book' was in the formulation of usable knowledge regarding the bile in diagnosing and (self-)medicating illnesses, which was applicable to all diseases and every patient. As all complaints depended on the state of one's digestive organs, the first thing to know was how properly or improperly the digestive apparatus was functioning. […] Moreover, Abernethy's bile theory was compatible with commonplace, empirical observations by lay people and was also highly usable by and applicable to anyone who wanted to self-treat. Patients – not only the sick but also the healthy – who felt slight malfunctions within their abdomens could read Abernethy's 'My Book' and purge themselves freely at home with blue pills (Ishizuka, 2021, pp 121-122).

The bilious invalid of the Regency period was born.

To understand the social, cultural, and literary impact of Regency biliousness, however, it is important to introduce the concepts of colonial and metropolitan biliousness (Ishizuka, 2021, pp. 114, 128). This terminology is used by Ishizuka to indicate a type of biliousness whose origin is to be found not in the type of constitution a person was born with (though one could have a predisposition toward bilious diseases), but rather in the external conditions dictated by their environment—specifically, excessive heat (Ishizuka, 2021, p. 125). As Ishizuka explains,

> Colonial heat from the sultry sun was universally recognised by many medical practitioners as an external factor that disrupted biliary secretion. Tropical invalids, returnees from the warm climates, were marked by the visible evidence of the effects of tropical heat on bile with their impaired livers. From the late eighteenth to the early decades of the nineteenth century, however, people living in the urban areas ofEngland experienced the same effects from artificial heat that natural heat exerted on the body. As Janković and Crowley cogently argued, the domestic life of middle-class people in this

> period radically altered with the pursuit of comfort, a concept newly invented in the late eighteenth century. People, especially city dwellers, gradually became accustomed to living in comfortable spaces furnished with artificial heating, fireplaces, stoves, and wick-lamp illuminations (2021, p. 125).

Thus, tropical climates and overcrowded cities could become sources of biliousness, respectively producing 'tropical invalids' and ailing urban dwellers. Furthermore, there was another source of unsanitary heat production, understood as deriving from one's own lifestyle. This was identified in the imbalance between the mental or physical exertion required to carry out a desk activity or manual job:

> Regency medical discourses of desk diseases exposed how 'the toils of desk' involved mental agitations that sapped the nervous energy required for proper digestion and consequently caused inveterate indigestion. With reference to the medical truism that the stomach had a strong sympathy with the brain and the nervous system, medical writers explained how a brain worker's continued application to business interrupted the digestive process (Ishizuka, 2021, p. 124).

W. M. Wallace's treatise on 'Desk Diseases' (1826) addressed the health implications of a burgeoning middle class increasingly 'engaged in brain work', which included 'bankers, officers', but also 'those who performed seated manual labour' (Ishizuka, 2021, p. 124). The picture that emerges is one of a society preoccupied with the health consequences of modernity, and where the condition of chronic invalidity was no longer a distinguishing feature of upper-class opulence and idleness, but a marker of social mobility.

Thus, the eighteenth century was concerned about diseases of overindulgence and comfort, famously denounced in George Cheyne's 1733 volume *The English Malady* (Porter & Rousseau, 1998, p. 55). Cheyne's publication painted the grim picture of an upper class that had become prone to nervous disorders due to a series of factors traceable to lavish lifestyles and rich diets (Porter & Rousseau, 1998, p. 55). Cheyne was among the most popular and influential of gout doctors and advocated for exercise and diet management as the best ways of restoring sympathetic harmony between the gut and the brain (Porter & Rousseau, 1998, p. 55-56; Taylor-Brown, 2018, p. 111).[33] At the turn of

[33] Contemporary knowledge that gout came from 'an increase in uric acid, the result of too much protein' confirms Cheyne's intuition about the origin and management of gout (Takei, 2005, https://jasna.org/persuasions/on-line/vol30no1/takei.html , accessed 20 March 2023). However, Cheyne

the nineteenth century, other influential doctors like Abernethy expanded Cheyne's ideas and acknowledged that gastro-intestinal health was paramount in the prevention of disease, both physical and mental, across all walks of life:

> John Abernethy published his *Surgical Observations* in which he championed the theory of gastric sympathy—that local nervous irritation could derange the digestive organs, which would in turn disorder the wider constitution of an individual. Scottish physiologist, Alexander Philip, also endorsed the power of "gastric sympathy", arguing that indigestion might assume an "inflammatory character" and transform from "a mere nervous affection" into "the source of all mischief". He considered indigestion to be a disease "not of any one set of organs but of the whole system" (Taylor-Brown, 2018, p. 112).

Both hunger and overeating could be the cause or the product of nervous disorders, and excessive mental strain was directly associated with dyspepsia, while 'A faulty digestion might starve the intellect of adequate resources of nervous energy, or vice versa, leading to nervous collapse' (Taylor-Brown, 2018, p. 117). Further, as mentioned above, key experiences of modern life in an imperialist society, such as living in crowded metropolitan areas or spending time in tropical climates, were deemed responsible for accentuating pathological outcomes in one's constitution. It is in this context that we see the development of an 'Age of Hypochondria', as Grinnell has defined it (2010). While recognising the term's elusiveness to any narrow definition Grinnell explains hypochondria as a problem of 'interpretation', a failure 'in the very ability rigorously to distinguish between illness and health' (Grinnell, 2010, p. 4). However, it is also a disease that stems from the societal pressure to exercise extreme forms of control over health, the body, and prevention, for example, through the rigorous management of diet and exercise. As Grinnell puts it,

> […] the anxiety and instability that characterized how health was experienced, enjoyed, lost, recovered, and normalized were not entirely ubiquitous, and as real and physically urgent as ill health was for the Romantics, an anxious relation to health was also cultivated in ways that frequently retraced lines of class, race, and nationality. Hypochondria primarily afflicted the bourgeoisie, so much so that it might not be possible to understand

was also a believer that 'metallic medicine' could cure gout, and frequently prescribed mercury purges (Porter & Rousseau, 1998, p. 56).

> one without the other, and thus to speak of a nervous nation in the Romantic period is to acknowledge the dominance of the middle classes and their efforts to shape the nation in their own image as a collective body composed of relatively leisured citizens whose wealth made possible an age of medical consumerism (2010, p. 8).

In the remainder of this section, I want to focus on the issue of control over physical and social bodies and how it is expressed as a recurrent theme in Austen's novels, particularly the ones where medicine takes centre stage. I will analyse how Regency biliousness and other common gastrointestinal disorders and their psychosomatic manifestations are portrayed in Austen's work, the bodies they affect, and the anxieties they create for the communities of the landed gentry at the centre of her narratives.

In considering representations of gastrointestinal ailments in medical and literary culture, Grinnell (2010) makes an important distinction between gout and biliousness, one of gender. While gout was commonly thought of as a masculine disorder, other forms of gut disorders like dyspepsia and indigestion seemed to resist gender stereotyping (Grinnell, 2010). Biliousness was among such gender-non-specific disorders: in Austen's 'novel of biliousness' *Sanditon*, for example, Diana Parker and her brother Arthur both admit to suffering from it (Ishizuka, 2021, p. 128). Significantly, the novel also witnesses the meeting of metropolitan and colonial bile at the seaside resort, respectively in Arthur's predilection of small rooms with 'brisk', artificial fire (*SAN* Ch. 10, p.56) and the West Indian Miss Lambe, who is offered 'tonic pills' and the experience of a dip with a bathing machine (*SAN* Ch. 12, p. 80; Ishizuka, 2021, p. 129). By contrast, gout is given prominence in *Persuasion,* affecting the character of Admiral Croft, a retired navy officer who decides to rent Kellynch Hall, the home of Anne Elliot's family, after the latter are forced to move to a cheaper place in Bath to restore their finances.

Following Ishizuka's analysis on biliousness, I wish to label Admiral Croft's complaint as "colonial gout", for it is pointed out by other characters, particularly by Sir Walter Elliott, that sailors are 'all knocked about, and exposed to every climate, and every weather, till they are not fit to be seen' (*PER* Ch. 3, p. 14). Though this quotation refers to the Admiral's external appearance, the struggles with gout described later in the novel are implicitly linked to his former lifestyle. The accuracy with which Austen describes Admiral Croft's self-management of gout is a testament both to her up-to date knowledge of the illness and the cures advanced by medical practitioners, and of its prevalence

among (male) members of her social class. Admiral Croft goes to Bath, a place becoming less fashionable by the Regency but still renowned for its hot waters, as soon as the symptoms appear, and manages his symptoms by walking, 'to keep off the gout' (Cossic-Pericarpin, 2017, p. 537; *PER* Ch. 18, p. 111). Dacia Boyle reports that the advice given by Admiral Croft's doctor was taken from real-life Dr Parry, who is mentioned in a letter as having prescribed a restrictive diet of bread, water and meat, and an excessive amount of walking, as a cure for a certain Mr Bridges' gout (Boyce, 2020, p.153).[34] Despite the gendered connotations associated with gout, both this disease and biliousness were thought of as having similar causes and cures, both being connected to food intake and lifestyle. Of the three last novels written by Austen, *Persuasion* is the only one that has no explicit mention of biliousness, although it is possible that the invalid Mrs Smith, with her 'severe and constant pain' might have been described as bilious by her contemporaries (*PER* Ch. 17, p. 102)[35]. Interestingly, the only character who is described as drinking the wholesome waters of Bath, perhaps to cure her own chronic illness, is Mrs Clay, the young widow who stays with the Elliot family as a companion for Anne's sister Elizabeth. In expressing disappointment at Anne's connection with Mrs Smith, Sir Walter Elliot makes an inadvertent comparison between the latter and Mrs Clay, another widow with no income nor connections.

Upon closer inspection, the thread that connects Admiral Croft's gout, Mrs Smith's ailments, and Mrs Clay's water-taking is composed of both their health struggles, and the threat they pose to Sir Elliot's name and social standing. Admiral Croft and his wife settle at Sir Walter's former home, one he reluctantly quits in order to reinvigorate his finances. Mrs Clay is suspected of encouraging his desire to remarry, thus securing her financial future (and threatening that of the Elliot sisters through the possibility of a new heir). Mrs Smith does not pose a material challenge to Sir Walter but is seen by him as the embodiment of a dangerous downward trajectory of his family's relations and status. This is visualised rather explicitly when Anne must choose between the sincere

[34] That this was the common medical prescription to relieve symptoms of gout and other gastrointestinal disorders is shown also by an article appearing on *The Boston Medical and Surgical Journal* some seventy years after the publication of Austen's novel (Potsdamer, 1887). The article sings the virtues of a famous Californian alkaline water—Carlsbad Mineral Water—and reports of gouty patients being recommended 'horseback exercise' and taking Carlsbad water, the latter 'always being heated first' (Potsdamer, 1887, p. 113).

[35] To a modern-day physician her symptoms appear to be those of 'inflammatory, and more than likely autoimmune, arthritis' (Boyce, 2020, p. 149).

pleasure of keeping company to her old friend and the ceremonious meeting with her distant aristocratic connections. Overall, the novel dismisses the legitimacy of Sir Walter's concerns with satire, as the narrative voice sympathises with Anne and ridicules Sir Walter's obsession with the performative aspect of social class ('Modest Sir Walter!', exclaims the narrator at one point, *PER* Ch.15, p. 100), yet some of these preoccupations are seemingly validated through the narrative overlapping of health and social status.

As soon as Admiral Croft's name is suggested to Sir Walter as a prospective tenant, his physical appearance is immediately equated with his moral and social value:

> "And who is Admiral Croft?" was Sir Walter's cold suspicious inquiry. Mr Shepherd answered for his being of a gentleman's family, and mentioned a place; and Anne, after the little pause which followed, added--"He is a rear admiral of the white. He was in the Trafalgar action, and has been in the East Indies since; he was stationed there, I believe, several years." "Then I take it for granted," observed Sir Walter, "that his face is about as orange as the cuffs and capes of my livery." (*PER,* Ch. 3, p. 16).

A first reading of this interaction must have readers frown at Sir Walter's elitism. Though the Admiral may not come from a titled family comparable to the Elliots,[36] he is a member of the gentry and therefore the recipient of unwarranted exclusionary behaviour. However, Sir Walter's unpolished comments mask a layer of shared anxiety toward the accumulation of money and disease elsewhere, on colonised lands, which can later be introduced and circulated into English soil. For the established families of the English landed class, there is a close similarity between new money and new diseases: both may seem to appear out of nowhere and spread fast, permanently altering established social dynamics. There is a distinction to be made between "colonial" diseases like cholera, which caused an epidemic and many deaths across Europe in the early 1830s,[37] and chronic illnesses such as gout and biliousness. Unlike infections, chronic illnesses exist in the liminal space between illness and health and cannot be eradicated permanently.

[36] This is not the place to analyse the Elliot family history, but it is worth noting that Sir Walter's baronetcy is suggested by Austen to have been purchased by his ancestors, which further increases the perception of his elitism. Austen links Sir Walter's 'dignity of baronet' to 'the first year of Charles II' (*PER*, Ch. 1, p. 3). As Andrew Cook reports in *Cash for Honours* that 'Charles II also followed his father's example of creating baronets at bargain basement prices. Charles was also responsible for the innovative step of openly employing agents to hawk baronetcies for him' (Cook, 2008, p. 265).

[37] For a "thing theory" approach to the history of cholera epidemics across the nineteenth-century globe and their links to the colonial imagination, see Mukharji, P. B. (2012). The "Cholera Cloud" in the Nineteenth-Century "British World": History of an Object-Without-an-Essence. *Bulletin of the History of Medicine*, 86(3), 303–332.

Therefore, chronic illnesses must entail a subtle but continuous change in the social understanding and management of disease. Thus, the management of an individual's body becomes linked to the management of the social body, that is, the environment in which the disease is named and understood. As I am about to illustrate, the portrayal of chronic illnesses in Austen's medical narratives is instrumental to the representation of the changing economic and social equilibrium of countryside society.

The equation of disease, particularly chronic illness, and social mobility, underpins a range of secondary characters and storylines in Austen's later novels. In *Emma*, the main character ponders over accepting an invitation from the Coles, a family of tradespeople who purchased a country estate, which prompts the narrator to provide more information about their background:

> The Coles had been settled some years in Highbury, and were very good sort of people--friendly, liberal, and unpretending; but, on the other hand, they were of low origin, in trade, and only moderately genteel. On their first coming into the country, they had lived in proportion to their income, quietly, keeping little company, and that little unexpensively; but the last year or two had brought them a considerable increase of means--the house in town had yielded greater profits, and fortune in general had smiled on them. With their wealth, their views increased; their want of a larger house, their inclination for more company. They added to their house, to their number of servants, to their expenses of every sort; and by this time were, in fortune and style of living, second only to the family at Hartfield (*EM* Vol II, Ch. 7, p. 143).

As with *Persuasion*'s Sir Walter, it is tempting to read this description solely in terms of the elitism displayed by Emma. The Cole family appears throughout the novel as happily integrated into Highbury life, and Emma's respect for them does increase over the course of her character arc. However, in the paragraph cited above, the narrator fades the boundary between Emma's own biased opinions, and those shared by a wider section of the Highbury society. There is a subtle preoccupation with the expansionistic aims of the Coles, whose influx of money and subsequent increased expenditures occur at a fast pace. Further, there is another detail about the Coles that should make audiences a little sceptical, or at the very least alert, about their moral qualities, which is their relationship with Mr Elton. The narrator says that 'The mention of the Coles was sure to be followed by that of Mr. Elton' for 'There was intimacy between them' (*EM* Vol II, Ch. 1, p.108).

At the start of the novel, the notion of a close friendship between them should not alarm the reader, yet later revelations of Mr Elton's character, of his desire to secure his financial and social comfort by marrying, rather hastily, a rich, unsuitable partner, should at the very least cast some doubt over the moral soundness of the values championed by the Coles.

This is the context in which the reader must understand Mr Cole's biliousness. The character does not receive a formal diagnosis or even a self-diagnosis of this illness, but Mr Woodhouse makes it known that 'Mr Cole is very bilious' (*EM* Vol II, Ch. 7, p. 146). Following Ishizuka's analysis of biliousness as emerging from 'mental agitations that sapped the nervous energy required for proper digestion and consequently caused inveterate indigestion' (Ishizuka, 2021, p.124), Mr Cole's biliousness can be seen as a direct consequence of his efforts to integrate into Highbury genteel society. Another confirmation of the association of biliousness with labour comes from another character who is described as singularly industrious in the novel. In fact, the word 'bilious' appears only once more in *Emma*, in reference to Mr Perry, who is so busy that 'he has not time to take care of himself' (*EM* Vol I, Ch. 12, p. 73). Mr Cole and Mr Perry are thus united in their mental exertions and their consequences on the body, but there is a marked difference between them. In addition to providing much-needed support to Mr Woodhouse, Mr Perry depends for his work and income on the families that commission him; therefore, he does not threaten the equilibrium of Highbury society and is afforded a higher degree of empathy and compassion by the narrator ('Poor Perry', *EM* Vol I, Ch. 12, p. 73), while Mr Cole's biliousness carries the mark of social mobility and economic expansion.[38]

At the other end of a set of characters exhibiting physical symptoms that can be attributed to "fashionable" Regency chronic illnesses like biliousness, gout, and rheumatism, originating in mental labour and economic mobility, is another group of characters that are distinguished by their varying degrees of hypochondria and nervous disorders. To this set belong Mr Woodhouse (and his daughter Isabella) in *Emma*, Mary Musgrove in *Persuasion*, and the Parker siblings in *Sanditon*. In these characters,

[38] Jonathan Grossman explains, through an analysis of the workings of politeness in *Emma*, that the social conflict between the established 'courtly' class and the emerging middle classes holds not merely financial power at its core, but is also a struggle between social and moral values, in which upper-class leisure, defined as a 'competitive struggle for proficiency in good manners', is replaced by middle-class consumption (1999, p. 160).

hypochondria takes the form of 'quick Apprehension and Vivacity of Fancy and Imagination' (Heath, 2011, p. 1246). Their bodily symptoms are either virtually absent, or showing up as nervousness, or in the case of the Parker family, a combination of real and perceived symptoms represented, however, not as legitimate complaints but as 'something less noble and more mockable' (Boyce, 2020, p. 153). All these characters are preoccupied with social change and its consequences for their community. Mr Woodhouse's hypochondria, as argued by Grossman, plays a crucial role in driving 'Emma's (and others') participation in the labor of etiquette', which includes Emma's recognition of the unsuitability of Frank Churchill as a prospective match for marriage, in favour of higher-status, family friend Mr Knightley (Grossman, 1999, p. 152). In other words, the hypochondriac body in *Emma,* as in later novels, is both a somatised expression of class-based anxiety and a weaponised entity that uses illness to propel conservative ideas about one's place within the social circles represented.

As Stephen Heath points out, while at the start of the nineteenth century hypochondria and hysteria were differentiated along lines of gender, there was still a tendency to overlap the two disorders in reference to women's experience (Heath, 2011). Eighteenth-century physicians

> Blackmore and Whytt considered them to be "the same malady", though they also maintained hysteria's relation to females, whose nervous system was "generally more moveable than in men". Hypochondria was associated with males, but female hypochondriacs were recognized. Of the three hypochondriac young adults of Jane Austen's *Sanditon* (1817), for example, two are female (Heath, 2011, p. 1247).

