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Deviant Sympathies and the Obstruction of Knowledge in Victorian Literature and Gynecology

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DEVIANT SYMPATHIES AND THE OBSTRUCTION OF KNOWLEDGE
IN VICTORIAN LITERATURE AND GYNECOLOGY

by

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written by Nicole Ann McManus

has been approved for the Department of English

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The final copy of this thesis has been examined by the signatories, and we
Find that both the content and the form meet acceptable presentation standards
Of scholarly work in the above mentioned discipline.
McManus, Nicole Ann (Ph.D., English)

Deviant Sympathies and the Obstruction of Knowledge in Victorian Literature and Gynecology
Thesis directed by Associate Professor Kelly Hurley

In this dissertation I analyze Victorian gynecology and literature and argue that texts in both of these fields betray a conflict between dominant and subversive narratives about women, their bodies, and their sympathies. While it is well recognized that sympathy played an important part in Victorian literature, moral philosophy, and cultural consciousness, what is not acknowledged in the literature on sympathy is its central role in Victorian efforts to gain knowledge about the female body. It was during the nineteenth century that the field of gynecology grew into a legitimate medical specialty; as such, a proliferation of work on the anatomy, physiology, and pathology of the female body occurred, in which sympathy, both between individuals and within the female body itself, recurs repeatedly. The dominant narrative was expressed largely through the writings of male physiologists and gynecologists, who defined women and their bodies as problematic barriers to the production of knowledge. Sympathy, both between individual women and between their bodily organs, was theorized in these texts as a pathological and feminine condition that repeatedly hindered the progress of Victorian medicine and science. I also identify a counter-narrative that contravened these medical diagnoses of feminine sympathies. In fiction by George Moore, Arthur Conan Doyle, Mona Todd, and others, I show that Victorian writers self-consciously responded to medical discourses that identified feminine sympathies as problematic. Instead, many of them suggest that a woman’s emotional and physiological sympathies could aid, rather than hinder, the production of medical knowledge. This dissertation explores the engagement between dominant and subversive
narratives about feminine sympathies, and proves that women’s bodies and their sympathies were crucial to Victorian theories of knowledge.
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CHAPTER ONE

Introduction

This dissertation moves beyond extant criticism on Victorian sympathy by arguing that for the Victorians, sympathy was fundamentally linked to the pursuit of knowledge—especially when that pursuit was directed at the female body. Though the considerable value accorded to sympathy during the nineteenth century is widely acknowledged, critics thus far have failed to ask how and why Victorian authors, physiologists, and medical professionals so frequently invoked sympathy in their efforts to gain knowledge of the female body. In this dissertation I draw on literary, gynecological, and scientific texts in order to demonstrate that the sympathies used to explain the female body were more than just a reflection of traditional gender norms that correlated women with feeling and men with reason, and that in fact, the sympathies used to explain the female body had consequences that far surpassed the realm of “feminine ailments.” Rather, the real and fictional medical treatment of women drastically shaped the Victorians’ understanding of knowledge, and put sympathy and the role of women at the center of that understanding.

This dissertation takes as its starting point the assumption that medicine and literature are disciplines that can be, indeed should be, read in tandem with each other. This is especially true of Victorian literature and medicine, since it was at this time that both the physician and the novelist struggled to achieve legitimacy and authority. More broadly, reading literature within the context of medicine, and vice versa, is relevant because, as Lawrence Rothfield points out, science is a “cultural phenomenon providing part of the cultural basis for literature just as other
kinds of intellectual activity do.”¹ To put it even more simply, medicine is part of the cultural landscape that invariably makes its way into literature. This is particularly evident in the novels that I have chosen to examine here, though it is also apparent in literature that does not purposefully take medicine as a theme but still includes characters that are doctors or patients, or literature that includes stereotypes, discursive assumptions, and epistemic tools that are used in medicine.²

Significantly, Rothfield also argues that Realist texts—like medical and scientific texts—are especially and inherently committed to the notion of truth. Therefore even when a text doesn’t take on the question of medical truth,

insofar as a narrative is realistic, it necessarily presumes some truthfulness (and therefore some authority) not only in what it represents but in the view it takes of what it represents. …the realist must be committed not to some general notion of truth or common sense, but to some particular epistemic trope: the normal/pathological opposition of medicine; or the juridical distinction between innocence and criminality; or the contractual distinction between fact and fiction.³

In the novels of Balzac, Flaubert, and Eliot, Rothfield finds that the normal/pathological distinction serves a heuristic end, allowing the “narrator to distinguish himself from his characters as a physician from his patients, and to make sense of them from a position of relative certainty as to what counts as significant.”⁴ In this way the realist novel strongly resembles the

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² Ibid., 178.
³ Ibid., 184.
⁴ Ibid., 160.
medical text, since “the celebrated distance and omniscience of the realist narrator is precisely the distance that separates those who are sick from those who recognize what sickness is.”

The authors that I examine here use and articulate this distance in unique ways, though in each case it depends on the kind of female body being represented, the level of sympathy that exists between the author and their character, and the level of sympathy that is encouraged between characters and readers. What I attempt to show in my analysis of each literary text is how the representation of the female body is altered as a result of these types of sympathy. In other words, I examine how decisions about narrative, for example, the use of first-person narration versus an omniscient narrator, shape representations of the female body and determine what kinds of sympathy are allowed or disallowed.

Deciphering what, exactly, sympathy meant during the height of the Victorian novel is a difficult task, in large part because it is difficult to define sympathy and distinguish it from oft-used synonyms such as empathy, pity, and compassion. As Evelyn L. Forget notes, “Despite the pervasiveness of the concept” during the eighteenth and nineteenth-centuries, “social theorists used sympathy in anything but an unambiguous way.” Depending on the author and the discipline, the term might be used to signify the imaginative apprehension of another’s experience, a shared or fellow feeling that unites individuals or groups of people, or—as I’ll discuss at length shortly—the transference of illness between different bodily organs. I refer to this final definition of sympathy (the transference of illness between different bodily organs) as somatic or physiological sympathy, while the previous two definitions (the imaginative

5 Ibid.
apprehension of another’s experience and a shared or fellow feeling that unites individuals or
groups of people) constitute what I call interpersonal or psychosocial sympathy.

A great deal of attention has been paid—from the eighteenth century to the present—to
the meaning and significance of interpersonal sympathy. According to Brigid Lowe, “…there
remains throughout the Victorian period a pervasive sense of the question of sympathy in the
intellectual atmosphere.”⁷ In addition to the wider “intellectual atmosphere,” theories of the great
Victorian novel were also suffused with the question of sympathy. As Rachel Ablow points out,
the Victorian novel “effectively retrained [the reader’s] ways of seeing, understanding, and
feeling,” and in this regard its “ability to encourage sympathy was consistently identified as
central to its effectiveness.”⁸

Reading the critical literature on sympathy and fiction during the eighteenth century,
Catherine Gallagher notes that fiction was thought to be a prime mode of encouraging moral
sentiments, since in reading fiction one was able to exercise sympathy, or “that process by which
one feels the joys and sufferings of another and may thereby be motivated to perform benevolent
actions.”⁹ Gallagher also highlights the role of the imagination in sympathy, since it was only
through our imagination that we could know and share feeling with others, especially when those
others were fictional characters. This is why, as Gallagher highlights, fiction was in some cases
thought to hinder sympathy, since sharing feelings with a fictional “nobody” was considered
more difficult than doing so with real heroes or heroines.

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⁷ Brigid Lowe, *Victorian Fiction and the Insights of Sympathy: An Alternative to the
Hermeneutics of Suspicion* (London: Anthem Press, 2007), 10.
⁸ Rachel Ablow, *The Marriage of Minds: Reading Sympathy in the Victorian Marriage Plot*
⁹ Catherine Gallagher, *Nobody’s Story: The Vanishing Acts of Women Writers in the
David Hume’s theories on sympathy are particularly interesting in this regard since he underscored both the difficulty of sympathy as well as its significance. According to Hume, all of our passions are nothing compared to the role of sympathy. As he put it, “our reputation, our character … and even the other causes of pride; virtue, beauty and riches … have little influence, when not seconded by the opinions and sentiments of others.”\(^\text{10}\) Sympathy not only allows us to communicate passions and feelings, but it actually determines them; for Hume, “hatred, resentment, esteem, love, courage, mirth and melancholy” are all passions that one experiences “more from communication” than from his/her “own natural temper and disposition.”\(^\text{11}\)

Under Hume’s view, a spectator, upon watching a surgeon prepare to operate on his patient, experiences terror because she sympathetically imagines the terror felt by the patient. For Hume, emotions are transmitted between people because “the passions are so contagious, that they pass with the greatest facility from one person to another, and produce correspondent movements in all human breasts.”\(^\text{12}\) Just like “strings equally wound up, the motion of one communicates itself to the rest; so all the affections readily pass from one person to another, and beget correspondent movements in every human creature.”\(^\text{13}\)

\(^{10}\) David Hume, *A Treatise of Human Nature* (Oxford: Clarendon Press, 1896), 316. Lauren Wispé notes that though Hume revised his *Treatise* to speak less about sympathy and more about “the sentiment of humanity” or benevolence, his “basic concern” was “moral evaluation, which depended primarily upon the sympathetic communication of feeling.” Wispé, *The Psychology of Sympathy* (New York: Plenum Press, 1991), 5.

\(^{11}\) Hume, 317.

\(^{12}\) Ibid., 605.

\(^{13}\) Ibid., 576. Another interesting component of Hume’s theory is his repeated mention of the “movement” in the breast that takes place when feeling is shared. What this seems to emphasize is the ready transmission of feeling. Sympathy in this light entails an open “breast” so that feeling can flow from one breast to another. As I’ll demonstrate shortly, this flowing transmission of feeling between bodily organs is exactly what Victorian gynecologists diagnosed their female patients with.
Hume identifies some limitations of sympathy, including the fact that it is circumscribed by similarity: “We sympathize more with persons contiguous to us, than with persons remote from us: With our acquaintance, than with strangers: With our countrymen, than with foreigners.” ¹⁴ Though an Englishman and an Italian might both see the death of a child as a horrible tragedy, according to Hume they are each more inclined to sympathize when the lost child and its family share their own nationality. Hume also argues that actually witnessing the tragedy is a necessary precursor to sympathy; for this reason, “the breaking of a mirror gives us more concern when at home, than the burning of a house, when abroad, and some hundred leagues distant.” ¹⁵ Sympathy, then, is strongly correlated with difference, or the degree to which I differ from the object of my sympathy. Increase the difference and my ability to share feeling with the object of sympathy is decreased, as is my ability to know and understand its condition.

This is where, according to Gallagher, Hume’s theory begins to suggest how fiction might actually encourage sympathy. As Hume points out, my ability to sympathize with another increases in proportion as their seeming difference decreases. Therefore, any mechanisms that shield or lessen the “‘otherness’ of the original sufferer” also increase the chances that I will be able to sympathize with him/her.¹⁶ Fictional characters, unlike real people, lack real connections to the real world, and in this way it is possible for readers to appropriate their feelings and experiences in whatever way they choose; “hence, they become a species of utopian common property, potential objects of universal identification.”¹⁷ Instead of hindering sympathy, “fiction,

¹⁴ Ibid., 581.
¹⁵ Ibid., 429. According to Hume, the effect of geographic or spatial difference on sympathy is much less than the effect of time, since though a merchant in the West Indies might feel concern for a hurricane hitting Jamaica, “few extend their views so far into futurity, as to dread very remote accidents” (429).
¹⁶ Gallagher, 172.
¹⁷ Ibid.
then, stimulates sympathy because, with very few exceptions, it is easier to identify with
nobody’s story and share nobody’s sentiments than to identify with anybody else’s story and
share anybody else’s sentiments.”18 While it is not my intention to assess the general question of
whether or not the nineteenth-century novel upholds Gallagher’s conclusion, what is pertinent is
the fact that both Hume, and Gallagher’s interpretation of Hume, underscore the idea that shared
feeling is at the foundation of our knowledge of other beings.

