

Revising the Clinic

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*Vision and Representation in  
Victorian Medical Narrative and the Novel*



MEEGAN KENNEDY



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## INTRODUCTION



# Vision, Representation, and the Production of Knowledge

Her relations with the world . . . pressed so incessantly and so forcibly on the springs of interest and curiosity, that there seems to have been hardly a moment when she was not observing, speculating, or analyzing and recording the results. . . . Perhaps the most distinctive feature of her literary faculty is her power of seeing and stating brief problems of life, and so conveying in a sentence the result of a process of observation and thought.

In 1885 E. B. Hamley, writing in *Blackwood's Edinburgh Magazine*, characterized George Eliot as having lived at a constant pitch of awareness, stimulated incessantly to practice and refine the arts of seeing and representing.<sup>1</sup> Victorian medical and literary authors alike grounded their work in a serious attention to these arts, and to exploring and evaluating the range of modes of observation and representation available to them. George Eliot is of course a necessary figure for the study of literature and medicine in this period, given her complex and legendary fascination in working out these questions. But the modes of “interest” and “curiosity,” and the proclivity for “observing” and “speculating,” or “seeing and stating,” are not exclusive to her; medical as well as literary communities intently examined and debated these. In particular, Victorian case histories usefully referenced a historically specific authority, based on a particular notion of truth, its collection, and its transmission. Clinical methods of observation and representation offered writers some useful and powerful strategies, conveying a sense of rigorous scrutiny, careful description and narration,

and professional knowledge. It is evident how useful these could be for novelists facing what Peter Brooks has called the “descriptive imperative” of the nineteenth-century novel, since physicians used these methods to meet the same imperative in medicine.<sup>2</sup> Thus, this book is interested in pursuing not only the question Gillian Beer asks—“How much do the discursive strategies of scientists and poets have in common?”<sup>3</sup>—but how and why do physicians and novelists share these discursive strategies; and how and why do the same strategies play differently in different kinds of texts?

Nineteenth-century literary and medical genres—in particular the novel and the case history—shared a central concern over different modes of seeing and stating; but diverging disciplinary norms constrained their use of these practices. Previous analyses of “medicine and the novel” have examined a common realist ideal, usually by reading novels with medical content. But even a realist methodology shared by the novel and by medicine did not find identical expression in both genres.<sup>4</sup> Lawrence Rothfield identifies “medical realism” by its clinical or diagnostic voice, and he suggests that a medical discourse might “help to shape such formal features as point of view, characterization, description, diegesis, or closure, even in the absence of terminology.” Indeed, “one should be able to find some of these same techniques at work in other realistic novels where doctors and patients do not appear as such or appear only at the margins of the story” (xiii, xvii). This book takes up Rothfield’s suggestion, arguing in part that nineteenth-century novels may employ clinical observation and representation even where medicine is not strictly at issue. Although many of my readings focus on medicine and the body, others demonstrate how novels profitably use these strategies even when they portray neither doctors nor illness. Case histories model not just compelling characters and motifs but also a textual methodology for Victorian novels.

If novelists free these techniques of seeing and stating from their anchor in medical prose, both medical writers and novelists revise them in use, adopting them in a manner that contradicts medical authority or norms, or in the interests of literary aims such as sympathy, sentiment, sensation, irony, humor, or morality. The medical case history likewise borrows narrative forms and strategies from the novel, even after physicians establish a normative clinical genre for the case history, and especially in cases where professional knowledge or abilities fail.

Both genres—the novel and the case history—are crucially oriented around issues of vision and representation in this period. Critical interest in Victorian visuality has burgeoned, ranging from visual art to ideologies of perception to the science of optics, reflecting the consensus that it was

a visual age.<sup>5</sup> I am most interested in how literary and medical notions of seeing and stating changed over time, in relation with each other and with nineteenth-century historical developments and professional structures such as the rise of dissection, practical microscopy, psychoanalysis, literary periodicals, serialized fiction, and the like.

One foundational assumption of this project is that seeing and stating are crucially linked: changes in seeing made new forms of representation necessary, while new theories of representation codified and valorized particular kinds of seeing. Previous work on the medical narrative in relation to nineteenth-century literature often focuses on a binary model of reading—Romantic or materialist (Janis Caldwell), sympathetic or diagnostic (Jason Tougaw)—which critics offer as an alternative to the flawed binary of “literature or medicine.”<sup>6</sup> However, despite these critics’ careful attention to how these modes are in fact interpolated rather than distinct, these vexed couplets can reimport an oppositional notion of genre. By parsing out the distinct stages of seeing and stating that novel and case history share, this book hopes to present another model of genre, one that can flexibly trace the changing relationship between medical and literary narratives.

Accordingly, I trace the development of three stages of the case history—curious, clinical, and psychoanalytic—and varieties of the novel—sentimental, realist, romantic—as they develop and deploy a range of modes of vision to suit specific and historically contingent disciplinary needs. My interest in charting and examining the types of vision that physicians and novelists employed owes much to Lorraine Daston and Peter Galison’s work on objectivity, and to Martin Jay’s thesis of competing scopic regimes within modern culture. He suggests a “contested terrain, rather than a harmoniously integrated complex of visual theories and practices.” Similarly, Chris Otter argues that “reductive visual paradigms should be replaced by a multiplicity of overlapping, intersecting, and contrasting perceptual ‘patterns.’”<sup>7</sup> It should be evident, then, that this project not only builds on but also complicates Foucault’s notion of the clinical gaze, both because the power relation of the gaze was not unambiguous, and because physicians themselves struggled to incorporate it. I analyze the development of each mode of vision out of a specific historical moment, defined in relation to the predominant concerns and tensions in that moment as writers differentiate themselves from the past; but “each new regimen of sight supplements rather than supplants the others,” as Daston and Galison caution.<sup>8</sup> Some modes of vision, like clinical observation, define themselves in reaction against the excesses of a previous mode; others, like speculation or Freud’s imperialist mapping, incorporate aspects of their predecessors. My

interest is not in how Victorian physicians and novelists actually saw, but in how they theorized seeing, and how those theories changed representation. Finally, none of these texts realizes its ideal of vision or representation. Each author brings a specific set of needs and interests to his work, so any individual ideal of vision, like clinical observation, can only be realized in a multiple and fragmentary way; that is, in its many partial textual instantiations. One of my aims is to explore how far a text can flirt with other modes of vision or incorporate other genres before it risks losing disciplinary identification.

I begin with the oscillation in many eighteenth-century case histories between “curious observations” and “curious sights.” Curiosity was a favored attribute of eighteenth-century science, but the most authoritative way to pursue that curiosity was through a carefully managed observation: the unusual phenomenon would be exhibited for an assembled audience of disinterested experimentalists. This empiricist practice valorized the individual “matter of fact” in order to counter a proliferation of theories and systems. At times, however, as chapter 1 demonstrates, if the phenomenon becomes spectacular or the audience become voyeurs—linked to the scene more through affect (interest) than rational evaluation—then “curious observation” gives way to “curious sight.” This brief survey of eighteenth-century case histories grounds later chapters examining how the clinical and psychoanalytic case histories respond to and rework curious observation.

Chapters 2 through 5 explore the Victorian development of a distanced observation associated with clinical realism. In this book, I use the term “clinical realism” (rather than “scientific realism” or “medical realism”) to locate this theory of accurate mimesis historically, shaped by the clinical methods of observation and communication established during the long nineteenth century. Chapter 2 examines how clinical observation, such as the accurate examination, careful quantification, and dispassionate stance associated with the autopsy, developed into a theory of clinical realism marked predominantly by mechanical objectivity, the term Daston and Galison use to identify a nineteenth-century moral ideal for producing scientific knowledge.<sup>9</sup> This ideal valorizes accuracy and precision to the extent that the human observer should resist not only bias but judgment or any kind of mediation, so that natural phenomena might be (nearly) mechanically recorded through the incessant, selfless labor and attention to detail of the scientist. It specifically excludes any form of imagination, intuition, or insight—modes associated with literary writing instead. I adapt this notion as “mechanical observation” rather than “mechanical objectivity,” to indicate my focus, and that of clinical realism, on modes of visual percep-

tion. Although Daston and Galison identify the mid-nineteenth century as the period when this construct became a dominant ideal for scientists, instances occur earlier in medical debates over the proper matter and means of producing case histories.<sup>10</sup> This model influences medical narrative throughout the century, despite requiring the physician to sacrifice his sensibility, even his visible authorial role, on the altar of objectivity.

The remaining chapters of the book trace what happens to mechanical observation—how it is revised, adapted, enlarged, and subverted in novels and case histories throughout the century. The ideal of clinical medicine emerged only through an uneven development and was never unchallenged, especially given the competing ideal of “medicine as an art,” which championed a third mode of vision, insight. Versions of human insight appeared in case histories coded variously as sensibility, sentiment, sympathy, and even speculation. The movement toward experimental medicine at midcentury, influenced by the French pathologist Claude Bernard, helped make space in medicine for a kind of insight, hypothesis, or “speculation.” This must be grounded in the clinical ideal of observation, even as it rehabilitates the notion of intuitive or imaginative judgment. Speculation and insight in nineteenth-century medicine, unlike mechanical observation, invite a sympathetic or humanist mode of investigation that acknowledges the subjective experiences of both narrators and their objects of study. The status of this subjective knowledge in medical narrative is ambiguous at best. It is explicitly disavowed at the peak of the early-nineteenth-century empirical backlash against theory but judiciously admitted, if under suspicion, from the midcentury.

Although Freud is not British, this discussion of the case history must conclude with his model of the genre. His cases, and his remarks on case-taking, proudly mark their difference from most clinical case histories, as is evident in the dismayed reactions of many of his contemporaries. These help demonstrate how far clinical ideals dominated Victorian medicine, in a formalization of the case history that would remain unquestioned until the work of late-twentieth-century medical humanists. Partly because Freud uniquely combines clinical observation with a curious sight and an intuitive, speculative insight, his narratives are no longer legible within the generic tradition associated with the discipline of clinical medicine. The overt discursive hybridity of the Freudian case history is one reason, I argue, for the contested role of psychoanalysis as “science,” and its welcome within the literary community. Another is Freud’s unique model of vision, a romantic vision that heroically explores, reads, and maps the resistant wilds of a labyrinthine hysteria. If speculation required an imaginative

projection into the unknown, Freud's probing gaze goes even further in its active intervention and conflation of diagnosis with treatment.

Each of these modes of vision demands its proper method of representation. While the curious observations of experimental philosophers are certified by their record in "plain speech," their curious sights attract an exoticizing, sentimental, sensational, or romantic discourse—a curious discourse, which knits narrator to reader through the circulation of a shared affective response to a spectacular textual "sight."

The ideal of mechanical observation, in contrast, requires a particularizing, distanced representation in order to properly communicate and preserve its enlarged, objective knowledge. This new form of methodical, detailed representation helps construct a clinical realism for science. The term "science," describing "a precise and demonstrable knowledge," has existed in English since the Middle Ages and was clarified during the early seventeenth century. However, Sydney Ross argues that it was only after the publication of the astronomer Herschel's *Preliminary Discourse on the Study of Natural Philosophy* in 1830 that "science" approached our modern sense of the term, implying "scepticism of authority; dispassionate description of phenomena; the framing of hypotheses capable of being tested; and the measurement of the limits of reliability of data."<sup>11</sup> Mechanical observation idealizes the notion of an almost automatic representation, in which seeing and stating are collapsed, but its clinical realist narrators set out their authorizing markers as anxiously as any experimentalist. The scientific article thus accrued a constitutive written style, marked by its visual scrutiny, fetishization of detail, and impersonal tone.<sup>12</sup> Although compliance with these norms differs, the clinical case history references the new scientific norms more consistently than its predecessors had, to mark itself as new and modern. The positivist ideology of nineteenth-century science, rooted in a narrative of progress, required that the achievements of early empiricists like Bacon and Boyle be superseded by the efforts of the Victorians, who by midcentury had claimed the title of "scientist."<sup>13</sup>

Surprisingly, clinical case histories continue to draw from these non- or even antirealist subgenres, especially the sentimental. Speculative moments in nineteenth-century case histories are often flagged by hedging, signaling an anxious care to demonstrate a judicious balance between science and imagination. In contrast, the florid speculations and literary prose of Freud's psychoanalytic case histories dramatize, by their difference from clinical norms, how decisively medicine had rejected literature and its insights. Significantly, medical narratives continue to engage with literary forms and techniques throughout the century, even if under erasure. Given the frequency with which literary prose appears in failed medical cases, it

is likely that retaining a range and variety of rhetorical strategies offered a distinct advantage in challenging cases.

In the story of the case history, then, eighteenth-century medical narrators authorize observation and plain speech but flirt with spectacle and curious discourse. Nineteenth-century physicians valorize (but do not entirely realize) mechanical observation and clinical realism, contracting the modes available to the author, and they experiment with speculation, expanding them again. And Freud forces a rupture between observation and insight, when his model of the physician as a visionary charting dark and treacherous depths fatally strains the capacity of the medical case history to contain his floridly romantic model of medical vision.

The changes in the nineteenth-century British novel are more complicated to survey, given the proliferation of generic types and subtypes throughout the century. The novel emerges from an eighteenth-century model of sensibility, in which virtue is attained and displayed through the visual circulation of suffering and sympathy, into a century marked by a remarkable array of generic models for the novel and its vision. These include five nodes in the history of the Victorian novel that I examine here: the staging of clinical medical realism in literary periodicals; the sentimental (mis)use of clinical observations in Dickens and Gaskell; the revision of mechanical observation to produce sympathetic realism in the early George Eliot; the experimentation with a speculative insight in the later Eliot; and the scientific mapping of a dark, exotic labyrinth, common to the imperial romance of both Freud and Rider Haggard. However, even when novelists borrow a methodology of clinical realism from medicine, their novels seek to convey insight about, as well as observation of, the world.

Of necessity, this study engages with the project of Victorian realism and the relation between literary and scientific forms of that project. Although there are almost as many definitions of realism as there are critics of realism, I focus here on the most salient characteristics for my study, predominantly its empiricist commitment to the details of experience; its overt concern with accuracy and reliability; its apparent desire for transparency and suspicion of mediation; its record of the quotidian rather than the extraordinary; its idealization of a dispassionate stance; and perhaps most important, its skeptical, deflationary approach. The protean term “romance” is useful to me here to describe primarily antirealist discourses, in particular the interest in “curious” people and events, and a florid solicitation of the circulation of affect through a sentimental, sensational, or melodramatic tone. A narrative with a pointed, exaggerated interest in historicity and documents (translation, transcription, editing) is likely to verge on the romantic in its overt attention to the mediation of representation.

Medical and scientific narratives, I argue, theorized and (ideally) modeled a clinical realism that combined disinterested skepticism with a compensatory fetishization of description. The relation between these and literary texts encouraged an ingrained skepticism in realist novels about our ability to see and communicate reality, as well as a laborious collection of factual detail in an effort to make up for our inherent limitations. Thus, reading Victorian novels in company with case histories allows us to see the extent to which the realist novel is not, as some critics have claimed, either naïve or in bad faith about its relation to reality, with the caveat that a clinical realism is often necessary but not sufficient for the novelist's goals.<sup>14</sup>

This book also works to expand our sense of what kinds of novels find a medical narrative methodology relevant and useful, if only for a partial, momentary, or even critical adoption. It is no surprise that Gothic novels often draw upon medicine, given the nineteenth-century tradition of the scientific Gothic. But sentimental fiction and the imperial romance can also reference this realist methodology. That is, clinical medicine offered a useful cultural resource for a range of literary authors and audiences, even when they did not fully subscribe to its tenets, because clinical discourse usefully referenced a historically specific authority and technique for collecting and transmitting knowledge, even though novelists might differ from physicians on the ultimate truth that was being served.

Miriam Bailin has argued for a "marginalization of medical knowledge and discourse" in early and mid-Victorian fictional scenes of "illness and recovery," which she finds uninflected by clinical discursive norms.<sup>15</sup> It is possible, however, that Victorian novelists' clinical realism may be masked by being deployed strategically rather than universally, and often in settings outside that of the sickroom. Thus, despite the useful work by critics like Athena Vrettos, Peter Logan, Jane Wood, and Maria Frawley, I am not focusing on the "illness narrative" in fiction; nor (like Roy Porter, Bailin, or Frawley) telling the patient's side of the story.<sup>16</sup> Indeed, it is not necessary to focus on the "illness narrative" in fiction in order to examine the uses of medical discourse in the novel. Rather, this book studies the case history as a narrative genre in order to understand how clinical-realist observation and representation get used not only in, but outside the realist novel, and not only as part of, but also beyond the illness narrative.

At the most basic level, this book is a history of the engagement of two literary forms, the novel and the case history. It is grounded in the claim that the changes in the genre of the case history and that of the novel are fundamentally in relation with one another throughout the nineteenth century. If this book somewhat uneasily combines two narratives—the

trajectory of the Victorian novel's revisions of medical observation and clinical discourse, and a literary history of the case history's flirtation with human insight—it is because, I contend, each of these stories cannot be fully told without the other.

## MEDICAL OBSERVATION AND MEDICAL AUTHORITY

The physician's eye, trained to a clinical gaze, often represents in Victorian novels a dispassionate, accurate evaluation, a keener access to reality, like that of a reliable but not omniscient narrator. While the ne'er-do-well father of an injured child, in Margaret Oliphant's *The Rector and the Doctor's Family* (1863), panics so that "his trembling nervous fingers and bemused eyes could make nothing of the 'case,'" his brother, Dr. Rider, shifts into professional mode in the midst of his own frustration and anger. "Both father and mother thought [the boy] dead," the novel comments, "but the accustomed and cooler eyes of the doctor perceived the true state of affairs. Edward Rider forgot his disgust and rage [at the negligent father] as he devoted himself to the little patient—not that he loved the child more, but that the habits of his profession were strong upon him."<sup>17</sup>

Rider's authority here derives from his capability for distanced observation, combined with a medical knowledge born of experience (his "accustomed and cooler eyes") to enable an accurate evaluation of the situation and competent, engaged action. What characterizes the doctor qua doctor here is the training that enables him to overcome himself as character, to submerge his mere individuality, his love, and his rage, and to become a type. "The Doctor" of Oliphant's title has earned his distinctive social authority by virtue of this skill, innately associated with the clinical gaze that Michel Foucault has identified. It had become an axiom of medical professionalism (although a contested one, as I will show) that the physician's knowledge could only be gained by cultivating this distanced view, one that paradoxically also sees more closely. A disinterested medical vision, it was thought, can peer beyond surface impressions to perceive the innermost workings of the body, emulating the anatomical dissections that inaugurated the clinical era.