I will explore the gendered discussion around nervous disorders and their bodily symptoms in the last section of this chapter, but for the current discussion I will consider nervousness, female hysteria, and hypochondria as different bodily expressions of the same disease. In *Persuasion*, a novel where illness and suffering take the form of 'physical, emotional, and financial trauma' (Boyce, 2020, p. 148), the character that embodies nervous hypochondria is Mary Musgrove. Her nervousness is explicitly linked to her failure to embrace motherhood and care ('I do not know that I am of any more use in the sick-room than Charles…I have not nerves for the sort of thing', *PER* Ch. 7, p. 38), but in addition to the social expectations that appear to oppress her within the narrow confines of the woman's sphere, she is also ostensibly preoccupied with the social

standing of her sister-in-law's suitor, Charles Hayter. Here is how Austen's narrator describes the Hayter family's position in society:

> Mr Hayter had some property of his own, but it was insignificant compared with Mr Musgrove's; and while the Musgroves were in the first class of society in the country, the young Hayters would, from their parents' inferior, retired, and unpolished way of living, and their own defective education, have been hardly in any class at all, but for their connexion with Uppercross, this eldest son of course excepted [i.e. Charles Hayter], who had chosen to be a scholar and a gentleman, and who was very superior in cultivation and manners to all the rest (*PER,* Ch. 9, p. 50).

When comparing the prospect of Henrietta Musgrove marrying Captain Wentworth as opposed to 'Cousin Charles', she declares that 'If he [Wentworth] should ever be made a baronet! … That would be a noble thing, indeed, for Henrietta! She would take place of me then, and Henrietta would not dislike that' (*PER* Ch. 9, p. 50). On the surface, she appears willing to suppress any jealousy she might feel for the honour of being connected to a titled family, but this consideration is immediately followed by another that 'It would be but a new creation, however, and I never think much of your new creations' (*PER* Ch. 9, p. 51). Once again, change as social mobility is the most unnerving, unsettling prospect for Austen's characters, tempering the joyful resolution provided by the novels' marriage plots.

How the medical narrative of *Sanditon* and its hypochondriac lodgers fits the model of social anxiety is perhaps less apparent, especially due to the unfinished state of the novel. John Wiltshire has described *Sanditon* as a novel of 'silliness' (1997), and indeed the survived fragment of the novel is

> […] exuberant, outlandish, terrifically animated, and comic. In fact, in the eleven and a half chapters that Jane Austen lived to complete, it's the most amusing, almost, one might say, the most manic, text that Jane Austen composed (Wiltshire, 1997, p. 96).

However, underneath the strong satirical framing and language is a narrative showcasing upper-class negotiations between the 'old' culture of leisure and the rapidly establishing culture of consumption. This cultural war is embodied in the very different families that dominate the narrative. As Ishizuka writes, 'the Parkers of Sanditon and the Heywoods of Willingden' serve as a juxtaposition of 'modernity, civilisation, and change' versus

'old values, stability, health' (2021, p. 129). But 'The narrative implicates another muted contrast: the Parkers' busyness/business contra Sir Edward Denham's genteel, aristocratic sensibility' (Ishizuka, 2021, p. 129). Mr Parker designs and builds a new town 'to profit from the leisure activities of an affluent class' preoccupied 'with its bodily well-being' (Wiltshire, 1991, p. 208). His daughters and son appear caught between this new rhetoric of industriousness and the old desire to live, as Arthur does, 'on the interest of his own little fortune, without any idea of attempting to improve it or of engaging in any occupation that may be of use to himself or others' (*SAN* Ch. 5, p.30). Their hypochondria lies in this tension, amplified by the contrast with their brother Sidney, who makes an appearance through excerpts from letters and seems to embody the values and lifestyle of labour and profit.

Significantly, hypochondria in *Sanditon* manifests itself primarily through bodily, rather than nervous, symptoms. Just like Mr Woodhouse, the Parker siblings are overly concerned about what they eat, and proffer judgement over any food item that is presented before them, with a marked concern over its wholesomeness for their constitution, as can be seen from a comparison of the texts:

> Emma thinks of sending them a loin or a leg; […] my dear Emma, unless one could be sure of their making it into steaks, nicely fried, as ours are fried, without the smallest grease, and not roast it, for no stomach can bear roast pork--I think we had better send the leg (*EM* Vol II, Ch. 3, p. 119).

> We think quite alike there. So far from dry toast being wholesome, I think it a very bad thing for the stomach. Without a little butter to soften it, it hurts the coats of the stomach. I am sure it does. […] It irritates and acts like a nutmeg grater (*SAN* Ch. 10, p. 90).

Unlike Mr Woodhouse, however, Arthur Parker is mocked for rationalising his desire to consume rich foods such as butter using the lay medical language of the day, with the emphasis on prevention and self-regulation that characterised it. As Wright explains, 'The first line of prevention is always a narrative one, and cautionary tales provide both the content and the formal structure of preventionist thinking' (Wright, 2016, p. 27). *Sanditon*'s twelve chapters seem to provide an elaborate cautionary tale against the excesses of prevention as hypervigilance over the body as a physical and social entity. At the same time, prevention is a form of escapism, for it 'draws the past and the future into

contact' by simultaneously requiring us to 'look back in regret at our current moment' and to 'imagine the foreknowledge' that will perpetually avoid disease (Wright, 2016, p. 26). Thus constructed, Sanditon is a place where members of the genteel class can take refuge both from disease, with an emphasis on 'fashionable bathing' as 'an illness prevention role' (Cossic-Pericarpin, 2017, p. 543), and from modernity as fast-paced change in power dynamics and values, brought about by the rise of capitalism and the middle classes. In this sense, *Sanditon* unites and expands upon the themes of displacement and the search for cures introduced in *Persuasion*, and the satirical focus on the body as a site of control over illnesses both personal and social, as it was for Mr Woodhouse in *Emma*.

As will be seen in the upcoming discussion on nervous disorders in *Middlemarch,* digestion, the gut, and the coats of the stomach continue to occupy a central space in Victorian debates on the body and mind connection, for 'the gastric component to nervousness was underpinned by a functional connection between digesting and feeling' (Taylor-Brown, 2018, p. 116). Eliot's organicist vision shifts the focus onto the mind as the main site of psychosomatic illness, reflecting contemporary ideas that 'poor living standards or dissatisfaction with social conditions are important causes of neurotic illness' (Hare, 1991, p. 44), yet moving away from Regency satire and into Victorian anxiety.

3.2 Eliot's Organicist Theory: *Middlemarch* and the Embodiment of Mental Strain

'One sees how any mental strain, however slight, may affect a delicate frame' (*MM* Ch. 67, p. 420). These are the words Lydgate pronounces after being called to visit Mr Bulstrode, who is suffering from a 'hypochondriacal tendency' and 'a lack of sleep, which was really only a slight exaggeration of an habitual dyspeptic symptom' and threatened 'insanity' frame' (*MM* Ch. 67, p. 420). Mr Bulstrode remarks that 'a constitution in the susceptible state in which mine at present is, would be especially liable to fall a victim to cholera', a disease that was sweeping Europe in the early 1830s (*MM* Ch. 67, p. 421).[39]

[39] For a detailed reading of cholera in *Middlemarch* see Mary Wilson Carpenter's 2010 article Medical Cosmopolitanism: "Middlemarch", Cholera, And the Pathologies of English Masculinity. *Victorian Literature and Culture, 38*(2), 511–528. Dr Diana Rose Newby spotted that Eliot's plan might have been to amplify the pandemic plot, as evidenced by the notes in her *Quarry*—see her LitHub article 'The Hidden Narrative in *Middlemarch* That 2021 Readers Will Spot', https://lithub.com/the-hidden-narrative-in-middlemarch-that-2021-readers-will-spot/, accessed 10 March 2023

In this scene, both Lydgate and Bulstrode are consumed with mental strain. Lydgate is facing a choice between losing the Hospital to his indebtedness and failing irremediably in his role of husband. Bulstrode is being tormented by the prospect of his past being revealed to the town, marking his downfall. Despite taking place in 1830, this passage fittingly encapsulates the change in the conceptualisation of the mind-body connection in 1870s society and medical science. New discoveries on the structure and functions of the brain took some of the focus away from dyspepsia and disorders of digestion, and placed newer, stronger emphasis on mental strain (Taylor-Brown, 2018, pp. 117-118). Of course, this transition occurred gradually and did not eradicate concerns over digestion and dyspepsia. In fact, it may be argued that changes in Victorian alimentation exacerbated existing concerns over the quality of the food ingested and the digestive issues they might create.[40] Dr Arthur Hill Hassall (1817–1894), for example, who was a physician and a microscopist, published a comprehensive guide on adulterated foods that informed the passing of the 1860 *Adulteration Acts* by Parliament ('Hassall, Arthur Hill', *ODNB*). Hassall produced a series of analytical reports for *The Lancet*, which were collected in the 1855 volume *Food and Its Adulterations*, containing 'original microscopical and chemical analyses' of a wide variety of foods and beverages consumed by 'all classes of the public'.[41]

Despite the persistence of concerns over disorders of the gut and their implications for the sufferer's emotional and mental wellbeing, the appearance of these symptoms became increasingly linked to disorders of the mind, such as mental strain. The changing conceptualisation of the symptoms implied that cures, too, were more focused on relieving the intellectual and emotional pressure on the mind than regulating the body. In the passage cited above, for example, Dr Lydgate sees the mind as the location of both the problem and the cure, and rather than prescribing daily exercise and dietary

[40] Clayton and Rowbotham's analysis found a sharp decline in the nutritional value of the average person's diet which became especially noticeable in the mid-to-late Victorian period, caused by the fall in production costs, the introduction—in urban areas in particular—of canned, processed foods, and the increased global trade, with products such as tinned meat being imported from 'Argentine, Australia, and New Zealand' (2009, p. 1238).

[41] One of the products that stands out in Hassall's analysis is Du Barry's *Revalenta Arabica*, a 'light and delicious breakfast Food' marketed 'to ladies, invalids, & sea voyagers' that claimed to 'speedily and permanently' remove disorders of the body and the mind, such as 'dyspepsia…constipation, acidity…nervousness, biliousness, affections of the liver and kidneys…palpitations of the heart…rheumatism, gout…low spirits…tremors…delusion, loss of memory, vertigo' (Hassall, 1859; Du Barry, 1850). Microscopical analysis revealed that this prodigious remedy was, in fact, common lentil flour (the name itself deriving from Ervalenta, or Ervum Lens—see Cazzuola, 1879).

restrictions, as an Austenian physician might have done, he insists that 'it would be well for Mr. Bulstrode to relax his attention to business' (*MM* Ch. 67, p. 421).[42]

In the last decades of the nineteenth century, the popular debate over health was permeated by an anxiety surrounding the human brain's ability to process the perceived overflow of information and stimuli that come from living 'in an age of electricity, of railways, of gas, and of velocity in thought and action' (Bonea, 2019, p. 56). This anxiety took many shapes, from fears surrounding overexertion in manual labour to concerns about the possible health risks of a premature or delayed mental development of children, which was thought to produce a dangerous enlargement or shrinking of the brain (Bonea, 2019). Such fears had significant political implications, especially as the later nineteenth century witnessed the development of public health and public education discourses. From a gender perspective, the idea that an imbalance of mental energies would affect bodily functions was long used as an argument against women's access to higher education, thought to potentially leave them barren.[43] In this section, I will explore the various manifestations of mental strain in *Middlemarch*, and how Eliot uses them as expressions of her organicist vision of the (literary) world.

Though the origin of various diseases may have increasingly been localised in excessive mental exertions, Victorian popular and medical discourses did nonetheless give ample space to their physical manifestations, drawing connections between the three organs of brain, gut, and heart. What unites these organs is the phenomenon of feeling. As mentioned earlier, Victorians—and Victorian women in particular—were taught to view their bodily health as resting on a fragile balance of resources, a framework borrowed from contemporary research in energy physics and from the economics of supply and demand (Taylor-Brown, 2018, p. 117). In this sense, 'A faulty digestion might starve the intellect of adequate resources of nervous energy, or vice versa, leading to nervous collapse' (Taylor-Brown, 2018, p. 117). Meanwhile, diagnostic medicine was

[42] In this exchange, there is a weighty implicit subtext of the conversation, which is that Lydgate is hoping to be offered financial help from Bulstrode, which acts as a distractive force in his interaction with the banker. When Bulstrode mentions leaving Middlemarch for a temporary residence at a place by the coast, in the name of 'salubrity', Lydgate almost absentmindedly agrees with the resolution without offering any further advice (*MM* Ch. 67, p. 421).

[43] Such discourses were often imbued with fears of social involution, or degeneration. For example, in the physiological study, 'Sex in Mind and in Education' (1874) medical psychologist Henry Maudsley (1835–1918) argued that, due to the impossibility of devoting equal energy resources to the brain and the reproductive system, women's intellectual work would come at the price of 'a puny, enfeebled, and sickly race' (cited in Leighton & Surridge, 2012, p. 199).

introducing significant advancements in the identification of heart disease, which had become perceived as among the most frequent causes of death, with one *Times* reporter going as far as to call it responsible—rather unscientifically and alarmingly, it must be noted— for '95 sudden deaths out of 100' (Blair, 2003, p. 291). Further, the heart was seen as the centre of sympathy, meaning the 'influence of one organ on another', yet by the second half of the nineteenth century it was believed that negative emotions and events were the ones to have the most lasting and impactful effect on the heart (Blair, 2003, p. 291).

The mid-Victorian popularity of the 'fatty degeneration of the heart' diagnosis is shown in *Middlemarch* through the vicissitudes of Edward Casaubon, the middle aged, short-lived husband of Dorothea Brooke (Blair, 2003, p. 291). Mental strain, gut, heart, and feeling are all deeply interconnected in Casaubon's storyline, which serves as both a cautionary tale and the representation of organicism at work in Middlemarch. As previously mentioned, Edward Casaubon's illness operates on both the narrative and figurative level. On the one hand, it frames Dorothea's regrettable choice of life partner as a youthful error she can recover from, creating the conditions for her growth. On the other hand, it uses the diseased anatomical heart of Casaubon to reinforce the notion of his inability to feel affection (Blair, 2003, p. 291). On examining the final moments of his illness, something else emerges, that is, a strong convergence of psychosomatic elements. While the plot foretells Casaubon's susceptibility to disease by emphasising his having 'no good red blood in his body' (*MM* Ch. 8, p. 45), his untimely death is punctuated by considerations over his mental state, represented by the devotion of his brain energies to a dead-end project, and the gradual sedimentation of his jealousy of his cousin's Ladislaw.

As reported by Halstead, George Eliot herself suffered from a range of health complaints, and she described having symptoms of indigestion, biliousness, and hemicrania in her lifetime (1946, pp. 420-21). Like many contemporaries, both fictional and not, the search for a cure brought her and her lifetime companion to various health spas and resorts (Shuttleworth & Dickson, 2021, p. 216). G. H. Lewes himself was diagnosed with nervous exhaustion and the pair is reported to have received advice from his doctor to 'seek "bracing air and rest from brain-work"' (Shuttleworth & Dickson, 2021, p. 220). In 1872, as Eliot was finishing *Middlemarch*, she experienced a relapse of nervousness that brought her and Lewes to Homburg 'in search of health' (Shuttleworth

& Dickson, 2021, p. 220).[44] In 1903, some twenty years after her death, Eliot's personal correspondence and diary entries were collected in the *Biographical Clinics* by physician and medical writer George M. Gould (1848-1922), in which he analysed the medical lives of fourteen Victorians (Halstead, 1946). Dr Gould pinpointed eyestrain as the common denominator and major disruptor of health of all the medical accounts, which included the "clinical" biographies of De Quincey, Darwin, and Nietzsche (Halstead, 1946). While his analysis was already considered outdated by Halstead's time, the focus on eyestrain and its domino effects on the body and mind speaks to the late-Victorian concern about mental fatigue and is crucial to understand the role and development of Casaubon's illness in *Middlemarch*.

Casaubon's eyesight is already declining during his courtship of Dorothea, when he admits to needing a reader for his evenings, and that he uses 'the utmost caution about [his] eyesight' (*MM* Ch. 2, p. 12). The narrator emphasises that his missing dioptres have been lost to the *Key to All Mythologies*, the ambitious research project to which he is devoted. The sensory focus on eyesight and the excessive stress it is put under is amplified by certain lateral discussions on the expectations of Dorothea as Casaubon's wife. Dorothea expresses her desire to learn the Greek alphabet so she may 'read Latin and Greek aloud to you, as Milton's daughters did to their father' (*MM* Ch. 7, p. 41). To this proposal, her uncle and guardian Mr Brooke objects that such a task would not be appropriate for a woman's mind and expresses regret at her niece's lack of proficiency at the better suited activity of playing the piano. Mr Casaubon, however, rejects such suggestions, indicating his dislike of music, to which Mr Brooke replies: 'the bow always strung—that kind of thing, you know—will not do' (*MM* Ch. 7, p. 42). This warning is not some straightforward advice against extreme fatigue, for it also places an important emphasis on the power of aurality. Hadjiafxendi's analysis of the novel has revealed that hearing plays a very important role in the construction of Eliot's realism (2014, p. 24). In this scholar's view, serving as a contrast to the dominant nineteenth-century idea of seeing as knowing, Eliot uses aurality 'to question the visual as the very premise of realism' (Hadjiafxendi, 2014, p. 24). This intent is present in her other novels, too, most notably

[44] As Shuttleworth and Dickson note, 'Homburg was much advertised in British newspapers, journals, and travel guides, boasting an unrivalled summer climate and the perfect conditions for curing nervous conditions' (2021, p. 220). This trip is thought to have inspired the writing of *Daniel Deronda*, Eliot's last novel.

in *The Mill on the Floss*, where Maggie's 'awakening of a sympathetic conscience' is described using language and metaphors that borrowed directly from German physician von Helmholtz's study on *The Sensations of Tone* (1856), which focused on hearing as 'a bodily form of sympathetic vibration' (Hadjiafxendi, 2014, p. 27). In *Middlemarch*, Casaubon's focus on eyesight is contrasted with Dorothea's aurality, to which the novel pays particular attention when, at a later point in the novel, Will Ladislaw complains about the limitations of artistic mimesis in pointing out that no painter could represent her voice (Hadjiafxendi, 2014, p. 29). I believe the significance of Eliot's representation of aurality is not, as Hadjiafxendi concludes, to reverse the binary opposition of male/visual and female/aural, but to reject a vision of humanity that compartmentalises sensory and emotive perceptions rather than embracing the fullness of sympathetic experience. In practice, this operates as a rejection of the scientific masculinity embodied by Casaubon and Lydgate, who fail to embrace interconnectedness and remain stuck in their own perspective, suffering physical and mental consequences for it. Casaubon represses feelings of 'jealousy and vindictiveness', and his body becomes rigid when Dorothea tries to help him stand (*MM* Ch. 61, p. 262). In her discussion on *Adam Bede*, Megan Kennedy writes that, for Eliot, 'lack of sympathy is actually a lack of knowledge. She implies that the accurate detail produced by a mechanical observation educates and enlarges the viewer' (2010, p. 140). It is possible to read *Middlemarch* as an amplified exploration of this notion—Casaubon is unable to finish his *Key*, not merely because his eyesight was compromised, but because his ultimate reliance on vision alone blocked all other possible avenues for sympathy and knowledge.