Hume’s friend and fellow Scotsman Adam Smith is another important link between
Enlightenment theories of psychosocial sympathy and Victorian theories of physiological
sympathy because he also underscored the epistemic properties of sympathy, arguing that our
ability to sympathize is correlated to the information that we obtain through our senses.
According to Smith, we are unable to form an accurate idea of what another experiences unless
we were able to share in the same physical experience. Instead, all we can do is try to “conceive”
what we would feel if we were in another’s position:

Though our brother is on the rack, as long as we ourselves are at ease, our senses will
never inform us of what he suffers. They never did and never can carry us beyond our
own persons, [sic] it is by the imaginations only that we can form any conception of what
are his sensations. …It is the impressions of our own senses only, not those of his, which
our imaginations copy. By the imagination we place ourselves in his situation, we
conceive ourselves enduring all the same torments, we enter as it were into his body and
become in some measure him, and thence form some idea of his sensations, and even feel
something which, though weaker in degree, is not altogether unlike them.19

18 Ibid.
As you can see, Smith is quite emphatic in his declaration that our senses “never did and never can” transport us beyond the realm of our physical bodies. What we know is always and only a function of what our senses tell us; to say we “know” what another feels is simply false because my sense data will never be identical to another’s and thus I can never fully know more than what I alone experience through my sense data or what I imagine.

Smith makes clear that this epistemic problem has distinct consequences for our ability to sympathize with another. Because we don’t know what “our brother” experiences upon the rack, we are forced to rely on our imagination to reconstruct his condition. Even if “in some measure” we become that person upon the rack, Smith’s qualifications are severe and make clear that sympathy is always on shaky epistemic ground. What I feel while watching my brother upon the rack is, for Smith, always a mere “copy” that is derived from my imagination. Knowledge gained from sympathy is thus an empirically inferior rendering of another’s “real” experience. This is the crux of the problem with sympathy, since it is never clear if one is “getting it right,” that is, accurately grasping the mental, physical, or emotional state of another person. Sympathy in this light can be deceptive, a fact that is important if we remember that for Enlightenment philosophers like Hume and Smith, sympathy was a necessary precursor to ethical behavior. In other words, the problem was this: How can we make good decisions with regards to our ethical behavior towards others if the information that we are using is based on imagination, not information, on feeling, and not (necessarily) fact? Furthermore, the relationship between sympathy and knowledge means that achieving sympathy at all is both difficult and fraught with problems, since—as Hume points out—we are less likely to sympathize with others and thus treat them ethically because we lack the necessary information to understand how they feel.
For my purposes, this difficulty is important because nineteenth-century encounters between women and their gynecologists were—in every respect—governed by the allegedly vast difference of sex between practitioner and patient. This felt difference was particularly potent since it was during the nineteenth century that male midwives, gynecologists, and obstetricians began to overtake women as the caretakers of pregnant and laboring women. Prior to this historical and medical shift, it was women—and women alone—who supervised pregnancy and facilitated birth. Laboring women were sealed from the outside world during delivery (hence the term "confinement"), and tended by a midwife as well as several female gossips. As Deanna K. Kreisel points out, “There were no men allowed in the chamber—either during the birth itself or throughout the lying-in period, which could last up to a month after delivery.” The exception to this rule was difficult or dangerous cases. According to Kreisel, ninety-eight percent of births “resulted in a safe delivery if left to their own course,” and in part because of this, most midwives delayed calling for an accoucheur or barber-surgeon until the case was very serious. “Long delays” like these “ ensured that the child was usually dead before the surgeon was called, which reinforced the practical dominance of craniotomy.” This system ensured that women

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20 Starting in the seventeenth century and until the nineteenth century, the term “gossip” actually referred specifically to those women who attended a woman at her birth. Interestingly, the English word is derived from the Old English word “godsibb,” which identified the people—both male and female—who sponsored an infant at his or her baptism. According to Ornella Moscucci, the gossip’s task was not only to witness the birth, but also to manage the household chores so that the new mother could focus all of her attention on caring for her newborn. Moscucci, The Science of Woman: Gynaecology and Gender in England, 1800-1929 (Cambridge: University of Cambridge Press, 1990), 43.

21 Deanna K. Kreisel, “Incognito, Intervention, and Dismemberment in Adam Bede,” ELH 70, no. 2 (Summer 2003): 563. Midwives most likely also delayed calling for a male surgeon due to the professional rivalries that erupted when men began to encroach on what had previously been the female midwife’s territory.

continued to trust female midwives, and thus there emerged “a clearly gendered division of labor associated with the care of women in childbirth: female midwives delivered live babies without any kind of overtly medical intervention, and male barber-surgeons delivered dead (and dismembered) babies by interventionist means with the aids of iron instruments.”

By the middle of the eighteenth century, however, man-midwives had successfully argued the case for their place in gynecological and obstetric care, and by the turn of the nineteenth century male surgeons were routinely delivering babies. Ornella Moscucci notes that between 1730-1770 man-midwives launched a public relations campaign against the midwife, arguing that midwives were ill-educated and ill-equipped to deliver safe and healthy babies. By 1800, public trust in the midwife had dwindled significantly, and members of the upper class in particular began to call for man-midwifes or surgeons. According to Wilson, this practice became a way for the upper classes to assert or solidify their superior class status.

In addition to their own calculated assault on the midwife’s training, the man midwife and surgeon/accoucheur also gained further precedence with the advent of the forceps. Though forceps, like a crochet hook, are made of metal and are considered a type of medical intervention, they allowed the man-midwife to intervene in difficult births without necessarily causing the death of the child. For example, previously when the mother’s pelvis obstructed the

23 Kreisel, 563, 64. Moscucci, however, questions the opposition between medical men/iron intervention and female midwives/natural birth. Moscucci cites the accoucheur Percivall Willughby, who instructed midwives about how to use the crochet most successfully in craniotomy. Moscucci also points out cases of female midwives who also used metal tools for intervention, including Sarah Stone, who demonstrated the use of forceps to students at the Queen Charlotte hospital in the 1790s and was thus likely using them in her own practice. See Moscucci, 48.
24 Moscucci, 50.
25 Ibid.
26 Wilson, 187.
passage of the infant, a craniotomy was performed—even if the infant was still alive—in order to save the life of the mother. The forceps, which were invented and kept secret by the Chamberlen family until approximately the middle of the eighteenth century, radically changed all that. With the help of the forceps, the man midwife could save the lives of mother and child and thus further his reputation as the most educated and effective person to facilitate birth.

In addition to the growing popular acceptance of the man-midwife, the very fact that male surgeons began focusing on childbirth meant that it became “de facto a part of medicine.” As such, the late eighteenth century and the first half of the nineteenth century witnessed a flurry of efforts among each of the three main medical licensing bodies in England—the Royal College of Physicians, the Royal College of Surgeons, and the Apothecaries’ Society—to determine who could train, and how they would train, to work as midwives, and later, gynecologists and obstetricians. I will not recount the full history of midwifery and its transformation into modern-day gynecology and obstetrics, but what is most important about that history is the fact that the entrance of men into the field of midwifery marked the start of a dramatic shift in the care of women’s bodies. Once midwifery became a part of the medical profession, the field slowly but steadily moved towards a highly-medicalized process that men alone were deemed qualified to superintend.

The Victorian period was a crucial time in this shift, and the encounters that took place between Victorian women and their gynecologists/obstetricians reveal that this shift was deeply complicated for both patient and practitioner. Sadly, representations of these encounters are largely one sided, as the only written and surviving evidence of them comes from the published

28 For the most detailed and clear description of the process by which gynecology and obstetrics became licensed and regulated in Britain, see Moscucci, 42-65.
textbooks and case notebooks of the male practitioners. From the start, then, any conclusions that we make about how Victorian doctors interacted with their female patients is limited by inherently biased information. Indeed, it is even difficult to draw strict conclusions about the male gynecologist’s version of these encounters with female patients, since published gynecology/obstetric textbooks and material were written largely by urban, rather than rural practitioners. As such, the nature of their cases, as well as their treatment of them, gives an already skewed portrait of what most Victorian women experienced during a visit to the gynecologist or during childbirth.

The evidence that does remain therefore requires that one approach it with reservations and a good dose of skepticism. Not only was the male gynecologist under siege by the female midwives whom he replaced, but he was also berated by professional colleagues who deemed gynecology and obstetrics a lesser, and less honorable specialty. This is apparent in the defensive posture that many authors invoked in order to assert their authority. For example, it was not uncommon for the author of a gynecology textbook to pointedly note that he has taken up the subject of women’s “complaints” only with reluctance. Even the so-called “Father of Gynecology,” American doctor J. Marion Sims, writes in his autobiography of his distaste for the work. Though in that same work he proceeds to prod, examine, and experiment upon a patient named Lucy quite energetically, Sims first declares, “If there was anything I hated, it was investigating the organs of the female pelvis.”

Sims makes these protestations in part because they are socially required of a man who presumes to spend his days viewing and touching the female generative organs. But he also protests because for him, and for his colleagues, the female body truly was a fearful space.

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Consider, for example, how Sims relays his treatment of a patient with a retroverted uterus (tilted backwards towards the spine rather than forward towards the bladder):

I commenced making strong efforts to push it back, and thus I turned my hand with the palm upward, and then downward, and pushing with all my might, when all at once, I could not feel the womb, or the walls of the vagina. I could touch nothing at all, and wondered what it all meant. It was as if I had put my two fingers into a hat, and worked them around, without touching the substance of it. While I was wondering what it all meant Mrs. Merrill said, “Why, doctor, I am relieved.” My mission was ended, but what had brought the relief I could not understand.30

As you can see, Sims understands the female body as an amorphous space. Describing his digital entrance into the woman’s body as if he were entering a maze (turning his hand, pushing back, pushing upward), Sims sounds as though he is excavating an endless tunnel. Though he has inserted his hand into his patient’s body, Sims claims that he “could touch nothing at all,” including “the substance of it.” These remarks are quite telling, and reveal how deeply foreign the female body is to this male doctor. Sims claims that he cannot see or touch “it,” I would argue, because “it” so strongly differs from the male penis. Unlike the male sex organ, which is visible, tangible, and a clear signifier for masculinity, power, and reason, here Sims describes the female sex organs as amorphous and obscure—a kind of black hole in which nothing can be distinguished or even seen. Given this understanding of the female body, and its contrast to the male body, it is no wonder that Sims and his colleagues conceived of the female body as nebulous and threatening. Largely invisible, intangible, and multiple in number, the female reproductive organs were seen as a dark space in which rules of medicine and metaphysics were

30 Ibid., 233.
consumed by nothingness. Like the “hat” in which Sims loses his hand, the female body is thus an all encompassing void that cannot be defined and touches all things and itself in its visual and tactile indeterminacy.31

It is also important to note that despite apparently relieving his patient, Sims himself remains unconvinced and unsure. In this regard too the female body stupefies the physician and surgeon, since Sims is unable to see the cause of disease just as he is unable to discern the source of the cure. Even when he was able to alleviate the patient’s suffering, then, the male practitioner was still left wanting, and wondering. As a result, there is a patent desperation for knowledge that pervades the work of Sims and his colleagues. According to gynecologists like Sims, it was the yearning for knowledge alone that compelled them to pursue gynecology even when their colleagues questioned the validity of the specialty as well as the purity of their motives. For instance, in the preface to the fourth edition of A Handbook of Uterine Therapeutics and of Diseases of Women, Edward John Tilt declares that he has chosen to reprint the text because, “of the departments of medicine, Gynecology is the least known,” and doing so will hopefully “diffuse a better knowledge of the diseases of women.”32 Likewise, in another textbook, Tilt sadly laments that “mists” envelope the “modicum of knowledge” that exists on women and her diseases.33 In that text Tilt doesn’t state what, exactly, causes these “mists,” or of what they are

31 Though Luce Irigaray does not cite Sims or his work, his remarks here read like the origin of her work on gynecology and the female reproductive organs. For example, Irigaray argues that the female sex organs encourage “the horror of nothing to see” since they are multiple and always touching. For Irigaray, woman is diagnosed against the single male phallus because her “incompleteness of form” “allows her organ to touch itself over and over again...without any possibility of distinguishing what is touching from what is touched.” Irigaray, This Sex Which is Not One, trans. Catherine Porter and Carolyn Burke (Ithaca: Cornell University Press, 1985), 26.
33 Tilt, Elements of Health, and Principles of Female Hygiene (Philadelphia: Lindsay and Blakiston, 1853), 117.
constituted, but in his *Handbook* he does argue that the freedom to explore and learn from the body “fails us when the functions of the generative organs of women become deranged.” The reason, Tilt tells us, is modesty, which “raises such a barrier between the patient and the practitioner, that she long conceals her sufferings, and when at last modesty bends to the duty of self-preservation, she naturally prefers the elder practitioner, and thus deprives the younger of the average opportunities of studying her diseases.”