Dr. Rider's distanced gaze is not a Foucauldian one, however. His authority is not simply that of a "clinical gaze," because his diagnostic eye both marks the forced submersion of his inner man and, paradoxically, enhances his humanity. His ability to "forg[e]t his disgust and rage" by losing himself in clinical observation paradoxically suggests what the

narrator must disavow—that “he loved the child more.” Oliphant is typical of Victorian novelists in her interest in the relation between two modes of vision, clinical observation and human insight. While some physicians thought these incompatible, novelists like Oliphant consider whether one may in fact enable the other.

Nineteenth-century British medical narratives increasingly project a realist medical discourse that both invokes and enacts this cultural authority, that of the disembodied, knowledgeable, and professional eye. The theory and ideology of medicine change in the 1830s, with the medical reform movement and backlash against “heroic” medicine; but medical education and practice do not change greatly until the advent of germ theory and antibiotics decades later. As a result, much of the progress of professional Victorian medicine occurs through changes to the structure of medical practice, including the representation of that practice in narrative form (the case history). This moves away from the spectacular, curious cases of the eighteenth century toward the dispassionate scientific ideals of the nineteenth.

These newly disciplined narratives are central to the construction of professional medicine. If a physician engages with a case by observing the signs, evaluating them in the light of his previous knowledge (diagnosing the illness), and suggesting action (treating the illness), the clinical case history completes the cycle by returning the product—new clinical experience, whether real or vicarious—to a now-enlarged body of professional knowledge.<sup>18</sup> These narratives invoke the insights of clinical observation through a prescribed narrative form, ritualizing the process of professional practice and realizing medical knowledge in a new, distinctive way.

This book will explore the two aspects of this cycle that nineteenth-century physicians teaching or revising the genre of the case history tend to emphasize: vision and representation. By combining clinical observation with realist representation, physicians had access to a powerful new methodology for producing a professional knowledge and identity. The advantages of clinical realism proved portable beyond the bounds of the medical narratives for which it was developed.

## MEDICAL OBSERVATION AND REPRESENTATION IN THE NOVEL

Given that clinical observation and representation come to evoke an ideal of accuracy and discernment, and carry a measure of cultural authority, it

is not surprising that novelists turn to it. It allows novels to describe and evaluate some object, or narrate and judge some process, whether it be a person, a landscape, a social system—or the efficacy of a particular style of housekeeping, the popularity of purchased pastries in a small town, or rumors of a bank failure.<sup>19</sup> The methodical, diagnostic gaze associated with the clinical close reading of an object facilitates a consideration of the moral, emotional, or spiritual, as well as physical, state of individual characters or of British society as a whole. However, even inanimate objects such as landscapes may resonate under diagnosis, and even authors who are ostensibly skeptical about scientific methods may adopt a clinical approach.

In Benjamin Disraeli's *Sybil* (1845), the narrator overtly takes on the role of a physician when diagnosing the town of Marney, which represents the sorry "condition of the People" of England.<sup>20</sup> The approach to the town appears "delightful" to the untutored traveler, who perceives only its situation "[i]n a spreading dale, contiguous to the margin of a clear and lively stream, surrounded by meadows and gardens, and backed by lofty hills, undulating and richly wooded." This pastoral scene is, however, a "[b]eautiful illusion," which the narrator rapidly dispels through authority gained from a kind of dissection, cutting through this superficially "merry prospect" to reveal the decay deep in the body of England. "[B]ehind that laughing landscape," the narrator warns, "penury and disease fed upon the vitals of a miserable population" (51).

Disraeli adopts the methodology of surgery and dissection for this description of a diseased England. His narrator searches deep to reveal the inner organs or "vitals" of England and the nation's hidden cancer, "full of pain." Despite the "traditional epithet of [the] country," this England is not so much merry as delirious, displaying a disordered and entirely symptomatic disconnect between face and flesh, appearance and reality, surface and depth. This is a pathological landscape, which to be cured must be opened to the fresh air and to the reformer's cleansing scalpel.<sup>21</sup> To provide that healing cut, the narrator records a series of details, from the general state of the "narrow and crowded lanes" and "cottages built of rubble," to a catalogue of the disorder in structures such as the "leaning chimneys" and "rotten rafters" (51–52).

Disraeli does refer to actual diseases, in a reference to the sanitary movement and Edwin Chadwick's 1842 *Report on the Sanitary Condition of the Labouring Population of Great Britain*. Disraeli's narrator returns again and again to the "open drains full of animal and vegetable refuse, decomposing into disease," the "foul pits," and "stagnant pools" of "dissolving filth" (52). The passage mentions typhus and malaria and describes "Fever,

in every form, pale Consumption, exhausting Synochus,<sup>22</sup> and trembling Ague” (52–53). Disraeli’s capitalization personifies these fevers as dread persons haunting the land—a literary touch at the deepest point of the narrator’s surgical exploration, testifying to novelists’ tendency to combine a clinical discursive methodology with more affecting techniques.

Disraeli’s “case history” of a literally diseased landscape points to the metaphorical power of clinical narratives in the hands of a novelist. Like the physician-turned-social reformer James Phillips Kay, Disraeli argues here for “England’s social problems as a kind of disease.”<sup>23</sup> These diseases are not only literal threats but also potent signifiers of the failures of domestic policy: cancers on the body politic. Although the scene offers the opportunity to fulminate about a number of moral and social ills—national security, crime, the economy, industrialization and labor relations, and the like—the narrator uses its public health failures as a synecdoche for the economic and political health of the land, and the consequences for England’s moral and spiritual health.

While individual persons in the scene suffer from particular diseases, this passage focuses its “diagnosis” on the landscape as a whole. It presents a clinical examination, not of any individual body, but of the landscape and the town, as synecdoches for the nation; and its reference to these fevers suggests how they sap life and health from the economic and social as well as the individual body. Disraeli, like other nonmedical novelists, demonstrates familiarity with medical observation and representation, and refocuses these to diagnose subjects other than characters. Rather than simply depicting and diagnosing the diseases of particular characters, the clinical perspective here examines and evaluates a social function. The narrative is structured by and oriented toward a clinical perspective, rather than merely recording some character’s use of that perspective; and clinical observation and narration become a mode of representation rather than simply being represented.

A novel may thus strategically employ a technique drawn from medicine, even when the plot—or novelist—is not particularly invested in medical or scientific culture. Acknowledging the uses of clinical realism beyond direct experience usefully opens up the available field of analysis beyond George Eliot, Charles Dickens, Sarah Grand, and others with established personal connections to the medical or scientific community. Disraeli is not known for his interest in science and medicine. The “Young England” movement of which he was a member generally scorned the statisticians working on public health, arguing that statistics distance the reader from the true human cost of endemic poverty. Indeed, Mary Poovey argues for

*Sybil* as “a counter to [the] anatomical realism” that she associates with Chadwick and Kay (137).

The case history boasts a unique relation to scientific narrative because of the inherently subjective interest of its human subject. Some physicians asserted the role of medicine as an art every time medical statistics and clinical science crested a new wave of popularity. As this book will show, case histories are more likely than other kinds of scientific texts to attempt a balance, albeit an uneasy one, between science and art, observation and insight. Like many case histories, Disraeli’s narrative juxtaposes medical practices such as diagnosis and dissection with more evocative descriptions of a pathology. This reformist approach links a critical observation of environment, as in public health treatises, to the human insight that must accompany any practice of the medical art.

### LITERARY REPRESENTATION AND INSIGHT IN MEDICAL NARRATIVES

While novelists made use of medical techniques of observation and representation, Victorian physicians did not entirely eschew literary techniques in writing case histories, even as the genre became more formal and less elastic. Despite the demands of increased hospital training for students, literary reading remained central to physicians’ reputation as men of letters. Edward Forbes argues in 1843 for the importance of literary and aesthetic subjects even in medical school. While the medical profession “must become more and more scientific every day,” he warns, “[t]he air of a hospital is mentally unwholesome, unless mingled with a full proportion of collegiate atmosphere. The very neighbourhood of literary and scientific studies has a purifying and elevating effect on the mind of the student.”<sup>24</sup> Thus, he concludes, the aim of a proper medical education must be to produce a physician who is at once “a scholar, a man of science, and a man of taste; and, above all, imbued with sound principles of religion and morality” (12). Forbes is echoing a widespread concern that physicians must continue to read literary texts, to retain not only their status as men of culture, but also their professional acumen.

The physician’s elevated status over surgeons, apothecaries, and irregulars had traditionally been due in part to his university training, little of which was required to be scientific until a medical school entrance examination on physics, chemistry, and biology was instituted in the 1880s. Although the divisions between the ancient “corporations” (physician, surgeon,

apothecary) diminished after the Medical Reform Act of 1858, which created a list of all licensed practitioners, new distinctions arose between provincials and their metropolitan colleagues, whose status as consultants and fellows of the professional societies were still supported by a liberal education.<sup>25</sup> Thus the author of an 1846 article in the *Dublin Medical Press*, referring to recently released statistics, decries the absence of bookshops in some areas of Ireland. He laments, “[T]here are many [towns] in which the medical practitioner can find neither book nor journal to enable him to keep his mind in a state of cultivation and his information equal to that of others more favourably circumstanced.” The article examines “*medical bookselling*” separately, since “the fatal mental repose which the absence of literary food and stimulus induces extends to this department.”<sup>26</sup>

Literary norms and strategies, even those of the devalued form of the novel, would have been familiar to most physicians as readers. Indeed, cases even late in the century testify to their continued influence. The physician Byrom Bramwell published as late as 1890 a “Case of So-called Perforating Tumour of the Skull” in which a large part of the history and examination are presented in dialogue with the patient’s mother (the patient was a four-year-old boy). The boy presented with his left eye discolored and protruding from its orbit, and with an orange-sized lump on his head. Bramwell cross-examines the mother while instructing his students in the case.<sup>27</sup>

DR. B. (to the patient’s mother). How long is it since you noticed the lumps on the boy’s head?

PATIENT’S MOTHER. Three weeks yesterday.

DR. B. How long has his eye been like that?

PATIENT’S MOTHER. Six or seven weeks. . . .

DR. B. (to the Students). The head is large.

PATIENT’S MOTHER. He always had a large head.

DR. B. Did you notice anything wrong with his head before the lumps appeared?

PATIENT’S MOTHER. No, there was nothing wrong with his head till three weeks ago.

DR. B. Was he quite well till three weeks ago?

PATIENT’S MOTHER. Yes. He was a strong healthy child. We noticed nothing the matter with him till three weeks ago. (250)

This interactive, inefficient manner of presenting the facts of the case is unusual, even in a book like this, reporting pedagogical lectures. In fact, dialogue had not been a normative part of medical representation since

the eighteenth century, when it was derived from the philosophical genre of the Socratic dialogue. By 1890, when Bramwell is writing, a distanced, terse, third-person prose had long constituted the normative discourse of a medical case history. Educated and practicing in Edinburgh, a center of British medicine, Bramwell, who later was knighted for his contributions to medicine, was already a Fellow of the Royal College of Physicians of Edinburgh, an instructor of medical students at the Edinburgh Royal Infirmary, and the author of a textbook and other writings on medical diagnosis and “case-taking.” His decision to present this case in dialogue is unlikely to follow from ignorance of the norms of medical representation.

Rather, this dialogue presents a striking pedagogical demonstration of how human emotion and error often obscure the true history of an individual case of disease, and how to elicit this history from a lay interlocutor. Further examination brings out what Bramwell calls “the confusion in the mother’s statement” about the progress of the disease (250). He eventually ascertains that the boy’s eye had become discolored six or seven weeks previously, he’d complained of headache a few weeks later, and then had become seriously ill with the appearance of the lumps. Bramwell’s presentation in dialogue emphasizes the performative nature of the diagnostic process and cannot help but resonate with literary portrayals of the anxious, loving, ultimately helpless mother. Despite Bramwell’s dispassionate reportage, her distress appears in her confusion over the dates, her denial of anything untoward about the child’s swollen head (“He always had a large head”), and her insistence that he was a “strong, healthy child” despite evidence that he’d been sick for some months (in fact, the left eye had been more prominent since birth). As with many medical case histories that flirt with literary techniques, Bramwell’s prose seems to tolerate the incursion of dialogue in part because this fatal case draws attention to the limits of medical knowledge and skill. It is this kind of fascinating juxtaposition of discourses that allows the genre of the case history to interrogate the development of “properly” literary and medical narratives.

As a result of this discursive hybridity, case histories can become porous to alternate methods of observation as well as representation. While the case above resists overt sentiment, a space for insight does sometimes open in Bramwell’s cases when he comments on the human circumstances of his patients, as with this patient with aneurysm:

This patient is very poor; he lives in lodgings with his wife; his rent is with difficulty paid; and yet he is not willing to come into hospital. He has not definitely told me so, but I suspect that his reason is this: he knows that

if he comes into hospital his house will be broken up, and his wife will have to go to the Workhouse. He wants, I suspect, to avoid that as long as possible. Now that is a plausible reason, and moreover, a reason which we can not only sympathise with, but also admire.<sup>28</sup>

The irony is strong here, for the patient will likely die without proper care. Although his professional knowledge argues that the patient is at risk outside the hospital, Bramwell voices his sympathy for him and his difficult choice. "I do not, under the circumstances, feel myself justified in pressing him too strongly to come into hospital," he concludes (119).

Bramwell's work suggests that, like many physicians, he cultivated an interest in the form and effect of medical representation. He sometimes notes the "beautiful" example a case presents of its particular diagnosis.<sup>29</sup> He is remarking, of course, on how perfectly these individual presentations exemplify the general type, but his choice of terms inevitably implies a kind of aesthetic of medical form. Bramwell also displays his awareness of literary concepts such as suspense and irony; he structures his cases to make the most of these. In one case, he tells the story of a servant girl who mysteriously died overnight, after a brief illness, and was thought to have been poisoned ("Stricture"). In the case of the impoverished young man, above, he describes the "peculiar and puzzling" pulse that the patient exhibited.<sup>30</sup> Using his skills, training, and tools, Bramwell takes on the role of medical detective in these cases, proving the servant girl to be suffering from perforated ulcer and the young man from aneurysm, distorting the true pulse sounds. He reports these histories in such a way that his readers must follow in his footsteps from perplexity and suspicion to certainty. He concludes by offering and confirming his diagnoses, bringing closure to these cases, with evidence provided by clinical technology (postmortem examination and the sphygmograph, respectively). Despite his reliance on clinical technology, the narrative structure of suspense and resolution promotes an appreciation of the physician's human insight as much as his clinical observation.

While these cases deftly manipulate a pattern of suspense and release familiar to readers of novels, another case displays Bramwell's acute sensitivity to irony. His "Remarkable Case of Euphoria" details the condition of a friend of his, an officer (physician) in the Indian Medical Service. This friend manages to remain cheerful and unaware of his fatal abdominal tumor even as it develops from "a small hard tumour about the size of an egg" to "a large tumour, fully the size of a child's head, of great hardness, and evidently malignant," one day before his death. Bramwell emphasizes

both the irony and the unlikelihood of the situation, pointing out that “[b]oth the patient and his wife seemed amazed when the presence of the tumour was pointed out to them.” “How it could possibly have escaped the attention of the patient, a most cultured and intelligent medical man, I am utterly unable to conceive,” he continues, “for it was impossible to place the hand on the abdomen without at once recognizing the large tumour and its dense, hard character.”<sup>31</sup> The irony here points to a human insight that drives this case history: the case is really not about the heavy tumor, which is unexceptional, but about this patient’s “remarkable” evasion of the unbearable weight of his own mortality.<sup>32</sup>

Bramwell’s subtitle for this collection identifies these cases as “some of the more interesting” ones in his experience. As I argue in the chapters to follow, it is not unusual for such curious cases to call forth a narrative that can escape the clinical norms set forth by nineteenth-century physicians. In fact, it is possible that the literary forms evoked here help to normalize or naturalize cases that otherwise disturb the case history—the narrative site of medical professionalism—particularly when these cases call attention to the boundedness of medical knowledge and practice.

The examples above open up numerous questions about the ways in which British novels and medical case histories share an interest in vision, representation, and genre, especially as the novel and the case history become professionalized over the course of the nineteenth century. The novels and cases I draw upon in this book testify to an influential rapprochement between these forms even while physicians were instructed to strive for a clinical discourse and novelists like George Eliot were chided for employing a “medical habit.”<sup>33</sup> Furthermore, the novels and cases examined in this book demonstrate that, although professional literary and medical writing are conceived of as antipathetic, they are not infrequently combined and even used against the grain of their native ideology.

## COMPLICATIONS OF DISCURSIVE HYBRIDITY

When novels import visual and representational norms from other disciplines, the resulting discursive hybridity complexly engages the ideologies underlying those norms. Thomas Hardy, in the short 1872 novel *Under the Greenwood Tree*, both deploys and ironizes a medical observation, in a scene of diagnosis early in the novel. This clinical way of seeing temporarily confers a discursive authority on Mr. Penny, the shoemaker, in a scene reminiscent of the demonstrations in a teaching hospital, where the

physician instructor would lead the students through the basics of patient history, examination, and diagnosis. Hardy's shoemaker performs his clinical expertise on two telling, but unlikely, patients: a shoemaker's last and a boot, which—under his expert gaze—yield crucial information about the symptoms and traumas of their owners. “Now whose foot do ye suppose this last was made for?” he asks his audience of villagers rhetorically, before launching into a demonstration of what can only be deemed professional knowledge.