As previously touched upon, feeling is the invisible tissue connecting sensory perception, sympathetic experience, and knowledge. Feeling is directly connected to the heart and the stomach, but it is also a response to memory, the inner vision of time. Memory plays an important role in Bulstrode's storyline, as Shuttleworth has noted (1984, p. 154). The psychosomatic resurfacing of his memories is the materialisation of long-buried guilt toward the knowledge that the fortune he built his life around should have been claimed by another legitimate heir. Eliot describes how Bulstrode's body reacts to the memories in vivid, realistic detail:

> […] intense memory forces a man to own his blameworthy past. With memory set smarting like a reopened wound, a man's past is not simply a dead history, an outworn

> preparation of the present: it is not a repented error shaken loose from the life: it is a still quivering part of himself, bringing shudders and bitter flavors and the tinglings of a merited shame (*MM* Ch. 42, p. 264).

As Shuttleworth explains, Eliot locates Bulstrode's memory in his bodily reactions, which include 'shudders, convulsions, palpitations', thus creating a strong interdependence between a person's life and history, physiology, and experience (Shuttleworth, 1984, p. 154). It is implied that these symptoms are somewhat responsible for Bulstrode's dyspepsia, just as Casaubon's consuming jealousy seemed to accelerate his heart failure, and it is notable how Dr Lydgate, who visits them both and recognises that the origin of their symptoms cannot be explained solely in physiological terms, is yet unable to connect more deeply to their emotional root. There is an undoubtable gender bias in Lydgate's prevalent focus on eyestrain, heart disease, or work-related stress in his diagnosis of the men. When newly widowed Dorothea experiences symptoms of a nervous disorder, he prescribes that the people in her life should 'let [her] do as she likes' and is able to conclude that 'she had been suffering from the strain and conflict of self-repression' more than from any weakness or illness of the body (*MM* Ch. 43, p. 268). Despite this display of awareness about the workings of emotional wellbeing, Lydgate fails to see the symptoms of repressed feelings in the other men he treats, as well as himself.

In fact, the discussion of mental strain in *Middlemarch* must include an analysis of Lydgate's character journey. Lydgate arrives, full of youthful optimism and updated medical knowledge, into a town that 'counted on swallowing…and assimilating him very comfortably' (*MM* Ch. 15, p. 99). Not unlike Dorothea, he makes the wrong choice as to life partner, and after his project of opening a new hospital for the diagnosis and treatment of fevers fails and he finds himself in a financial crisis, Lydgate eventually forgoes his initial career aspirations and becomes a high-charging physician working between London and 'a Continental bathing place' (*MM* Finale, p. 512). He "sells out", betraying his principles for marital peace; he abandons the 'fine America' of pathology and writes a treatise on 'Gout, a disease which has a good deal of wealth on its side' (*MM* Finale, p. 512). Porter and Rousseau present the possibility that the tragic irony of Lydgate's treatise on gout may hide the more serious experience of male depression (1998, p.170). The word "suppression", which Lydgate uses to diagnose Dorothea, was the common term for various symptoms of what twenty-first century doctors would call depression, and in the

nineteenth century 'gout also became the vehicle for explaining "suppressed" illness, even "suppressed" emotions and feelings', meaning that suppressed gout was linked by some doctors to the development of depression in men (Porter & Rousseau, 1998, p. 168). There is a certain subtle symbolism in Eliot's choice of focusing on Lydgate's "surrender" to high-paying research on gout, combined with his premature passing aged fifty and the lack of explanation as to the exact cause of his, a doctor's, death (Porter & Rousseau, 1998, p. 168). Because Eliot's medical sources on the effects of suppressed gout are unknown and opinions differed even among Victorian medical men, this theory bears a high amount of speculation, yet it would appear to reinforce both the close connection between feeling and body, and the representation of men's suppressed emotions and its effects throughout the novel (Porter & Rousseau, 1998, p. 168).

When it comes to George Eliot and her sources, critics have sometimes been quick to draw a direct line between the (amateur) scientific publications of G.H. Lewes and the ideas she communicates in her novels. We know from Eliot's *Quarry* that her preparation for *Middlemarch* was meticulous (though perhaps not as varied as it could have been, for most of her medical sources came from the *Lancet*), and that it involved several scientific articles. Further, as Diana Postlethwaite notes, 'even before she met Lewes and became "George Eliot", Marian Evans was engaged in contemporary scientific thought' (2001, p. 100).[45] Science was therefore a common interest for Lewes and Eliot, which they expressed through different, and often complementary, avenues. Lewes worked on what is perhaps his best-known work, *The Physiology of Common Life*,[46] just as Eliot was writing *Adam Bede* (Postlethwaite, 2001, p. 107). 'There was a fundamental intellectual affinity', as Postlethwaite puts it, 'between their endeavors: Lewes aspired to be a "poet in science"; Eliot, to be a "scientific poet"' (2001, p. 107). Though their partnership of life and mind was perhaps more flawed than the usual tendency to represent it,[47] it has

[45] Postlethwaite emphasises Eliot's early interest in phrenology as 'a kind of "geology of the mind' and reports a trip to London in the summer of 1844 during which she had her head "cast" by phrenologist James Deville. In addition to the (pseudoscientific, and prone to all kinds of biases) claim that character could be detected through "cranioscopy", the appeal of phrenology lay in the then-controversial idea that the brain was the organ of the mind, and that regions of the brain could control or determine personality (2001, p. 104).

[46] We may consider the fact that the theory on nerves it contained was read by Pavlov in its German translation as a marker of Lewes' success as amateur physiologist (Smith, 1976, p. 7).

[47] See for example Beverly Rilett (2017), 'The Role of George Henry Lewes in George Eliot's Career: A Reconsideration' *George Eliot—George Henry Lewes Studies* 69, (1), pp. 2-34. doi:10.5325/georelioghlstud.69.1.0002

been shown that their ideas were mutually influential, and *Middlemarch*, described as the most "scientific" of Eliot's novels (Postlethwaite, 2001, p. 114), incorporates several conceptualisations of physiology and science-adjacent topics that are found in Lewes' treatises.[48]

This was a necessary preamble for discussing the value of scientific concepts in *Middlemarch*, many of which are fictionalised expressions of ideas elaborated by Lewes. Apart from the formerly discussed representation of Lydgate's professional struggles and research interests in pathology, which were recognised as deeply rooted in the experience of late 1820s physicians, the novel subsumes science and scientific thought into larger theorisations of society and politics, according to the author's organicist vision. Here is where the influence of G.H. Lewes' writings is most noticeably felt. Years prior to obtaining her pen name and writing her first novel, Marian Evans published a review of two volumes by W. H. Riehl (1823-1897) in an essay called 'Natural History of German Life' in which she embraced the Comtean hierarchy of sciences, of which "concrete" social sciences constituted the top tier (Postlethwaite, 2001, p. 105). As Postlethwaite explains,

> Comte organizes the universe into a hierarchy of sciences, from mathematics and astronomy –the most abstract –up to biology and "social physics" –the most concrete (and note that Comte places the concrete "above" the abstract in his conceptual hierarchy). When the ultimate, positivistic stage is reached, the fundamental unity of all sciences will be clear, "all phenomena . . . particular aspects of a single general fact" (Comte, *Cours*, p. 72). Once the "chasm between physics and physiology" has been bridged, the universality of causality and law established throughout the organic as well as the inorganic creation, the doors will be opened to a new, scientific, view of humanity (2001, p. 106).

Middlemarch itself is a sociological and psychological analysis first and foremost, despite its deep engagement with medical science, as its subtitle, 'A Study of Provincial Life', makes no attempt to hide.[49] This information is very important for the

[48] In 'George Henry Lewes, The Real Man of Science', Beverly Rilett retraces the reception of Lewes' essays on Comte, aimed at popularising the French thinker for a British audience, and reports of a spat between Eliot and fellow writer and friend Harriet Martineau, who had (according to Eliot) shown her ignorance in her criticism of Lewes' work (2016, p. 6).

[49] Forming part of the life sciences, medicine was considered by Comte as below the social sciences but above more abstract sciences like mathematics or physics (Sklair, 2003, p. 36).

understanding of how the body-mind connection is represented in the novel by Eliot, because the author does not only create a realistic representation of an 1820s perception of bodily ailments and their causes and effects in the phenomena of the mind, but she also integrates all these physical bodies into a complex interdependent social organism that is at once a spider-web of connections and a unified entity. Thus, individual bodies become collective bodies; particulars become universals in *Middlemarch*. Through the distance given by the historical setting and the narrative imagination, only the author herself is able to discern and explain this complexity:

> I at least have so much to do in unraveling certain human lots, and seeing how they were woven and interwoven, that all the light I can command must be concentrated on this particular web, and not dispersed over that tempting range of relevancies called the universe (*MM*, Ch. 15, p. 91).

As quoted by Shuttleworth, in *The Foundations of a Creed* Lewes states a theory of motion as feeling, which Eliot incorporates into *Middlemarch* (1984, p. 159). In this text, Lewes wrote that 'In a vital organism every force is the resultant of *all* the forces; it is a disturbance of equilibrium, and equilibrium is the equivalence of convergent forces' (Shuttleworth, 1984, p. 159). Shuttleworth uses the example of Casaubon's inner disappointment with his lack of passionate feelings at the prospect of his impending nuptials as an example of Eliot's use of Lewes' theory of motion to portray a character's psychology, and shows how, in the novel, action is often regarded as a discharge of emotional energy (Shuttleworth, 1984). By contrast, inaction is often described as lack of motion, rather than outright stillness. The adjective "motionless" appears eight times in the novel and, in most of the occurrences, it describes a situation in which the characters are stunned by, or intimidated by, their feelings, interrupting the flow of energy in their bodies:

> Dorothea sat *almost motionless* in her meditative struggle, while the evening slowly deepened into night. But the struggle changed continually, as that of a man who begins with a movement towards striking and ends with conquering his desire to strike (*MM* Ch. 62, p. 266, my emphasis).

> Rosamond and Will stood *motionless*—they did not know how long—he looking towards the spot where Dorothea had stood, and she looking towards him with doubt. (*MM* Ch. 78, p. 479, my emphasis)

> Dorothea was afraid of her own emotion. She looked as if there were a spell upon her, keeping her *motionless* and hindering her from unclasping her hands, while some intense, grave yearning was imprisoned within her eyes (*MM* Ch. 83, p. 497, my emphasis).

I have drawn attention to the sociological and psychological aspects of feeling, energy flow, and interconnectedness in *Middlemarch* not merely to provide a better understanding for the context in which scientific knowledge and language is included in the novel, but also to show how the body occupies a primary role in all these interdependencies. Laura Otis has argued that Eliot's insistence on the interconnectedness of the body is, to some extent, going against the emerging scientific discourse on the cell (Otis, 2005, p. 136). One of the ways in which cell theory was received in popular and literary culture was a new emphasis on the individual, what she labels the 'membrane model' (Otis, 2005, p. 136). According to this model, membranes of the cell become boundaries of identity, containing information about the self, such as memory and heredity (Otis, 2005, p. 136). Otis' monograph *Membranes* (2000) is devoted to the analysis of late-Victorian scientist-writers and to 'comparing the words that they used to describe cells and individual people' (Otis, 2005, p. 136). Otis found, in that analysis, 'a cultural pattern of defining healthy people, minds, and nations, by means of protective, semi-permeable boundaries' (Otis, 2005, p. 136). However, that analysis did not account for writers like George Eliot, who did not emphasise 'individual cells as protagonists' but 'conceived of individuals as intersecting points in a social network' and opposed visualisations of 'nerve nets' to those of cell conglomerates (Otis, 2005, p. 136). This representational opposition might be seen as a literary extension of a longstanding dispute in the late-Victorian scientific community about the structure, or rather the composition, of nerves. This debate was put to an end in 1907, when American biologist Ross G. Harrison (1870-1959)

> […] reported his successful growth [achieved adapting a technique for lab-grown cultures of bacteria] of nerve cells from segments of amphibian embryonic tissue. Harrison's experiments were noteworthy for finally resolving a longstanding dispute over whether the nervous system was composed of individual nerve cells (neurons) or a continuous network of protoplasmic fibers (Reynolds, 2018, p. 88).

Scratching beyond the surface, though, there is a lot more complexity and nuance to this debate, in which G. H. Lewes played a significant, and often overlooked, part

(Price, 2014, p. 108). In *Problems of Life and Mind*, Lewes articulated the hypothesis that the 'neuroglial cells', the non-neural cells found in the brain, had an important function within neural processes, something which recent studies have discovered has a lot of merit (Price, 2014, p. 108). Further, Lewes wrote in his *Physiology of Life and Mind* 'that the Brain is only one organ of the Mind, and not by any means the exclusive centre of Consciousness.' (in Menke, 2000, p. 621). According to Lewes, somatic and spinal nerves were extensions of the brain, therefore of consciousness (Menke, 2000, p. 621). Price and Menke's work uncover (and recover) the merit and lingering influence of Lewes's scientific research in a lot more detail and depth than I can attempt here, but the key idea I wish to emphasise is that 'Lewes argued for a holistic, *embodied* conception of the mind: "both physiologically and psychologically it is *we* who feel, and not any particular organ" and "this *we* means the total sensibilities of the whole organism"' (Price, 2014, p. 111).[50]

Reading *Middlemarch* with this knowledge, there can be little doubt that Eliot shared these views. Organicism is what allows Eliot to connect the microscopical with the macroscopical; the cell (or diseased tissue, in Lydgate's diagnosis) with a person's entire physical, emotional, and mental wellbeing; the individual body with the social body with its complex, interconnected ramifications. Mental strain, intellectual effort, emotional overload, all these elements are assimilated both by the individual bodies, expressed as insomnia, dyspepsia, or tremors, and by the social organism, setting off a chain of mechanical reactions that open certain storylines and interrupt the flow of others. Significantly, it is the characters that are able to recognise emotions and render unconscious processes conscious that are rewarded in the narrative construction of the multiplot, namely Dorothea and Will Ladislaw.[51] Mental strain and the repression of the flow of Energy (i.e. of emotions) signals the ruin of Casaubon, Bulstrode, and Lydgate, independent of the moral qualities they exhibit and for which they are either praised or chastised by the narrator. As Dorothea reaches emotional maturity, she moves past the

[50] One other significant contribution by Lewes was that he advocated strongly for a distinction between volitional, conscious processes, and unconscious, mechanical reflexes in the mind. He argued that unconscious cognition was 'a Sentient state, not the entire absence of Sentience we attribute to a machine' (Price, 2014, p. 111). At the same time, for sentience to occur unacknowledged from consciousness, he postulated that the process must be, to some extent, mechanical (Price, 2014, p. 111). This conceptualisation marries vitalism and organicism, for 'Whilst the nervous system played a central role in Lewes' system, he held that "*every neural phenomenon involves the whole Organism"* (Price, 2014, p. 111).

[51] Duncan has identified Ladislaw as the spokesperson of Eliot's organicism (and, I might add, of a successful model of masculinity), for he defines the artist as possessing 'a soul in which knowledge passes instantaneously into feeling, and feeling flashes back as a new organ of knowledge' (2013, p. 480).

fatigue and delirious state in which she had been found by Lydgate ('she was talking deliriously, thinking aloud', *MM* Ch. 48, p. 299). In the following passage, I have emphasised some phrases that highlight how Dorothea directs her mental efforts toward self-consciousness at a crucial time in which she is striving not to succumb to the physiological manifestations of her emotions:

> Her world was in a state of convulsive change; the only thing *she could say distinctly to herself* was, that she must wait and think anew. One change terrified her as if it had been a sin; it was a violent shock of repulsion from her departed husband, who had had hidden thoughts, perhaps perverting everything she said and did. Then again she was *conscious* of another change which also made her tremulous; it was a sudden strange yearning of heart towards Will Ladislaw. It had *never before entered her mind* that he could, under any circumstances, be her lover: conceive the effect of the sudden revelation that another had thought of him in that light—that *perhaps he himself had been conscious* of such a possibility,—and this with the hurrying, crowding vision of unfitting conditions, and questions not soon to be solved (*MM* Ch. 50, p. 304-305, my emphasis).

At this stage, Dorothea accepts the convulsions and tremors of her body and the physical manifestations of a new consciousness, which allows her to see how her present condition came into being—namely, the jealousy and suspicions of infidelity of her late husband—and her path forward, traced by these new feelings for Will Ladislaw that had been growing unconsciously, but are now visible in her mind. Mental strain becomes emotional clarity, as it is made rather explicit in the final confrontation between Dorothea and Rosamond, whom she suspects of harbouring romantic feelings for Will:

> *All the active thought* with which she had before been representing to herself the trials of Lydgate's lot, and this young marriage union which, like her own, seemed to have its hidden as well as evident troubles—*all this vivid sympathetic experience returned to her now as a power*: it asserted itself *as acquired knowledge* asserts itself and will not let us see as we saw in the day of our ignorance (*MM* Ch. 80, p. 485, my emphasis).

Thus, in *Middlemarch* there seem to be only two sets of people that successfully mediate the flow of energy between body and mind, recovering from mental strain and achieving clarity of feeling: artists and women.

3.3 Femininity, the Body, and Nervous Disorders

As the discussion on biliousness, hypochondria, and mental strain demonstrates, nervous disorders in the nineteenth century were by no means the exclusive domain of female bodies and minds. Nevertheless, the perception of women's mental and physical frailty created deep-seated beliefs over women's proneness to psychological disorders, which is in turn reflected on the literature of the period.[52] In this section, I want to discuss the ways in which Austen and Eliot both reinforce and challenge the notion of women's psychological fragility in their representation of feminine nervousness, which shows significant common ground between the two authors. Neither writer can be exempted from the criticism of leaning into the cultural and literary trope of the nervous woman, for they both choose to depict female characters whose symptoms and causes of illness are mainly psychological. Nonetheless, the way in which Austen and Eliot represent female nervousness is not grounded in biological determinism, but rather in socioeconomic conditions.

Save for a few notable exceptions, such as Harriet Smith's "putrid fever" in *Emma*, Mrs Croft's blisters, and Mrs Smith's pains in *Persuasion*, Austen avoids representing physical ailments in women. Instead, as I have touched upon in Chapter 2, she gives detailed representations of nerves, fatigue, and distress, conditions which carry their own bodily symptoms. Some attention has already been given to Mrs Bennett's tremors and convulsions, deriving from the pressure of having her five daughters' marriages and security as the sole 'business of her life' (*PP* Ch. 1, p. 5), and to the 'hysterical agitations' exhibited by Mary Musgrove when overwhelmed by motherly duties and general expectations of feminine behaviour (*PER* Ch. 12, p. 74). In this section, I wish to focus on some of the positive characters in Austen's later novels, and their struggles with nervous disorders. As I will demonstrate through a comparison with Eliot's representation of female nervousness, both writers are intentional in their portrayal of nervous disorders as the consequence of stifling environments, emotional repression, and social norms. Two of Austen's characters who exhibit and battle with these symptoms are Jane Fairfax in *Emma*, and Anne Elliot in *Persuasion*.

[52] See, for example, Arnaud, S. (2015). *On Hysteria: The Invention of a Medical Category Between 1670 and 1820*. Chicago: Chicago University Press. Chapter 5 on 'Relating Fits and Creating Enigmas: The Role of Narrative' explains how women's hysterical symptoms became embedded, in various forms, in the literary narratives of late eighteenth- and nineteenth-century fiction.