As you can see, the difference of sex between patient and doctor not only alienates them from one another personally, but it also prevents the physician from increasing his knowledge. There is a loud note of desperation in Tilt’s comments about the younger physician’s inability to improve his knowledge and skills, and this dynamic likely encouraged younger gynecologists in particular to treat their female patients as mere means to knowledge.

Interestingly, one of the ways the male gynecologist overcame popular skepticism of his work was by manipulating how the public perceived his relationship to knowledge and sympathy. In her work on the eighteenth-century debates over the man-midwife, Sheena Sommers argues that both opponents and advocates of male midwifery invoked discourses about natural law, sexual difference, and reason. One consequence of this is that “birth and maternity increasingly came to be defined as matters that could only be fully managed and understood through detailed, objective, and professional learning, rather than through experiential

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34 Tilt, *Handbook*, 2. Tilt goes on to suggest that female practitioners would have a significant advantage in this regard, since patients would be more willing to disclose their true condition to a physician of the same sex. Regrettably, Tilt argues, women’s menstrual cycles and the likelihood of pregnancy ultimately render women incapable of performing the job of physician adequately.

35 Tilt also indicates that knowledge of the female “generative organs” was skewed because it was only in the direst of conditions that women grudgingly visited the doctor. Thus, the gynecologist’s “modicum” of knowledge was largely limited to pathological cases rather than normal physiological processes. As I will demonstrate shortly, this dramatically influenced gynecology theories, since even processes that we now know to be “normal” were deemed “abnormal” or due to a specific patient’s pathology.
knowledge.” Sheena Sommers suggests an epistemic shift in which the female midwife’s lengthy experience of birth was superseded by the rational and detached knowledge exemplified by the university-educated physician. Knowledge, as we saw in the excerpts from Tilt and Sims, was thus a crucial rhetorical tool used by gynecologists to undermine their female competitors.

In addition to possessing superior knowledge of the female body, the man-midwife also advertised his ability to properly balance this knowledge with his sympathy for the patient. The female midwife, he argued, lacked knowledge as well as the levelheaded objectivity to use it. Like Sommers, Lisa Cody confirms that this argument was successful in large part because the advent of “science” negated the personal experience that had previously been the midwife’s primary qualification. As a result, the man midwife successfully argued that “women’s passion and sympathy” limited “their capacities for the rationality required in all medical endeavors.”

Whether woman’s inherent sympathy was used for or against her, the underlying assumption remained that women are better able to understand and sympathize with their patients because of their shared physiology. Knowledge and sympathy here are tied together in the most intimate fashion, with sexual difference functioning as a determining factor of one’s ability to sympathize and to know. In the case of the male gynecologist, biological sex acted as a barrier to knowledge and sympathy for his female patients; sexual difference, it seems, produces only a kind of disknowledge, or knowledge that is partial and unaided by shared feeling.

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It is this obstacle that compelled the man midwife to position himself and his relationship to knowledge and sympathy. With the help of an increasingly scientific medical field, the man midwife portrayed the female midwife’s sympathy as a drawback rather than an asset; in her place, he presented himself not only as a learned physician who possessed superior knowledge, but as a man who was uniquely able to sympathize with the female patient while still remaining completely rational and objective. “In their writings, men-midwives stressed their own superior rationality and their ability for ‘masculine sympathy.’”38 Sommers confirms the link I see between biological sex, sympathy, and knowledge, and suggests that the man midwife’s campaign was successful because he presented himself as an unsexed “thinking machine.” Sommers borrows the term “thinking machine” from the French surgeon Louis Lapeyre, who wrote that in contrast to the midwife, who is an “animal, who has nothing of the woman left,”39 the man midwife is “no more than a thinking machine actually at work, and entirely occupied with the thoughts of conducting the operation he is employed about, to an happy issue… He is a being who, in a moral sense, may be said to belong to neither sex…”40

Lapeyre’s remarks succinctly articulate the close relationship between biological sex, feeling, and knowledge in eighteenth- and nineteenth-century women’s care. For Lapeyre, the man midwife is the superior birth attendant because his cold, detached objectivity rivals that of an inanimate machine. In becoming a “thinking machine,” the man-midwife becomes sexless as well, since it is only without the encumbrance of sex that he is able to treat his patient successfully. Sommers illustrates the paradox inherent in this position, noting that it was his

38 Sommers, 95.
39 Louis Lapeyre, *An Enquiry Into the Merits of These Two Important Questions: I. Whether Women with Child Ought to Prefer the Assistance of Their Own Sex to that of Men-Midwives…* (London: S. Bladon, 1772), 35
40 Ibid., 59.
manhood that was said to make the male practitioner “more suited for rational thought than was his female counterpart,” and yet it was also something that he had to “spin” by arguing that as a “thinking machine” he could ignore and transcend his sex though he would be viewing women’s reproductive organs on a daily basis. According to Sommers, the man-midwife’s reframing of his knowledge and sympathy, along with the larger shift from experiential to scientific modes of medical practice, are what allowed the male practitioner to shift his public image from “hack surgeon” into “cultivated specialist.”

It is important to note, however, that this shift in attitudes towards the male gynecologist did not happen overnight, and as a result the male practitioner was forced to defend his chosen specialty throughout the nineteenth century. Furthermore, the alienation between the male doctor and female patient—and its epistemic effects—remained constant through the nineteenth century, in large part because of popular discourses that continued to represent men and women as irreparably different. Evolutionary discourses that labeled women as less-developed versions of men, as well the ideology of separate spheres, encouraged the male gynecologist to see his female patient through a lens of Otherness. This is evident in the shift from sympathy to pity that I identify below through a comparison between early man midwives and the formally trained obstetrician and gynecologists that followed them. Unlike the eighteenth-century man-midwives who (purposefully) demonstrated sympathy for their patients, by approximately the mid-nineteenth century the gynecologist is clearly full of pity, rather than sympathy, for his suffering patient.

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41 Sommers, 99.
42 Ibid., 102.
43 As my chapter on the medical woman illustrates, this is particularly true because the last quarter of the nineteenth century also saw the advent of the female doctor, which again raised questions about why and if men should or needed to practice gynecology and/or obstetrics.
For instance, an unnamed author in *Lancet* writes that in cases of hysteria, it is advisable that doctors evince “very wise pity” which perhaps even reveals to the patient that the doctor does not entirely believe that her symptoms are real.\(^\text{44}\) Dr. Fleetwood Churchill says of women with vaginal fistulas, “It is scarcely possible to conceive an object more loudly calling for our pity, and strenuous exertions to mitigate, if not remove, the evils of her melancholy condition.”\(^\text{45}\) While women with fistulas garnered the most sympathy, even women with commonplace gynecological ailments were pitied; that pity, as you can see above, was used to justify all manner of procedures, including—in some cases—those that were doubtfully in the patient’s best interest. Indeed, note that Churchill refers to his patient as an *object* of pity. Rather than writing that the patient is “someone more loudly calling for our pity,” Churchill’s use of “object” underscores that his patient is not a person with whom he readily sympathizes; instead, she and her body are inanimate things that he investigates in order to further his real interest, which is knowledge.

Also of note is the fact that Churchill himself denotes that what he feels is pity rather than sympathy. This reveals the deep divide that existed between the male gynecologist and his female patient since pity, more so than sympathy, carries with it a degree of condescension. In her book *Upheavals of Thought: The Intelligence of the Emotions*, Martha Nussbaum writes that though pity “has recently come to have nuances of condescension and superiority to the sufferer that it did not have when Rousseau invoked *pitié,*” it is more widely used to refer to sharing

\(^{44}\) Anonymous, “Hysteria,” *The Lancet* 95, no. 2434 (23 April 1870), 596. The author calls for “very wise pity,” meaning that the doctor should take care to mitigate any outward expressions of pity or sympathy, since those were thought to encourage a woman in the performance of her disease. Hence the reason that in cases like that the author even suggests going so far as to doubt explicitly the truth of the woman’s symptoms.

another’s feelings when he or she is undeservedly afflicted with trouble or hardship. In other words, pity differs from sympathy largely in that it refers specifically to sharing sorrow or hardship, rather than shared feeling of any kind, i.e. an experience that doesn’t necessarily cause hardship and which would inspire sympathy and not pity. To my mind, however, Churchill’s sentiment above does smack of condescension and superiority, and we see precedence for this condescending pity in Smith and Hume.

Smith most often speaks of pity as a type of compassion that we feel when we witness the suffering of another. The tender mother or the overly indulgent father, Smith writes, can be the object of pity in which “there is a mixture of love.” Cases like this “can never be regarded with hatred and aversion, nor even with contempt, unless [sic] by the most brutal and worthless of mankind.” However, when describing what one feels while watching the punishment of a criminal, Smith’s theory of human emotions is somewhat less benevolent. In such a case, the criminal “ceases to be an object of fear,” and “with the generous and the humane he begins to be an object of pity.” Admittedly, the conditions of my analogy are not identical; the criminal waiting to be hanged has (supposedly) done something to deserve his pity, while the woman suffering from excessive menstrual cramping has not. And yet, in both cases, there is a sense of removal, or imposed psychological distance, between he who is suffering and he who pities the sufferer. Watching the criminal being put to death, I feel sorry for him knowing that I am not him and that I will never be in his situation. This feeling, though one might call it pity as Smith does, does not rest on truly shared feeling and instead rests on the same vast difference that is apparent when Churchill pities a patient who suffers from a condition that he will never himself experience.

46 Smith, 63.
47 Ibid.
In contrast to Smith, Hume is much more forceful in his assessment of pity’s negative component. For Hume, pity is equal parts good will and ill will: “…the misfortunes of our Fellows often cause Pity, which has a strong Mixture of Good-will. This Sentiment of Pity is nearly ally’d to Contempt, which is a Species of Dislike, along with a Mixture of Pride. I only point out these Phaenomena, as a Subject of Speculation to such as are curious with regard to moral Enquiries.” As you can see, Hume’s understanding of pity is one that includes negative feeling for the sufferer, so much so that Hume identifies it as “contempt” or “dislike.” In addition, his mention of “pride” as another component of this kind of pity tellingly suggests that pity can be, in some cases, a condescension that one feels towards another who is less fortunate. As in both Smith’s example of the criminal and in the dynamic between male doctor and female patient, he who feels pity for the sufferer does so in combination with his own pride and glib satisfaction at being the one who pities rather than she who is to be pitied.

I argue that the male practitioner’s shift from sympathy to pity for his female patients was due to the growing numbers of female patients and the doctor’s exposure to them. It is also a result of the vigorous and pervasive social discourse that portrayed women as alien to men, thereby reassuring the male practitioner of his superior biological sex and the fact that he would never have to endure his patients’ suffering—including the pain of being treated like a laboratory specimen who is prodded, cut, and pitied rather than thoughtfully cared for. Pity is the natural outcome of repeated exposure to his patients’ suffering, particularly when that suffering—and the one who is suffering—are deemed so foreign that the physician cannot possibly imagine himself in the same state of suffering.