“It was made for Geoffrey Day's father [Penny explains], over at Yalbury Wood. Ah, many's the pair o' boots he've had off the last! Well, when 'a died I used the last for Geoffrey, and have ever since, though a little doctoring was wanted to make it do. Yes, a very queer natured last it is now, 'a b'lieve,” he continued, turning it over caressingly. “Now you notice that there”—(pointing to a lump of leather bradded to the toe), “that's a very bad bunion that he've had ever since 'a was a boy. Now this remarkable large piece” (pointing to a patch nailed to the side), “shows a' accident he received by the tread of a horse, that squashed his foot a'most to a pomace. The horseshoe came full-butt on this point you see.”<sup>34</sup>

Penny offers here a particular kind of evaluation: a diagnosis. The shoe last is curious, “queer natured.” It is symptomatic, with its bradded leather lump and nailed-on patch, of a history of pathology, whether the suffering be chronic and quotidian (the bunion) or extraordinary (horse accident). Penny expertly reads its symptoms, correlating each to its cause and commenting on the distinguishing marks in an almost pedagogical manner, with his audience circled around him respectfully, like medical students in an operating theater watching a surgeon discourse on a difficult case. The shoe last functions as a synecdoche for the foot and the patient; and Penny's dispassionate, informed gaze on it, his expert reading of its symptoms and their causes, confers a certain authority on him. As Peter Mere Latham explains to students, his role as a hospital lecturer is that of a “demonstrator of medical facts”: “engaged to direct the student where to look for, and how to detect, the object which he ought to know; and, the object being known, to point out the value of it in itself and in all its relations.” This is precisely what Penny does for his auditors.<sup>35</sup> A medical methodology is suggested throughout this scene by its atmosphere and tone, and in Hardy's specific word choices: by Penny's easy air of expertise and specialized knowledge of the trajectory of the lived-in body, his descriptive interest in physiological peculiarities marking that trajectory (a bunion, a “squashed” foot, and

other “deformed” aspects of the body), and his activity in what Hardy terms “doctoring” and “operating” upon his subjects.

Medical observation and its authority are useful to Hardy because they enable the reading of less tangible realities, in an allegorical reading of character. When Penny turns to the boot of the new schoolmistress, Miss Fancy Day, his diagnostic gaze allows him to explicate the family “likeness between this boot and that last,” between the “deformed” foot and the “pretty” one. The narrator, too, takes on this diagnostic mode of observation, in a delicate examination of character.

There, between the cider-mug and the candle stood this interesting receptacle of the little unknown’s foot—and a very pretty boot it was. A character, in fact—the flexible bend at the instep, the rounded localities of the small nestling toes—scratches from careless scampers now forgotten—all, as repeated in the tell-tale leather, evidencing a nature and a bias. (26)

Fancy may be at this point “the little unknown,” but her character is both foreshadowed by her name and circumscribed by the ambivalent qualities evident in her boot: pretty, flexible, childlike, and “nestling”; “careless” or even thoughtless; energetic and not entirely demure (she “scampers”); and unreflective (her scampers are “now forgotten”). The boot is “light” of foot; not only nimble of foot but also, perhaps, footloose. Under the directed examination of the narrator, the boot reveals itself, and by extension its owner, as playful, unencumbered, easily influenced, and difficult to steady, perhaps even inconstant. The “tell-tale” leather records Fancy’s “nature” and her “bias” as clearly as her father’s shoe last reports on his hardworking life, although, as often occurred with physical symptoms in the era before germ theory, the definitive diagnosis must be deferred. The novel centrally pursues just this question of Fancy’s possible lightness of character, asking its readers which of the two, Fancy or Geoffrey, is more truly “deformed.” Hardy’s novelistic process is founded upon, and requires of readers, this kind of diagnosis, in which disinterested, detailed observation of the world may ground a human insight into its reality.

Medical observation in the novel does not necessarily remain unchallenged. Not all Penny’s listeners accept his diagnostic authority, although he asserts both its truth and its specificity to his informed experience. “To you, nothing,” he modestly avers, “but ’tis father’s voot and daughter’s voot to me as plain as houses” (26). Penny’s expert demonstration only momentarily allows him to assume that authority, and the suggestive diagnosis of Fancy is in question throughout the novel. However, Geoffrey’s last and

Fancy's boot demonstrate the symbolic potential of medical practices in a narrative. They foreground questions of authority and expertise, observation and interpretation, even when they are ironized.

I do not mean to suggest that all instances of close examination in the novel should be understood as diagnostic readings. Hardy draws on a variety of descriptive modes to depict rural village life. He often sets the scene with recourse to a botanical vernacular, to use Amy King's term, as with the opening of the chapter "A Confession":<sup>36</sup>

Fuchsias and dahlias were laden till eleven o'clock with small drops and dashes of water, changing the colour of their sparkle at every movement of the air; and elsewhere hanging on twigs like small silver fruit. The threads of garden-spiders appeared thick and polished. In the dry and sunny places dozens of long-legged crane-flies whizzed off the grass at every step the passer took. (128)

After this scene's record of natural history at high summer, Fancy is surrounded by early apples and butterflies, birds and hollyhocks, in a synecdochal enunciation of her bloom and a descriptive articulation of rural Wessex. This passage doesn't draw on clinical realism, but it helps establish the dominance of visual examination in the novel, and it works with clinical observation to ground and authenticate Hardy's imagined world.

Hardy's nuanced use of the trope of professional examination and diagnosis demonstrates how a novel's adaptation of medical discourse often resists simple reading. Even novels that adopt a clinical discourse do not spurn all affect or affect a disinterest in human character. On the contrary, as I will show, because the effect of genre differs depending on its context, novels often adopt a clinical discourse partially, momentarily, strategically. Esther Summerson's competent, experienced eye enables her to detail the symptoms of an ill-run household during her visit to the Jellybys in Dickens's *Bleak House*: the "tarnished" nameplate, "litter" in the rooms, "marshy" atmosphere, unkempt curtains, rumped and torn stair-carpets, uncooked dinner, and above all the injured and filthy condition of little Peepy, who had fallen down the dark, ill-kept stairs and is superbly ignored by his mother (51, 52, 55). These symptoms would signify within the midcentury discourse on public health, or to any reader familiar with contemporary theories of domestic hygiene. However, Esther's enumeration does not register an emotional distance from the situation, as might be suggested by the act of diagnosis. Rather, it only intensifies her—and presumably the reader's—pity for Peepy. Ultimately, the focused, diagnostic, clinical detail of medical observation can be deployed to much greater range of effect

in the more forgiving contexts of a novel than it can in a Victorian case history.

### THE “CASE,” GENRE, DISCIPLINE, AND PROFESSION

The case is a peculiar genre, perched as it is—like the novel—between an individual and a more general knowledge. The modern “case,” an anecdote or exemplar, collects details about an occurrence or person in order to come to some conclusion. The *Oxford English Dictionary* lists the earliest textual example in the 1400s, the “case of conscience,” concerning theology and philosophy. The legal case appears in print in the 1500s; the medical case in the 1700s; and the police case in the 1800s. The philosophical case, like the curious medical cases of the eighteenth century, signifies the singular or the extreme, “the exception that proves the rule.” An alternate tradition presents a case as typical or representative, an illustration of a general type.<sup>37</sup> Because it allows this mediation between the individual and the general, the phrase “a case of malaria” implies both a detailed narrative of an individual patient’s unique history and the broader context of a disease type. It offers the interest of an anecdote within the rigor of a classificatory system. But the case attracts controversy, because it sits at the center of a debate over truth and disciplinary norms.

The authority of the case suffers from its association with casuistry, a method of ethical philosophy that argues through the individual case of conscience. The case seems to assert a general truth despite its basis on limited, individual experience, and because it deploys a possibly fictional narrative. Opponents of the case study argue that even if a case is true, it might not be relevant, representative, or significant.<sup>38</sup> Harvard Law School introduced the case method of instruction in the early 1870s to some debate, which also erupted when W. B. Cannon suggested in 1900 that American medical schools should also move to a case method.<sup>39</sup> Although the case lacks the authority of logic or the force of numbers, it strengthens an argument through its narrative appeal, which some critique as illogical and manipulative. This narrative force, with its ability to navigate between the individual and the universal, also makes it useful to novelists. Novels like Jane Austen’s *Sense and Sensibility*, Wilkie Collins’s *The Moonstone*, or Oscar Wilde’s *The Picture of Dorian Gray* turn upon extended case histories.<sup>40</sup>

The narrativity of the case becomes explicit when it becomes a case history. In referencing “history,” the case draws upon an ideal of linearity, of teleology, and of fact. The “true history” sets itself over and against the

“romance” in the seventeenth and early eighteenth centuries;<sup>41</sup> it is in its role as “history” that the case dissembles its interest in the curious, that which is both anomalous and singular. Despite the changes in contemporary historiography, during the nineteenth century the narrative of “history” records the normative or symptomatic; anything else is “lost to history” or becomes myth. And the teleology of “history” narrates the destiny of the group—nation, clan, dynasty—rather than the individual. In the case history, the scope of history contracts to fit the singular fact.

This book will show that case histories work like novels or other genres: not monolithically, but realized through an accumulation of contingent instances. They adapt other genres or modes and develop in a historically specific cultural field in which other genres are also developing. Genre is inevitable but never sufficient; it cannot entirely direct its effects. If Frederic Jameson reads a text “as the coexistence, contradiction, structural hierarchy, or uneven development of a number of distinct narrative systems. . . [as] a synchronic unity of structurally contradictory or heterogeneous elements, generic patterns and discourses,” I am most interested in how a text works to manage, although not always contain, that heterogeneity in the interests of a particular knowledge and community.<sup>42</sup> I argue that genres allow authors to establish, as a normative frame, a discourse that may confer narrative and professional authority within their historical context—for nineteenth-century medicine, clinical discourse. However, to meet specific demands, their text may strategically incorporate or even discredit other discourses, as in sentimental medicine or Hardy’s shoemaker scene. While Jameson argues that “genres are essentially literary *institutions*, or social contracts between a writer and a specific public, whose function is to specify the proper use of a particular cultural artifact” (106), genres also constitute disciplines as institutions. Beer argues that “genres establish their own conditions which alter the significance of ideas expressed within them.”<sup>43</sup> Genres also attempt to establish their own readership, specifying the disciplinary codes that restrict what counts as knowledge; the difficulty of this task becomes especially clear in Freud.

Nineteenth-century novels and case histories are texts woven from diverse genres, each entailing particular professional and class benefits and disadvantages. Clinical scientific ideology and nineteenth-century literary criticism largely construe these genres as conflicting. Novels and cases must serve simultaneous discrete imperatives: the demand to show objectivity or transmit knowledge; a subjective demonstration of affect; a professional notion of rigor, value, or rectitude; and disciplinary notions of truth.

Disciplines name, access, and limit the cultural authorization of dif-

ferent kinds of knowledge. The archive, which Foucault calls “a complex volume, in which heterogeneous regions are differentiated or deployed, in accordance with specific rules and practices that cannot be superposed,” gets revisioned when seen as a discipline: a cohesive and harmonious whole consistent with an internal logic and teleology.<sup>44</sup> Although, as he notes, the archive must “take account of statements in their dispersion, in all the flaws opened up by their noncoherence, in their overlapping and mutual replacement” (127), my project emphasizes instead how the end of “discipline” is order. Participants agree to ignore the dispersion and noncoherence of these constituent statements, condemn them as unruly, or read them as aligned in some crucial way with one another, to preserve the greatest possible sense of consistency, community, and common purpose. I do not examine unpublished case histories here; published narratives are more likely to project community norms of discourse. Discussions of professional methodology became especially acute just before and after midcentury for both medicine and the novel.<sup>45</sup> These often focus on techniques of visual observation (collection of knowledge) and representation (transmission of knowledge), two actions that ground generic distinctions in literary and medical narrative. In both, professional norms of seeing and stating help limit or control the relationship between author and audience, especially any “interested” visual and affective relation between text and reader.

Given the roots of “discipline” in teaching and discipleship, the concepts of history, lineage, and tradition anchor literature and medicine as disciplines, or knowledge projects, and the novel and the case history as disciplinary documents. Although few texts are generically “pure,” the nineteenth-century case history faces a uniquely heterogeneous set of demands: it must produce both a fact and a story, represent both a disease and a person, display both the disinterested stance of the man of science and the physician’s subjective insight. The struggle over disciplinarity is visible within the case history; it looks to literature even as it asserts medicine as an autonomous, scientific practice.

Debates over the pressures of science and professionalism markedly shape nineteenth-century medicine.<sup>46</sup> Before the Medical Act of 1858, the three branches of medicine (physicians, surgeons, apothecaries) were presided over by the London-based corporations.<sup>47</sup> Victorian physicians’ membership in the traditional professions (Navy, the Church, law, and medicine) was transformed by the development of a broader, bourgeois professionalism. Despite the growing dominance of ideals of clinical medicine, Victorian physicians gained more cultural capital from their classical, liberal education than their scientific training. Even hospital consultants

resisted privileging science over a classical (Oxbridge) education, good character, and experience.<sup>48</sup> M. Jeanne Peterson notes that “medical men themselves . . . shared with their lay patients . . . a belief in the superior virtues of liberal learning and gentlemanliness and the inferiority of technical training and skill. The struggle for the authoritativeness of medical knowledge had to be waged not only in the public arena but within the doctors themselves.” Medical students did not have to pass a preliminary exam on physics, chemistry, and biology until the 1880s.<sup>49</sup>

This book focuses on the broad trends in nineteenth-century British medicine, at first toward increased visual discipline and textual restriction, then toward a freer, more speculative inquiry. But at every point many physicians resisted the dominant mode of inquiry (the hegemonic discourse, if you will), and others strayed ahead toward an emerging one. Even later in the century, some physicians declared that clinical practices destroyed the “art” of medicine; others, such as antivivisectionist physicians, accepted clinical medicine but decried experimental science.<sup>50</sup> Other physicians might “routinely invoke science as the foundation of medicine” but in practice emulate “the gentleman, broadly educated and soundly read in the classics.”<sup>51</sup> Indeed, the *Lancet* endorsed polite letters by retaining “Literature” in its title until 1871; and in 1882 the Charter of the Royal College of Physicians—the most prestigious of the medical societies—listed as criteria to become a Fellow, “not only ‘Professional Eminence’ and ‘Distinction in . . . Science’ but also ‘Distinction in Literature’ and ‘Social Position.’”<sup>52</sup> However, scientific professionalism offered other benefits: it allowed physicians to transform an occupation associated with messy bodies, personal service, and physical manipulation into one associated with precision, expertise, and rationality.

Nineteenth-century debates over “literature and science” indicate both the instability of disciplinary boundaries and their growing importance in regulating modern culture.<sup>53</sup> The Romantic era marked the “beginning of an anxiety” over disciplinary difference, with William Blake’s fiery criticisms of Isaac Newton.<sup>54</sup> By the end of the century, T. H. Huxley’s defense of science education met Matthew Arnold’s refusal to acknowledge the educational value of science.<sup>55</sup> And Freud highlights the rigor of his prose to claim the status of the “man of science” instead of the “man of letters.” Twentieth-century critics replayed both the debate and the divide. C. P. Snow’s “two cultures” prompted F. R. Leavis’s fierce defense of “literary intellectuals” against the increasing cultural authority of science.<sup>56</sup> The discussion erupted into controversy again with the science wars of the 1990s, contesting the authority of literary and cultural critics to examine scientific practice.

In the novel, disciplinary exchange is more easily tolerated, even after Blake and Coleridge had established and defended literature's purpose as an aesthetic, rather than simply moral, instructive, or pleasurable, text. The permeable discursive borders of the novel can embrace even irregular medicine. Dickens could reanimate the old medical controversy of human spontaneous combustion, in *Bleak House*, garnering scorn from G. H. Lewes, and George Eliot could explore animal magnetism in an experiment like *The Lifted Veil*. Many writers also drew on the sciences of the mind and body; novelists from Godwin, Austen, and Charlotte Brontë, through Walter Scott, to Stevenson and Du Maurier applied or anticipated medical theories of melancholy, hysteria, amnesia, paranoia, and the subconscious.<sup>57</sup> Nicholas Dames shows how the very theory of the Victorian novel develops from contemporary physiology.<sup>58</sup>

### WHY THE CASE HISTORY?

With the rich and variegated territory of the Victorian novel spread out like an intriguing landscape, why would any critic spend time pursuing a little-known genre like the case history? Reading novels and case histories against one another interrogates the history of the novel; it opens a new view onto Victorian culture; and it allows us to trace how disciplines develop in and through texts. The rich genre of the medical case history—which boasts an extensive, though little-known, archive—illuminates the history and context of the British novel in several ways. First, the novel borrows from the case history. Critics have identified various prose genres as models for the novel, but the medical case history remains a rich resource that too few readers consider.<sup>59</sup> Some early prose genres that critics have discussed include the newspaper, travel narrative, captivity narrative, spiritual autobiography, conduct book, and anthology.<sup>60</sup> The case history provides another compelling example of a developing narrative model. It illustrates how authors can construct genre and disciplinarity as difference, even while strategically deploying a heterogeneous text; and it offers a model of narrative in which fictional status and the attempt to represent historicity are crucial to the authority of the text.

Second, the case history foregrounds its status as a text, even a literary text, by sharing literary strategies with the novel. Medical authors develop a genre of the case history through a disciplinary anxiety arising from their incorporation of medical observations into a record shaped by the conventions of narrative. But Victorian physicians defined themselves as readers—"men of letters." Writing in and reading elite periodicals, living among

and socializing with their literate peers, they were likely to be familiar with norms of the contemporary novel even if they were not themselves novel-readers. Their notions of narrative were accordingly likely to be informed by developments in the British novel.

Third, the case history shares one of the novel's major concerns: how to narrativize the self. If the novel is a textual mechanism for producing subjectivity, the case history similarly constructs the modern subject. Of course, the case history, by combining previous history, patient autobiography, and chronicle of observation, helps to constitute not a fictional but a real historical subject. But by corralling the experience of the body within particular categories of the self, the case history provides an alternative narrative structure that makes available the model of a coherent subjectivity accumulated through experience.

Finally, the formal and generic evolution of the case history roughly tracks, and illuminates, that of the novel. Like the novel, the case history traces a path from a curious sensibility of the eighteenth-century case history, through the realism of the clinical era, dedicated to the precise rendition of surfaces, and finally blossoms inward with Freud. And like the novel, the case history demonstrates two disjunct strands in its realist and romantic discursive traditions, with authors and contemporary critics defending one against the other in an oppositional model of genre. The tremendous archive of the case history, still relatively unexplored, offers a vast textual resource to critics of the novel.

The genre of the case history also localizes some of the most contentious questions shaping Victorian society. With the rapid developments in scientific knowledge and methodologies, some of the period's most prominent cultural critics mounted debates over the proper role of science in culture, a concern that underlay narrative choices in many nineteenth-century novels and case histories. Novelists from Dickens and Collins to Eliot and Hardy articulate a struggle to find the proper relationship of science to art. The medical case history usefully focuses nineteenth-century debates over the nature of truth, from the discussions of a mechanical objectivity common to realist novels and medical texts, to the question of distinct modes of truth, as when Gaskell reminds us that the novel, medicine, and religion differently consider the bodily transformation we call death.