Jane Fairfax returns to Highbury under the pretence of curing the lingering symptoms of a bad cold by spending time in a familiar environment, or, as she justifies it, by trying 'an air that always agrees with her' (*EM* Vol II, Ch. 1, p. 112). In reality, she is planning to meet her secret fiancé, Frank Churchill. Frank's very ill aunt and former guardian is extremely protective of the family fortune and would oppose his marriage to penniless Jane, prompting the red herrings, secretive gift-giving, and strange behaviours of this subplot of the novel, which has been read through the lens of detective fiction.[53] When Emma first sees Jane after the latter's prolonged absence from Highbury, she is struck by her elegance and bloom, even though she appears to notice 'a slight appearance of ill-health' (*EM* Vol II, Ch. 2, p. 116). As Amy King has shown, the concept of bloom and the use of botanical language derived from Linnaeus signals in Austen not only health, beauty, and sexual prime, but also marriageability in its broader social and economic connotations (King, 2003, p. 143). In acknowledging Jane's bloom, Emma recognises the qualities she could bring to a marital union, her elegance and accomplishment. The socioeconomic layer of meaning associated with bloom in Austen also explains why Emma perceives no contradiction in noticing hints of bloom and illness at once in Jane Fairfax face, though second-time readers may find a clue, here, that something is not quite as it should be. Whether this initial indicator of physical illness is real or perceived through the influence of Miss Bates' account, Jane's health does deteriorate throughout the novel. However, the symptoms she exhibits later in the plot are linked to the difficulties she faces in keeping the secret of her engagement while facing the rising pressures of finding employment to support herself financially, of witnessing her fiancé's flirtatious behaviour toward Emma, and of having to bear everyone's (especially Emma's) speculations about a secret admirer of hers. Gradually, the weight of her deception and the uncertainty surrounding the effective likelihood of her marriage to Frank prove unbearable, and she becomes 'wearied in spirits' (*EM* Vol III, Ch. 6, p. 250). As Anita Gorman notes, 'In Austen's later work, hysterical symptoms—those of Fanny Price and Jane Fairfax come to mind—stem less from self-imposed romantic delusions than from outside forces' (Gorman, 1993, p. 104). Gorman's analysis of Fanny Price in *Mansfield Park* shows how 'her behavior may on occasion mimic hysterical

[53] See, for example, David H. Bell. (2007). Fun with Frank and Jane: Austen on Detective Fiction. *Persuasions: The Jane Austen Journal Online, 28*(1) https://www.jasna.org/persuasions/online/vol28no1/bell.htm , accessed 12 March 2023.

symptoms but she is saved from hysteria by her inner strength, sensitivity, strong moral principles, and Austen's narrative point of view (Gorman, 1993, p. 113). This is to say that Austen balances physical weakness with emotional strength as a way of increasing the readers' empathy toward the struggles of her characters, thus validating feminine nervousness as originating from external factors. I would take this idea further and argue that Austen's balancing act expertly complements the representation of nervous symptoms with physical strength, and vice versa. Jane Fairfax's emotional distress during the gathering at Randalls is counterbalanced by her insistence on walking home unescorted, needing 'the comfort of being sometimes alone' (*EM* Vol III, Ch. 6, p. 251). By contrast, in *Persuasion,* Anne Elliott's walk with her sister, Henrietta and Louisa Musgrove, and Captain Wentworth, during which she barely speaks and is forced to be privy to Wentworth's courtship of Louisa, ends with her physical exhaustion and her being taken home in Admiral Croft's carriage. For Austen's heroines (I ascribe Jane Fairfax's character to the category), the display of nervous symptoms is accompanied both by the legitimisation of their feelings, and by a parallel emphasis being placed on the strength of their bodies. Similarly, when the body collapses, these women's strength is shown in their moral fortitude and their ability to bear the emotional load that is placed upon them. John Wiltshire has noted how, in *Emma*, Mr Woodhouse tells Jane that 'young ladies are very sure to be cared for', essentially positioning women as eternal patients, at once entitled to be cared for by others and robbed of their agency (Wiltshire, 1992, p. 119). Jane Fairfax lacks agency with respect to the future of her marriage to Frank, and Anne Elliot's situation is not much different, for rules of propriety and gender politics prevent her from talking explicitly with Captain Wentworth about her feelings, forcing her to wait, with some degree of passivity, for a declaration of love. Her frustration reaches its peak during the scene at the theatre, when her new suitor Mr Elliot exploits his social advantage to claim her company and prevent her from interacting with the Captain. 'When her own mistress again…she found herself accosted by Captain Wentworth' (*PER* Ch. 20, p. 126), notes the narrator, showing concisely the negative impact of social conduct rules on women's agency and emotional health.[54] In Austen's game of contrasts, feminine nervousness is not so much the product of delicate frames

[54] This is also reminiscent of Emma's remark to Mr Knightley about the difficulties of dependance: 'That's easily said, and easily felt by you, who have always been your own master' (*EM* Vol I, Ch. 18, p. 103).

and minds, but of the society-dictated impossibility to express themselves as their male peers. When Frank Churchill appears at Randall feeling 'cross', complaining about the heat, and talking of moving to Switzerland, he is "cured" by Emma's emotional labour, and calms down. And when Captain Wentworth is consumed by feelings of regret at having encouraged Louisa's imprudent jump at Lyme, as he is travelling to break the news to the young woman's family, he suddenly addresses Anne with a view to consult her on the best course of action. As soon as she agrees with his plan 'he was satisfied, and said no more' (*PER* Ch. 12, p. 79). Austen's two main cures for women's emotional repression and the associated hysterical symptoms are extensive walking, and private recollections. Here is an excerpt of Anne Elliot processing her feelings after an unexpected interaction with Captain Wentworth:

> […] neither Charles Hayter's feelings, nor anybody's feelings, could interest her, till she had a little better arranged her own. She was ashamed of herself, quite ashamed of being so nervous, so overcome by such a trifle; but so it was, and it required a long application of solitude and reflection to recover her (*PER* Ch. 9, p. 54).

Self-reflection, in Austen's works, calms the body and the mind of her heroines, and those characters who are unable to sit alone with their thoughts, such as Mrs Bennett and Mary Musgrove, are the ones who appear most affected by nervous disorders.[55]

The importance of the quiet recollection of feelings is one of the distinctive features of Austen's Romanticism, bearing strong similarity with the Wordsworthian principle of 'emotions recollected in tranquillity'—even though Wordsworth intended for recollections to organise the 'spontaneous overflow' of poetry, rather than women's emotional overload (Mason, 2007, p. 82). This emphasis on solitary recollections is not featured as explicitly in Eliot's writing, despite the similar manifestations of women's nervousness that feature in her novel. However, something else occurs in *Middlemarch*,

[55] In her juvenilia writings and earlier novels, *SS* and *NA* in particular, Austen also shows the intersections of women's botanical remedies with the emotional support of the love of friends and family. One self-medication which was commonly used for treating nervous and hysterical symptoms in women was lavender water, and Austen mentions this treatment in the aforementioned novels, as well as the novella "Kitty, or the Bower" (Spear, 2020, p. 217-218). In *SS*, both Elinor and Marianne are revived with lavender water, while in *NA* Marianne takes up the role of healer, using lavender to revive her friend Miss Tilney. It is interesting that in *Persuasion*, with a "hysterical" character like Mary Musgrove, lavender water is never shown, and I believe this mirrors the gradual shift in the understanding of nervousness as primarily psychological in nature.

which is that the crushing weight of Dorothea's emotional load is acknowledged by Lydgate after he visits her:

> "Let Mrs. Casaubon do as she likes," he said to Sir James, whom he asked to see before quitting the house. "She wants perfect freedom, I think, more than any other prescription." His attendance on Dorothea while her brain was excited, had enabled him to form some true conclusions concerning the trials of her life. He felt sure that she had been suffering from the strain and conflict of self-repression; and that she was likely now to feel herself only in another sort of pinfold than that from which she had been released (*MM* Ch. 50, p. 305).

Lydgate's interaction with Dorothea at this moment is coloured with sincere empathy and human connection and appears not to be much affected by gendered behaviours, save for the administration of 'sal volatile', an 'aromatic alcoholic solution of ammonium carbonate' (*MM* Ch. 50, p. 305; Hornback, 2000, p. 305). Nevertheless, he believes Dorothea's self-evaluation of her bodily strength even as she experiences significant mental distress. Many readers, past and present, have seen Lydgate and Dorothea as the unfulfilled potential of a true marriage of minds and intentions. One of them was Henry James, who wrote that the two characters are 'two suns in her [i.e. Eliot's] firmament' and 'Towards the close…are brought into momentary contact so effectively as to suggest a wealth of dramatic possibility between them' (Hornback, 2000, p. 580). Caldwell notes that Lydgate and Dorothea's encounters are 'brief, but, interestingly, quite symmetrical' (2004, p. 162)—he provides medical advice and support during Casaubon's illness as well as a project she is enthusiastic to sponsor, and she offers financial assistance toward his hospital as well as interceding to placate his conflict with Rosamond. Because of this symmetry, Lydgate and Dorothea interact as equals, and she is free to behave in ways that Lydgate admittedly finds repulsive in a potential wife, as he believes that charm, in a woman, should look less like earnest, thoughtful conversation than the ability 'to produce the effect of exquisite music' (*MM* Ch. 11, p. 61). The parallels between Dorothea and Lydgate, however, do not end at their respective acknowledgment of their unhappy marriages. In diagnosing self-repression as the cause of Dorothea's malaise, Lydgate displays insight and awareness alongside denial and naïveté, for he fails to see that Dorothea's state of mind is replicated, with slightly different symptoms, in his own domestic environment.

The first glimpses readers get of Dorothea's married life are filled with the vocabulary of oppression. After the honeymoon in Rome, Dorothea begins to see that her idea of an 'active wifely devotion which was to strengthen her husband's life and exalt her own' (*MM* Ch. 20, p. 123) was terribly misguided, and that

> […] the stifling oppression of that gentlewoman's world, where everything was done for her and none asked for her aid—where the sense of connection with a manifold pregnant existence had to be kept up painfully as an inward vision, instead of coming from without in claims that would have shaped her energies (*MM* Ch. 20, p. 173).

Despite appearing positioned as embodying radically different ideas of womanhood, Dorothea's situation is much closer to Rosamond's than it may seem. Both are drawn to marriage for the wrong reasons, for both displace their own self-fulfilment in their husbands' life purpose, and they find themselves equally disappointed by their choice. Rosamond projects her idea of financial success and fashionable lifestyle onto the rising medical profession and sees Lydgate as the person who will materialise her desired lifestyle in her place. This is not too distant from Dorothea's search for a father figure who will invest his time in her development and guide her in the process. On the other end of the equation are two men who see wives as ornaments to their established lives and find themselves hindered, rather than uncritically supported, in their newly married lives. Carroll (2009) has examined Eliot's masterful unpicking of the two major narratives of Victorian England, those of vocation and marriage. In depicting the cloud of miscommunication and gender expectations surrounding the institution of marriage, Eliot also situates the origin of women's nervousness in the oppressive construction of domesticity.

In amplifying Rosamond's discomfort and perceived oppression within her marriage I do not wish to overextend the amount of sympathy the narrator displays toward her character. It is very tempting to read Rosamond's arc through a contemporary feminist lens and condemn Lydgate's part in the failure of the marriage, from his condescending language to his own emotional repression, which provide reasonable explanations for why Rosamond was seeking validation from other men such as Captain Lydgate and Will Ladislaw. Doreen Thierauf has gone as far as reading Rosamond's insistence on going horseback riding while pregnant as evidence of her intention to procure an abortion (Thierauf, 2014, p. 482). Thierauf's analysis is compelling, especially insofar as it

highlights the importance of desirability for Rosamond and her finding herself at a crossroads between her changing body and the renewed attentions she was receiving from Captain Lydgate (Thierauf, 2014, p. 484). Nevertheless, the novel itself provides very little information that could support such a reading. While the narrator makes Dorothea's thoughts and aspirations known to the readers, Rosamond's inner life remains somewhat mysterious. Her physicality and outer appearance are often the sole descriptors for her behaviour, notably the movements of her gold locks and "swan-like" neck.[56] Nevertheless, there are some indicators that her confrontational behaviour toward her husband and lack of support of his medical career are rooted in her own self-repression. After her miscarriage she notices that her husband 'elapsed into what she inwardly called his moodiness—a name which to her covered his thoughtful preoccupation with other subjects than herself' (*MM* Ch. 58, p. 361). This sentiment is not wholly unrecognisable from Dorothea's bitter realisation that 'She was always trying to be what her husband wished, and never able to repose on his delight in what she was' (*MM* Ch. 48, p. 295).

If Austen's female characters are shown seeking temporary solitude to recollect and process their emotions, Eliot depicts women regulating their emotions and organizing their thoughts through tears. Tears are, of course, an inherently gendered phenomenon, being socially sanctioned as an expression of distress for women while simultaneously condemned in men. Thus, we see all of Austen's heroines cry at key moments. In *Middlemarch*, however, tears do more than relieve momentary misery. As Cantwell argues, tears undertake, for Eliot, a symbolic role that plays into Victorian ideas of flow, circulation, and interconnectedness (2019, p. 29). According to Cantwell, Eliot distances her characters' tears from contemporary sensation writing and melodrama, which emphasises the performative nature of women's tears as a vehicle of 'a range of intense emotional responses, from hysterical overwhelm to profound grief and moral regeneration' (2019, p. 29). Instead, she 'pursues a more scientific interest in these bodily fluids as they manifest each person's history of inherited traits' (Cantwell, 2019, p. 29). Caldwell's analysis focuses on Rosamond and Dorothea's tears as representative of their connection to their lineage. Rosamond cries, somewhat performatively, to encourage Lydgate's proposal and secure her social climb, and Dorothea is shown sobbing for the

[56] Gillian Beer's *Darwin's Plots* (2009) analyses Darwinian influences in Eliot's language and plots, with particular emphasis on the subject of sexual selection.

first time during her honeymoon, after realising that the promise of self-fulfillment she had attached to her married life had been misplaced. I think the analysis holds up to scrutiny, especially in the context of Darwinian language and imagery in *Middlemarch*, but I also want to draw attention to the women's tears as something that connects them, in a socially acceptable way, to both their inner journey and their social role in the town. Rosamond's sobs are described as "hysterical", the only use of the word in the novel. The narrator purposefully refrains from engaging in Rosamond's thoughts and feelings, which amplifies the perception of her character as vain and superficial, yet in acknowledging her hysterical outbursts there is a parallel recognition of self-repression and its damaging effects. Similarly, when Dorothea finally submits to her feelings for Will, she spends an entire night crying. The language that describes this scene is significant, for it purposefully attributes strength, both physical and emotional, to the act of shedding tears and its effects:

> […] she besought hardness and coldness and aching weariness to bring her relief from the mysterious incorporeal might of her anguish: she lay on the bare floor and let the night grow cold around her; while her grand woman's frame was shaken by sobs as if she had been a despairing child (*MM* Ch. 80, p. 485).

Dorothea is described as both child and warrior, submitting to her emotions while remaining unbothered by the harsh conditions of her environment. Her goal, however, is not to defeat the pain, but to embrace and understand it:

> She was vigorous enough to have borne that hard night without feeling ill in body, beyond some aching and fatigue; but she had waked to a new condition: she felt as if her soul had been liberated from its terrible conflict; she was no longer wrestling with her grief, but could sit down with it as a lasting companion and make it a sharer in her thoughts (*MM* Ch. 80, p. 485).

In *Middlemarch*, tears are the connecting fluid that brings together bodily and mental experiences for women. Dorothea's tears signal the soundness of her mind that is mirrored in her bodily strength, while Rosamond's reveal the hysterical self that is behind her façade of self-collectedness and performative gender norms. In both instances, they fulfil a specific function, that of relieving nervous disorders and regulating bodily and emotional health.

In this section, I have compared Austen and Eliot's different, yet comparable, representation of the strategies adopted by their female characters to counterbalance the effects of the nervous disorders they are prone to because of their socioeconomic position and the limitations connected to it. Thus, the writers can represent the ways in which nervousness occurs in women—deriving more from emotional repression than intellectual strain, social mobility, or valetudinarian attitudes—while also demonstrating effective, even transformative coping mechanisms. Even though they do not transgress the boundaries of authoritativeness within which they are circumscribed, both Austen's and Eliot's female characters are able to model several positive behaviours that succeed, even more than male characters of varying degrees of authoritativeness, in analysing and interpreting life and society. The last chapter of this dissertation is dedicated to the issue of authority and the ways in which it is signalled within the context of lay and professional medical science. As with nervous disorders, Austen and Eliot seemingly construct authoritativeness as the domain of their male characters in their novels, only to subtly deconstruct the authoritative gaze through the outwardly unthreatening yet fruitful ways in which their heroines use knowledge and power.

4 'A Nurse by Profession': Gender, Authority, and the Doctor

4.1 Challenges to Medical Authority in Austen's Works

Writing about *Sanditon*, Amy Mallory-Kani comments that 'The voice of institutionalized medicine is indirectly included in the novel through dialogue and narration […] but the words of a doctor—any doctor—are conspicuously absent' (2017, p. 315). As the discussion of Chapter 3 has shown, this is not limited to *Sanditon* but is a recurring feature of Austen's novels and one that contrasts with the prevalence of medicine as a thematic and plot element. In *Emma*, Mr Perry is as central to the cohesion of the Highbury community as he is to the validation of the worries of 'valetudinarian' Mr Woodhouse, which is demonstrated by the fact that his name is mentioned a total of 83 times in the novel, not far behind the very loquacious Miss Bates (Cooper, 2016, p. 132). During a scene that bears some resemblance to that in which Lydgate diagnoses Dorothea's overexertion in *Middlemarch*, Mr Perry expresses his concern about Jane Fairfax's 'nervous fever' and notices that 'her spirits seemed overcome' (*EM* Vol 3, Ch. 9, p. 268). However, the novel reports his diagnosis of Jane in the form of indirect speech

during a conversation between Emma and Mr Perry at Hartfield, thus blurring the lines between gossip and medical professionalism. According to Liz Cooper, Austen based the character of Mr Perry on real-life physician Dr Caleb Hillier Parry, 'a well-known Bath physician, whom she mentions in several letters to her sister, Cassandra' (2016, p. 132).[57] Perry's "demotion" to mere country apothecary in the novel produces a humorous contrast between his actual claims to medical expertise and the quasi-religious trust the Highbury community grants him (Cooper, 2016, p. 136).

Mr Perry's ubiquitous presence in *Emma* is also a sign that his practice still resembles that of an eighteenth-century doctor, operating a 'client-based form of treatment catering to the whims of their often hypochondriacal patients' (Logan, 1991, p. 199). In the novels that follow, doctors are a rare sighting, or a mere mirage. *Persuasion*'s surgeons appear only during times of crisis, and in *Sanditon* Mr Parker searches for a doctor as an investment toward increasing the appeal of his coastal resort, while the value of a medical practitioner is questioned by some of the residents themselves ('What should we do with a doctor here?' *SAN* Ch. 6, p. 35). In this chapter, I will analyse the progressive removal of medical men from Austen's plots in the context of a parallel increase in the female protagonists' medical authoritativeness. Though the professionalisation of general practitioners was about to strengthen the social role and authoritativeness of (male) doctors, Austen's last novels challenge the idea that medical knowledge should be the exclusive domain of masculine authority. Women's medical competence, in *Persuasion* and *Sanditon*, is presented as a successful balancing act of diagnostic efforts and compassion, accomplished through the combination of popular medical knowledge with nurture and care.