48 Hume, 139.
49 As I note in my chapter on the medical woman, this was actually one of the reasons that men feared female doctors, since if they became doctors women would then be able to look upon and study men just as men had become used to looking upon and studying women.
In light of this discursive and social setting, which prevented the male doctor from sympathizing with his patients and also compelled him to negotiate the balance between knowledge and sympathy, it is particularly fascinating that it was sympathy that male gynecologists used in order to explain the supposedly pathological processes of the female body. Indeed, it wasn’t just psychosocial sympathy that was used to explain female illness, but a reinvigorated theory of somatic, or physiological sympathy as well. According to the Victorian gynecologist, hysteria, for example, was transmitted first and foremost when women were exposed to other women suffering from hysteria. Sympathy in that case was deemed the mode by which one woman might “contract” the pathological feelings of her fellow woman. In addition, however, the gynecologist and physiologist also argued that another mode of sympathy was at work in cases of hysteria. This mode, which I refer to as somatic sympathy, was also used to explain why a woman’s breasts ached when she was menstruating. Put simply, women’s bodily organs—like the women themselves—witnessed disordered feeling in others (in this case other bodily organs or systems within their own bodies) and subsequently contracted that same disorder or disease. Using this theory, the gynecologist was able to explain why hysterical patients exhibited a very wide variety of seemingly unconnected symptoms, since he could now argue that a spasm in the leg was likely the result of sympathy and disease that had been contracted from the uterus.50

50 The matter of proving this correlation, of course, was quite difficult, though in recent medicine and science there has been related work done on so-called “mirror neurons.” According to Sophie Ratcliffe, mirror neurons are those that “become active when witnessing the actions of others.” What’s interesting for the literary critic are the criticisms of these mirror neuron theories, which argue—in a vein similar to John Ruskin’s critique of the pathetic fallacy—that “there is no reason that a mirroring of cellular neural activity actually connotes a mirroring of the same emotional feeling.” Ratcliffe, *On Sympathy* (Oxford: Clarendon Press, 2008), 12.
I will turn to several specific arguments for somatic sympathy shortly, but it is important first to emphasize that clearly, the female body during the Victorian period was deeply entrenched within multiple theories of sympathy. This is in itself a much more extensive claim than the general argument that Victorian women were identified with feeling and the private sphere while men were associated with reason and the public sphere. Rather, what we see upon examining contemporary gynecological and physiological treatises is the deployment of a host of theories of sympathy that were used to better classify “normal” versus “pathological” female behavior and bodily states. As gynecology developed into a legitimate medical specialty during the second half of the nineteenth century, somatic sympathy in particular was transformed from a general physiological concept into a decidedly gynecological ailment, one that drew on preconceived ideas about women as utterly feeling creatures in order to give medical credence to diseases and diagnoses that were really an attempt to deal with allegedly unacceptable behaviors in women.

In his treatise on hysteria, Robert Brudenell Carter avers that “there is no mental instinct so universal throughout the whole human race, as the desire for sympathy….” More so than in men, in women the instinct is multiplied “tenfold” because a woman possesses a stronger desire for sympathy, and also because “the sense of self-dependence [is] comparatively feeble, so that, in her, the desire often amounts to a morbid and insatiable craving, which must be gratified at the expense of any pain or inconvenience.”\textsuperscript{51} As you can see, Carter understands sympathy as a feminine pathology; women, unlike men, possess a weak constitution and lack of willpower, both of which make her need and crave sympathy in a way that exceeds “normal.” Significantly,

Carter does not explain exactly what qualifies as pathological versus normal sympathy, and thus the boundaries used to define normal versus pathological symptoms remain vague.

Under Carter’s theory, sympathy in excess, or sympathy that exceeds “adequate” levels, is the source of hysteria. Though he writes that terror is the most common feeling that incites a hysterical fit or disorder, Carter repeatedly points to the significant role that sympathy plays in causing hysteria. For example, Carter argues that the expressions of sympathy shown to women who have suffered a hysterical paroxysm likely only ensure that the patient will be inclined to “suffer” another. As he puts it, “the fuss and parade of illness, and the sympathy consequent upon it, are frequently found to possess irresistible attractiveness.”52 There are many reasons, to be sure, why Victorian women might have “performed” an illness in order to garner attention and demonstrations of affection from their children, friends, husbands, and physicians. And, to his credit, Carter does allude to the pressures and restrictions that may have prompted Victorian women to fake illnesses, writing that woman is “more often under the necessity of endeavouring to conceal her feelings.” For this reason, Carter writes, there is “little room for wonder, at the occurrence of voluntary hysteria,” in which women experience the “gratification of exercising a newly-acquired power.”53

In addition to a desire for the sympathy of others, Carter argues that a large number of cases of hysteria are the result of women witnessing and sympathizing with other women suffering from hysterical attacks. Addressing why groups of women seem to suffer hysterical

52 Ibid., 43.
53 Carter, 43. Carter distinguishes between three varieties of hysteria, including primary, secondary, and tertiary hysteria. Primary hysteria, he writes, describes fits of hysteria that are produced by an original experience or emotion, while secondary hysteria occurs when a patient is exposed again to the events that incited her first hysterical paroxysm. Tertiary hysteria, which Carter refers to as “voluntary hysteria,” occurs when the patient purposefully recollects the emotions and conditions that caused her first paroxysm in an effort to repeat it.
attacks at the same time, Carter writes that it is not merely imitation that prompts the group attacks. Imitation, he writes, “generally has reference to the conduct of people superior in some way to those practicing it; and hence would only come into play as a spring of action, if the hysteria of the mistress was found to be commonly reproduced in her servants, of the governess in her pupils, of the matron in the paupers under her control.”\textsuperscript{54} In contrast, when hysteric are of the same socio-economic status, it is not imitation, but sympathy that spreads the attacks, since in that case, the persons coincidentally attacked are usually those who have community of interests and feelings; as the inmates of a workhouse, the pupils at a school, or the servants in a house. … paroxysms occurring simultaneously, or nearly so, in persons whose positions are coequal, may often be referred to the sympathy naturally existing between them, and to the emotions called forth by the sight of any punishment, indignity, or wrong, befalling one individual, but which each of the others may expect to suffer in turn.\textsuperscript{55}

Carter calls these “reflected feelings,” presumably because they only occur in persons who inhabit identical social and economic groups.

Several things are of note here. First of all, though Carter doesn’t state it explicitly, his theory of hysteria directly correlates sympathy, knowledge, and women’s bodies. Knowing and sharing another woman’s condition, he argues, incites sympathy and can cause shared hysterical fits. Put simply, a woman’s body—including all the organs and systems that are stimulated during a hysterical attack—responds when she understands and sympathizes with another woman undergoing a fit. Carter also underscores that difference was a crucial component of Victorian understandings of sympathy. This is evident when he argues that “reflected feelings”

\textsuperscript{54} Ibid., 40.
\textsuperscript{55} Ibid., 40-41.
are what cause women to become hysterical themselves when they observe another woman having a hysterical fit. Implicit in the reference to reflection is the notion that the original object and the reflected object are, in fact, identical. My face does not produce a reflection of my friend Lucy’s face when I gaze into a mirror, just as a servant cannot truly reflect, or experience firsthand, the feelings of her mistress. To “catch” hysteria from another woman, the two women must first resemble each other sufficiently, else the one cannot experience the other’s “reflected feelings.” Carter confirms as much in the examples he uses to differentiate between real sympathy and imitation, writing that only when there is a “community of feeling” between people of “coequal” status can sympathy be transmitted. Like the encounter between the Victorian gynecologist and his female patient, difference—whether it is that of socio-economic status or biological sex—prevents sympathy as well as the communication of knowledge. The servant cannot feel and cannot know what her mistress feels. The gynecologist cannot understand how his patient feels during a hysterical fit, and consequently he is unable to know and identify her condition. In both cases it is clear that sympathy directly impacts and is directly impacted by the ability to know and share another’s condition; in the case of the gynecologist, being able to sympathize or not determines whether he can successfully identify and treat his patient’s ailment.

Just as sympathy was invoked in order to explain some of the causes of hysteria, gynecologists also used it to explain the physiological effects as well. As I will demonstrate shortly, hysteria was the key disorder through which Victorian gynecologists articulated the female body’s pathological sympathies. Though the famous Victorian psychiatrist Henry Maudsley was no doubt the biggest proponent of physiological sympathy theories, Maudsley’s
father-in-law, John Conolly, first proposed the idea in an 1833-35 medical encyclopedia.\textsuperscript{56}

According to Conolly, who became well known for his humane treatment of patients while he was the superintendent of the Hanwell Asylum in Middlesex, “the disorder to which the name of hysteria seems justly given … assumes shapes so various that it would be in vain to attempt to describe them all. There seems to be no function or organ in which irregularity may not be induced in an hysterical constitution.”\textsuperscript{57} When describing how the physician treats aortic irregularities in hysteria patients, Conolly writes tellingly that “the practitioner himself is harassed with the fear of organic disease.”\textsuperscript{58} In other words, hysteria manifests a very wide range of symptoms, and each of these symptoms, elevated heart rate, for example, mimics an “organic” disease. When Conolly refers to “organic disease,” he is drawing a distinction between “real” disease, and disease that is induced by hysteria. In the latter case, the disease is not “real,” in the sense that a hysteric’s rapid heart rate doesn’t signify that she has a heart condition, but rather, that her hysterical condition is causing her heart and her body to mimic a different “organic,” or “real” disease.

Conolly’s colleague F.C. Skey more bluntly describes this distinction in his treatise on hysteria, writing,

\begin{quote}
Every part of the body may become, under provocation, the seat of an apparent disease that in reality does not exist—\end{quote}

that it may and often does assume all the attributes of reality with an exactness of imitation which nothing short of careful and accurate

\textsuperscript{56} Conolly was not the first to suggest that there was sympathy between parts of the body, but he was the most notable practitioner to specifically identify women’s bodies, and hysteria in particular, as especially prone to sympathetic symptoms and disease.

\textsuperscript{57} John Forbes, Alexander Tweedie, and John Conolly, eds., \textit{The Cyclopaedia of Practical Medicine; Comprising Treatises on the Nature and Treatment of Diseases, Materia Medica and Therapeutics, Medical Jurisprudence, etc., etc.}, vol. 2 (London: Sherwood, Gilbert, and Piper, and Baldwin and Cradock; Whittaker, Treacher, and Co., 1833), 560.

\textsuperscript{58} Ibid., 559.
diagnosis can distinguish from the real disease. You think this impossible. Surely you know a diseased knee-joint, you reply, when you see it. You find severe pain, aggravated by the slightest movement. The temperature of the joint may be raised, and it is slightly swelled. You leech, you blister, you employ an iodine liniment … you may even resort to issues, but the evil remains in spite of all your remedies, which have been applied to the wrong “system.” It is the nervous, not the vascular, that is involved, but the nervous has imitated the vascular and deluded you and led to the employment of false remedies… The case, on more perfect investigation, proves to be one of local nervous irritation, or Hysteria.59

I quote from this section at length because Skey’s remarks are typical of mid-century writings on hysteria and its physiological aspects, but also atypical in the near hysteria that Skey himself exhibits. In addition to italicizing—with seeming paranoia—his statement about body parts serving as sites for nonexistent illnesses, Skey’s scenario of a practitioner treating a hysteric’s knee ailment bespeaks his own anxiety. Rapidly describing what a practitioner would do to diagnose the illness, Skey reveals the uncertainty and fear that the hysteric’s illness induces in her physician. Finally, it is important to note that while Skey and Conolly admit the possibility of imitative disease occurring in any of the body’s organs or systems, and thus presumably in men and women, they both strongly link it to the female body by correlating the phantom illnesses with hysteria.