The case history also allows us to study the Victorian period's particular interest in visibility, characterized, as critics like Jonathan Crary and Kate Flint have shown, by remarkable changes in aesthetic theory, in art itself, and in how visual images are narrativized in texts. Medical narratives channel and magnify this "visual turn." Physiologists debated the mechanism

of perception, complicating simple tropes of vision. Medical instruments offered new possibilities for extending sight and for representing information visually, with not just the new achromatic microscope, but also instruments like the sphygmograph, which could graph the body's rhythms, rendering them visible for the first time. Visual "figures" like graphs and tables functioned magically in medical narratives by signifying rational, scientific work even as they allowed a continued focus on curious bodies.

The case history also illuminates the history of periodical publishing, as medical cases gradually disappear from general-circulation periodicals, like the *Gentleman's Quarterly*, to surface in new professional medical journals. In Thomas Wakley's reformist *Lancet*, "the case" enables the development of forensic medicine, paralleling the rise in juridical discourse during this period. Like the lurid police "Case-Book Fiction" of the 1850s and 1860s, forensic medical cases help introduce new literary genres like detective and sensation fiction. The links between police and forensic medical cases, both precursors of detective fiction, become especially clear in novels like Collins's *The Moonstone*. With the midcentury drive toward standardizing and professionalizing the case history, the new status of the case history as an analytic tool made it an important narrative model (and in novels, a trope) for the diagnosis of ills in what Poovey has termed the Victorian "social body."

The case history obviously tracks the rise of professionalism in the Victorian period. Science moves away from the natural history model of the amateur toward a centralized model of specialization and expertise. This trend affects medical authorship and authority, and the development of specialized journals.<sup>61</sup> In the early 1830s England of *Middlemarch*, the science of a Parisian-trained Lydgate can collaborate with that of the vicar Farebrother, whereas at midcentury, a self-trained scientist and popularizer like George Henry Lewes must work hard to become a respected member of the physiological community.

Rapid industrialization also becomes focalized in the rich archive of the case history, which increasingly details railway and factory accidents. Case histories in occupational medicine allow labor to define the body in new ways and revisit the vexed questions of class and environment. Old concerns about the decadent rich and the "criminal" poor gained scientific status with the use of statistics. The case also grounds public health initiatives once investigators like John Snow began tracking clusters of cases to understand the geography and, eventually, the etiology of diseases like cholera. The phenomenon of public health, and its incorporation into novels like *Sybil*, suggests that when narrative turns the attention from the

individual to the aggregate, the narrator's voice negotiates a new kind of authority.

The case history is especially useful for studies of developing notions of gender and sexuality in the Victorian period. From debates over man-midwives and chloroform for childbirth, to nursing reports from the Crimean War, and from Weir Mitchell's hysterics to Havelock Ellis's inverts, the case history offers a newly authoritative unit of knowledge from which Victorians may build certainty in contested questions of gender and sexual identity. The work of Martha Stoddard Holmes demonstrates how usefully medical narrative testifies to Victorian cultures of disability as well.

Finally, Victorian case histories also allow us to track developments in fields that deserve focused investigation but range largely beyond the scope of this book. The case history also mediates vexing questions of empire by providing a textual site for medicalizing racial and cultural differences. And case histories chronicle the birth of a professional imperial medicine. Here a narrative structure native to British bourgeois professionalism attempts to tame a florid tropical environment and contain what was perceived as a foreign threat to the vulnerable, expanding British national body, whether domestically (as in cholera) or overseas (as in remittent fever). Overall, the case history, as a genre, offered Victorian novelists a powerful narrative instrument for the analysis and management of their world. Individual case histories, read closely and as a corollary to novels, help clarify some of the most significant questions agitating British Victorian culture.

Many scholars of literature and medicine focus on medical scenes in literary texts, reflecting the persistent perception that medical narratives are, as they claim to be, strictly functional. Critics who do acknowledge the importance of narrative in medicine often identify with the field of "narrative medicine," a pragmatic pedagogical or reformist project to improve the practice of medicine. Work in these fields, while valuable, can rely upon a notion of the text as a simple reproduction of reality that broadens the physician-reader's humane understanding of individual suffering. The value of reading would be its ability to prompt a vicarious experience of sickness through an illness narrative that reliably communicates the subjectivity of the patient. This practice draws upon a universalizing model of textuality, and it relegates literary texts to a strictly instrumentalist function. Because cultural studies of medicine is grounded in the history and theory of the novel and of medicine, it can more flexibly appreciate the historically contingent relation of writers to the larger culture. However, this approach does not always recognize the specificity of the text and its language. My work argues that the cultural studies of medicine should sustain a close

formal reading of the text and a sensitivity to its language as well as its culture. This book pursues a rigorous analysis of textuality in order to illuminate how both form and culture shape the history of disciplines.

The chapters of this book lay out a general, but not necessarily chronological, cultural history of “the case history and the novel.” My first two chapters briefly chart the historical shift from the eighteenth-century case history, which negotiates between the curious observations of the “New Science” and some less-admissible curious sights, to the nineteenth-century case history, which valorizes mechanical observation recorded with a clinical realism. Chapter 2 examines the growth of restrictions on clinical seeing and stating, with the development of mechanical observation; and demonstrates how lay Victorian readers and writers could share a discussion of clinical medical norms through their performance in the “literary commons” created by Victorian periodicals.

The following three chapters examine what happens to the restrictive ideal of mechanical observation as it is intensified, revised, and supplemented by literary and medical writers. These chapters track the complex relation between novel writing and case history writing during the mid-century surge of the Victorian novel. I examine the subversion of clinical observation by sentiment in Dickens and Gaskell and in medical cases; the reorientation of mechanical observation toward sympathy in George Eliot’s early fiction; and the freeing of the speculative gaze in experimental medicine as well as in Eliot’s later novel *Middlemarch*. I map the circulation of modes of vision and representation between disciplines and the genres that help to constitute them. These chapters argue for the traffic between disciplines of a shared constellation of visual and textual methodologies, which are always revised in use to align more completely with particular disciplinary aims.

The final chapter turns to Freud to understand what happens to the story of the case history in its relationship with the novel. As Freud explores, reads, and maps the knotted mind of the patient, his imperial romance does not disguise its debt to literary modes, however vexed that debt may be for Freud himself. It is at this point that, while novels may strategically tap various stages of clinical realism for its cultural authority and effect of precision and accuracy, medicine itself turns decisively away from the novel and its insights and rededicates the case history to clinical observation and the clinical voice.

## CONCLUSION



FATHER. Come hither, Charles; what is it that you see grazing in the meadow before you?

CHARLES. It is a horse. . . .

FATHER. . . . Let us see if you can tell how a horse differs from a cabbage?

CHARLES. Very easily; a horse is alive.

FATHER. True; and how is every thing called which is alive?

CHARLES. I believe all things that are alive are called *animals*.

FATHER. Right . . .

FATHER. Now, then, observe what particulars we have got. *A horse is an animal of the quadruped kind, whole-hoofed, with short erect ears, a flowing mane, and a tail covered in every part with long hairs. . . . Do you know now what we have been making? . . . A DEFINITION. . . . It is a kind of chase, and resembles the manner of hunting in some countries, where they first enclose a large circle with their dogs, nets, and horses; and then, by degrees, draw their toils closer and closer, driving their game before them till it is at length brought into so narrow a compass that the sportsmen have nothing to do but to knock down their prey.*<sup>1</sup>

John Aiken's and Anna Letitia Barbauld's aptly named "A Lesson in the Art of Distinguishing," a parable for young readers, is remarkably suggestive about both the promise and the pitfalls of genre, which (like definition) relies upon careful observation, and upon a categorization that is narrow enough to be distinctive, yet broad enough to encompass the entire population of a type. The descriptive power of such an approach is evident; its dangers, like faulty premises or a rigid, territorial notion of categorization and ownership, are also evident above.

Physicians, like young Charles, often observed in order to find difference; they worked to distinguish typhus from typhoid fever, or measles

from scarlet fever. These chapters have, however, attempted to trouble the accretion of difference between novels and medical texts, by distinguishing some of their common visual and narrative strategies.

This book has focused on particular genres—the novel and the case history—and on the British context in the nineteenth century, but it also hopes to lay out a more flexible, dynamic, and relational model of genre. While I draw on Frederic Jameson's construct of genre as a nuanced response to social structures and Michel Foucault's notion of genre as archive, I propose a model of genre as contingent, strategic, and situational. The visual and representational strategies I examine here help to determine genres like the clinical case history or the sentimental novel, but they are mobile and scalable; they can be imported strategically and are shaped by context. The genre of any text is formed in a complex negotiation. While we tend to privilege the author's voice and rhetorical authority, the text is constructed and consumed under the sometimes conflicting pressures of disciplinary norms and the perceived expectations of readers. Chapter 3 demonstrates how surprisingly often physician-writers deploy a sentimental discourse momentarily, in apparent contradiction of clinical norms, but strategically, to meet a contextual demand.

Such a reading of genre will necessarily affect how we study the history of medicine. This book argues that physicians were and are writers, working in a narrative genre (the case history) with a history like any other literary genre. Moreover, physicians worked in the context of an explosion of print. The field of periodical studies demonstrates how fully physicians and novelists were reading and writing each other in the same pages. As literate workers physicians would have read and discussed novels and reviews of novels; their nonscientific reading is likely to have shaped their writing of medical narrative and their interpretation of cases.

The history of medical writing casts ripples on so-called literary writing as well, when novelists make strategic use of clinical modes of seeing and stating. I have suggested that a newly rich and varied interplay of discursive hybridity in the novel may be revealed and examined, once we consider that medical modes of seeing and stating may be useful to the novel outside their original context. While Victorian studies has long been an interdisciplinary field, with critics delving into the novel's relation to political economy, photography, and anthropology as well as medicine (to name a few examples), the recent surge in periodical studies speaks to a new interest in how many Victorian novels were written for and read in periodicals, that is to say, in the immediate context of other genres. The *Waterloo Directory* points out that the sheer volume of newspaper, periodical, and other print

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media in the Victorian period was more than one hundred times that of books. The Victorian novel was published in, read in, and crucially shaped by these adjacent texts, and only a more flexible model of genre will allow us to capture the nuances of their relation. The medical case history and the Victorian novel both risked much and gained much from their shared use of curious, clinical, and literary sights and insights, even as they developed toward different disciplinary goals and different truths.

## NOTES



## INTRODUCTION

1. [Hamley], "Life and Letters," 170.
2. Brooks, *Realist Vision*, 17.
3. Beer, *Open Fields*, 149.
4. See Rothfield, *Vital Signs*.
5. See Isobel Armstrong, "Transparency" and *Victorian Glassworlds*; Nancy Armstrong, *Age of Photography*; Beer, "Authentic Tidings"; Flint, *Visual Imagination*; Brooks, *Realist Vision*. Recent critics discussing objectivity or disinterestedness in relation to visuality include Anderson, *Powers of Distance*; Levine, *Dying to Know*. See also Krasner, *Entangled Eye*. On the history of optics and visuality including the Victorian period, see Isobel Armstrong, "Sub-Visible World"; Crary, *Techniques*; Crary, *Suspensions of Perception*; Cartwright, *Screening the Body* (although this focuses on a postcinematic visuality).
6. See Caldwell, *Literature and Medicine*; Tougaw, *Strange Cases*.
7. Jay, "Scopic Regimes of Modernity," 4. Otter, *Victorian Eye*, 21.
8. Daston and Galison, *Objectivity*, 318.
9. See Daston and Galison, *Objectivity*; Daston and Galison, "Image of Objectivity."
10. Crary identifies an early-nineteenth-century break from naïve eighteenth-century optical theories. Whereas at first "the . . . observer confronts a unified space of order, unmodified by his or her own sensory and physiological apparatus," later subjectivity unavoidably shapes and mediates perception, because "vision is always an irreducible complex of elements belonging to the observer's body and of data from an exterior world." Despite W. J. T. Mitchell's caveats, textual evidence suggests that the shift began at about 1830 in medicine and physiology. Crary, *Techniques*, 55, 70–71; Mitchell, *Picture Theory*, 19–21.

11. Ross, "Scientist," 67, 82. Ross locates one watershed moment in 1620, when Bacon published the *Novum Organum* (67). Bacon argued that knowledge "must gradually evolve, using observation and experiment, by refining and clarifying its former partial truths."

12. This shift has itself been quantified by Gross. Rhetorical elements of the modern scientific report include complex noun phrases, navigational infrastructure (abstract, subheadings), detailed citation practices, and prominent visual elements (graphs, tables). See Gross et al., *Communicating Science*; Dear, "Totius in Verba"; Dear, "Introduction," in *Literary Structure*; Vickers, "Royal Society."

13. The word "scientist," first suggested by William Whewell in 1834, aroused vigorous debate and as late as c. 1910 was still considered "a colloquialism" inferior to the more traditional "man of science." Ross, "Scientist," 75. Whereas "natural philosophy" was a gentlemanly interest, science was not considered an autonomous profession—one which could itself confer social standing—until the 1830s. Susan Cannon, *Science in Culture*.

14. I follow critics like George Levine (*Realistic Imagination*) and Harry Shaw (*Narrating Reality*), who are among the most forceful critics working to complicate our understanding of realism, countering charges that realist novels impose a totalizing vision and are deluded or deceptive in their claims of a transparent access to the real.

15. Bailin, *Sickroom*, 3.

16. Vrettos, *Somatic Fictions*; Logan, *Nerves and Narratives*; Wood, *Passion and Pathology*; Frawley, *Invalidism and Identity*; Porter, *Patients and Practitioners*.

17. Oliphant, *Doctor's Family*, 87.

18. Shapin and Schaffer in *Leviathan* discuss the scientific report as a means of replicating experiments for a wider audience, providing a virtual audience for the experimenter and a virtual experience for the reader. Although eyewitnesses were no longer crucial as testimonials to the authenticity of Victorian experiments, the scientific report remained to certify individual experiences as professional, and thus communal, knowledge.

19. These examples are drawn from Dickens, *Bleak House*; Eliot, "Brother Jacob"; and Oliphant, *Hester*.

20. Disraeli, *Sybil*, 193. He uses this phrase throughout the novel, as well as in the advertisement at the beginning.

21. Disraeli literalizes the imperative that Pamela Gilbert identifies in midcentury medical mapping: to open up and illuminate the dark spaces of poverty. See Gilbert, *Mapping*, 27–54.

22. Synochus is a continued (not remittent or intermittent) fever; the term is little used after the 1840s.

23. Poovey, *Social Body*, 58.

24. Forbes, *Inaugural Lecture on Botany*, 11.

25. Peterson, *Medical Profession*, 60. For a sense of the contentious debates over the medical curriculum, see Romano, *Making Medicine Scientific*.

26. "Literary Tastes," 413 (emphasis in original).

27. Bramwell, "Perforating Tumour."

28. Bramwell, "Diagnostic Value," 119.

29. Bramwell, "Perforating Tumour," 252; Bramwell, "Stricture of the Oesophagus," 200.

30. Bramwell, "Diagnostic Value," 115.

31. Bramwell, "Remarkable Case," 58.

32. It is rare, but humor also surfaces in the case history, as in John Elliotson's report of a single woman in her thirties with an abdominal disorder, who adamantly denied pregnancy: "She had a pulse of 80; something within her had a pulse of 128; and what that was, I left her to settle by herself. All that I could say was, that if she waited patiently, the whole of the disease would come away, to a certainty, in two or three months." Elliotson et al., *Principles and Practice*, 61.

33. Colvin, Review of *Middlemarch*, 144.
34. Hardy, *Greenwood Tree*, 24.
35. Latham, *Collected Works*, 27.
36. King, *Bloom*.
37. The great seventeenth-century physician Thomas Sydenham, for example, grounded his classificatory system on his observations of individual cases, as did Giovanni Morgagni in the eighteenth century. But the case's reference to a norm of disease did not become predominant until the nineteenth century.
38. See Kathryn Montgomery Hunter, *Doctors' Stories*, 71–73, 81–82.
39. W. B. Cannon, "Case Method"; Epstein, *Altered Conditions*, 51n84.
40. Critics who discuss the case as a model for the narrative of individual experience have focused largely on the relevance of the philosophical case. See McKeon, *Origins of the English Novel*, 82–83; J. Paul Hunter, *Before Novels*, 290–94; Starr, *Defoe and Casuistry*. Thomas Laqueur has posed the realist medical "case" as a narrative model for the humanitarian empathy that underwrites the novel ("Bodies, Details").
41. See especially McKeon, *Origins of the English Novel*.
42. Jameson, *Political Unconscious*, 138, 141.
43. Beer, *Open Fields*, 186.
44. Foucault, *Order of Things*, 128.
45. In the novel, debates over genre and style emerge in the 1830s and 1840s, with Bulwer-Lytton; the 1860s, with the sensation novel crisis; and the 1870s, with high realism. In medicine, clinical realism as a narrative technique reached a climax in the 1830s and 1840s, while debates over the use of graphing technology and statistics peak in the 1860s.
46. Nineteenth-century medicine was essentially international. British authorities seem to cite continental sources more often than American sources. But British medical treatises were often published in American editions, and British medical journal articles reappear in American journals.
47. The Royal College of Physicians of London was most prestigious and chartered in 1518. The Royal College of Surgeons of London was chartered in 1800; surgery was technically a craft rather than a profession but proved upwardly mobile. Finally, the Society of Apothecaries was chartered in 1617. Apothecaries were associated with trade because they sold medicines, but they fought to attain recognition for practicing medicine.
48. These were physicians and surgeons with hospital and teaching appointments in the metropole. Lawrence examines debates over traditional education versus a German-style continental curriculum ("Incommunicable"). Peterson identifies a rift between the London-based consultant and the provincial general practitioner. These new loyalties superseded the old tripartite divisions in both London and the provinces (*Medical Profession*).
49. Peterson, *Medical Profession*, 60, 135. See also Bynum, *Science*, 176–84.
50. Romano, *Making Medicine Scientific*, 162.
51. Christopher Lawrence, "Incommunicable," 505.
52. Quoted in Peterson, *Medical Profession*, 173.
53. See Hollinger, "Knower and Artificer."
54. Collini, "Introduction," x.
55. Huxley, "Science and Culture"; Arnold, "Literature and Science."
56. Snow, *Two Cultures*; Leavis, "Two Cultures?"
57. See Shuttleworth, *Charlotte Brontë*; Rylance, *Victorian Psychology*; Dames, *Amnesiac Selves*; Otis, *Networking*; Michael Davis, *George Eliot*.
58. Dames, *Physiology of the Novel*.
59. A few studies, especially recently, focus on the genre of the case history in relation to the novel. Small includes an extended reading of medical case histories of the "love-mad

woman.” Sill argues that study of the passions contributed to the empiricism that founds both eighteenth-century medicine and the novel. Caldwell examines the “double vision” of “Romantic materialism” in pre-Darwinian British literature and medicine, which, she argues, must read the world both empirically and imaginatively. She also discusses what she sees as a bipartite structure of the case history (“history” and “physical”). And Tougaw, whose project is perhaps closest to mine in scope and its focus on the case history as a genre, argues for a dual mode of reading (diagnosis or sympathy) through which novels and case histories make sense of the conjunction of pathology and identity. Small, *Love’s Madness*; Sill, *Cure of the Passions*; Caldwell, *Literature and Medicine*; Tougaw, *Strange Cases*.