In Chapter 2, I have introduced the topic of nursing in Austen's novels, along with its cultural significance as a socially sanctioned way for women to practice lay medicine and provide support to each other. Jane Austen's beloved sister Cassandra 'nursed her day and night' in the final stages of her illness, and 'Jane died in Cassandra's arms during the night of July 17', 1817 (Bartlett, 2021, p. 95). In *Emma*, nursing and nurturing are the key to accessing sympathy toward a heroine Austen reportedly believed that 'no one but

[57] Dr Parry was a physician who provided his services to the Austen family. I have mentioned him in Chapter 3 for the resemblance found between Parry's real advice on the treatment of gout, and that given to gouty Admiral Croft upon his arrival at Bath in *Persuasion*, as discussed in Dacia Boyce's article (2020, p. 153).

myself will much like' (Justice, 2012, p. 373). Emma is seen in the role of caregiver to her father, and briefly to Harriet as well, when she is confined to her bed due to a bad sore throat—unlike Mr. Elton, whose priority is to 'escape the infection' (*EM* Vol. I, Ch, 15, p. 89), Emma sits with Harriet for 'as long as she could, to attend her in Mrs. Goddard's unavoidable absences, and raise her spirits' (*EM* Vol. I, Ch. 13, p. 78). *Emma*, however, with its marked emphasis on valetudinarianism, popular remedies, and an apothecary's medical advice, never quite allows feminine nursing and medical knowledge to take centre stage. This changes with *Persuasion*.

Austen's last completed novel takes readers on a journey that follows the introspections of a character who, at the beginning of the plot, is shown as deeply rooted in the feminine sphere. As Perri Klass has observed, at the time of the inciting incident (Anne and Wentworth crossing paths once again),

> Anne has seamlessly made the transition from a pediatric patient—that is, a lovely marriageable girl of nineteen, to a past-her-prime fading woman of twenty-seven, an attentive daughter to her domineering selfish father, a doting aunt to her married sister's children—her state, in other words, is incipient spinsterhood (2021, p. 122).

In a sense, Anne could be seen as embodying the values of late eighteenth-century moralists such as Thomas Gisborne, who in *Duties of the Female Sex* (1796) wrote that women's character was especially developed and suited for this kind of labour, for 'contributing daily and hourly to the comfort of husbands, of parents, of brothers and sisters, and […]in the intercourse of domestic life, under every vicissitude of sickness and health, of joy and affliction' (Gisborne 1796, in Wiltshire, 1992, p. 166). As Anne's character gradually abandons this initial state and feels a new wave of romantic desire, her authoritative status changes from the gendered expectations of her labour as a nurse and caregiver, to her active participation as a quasi-professional dispenser of medical advice. This change is shown in full force during the episodes of trauma and injury so integral to the development of the story.

John Wiltshire has advanced the argument that, in *Persuasion*, 'femaleness and nursing are…ideologically linked', but that the type of femaleness constructed by the novel is poignantly restricted to 'the nurturing and nurturant' female figure, a type of woman whose 'own purposes and sexual desires will be subordinated to, and sublimated in, her ministrations to the child or to the patient' (Wiltshire, 1992, p. 168). There is much

evidence in favour of this interpretation, not least Anne's initial self-removal from the dance floor and her desire to 'be unobserved', which is detrimental to her mental health—'her eyes would sometimes fill with tears as she sat at the instrument' (*PER* Ch. 8, p. 52). Where my interpretation differs from Wiltshire's is in analysing how the relationship between nursing skills and desire changes throughout the novel. According to Wiltshire, the erotic component becomes an integral part of nurturing womanhood because of the themes that are prioritised in this novel: 'because *Persuasion* depicts the body as fragile and vulnerable, nursing does emerge as an important value, despite its association with the sexually and socially subordinate' (Wiltshire, 1992, p. 169). While the discussion in Chapter 2 about the role of Nurse Rooke in the plot of the novel does give credit to the importance of nursing in *Persuasion*, I believe that Anne's character experiences a distancing from traditional female nursing as she regains a status of desirability. In turn, her renewed desirability contributes significantly to the display of authoritativeness that Anne exhibits during the novel's central medical crisis, that is, Louisa's accident.

Barbara McLean (1993) has provided a reading of Anne's character in *Persuasion* as displaying a professional doctor's qualities. Her prowess as a doctor emerges preponderantly in the aftermath of Louisa's fall and consequent head injury. In this moment,

> It is Anne who takes charge. She begins in the manner of what we now call triage, which is defined in Dorland's medical dictionary as "The sorting out of casualties of … disaster, to determine priority of need and proper place of treatment" (1610). Anne takes the active role of triage officer, crying out to Captain Benwick to assist Captain Wentworth: "Go to him, go to him … for heaven's sake go to him … Leave me, and go to him." […] she gives clear instructions of what must be done: "Rub her hands, rub her temples," and summons the wherewithal to provide the only drug on hand: "here are the salts," she says, and then positively commands Benwick to "– take them, take them" (Austen, 110). Captain Benwick, rather than taking control of the disaster himself, obeys Anne's orders and responds (McLean, 1993, p. 174).

I agree with McLean's analysis of Anne's behaviour as a type of 'professional persuasion', meaning that she does not engage in the dynamic of 'power and control' that characterised professional (and male-dominated) medicine and instead operates an indirect manoeuvring of the situation, switching 'from forceful commands to calm

suggestions. Once her authority is established, she no longer needs to be demonstrative, and she pulls back' (McLean, 1993, pp. 172-173). For example, her suggestion that Lyme resident Captain Benwick should be the one to call a surgeon appears at once obvious and clever to the frightened crowd, establishing Anne's presence of mind and authoritative judgement. Once attentions have been captured, she seemingly retreats into a more socially comfortable display of feminine qualities, but retains control over the situation:

> Anne, attending with all the strength and zeal, and thought, which instinct supplied, to Henrietta, still tried, at intervals, to suggest comfort to the others, tried to quiet Mary, to animate Charles, to assuage the feelings of Captain Wentworth. Both seemed to *look to her* for directions (*PER* Ch. 12, p 80, my emphasis).

I have chosen to emphasise the act of looking, here, for this scene is pivotal to the complete reversal of Anne's initial condition of soon-to-be spinster, unheard and unseen. The gaze projected by the men at the scene of the accident is not sexualised, for they are looking *to* her and not *at* her, searching for guidance rather than projecting desire. In a sense, in this moment Anne fills a role that allows her to transcend her sexuality and become a figure of authority, just as male doctors were expected to transcend their own sexual impulses in treating female patients.[58] However, her ability to fulfil this role is only made possible thanks to the process of reblooming that occurs during a time of increased social activity, away from her role of caregiver and nurse.

As I have made clear, Anne has thus far been very much invisible to many of the characters. She is barely considered by her family in their decision-making process; she is actively ignored by Captain Wentworth; and she is taken for granted by the Musgrove sisters. Anne herself aliments her marginality and invisibility by insisting on playing the piano over dancing. At Lyme, however, her body "reblooms" and she is once again desired by Captain Wentworth and attracts a new suitor in Mr Elliot. More importantly, Anne allows herself to be desiring ('Anne felt that she should like to know who he [i.e. Mr Elliot] was', *PER* Ch. 12, p. 75). Even grieving Captain Benwick is frequently 'drawing near her' (*PER* Ch. 12, p. 73).

It is useful, here, to include a brief digression on the concept of "bloom" and botanical language in Austen's work, which I have introduced briefly in the discussion of

[58] As I discussed in Chapter 2, such was the claim of late-eighteenth-century surgeon Louis Lapeyre, who used this argument to promote the choice of male midwives among wealthy upper-class women.

health in *Emma* in Chapter 3 but deserves some clarifications here. Amy King's monograph *Bloom: The Botanical Vernacular in the English Novel* (2003) has examined the sociocultural implications of Austen's use of vocabulary derived from the Linnean botanical tradition. In *Persuasion*, it is no coincidence that Anne's reblooming should occur at Lyme, a place that 'was known…in the late eighteenth century as a center of a kind of turn-of-the-century ecotourism, where the novel pleasures of sea-bathing and fossil-hunting were jointly available' (King, 2003, p. 129). In Lyme, there is an external and natural cause to Anne's reblooming, the sea air and breeze (King, 2003, p. 129). However, these factors are only activated by the erotic component in the plot, which is to say that 'the presence of the correct suitor is essential to bloom', which 'acts as a narrative agent in the service of the delays and indecisions of desire' (King, 2003, p. 131). Having implications that go beyond mere physical appearance, bloom grants visibility not just of external beauty but of personhood, as implied by the ambiguous line with which the narrative voice interprets Captain Wentworth's expressive look on witnessing Anne's first encounter with Mr Elliot: 'That man is struck with you, and even I, at this moment, see something like Anne Elliot again' (*PER* Ch. 12, p. 75). Within this landscape of newfound visibility of both physical appearance and character qualities that Anne's authoritative presence increases. This is the context surrounding Anne's role in the aftermath of Louisa's concussion.

In Lyme, Anne takes on the role of rescuer, both emotional and physical. She attends to Captain Benwick's wounded soul by offering comforting words and her knowledge of poetry, and after Louisa's fall she

> […] acts the perfect doctor […] She instantly assesses the damage, offers useful advice, proffers a remedy, rationally sends for appropriate help for the central victim, determines the place of treatment, and calms and soothes those less afflicted. She does all this with the exact amount of authority needed, and is happy to move from overt power to mild persuasion when the others eventually regain their composure (McLean, 1993, p. 173).

The effects of Anne's evolving power dynamic are twofold. On the one hand, her actions demonstrate her suitability for life as a naval officer's wife, compared to the other women in her company—this is, in other words, the culmination of her "bloom" as marriageability (King, 1993, p. 143). On the other hand, this moment marks her emancipation from the constraints of masculine authority. It should be noted that this

emancipation pushes at, but does not burst through, the confines of the feminine sphere. Anne remains a valuable and valued nurse, but after the accident her role as nurse is viewed within a framing of competence instead of being a gender-based expectation. For example, Captain Wentworth points at Anne as the best candidate for nursing Louisa in here recovery, not because of the women's personal relationship, but because Anne is the most competent for the job: 'If Anne will stay, no one so proper, so capable as Anne' (*PER* Ch. 12, p. 82).

Though McLean connects more strongly Anne's rejection of masculine narrative authority with her almost appropriation of medical authority in the narrative, my argument is that Anne's authoritative status in *Persuasion* is inextricably linked to her journey of reblooming and re-acquiring, in a less conventional and more self-determined way, a status of marriageability. Nevertheless, Anne's personal journey is encompassed in a narrative that does challenge medical authority, especially in the way it engages with the public discourse surrounding the end of the strict hierarchy of medical professionals and the rise of the general medical practitioner (McLean, 1993, p. 175). With Anne's display of lay medical knowledge and its authoritative effects, *Persuasion* often blurs the lines between lay and professional medicine and questions the role of medical men. This critique is explored more explicitly in Austen's unfinished novel *Sanditon*, where the author 'has something significant to say about the medical profession's loss of authority over its patients in an era of popular medical texts encouraging self-help' (Darcy, 2018). Far from the bloom narrative, in this novel the character of Charlotte Haywood fills the gap left by this loss of professional authority with her observant satire of the invalids that surround her.

In *Sanditon*, the question of authority is multi-layered. On the one hand, the novel shows the clashing systems of professional medicine and the art of 'self-doctoring' (*SAN* Ch. 5, p. 30). As John Wiltshire has pointed out, Sanditon the town is 'a monument to the new affluence, the new leisure and new consumerism' that is growing in the late 1810s (Wiltshire, 1992, p. 206). Though Mr Parker has failed to supply a trained doctor, Sanditon offers, at a price, numerous home remedies and non-medicinal cures, from sea air and 'immersion' to donkey milk, as treatment for various complaints. The novel explores the dangerous consequences of 'a sophisticated society's preoccupation with its bodily well-being', which goes so far as to exploit the 'proclivities of the body for profit'

(Wiltshire, 1992, p. 208). Within the workings of consumerism, however, is a fervent debate over medical authoritativeness—whether it belongs to an overarching medical theory, is found in the expertise of trained professionals, or is fragmented into lifestyle and medicinal cures that target the needs of specific constitutions. In Mallory-Kani's account,

> Austen's novel presents a range of views about medical authority: while some of the novel's characters believe that only doctors can administer medical care and advice, others deride the influence of medical professionalism on lay remedies and practices. Moreover, a few of *Sanditon*'s characters remain suspicious of sickness in general (2017, p. 313).

The novel's heroine, Charlotte Heywood, belongs to the category of those relying on the knowledge of educated medical practitioners. When she first learns that Mr Parker's sister Susan has endured a very painful operation such as teeth-removal after being 'convinced' by her sister that 'much of the Evil lay in her Gum', she declares her dislike of 'self-doctoring' (*SAN* Ch. 5, p. 30). Rather than resolving to such extreme measures, Charlotte would 'be so anxious for Professional advice, so little venturesome for myself, or any body I loved!' (*SAN* Ch. 5, p. 30). Within an environment that often uses disparaging words toward professional doctors ('let us have none of the Tribe at Sanditon', *SAN* Ch. 6, p. 35),

> Austen displaces the authority of the male doctor and instead grants significant diagnostic power to a laywoman without any formal, clinical training. Moreover, she accomplishes this through a fictional, ironic discussion of medical authority that mimics the clinical tone of modern medical discourse (Mallory-Kani, 2017, p. 315).

Charlotte's diagnostic, observational powers are focused especially on Arthur, Susan and Diana Parker, resolved to determine whether their complaints come from fancy or actual bodily symptoms. Charlotte arrives at their first meeting at the Terrace House acknowledging her assumptions, which are sometimes met and at other times disproved by what she observes. For example, Charlotte notices that Susan Parker's invasive dental operation has predictably left her 'more thin and worn' in comparison with her sister, whereas she admits her surprise in finding Arthur Parker 'quite as tall as his brother [i.e. Tom Parker, an investor in the resort], and a great deal stouter, broad made and lusty, and with no other look of an invalid than a sodden complexion' (*SAN* Ch. 10, p. 56). In a

doctor-like manner, Charlotte listens to the patient narratives provided by the Parker "invalids", yet at the same time she compares the accounts she is given with the information she is able to collect on her own. In a way that marks a departure from a Foucauldian-like clinical gaze, however, she also approaches her "patients" with compassion, empathising about the physical pain of a body enduring surgery pre anaesthesia, and widening her observational field to include signs that describe not just the body but how a body functions in social circles. Charlotte has no 'desire to further the financial or scientific interests of clinical medicine. Rather, her diagnostic authority evolves out of a practical and compassionate—if somewhat ironic—engagement with the inhabitants of Sanditon. (Mallory-Kani, 2017, p. 320). For example, she notices Diana's role as 'evidently the chief [sic] of the family; principal Mover and Actor', and how her invalidity does not prevent her from being very much sociable and busy—she finds a place Mrs Griffith can rent and is able to secure maids and other necessary personnel for the running of a home (*SAN* Ch. 10, p. 56).

In *Sanditon*, Charlotte's perspective oscillates between a recognisable Foucauldian clinical gaze, which separated the patient's body from its embodied self, and a narrative approach to medicine reminiscent of Charon's theory. For example, while seated next to Arthur Parker at dinner, Charlotte notices the contradictions between Arthur's own narrative of his symptoms and his body, and the knowledge she has gathered through both keen observation and personal experience. She notes how Arthur's claim to drinking 'rather weak Cocoa' is immediately disproved by the 'very fine, dark-coloured Stream' of the beverage he pours for himself (*SAN* Ch. 10, p. 59). When Arthur uses scientific phrases such as 'coats of the stomach' to justify his generous spread of butter,

> Charlotte could not but suspect him of adopting that line of Life principally for the indulgence of an indolent Temper, and to be determined on having no Disorders but such as called for warm rooms and good Nourishment (*SAN* Ch. 10, p. 60).

Despite using the evidence she collects to disprove what she labels as the Parker siblings' 'enjoyments in Invalidism' (*SAN* Ch. 10, p. 60), Charlotte also displays a mature consciousness of the biases she herself might bring into her observations. One of Charon's features of narrative medicine is singularity, which is the recognition that to narrate is to create, that 'telling does not merely expose or report that which exists prior to the narrating. It produces it' (Charon, 2006, p. 45). Even rigorous, scientific medical

observations are affected by the singularity of narration, which is to say that scientific narration is a creative act. A dermatologist's meticulous description of a case of psoriasis, for instance, is influenced by 'prior categories, diagnostic impulses, comparative memory, conventionalized diction, and concurrent clinical facts' (Charon, 2006, p. 46). Lacking both extensive medical knowledge and life experience, Charlotte Haywood acknowledges that her stances on health are informed largely by comparisons with herself and her family, who by her own admission have a history of good health. At the Terrace House, she inwardly remarks that opening a window and using medicinal cures in moderation is preferable to Susan Parker's established habit of taking salts and drops from 'several Phials' (*SAN* Ch. 10, p. 56). [59] Yet when Arthur explains his view that a home fire helps relieve symptoms from damp air, Charlotte acknowledges how fortunate she is in finding that air 'has always some property that is wholesome and invigorating to me' (*SAN* Ch. 10, p. 58). Even if she remains firm in her opinions, Charlotte is able to acknowledge the context from which they emerge, and it is the lack of such awareness displayed by other characters that invites her ironic comments. This becomes plain in the conversation she entertains with Arthur about the effects of green tea.

The exchange takes place after Arthur Parker expresses shock after learning that Charlotte would rather drink green tea than cocoa in the evening, for he associates green tea consumption with severe nervousness, even body paralysis:

> It acts on me like Poison and would entirely take away the use of my right side before I had swallowed it five minutes.—It sounds almost incredible—but it has happened to me so often that I cannot doubt it.—The use of my right Side is entirely taken away for several hours! (*SAN* Ch. 10, p. 61).

Arthur Parker was not alone in worrying about the potential side effects of green tea. In fact, green tea was the object of an increasing amount of scientific research and cultural discussion in the first half of the nineteenth century (Dickson, 2017, p. 79). As Melissa Dickson has reported, Chinese green tea was the most commercially widespread type of tea in Britain at the start of the 1800s, and 'only lost its primacy when cheaper, black tea

[59] This advice is in line with the notion, popular in Austen times, that artificial heat was the cause of many disorders, and especially that it was 'conducive to biliousness', as discussed in Chapter 3 (Ishizuka, 2021, p. 125).

from Assam and Ceylon flooded the market in the latter half of the century' (2017, p. 79). As Dickson's research has shown,

> Green tea was, in this period, an object of anxiety that opened the body to dangerous external influences, and a number of contemporary medical treatises on nervous disorders emphatically declared that it should be avoided by all persons with weak nerves. In his 1828 work on diet and regimen, for instance, James Rymer claimed that "all nervous disorders are certainly aggravated by the use of tea," and that the "internal tremor which it often occasions" is worse in green tea than black (Dickson, 2017, p. 79).