For Conolly, the link between women, hysteria, and imitative illness is sympathy, that is, the sympathy that exists between their organs and bodily systems. As he puts it, “That certain

states of the uterus, causing peculiar sympathies in different parts of the frame, are the causes of hysteria, is an opinion of great antiquity, and has been supported by nearly every observer from the time of Hippocrates, who has often been quoted as saying that a woman’s best remedy in this disorder is to marry and bear children.” 60 Conolly is overzealous in suggesting that “every observer from the time of Hippocrates” has noted the connection between sympathy and hysteria, but his remarks do raise two important points: firstly, sympathy between bodily organs was a well-recognized component of British physiology through the nineteenth century, and secondly, the rise of gynecology, alongside the rising importance of physiology during the Victorian period, meant that the idea of physiological sympathy was a convenient explanation for so-called disorders that vexed male gynecologists. 61

Like the rise of interest in psychosocial sympathy that occurred during the Enlightenment due to philosophers such as Smith and Hume, somatic sympathy also experienced a growth of interest during the mid-eighteenth century. According to Forget, the widespread acceptance of somatic sympathy ensued when Robert Whytt was appointed professor of medicine at the University of Edinburgh in 1747. In contrast to earlier mechanistic models of the body, Whytt argued that a “sentient principle” was responsible for receiving stimuli and directing the body in its conscious reactions and unconscious reflexes. Though Whytt and his colleagues William Cullen, Alexander Monro, and John Gregory differed in the particulars of their physiological theories, what they shared was an understanding of a dynamic process whereby the body was able to communicate with itself, transmitting sense data as well as illness and disease. 62 For Whytt, the nervous system was the center of this process, and while “the minute structure of the

60 Cyclopaedia, 569.
61 Along with hysteria, Conolly also identifies physiological sympathy as a factor in hypochondria.
62 Forget, 292.
nerves, the nature of their fluid, and those conditions on which depend their powers of feeling
and communicating motion to the body, lie much beyond our reach,” Whytt declared that “we
know certainly, that the nerves are endued with feeling, and that as there is a general sympathy
which prevails through the whole system; so there is a particular and very remarkable consent
between various parts of the body.”

Somatic sympathy is thus a function of the nervous system’s ability to transmit data to all
the organs and tissues of the human body; in theory, sympathy between organs exists in all
human bodies, whether male or female. Like Conolly and Skey, however, Whytt and his
colleagues were also quick to note that certain bodies demonstrate an excessive degree of
nervousness, sensibility, or somatic sympathy. Though there are “very few disorders which may
not in a large sense be called nervous,” Whytt’s interest lies chiefly in those disorders that are “in
a great measure, owing to an uncommon delicacy or unnatural sensibility of the nerves.” Due
to the delicacy of their nerves and constitution, as well as to the remarkable sympathy that exists
between the female reproductive organs—the breasts and uterus in particular—female bodies
and “feminine” disorders formed a very prominent category within the larger theory of somatic
sympathy.

Within this medical and scientific context, it is not surprising that Victorian
gynecologists—beset by cases of hysteria—used somatic sympathy as a way of explaining why,
for instance, an hysteric might exhibit spasms in her legs, pain in her head, and excessive
menstrual bleeding. Conolly, in his analysis of hysteria, argued that the female body as a whole

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63 Robert Whytt, *Observations on the Nature, Causes, and Cure of those Disorders which have
been Commonly Called Nervous Hypochondriac, or Hysteric, to which are Prefixed some
Remarks on the Sympathy of the Nerves* (Edinburgh: T. Becket, P. DuHondt, and J. Balfour,
1764), v-vi.
64 Ibid., iv.
is overly sensitive to any change in any of its systems. “The digestion of food, the circulation of the blood, the judgment, the affections, and the temper”: all of these things, he argues, prove that “there can, therefore, be no reasonable doubt entertained that in a great many cases—perhaps we might say in the majority of cases—the cause of hysteria is some more or less discoverable irritation existing in some part of the uterine system, exercising its wide influence on the susceptibilities of a nervous system by nature too easily affect by all impressions.”65 While later in the century Freud and other psychoanalysts would devote more attention to the mental impressions that incite hysterical fits, here Conolly indicates that hysteria is also caused by “impressions” that are shared between bodily organs and systems. More than just inanimate organs that perform their distinct duties in isolation, what Conolly suggests is a dynamic system of feeling organs in which one organ can communicate its “impression,” state, or condition to another organ and consequently change its state.

Without a doubt, this process strongly resembles what happens when I witness another person’s tragedy and feel sympathy for her. As Forget notes, there were strong correlations between physiological and psychosocial sympathy: “The epistemological continuity between the physiological theories of the Edinburgh medical school and the social theories of Smith and Hume seems apparent. The same principle explains the action of sensation, the coordination of the organs of the body, and the ‘social principle’ that allows ‘fellow feeling’ to emerge in a society.”66 There are, however, some key differences, including the fact that organs do not meet the necessary conditions for sympathy to occur. Most obviously, organs are not capable of thinking or knowing, both of which, as I suggested earlier, are necessary for some one to share in the feeling of another. If the intestines don’t “know” what the uterus is feeling, then it is not

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65 Conolly, 569.
66 Forget, 292.
possible for them to sympathize. And, even if the intestines could somehow—through information transmitted through the nervous system—understand that the uterus was in pain, it is still quite a stretch of the imagination to assume that they would exhibit a similar distress out of pure sympathy. My point here isn’t to question the flaws in nineteenth-century physiology or gynecology, but rather, to note that what we might call the gynecologist’s figurative use of the term sympathy had very real consequences for his patients. Thus though it was but a kind of trope, sympathy—with its attendant diagnoses and supposed symptoms—became for many women a physical reality that could determine their health and wellbeing, medical treatment, and in some unfortunate cases, even their lifespan.

Because his work was widely read and bridged disciplines such as physiology, gynecology, and psychiatry, Maudsley is a useful touchstone for understanding the content and popularity of theories of physiological sympathy. In his highly influential *Body and Mind* (1870), Maudsley describes physiological sympathy, arguing that a sympathetic connection between different parts of the body is responsible for normal processes as well as pathological conditions. In both women and men:

All parts of the body, the highest and the lowest, have a sympathy with one another more intelligent than conscious intelligence can yet, or perhaps ever will, conceive; …there is not an organic motion, visible or invisible, sensible or insensible, ministrant to the noblest or to the most humble of purposes, which does not work its appointed effect in the complex recesses of mind; … the mind, as the crowning achievement of
organization, and the consummation and outcome of all its energies, really comprehends the bodily life.\textsuperscript{67}

While physiological sympathy operates in both women and men, for Maudsley the process is significantly shaped by sex, since the “generative organs” are “notably united in the closest sympathy,” such that “the general uniformity among men in their passions and emotions is due to the specific sympathies of organs, just as the uniformity of their ideas of external nature is due to the uniform operation of the organs of sense.”\textsuperscript{68} In other words, just as a woman’s breasts may exhibit sympathy with her uterus, so too do a person’s—male or female—reproductive organs correspond with his or her “ideas of external nature.” Not only do the reproductive organs affect the functioning of other bodily organs, but they are also able to affect the organs that determine what we think and how we feel.

In Maudsley’s view, sympathy is primarily an epistemological and physiological property. The epistemological ramifications of sympathy are evident when Maudsley likens it to a type of intelligence that eludes the rational mind as well as sense data like sight and touch. Put simply, bodily sympathy amounts to a realm of knowledge that cannot be grasped by empiricist or rationalist methods: Maudsley can’t see how sympathy influences the nervous system, nor can he deduce its mysterious processes through logical contemplation. It is a type of knowledge that transcends, and requires methods that transcend, the tools of traditional medicine and science.

Sympathy, especially as the female body manifests it, is thus a direct challenge to empirical science, the supremacy of the male doctor, and Western medicine itself. I argue that this challenge explains why Victorian gynecologists invoked sympathy in their diagnoses of

\textsuperscript{67} Henry Maudsley, \textit{Body and Mind: An Inquiry into Their Connection and Mutual Influence, Specifically in Reference to Mental Disorders} (New York: D. Appleton and Company, 1871), 102.

\textsuperscript{68} Ibid., 33.
women. If, for the Victorians, sympathy was a psychological, physiological, and epistemic enigma, then it makes sense that gynecologists would use it to explain cases and bodies that were similarly difficult and with which the doctors themselves had a hard time sympathizing. In this way, the Victorian diagnosis of somatic sympathy neatly encapsulates the much larger and more widespread Victorian conception of the female body as similarly unknowable, dark, and impenetrable. Furthermore, it also draws on preconceived and ideological assumptions about women, namely, that they are generally more sympathetic and feeling than their male counterparts. Like much Victorian science and medicine, then, sympathy—and the scientific and medical discourse behind it—was employed to validate the biological basis of sex difference. And, once again, I’d like to emphasize the “difference” in sex difference, because it was the vast difference between patient and physician that prevented doctors from sympathizing with their patients, and which also prompted those practitioners to diagnose these vexing cases with an alleged condition that further identified them and their bodies as dark, obscure, and epistemically challenging.

As you can see, multiple forms of sympathy were at work when the male gynecologist encountered his female patients. The primary purpose of this dissertation is to trace these various manifestations and types of sympathy, ultimately asking how the connection between sympathy and knowledge shaped medical and popular understandings of women’s bodies. More broadly, however, this dissertation also argues that for the Victorians, sympathy and knowledge were inextricably linked. From the difficulty of sharing feeling with someone without full knowledge of their condition, to the difficulty of diagnosing disease in bodies that exhibit somatic sympathy: in both cases and in others it is clear that Victorian ways of knowing were deeply intertwined with ways of feeling. Nowhere is this fact more evident than in the relationship between the male
gynecologist and his female patient, and thus this dissertation situates the female body and its relationship to sympathy amongst larger questions about how the Victorians envisioned the process of knowing. More than just a secondary specialty within the medical profession, then, the sympathetic female body bore consequences that are apparent in fields as diverse as literature and literary genre, medicine, psychology, and philosophy.

I draw on each of these disciplines in my first chapter, “Who Delivers Dorothea’s Baby? Medicine, Knowledge, and George Eliot’s Conspicuous Lack of Sympathy in Middlemarch.” Here I argue that Eliot’s masterpiece investigates and upholds the value of sympathy between individuals. Sympathy, Eliot indicates, has the power to redeem even the most egocentric character from the prison that is narcissism. And yet, despite its power, Middlemarch denies sympathy to the procreative female bodies in the novel by excising them from the narrative in a way that cannot be fully explained by merely citing Victorian prudishness. Rather, much like her counterparts in Victorian gynecology, in Middlemarch Eliot consistently aligns the female body with darkness and uncertainty; just as the female body is a difficult problem for the gynecologist and his search for medical truths, so too is it shown to be a nuisance for Eliot’s narrative and its vision of sympathy.

In my second chapter, “Shared Feeling and the Rebuke of Naturalism in George Moore’s Esther Waters,” I suggest how Moore paradoxically subverts both the Victorian censors and elements of naturalism by foregrounding his heroine’s unique and embodied experiences. On the one hand, Moore was widely criticized for his gritty and allegedly naturalistic portrayal of Esther’s childbirth in a London free hospital. On the other hand, however, this scene, along with many others in the novel, eschews the truly naturalistic depiction of Esther and her body and instead criticizes the Zola-esque doctors who would treat her as a lump of flesh fit only for
dissection. Unlike Zola, in *Esther Waters* Moore at times relinquishes the power of the omniscient narrator in order to give voice to Esther and her experiences. As I demonstrate, the result of this technique is a deeper level of sympathy with Esther—one that is shared by both the reader as well as Moore himself.