For books on the case history generally, see Tougaw; Epstein. Article-length histories include Temkin, “Sinn’-Begriff”; Reiser, “Creating Form”; Stoockle, “History-Taking”; Hurwitz, “Form and Representation”; Gilles, “Patient History”; Laqueur, “Bodies, Details”; Rylance, “Theatre and Granary.”

60. See Nancy Armstrong, *Desire and Domestic Fiction*; Lennard Davis, *Factual Fictions*; J. Paul Hunter, *Before Novels*; McKeon, *Origins of the English Novel*; Price, *Anthology*.

61. See Peterson, “Medicine,” 24.

## CHAPTER ONE

1. Locke, *Essay Concerning Human Understanding*, 8 (II.ix). For a discussion of Molyneux’s question, and of perception in the tradition of empirical philosophy, see Law, *Rhetoric of Empiricism*.

2. Chesselden, “Account of Some Observations,” 448. The name is usually spelled Chesselton.

3. Most historians of medicine perceive the eighteenth century as a period of dormancy in the development of European medicine between two significant philosophical and practical developments: the New Science of the seventeenth century, and the clinical and experimental medicine of the nineteenth. See Porter, “Laymen, Doctors,” 288.

4. Shapin and Schaffer, *Leviathan and the Air-Pump*, 56.

5. *Ibid.*, 65–69.

6. Chesselden, “Explication.”

7. Although surgeons and apothecaries might keep or even publish case histories, most printed case histories are authored by physicians. Practitioners who referenced the Royal Society or adopted experimentalist methods were also more likely to be physicians.

8. The patient retained power in the relationship with his physician through the eighteenth century, as Porter has shown (“Lay Medical Knowledge”).

9. Pargeter, *Observations on Maniacal Disorders*, 103; Cheyne, *English Malady*; Monro, “Remarks.”

10. See Richard Foster Jones, “Science and English Prose Style”; Christensen, “John Wilkins”; and Nicolson, *Seventeenth Century*. The influential arguments of these early commentators do not account for the “Rhetorick,” or even the rhetoric, which persists in Royal Society texts; their conclusions have been revised. See Vickers, “Royal Society”; Dear, “*Totius in Verba*.”

11. From C. R. Weld (1848), *A History of the Royal Society*, London, I, 146–48; quoted in Hall, “Early Royal Society,” 60.

12. V:iv [1728]; quoted in Jones, “Science and English Prose Style,” 84.

13. Sprat, *History*, 111, 13 (emphasis in original).

14. Royal Society member John Wilkins pursued the injunction to equate words and things with his project of creating a “Real Character” in which each thing would be represent-

ed by a single sign, legible to readers of any language. Signs would follow a logical progression, so that the sign for “dog” would incorporate the sign for “animal,” and so on. Mermaids, fairies, and the like had no signs, as they did not exist and hence were not truly “things.”

15. I will adopt the eighteenth-century spelling, “Rhetorick,” to distinguish the Royal Society’s term, with all its connotations, from our modern usage of “rhetoric”: any set of stylistic rules and principles, unavoidable in any organized discourse.

16. Fairfax, “Bullet Voided by Urine,” 803.

17. Daston and Park, *Wonders*, 259.

18. Law argues that empiricism accomplishes this focus on perception through an unacknowledged emphasis on rhetoric and on language (*Rhetoric of Empiricism*).

19. Barbara Stafford also examines the eighteenth-century “antimony . . . between spectacle, or gawking at heaped-up goods, and observation, or the reasoned apprehension of phenomena.” *Artful Science*, xxvi.

20. See especially Benedict, *Curiosity*; Tougaw, *Strange Cases*.

21. These included, besides the *Philosophical Transactions* of the Royal Society, the French *Journal des Savants* and *Histoires et Mémoires de l’Académie Royale des Science*, and the Italian *Giornale de litterati*. See Daston, “Marvelous Facts,” 259.

22. Daval, “Extraordinary Rainbow”; de Vallemont, “Small Egg”; “Part of a Letter . . . Account of a Double Pear”; Conny, “Shower of Fishes.”

23. Molineux, “Epidemick Distempers,” 105.

24. Cheyne, *English Malady*, N2.

25. McKeon, *Origins*, 47.

26. See Dennis Todd on the epistemological issues raised by physicians’ response to the Mary Toft (rabbit-birth) case (*Imagining Monsters*); and Stafford on the eighteenth-century nexus between science and entertainment, truth and foolery (*Artful Science*). Terry Castle suggests that spectators might actually want to be deceived (“Culture of Travesty”).

27. Pargeter, *Maniacal Disorders*, 109; Myddelton, “Extra-Uterine Conception,” 337.

28. On the “physician of the mind,” see Sill, *Cure of the Passions*, 13–34. The literature on eighteenth-century medicine and sensibility is considerable. See especially Van Sant, *Eighteenth-Century Sensibility*, 50–59, for a comparison of the mechanism of sensibility—as an observation of suffering, which excites a sympathetic response—in the literary context and that in the physiological one. On “sympathetic practitioners” and how the eighteenth-century John Gregory, in *Observations on the Duties and Offices of a Physician* (1770), theorized that practitioners need both “sympathy” and “composure,” see Ward, *Desire and Disorder*, 30–53; Caldwell, *Literature and Medicine*, chap. 2.

29. Mandeville, *Hypochondriack and Hysterick Diseases*, 19–20.

30. Cheyne, *Health and Long Life*, xvii.

31. Pargeter, *Maniacal Disorders*, 49 (emphasis in original).

32. Although Boddington and two others write the main portion of the text, it is framed and thus “authored” by Henry Baker. See Baker et al., “Margaret Cutting,” 143.

33. “Two Letters from a Gentleman,” 1499–1500.

34. Watt, *Rise of the Novel*, 188, 157.

35. Dent, “Worms Found in the Tongue,” 220.

36. Despite the apparent conflict with the ideal of a disinterested observation, terms like “entertainment” (as in the water-newt case) do not seem to disrupt the experimentalist’s contract with witnesses. The term can indicate intellectual exercise, as in this discussion of fluid dynamics in rivers: “As it is a problem somewhat curious, though’ not difficult, and its solution not generally known . . . I thought it might give some entertainment to the curious in these matters, if the whole process were published.” Robertson, “Water under Bridges,” 493.

37. Parsons, “Hermaphrodite,” 142, 143 (emphasis in original).

38. Todd comments that “the English fascination with monsters and their willingness to pay to see them were almost proverbial” (5).

39. See Byrd, “Negro-Boy”; Parsons, “White Negro”; “Of the Posture Master”; Machin, “Distempered Skin”; Baker, “Distempered Skin.” Baker mentions that the patient was “shown at London by the name of the porcupine-man” (22).

40. The extended debate over the efficacy and safety of transfusion included three previous articles or notices regarding the experiments in transfusion in Paris: Denis, “Letter . . . Touching the Transfusion of Blood,” briefly discussing a dog-to-dog transfusion; Denis, “Letter . . . Touching a Late Cure,” an extensive account with cases and a detailed explanation of equipment arrangement for performing a transfusion; Denis, “Letter . . . Touching the Differences Risen,” detailing the legal investigation into the man’s death, which Denis attributes to arsenic poisoning. The *Philosophical Transactions* also publishes an anonymous article claiming British priority in the procedure: “Advertisement Concerning the Transfusion of Blood.”

41. Denis, “Letter . . . Touching a Late Cure,” 617, 620. For a second transfusion, Denis lists the spectators as “several very able physicians, Bourdelot, Lallier, Dodar, de Bourges, and Vaillant” (621). He claims “that divers phisytians, and other persons worthy of credit, that have seen [the patient], can render an authentick testimony to all the circumstances here advanced by me” (624).

42. *Ibid.*, 620.

43. Stack’s case is one of several on unusual lactation. In 1674 “a Person of great veracity in Germany” wrote to the editor of the *Philosophical Transactions* “concerning an aged Woman of 60 Years, giving suck to her Grandchild” (the author’s own child). In 1741 Robert, Lord Bishop of Cork wrote to the Royal Society about “a Man who gave Suck to a Child.” Unfortunately, the suckling had occurred long before the bishop met him, so unlike Stack he could not witness it firsthand; but “[t]he bishop looked at his breasts, which were then very large for a man; and the nipple was as large or larger than any woman’s he ever saw.” Stack, “Woman,” 140 (emphasis in original); “Relation Written . . . Concerning an Aged Woman”; Robert, Lord Bishop of Cork, “Man Who Gave Suck,” 517.

44. Manginot, “Unusual Medical Case,” 756.

45. Denis, “Letter . . . Touching a Late Cure,” 622.

46. Chesselden, “Young Gentleman,” 450, 448.

47. See, for example, Barker-Benfield, *Culture of Sensibility*, 1–35; Mullan, *Sentiment and Sociability*, 210–40; Brissenden, *Virtue in Distress*, 35–45; Flynn, “Running out of Matter”; Rousseau, “Nerves, Spirits, and Fibres”; Van Sant, *Eighteenth-Century Sensibility*, 1–16.

48. Pye-Smith, “Medicine as a Science,” 309.

49. For the lack of public confidence in establishment medicine, see Peterson, *Medical Profession*, 38, 90. Homeopathy and other peculiar practices had rapidly established colonies of support in influential patient populations. By professionalizing and regularizing care, by repudiating both quacks and “heroic medicine” as unscientific, and by distancing their work from the craft of surgery and the trade of apothecary, reformist physicians hoped to regain market share and public trust, and to secure a position in the powerful new professional class. However, as George Eliot’s *Middlemarch* dramatizes, patients themselves were not sure they wanted reformist, professional physicians.

50. Medical schools affiliated with hospitals and providing intensive clinical training were rare until the latter half of the century. The Medical Reform Act of 1858 established ground rules for licensure, but there was no universal exam until 1884. Physics, chemistry, and biology were not generally required for entry into medical schools until the 1880s. See Peterson, *Medical Profession*, 5, 60, 64, 241; Warner, *Therapeutic Perspective*, 175ff.

51. The *Lancet* was the best known reformist organ, although the *London Medical and Surgical Journal* also exposed incompetent practitioners. Medical journals provided a central

force for reform. See Crawford, "Scientific Profession," esp. 223; Warner, "Idea of Science," 138–42.

52. Warner, *Therapeutic Perspective*, 182.

53. Georges Canguilhem has analyzed this shift toward perceiving pathology as a physiological state along a continuum of bodily conditions; Warner places the shift in the bodily ideal from "natural" to "normal" around the 1850s. Canguilhem, *Normal and Pathological*; Warner, *Therapeutic Perspective*, 87. See also Huet, *Monstrous Imagination*.

54. Canguilhem, *Normal and Pathological*, 69–85.

55. Gould and Pyle, *Anomalies and Curiosities*, 2, 1.

56. Barnes, *William Dempster*; Clanny, *Mary Jobson*; Millingen, *Curiosities*; Sayre, *Remarkable Case*. Thomas Renwick published in 1817 a pamphlet, *Narrative of the Case of Miss Margaret McAvoy* (with "some optical experiments" on what he later explained as "her peculiar powers of distinguishing colours, reading &c., through the medium of her fingers"). Renwick's (and Miss McAvoy's) claims invited a rebuttal by Joseph Sandars, which was itself rebutted by Renwick. See Renwick, *Narrative of the Case*; Renwick, *Continuation of the Narrative*; Sandars, *Hints to Credulity!*

57. Stafford talks about this gesture as a crucial component of the Enlightenment itself: "Most fundamentally, to enlighten meant unmasking charlatanism of every stripe by teaching the public its conning stratagems. . . . Fear of contaminating pristine or authentic experience reached epidemic proportions in the second half of the eighteenth century" (74). Enthusiasm for an unmasking "enlightenment" pervades the case history most strongly in the early nineteenth century.

58. Greenhow, "Concussion of the Brain," 392. The case is "reported (with a drawing) by Mr. H. M. Greenhow," but Mary K. is actually "under the care of" Mr. T. M. Greenhow (392).

59. Rick Rylance argues that the curious is not even much obscured. Analyzing two contrasting elements of the nineteenth-century case history, the "granary" (practical, methodical) and the "theatre" (spectacular, curious), he notes the persistence of the theatre in cases throughout the century, specifically in tone, narrative conventions, the diversity of journal contents, and "the sustained and substantial presence of the bizarre, the grotesque, the freakish, and the comical." "Theatre and Granary," 262–63.

## CHAPTER TWO

1. Latham, *Collected Works*, 29, 37–38.

2. Janis Caldwell complicates this trajectory by arguing that clinical medicine in fact is grounded on the same "Romantic materialism" that nurtured Romantic literature, a "dialectical hermeneutic" that "tacked back and forth between physical evidence and inner, imaginative understanding." Caldwell's readings are persuasive, but I am more interested in tracing the expression of empirical ideals in nineteenth-century case history writing, examining how and why these ideals seemed to demand the exclusion of any subjective insight, despite the impossibility of this aim. Despite the existence of the productive "Romantic materialism" that Caldwell examines, many cases demonstrate their allegiance instead to the ascendant epistemology that Lorraine Daston and Peter Galison have termed "mechanical objectivity." In chapter 5, I examine the shift at midcentury when case histories may once again acknowledge imagination and insight, now coded as "speculation" and "hypothesis." Caldwell, *Literature and Medicine*, 1.

3. Clinics (publicly funded hospitals) first arose in France, shifting the intellectual center of medicine from Edinburgh to Paris for much of the nineteenth century. See Ackerknecht,

*Paris Hospital*; W. F. Bynum, *Science*; Foucault, *Birth of the Clinic*; Peterson, *Medical Profession*; Shryock, *Development*; Warner, *Against the Spirit*; Warner, "Idea of Science."

4. In an 1816 casebook by a Bristol surgeon, James Bedingford, 32 of the 34 cases underwent an autopsy after death. Fissell, "Disappearance," 100.

5. Epstein, *Altered Conditions*, 51.

6. Caldwell locates the beginnings of the modern format in the 1820s, and Epstein comments that the "more or less standard order . . . began to be established in the early nineteenth century and became codified in the last decade of the century." My research suggests that the modern format begins to emerge in the first decade. Gilles argues that around 1860, the "symptom" (the patient's subjective experience of disease) became distinguished from the physician's observation of the "objective signs" of disease. See Caldwell, *Literature and Medicine*, 149; Gilles, "Patient History," 493.

7. Finlayson, "Examination and Reporting," 39.

8. Ferriar, *Medical Histories* (1792), iii–iv.

9. Analogy persists in that the individual patient with phthisis was understood as an analogue of the normative patient with phthisis; but analogies between diseases, as in the old nosologies, became problematic. The physician William Osler warns in 1892,

[T]here is a form of acute phthisis which may closely simulate ordinary pneumonia. . . . A healthy, robust-looking young Irishman, a cab-driver, who had been kept waiting on a cold, blustering night until three in the morning, was seized the next afternoon with a violent chill, and the following day was admitted to my wards at the University Hospital, Philadelphia. He was made the subject of a clinical lecture on the fifth day, when there was absent no single feature in history, symptoms, or physical signs of acute lobar pneumonia of the right upper lobe. It was not until ten days later, when bacilli were found in his expectoration, that we were made aware of the true nature of the case.

Here analogy is held up as an inexact science, corrected by the newer diagnostic methods of germ theory. Osler, *Principles and Practice*, 211. See also Foucault, *Birth*, 100–101.

10. Fissell, "Disappearance," 103.

11. Frawley, *Invalidism and Identity*, 5.

12. Foucault, *Birth*, 89.

13. The interest in surfaces does not contradict the clinic's interest in delving into the body (through autopsy and new technologies like the laryngoscope); these conceptually extend the surfaces visible to the clinical gaze. See also Foucault, *Birth*, 128–29.

14. Foucault, *Birth*, 113 (emphasis in original).

15. Cheyne, *English Malady*, 307–11.

16. Morgagni, *Seats and Causes*, xxxi.

17. Daston and Galison, "Image of Objectivity," 87–88.

18. Morgagni, *Seats and Causes*, 819 (XXVI:31).

19. Caldwell usefully examines a similar shift in anatomical atlases, away from the subjectivity of the "animated cadaver" and toward an aesthetic displaying "the physical body, shorn of emotion, imagination, agency, individuality, and personhood." Ironically, the human subjects in the images she discusses are all cadavers, whether animated and emotive, or unexpressive and inert. Caldwell, "Strange Death," 343.