Thought to overstimulate the stomach, this sought-after beverage became associated with dyspeptic disorders, too, and in the famous gothic story 'Green Tea' (1869) by Sheridan Le Fanu it 'encoded discourses of gastrointestinal health into a narrative traditionally read for its depictions of delusional insanity' (Taylor-Brown, 2018, p. 127).[60]

Despite being associated with the overstimulation of the nerves, the side effects reported by Arthur Parker are much more severe ('it acts on me like Poison') and specific ('my right Side is entirely taken away'), so much so that there is some acknowledgment on his part that the whole ordeal 'sounds almost incredible' (*SAN* Ch. 10, p. 61). Interestingly, Charlotte's use of irony in her response to Arthur's remark does not emerge from her lack of empathy for his own narrative of his symptoms. Rather, it emerges from certain indications that Arthur's opinions on green tea, which he overgeneralises indiscriminately by making assumptions about Charlotte's nerves, are not the product of his independent reasoning, but the uncritical absorption of his sisters' anxieties: 'She soon found that he had caught something from *them* [i.e. his sisters]' (*SAN* Ch. 10, p. 60). Nevertheless, her response is interesting in its ambiguity, for she never openly discloses where seriousness ends, and irony begins:

> "It sounds rather odd to be sure," answered Charlotte coolly, "but I dare say it would be proved to be the simplest thing in the world by those who have studied right sides and green tea scientifically and thoroughly understand all the possibilities of their action on each other." (*SAN* Ch. 10, p. 61)

[60] Reverend Jennings, the protagonist of Le Fanu's story, drinks copious amounts of green tea to carry out some research projects and begins to have horrifying hallucinations involving a monkey with red eyes—as Taylor-Brown notes, the aesthetic of Jennings' hallucination bears striking resemblance to the popular concept of the 'demon of dyspepsia' (2018, p. 127).

According to Mallory-Kani, Charlotte 'shows that she generally believes in the authority of medical science, but not necessarily in the elite viewpoints of the doctors and scientists who traditionally practice it' (2018, p. 321). Part of this conceptualisation is the idea that Charlotte is implicitly criticising the hyper-specialisation of medical culture by implying the ridiculousness in the notion that doctors should study 'right sides' as separate from the body as a whole (Mallory-Kani, p. 321). Melissa Dickson reaches a similar conclusion starting from a different premise, that is, she postulates that Charlotte's criticism refers to a specialism of another nature, mocking 'the contributions of medical and scientific communities to studies on the pernicious effects of tea drinking' (2017, p. 80). Rather than an explicit critique of the growing hyper specialisation of medical research, however, I would argue that Charlotte's satire is directed at the idea that the scientific method can be used to reinforce 'rather odd' ideas (*SAN* Ch. 10, p. 61). In this sense, Charlotte's support for medical authority is conditional to the purpose and context in which it is applied. Unlike Arthur and unlike many of the Sanditon residents, she 'does not uncritically absorb clinical medical ideas' but is ready to check the information she is given against her own knowledge and experience (Mallory-Kani, p. 321).

In *Persuasion* but especially in *Sanditon*, Austen writes women who take on roles of medical authority, either by defying gender expectations in taking control over situations of medical emergency (Anne Elliot), or by challenging the often-unquestioned opinions over health management and medical treatments of invalids (Charlotte Haywood). In the virtual absence of medical men in these novels, both Anne and Charlotte occupy, at times, "masculine" authoritative roles, but their medical authoritativeness is rooted in compassion and understanding, not in a desire to have their opinion prevail. In short, they each navigate the boundary between lay and professional medicine and question the use of medical knowledge as the only display of authority, preparing the ground for the further exploration and interrogation of these themes that occurs in Eliot's *Middlemarch*.

4.2 Lydgate, Dorothea, and The Politics of Diagnosis and Sympathy in *Middlemarch*

In contrast with Austen's medical narratives, the 'medical tribe' is central to the multiplot and themes of *Middlemarch*, and so is the issue of authoritativeness in medicine and medical practitioners, explored through Dr Lydgate's thwarted attempts to establish a

successful countryside practice and build on medical knowledge about the development and spread of diseases. As readers follow the rise and fall of Lydgate's authoritative presence in Middlemarch, there emerges a sense that his clinical gaze is not the sole or even the best form of authoritativeness, but that sympathy and narrative competence can become sources of authority with a transformative power. The character who embodies this other form of authority and a 'vision of social interconnections' is Dorothea, to whom Lydgate becomes dependent for both his social and financial stability in the town (Shuttleworth, 1986, p. 170). By turning the focus on how the interdependence of Lydgate and Dorothea comes into being, and its effects on the narratives of gender, medicine, and authority, I aim to illustrate how Eliot uses organicism to present a form of knowledge capable of subsuming the clinical gaze within narrative competence, and detached diagnosis within interconnected sympathy.

Before I can zoom in on the relationship between Lydgate and Dorothea and how it affects the interplay of medical authority and narrative sympathy in the text, it is important to identify the medical and social sources of Lydgate's authority. In fact, Lydgate's storyline takes place during the rise of the general medical practitioner that occurred over the first decades of the nineteenth century and affected how medical authority was exercised in doctor-patient interactions. Upon his arrival in Middlemarch, Lydgate disrupts the medical equilibrium of the town because his background and knowledge elude simplistic classifications: he is not a physician but he is a gentleman by birth, and 'has studied in Paris, knew Broussais; has ideas…wants to raise the profession' (*MM* Ch. 10, p. 59).[61] However, despite the widespread conservatism that challenges his integration in the community, a series of diagnostic successes increases Lydgate's authoritativeness. His innovative medical techniques are especially appreciated by Casaubon, whose treatment by Lydgate can be seen as a perfect exemplification of the general practitioner's diagnostic practice.

[61] The novel is set at the end of the 1820s, a time when the rise of the figure of the general practitioner was accompanied by a movement calling for 'the destruction of the ancient medical corporations which symbolised the conception of medical practice divided into hierarchical orders: physicians, surgeons and apothecaries' (Parry, 1976, p. 117). In *Middlemarch*, Lydgate challenges this hierarchy by showcasing his medical knowledge, for example when he corrects a diagnosis by Middlemarch physician Dr Minchin, who 'privately pronounced that it was indecent in a general practitioner to contradict a physician's diagnosis in that open manner' (*MM* Ch. 45, p. 279).

As Caldwell has reported, in the late 1820s a doctor's diagnosis was the culmination of a process combining patient narrative with the 'signs that he has detected from physical examination', which in the 'clinical era' of the nineteenth century included 'thorough palpation, auscultation (listening to body sounds), and measuring various bodily signs (pulse, breathing, temperature)' (2004, pp.143-144). In Caldwell's analysis,

> George Eliot […] shows the general practitioner at the intersection not only of interpersonal and scientific medicine, but also of patient-centered and doctor-centered medicine. When Lydgate examines Edward Casaubon, for instance, he combines scientific advances with techniques developed long before such technology. The narrator tells us that Lydgate "used his stethoscope (which had not become a matter of course in practice at that time)" (M, 279). The stethoscope, invented by the French physician Laennec in 1819, was still an innovation, especially in British rural areas. Medical historians have considered its invention and use a landmark in diagnosis (2004, p. 162).

If the stethoscope is representative of doctor-centred medicine and signifies the beginning of a movement toward what Daston and Galison have called 'mechanical objectivity' (2007, p. 115), [62] Lydgate's interactions with Casaubon also show some of the qualities of patient-centred medicine. On Lydgate's second visit to Casaubon, for example, the doctor-patient meeting occurs outside of a clinical environment, for Casaubon requests that the doctor is 'sent to [him] in the Yew-Tree walk' (*MM* Ch. 42, p. 262). As Lydgate observes Casaubon walk with much impediment, he is seen empathising with his condition:

> Lydgate, conscious of an energetic frame in its prime, felt some compassion when the figure which he was likely soon to overtake turned round, and in advancing towards him showed more markedly than ever the signs of premature age (*MM* Ch. 42, p. 262).

Lydgate's gaze, in this moment, mixes the medical information he possesses about Casaubon's diagnosis with human compassion, and there is a sense of genuine human connection being built. After walking together in conversation, Casaubon requests that Lydgate disclose information about the imminence of his death 'as a friendly service', an indicator that he did not expect that the doctor should provide this kind of information as a standard practice (*MM* Ch. 42, p. 263). Lydgate's reply is an example of how he 'shows

[62] As I have discussed in Chapter 1.

deference to his patients' in his clinical practice (Caldwell, 2004, p. 164). He admits the limitations of medical knowledge by explaining the impossibility to draw exact conclusions, then advances his diagnosis of 'fatty degeneration of the heart' but, unlike a twenty-first century doctor, he intentionally leaves out 'anatomical [and] medical details' that might confuse his client-patient (*MM* Ch. 42, p. 264).

Despite the scattered evidence that Lydgate can adapt his medical training to the context of Middlemarch (Caldwell, 2004, p. 162), especially when dealing with clients—such as Casaubon or Fred Vincy—whom he perceives as educated or of comparable social standing, he soon becomes too heavily reliant on his ability to diagnose. His diagnostic practice gradually moves away from patient-centred medicine and toward a Foucauldian clinical gaze. As I have briefly introduced in Chapter 1, and as critics like Tambling have explained, one of the main reasons why Lydgate's medical practice has been read through a Foucauldian lens is that *Middlemarch* and Foucault's *Birth of the Clinic* have a common denominator in the figure of Xavier Bichat:

> From an eighteenth-century classificatory medicine which seems to need no body in order to define disease, *The Birth of the Clinic* marks out transitions that show changes toward firstly a medicine of symptoms, and then, with Bichat, a medicine that addresses itself to tissues: anatomo-clinical medicine, medicine where the body of the patient is all-important (Tambling, 1990, p. 942).

In other words, the Bichatian focus on the body as the site of disease through the degeneration of tissues is what increases Lydgate's confidence in his diagnosis, and at the same time what allows comparisons between his medical authoritativeness and the Foucauldian (dehumanising, alienating) clinical gaze. In a slight departure from Tambing, Peter Logan's interpretation of Lydgate's authoritative gaze in *Middlemarch* is a successful negotiation of Romantic hermeneutics, which give a primary role to the imagination, and the Foucauldian clinical gaze (1991, p. 205). Logan acknowledges Lydgate's hyper focus on the body and its symptoms, but also recognises the importance of the doctor's imagination to fill the gaps left by imprecise medical instruments and the difficulty, pre-anaesthesia, to physically open the body for inspection (1991, p. 205).

For example, Lydgate's exercise of the clinical gaze, separating the body from its embodied self, can be seen in the way he treats Mr Trumbull's pneumonia as a case study and an opportunity 'for trying the expectant theory upon' (*MM* Ch. 45, p. 279), which

meant observing the course of the disease on the body without any drugs. This is Lydgate at his most Foucauldian, distancing himself from the patient's individuality to indulge in what Logan defines as 'sensory penetration' (1991, p. 202). The clinical gaze penetrates the body through the mediation of instruments—the thermometer and the microscope—which keep the bodily surface intact. In fact,

> The sounds Lydgate hears with his stethoscope, while originating in the interior, are heard at the surface of the skin; the 'secretions' are, by definition, already part of the exterior world at the moment they are secreted. Thus, although these procedures may be called a form of penetration, in fact each of them respects the material integrity of the body's shell. Each is a mediated form of reaching into the body, so that Lydgate is inevitably stationed at one remove from the interior (Logan, 1991, p. 202).

The skin poses an impenetrable barrier for Lydgate because he works at a time when anaesthesia was not a known medical practice. It was 'not introduced until 1846' and was 'commonly consisting of chloroform on a rag', but its widespread diffusion would only occur post-1872 [63] when 'John Lister introduced the use of carbolic acid spray to produce an aseptic operating field' and reduce the risks posed by opening the living body (Logan, 1991, p. 203). This is relevant because breaking the external boundary of the chloroformed body is only possible if the patient surrenders consciousness and bodily autonomy to the authority of the medical professional. As this is not yet attainable in Middlemarch, one observes how Mr Trumbull is not wholly alienated from the process. He possesses an amateurish knowledge of medicine that increases his pride in the fact that his body 'furnished objects for the microscope' (*MM* Ch. 45, p. 280). Nevertheless, the language used by the narrator points to a perceivable imbalance of knowledge and authority within the Lydgate-Trumbull relationship of doctor and patient. Lydgate is at least partially motivated by the desire to prove his worth as 'something better than an every-day doctor' and sees Mr Trumbull's 'robust' body as a sign of a constitution that would bear healing without drugs. The words used to describe Mr Trumbull's relationship to Lydgate's medical evaluations are 'acquiesced' and 'went without shrinking', his enthusiasm 'made rather pathetic by difficulty of breathing' (*MM* Ch. 45, p. 280). Because of this morally ambiguous light in which the narrative voice presents the episode, it has been named as a moment of dangerous closeness to a human experiment—unlike

[63] Coincidentally, the year in which the first edition of *Middlemarch* was published.

previous rumours about Lydgate that were spread through Middlemarch, readers can trace the truth behind claims that 'Lydgate played even with respectable constitutions for his own purposes (Menke, 2000, p. 632; *MM* Ch. 45, p. 280).[64]

Here we reach the core of two important problems with Lydgate's exercise of his medical gaze in the novel. Lydgate expects his authoritativeness to be a direct product of his rigorous scientific method and feels entitled to ignore other kinds of authoritative power, for example the power of narration. When Fred Vincy is diagnosed with 'typhoid fever', readers are reminded that Lydgate 'had known Louis in Paris, and had followed many anatomical demonstrations in order to ascertain the specific differences of typhus and typhoid' (*MM* Ch. 16, p. 105). He provides the correct diagnosis without much effort, but the narrator notes Lydgate's frustration at having to listen to Mrs Vincy's 'narrative' about her son, which in his view contained 'every point of minor importance' (*MM* Ch. 26, p. 164). This is reminiscent of Caldwell's analysis of the medical diaries of Richard Paxton (1799) and Richard Bright (1827), discussed in Chapter 1 (2004, p. 144). Paxton's account of a boy suffering a snakebite included details that Lydgate would have found irrelevant, such as the teenage boy's psychology and motivations for finding himself in the snake's territory. By contrast, we might imagine that Lydgate would have written medical reports in the style of Bright's, with specialised medical language and deprived of other observations. However, in focusing only on the clinical details, Lydgate misses important contextual information that leave him with inadequate knowledge to navigate key social situations.

This social inadequacy becomes clear when he diagnoses Nancy Nash's pain as a case of cramp and not of 'tumour' as had initially been misdiagnosed by another doctor, and prescribes a cure of 'a blister and some steel mixture'[65] in addition to 'rest', and 'good food' (*MM* Ch. 45, p. 279). Lydgate's cure is successful but slow and painful, and the

[64] Menke's study on vivisection in the works of Lewes and Eliot draws attention to the fact that the novel appears to draw connections between Lydgate's beginnings in physiology, making 'galvanic experiments' on frogs and rabbits, and his failed courtship of Laure, ending in the married actress' on-stage murder of her husband, which is deemed an accident by the police (2000, p. 633). As Menke comments, 'Lydgate's frustrating experiments on rabbits and frogs frame his thwarted romance with a woman he cannot discern as a murderess, even though he has seen her commit the murder' (2000, p. 633). The passage is illuminating not just because it 'may prepare us for some of his problems with Rosamond', but also because it should alert readers to some of the ethical boundaries Lydgate is prepared to cross in the pursuit of science.

[65] As the editor of the text specifies, a blister was a 'vesicatory plaster, designed to raise a blister on the skin' (Hornback, 2000, p. 279).

main narrative being circulated about Nancy's case continues to involve the idea of tumour. Further, there is an aura of intimidation surrounding Lydgate's medical knowledge and professional practice that prevents open communication between himself and his patients, who secretly resort to traditional cures such as 'boluses'[66] and pills:

> Even good Mr. Powderell, who in his constant charity of interpretation was inclined to esteem Lydgate the more for what seemed a conscientious pursuit of a better plan, had his mind disturbed with doubts during his wife's attack of erysipelas, and could not abstain from mentioning to Lydgate that Mr. Peacock on a similar occasion had administered a series of boluses […] At last, indeed, in the conflict between his desire not to hurt Lydgate and his anxiety that no "means" should be lacking, he induced his wife privately to take Widgeon's Purifying Pills, an esteemed Middlemarch medicine, which arrested every disease at the fountain by setting to work at once upon the blood (*MM* Ch. 45, p. 278).

These moments show that, though respect for the professional figure of the doctor may be growing, the same authoritativeness is not granted to the type of medicine he promotes. The inhabitants of Middlemarch are for the most part still strongly anchored to an older idea of medicine, one that draws 'emphasis on what is visible or tangible, on the drama of treatment, the colour and bulk of physic' (Logan, 1991, p. 200). As I have discussed in Chapter 3, Lydgate's unpreparedness for recognising the authoritativeness of his patients' narratives is a key factor in the decline of his own authoritative status, however competent he may be.

Another reason for the gradual decline of Lydgate's authority is his belief that scientific thought should have authority in all aspects of life. The narrative voice challenges this aspect by revealing the 'spots of commonness' that 'lay in the complexion of his prejudices' (*MM* Ch. 15, p. 96). Specifically, Lydgate's fatal flaw lies in the fact that the 'distinction of mind which belonged to his intellectual ardor, did not penetrate his feeling and judgment about furniture, or women, or the desirability of its being known (without his telling) that he was better born than other country surgeons' (*MM* Ch. 15, pp. 96-97). Under this seemingly ordinary sentence about Lydgate's lack of knowledge in areas outside of medical science lies the more profound revelation that Lydgate's

[66] In the eighteenth and nineteenth centuries, a synonym, often used in a derogatory way, for a large pill ('bolus, n.', Oxford University Press. https://www.oed.com/view/Entry/21165?redirectedFrom=bolus, accessed 15 May 2023).

worldview naively places science above all other systems of interpretation. He chooses to restrict such elements as social structures, gender norms, and class identifiers, from his field of observation, and it is this choice which ultimately causes his marginality in Middlemarch. Nowhere is Lydgate's delusion more evident than in his marriage with Rosamond.

After the disastrous outcome of his pursuit of Laure's affections in Paris, Lydgate vows to view women 'scientifically', yet his encounters with Dorothea and Rosamond show that he is driven by prejudice—in its dual meaning of sexism and preconceived notions—rather than by anything that could be derived from science. The narrator notes how his opinion of Dorothea had been 'guided by a single conversation' (*MM* Ch. 11, p. 61), and that 'Lydgate … might possibly have experience before him which would modify his opinion as to the most excellent things in woman' (*MM* Ch. 11, p. 62). Similarly, the narrator does not refrain from emphasising that his evaluation of Rosamond is corrupted by his views of women's intelligence as

> […] polished, refined, docile, lending itself to finish in all the delicacies of life, and enshrined in a body which expressed this with a force of demonstration that excluded the need for other evidence (*MM* Ch. 16, p. 105).