While the majority of this dissertation focuses on the way that male doctors treated the bodies of female patients, in chapter three, “Man-Midwives, Lady Doctors, and the Tenuous Balance of Knowledge and Sympathy in Victorian Medical Woman Fiction,” I address the sub-genre of medical woman fiction and her real-life counterpart, the Victorian “Lady Doctor.” In this chapter I take as my starting point the rise of the man-midwife during the eighteenth century, outlining how assumptions about sex and gender, knowledge, and feeling were used, in various ways and at different historical moments, to exclude women from the practice of medicine. Indeed, as my analysis of medical women fiction written by and about female doctors suggests, shared feeling was often a rhetorical tool that authors wielded in order to express favor or disapproval of women in medicine. Regardless of the kind of medical professional—e.g. nurse versus physician—when women attempted to gain knowledge it was invariably seen as an extension or perversion of her “natural” ability to sympathize with others.

In my final chapter, “Lady Patients, Canines, and the Knife: Shared Sympathies in Victorian Vivisection and Gynecology,” I identify and explore the previously unnoticed parallels made during the Victorian period between the gynecology patient and the vivisected animal. Not only did the antivivisection movement and the rise of gynecology as a legitimate medical specialty occur at the same historical moment, but they also drew on a shared repertoire of images and ideas about the foreign bodies that were eagerly being dissected in order to gain knowledge. Though their “patients” were quite different, in gynecology texts and in vivisection
manuals the female body and the body of the vivisected animal are similarly shown to be
deceptive, that is, able to exhibit symptoms that are not necessarily indicative of real disease. In
this way, I argue, the female body and that of the vivisected frog, for example, were vexatious
because they undermined empirical science and hindered the effort to know and “cure” them.
CHAPTER TWO
Who Delivers Dorothea’s Baby?

Medicine, Knowledge, and George Eliot’s Conspicuous Lack of Sympathy in Middlemarch

Knowledge and sympathy share an intimate relationship in Eliot’s Middlemarch. The novel examines Victorian medical reform and sympathy between characters at length, and suggests that psychosocial sympathy between individuals is fundamental to scientific and ethical knowledge. However, representations of the procreative female body in the novel strongly contrast with this epistemological model, as these bodies are excised from the narrative and only signified through darkness and obscurity. In this way Middlemarch denies sympathy to procreative female bodies. Because sympathy is, as I will illustrate, closely tied to Eliot’s understanding of knowledge, this act of narrative elision signifies a systematic disavowal of the female body as a reliable source of knowledge.

Critics uphold Eliot’s elision of female bodies, and instead focus their critical attention on Lydgate’s treatment of Fred Vincy, Casaubon, and Raffles.¹ This is particularly surprising given

¹ Most recently, Lilian Furst’s “Struggling for Medical Reform in Middlemarch” offers a comprehensive survey of medical reform in the novel, paying especial attention to the professional rivalries between Lydgate and his fellow practitioners. Furst does not address the obstetric and gynecological cases in the novel, and though she does mention Nancy Nash’s case, it is only to more accurately survey the changing medical hierarchy in Britain circa 1830. See Furst, “Struggling for Medical Reform in Middlemarch,” Nineteenth-Century Literature 48, no. 3 (1993): 344-45, 351-52. See also Peter M. Logan, “Conceiving the Body: Realism and Medicine in Middlemarch,” History of the Human Sciences 4, no. 2 (1991): 197-222. Logan’s analysis richly contextualizes medicine in the novel, and also briefly mentions Nancy Nash’s case. However, like in Furst, this is the only female medical case mentioned in Logan’s article, and at no point does Logan acknowledge or assess its implications for sex or gender. In other words, neither Furst nor Logan thoroughly explore Nancy’s case, nor do they address the medical, epistemological, or political consequences that arise as a result of her female sex. C.L.
the narrator’s assertion that Lydgate “cared not only for ‘cases,’ but for John and Elizabeth, especially Elizabeth.” Eliot’s tone here is deliberately playful, and these remarks foreshadow Lydgate’s susceptibility to Rosamond Vincy’s feminine wiles. They also, however, implicitly underscore the fact that female patients would have comprised a significant portion of Lydgate’s surgical practice. By approximately 1830—when the novel is set—and certainly by the time Eliot began composing the text in 1869, male surgeons and even physicians had assumed responsibility for tasks that had previously been the province of the female midwife. These tasks included labor, delivery, and routine gynecological care, and an unknown surgeon in a small provincial town would likely cultivate his practice by earning the trust and loyalty of women.

Cline points out a possible reason for the critical attention given to Lydgate’s treatment of Casaubon, Raffles, and Fred Vincy, noting these cases—“fatty degeneration of the heart,” typhoid, and delirium tremens, respectively—correspond directly with Eliot’s medical and scientific reading leading up to the composition of the novel. See Cline, “Qualifications of the Medical Practitioners in Middlemarch,” in Nineteenth Century Perspectives, ed. Clyde de L. Ryals (Durham, N.C.: Duke University Press, 1974), 271-81.


3 Historically, physicians ranked at the top of the medical hierarchy, and presumably had a classical education in physic as well as better breeding, both of which enabled them to assess disease and render diagnoses. Surgeons, less educated and more associated with the physical labor of treating patients, were more frequently employed because they charged less than physicians but were thought more expert than apothecaries, who were considered little better than tradesmen in drugs. As Furst notes, these once rigid boundaries were “becoming more porous by about 1830, especially in the provinces.” Furst, “Medical Reform,” 344. This meant that physicians, surgeons, and apothecaries frequently became embroiled in disputes about their respective commissions; not only did surgeons begin taking on cases and tasks that were traditionally the province of physicians, but also “some physicians were taking on the degrading manual tasks of surgery, and even of midwifery and pharmacy, to supplement slender incomes” (344). The surgeon Lawson Tait suggests the consequences of this professional competition, lamenting that patients are so desperate from relief from their “chronic” conditions that they “wander about and rarely give any one practitioner a very prolonged trial” (45). That is, patients fail to give individual therapies time to be effective, and instead rapidly avail themselves of the host of other practitioners—physicians, surgeons, apothecaries, and quacks—who were all eager to earn the patronage of these habitual patients. Tait, Diseases of Women (London: Williams and Norgate, 1877), 45. For a more thorough assessment of the vast consequences that these professional changes had on gynecology and obstetrics in particular, see Moscucci.
during their labor. Lydgate’s interest in “Elizabeth” takes on a deeper resonance in light of this historical context, for gynecology and obstetrics would have been a vital component of his practice.

Nancy Nash is the first female patient that Lydgate treats, and though her case is not explicitly designated as gynecological, it is significant because it sets up how the novel formulates the female body’s relationship to knowledge. More specifically, it evokes contemporary gynecological theories that diagnosed the female body as inherently duplicitous. For instance, the epigraph to the chapter that details Nancy’s tumor is from Sir Thomas Browne’s *Pseudodoxia Epidemica: or, Enquiries into Very Many Received Tenents, And Commonly Presumed Truths* (1646). Browne’s text was a popular seventeenth-century encyclopedia of what he saw as pervasive epistemic fallacies in science, religion, philosophy, and history.\(^4\) Beginning the chapter in this way, Eliot frames the debate over Nancy’s tumor as a question of knowledge, especially its validity and the conditions for its production. Eliot also mocks the methods that Middlemarch residents use to assess Lydgate’s medical skill and knowledge, noting that though they had initially been reluctant to patronize the newcomer at the expense of their “medical man” Mr. Gambit, once Lydgate arrived in town, “there were particulars enough reported of him to breed much more specific expectations and to intensify differences into partisanship; some of the particulars being of that impressive order of which the significance is entirely hidden, like a statistical amount without a standard of comparison, but with a note of exclamation at the end” (361). Browne’s *Pseudodoxia Epidemica* argues that

\(^4\) The full epigraphs reads: “‘It is the humour of many heads to extol the days of their forefathers, and declaim against the wickedness of times present. Which notwithstanding they cannot handsomely do, without the borrowed help and satire of times past; condemning the vices of their own times, by the expression of vices in times which they commend, which cannot but argue the community of vice in both. Horace, therefore, Juvenal, and Persius, were no prophets, although their lines did seem to indigitate and point at our times’” (Eliot 359).
empirical observation of evidence is paramount for all knowledge, and here we see Eliot seconding those methods, satirizing the apparent lack of facts on which the Middlemarch residents base their changed opinions, and underscoring that it is a woman’s body that provides the basis for all of this medical and professional uncertainty.5

More importantly, the educated Victorian reader would have understood Nancy’s case to be gynecological not merely because she is female, but because Eliot describes the case as a troublesome hindrance for Lydgate and the progress of medical knowledge. In this way, Eliot alludes to medical and popular depictions of the female body that portrayed it as a difficult conundrum that complicated the efforts of those who attempted to know and cure it. Eliot’s first mention of Nancy’s illness occurs when her employer, Mrs. Larcher, becomes “charitably concerned” about Nancy’s “alarming symptoms” (365). Though the narrator does not provide the details of these symptoms, it is noteworthy that Mrs. Larcher’s concerns for Nancy are in fact “charitable,” that is, presumably not from true shared sympathy, but more likely due to a sense of duty or even officious nosiness. Upon examination, Dr. Minchin diagnoses Nancy with a tumor, and recommends her to the town infirmary. According to the town gossips, this tumor is “at first declared to be as large and hard as a duck’s egg, but later in the day to be about the size of ‘your fist’” (365). These same gossips also speculate on possible cures for Nancy’s ailment, and

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5 Eliot observes that the residents based their original opinions about Lydgate on a “total deficit of evidence,” namely, on feelings “situated perhaps in the pit of the stomach or in the pineal gland. . .” (360-61). While this is exactly the sort of scientific lingo that critics lamented in Eliot’s fiction, the allusion to the pineal gland is telling in that it was thought by many—including Descartes—to be the source of communication between mind and body, i.e. the mode by which the mind willed the physical body to motion and changes in the body produced effects in the mind. In his Ethics, which Eliot translated, Spinoza famously criticized Descartes, arguing that the philosopher’s conclusions about the pineal gland were neither based in self-evident premises nor on direct observation. As I suggested in chapter one, sympathy is intimately tied to debates on the mind/body connection. Eliot’s allusion to the pineal gland invokes this debate and further highlights her studied appraisal of the methods used to obtain knowledge, whether that knowledge is medical, interpersonal, or philosophical.
recommend both surgery as well as oil and “‘squitchineal,’” which, when “taken enough of into the inside,” will slowly dissolve the tumor (366).\(^6\) Dr. Minchin is the person most qualified to diagnose and treat Nancy. Yet given that his diagnosis of a tumor is later revealed to be incorrect, his medical knowledge is rendered as questionable as the residents’, who seem equally inclined to apply topical remedies as to surgically remove the tumor—in both cases without sufficient data to justify either course of treatment.

This destabilization of the medical hierarchy is compounded when Lydgate corrects Minchin’s diagnosis and identifies Nancy’s case as one of mere cramp. As a physician, Minchin has presumably received more formal education and training in diagnosis. As a surgeon, Lydgate’s province is the menial and physical labor of treatment, not diagnosis. The scene thus appears to be, and is in part, an allusion to the dramatic restructuring of the medical profession that occurred throughout the nineteenth century. However, especially in regards to advances in surgery, antisepsis, and anesthesia, gynecology and obstetrics were at the forefront of the widespread changes taking place in the medical profession.\(^7\) Along with evidence that links

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\(^6\) According to the Broadview editor of the novel, squitchineal is a colloquialism for cochineal, a red dye made from the crushed bodies of the tropical insect dactylopius coccus that was also used for various medical purposes in the nineteenth century (366n5).