20. Bennett, *Clinical Lectures*, iii.

21. See Reiser, *Reign of Technology*.

22. Bramwell, *Practical Medicine*, 25.

23. Peterson, *Medical Profession*, 172.

24. Holland, *Mental Physiology*, 18–19.

25. Sims, *Discourse*, 99–101.
26. Latham, *Collected Works*, 69 (emphasis in original).
27. “Empiricism” is a difficult term at about this time. While it ostensibly refers to the practice of empirical science—induction based on material observations rather than deductions from the theories of eighteenth-century and earlier medical authorities—it also was associated with quackery, because alternative practitioners (“empirics”) were thought to rely on seat-of-the-pants experience rather than book learning. The difficulty is evident in James Sims’s text, for example, where, in order to valorize “empiricism,” he must also explicitly disassociate it from quackery.
28. Stillé, *Elements*, 34.
29. Daston and Galison, “Image of Objectivity,” 82–83.
30. Daston and Galison, *Objectivity*, 123.
31. Stillé, *Elements*, 46 (emphasis in original).
32. Stillé quotes from Baglivi here. Ironically, he cites early physicians to support his empiricism.
33. Daston and Galison, *Objectivity*, 229.
34. Bramwell, “Value of Cultivating,” 243; Levine, *Dying to Know*, 27.
35. See Levine’s nuanced discussion of the ideal of self-abnegation in *Dying to Know*.
36. W. J. T. Mitchell, *Picture Theory*, 325.
37. Elliotson et al., *Principles and Practice*, 18, 50; Williams and Clymer, *Principles of Medicine*, 436; Laycock, *Lectures*, 34; Hartshorne, *Essentials*, 21 (emphasis in original); Bramwell, “Value of Cultivating,” 237.
38. Bigelow and Holmes, “Medical Observation,” 3–4; Bullitt, “Art of Observing,” 399.
39. Warter, *Observation in Medicine*, vii.
40. Warner, *Against the Spirit*, 175.
41. Huet, *Monstrous Imagination*, 188. In 1920, Hilaire Belloc explains this paradox, discussing the figures at Madame Tussaud’s: “it is precisely because the likeness is so great, precisely because the effect is so parallel to that of reality, that we note the minor details in which illusion is not achieved.” Introduction to John Theodore Tussaud, *The Romance of Madame Tussaud’s* (New York: Doran, 1920), 27, quoted in Huet, 188. Benjamin, “Work of Art,” 220.
42. See Jennifer Tucker, *Nature Exposed*, for a nuanced examination of how photography both inspires and resists Victorian scientists’ ideals of truth and accuracy.
43. Barbara Stafford argues for a somewhat different version of eighteenth-century visual truth: “William Cheselden, in the monumental *Osteographia* (1733), required his artists to represent bones without showing the forming hand behind the image. ‘Objectivity,’ or the honest conduct of the practitioner, was thus synonymous with the absence of any visible sign of manufacture. The rise of objectivity as a scientific ideal in the early modern period was facilitated by the development of measuring and distancing apparatuses. These truly ‘automatic’ devices seemed to preclude shady handling and phony gadgetry.” But Cheselden’s ideal of an absent artist in fact requires the artist to intervene by leaving out any evidence of his presence. The artist draws the skeleton, not the tripod holding it or the men steadying it: he draws truth to [what he knows to be true] nature. In contrast, the mechanical observer of the nineteenth century must include whatever data were collected, even artifacts indicating the situation and role of the observer. Stafford, *Artful Science*, 103.
44. Gallagher, *Nobody’s Story*, 173–74.
45. Blanc, “Typhoid Fever,” 191.
46. The case also references new medical technologies. Blanc pairs it with the case of “a young English lady” in Gogo, India, with a very high fever due to typhoid. Her “Thermometrical Register” (temperature chart) is reproduced directly underneath Mr. P——’s case (191).
47. See Fissell on the “disappearance of the patient” (as a person and a voice) from the clinical case history.

48. Pye-Smith spoke at the annual meeting of the British Medical Association held at Ipswich on August 1, 1900. Cheever, "Value of Statistics," 449; Bennett, *Clinical Lectures*, 28; Bramwell, *Practical Medicine*, 23; Pye-Smith, "Medicine as Science," 309. See also Foucault, *Birth*, 120–22.

49. Porter, "Lay Medical Knowledge."

50. Rothfield, *Vital Signs*, 99. Examples of recent research into popular science culture include the Science in the Nineteenth-Century Periodical project and the Science Index of the Athenaeum Projects, especially the Index of Reviews and Reviewers, which indexes the book reviews in the *Athenaeum* between 1828 and 1870. Gillian Beer has discussed the "wonderful inclusiveness of generalist journals at that time." Rick Rylance also briefly examines the inclusion of medical cases in general-circulation periodicals, as well as the "literary" character of the specialized medical periodicals. Beer, *Open Fields*, 202–3; Rylance, "Theatre and Granary."

51. Latham, *Collected Works*, 44.

52. Frawley, *Invalidism and Identity*, 18.

53. Hills, *Instructions to Patients*, 7, 4, 2. Hills largely reprints this series of questions from homeopathic treatises dating back to mid-century.

54. Peterson, "Medicine," 256.

55. Topham, "Bridgewater Treatises," 249.

56. [Lankester], review of Bennett. Texts that were considered appropriate for a popular readership include Beale (9 February 1856); *Poor Man's Guide* (26 January 1856); J. L. Levinson's *Obscure Nervous Diseases*, popularly explained (12 April 1856, 1485); T. Wharton Jones, *Defects of Sight* (1 August 1857, 973); Spencer Thomson, *The Structure and Functions of the Eye* (5 December 1857, 1517); Benjamin Ridge, *Health and Disease* (5 March 1859, 324); Forbes Winslow, *On Obscure Disease of the Mind and Disorders of the Mind* (22 September 1860, 388); James Wylde, *The Magic of Science: A Manual of Easy and Instructive Scientific Experiments* (12 January 1861, 48).

57. [Lankester], review of Johnson.

58. [St. John], "Life of Cullen."

59. [Lankester], review of Hall.

60. [Lankester], review of Churchill.

61. [Lankester], review of Lobb.

62. [Lankester], review of Johnson.

63. [Lankester], review of Taylor.

64. [Lankester], review of Ferguson; review of Burgess.

65. [Lankester], review of Ross; [Noble], review of Neilson; [Lankester], review of Ridge.

66. Cooley, "Inverted Vision."

67. [Lankester], review of Ramsbotham; [Lankester], review of Barker; [Lankester], review of Fermer, 36.

68. Holland, "Wellcome Index."

69. Thackeray, letter to G. H. Lewes (November 1, 1859), quoted in Smith, "Our Birth,"

7.

70. Altick, *English Common Reader*, 359, 95.

71. Dawson, "Cornhill Magazine," 147.

72. [Thompson], "Under Chloroform," 499.

73. Anstie, "On Physical Pain," 458, 459

74. Dawson discusses the possible adverse effects from Herschel's use of a remarkably professional level of discourse for the *Cornhill's* "Notes on Science." Dawson, "Cornhill Magazine," 147–48.

75. MacLaren, "Management," 515–16. MacLaren had some medical training, but he made his living as a proponent of physical fitness.

- 76. Macmillan, "Human Vegetation," 461, 462.
- 77. Anstie, "Corpulence," 458.
- 78. Anstie, "Medical Etiquette," 163.
- 79. Whitehead, "Broad Street Pump," 113.

### CHAPTER THREE

1. Dickens, *Dombey and Son*, chap. 4, 36. Further references to this novel will give chapter and page number from this edition.

2. Jude V. Nixon argues that Dickens "believed that science and the imagination, troped as fact and fancy, head and heart, should operate dialectically." While this is true, this chapter argues that this dialectic functions within, not between, the different genres of scientific and literary narrative ("Dickens and Science," 267).

3. Kaplan, *Sacred Tears*, 5, 37.

4. Bailin, *Sickroom*, 79.

5. Indeed, Kaplan, among others, connects it to the "moral sentiments." I will, however, be using "sentiment" in a more modern and restricted sense, referring to the force animating sentimentalism rather than to "emotion" generally. And although eighteenth-century commentators do contemplate humankind's "sympathy" with the rich and prosperous, my concern here is with "sympathy" in its more common modern relation to sorrow and suffering.

6. Kaplan, *Sacred Tears*, 37.

7. Stephen, in the *Cornhill*, defines sentimentality as the use of "tender emotions in an improper manner," and affiliates it with what is "theatrical and affected." A sentimental author has "begun to think about himself, and how cleverly he could describe the sources of tender emotion, and how pleasant it was to stimulate their action." Sterne, he says, "likes to make himself and some of his readers cry" ("Sentimentalism," 69, 71).

8. Lerner, *Angels and Absences*, 183. Adam Smith makes a similar distinction in discussing "extreme sympathy with misfortunes which we know nothing about," calling it "a certain affected and sentimental sadness, which, without reaching the heart, serves only to render the countenance and conversation impertinently dismal and disagreeable." Smith, *Moral Sentiments*, 197 (pt. III, chap. 3). Further references to this text will give part, section (if relevant) and chapter number, along with page number.

9. Hume, *Treatise*, 368 (bk. III, pt. iii, sec. 1) (emphasis in original). Further references to this text will give book, part, and section number, along with page number.

10. Smith, *Moral Sentiments*, 162 (III.1).

11. Jaffe, *Scenes of Sympathy*, 32. Other critics discussing this association include Amit Rai, who links sympathy and spectacle; and Laura Hinton, who discusses Hume and sympathy as a spectacle, and Smith and sympathy as spectatorship. Hinton also discusses how the sympathetic spectator acts as fetishist and voyeur (3). See Rai, *Rule of Sympathy*, xiv; Hinton, *Perverse Gaze*, 2, 23.

12. Other critics have examined the power relation inherent to, but never fully acknowledged by, sympathy's benevolent relation to the sufferer. Roberts emphasizes the unequal power relationship in sympathy and its need to both consume and inhabit another's suffering (*Schools of Sympathy*, 9). Rai discusses how sympathy is implicated in colonialism not just despite but through its expressed interest in humanitarianism (*Rule of Sympathy*, xiii).

13. Hume, *Treatise*, 368 (III. iii.1).

14. Smith, *Moral Sentiments*, 201 (III.3).

15. Hume, *Treatise*, 207–8 (II.i.11).

16. Smith, *Moral Sentiments*, 4–5 (I.i.1).

17. Especially Gallagher, *Nobody's Story*; Roberts, *Schools of Sympathy*; Lenard, *Preaching Pity*; Lowe, *Insights of Sympathy*. See also Jaffe, Hinton, Rai, and Stoddart, "Tracking the Sentimental Eye."

18. Literary critics have also examined the role of visuality in producing sentimental readers. My understanding of the sentimental gaze in Dickens's narrators differs from that of Stoddart, who argues that "[t]he sentimental eye . . . attempts to stabilize [the] oscillating perspective" between a fixed, stable perspective or a fluctuating series of individual, embodied, "particularized acts of viewing" ("Tracking the Sentimental Eye," 196). The sentimental eye in the texts I examine here offers, I would say, rather a supplement to or an alternate vision than an attempt to consolidate multiple perspectives.

19. [Stephen], "Sentimentalism," 74–75.

20. Stoddart, "Tracking the Sentimental Eye," 195, 196.

21. Critics of sympathy have examined how it relies on and produces difference, but I am interested in what sympathy claims to do more than how it may actually operate. See, for example, Gallagher, *Nobody's Story*, xvii–xviii; Jaffe, *Scenes of Sympathy*, 32; Rai, *Rule of Sympathy*, xix, 22.

22. Kneeland, "Contagiousness," 4.

23. Isham and Keyt, "Editors' Preface," iii.

24. Sansom, *Manual*, 5–6.

25. Hope, *Treatise*, 401. The false hope on the deathbed is a common trope of sentimental medicine. John Ferriar explains, "[T]he patient appears better . . . and hopes of recovery are given. In the height of this security, the fatal stroke arrives: every one is astonished; and an event which ought to have been foreseen and foretold, passes for sudden death." Ferriar, *Medical Histories*, 92.

26. See Kennedy, "Poor Hoo Loo"; Thraillkill, "Killing Them Softly."

27. Ferriar, *Medical Histories* (1810), 193–94.

28. Williams, *Authentic Narrative*, 20.

29. Williams and Clymer, *Principles of Medicine*, 440. This passage does not seem to appear in later editions.

30. "A London Curiosity," 95.

31. See Holmes, *Fictions of Affliction*.

32. Carpenter, *Principles of Human Physiology* (1868), 533, 545.

33. Swain, "Diseased Conditions," 542.

34. Occasionally such identification with the patient can backfire, as when John Elliotson discusses cretins in the Swiss Alps. "Some females have a great number of these children," he says. "They have desires, like other people; and they fall in love with each other, and marry." To this point, a sympathetic identification helps to clarify the context of this medical problem. But he continues, "Certainly *nobody else* would marry them." This offhand comment at once destroys the fragile insight linking the physician to his patient and retrospectively casts all affective response as likewise unprofessional and unhelpful (*Principles and Practice*, 545–46; emphasis in original).

35. Stoddart, *Anecdote Biographies*, 124–25.

36. Miriam Bailin identifies the sentimental as a force sublimating the frictions of social ambition ("Dismal Pleasure"). This anecdote about Thackeray suggests that perhaps his focus on the sentimental as a measure of writerly success similarly deflects professional judgments into aesthetic ones.

37. See Lerner, *Angels and Absences*, 177.

38. Dickens, *Dombey and Son*, 14.156, 158–59, 160, 164–65.

39. Similar romanticized deaths occur with adults: see the deaths of Paul's mother and Alice.

40. For the lack of clear diagnoses in sentimental child deaths in the Victorian novel, see Lerner, *Angels and Absences*, 154ff.
41. For a sampling of readers' sentimental responses to Nell's death, see Lerner, *Angels and Absences*, 174–77, 179.
42. Dickens, *Old Curiosity Shop*, chap. 72, 539–40. Further references to this novel will give chapter and page number from this edition.
43. Huxley, "Vulgarity of Little Nell." The quotations from Dostoevsky are from bk. 10, chap. 5.
44. See Lerner, *Angels and Absences*, 180–83. Evangelical contemporaries of Dickens also critiqued his deathbeds as shallow; see Lerner, *Angels and Absences*, 202–4. Henry Hallam critiqued Paul's death as "pure business"; see Kaplan, *Sacred Tears*, 47.
45. This pattern obtains also in less-celebrated deaths in Dickens, such as those of little Johnny and Betty Higden in *Our Mutual Friend*.
46. Jalland, *Death*, chaps. 1–3, esp. 52, 59.
47. Taylor, *Manual*, 42.
48. Dyson, *Inimitable Dickens*, 44.
49. Dickens, *Old Curiosity Shop*, 43.324, 327; 44.330–31; 45.338, 340–41.
50. Dickens's process of "taking the histories" of fallen women admitted to Urania Cottage demonstrates a number of similarities with the system of "case-taking" in clinical medicine, including the anxiety over inadvertently prompting misleading or fallacious responses from the patient. Anderson, *Tainted Souls*, 73–74.
51. Anderson, *Tainted Souls*, 10.
52. Lerner discusses the term "old-fashioned" in reference to its dialect meaning, "precocious, knowing" (*Angels and Absences*, 89). While this meaning of the term may provide an overtone to Paul's character, Dickens clearly uses it here as a kind of diagnosis, to suggest his unearthliness, his being not long for this world. Thus, Paul's increasing delicacy means he "grows more and more old-fashioned" (the title of chapter 14); and his death is not the moment when he "loses his old-fashionedness," as Lerner suggests (90), but when he becomes more old-fashioned than ever, as is clear in Dickens's apostrophe, "The old, old fashion—Death!" (16.191).
53. *The Old Curiosity Shop* was followed (in *Master Humphrey's Clock*) by *Barnaby Rudge*, after which the frame story was brought to a close.
54. Trodd et al. note that the tradition of "cabinets of curiosities" and antiquarian collection extends into the nineteenth century, with texts like Thomas Wright's *A History of Caricature and Grotesque in Literature* (1865) and William Fairholt's *Eccentric and Remarkable Characters* (1849). Collections of medical curiosities were published as late as 1897, with George Gould and Walter Pyle's *Anomalies and Curiosities of Medicine*. But these were primarily eighteenth-century projects, and Dickens signals that his tale is modeled on eighteenth-century literature by referencing, in his three prefaces, Sheridan, Goldsmith, Fielding, and Sterne.
55. Kaplan analyzes the relation between Dickens's sentimentality and the tradition of the "moral sentiments" of the eighteenth century (*Sacred Tears*, 39–70).
56. Dickens comments in letters to this effect: "I am breaking my heart over this story," "Old wounds bleed afresh when I only think of the way of doing it. . . . Dear Mary died yesterday, when I think of this sad story" (*Letters* II, 170 [to Cattermole] and II, 181–82). Qtd. in MacPike, "Old Curiosity Shop," 35.
57. Dickens, *Letters*, 188 (to John Forster, [?17] January 1841).
58. Dickens's Edinburgh speech, delivered on 25 June 1841. Dickens, *Speeches*, 10. Qtd. in MacPike, "Old Curiosity Shop," 35.
59. Kaplan, *Dickens*, 268.
60. Vrettos, *Somatic Fictions*, 1.

61. Gaskell, *Ruth*, 346.
62. Osler, *Principles and Practice*, 40.
63. Ferriar, *Medical Histories and Reflections* (1792), 74–75.
64. Haley, *Healthy Body*, 6, 7.
65. d’Albertis, *Dissembling Fictions*, 93, 92.
66. Jaffe, *Scenes of Sympathy*, 78.
67. Buchan, *Domestic Medicine*, 135.
68. Elliotson et al., *Principles and Practice*, 188–89.
69. Buchan, *Domestic Medicine*, 113, 136.
70. Elliotson et al., *Principles and Practice*, 194.
71. Yonge, *Heir of Redclyffe*, 429.
72. Jalland, *Death*, 26.
73. An important exception to this might be the death of the protagonist’s mother, which so often (as in *Dombey*) instead propels the newly orphaned protagonist into both action and agency.

## CHAPTER FOUR

1. Imraad Coovadia similarly argues, “[b]ecause George Eliot is acutely conscious of the distorting power of figurative language, she employs metaphors rather carefully—and so we can place considerable interpretive pressure upon those she does use” (“George Eliot’s Realism,” 824).

2. See Yeo, “Scientific Method,” 282ff; Yeo, *Defining Science*, 102–6.

3. Helmholtz, “Theory of Vision,” 147; Watson, *Lectures*, 15.

4. See, for example, J. Hillis Miller, countered by Levine and D. A. Miller, among others. For a critique of George Eliot’s realism, see, for example, MacCabe, countered by Lodge, Beer, and Shaw, among others. Coovadia also references this debate (820–21). J. Hillis Miller, “Optic and Semiotic”; Levine, “Hypothesis of Reality”; Levine, *Realistic Imagination*; D. A. Miller, *Narrative and Its Discontents*; MacCabe, *Revolution of the Word*; MacCabe, “Realism and the Cinema”; Lodge, “Classic Realist Text”; Beer, *Darwin’s Plots*; Shaw, *Narrating Reality*.

5. Shuttleworth, *George Eliot*, 206.

6. Colvin, review of *Middlemarch*, 144.

7. See Levine, *Realistic Imagination*, 252–74; Shuttleworth, *George Eliot*; Beer, *Darwin’s Plots*, 137–68; Rothfield, *Vital Signs*, 84–119; Logan, *Nerves and Narratives*, 166–96; Mason, “*Middlemarch* and Science”; Tambling, “*Middlemarch*, Realism”; Wormald, “Microscopy and Semiotic”; Menke, “Fiction as Vivisection.”