Throughout the novel, Rosamond is described in such language as to denote the strong influence of Darwin's ideas on Eliot's work, compared to a 'swan', a 'graceful long-necked bird', and a 'bird of paradise' (*MM* Ch. 11, p. 57; Ch. 75, p. 466; Finale, p. 512).[67] In projecting character and moral qualities onto the "shrine" of Rosamond's body, Lydgate misses or ignores important signs that their aspirations might not be aligned. Though Lydgate's gaze at this point is far from clinical or scientific—being sexualised, objectifying—there are parallels to be made between his modus operandi as a clinical practitioner and his behaviour as a man. As Logan eloquently put it,

> In judging her inner character, he employs his 'scientific view of woman', reading her bodily signs much as he reads the bodies of his patients. He operates on precisely the same assumption of a strong, one-to-one correspondence between representation and

[67] Gillian Beer has amply documented the presence of Darwin in Eliot's later novels in particular, especially with regard to ideas about sexual selection: 'he [i.e. Darwin] makes it explicit in *The Descent* [*of Man*, published 1871] that, in contrast to all other species (where the *female* most commonly holds the power of selection), among humankind the male dominates choice' (2009, p. 197).

> meaning when he argues that her physical mannerisms and poise - her bodily signs - adequately convey the truth about her identity (1991, p. 210).[68]

Thus, Rosamond's neck movements, sensuous poses, and deep looks are interpreted as the one-to-one equivalent signs of her inner life, and Lydgate is as confident in his ability to discern her character as he is about the superiority of his medical skills and knowledge amid the Middlemarch medical men. Yet Eliot demonstrates how feelings can both be theatrically displayed, as Rosamond does with carefully staged movements of her neck ('she gave her neck a meditative turn', *MM* Ch. 36, p. 219), and resurface momentarily without the support of knowledge and experience, which is what happens during Lydgate's engagement. Rosamond's 'helpless quivering', the tears gathering on her eyes 'like water on a blue flower' and then falling 'over her cheeks', are all that 'shook flirtation into love' for Lydgate, who 'actually put his arms round her, folding her gently and protectingly—he was used to being gentle with the weak and suffering—and kissed each of the two large tears' (*MM* Ch. 31, p. 189). In this moment, his emotional response is explicitly equated to his actions as a medical practitioner. Although the embrace might have the appearance of an empathetic response, it also functions as further proof of the way in which Lydgate superimposes his own reading of the body over the narrative that can be told by the embodied self. As the narrator explains, 'This was a strange way of arriving at an understanding, but it was a short way' (*MM* Ch. 31, p. 190).[69] Far from this Foucauldian, dehumanising gaze, the way in which the plots of Lydgate and Dorothea are intertwined is evidence of a conscious project on Eliot's part, that of providing alternative, transformative models for the pursuit of knowledge. In fact, Dorothea's model for knowledge places sympathy and compassion at its centre.

Dorothea fulfils many roles in *Middlemarch*. Both structurally and situationally in the plot, she functions as an alternative type of womanhood to that presented by

[68] Logan's aim, here, was to demonstrate the dangers of Lydgate's views about the relationship between science and the imagination, or representation. After discovering medical science through the pleasure of reading, Lydgate abandons all works of fiction and 'tries to place science essentially outside representation, outside the arbitrariness of language, and thus to deny that his imaginative reaching beyond the boundary of empiricism has any hermeneutic difficulties' (Logan, 1991, p. 209). Within this aesthetic reading, Rosamond encapsulates the 'disjunction between sign and signification that Lydgate refuses to acknowledge' (Logan, 1991, p. 210).

[69] Of course, Lydgate and Rosamond never do reach an understanding, as any serious communication they attempt is a painful display of their fundamentally mismatched characters, which makes physicality the only path toward conflict resolution—Lydgate 'pets', 'pats', and 'caresses' his wife as ways to avoid verbalising his resentment.

Rosamond. This is made rather explicit in the text, with several men (Lydgate included) comparing their respective qualities and idealising one or the other as the perfect embodiment of femininity. In the last book of the novel, Dorothea and Rosamond are also placed in direct confrontation over their respective connections with Will Ladislaw, and the mutual jealousies emerging from them. Within the medical narrative of the novel, however, Dorothea represents a different type of science than Lydgate's, or rather a different set of guiding principles for a kind of science that is capable of unifying self and body, objectivity and empathy.

Dorothea's incursions in the medical narrative of *Middlemarch* revolve around her changing relationship to Lydgate. Her character is motivated by the wish to acquire knowledge and by the desire of 'doing good', of having a social impact (*MM* Ch. 3, p. 19). She enters marriage to pursue knowledge and seeks the expertise of other men she perceives as figures of authority to follow her charitable instincts. On her first encounter with Lydgate, which is narrated from the perspective of external onlookers on the interaction, Dorothea enquires about 'cottages and hospitals', wishing to know about 'the way in which the health of the poor was affected by their miserable housing' (*MM* Ch. 11, p. 59; Ch. 44, p. 272). Lydgate had reluctantly engaged in the conversation with her, in a display of his unwillingness to discuss matters of medicine with anyone (especially a woman) he did not perceive as thoroughly knowledgeable on the subject, until his financial struggles propel him to seek funding for the New Hospital from her. In the interactions between Lydgate and Dorothea that follow, the authoritative status of each sees fluctuations and mutations as the power of scientific discourse gradually gives way to narrative power.

Caldwell's analysis meticulously documents the multiple shifts in Dorothea and Lydgate's relationship. During the fatal illness of Casaubon, Dorothea invokes the authority of medical science—'You know all about life and death. Advise me. Think what I can do' (*MM* Ch. 30, p. 182). Here, 'Lydgate resists the temptation to pronounce, supplying sympathy instead of medical knowledge' (Caldwell, 2004, p. 164). The 'involuntary appeal' by Dorothea awakens in Lydgate a vision of souls 'moving with kindred natures in the same embroiled medium, the same troublous fitfully illuminated life' (*MM* Ch. 30, p. 182). At this moment, he realises the limitations of medical power and is taken aback by the expansive possibilities of human connection. In Caldwell's

words, ‘Though ostensibly the authority figure in this encounter, Lydgate considers himself the recipient of something important from Dorothea’ (2004, p. 164). After Casaubon’s death and during Dorothea’s delirium, she once again resists the clinical gaze through the power of narrative: ‘She knew him, and called him by his name, but appeared to think it right that she should explain everything to him’ (*MM* Ch. 48, p. 299). This is the last instance of Dorothea being, to some extent, the focus of Lydgate’s medical gaze, as she is semi-unconscious in a moment of deep physical distress. In the third and most significant encounter between the two characters, Lydgate’s medical authority has been crushed under the weight of the allegations made against him, stretching to the claim of his being an accomplice of murder after the suspicious death of Raffles while at Bulstrode’s home. The meeting between Lydgate and Dorothea is officially about the fate of the hospital administration and her future funding, but it quickly transforms into an opportunity for Lydgate to reclaim his narrative and repair his sense of self, under Dorothea’s guidance.

In the moments that precede Lydgate’s arrival, Dorothea establishes her authoritative status by foregoing any ‘deference to her masculine advisers’, namely her brother-in-law’s attempt to prevent her from engaging in the ‘Bulstrode business’ (*MM* Ch. 76, p. 469). Yet, the narrator explains, ‘Nothing could have seemed more irrelevant to Dorothea than insistence on her youth and sex when she was moved to show her human fellowship’ (*MM* Ch. 76, p. 469). In this moment, Dorothea rejects her social position as a ‘very young woman’ and asserts her narrative authority, first by recalling ‘all the past scenes which had brought Lydgate into her memories’, then by connecting her own narrative to Lydgate’s (*MM* Ch. 76, p. 469).[70] Lydgate appears reticent to tell his version of the facts, but slowly succumbs to the ‘temptation’ represented by Dorothea’s words, expressing ‘assurance of belief in him’, and invitation to tell the truth, his truth (*MM* Ch. 76, p. 470). Lydgate is shown taken aback by this invitation-temptation, for

> The presence of a noble nature, generous in its wishes, ardent in its charity, changes the lights for us: we begin to see things again in their larger, quieter masses, and to believe that we too can be seen and judged in the wholeness of our character. That influence was beginning to act on Lydgate, who had for many days been seeing all life as one who is

[70] Later, Lydgate appears to validate her effort in transcending the social role to which she is confined by her gender by commenting that ‘She seems to have what I never saw in any woman before—a fountain of friendship towards men—a man can make a friend of her’ (*MM* Ch. 76, p. 474).

> dragged and struggling amid the throng. He sat down again, and felt that he was recovering his old self in the consciousness that he was with one who believed in it (*MM* Ch. 76, p. 470).

As Caldwell points out, in the passage where Lydgate is debating whether or not to confide in his interlocutor, 'Rather than sustaining the light-as-knowledge metaphor in contradistinction to the web-as-relationship metaphor, at this point in the novel the narrator intermixes his metaphors' (2004, p. 168). Lydgate, who considers light as a scientific tool to analyse the minuscule details of the world, here changes his perspective to the macroscopic 'masses' of life and is able to perceive their wholeness. He is also capable of inserting himself within this larger field of vision, and in seeing his connection to the larger life, he recovers his sense of self. Caldwell notes how,

> In Lydgate's medical model, light penetrates tissue, splitting it through analysis, until imagination reconnects the fragments in the form of a theory. In Dorothea's model, human relationship "changes the lights" - it is itself a distinct kind of knowledge - by which we re-see the "larger, quieter masse of social connections, as well as the "wholeness" of our individual character. The splitting light of scientific knowledge becomes, in Dorothea's hands, the changing "lights" of "belief" that can draw things together (2004, p. 169-170).

In Caldwell's interpretation, by building larger connections through her imagination and sympathy, Dorothea represents an alternative model for knowledge production that accounts for all the layers of humanity, while science tends to separate the phenomena from the life force—or, as Eliot calls it, the 'Energy'—that connects them. Sally Shuttleworth, too, has focused on Dorothea as an alternative model for scientific knowledge by calling her the 'true physician' of *Middlemarch*, one capable of providing guidance 'through her vision of social interconnections' (1986, p. 170). However, Eliot's realism prevents her from fully ascribing physician qualities to Dorothea, as her character is firmly grounded in her age, class, and gender. Despite her transformative narrative power, which has a healing quality to Lydgate ('he had found room for the full meaning of his grief' *MM* Ch. 76, p. 471), she also exhibits signs of ignorance deriving from her being far removed from the life of the people she wants to help. If Dorothea can choose to set aside her 'youth and sex', we witness Lydgate smiling at her 'childlike grave-eyed earnestness', comparing her to the 'Virgin Mary', looking down 'with those clear eyes at

the poor mortals who pray to her', and finally concluding that 'her love might help a man more than her money' (*MM* Ch. 76, p. 474). Moreover, as Shuttleworth has noted, Dorothea's organicist sympathy and model for knowledge is not put to the test, since 'Following her [metaphorical] awakening', culminating in her marriage to Ladislaw, George Eliot promptly removes her from the town' (1986, p. 171).

Neither Lydgate's not Dorothea's models for knowledge are successful on their own. Rather than reframing Dorothea as the raw model for 'true' science in *Middlemarch*, I believe it is more useful to look at her interactions with Lydgate and the other men who cross her path as a dialectical process through which mechanical objectivity and the clinical gaze emerge transformed through the encounter with narrative sympathy. This expanded notion of science emerging as the synthesis of Dorothea and Lydgate's dialectical encounters is the closest to Eliot's vision of interconnectedness and sympathy as forms of knowledge. As reported by Lewes Carroll, Eliot had once declared that 'molecular physics is not the direct ground of human love and moral action' (Carroll, 1992, p. 237).[71] I interpret this as a refusal to consider science as separate from the human inner life, which is also a refusal to relegate feminine qualities to social and scientific marginality. Dorothea's use of sympathy as a key to knowledge is, again, a transformative power. Those who ignore and resist it, like James Chettam and Casaubon, are either rejected by her or rapidly fade away, while the men who engage with her 'full nature', like Lydgate, but especially Ladislaw, are able to envision—even though they may not achieve it—a path for channelling their knowledge and vital energy into 'external social channels' (Shuttleworth, 1986, p. 172).

4.3 Returning the Gaze: Female Protagonists and Narrative Authority

As I have shown in the previous sections, both Austen and Eliot emphasise the expansive and transformative possibilities that traditionally feminine values, such as care and empathy. In the medical narratives by Austen and Eliot, these values are projected outside of the feminine sphere and become integral to their novels' construction of medical knowledge and authority. In this final section, I will expand upon the notion of narrative

[71] This quotation refers to Eliot's 'well-known reply to the Hon. Mrs Henry Frederick Ponsonby who had confessed to be becoming indifferent to her fellow human beings after studying molecular physics' (Carroll, 1992, p. 237).

power and discuss the active ways in which female characters use narration to reclaim their subjectivity and reject the dehumanising effects of the (male) clinical gaze.

As discussed, the notable absence of doctors in Austen's novels can already be perceived as a conscious decision on the author's part to deprioritise, within the narrative space of the novel, the clinical authority of male characters whose opinions would have prevailed in the historical and social contexts represented. However, what I am interested in exploring, here, is the way in which Austen displaces the gendered struggle for authority into the larger discourse on the authoritativeness of literature and literary genres. Using her protagonists and narrative framings as the vehicle, Austen uses discussions on reading preferences as well as on authorial power to assert the authoritativeness of women-produced literature and, by extension, of its cohort of readers. As will be seen, the tones of the discussion in *Sanditon* appear to anticipate the emerging debate over the relationship between literature and science.

It has been noted that Austen's later novels include a heavier display of professionalism and the professions.[72] In *Emma*, *Persuasion*, and *Sanditon*, leisure and professional classes are integrated much more closely within the communities they are inserted in, even though this integration is not without its problems and anxieties, as I have described in Chapter 3. In this context of increased professionalism, more attention is also paid to the writing profession, which is expressed indirectly through lateral discussion on reading and novels. Using arguments on the different reading preferences and expectations of male and female characters as her fictional debating ground, Austen legitimises both her own professional figure and the authority of the literature written by women. As Barbara McLean writes in the introduction of her article on Anne Elliot's medical knowledge,

> In *Persuasion*, Anne rightly points out that men "have had every advantage of us in telling their own story. Education has been theirs in so much higher a degree; the pen has been in their hands" (234). Although she clearly presents the subordinate position of women in a patriarchal culture, there is a twofold irony in Anne's statements. Internally, within the novel, Frederick Wentworth has just dropped his pen in the narrative when Anne makes this observation; it is, significantly, no longer in his hand – and externally, it is

[72] See, for example, A. Drum (2009). Pride and Prestige: Jane Austen and the Professions. *College Literature, 36*(3), 92–115, http://www.jstor.org/stable/20642039, accessed 3 May 2023.

> Jane Austen, a woman writer, who has written the novel. The pen is very much in her hand (McLean, 1993, p. 170).

In Austen's novels, there is often a marked, meta-literary connection between life and the literary imagination. Setting aside *Northanger Abbey*, whose entire plot revolves around the main heroine learning to navigate the differences between fact and fiction, this connection is most evident in *Persuasion*, where literature has a strong influence on character action. Sir Walter Elliot, for example, 'never took up any book but the Baronetage'; his entire existence is condensed in his title, and the book of Baronetage sanctions and preserves his lifestyle from external influences that could change it (*PER* Ch. 1, p. 3). For Captain Benwick, talking about poetry, which Anne acknowledges is a subject 'his usual companions had probably no concern in', is in fact a proxy for talking about his feelings (*PER* Ch. 11, p. 72). Anne indulges him, but recognising how excessive emotional responses to poetry can prolong a state of distress rather than facilitate catharsis, she 'ventured to recommend a larger allowance of prose in his daily study', selecting them based on the presence of 'highest precepts' and 'the strongest examples' (*PER* Ch. 11, p. 72). The narrative voice comments that Anne was 'feeling in herself the right of seniority of mind', and her authoritative status has an effect on her interlocutor, who 'noted down the names of those she recommended, and promised to procure and read them' (*PER* Ch. 11, p. 72). Lastly, in the scene quoted earlier by McLean, Captain Harville is adamant in justifying his ongoing grief about the loss of his sister using an analogy between men's bodily and mental frames—'as our bodies are the strongest, so are our feelings' (*PER* Ch. 23, p. 165). Captain Harville derives his supporting examples from literature: 'I do not think I ever opened a book in my life which had not something to say upon woman's inconstancy. Songs and proverbs, all talk of woman's fickleness' (*PER* Ch. 23, p. 165). Interestingly, Anne uses an almost scientific approach to reject these claims. She recognises that they each hold a gender bias in their perspective of the other, and refuses to 'allow books to prove anything' (*PER* Ch. 23, p. 165). I believe that two things are especially significant, here. The first is that Austen frequently presents the conflict about literature in gendered terms, for, as Anne Elliot reminds us, the term "literature" encompasses the term "education". The second is that Anne's remark that fiction cannot be used to legitimise (pseudo)scientific discourses appears to mark the beginning of a separation, in concerns and methods, between literature and science. The

distinction is most evident in the Conversation between Charlotte Haywood and Sir Edward Denham.

Charlotte and Sir Edward meet outside the library in Sanditon, where Charlotte had previously put down a copy of Frances Burney's *Camilla*. Here, Sir Edward is searching for a book to give his sister and asks Charlotte for recommendations, declaring that

> You will never hear me advocating those puerile *emanations* which detail nothing but discordant principles incapable of *amalgamation*, or those *vapid tissues* of ordinary occurrences, from which no useful deductions can be drawn. In vain may we put them into a literary *alembic*; we distil nothing which can add to science (*SAN* Ch. 8, p. 45, my emphasis).

I have chosen to emphasise some of the scientific lexicon used by Sir Edward, pertaining to the fields of biology and chemistry, because of the way it is used to increase the authoritativeness of Sir Edward's opinions.[73] As Mallory-Kani has commented, 'Sir Edward attempts to lend scientific credence to his literary enthusiasm through his use of medical terms like "vapid tissues," yet ends up catching the diseases against which he tries to arm himself', that is, he loses any claims to authoritativeness (2017, p. 322). Also using somewhat scientific language, the narrative voice representing Charlotte's thoughts diagnoses Sir Edward's illness by concluding that 'he had read more sentimental novels than agreed with him' (*SAN* Ch. 8, p. 46). Just as Charlotte's diagnoses of hypochondriac disorders among the Sanditon crowd strongly frame the readers' understanding of real and imagined illnesses in the town, so her opinions on poetry and novels both reinforce the authoritativeness of her perspective and challenge that of her male interlocutors. During a previous interaction between Charlotte and Sir Edward, she corrects his memory of Scott's poetry and rejects his idolisation of Robert Burns:

> "Do you remember," said he, "Scott's beautiful lines on the sea? Oh! what a description they convey! They are never out of my thoughts when I walk here. That man who can read them unmoved must have the nerves of an assassin! Heaven defend me from meeting

[73] According to the Oxford English Dictionary, for example, it is only from the late eighteenth century that the word "amalgamation" begins to be used in the figurative meaning of "The action of combining distinct elements, races, associations, into one uniform whole' ('amalgamation, n', *OED Online*. Oxford University Press. https://www.oed.com/view/Entry/5979?redirectedFrom=amalgamation, accessed 4 May 2023)

> such a man unarmed." "What description do you mean?" said Charlotte. "I remember none at this moment, of the sea, in either of Scott's poems." […] “I have read several of Burns's poems with great delight," said Charlotte as soon as she had time to speak. "But I am not poetic enough to separate a man's poetry entirely from his character; (*SAN* Ch. 7, pp. 39-40).