\(^7\) Gynecology and obstetrics were central to debates about the restructuring of the medical hierarchy not only because surgeons and physicians were now competing for business that used to be the sole province of the female midwife, but also because gynecological and obstetric cases were often very difficult to classify and hence difficult to assign to a given type of practitioner. The obstetric physician Robert Barnes underscores as much, and points out that in the case of an apparent Caesarean section, the obstetric physician would be liable to censure if, upon opening the abdominal cavity, he found and removed not an infant but a large tumor. Barnes’s larger point is that gynecological and obstetric conditions do not readily conform to the social and political dictates of the medical profession. Gynecology and obstetrics were also at the forefront of changes in the medical hierarchy because ovariotomy was integral to the rise of surgery. As developments in the procedure were made by surgeons such as Tait, Thomas Spencer Wells, and Isaac Baker Brown, esteem for surgery and acceptance for the procedure grew, making diseases of women a focal point for the hotly contested changes taking place within the profession.
Nancy’s case to changes taking place in the medical profession, especially those in gynecology and obstetrics, the charwoman’s case also evokes debates that were specific to Victorian gynecology and obstetrics. One of the first signals that Nancy’s case is gynecological is the townspeople’s suggestion that the treatment might require medicine taken “into the inside.” This suggestive description, along with the fact that the narrative directly juxtaposes the charwoman’s illness alongside Borthrop Trumbull’s pneumonia, feminizes Nancy’s case. In contrast to Nancy, Trumbull is described as a “robust man” who offers Lydgate an opportunity to try his “expectant theory upon,” so that, leaving “an interesting disease . . . as much as possible to itself . . . the stages might be noted for future guidance” (367). Trumbull’s lung infection is clearly defined. It is also an “occasion for medical science,” a chance to evaluate a “rational procedure,” and therefore a “general benefit to society” (367). This is clearly no ordinary case of pneumonia. Rather, it is imbued with vast significance and is represented as an opportunity to further medical knowledge and its “rational” methodologies.

Nancy’s tumor, on the other hand, affords no advancement of medical knowledge, and is instead associated with the townspeople’s popular superstition and ignorance. Indeed, the case represents a kind of narrative ignorance, since not only is it unclear if Lydgate’s diagnosis is necessarily correct, but it is also unclear what kind of cramping Nancy might be experiencing—

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8 This association with superstition is significant because feminine ailments and healing have long been associated with superstition, ignorance, and magic. Common practices of confinement, e.g. sealing the birth room, isolating the mother, prohibiting discussion about the events of labor, are one possible reason for this correlation. Barbara Ehrenreich and Deirdre English argue that midwives have often been grouped along with witches since the Middle Ages, largely because at that time their empirical methods challenged the metaphysical, faith-based modes of treatment supported by the Church. Ehrenreich and English, Witches, Midwives, and Nurses: A History of Women Healers (Old Westbury, N.Y.: The Feminist Press, 1973).
i.e., menstrual, intestinal, or muscle cramping.9 As I will illustrate, the charwoman’s excessive bodily feeling and physiological sympathy is what impedes medical knowledge and diagnosis, and in this way Eliot feminizes her case and associates it with the burgeoning field of gynecology. Unlike male bodies, which can be investigated and diagnosed with the help of empirical methods, here the object of gynecological knowledge is actually resistant to being known.10 Not only is Nancy’s tumor misdiagnosed and purportedly non-existent, but it is also identified as of a “wandering sort”: “. . .by-and-by Nancy, in her attic, became portentously worse, the supposed tumour having indeed given way to the blister, but only wandered to another region with angrier pain” (366). Importantly, Eliot does not identify the location of Nancy’s tumor, and instead indicates that the tumor “wanders” through various “regions” in Nancy’s body. I will explain in more detail why a wandering tumor would have had distinct gynecological connotations for Eliot’s readers shortly. The verb “to wander” is very revealing in itself, however, as it suggests that the mass moves aimlessly and without purpose through the body. A tumor like this would present a significant challenge to any medical practitioner, and thus Nancy’s case stands in clear contradistinction to Trumbull’s as one that frustrates medical

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9 On one hand the fact that it is a female patient who is experiencing “cramp” seems to suggest that the malady is menstrual or gynecological in nature. On the other hand, Lydgate does suggest “good food” as treatment for the condition, thereby implying that the cause is intestinal rather than gynecological. Given that Victorian doctors theorized a strong sympathetic link between the reproductive organs and the digestive system, however, I’d argue that the type of cramp is deliberately vague, since cramp in the uterus, for example, could presumably cause cramping in the intestinal tract as well.

10 Of course, Trumbull is sexed as well, as demonstrated by Eliot’s reminders that he is a “robust man” who receives a “rational” course of treatment. However, examining the two cases side by side—as they are juxtaposed in the novel—it is apparent that Trumbull’s pneumonia is coded as universal or unsexed, thus marking Nancy’s gynecological case quite distinctly as gynecological, feminine, and subordinate by comparison.
science rather than aiding it. Eliot heightens the antagonism between the tumor and medical knowledge by anthropomorphizing the tumor’s “angry” pain. Nancy’s tumor is an angry symptom of an unknown pathology, and is therefore clearly anathema to the medical progress made in Trumbull’s case.

More specifically, Eliot’s characterization of Nancy’s tumor as “wandering” links it with gynecological ailments that were thought to arise from bodily sympathy. A possible source for this depiction lies in the fact that the surgeon James Paget, like Maudsley, identified a strong correlation between physiological sympathy and gynecological disorders. Paget attended both Eliot and Lewes’s son Thornie, and his work is amply represented in the Lewes/Eliot library. In his Lectures on Surgical Pathology (1863), Paget highlights how sex influences physiological sympathy, and also outlines a case that bears striking similarities to Nancy Nash. Describing mammary tumors, Paget remarks that they appear

most commonly in young unmarried or barren women, their beginning often seems connected with defective or disordered menstruation. The law which, if we may so speak, binds together in sympathy of nutrition the ovaries and the mammary glands, the law according to which they concur in their development and action, is not broken by one

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11 This is particularly true because the tumor is, in fact, nonexistent. In this regard it is an irrelevant distraction from medical knowledge in that it is not real, and also because its alleged origin is unknown and thus obscure to medical science.

with impunity to the other. The imperfect office of the ovary is apt to be associated with erroneous nutrition in the mammary gland.\textsuperscript{13}

Unlike his colleagues specializing in nervous disorders like hysteria, epilepsy, or catalepsy, Paget’s main concern is the source of nutrition that feeds all types of tumors. And yet the passage above illustrates quite clearly that Paget’s ideas have also been strongly influenced by theories of physiological sympathy, especially in regards to the female reproductive system. For Paget and his colleagues, it is “law” that the breasts and the ovaries communicate and share pathological states, and that the “concurrence” between a woman’s reproductive organs can cause the transfer and/or transplantation of a tumor from a woman’s breasts to her ovaries.

It is just this sympathetic movement through the female body that Paget goes on to describe in the case of a “laundress” with a “fatty tumour, as large as a foetal head, above her ilium. . .”\textsuperscript{14} According to Paget, though parts of this pelvic tumor were “as hard to touch as cartilage,” it also “appears to move so freely in the soft fat-tissue about them, that one might have thought them loose bodies, or fluids within cysts.”\textsuperscript{15} Tumors like this one “show no real imitation of malignant disease,” and Paget “once, indeed, saw a case in which the end of a pendulous fatty tumour in a woman’s perineum was so ulcerated that it looked like cancerous disease: but after a week’s rest in bed, during which the patient menstruated, it lost its malignant aspect. It now acquired . . . clean, inverted and over-hanging, wedge-shaped, granulating edges.”\textsuperscript{16}

\textsuperscript{13} Paget, \textit{Lectures on Surgical Pathology, Delivered at the Royal College of Surgeons of England}, vol. 2 (London: Longman, Brown, Green, and Longmans, 1853), 259.
\textsuperscript{14} Ibid., 99.
\textsuperscript{15} Ibid., 99-100.
\textsuperscript{16} Ibid., 100-101.
In his transcription of both the pelvic and the perineum cases, Paget yokes the patients’ pathology to her biological sex. In the case of the laundress, the tumor is located in her pelvic region, and seemingly as big as a “foetal head,” while in the latter case the patient’s menses cause an apparently malignant tumor to change its constitution so that it appears benign. Whether it is tumors that rapidly change in constitution or those that move “freely” through the body’s dark cavities, in Paget’s text the female sex organs represent a distinct challenge to medical science. Dubious and volatile, women’s bodies and their innate sympathies make difficult Paget’s effort to pinpoint a tumor’s source, location, and cure. The parallels between the cases elaborated in Paget’s work and *Middlemarch* are clear, most significantly in that the etiology and location of Nancy’s supposed tumor is unknown, as is its pathway through her body. In this regard it is identified as sympathetic in nature, that is, arising from the excessive feeling existing between the unseen sympathetic connections in the female body. Nancy’s supposed tumor is said to “wander” because it is unclear why and how it travels through her abdominal cavity. Her procreative body is thus imagined as a dark, amorphous cavity, the workings of which—especially in contrast to Trumbull’s clear-cut case of lung infection—remain unknown and potentially unknowable.

Eliot’s portrait of Nancy’s supposed tumor as an amorphous and obscure condition aligns it with cases of physiological sympathy, thus painting her condition as “feminine,” as well as pathological. It also indicates that Eliot understood that there were multiple forms of sympathy, all of which were deeply affected by sex and gender and could also influence the production of knowledge in many ways. This bears on Victorian ways of knowing because in *Middlemarch* Eliot pits feminine physiological sympathy against the certainty of masculine empiricism. This opposition is evident in the juxtaposition of Nancy’s case with Trumbull’s, its association with
the ignorant locals, and the quickness with which Minchin misdiagnoses the tumor. It is also apparent when Lydgate reflects upon the way that his diagnosis of cramp is received. Noting that both Nancy and the Middlemarch residents persist in believing that Nancy suffered from a tumor that Lydgate miraculously cured, Eliot’s narrator interjects an interesting moment of free indirect thought: “How could Lydgate help himself? It is offensive to tell a lady when she is expressing her amazement at your skill, that she is altogether mistaken and rather foolish in her amazement. And to enter into the nature of diseases would only have added to his breaches of medical propriety. Thus he had to wince under a promise of success given by that ignorant praise which misses every valid quality” (366). While it is clearly the narrator’s voice that asks “How could Lydgate help himself,” it is unclear whether or not it is the narrator who expresses the “offense” of revealing a lady’s ignorance to her, or if these are Lydgate’s thoughts regarding the situation. Eliot’s use of “your” effectually blends the narrator’s perspective with Lydgate’s.

Elsewhere in the novel, however, the narrator admonishes the unequal distribution of narrative attention and sympathy. In an oft-cited scene following Dorothea’s marriage to Mr. Casaubon, the narrator interjects to assert Casaubon’s right to the reader’s (and the narrative’s) sympathy: “...but why always Dorothea? Was her point of view the only possible one with regard to this marriage? I protest against all our interest, all our effort at understanding being given to the young skins that look blooming in spite of trouble; for these too will get faded, and will know the older and more eating griefs which we are helping to neglect” (242). In this somewhat disingenuous and self-reflexive interlude, Eliot’s narrator compels readers to acknowledge their complicity in sympathizing for Dorothea at Casaubon’s expense. She quickly underscores the ethical consequences of this sympathy, suggesting that it is the duty of both
reader and narrator to attend to Casaubon’s perspective and “eating griefs” rather than “helping to neglect” them.