8. Deanna Kreisel also directs critical attention to the importance of medical discourse, particularly obstetric rhetoric, in this early novel (“Incognito”).

9. Shuttleworth reads *Adam Bede* in relation to natural history and a passive observer who reflects the world. King places George Eliot in the context of natural history when she started to write fiction. Mason places George Eliot and Lewes in relation to the competing empiricisms of John Stuart Mill, William Whewell, and Herbert Spencer, and Levine points to her friendships with T. H. Huxley, John Tyndall, and W. K. Clifford. Shuttleworth, *George Eliot*, 23–50; King, *Bloom*, 166–72, 79–86; Mason, “*Middlemarch* and Science”; Levine, *Realistic Imagination*, 253. In addition, the character Charles Meunier, in George Eliot’s short story “The Lifted Veil” (1859), suggests the physiologist Charles-Edouard Brown-Séquard. See Eliot, *Lifted Veil*; Flint, *Visual Imagination*, 102–5.

10. Eliot, *Quarry for Middlemarch*; Kitchel, “Introduction,” 8; Gray, “Pseudoscience,” 413.

11. Thomson, *Recollections and Reflections*, 282.

12. See O'Connor, *Founders of British Physiology*, 116–17.
13. See, for example, Coovadia, “George Eliot’s Realism and Adam Smith”; Logan, “Fetish of Realism.”
14. Spencer, “Genesis of Science.”
15. Williams and Clymer, *Principles of Medicine*, 371; Holland, *Medical Notes and Reflections*, 28; Bennett, *Clinical Lectures*, 4.
16. Watson, *Lectures*, 15 (emphasis in original); Forbes, *Inaugural Lecture on Botany*, 8 (emphasis in original); Holland, *Medical Notes and Reflections*, 28.
17. This concern reflected the difficulties of using such instruments. Bennett warns that “[t]he art of observation is at all times difficult, but is especially so with a microscope, which presents us with forms and structures concerning which we had no previous idea. Rigid and exact investigation, therefore, should be methodically cultivated from the first” (*Clinical Lectures*, 69).
18. George Eliot, *Adam Bede*, ed. Valentine Cunningham (New York: Oxford University Press, 1996), 175, 177. In the 1867 Blackwood edition, George Eliot strengthens her emphasis on the importance of the “faithful account” by amending the text to read, “my strongest effort is to avoid any such arbitrary picture.” She also removes the 1859 reference to the “clever novelist,” stating instead, “Certainly I could [romanticize my characters], if I held it the highest vocation of the novelist to represent things as they never have been and never will be.” This allows for the possibility of realist novelists; the previous version could imply that all novelists are “clever [e.g., romantic] novelists.” George Eliot, *Adam Bede*, ed. Gordon S. Haight (New York: Holt, Rinehart, and Winston, 1965). All further references will be to the Cunningham edition, based on the 1859 edition of the novel. See also “The Sad Fortunes of the Reverend Amos Barton” for a similar passage disdaining “fertile imagination.” It prefers “faithfulness” to “the humble experience of an ordinary fellow-mortal,” which produces sympathy. Eliot, *Scenes of Clerical Life*, 59.
19. Gunn, “Dutch Painting,” 368.
20. Eliot, review of Ruskin, 626; Ruskin, *Modern Painters*, IV.7.16.
21. Ruskin also used the trope of deformed or distorted reflections, in *Stones of Venice*, although somewhat differently. He disdains optical devices, thinking a culture steeped in such experience would be coarsened to true aesthetic experience. Without them, an ideally artistic vision is possible. See Isobel Armstrong, “Transparency,” 144; Isobel Armstrong, “Microscope,” 43–46.
22. In “The Sad Fortunes of the Reverend Amos Barton” and “Mr. Gilfil’s Love Story,” the narrators similarly defend realist texts against romantic readers. Eliot, *Scenes of Clerical Life*, 59, 87.
23. Gillian Beer suggests that this kind of pleasure is an important commonality between scientists and authors. Beer, *Open Fields*, 152.
24. George Eliot knew how hard it is to make a flawless mirror. While visiting Munich in 1858, she and Lewes met Baron Justus von Liebig, a professor of chemistry there. “He is now occupied with a new invention, that of silver mirrors,” wrote Lewes to the publisher John William Parker Jr., “and he has gone over the whole process with us, explaining each detail, and finally presenting Marian with a mirror of remembrance.” Eliot, *Letters*, I, 276 [12 May 1858].
25. She shared these concerns with Lewes; see Isobel Armstrong, “Microscope,” 40–43.
26. For a different articulation of this philosophy, see an early letter to John Blackwood (Eliot, *Letters* II, 362 [12 July 1857]).
27. Daston and Galison, *Objectivity*, 121, 185.
28. Daston and Galison, *Objectivity*, 174, 176, 197, 203.
29. Levine, *Dying to Know*. See Charles Babbage in 1830 on both “minute precision” and

the “occasional discordance from the mean, which attends even the most careful observations”; or John Herschel, also in 1830, on “the erroneous judgments we unconsciously form from” sensory experience and the “illusion which the senses practice on us.” Babbage, *Decline of Science*, 168 (emphasis in original); Herschel, *Preliminary Discourse*, 81–82; Daston and Galison, “Image of Objectivity,” 82–83.

30. Amy King also notices this suggestion of the botanist. King, *Bloom*, 169.

31. Amanda Anderson also notes the “active, vigilant self-suppression . . . which paradoxically required stringent personal practices” to attain self-regulation. Anderson, *Powers of Distance*, 11.

32. Anderson surveys some critiques and defenses of detachment along these lines. *Ibid.*, 23–33.

33. Daston, “Moral Economy of Science,” 21, 23. Janis Caldwell nods to this concept but recasts “morality” as “affect” when she observes, “Nineteenth-century objectivity was, despite its rhetoric, not at all free of affect, but rather reached toward a different kind of affect, that of faithfulness to the object, careful craft, precision, and self-restraint.” Caldwell, “Strange Death,” 350. While I concur with her description of the objective aesthetic, I might term its aim not a “kind of affect” but a “kind of subjectivity” or perhaps Anderson’s term, a “lived relation” (178). These, to me, suggest the conundrum of mechanical observation; that it is designed to specifically not hold or channel feeling, but that it is inescapably in relation to the self and its affect.

34. Andrew H. Miller, “Bruising,” 302. Anderson’s discussion of George Eliot also places her realism in the context of mechanical objectivity, as I do, but my interest is specifically in the visual structure of the realist ideal.

35. Logan, *Nerves and Narratives*, 170.

36. See especially Lewes’s *Principles of Success in Literature*, a series of essays published in the *Fortnightly Review* in 1865.

37. Skilton, *Early and Mid-Victorian Novel*, 159. The *Westminster Review*, similarly, thought Trollope should “refrain from striking off more copies of an idea than the plate will bear.” “Contemporary Literatures: Belles Lettres,” 134.

38. The quotation appears in a letter Blackwood wrote to George Eliot (*Letters* II, 291 [30 January 1857]).

39. Stillé, *Elements of General Pathology*, 46 (emphasis in original).

40. *Ibid.*, 36, 39, 42. Eliot, *Adam Bede*, 42.

41. Daston and Galison, *Objectivity*, 120.

42. This trope reappears at the end of the book, when Mr. Irwine realizes the enormity of Arthur’s offense, and how very close he had come to disclosing it. He muses, “[I]t was cruel to think how thin a film had shut out rescue from all this guilt and misery. He saw the whole history now by that terrible illumination which the present sheds back upon the past” (407).

43. See Horton, 104, 121.

44. Crary contends that “[n]oninstrumental descriptions of the camera obscura are pervasive” during the nineteenth century, but George Eliot clearly turns to it as a means to an end: producing a humanist realism. Crary, *Techniques*, 33.

45. Helmholtz famously concludes his lecture, “[I]f an optician wanted to sell me an instrument which had all these defects [that are in the human eye], I should think myself quite justified in blaming his carelessness in the strongest terms, and giving him back his instrument.” Helmholtz, “Recent Progress,” 141; Helmholtz, *Description of Ophthalmoscope*, 8, 9.

46. Descartes had famously explained how to create a camera obscura using a human or bovine eye as the lens (Crary, *Techniques*, 47, quoting from *La Dioptrique* [1637]), and another seventeenth-century scholar, Kaspar Schott, revised the experiment (Hammond, *Camera*

*Obscura?* 31). Helmholtz, *Description of an Ophthalmoscope*, 8, 9; [Noble], review of Wilson. Interestingly, given George Eliot's defense of color blindness in 1857 in "Janet's Repentance" (265), the notice of Wilson's camera obscura book immediately followed the notice for his *Researches on Colour-Blindness*.

47. Hammond, *Camera Obscura*, 132, citing *Photographic News*, December 1859. Spiller credits Allan B. Dick as coauthor.

48. Ward, *Microscope Teachings*, 82, 85.

49. Crary offers a lengthy examination of this break. Isobel Armstrong associates it not only with the "collapse" of the "connection between veridical correspondence and the viewing subject as a privileged form of knowing," but also with the rise of a "consumer-observer, whose body became codified and fragmented into multiple areas of sensory experience as a consequence of the arbitrary relation between stimulus and sensation." Armstrong insists that critics account for "rival epistemologies of seeing" and "the uncomfortable interventions of mediation" ("Microscope," 34–35).

50. Crary points to "the texts of Marx, Bergson, Freud, and others," where "the very apparatus that a century earlier was the site of truth becomes a model for procedures and forces that conceal, invert, and mystify truth." See also Kofman on the deceptive nature of the camera obscura in Marx, Freud, Nietzsche, and Descartes; and Mitchell on the double meaning of the camera obscura. Crary, *Techniques*, 29, 32, 33; Kofman, *Camera Obscura of Ideology*; W. J. T. Mitchell, *Iconology*, 171, 178.

51. Bennett, *Clinical Lectures*, 69.

52. See Beer, *Darwin's Plots*; Shuttleworth, *George Eliot*. Jane Wood comments that "Bernard's work on pathology and physiology was a major influence on the ideas of G. H. Lewes, whose copy of *Leçons sur la physiologie et la pathologie du système nerveux* (1858) is extensively annotated" (*Passion and Pathology*, 93).

53. Bernard, *Experimental Medicine*, 148, 21–22.

54. See Daston and Galison, "Image of Objectivity," 98, and Crary, *Techniques*, 16–17. These reject the notion that the advent of photography hastened the development of a theory of mechanical observation. Rather, photography provided scientists with an important trope for figuring mechanical observation through a familiar and culturally authoritative reference.

55. The camera is simply a camera obscura with a photographic plate in place of the mirror. The *Magazine of Science* featured a camera obscura on the cover of its first issue, in 1839, noting Talbot's and Daguerre's "newly discovered invention of Photogenic Drawing," "which is the natural property of the camera obscura, made permanent." See Hammond, *Camera Obscura*, 128. While the camera does combine the observing and recording functions of the camera obscura, Bernard does not acknowledge that it still requires agency and intervention on the part of the operator.

56. Daston and Galison, examining scientific atlases, perceive a midcentury scientific optimism (like Stillé's or Bernard's) about the possibility of evicting subjectivity altogether. Flint, however, surveying scientists, writers, and artists more generally, concludes that "[o]bservation, however careful, is—and this came to be well recognized by Victorians—never removed from the exercise of subjectivity." Flint, *Visual Imagination*, 30.

57. My reading differs somewhat from that of Amanda Anderson, who also examines this conflux of ideas in George Eliot. Anderson discusses the close observation as one with what it produces, thus referring to "Eliot's . . . sympathetic observation." She argues that "Eliot shows how the stance of detached analysis undermines the individual's moral character and responsiveness" (*Powers of Distance*, 12). I consider, instead, how Eliot's early work carefully separates the steps of observation, representation, and sympathy even as it argues that realism can *produce* sympathy. Clinical realist vision in *Middlemarch*, by contrast, does involve sympathy and imagination from the outset.

58. Ruskin, *The Stones of Venice*, II, 161; Ruskin, *Modern Painters*, IV.1.17. Mansell points out that George Eliot attempts to fix this problem by making her realism represent the (mediated) reflection of reality in the artist's mind, not reality directly. But while Mansell discusses art as a mirror, George Eliot figures the observer's mind as the mirror, and the artwork as a representation of it. Mansell, "Ruskin," 205.

59. Eliot, "Janet's Repentance," in *Scenes of Clerical Life*, 268.

60. Eliot, letter, 18 February 1857. See also a letter to William Blackwood (*Letters* [18 February 1857]) and to Sara Hennell (*Letters* III, 90 [24 June 1859]), and her essay "The Natural History of German Life" (*Westminster Review*, July 1856). An 1853 review in the *Spectator*, "My Novel," called for just such a conception of authorship. George Brimley describes a mirroring realism that, informed by the imagination of the poet, would call forth sympathy for the common worker: "Would such a work of art be possible? A mirror that should show to a nation of workers . . . its own life . . . as it might reflect itself upon the imagination of a great poet, who to masculine understanding trained by observation and study should add the large heart and the clear eye to which nothing human is uninteresting or blank?" Reprinted in Brimley, *Essays*, 286.

61. Ironically, the moments at which the narrator clearly solicits readerly sympathy often accompany not the glimpses of a "monotonous homely existence" valorized in chapter 17, but rather scenes perilously close to the extremities of "indigence" or "wretchedness," although perhaps not the "picturesque sentimental" variety the narrator excoriates (177, 178).

62. Eliot, *Letters* III, 110–11 (5 July 1859) (emphasis in original).

63. Daston, "Escape from Perspective," 603.

64. *Ibid.*, 616.

65. Daston, "Moral Economy of Science," 20.

## CHAPTER FIVE

1. George Eliot elsewhere similarly aligns polished surfaces with reflection and egoistic distortion: in *Adam Bede* the vain Hetty Sorrel "often took the opportunity, when her aunt's back was turned, of looking at the pleasing reflection of herself in those polished surfaces, for the oak-table was usually turned up like a screen . . . and she could see herself sometimes in the great round pewter dishes that were ranged on the shelves above the long deal dinner table, or in the hobs of the grate, which always shone like jasper." Like the more deliberate "mirror" scene in her bedroom, this passage signals the vanity and superficiality of character that will condemn Hetty. Eliot, *Adam Bede*, ed. Cunningham, 73.

2. Eliot, *Middlemarch*, 248 (bk. III, chap. 27). All further references to this novel will be given with book, chapter, and page number.

3. Other mirrors in the novel all suggest distorted vision, self-deception, and vanity: "[Mr. Casaubon] thinks with me,' said Dorothea to herself, 'or rather, he thinks a whole world of which my thought is but a poor twopenny mirror'" (I.3.23); "This was not the first time that Mr. Bulstrode had begun by admonishing Mr. Vincy, and had ended by seeing a very unsatisfactory reflection of himself in the coarse unflattering mirror which that manufacturer's mind presented to the subtler lights and shadows of his fellow-men . . ." (II.13.123); and, in reference to the townspeople's low estimation of Casaubon, "I am not sure that the greatest man of his age, if ever that solitary superlative existed, could escape these unfavourable reflections of himself in various small mirrors; and even Milton, looking for his portrait in a spoon, must submit to have the facial angle of a bumpkin" (I.10.77–78).

4. Feltes, "Eliot's 'Pier-Glass.'"

5. Bernard, *Experimental Medicine*, 16.

6. Crary, *Techniques*, 92 (emphasis in original). See also Müller, "'Subjective' Phenomena of Vision," in *Elements of Physiology*, 740–44.

7. Wormald, "Microscopy and Semiotic," 517. George Eliot writes at a watershed moment for microscopists, due to the work of Ernst Abbé on resolution and the development of aniline dyes. Although British instrument makers resisted Abbé's innovations, the aniline dyes alone allowed much better visualization of the object, making the microscope a much more powerful tool than previously. On Abbé, see Hacking, *Representing and Intervening*, 194.

8. MacCabe, "Realism and the Cinema," 39.

9. One of Abbé's improvements to the microscope in the 1870s was that he devised a way to increase the light collected in an objective, improving resolution without magnification.

10. Wormald, too, notes that "the narrator's own project of representation is compromised" in this passage and contrasts the narrator's skepticism with Lydgate's naïve enthusiasm (519).

11. Bennett, *Clinical Lectures*, 69; Laycock, *Lectures*, 74; Quekett, *Practical Treatise*, 208. The "specters" quotation is from Thomas Williams, "On the Pathology of Cells," *Guy's Hospital Reports* 1 (1843), 424; quoted in Reiser, *Reign of Technology*, 79.

12. Wormald points out that the rainbow of light surrounding Rosamond, in the "gossamer web" passage, represents "the symptoms of chromatic aberration" which flawed early microscope lenses. Pritchard notes that "the great and sensible dispersion, which envelopes every object seen through [ordinary compound microscopes] in a false prismatic halo, and utterly obliterates all its delicate markings and structure, renders this instrument almost useless for investigation." However, achromatic microscopes were available by the mid-1820s, when Lydgate would have been studying medicine. Wormald, "Microscopy and Semiotic," 523; Pritchard, *Microscopic Cabinet*, 105–6; Carpenter, *Microscope* (1901), 148–50. Interestingly, the problem of spherical aberration is caused by "the fact that you polish a lens by random rubbing" (producing a spherical surface)—the same process that renders the pier-glass an unreliable source of information about the world. Hacking, *Representing and Intervening*, 193.

13. Bennett, *Clinical Lectures*, 65. See also Reiser, *Reign of Technology*, 80.

14. Bernard valorized, as a necessary "mastery," this engagement with the flaws of the instrument. Shuttleworth argues for the shift from *Adam Bede* to *Daniel Deronda* as a shift from passive to active, and from natural history to experimental science. Shuttleworth, *George Eliot*, xii, 24–50, 175–200.

15. MacCabe, "Realism and the Cinema," 44, 43 (emphasis in original).

16. J. Hillis Miller perceives a "strict homogeneity" between different scales in *Middlemarch*, but the passage emphasizes the same dispersal of truths that Miller perceives elsewhere in the novel ("Optic and Semiotic," 69).

17. Beer, "Authentic Tidings," 90–91.

18. Improvements to the instrument in the 1860s had made it possible to turn a turret with multiple objectives on it, which greatly facilitated the process George Eliot describes.