It is a gentle assertion of authority, but a significant one, nonetheless. In *Persuasion*, but especially in *Sanditon*, Austen writes women who are just as knowledgeable, if not more so, than their male interlocutors, and who use said knowledge to stand their ground despite recognising the limitations imposed onto their educational background by their gender. Gregory Tate has seen in Austen an intentional desire to address the inequality embedded within ‘The professionalization of literature and science, and the general exclusion of women from this process’ (Tate, 2015, p. 345). Anne Elliot’s complaint that education has been monopolised by men is echoed in the following excerpt from a letter Austen addressed to James Stanier Clarke in 1815, in which she commented on his ‘persistent suggestions that she should write a novel about a clergyman, a thinly veiled portrait of Clarke’ (Tate, 2015, p. 345):

> Such a Man’s Conversation must at times be on subjects of Science & Philosophy of which I know nothing […] And I think I may boast myself to be, with all possible Vanity, the most unlearned, & uninformed Female who ever dared to be an Authoress (quoted in Tate, p. 345).

There is a similarity between the way in which Charlotte rejects Sir Edward’s claims about poetry and the irony used by Austen in refusing to consider Clarke’s suggestion, for both revolve around a seeming devaluation of the speaker’s authoritativeness. Charlotte doubts her memory of Scott and diminishes her own poetic sensibility, while Austen declares herself ‘the most unlearned, & uninformed Female’. However, just as Charlotte’s thoughts reveal her private resistance to Sir Edward’s display of power, so it is possible to read Austen’s letter as a declaration of her authorial independence.

According to Tate, ‘*Sanditon* presents both medicine and the novel as professional forms of knowledge production that can correct the mistakes of enthusiasm’ (2015, p. 340). Sir Edward Denham unites misguided enthusiasm for both medicine and literature, which is represented by his unchecked use of professional medical jargon and literary quotes. Both of these attitudes, Tate reminds, are reminiscent of a culture of consumerism

and increased professionalisation. In fact, 'Linguistic extravagance is primarily attributed in *Sanditon* to uninformed amateurs rather than professional practitioners, as is the commercial exploitation of illness' (Tate, 2015, p. 351). For example, Mrs Griffiths is said to have 'never deviated from the strict medicinal page', except for some 'tonic pills', which Kathryn Sutherland's edition explains were a 'patent medicine with investors, like Mrs Griffiths's cousin, in the business of their manufacture and care' (*SAN* Ch. 11, p. 64; Sutherland, 2019, p. 80). Therefore, narrative competence is presented by Austen as the antidote to both ignorant parroting of medical and literary knowledge, and to unrestrained consumption. At the library, Charlotte decides against caving to the 'many pretty temptations' offered by the place, and refrains from borrowing Frances Burney's *Camilla*, as 'she reflected that at two and twenty there could be no excuse for [..] her to be spending all her money the very first evening' (*SAN* Ch. 6, p. 32).[74] Far from relegating her to the realm of the imagination (as was the case with *Northanger Abbey*'s Catherine Morland), narrative competence allows Charlotte to remain an objective, authoritative observer of the literary and the medical worlds that surround her.

Unlike the protagonists of *Persuasion* and *Sanditon*, the female characters in *Middlemarch* are rarely granted full narrative power, for the narrative voice is external and distant, both spatially and temporally. In fact, as Caldwell has written, both the medical dilemma and the narrative technique exhibited in the novel rely on the 'tension between the outside and the inside', that is, between the individual self and the social self (Caldwell, 2004, p. 156). Earlier in the chapter, I have discussed how the evolving relationship between Dorothea and Lydgate incorporates and reframes this tension to show the limitations of medical authority, and how narrative power supported by sympathy can have transformative effects. Here, I want to analyse narrative power and gender by looking more closely at the character of Rosamond and the way she uses self-narration to challenge the limitations of her social role as a married woman.

It would be easy to dismiss Rosamond's character as antagonistic to the success of Lydgate in Middlemarch, and from a plot perspective her function is largely described as a hindrance to Lydgate's development as a person and a doctor, in clear contrast with the way Dorothea changes both Ladislaw and Lydgate with her narrative knowledge and

[74] As Kathryn Sutherland notes in the critical edition of Sanditon, this is an instance of clever metaliterature, as the namesake protagonist of *Camilla* makes the mistake of 'overspending on keepsakes and clothing on her visit to the fashionable spa town of Turnbridge Wells' (Sutherland, 2019, p. 78).

empathy. At the end of the scene in which Lydgate obtains renewed confidence in himself through his dialectical exchange with Dorothea's narrative knowledge, any hope that he may stay in Middlemarch and learn from his mistakes to build a successful, impactful career is quickly dashed by the reminder that Rosamond 'has set her mind against staying. She wishes to go. The troubles she has had here have wearied her' (*MM* Ch. 76, p. 472). And though the novel gives Rosamond a glimpse of growth during the confrontation with Dorothea, the Finale, which sees her married to a wealthy physician in London after Lydgate's death by diphtheria, takes away all character progress save for the acknowledgment that she 'never committed a second compromising indiscretion' (*MM* Finale, p. 512). Nevertheless, beneath the surface of her antagonistic role in Lydgate's narrative lies a principal female character who is capable to use her narrative power to resist the societal constrictions placed upon her.

As Doreen Thierauf has argued, whether Rosamond's arc is interpreted through a feminist or a conservative lens, one must be 'willing to acknowledge the simple fact that Rosamond's determined undermining of her husband's material and intellectual aspirations is a radical—and radically successful—program of self-fulfillment' (Thierauf, 2014, p. 481). In other words, Rosamond's character is much more successful at accomplishing what she sets out to do at the beginning than the other female characters are. Thierauf sees Dorothea's incomplete success in the fact that she becomes a 'immensely diffusive' influence on those around her, rather than accomplishing 'grand social and intellectual ambitions' (*MM* Finale, p. 515; Thierauf, 2014, p. 482). It is debatable whether Dorothea's ambition reached that far to begin with, for her openly acknowledged desire was to be useful to her husband and help others, even though it was channelled into grander intellectual and social projects such as learning the classics and improving public health in Middlemarch. This is the first point of divergence between Dorothea and Rosamond's success, as Rosamond's vision for herself—that of being married to a wealthy London doctor—is made clear from the beginning. Having made a mistake in the selection of her husband, Rosamond's success becomes quickly dependent on her 'determined undermining' of her husband (Thierauf, 2014, p. 481), which is accomplished primarily through narrative and through her active gaze.

The power of Rosamond's self-narration and gaze is explored in the concluding scenes of the twenty-seventh chapter of the novel, when Lydgate ridicules another of

Rosamond's suitors for attempting to woo Rosamond with the latest issue of *The Keepsake*, 'one of a series of nineteenth-century literary annals, consisting generally of sentimental prose and verse and inane, simperingly pretty illustrations' (Hornback, 2000, p. 170). Everything in this scene is gaze activated: Lydgate is scornfully turning the pages and 'seeming to see all through the book in no time'; Rosamond's eyes are fixed on his 'large white hands' (*MM* Ch. 27, p. 171). Upon leaving the Vincy household, Lydgate returns to his medical experiments—his scientific gaze directed at 'a process of maceration', as 'the primitive tissue was still his fair unknown' (*MM* Ch. 27, p. 172). As Jeremy Tambling has pointed out, 'The maceration […] exists in counterpoint to the softening that is happening to Lydgate under Rosamond's gaze and her "idea" that they are to be engaged' (Tambling, 1990, p. 591). Unobserved to him, readers are made aware of the fact that Rosamond too possesses a gaze, and that her gaze has the ability to materialise her ideas:

> Circumstance was almost sure to be on the side of Rosamond's idea, which had a shaping activity and looked through watchful blue eyes, whereas Lydgate's lay blind and unconcerned as a jelly-fish which gets melted without knowing it (*MM* Ch. 27, p. 172).

Most of the marital issues experienced by Rosamond and Lydgate can be traced back to this dynamic: Lydgate believes to be the one in control only to be caught by surprise by Rosamond's behaviour, who often acts in pure violation of her husband's wishes, in pursuit of her own material happiness. As Thierauf has said, there is a 'struggle over the decision-making power central to their marriage' (2014, p. 482). In this power struggle, Rosamond uses the narrative of disappointed expectations, regarding their income and living standards, to hold Lydgate accountable for decisions that do not have profit as the principal goal. When confronted about her decision to independently write to her husband's wealthy relative as to avoid having to move to a smaller house, Rosamond refuses to promise never to interfere again. Her strategy is twofold. Firstly, she dissects Lydgate's words and points out their cruelty: 'You have spoken of my 'secret meddling,' and my 'interfering ignorance,' and my 'false assent.' I have never expressed myself in that way to you, and I think that you ought to apologize' (*MM* Ch. 65, p. 412). Secondly, she proceeds to reframe her actions in the context of avoiding financial struggle: 'I think it was to be expected that I should try to avert some of the hardships which our marriage has brought on me' (*MM* Ch. 65, p. 412). Cara Weber has analysed the theatricality of

Rosamond's behaviour, which consists of 'learned, trained, even mechanical…ladylike traits' acquired at the school of Mrs Lemon (2012, p. 505). According to Weber, Rosamond sacrifices the practice of selfhood (which characterises Dorothea) for the performance of it. This performance relies on a dogmatic ideology of femininity which serves 'to cover up how much effort goes into the constant production of Rosamond' (Weber, 2012, p. 505).

I have introduced this aspect of gender ideology as a reminder that, however successful at achieving her personal goals, Rosamond's narrative power and feminine gaze is established as harmful and dehumanising to herself. To succeed in excusing her violation of boundaries, it is inevitable that Lydgate 'think of her as if she were an animal of another feebler species. Nevertheless she had mastered him' (*MM* Ch. 65, p. 412). In other words, Rosamond's use of narrative power is framed as unethical not only because it breaks Lydgate's professional (and socially valuable) aspirations, but also because it ultimately proves regressive and destructive to herself, and to all the women like her who have embraced the gendered education promoted by the Mrs Lemons of Victorian England. Nevertheless, I would argue that Rosamond's character continues to disarm and enrage readers because of her forceful use of narrative power, which allows her to succeed in a power struggle with a much more authoritative man of science. Having abandoned all interest in literature, Lydgate is incapable of using literary categories to contrast the authoritative presence of narrative in his life. At the same time, in their clashing display of narrative and scientific authority, Rosamond and Lydgate embody, even more than Charlotte Haywood and Sir Edward did, the growing incommunicability between literary and scientific thought. Only the authorial voice can reconcile these systems of thought, placing characters and actions under a new, all-encompassing 'light, as of oxy-hydrogen, showing the very grain of things, and revising all former explanations' (*MM* Ch. 15, p. 95).

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Summary

Questa tesi nasce dal desiderio di esplorare un sottoinsieme del rapporto tra la letteratura e la scienza, che è il rapporto tra il romanzo e la medicina. A partire dal tardo Settecento, infatti, il nuovo genere del romanzo comincia ad assorbire e rielaborare contenuti della scienza e della medicina in particolare, parallelamente ad una trasformazione della professione medica. Nell'area britannica, che è il focus del mio lavoro, i primi decenni dell'Ottocento vedono da un lato l'introduzione di nuovi strumenti medici quali lo stetoscopio e il termometro nella prassi diagnostica, dall'altro il venir meno di quella rigida struttura gerarchica della professione, che vedeva *physicians*, *surgeons* e *apothecaries* separati per formazione e tipologia di clientela. All'educazione classico-umanistica, nel corso dell'Ottocento comincia a prevalere quella scientifica, elemento che si riflette nella scrittura medica, poiché i dati derivanti dall'osservazione del medico, aiutata dagli strumenti sopra citati, gradualmente prevale sull'ascolto della narrazione del paziente. L'autorità della figura del medico ne esce quindi rafforzata, mentre il paziente si sottopone in forma sempre più passiva allo sguardo diagnosticante del dottore.

In *Nascita della clinica* (1963), Michel Foucault ha analizzato questo crescente sbilanciamento nella distribuzione, tra dottore e paziente, del rispettivo grado di potere. L'espressione 'sguardo medico' coniata da Foucault denota quella progressiva disumanizzazione del paziente da parte della figura medica, che lo guarda come corpo da decifrare, seguendo i segni di una nuova grammatica della patologia in grado di descrivere la struttura della malattia separandola dalla struttura dell'identità della persona malata. I descrittori della malattia vengono codificati e applicati a ciascun individuo portatore di malattia, indipendentemente dalle proprie caratteristiche individuali. Se lo sguardo medico standardizza e omologa, guidato dall'analisi scientifica, lo sguardo umanistico-letterario restituisce umanità e identità alla persona malata. In *Medicina narrativa* (2006), Rita Charon riconsegna dignità all'individuo sottoposto allo sguardo medico analizzante attraverso la proposta di una pratica medica che riabbracci gli elementi della cultura umanistico-letteraria a lungo respinti dalla clinica descritta da Foucault. In particolare, Charon propone la competenza narrativa come elemento integrante della preparazione medica, poiché solo attraverso la narrazione è possibile riconosce i confini, spesso malleabili, tra sé e altro, tra individuo e corpo.

Ho introdotto Foucault e Charon perché *Nascita della clinica* e *Medicina narrativa* sono due testi chiave per l'impostazione della mia ricerca. Questa tesi, infatti, si sviluppa attorno a due autrici, Jane Austen (1775-1817) e George Eliot (1819-1880), le cui opere attraversano, riproducono e discutono la trasformazione della medicina in disciplina scientifica e l'incremento dell'autorità conferita alla professione medica, con la conseguente riduzione del ruolo della narrazione del paziente. La scelta di due autrici è intenzionale e legata a due ragioni principali. In primo luogo, ho voluto impostare la mia ricerca con una prospettiva di genere perché i corpi femminili hanno occupato un ruolo centrale all'interno degli sviluppi della scienza medica e delle tecnologie utilizzate nella pratica diagnostica ottocentesca. Ad esempio, come si vedrà nel secondo capitolo, l'emergere della ginecologia quale disciplina prevalentemente maschile ha al contempo contribuito ulteriormente alla patologizzazione del corpo femminile e limitato la possibilità delle donne di formarsi nelle discipline mediche, relegandole ad un ruolo prettamente assistenziale. In secondo luogo, credo che ci sia una questione di genere all'interno del rapporto tra letteratura e medicina, o, volendo fare un passo indietro, nel rapporto tra arte e scienza. In *Objectivity* (2007), Lorraine Daston e Peter Galison ricostruiscono la codificazione dell'oggettività come prerequisito dello sguardo scientifico quale sforzo da parte dello scienziato (storicamente, di genere maschile) di sopprimere l'io soggettivo, emotivo, e artistico come precondizione per il raggiungimento della verità scientifica. L'oggettività scientifica così strutturata comportava necessariamente l'esclusione delle donne, ritenute non in grado di rimuovere la loro parte emozionale, ritenuta predominante e totalizzante, ma anche l'esclusione di qualità associate al genere femminile, quali empatia e cura, dalla pratica scientifica. Se in altre discipline scientifiche sviluppatesi nell'Ottocento, per esempio la botanica, questa assenza potrebbe passare inosservata, lo stesso non si può dire per la scienza medica, dove la componente umana è centrale e dove una pratica disumanizzante come quella descritta da Foucault privilegia un certo tipo di corpi e può influire negativamente sul percorso di guarigione.

Sia nei romanzi dell'ultima Austen (*Emma*, *Persuasion*, e l'incompleto *Sanditon*) che in *Middlemarch* di Eliot, la medicina è parte integrante degli intrecci, della caratterizzazione dei personaggi, e degli sviluppi tematici. Inoltre, focalizzando l'attenzione sulle narrazioni mediche di Austen ed Eliot, emerge la volontà di entrambe

le autrici di integrare qualità femminili come l'empatia e la cura nel contesto della professione medica. Nel confronto tra i modi in cui Austen ed Eliot utilizzano la medicina come spunto tematico e narrativo, la mia tesi si propone di sottolineare come le autrici riescano a riappropriarsi di un insieme di qualità femminili, intese come frutto della socializzazione e non come proprietà innate, quali valori meritevoli di inclusione nella pratica medica e in grado di produrre risultati anche trasformativi. Inoltre, le autrici riescono spesso a contrapporre l'autorità della narrazione allo sguardo medico di stampo foucaultiano, sfidando le tradizionali strutture di potere e mostrando i vantaggi dati dall'integrazione di modelli narrativi all'interno della scienza medica in tutte le sue declinazioni.

Questa tesi si occupa di sistemi di conoscenza e di sistemi di potere. I primi due capitoli cercano di ricostruire una cornice storica per la successiva analisi letteraria, situando i problemi del divario tra letteratura e scienza, della crescente professionalizzazione della medicina e del ruolo delle donne nella medicina all'interno del contesto storico e culturale ottocentesco. Il primo capitolo ripercorre le tappe che hanno permesso alla medicina di ottenere autorevolezza scientifica nel corso del diciannovesimo secolo, e si interroga circa il ruolo occupato dalla scienza medica nella questione del divario fra le "due culture" (scienza e letteratura) sollevata da C. P. Snow negli anni Sessanta. Il secondo capitolo pone l'accento sul rapporto delle donne con la medicina del diciannovesimo secolo, sia come pazienti che come figure professionali, ad esempio levatrici e infermiere. Infatti, nel corso dell'Ottocento si sviluppa il ramo della ginecologia, disciplina ad accesso esclusivamente maschile, e viene meno il coinvolgimento di figure mediche femminili quali levatrici e infermiere in contesti, come il parto, dove il corpo femminile è protagonista. Una parte del capitolo è inoltre dedicata ai i modi in cui la medicina ha favorito una visione patologizzata dei corpi e delle menti delle donne. Infine, il capitolo introduce le narrazioni mediche di Austen ed Eliot, soffermandosi su convergenze e divergenze fra le autrici. Il terzo capitolo indaga una declinazione del rapporto tra sguardo clinico e competenza narrativa, ovvero la relazione fra corpo e mente. Infatti, una conseguenza della crescente specializzazione della medicina è la graduale separazione tra disturbi del corpo e disturbi della mente, questi ultimi esplorati quasi esclusivamente dalla psicologia. Ambientate in un'epoca in cui i collegamenti e le influenze reciproche tra corpo e mente rimanevano parte della

concezione dominante della medicina popolare e non, le narrazioni di Austen ed Eliot utilizzano rappresentazioni di disturbi sia fisici che mentali per evidenziare i limiti della scienza medica. Inoltre, i modi in cui malattie quali il temperamento bilioso (*biliousness*), la gotta, l'ipocondria e i disturbi nervosi entrano nei meccanismi narrativi rivelano le ansie delle autrici e della loro epoca riguardanti la crescente mobilità economica del ceto medio e il parallelo declino della società aristocratica. Infine, il quarto capitolo esamina le modalità con le quali Austen ed Eliot costruiscono modelli alternativi di autorità, attraverso strutture narrative, personaggi e traiettorie di successo o di fallimento. La sezione finale è dedicata a come le due autrici riescano a rivendicare l'autorevolezza del potere narrativo e le sue possibilità trasformative. Dopotutto, sia Austen che Eliot detengono il potere narrativo per eccellenza che è lo sguardo letterario, capace di tenere insieme dove la medicina tende a dividere, di provocare empatia verso ciò che lo sguardo medico si propone, forse crede, di interpretare oggettivamente.