19. Carpenter, *Microscope* (1891), 62 (emphasis in original). Isobel Armstrong discusses the incommensurability of vision inside and outside the microscope. Hacking considers whether or not we even do "see . . . with a microscope." Armstrong, "Microscope," 31; Hacking, *Representing and Intervening*, 187.

20. MacCabe, "Realism and the Cinema," 49.

21. Lydgate had hoped to combine medical practice with intellectual inquiry "in the hope that the two purposes would illuminate each other: the careful observation and inference which was his daily work, the use of the lens to further his judgment in special cases, would further his thought as an instrument of larger inquiry" (100).

22. Lawrence Rothfield also notes that in *Middlemarch* "the medical perspective . . . is supplemented by other equally valid perspectives with other narrative possibilities" (*Vital Signs*, 89).

23. See Shuttleworth, *George Eliot*, 22–23, 145; Levine, “Hypothesis of Reality,” 12; Mason, “*Middlemarch* and Science,” 60.

24. For Lewes’s defense of science, in *Problems of Life and Mind* (1874), as an “Ideal Construction,” see Shuttleworth, *George Eliot*, 22–23; Levine, *Realistic Imagination*, 252–90; Levine, “Hypothesis of Reality,” 11–14; Rylance, *Victorian Psychology*, 259–60. Shuttleworth also examines experimental science and physiology in *Middlemarch* (*George Eliot*, 143–74). Mason identifies the mid-1860s as the period when Lewes started to consider the scientific imagination. Logan examines Tyndall’s 1870 “Scientific Use of the Imagination” in relation to *Middlemarch*. Beer discusses imagination in Darwin and *Middlemarch*. Flint examines the scientific imagination in Tyndall and Lewes. See also Yeo on the development of the scientific method in the nineteenth century. Mason, “*Middlemarch* and Science,” 152, 60, 65; Logan, *Nerves and Narratives*, 181–82; Beer, *Darwin’s Plots*, 141–42, 48–55, 49–80; Flint, *Visual Imagination*, 62–63, 113–15, 307–8; Yeo, “Scientific Method.”

25. Bernard, *Experimental Medicine*, 24. In discussing experiment, Bernard moves away from the extreme automatism he requires of observation and offers a role for imagination. Shuttleworth points out that Lewes, too, “extending these premises, argues that the processes of fiction are indispensable to the Experimental Method, for science is ‘Ideal Construction’” (*George Eliot*, 22–23). However, Bernard cautions that once the experiment is in train, “the experimenter must now disappear or rather change himself instantly into an observer” by setting his hypothesis aside lest it color his observations (22).

26. Lewes makes this explicit in his *Problems of Life and Mind*, explaining, “The grandest discoveries, and the grandest applications to practice . . . have revealed by the telescope of Imagination what the microscope of Observation could never have seen” (315–17 [bk. I]).

27. This shift resembles what Peter Galison identifies as a “judgment against objectivity,” where the product of mechanical observation is thought less reliable than the image interpreted through a holistic cognitive process that only an expert can perform. The “objectivity, facticity, and scientific management” of mechanical observation, that is, “yielded to a new world of sorting nature in which judgment, subjectivity, artisanal practice, and theory were heralded as vital to the scientific project of visual classification.” However, he sees the “judgment against objectivity” as occurring much later, in the twentieth century; and the shift he observes does not center on speculation. Galison, “Judgment against Objectivity,” 343.

28. Generally, American physicians were more vehement converts to empirical methods early in the century, and British physicians seem more accepting of speculation later. On the importation of empirical methods to America and the growing resistance to theory-based medicine, see Warner, *Spirit of System*, especially 239–45.

29. Stillé, *Elements of General Pathology*, 46 (emphasis in original).

30. Review of Robertson, *The Nature and Treatment of Gout*, 20; Stillé, *Elements of General Pathology*, 31, 28–29 (emphasis in original).

31. Crampton, “Diseased Appearance,” 301–2; Lawrence, *Lectures*, 34; Watson, *Lectures*. For Eliot’s knowledge of Watson, see Eliot, *Quarry for Middlemarch*, I, 17; Kitchel, “Introduction,” 40n66. Watson’s phrase is repeated through at least the fourth (1857) edition. The “advertisement to the first edition” comments that the text derives, with almost no revision, from lecture notes first prepared in 1836–37; and the “advertisement to the fourth edition” suggests that no further revision has taken place since then; so that Watson’s suspicion of speculation in 1857 is likely a holdover from an 1830s perspective.

32. Meryon, *History of Medicine*, 5; Carpenter, *Principles of Human Physiology* (1855), 736; Carpenter, *Principles of Human Physiology* (1876), 791. Carpenter’s comment about speculation as a “stimulus” appears in earlier editions as well.

33. Laycock, *Lectures*, 34; Guy, *Forensic Medicine*, 205; Holland, *Medical Notes and Reflections*, 24, 25.

34. Brinton, "Alimentary Canal," 11.
35. Laycock, *Lectures*, 39; Russell, *History and Heroes*, 115. Although Russell had his degree from Edinburgh and a practice on Harley Street, his comments come in a sense from the margins, since he was an advocate of homeopathy.
36. Laycock, *Lectures*, 38; Holland, *Medical Notes and Reflections*, 26.
37. Quoted in "Minutes of the Twenty-third Annual Session," 556.
38. Huxley, "Progress of Science," 64–65.
39. Bramwell, *Practical Medicine*, 8 (emphasis in original).
40. Bramwell, "Minute Observation," 238, 240, 243.
41. Bramwell, *Practical Medicine*, 43. Bramwell in this last passage quotes Gairdner, "Physiognomy of Disease," 8.
42. See Yeo, "Scientific Method," 269.
43. Lewes, *Problems*, I, 289. Lewes started writing this text in the late 1860s (although it was not published until 1874). See Levine, "Hypothesis," and Flint, *Visual Imagination*.
44. Isobel Armstrong has discussed a similar phenomenon, deriving from a very different kind of visuality, the "optical illusions available in street and pleasure garden" that may "suggest experiments with different subject positions, control, displacement, obliteration, power, centrality, powerlessness" ("Transparency," 143). Unlike George Eliot's imagined speculative shifts (and like the magic lantern Mr. Irwine suggests to Arthur in *Adam Bede*), however, these instruments embrace the "pleasure of deception."
45. Isobel Armstrong examines how glass allows the gaze to both move through it and be arrested by how "one's body can be, glancingly, inadvertently, and in discontinuous fragments, reflected back from the environment," although she is focusing here on plate glass in the spectacular urban environment (*Victorian Glassworlds*, 99).
46. Hogg, *Microscope*, 75–76 (emphasis in original).
47. James, "Preface," 84.
48. Beer, *Open Fields*, 164.

## CHAPTER SIX

1. Marcus, "Freud and Dora," 65.
2. Frankland, *Freud's Literary Culture*, 203.
3. Freud, *History*, 3.
4. A shortened version of Marcus, "Freud and Dora," appears in Bernheimer and Kahane, *In Dora's Case*. Classic discussions also appear in Mahony, *Freud's Dora*; Jacobus, *Reading Woman*; Showalter, *Hystories*; Moi, "Representation of Patriarchy"; Hertz, "Dora's Secrets, Freud's Techniques." *Dora* achieved canonical status not only due to its rich suggestiveness as a text, but also because it punctuates important developments in Freud's thought. It follows Freud's theories of hysteria and of dreams and coincided with his theories of sexuality, all major elements of his work, readily popularized into the cultural imaginary. *Dora* also dramatizes the crucial psychoanalytic principle of resistance, as only a "failed" case history can (*Dora* breaks off her analysis); and it forced Freud to take account of transference, another crucial element of psychoanalytic theory.
5. Breuer and Freud, *Studies on Hysteria*, xxxi. The "true" origin of psychoanalysis is disputed. See Strachey, "Editor's Introduction," 57. Breuer commented that the patient Anna O. herself had pioneered the "talking cure" (29–30). For a feminist argument promoting Anna O.'s contribution, see Hunter, "Hysteria, Psychoanalysis, and Feminism."
6. Wood, *Passion and Pathology*, 107.
7. Gilman, *Freud, Race, and Gender*, 115.

8. Winter, *Freud*, 132–41, 149–52. She also discusses Freud's efforts to distinguish psychoanalysis from the two most relevant medical fields, psychiatry and neurology.
9. Winter, *Freud*, 123.
10. Freud, "Aetiology," 220.
11. As chapter 5 noted, the validity of microscopic findings was debated due to many variables: the unreliable performance of the human eye, the flawed technology, the need for a skilled operator, the variability of reports even from reliable microscopists, and the changing standardization of the instrument itself. See Reiser, *Reign of Technology*; Schickore, *Microscope and Eye*.
12. Freud, *Dora*, 5. All further references to this text will be to this edition.
13. Holland, *Medical Notes and Reflections*, 20.
14. Freud had been trained in the mechanistic model of empirical science influenced by Hermann von Helmholtz, together with its strictures against speculative insight. See Frankland, *Freud's Literary Culture*, 35. Valerie Greenberg argues that "[p]hysics [rather than biology] becomes . . . the ultimate provider of legitimacy for the new science: physics lends psychoanalysis its prestige." However, medicine was the community where Freud had to gain acceptance. Greenberg, "Freud and Physics," 246.
15. Breuer and Freud, *Studies on Hysteria*, 166.
16. Breuer and Freud, *Studies on Hysteria*, 135.
17. Freud, "Aetiology of Hysteria," 220.
18. Freud, *Dora*, 18.
19. Stern, *Zeitschrift für Psychologie und Physiologie der Sinnesorgane*, XXVI (1901), 133; and "Professor" Liepmann [Jones does not further identify the author], *Monatschrift für Psychiatrie und Neurologie*, 1901, 237; cited in Ernest Jones, *Sigmund Freud*, 361.
20. Webster, *Freud Was Wrong*, 257.
21. Bullough, *Science in the Bedroom*, 91.
22. Marcus, "Freud and Dora," 83.
23. Reidel-Schrewe, "Freud's Début," 8.
24. Breuer and Freud, *Studies on Hysteria*, 144.
25. Literary texts Freud discusses include Schreber's memoir, Dostoevsky, Empedocles' poems, Hebbel's *Judith*, Jensen's *Gradiva*, and Hoffmann's *The Sandman*. For Connolly's cases in *An Inquiry Concerning the Indications of Insanity* (1830), or psychiatrists' readings of *Hamlet* at midcentury, see Small, *Love's Madness*, 48–57.
26. Breuer and Freud, *Studies on Hysteria*, 265.
27. "Professor Freud and Hysteria," 103.
28. Breuer and Freud, *Studies on Hysteria*, 49.
29. See footnote to the case of Fräulein Elisabeth von R. (*Studies on Hysteria*, 169–70).
30. Breuer and Freud, *Studies on Hysteria*, 25–26.
31. "Curious," *Oxford English Dictionary*.
32. Freud, "Aetiology of Hysteria," 199.
33. "Professor Freud and Hysteria," 103–4.
34. Jameson, *Political Unconscious*, 106–7.
35. Critics who have focused on the centrality of reading, writing, and translation to his work include Bernheimer, "Introduction, Part 1," 10–11; Gallop, "Keys to Dora"; Ramas, "Freud's Dora, Dora's Hysteria," 149; van den Berg, "Reading Dora Reading"; Gilman, "Preface"; Kofman, *Freud and Fiction*; Mahony, *Freud as a Writer*; Marcus, "Freud and Dora"; Rieff, "Introduction," ix. Reidel-Schrewe, "Freud's Début in the Sciences," 1–2, 2–15. Frankland offers an extensive discussion in *Freud's Literary Culture*.
36. Mahony, *Freud as a Writer*, 9–12.
37. Frankland examines how Freud's methodology is grounded in literary work, especially

in *Interpretation of Dreams* (117–61). He discusses free association, condensation, and displacement, for example, and compares elements of analysis to styles of literary criticism. I focus here on the earliest elements of psychoanalysis and on the dialogic figuration and interpretation that is central to it. I agree with Frankland that “literary criticism is . . . the mother of psychoanalysis, vitally procreative and yet taboo” (117).

38. Breuer and Freud, *Studies on Hysteria*, 280.

39. Although Freud discusses the limits of the “cathartic method” in *Studies on Hysteria*, he uses a version of it in most of his full-length case histories (261).

40. Freud, *Complete Letters*, 212. Quoted in Showalter, *Hystories*, 40.

41. See Mahony, *Freud as a Writer*, 23, 241, for example.

42. Breuer and Freud, *Studies on Hysteria*, 290; Freud, “Aetiology of Hysteria,” 205.

43. Freud, *Dora*, 34–35. This involvement of the body differentiates hysteria from other neuroses (*Dora*, 35). Occasionally the hysteric’s symptoms do indicate “merely” a physical problem (*Dora*, 10).

44. Freud, *Dora*, 76.

45. Ironically, Freud uses nonorganic objects—sand, wire—rather than organic ones—seed, skeleton—to represent organic (bodily) injury.

46. Freud, *Dora*, 46. The word “simultaneously” is in italics in the English version but not stressed in the original German. Freud, “Bruchstück Einer Hysterie-Analyse.”

47. The “clues” can be nonphysical: Frau Cäcilie also suffers from hallucinations, “the explanation of which often called for much ingenuity.” The vision of Freud and Breuer hanging from two trees in the garden follows a disagreement with her doctors; she had decided that “[t]here’s nothing to choose between the two of them; one’s the *pendant* [match] of the other” (181). This tenuous association, offered in a footnote, provides Freud’s very last word in the case of “Frau Elisabeth von R.”

48. Symonds, *Letters*, 821.

49. Frau Cäcilie M., in *Studies on Hysteria*, 180.

50. Freud’s anxious eagerness to disavow the roman à clef recalls the efforts of eighteenth-century authors who “stressed their renunciation of personal satire and slander.” However, unlike Freud, they reference the roman à clef in order to claim fictionality rather than factuality: “the explicit fictionality of their works initially recommended them as wholesome goods.” Gallagher, *Nobody’s Story*, xvii.

51. Freud differs from his predecessors in the eighteenth century in that his sly promise of “intimacies” attempts to deny the vulgar gaze of the crowd, while inviting select readers to consider and share his privileged view.

52. Beer, *Open Fields*, 156. See also 181–82.

53. See Frankland, *Freud’s Literary Culture*.

54. Auerbach, “Magi and Maidens,” 297–98.

55. Katz provides an extended discussion of “The Politics of Romance” (*Rider Haggard*).

56. Likewise, in the sentence describing the “quota of affect” cited earlier, Freud offers a mathematical model—“If we . . . try to represent the ideational mechanism in a kind of algebraical picture”—but never follows through with a picture or equation.

57. Frye, *Anatomy of Criticism*, 193, 195.

58. Frankland also discusses Freud’s self-positioning as hero, but he focuses on Freud’s interest in the “classical hero” or in a specific literary hero like Faust (10, 206–7).

59. Frankland, *Freud’s Literary Culture*, 32; Richard Armstrong, *Compulsion for Antiquity*, 114–20; Rudnytsky, “Freud’s Pompeiian Fantasy,” 228.

60. Freud, *Interpretation of Dreams*, 490 (emphasis in original).

61. Freud, “Aetiology of Hysteria,” 192.

62. See, for example, Levine’s comments on Bacon (*Dying to Know*, 22).

63. Freud, "History of Psycho-Analytic Movement," 23.
64. Breuer and Freud, *Studies on Hysteria*, 128, 139.
65. Hake, "Saxa Loquuntur," 148.
66. Freud's describing the antiquities as "priceless though mutilated" recalls Frye's comment that "[m]utilation . . . is often the price of unusual . . . power" in romance (193).
67. Galison, "Judgment against Objectivity."
68. Freud, "Bruchstück Einer Hysterie-Analyse," 18.
69. Stanley followed the Congo from Lake Tanganyika to the Atlantic Ocean, proving that the Congo, not the Nile, originates at the lake. He also identified the source of the Nile, by circumnavigating Lake Victoria rather than traveling up the river to its origin. Soon after, Stanley was hired by Belgium's King Leopold II to advise his notorious colonial projects in the Congo.
70. See Freud, *Dora*, 44, 46, 110.
71. Stanley's *Through the Dark Continent* was first published in London in 1878. The text included a foldout map of his journeys. Freud was certainly aware of Stanley's journeys, whether in English or German. There were at least sixteen books by or about Stanley's explorations published in German in the late nineteenth century, including two editions of *Durch den dunkeln Weltheil* in 1878 and 1881.
72. Laycock, *Lectures*, 65.
73. Frankland notes a possible allusion to Faust here (*Freud's Literary Culture*, 207). Freud persistently codes the hysteric as "other" despite symptoms of hysteria in his own narrative.
74. In 1906 Freud listed, as one of "ten good books," Kipling's *Jungle Book*. He had recommended other Kipling stories to Fliess. See Gay, *Reading Freud*, 98, 104. Richard Armstrong also briefly discusses Freud as an imperialist (*Compulsion for Antiquity*, 121–26).
75. The fifteen-month rush of composition (January 1885 to March 1886) that produced *King Solomon's Mines*, *Allan Quatermain*, *Jess*, and *She* occurred only four years after his disgruntled departure from Africa, feeling "betrayed" by "Gladstone's treachery" in ceding British rule of the Transvaal. Katz, *Rider Haggard*, 11; Monsman, *Rider Haggard*, 37–40.
76. Horace G. Hutchinson, "Sir Rider Haggard's Autobiography," rev. of *The Days of My Life*. *Edinburgh Review*, 244 [October 1926], 344; quoted in Katz, *Rider Haggard*, 1.
77. Winter, *Freud*, 210.
78. Bruce Mazlish also reads Freud alongside Haggard. He notes their shared interest in "the buried past," "the eternal feminine," Darwinian race theory, and "the Dark Continent of the mind," although he identifies Haggard as "embracing" the unconscious, while Freud seeks to master it ("Triptych," 741–43).
79. Stiebel, *Imagining Africa*, viii.
80. Haggard, *She*, 195, 199.
81. Unlike Bruce Mazlish, I place this as a convention of romance, not a nod to realism in Haggard's text. Mazlish, "Triptych," 732.
82. Graham Dawson, *Soldier Heroes*, 59.
83. Freud, *Autobiography*, 153.
84. Winter also examines Freud's "mixed results" in the scientific and the cultural realms (207).

## CONCLUSION

1. Aiken and Barbauld, "Evenings," 138–39, 143.

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