That duty, however, is clearly neglected in the scene above when Eliot’s free indirect style aligns the narrator with our protagonist Lydgate. This is an instance of what I will refer to as narrative sympathy, which, as Dorrit Cohn points out, has a long precedence of being associated with free indirect style. According to Cohn, “attitudes of sympathy or irony” are a necessary consequence of free indirect style (which she calls narrated monologue) because “they cast the language of a subjective mind into the grammar of objective narration,” which can “amplify emotional notes, but also throw into ironic relief all false notes struck by a figural mind.”17 Put simply, the “translation” of a character’s thoughts into the narrator’s words magnifies either their shared sympathy or the ironic distance between them. More recently, Koenraad Vermeiren argues that nineteenth-century novelists invoked free indirect style in order to purposefully and selectively bestow sympathy on characters “only when they can draw on certain cultural beliefs: the belief that the thoughts and feelings running through the character’s minds are not performative but authentic; the belief that these thoughts and feelings are a sign of adaptational strength; and the belief that among these thoughts and feelings, the latter tend to predominate.”18 For Vermeiren, free indirect style in the nineteenth-century novel represents sympathy between narrator and character as well as the narrator’s relinquishment of “cognitive dominance”; in moments of free indirect style, the narrator cedes cognitive control over a

character, instead granting her a depth and freedom of thought that is not equally bestowed on
other, less sympathetic characters.¹⁹

There can be no doubt that Eliot retains “cognitive control” over Nancy Nash, though not
over Lydgate. In this way narrative sympathy functions to endorse Lydgate’s assessments about
Nancy’s intellect, medical knowledge, and the difficulties of dealing with female patients.
Nancy’s case provides a more complete picture of medical knowledge and sympathy in
_Middlemarch_ because it demonstrates how Eliot deploys narrative sympathy in order to disallow
readerly sympathy for Nancy’s physiological sympathy. Through free indirect discourse as well
as the manipulation of narrative events, Eliot subtly compels readers to identify and sympathize
with characters whom she has imbued with moral worth. What critics have failed to notice,
however, is that the objects of Eliot’s sympathy are of epistemic, as well as moral, worth. More
than directing feeling towards or away from Lydgate and Nancy, what Eliot does is to channel
sympathy towards objects and methods of knowledge. Because he is supremely pragmatic and
empirical, Lydgate and his methodologies garner Eliot’s sympathy. In contrast, Nancy, as well as
the dubious knowledge and methods associated with her “wandering” tumor, are both treated as
obscure—both narratively and thematically—and thus undeserving of the reader’s attention and
sympathy.

The relationship between sympathy and knowledge in Eliot’s work is one that critics
have not failed to note. Reading across Eliot’s oeuvre, Ellen Argyros suggests that “one would
be hard-pressed to identify a more important or saturated abstract noun in her lexicon than
‘syrmpathy.’”²⁰ “Saturated” is an apt way to describe Eliot’s treatment of sympathy, and

¹⁹ Ibid., 54-56.
²⁰ Ellen Argyros, _Without Any Check of Proud Reserve: Sympathy and its Limits in George
Eliot’s Novels_ (New York: Peter Lang, 1999), 1.
Middlemarch in particular demonstrates a near constant preoccupation with the epistemic, ethical, and aesthetic implications of sympathy. Neil Hertz asserts that Eliot’s works are “explicitly about the imagining of others—about the status of the image of one person in the imagining mind of another—the play between the imaginer and the imagined, between author and character, and the possibility of a narcissistic confusion developing between the one and the other…” In addition to the possibility of “narcissistic confusion,” Hertz also argues that Eliot’s characters exhibit resistance as they confront the feelings and experiences of another. As a result of a “powerful narcissistic investment in an image of the self,” he suggests, the experience of imagining another and thus sympathizing with them often amounts to being “jolted into the consciousness” of another, with the “jolt” being all the more powerful because the resistance to this imagining and sympathizing is so great.

Nowhere is this difficulty more apparent than in Middlemarch, and in the relationship between Mr. and Mrs. Casaubon. Mr. Casaubon is shown to be mentally and emotionally impenetrable, and it is this quality that prevents Dorothea from fully knowing and loving him. Were Casaubon able to share his thoughts and feelings with his wife, perhaps Dorothea would not have so strongly resisted his entreaties for her to finish his life’s work. Michael Davis confirms Hertz’s argument about narcissism’s hindrance to sympathy, and sees egotism as a looming specter that not only haunts all of Eliot’s characters but is also representative of Eliot’s ambivalent stance towards the human mind: “As much as it celebrates the mind’s potential . . .

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22 Ibid., 29.
Eliot’s description always conveys a sense of its complexity, a complexity which threatens to defeat any attempt, by scientist, novelist or ethicist, to understand it comprehensively."^{23}

In the absence of an accurate imagining of another’s feelings, one is left with knowledge of the Other (and her mind) that is incomplete, partial, and likely shaped by one’s own ego and feelings.\(^{24}\) Argyros, Hertz, and Davis discuss psychosocial sympathy at length, but as my analysis of Nancy Nash suggests, there is more than one mode of sympathy in *Middlemarch*. Examining each of these modes rather than just psychosocial sympathy offers a stronger portrait of how Eliot understood sympathy, and it also illustrates the novel’s stance on the related issues of gender, medicine, and knowledge more clearly. While psychosocial sympathy is aligned with knowledge and shared understanding, Nancy Nash’s physiological sympathy is not given that privileged position, and is instead aligned with darkness and uncertainty. In this regard Eliot examines multiple modes of sympathy, imbues each with distinct assumptions about sex and gender, and subsequently manipulates the narrative in order to express favor or disfavor for particular kinds of sympathy. The physiological sympathy evinced through the charwoman’s feminized and phantom tumor is enough, in the eyes of the narrative, to warrant the reader’s loss of sympathy for her. Lydgate’s dogged attempts to gain knowledge, coupled as they are with his steady moral and sympathetic standards, earn him the respect of the narrative and the sympathy of the reader and the author. Examining the two cases in tandem makes clear that for Eliot,


\(^{24}\) This is dramatized in Lydgate and Rosamond’s courtship, when the narrator pities their mutual ignorance of the other: “Poor Lydgate! or shall I say, Poor Rosamond! Each lived in a world of which the other knew nothing” (155). Living only in their own “worlds,” or minds, Rosamond and Lydgate both lose sight of reality; while Lydgate fails to see his future wife’s narcissism, Rosamond likewise ignores any evidence of Lydgate’s shortcomings. Instead of sympathizing with each other, Rosamond and Lydgate are blinded by the projections of their own egoistical desires. *Middlemarch* punishes them quite ruthlessly for this egoism, too, trapping them both in a hapless marriage that provides neither with financial, emotional, or intellectual satisfaction.
different modes of sympathy are coded with assumptions of gender and associated with modes of knowledge. In her encouragement or disavowal of sympathy for certain characters, Eliot likewise encourages or denies types of knowledge and ways of knowing.

Nancy’s case, and its echoes of Paget’s *Lectures on Surgical Pathology*, demonstrates that the Victorians envisioned very distinct kinds of sympathy. It also underscores how different kinds of sympathy compelled intersections between disciplines such as physiology, philosophy, gynecology, and literature. It has been my contention thus far that Eliot’s allusions to physiological sympathy through Nancy’s tumor are also allusions to modes of knowledge. In the Trumbull and Nancy cases, Eliot opposes conflicting and gendered epistemologies, and clearly validates the methods and the objects of the former. *Middlemarch* also explores the link between physiological sympathy and knowledge through its treatment of hysteria. Medical texts and anxiety about hysteria multiplied in Britain throughout the nineteenth century, and as this dissertation suggests, it is at this time that the disorder became associated—both in literature and medicine—with sympathy. The result of this relationship is a series of discursive engagements that I have begun to outline in *Middlemarch*.

Another intersection between knowledge and sympathy is evident in Eliot’s descriptions of Dorothea’s obstetrical care and her symptoms of hysteria. In both cases Eliot explores multiple modes of sympathy in order to articulate and engage with gendered theories about knowledge. I’ll consider Dorothea in relation to Victorian understandings of hysteria first. For

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26 Logan argues that anxiety regarding hysteria increased at the end of the eighteenth century in part because the disorder, once largely associated with the aristocracy, had begun to manifest among the growing middle class. According to Logan, this new body was defined by its nervous susceptibilities, which were variously diagnosed as hysteria, hypochondria, melancholy, spleen, vapours, or simply nerves (Logan 1).
Jill Matus, Dorothea is coded as “mildly hysterical.” Matus explains Eliot’s allusions to Dorothea as a modern-day Saint Teresa, and argues that in Dorothea Eliot dramatizes the conflict between masculine productive and feminine reproductive energies. According to Matus, for Dorothea, “the world of ideals, the lofty realm, with male learning, knowledge, and truth,” is “symbolically the realm of the Father,” while “feminine affections and the yearnings of womanhood, at first so severely devalued in Dorothea’s hierarchy of worth, are associated with the Mother.”

Two things are of especial note here. First is Matus’s observation that masculine knowledge stands in opposition to feminine “affections and yearnings.” Though it is not her example, we see the opposition that Matus identifies in the contrast between Nancy’s alleged tumor and Trumbull’s pneumonia. In the first case the disease is thought to be subjective and even imaginary, while in the second it is clear-cut and treatable. Secondly, Matus cites hysteria as the outcome of this opposition. For her, the opposition is between male production and female reproduction, with women being repressed and identified only through their biological reproduction while men are linked to more lofty and intellectual pursuits. According to Matus, this opposition and repression makes the narrative a product of hysteria, since the narrative as a whole represses Dorothea’s productive and sexual energies and fails to articulate “the way gender and sexual difference are structured to support ideologically determined notions of female functions. . .” I agree with Matus, and would only add feminine ways of knowing to the opposition she identifies between male productive efforts and female reproduction. In Nancy’s

case in particular we see how Eliot denigrates knowledge gained from the female body, thereby further privileging masculine modes of knowledge.

Like Matus, it is not my intention to prove either that Dorothea or *Middlemarch* is hysterical. What my analysis does share with Matus’s is an insistence that Eliot’s novel consistently yokes gendered notions about knowledge to gynecological pathologies such as hysteria. Hysteria was a disorder that garnered attention in a wide-range of disciplines during the nineteenth century, including evolutionary biology, physiology, and psychology. Critics have thoroughly documented Eliot’s exposure to these fields, and we can assume that her exposure to hysteria theories was therefore considerable. In Dorothea, Matus sees Eliot anticipating Josef Breuer’s vision of Saint Teresa of Avila, the ambitious and socially repressed patron saint of hysteries. Though Eliot and Breuer both identify sexual repression as the primary cause of hysteria, Matus argues that *Middlemarch* goes further than Breuer and Freud’s *Studies in Hysteria* (1893-95) in its indictment of the restrictive nineteenth-century social structures that compelled repression and hysteria in “ardent” women like Dorothea Brooke. Matus’s analysis is richly suggestive, and is also helpful for its concise summary of the sporadic fits to which Eliot was herself subject. The scene in which Dorothea experiences a hysterical paroxysm after

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31 Matus cites two noteworthy examples, the first of which occurs in 1838, when loud music at a dance incites an hysterical fit in Eliot, and the second of which occurs when—according to John Cross—she exhibits “hysterical sobbing” at a Birmingham festival. See Matus, “Saint Teresa,” 231. Joan Bennet also confirms that Eliot was subject to “emotional excitability, fits of acute
interrupting Rosamond’s tête-à-tête with Will Ladislaw is quite telling in this regard, and as I will show, closely parallels the description of hysteria in Carter’s *On the Pathology and Treatment of Hysteria* (1853). Lewes and Eliot owned Carter’s treatise, and in Dorothea’s fit and its conclusion—Rosamond’s confession to Dorothea—Eliot draws on Carter’s understanding of hysteria as a disorder that is intimately tied to both the physiological sympathies of nerves as well as the psychosocial sympathy existing between individuals.

Carter classifies hysteria as either “simple” or “complicated.” By “simple” hysteria, Carter means cases in which the patient’s fits and their consequences are largely physical. Though serious, patients exhibiting “hysterical spine,” “hysterical knee,” “hysterical neuralgia, &c.,” differ from patients with complicated hysteria in that they are not prone to “moral and intellectual, as well as physical, derangement.” Regardless of the type of hysteria, Carter asserts that a primary hysterical fit, or “paroxysm” marks the start of “derangement”:

By hysteria, then, is intended a disease which commences with a convulsive paroxysm, of the kind commonly called “hysterical.” This paroxysm is witnessed under various aspects, and in various degrees of severity, being limited, in some cases, to a short attack of laughter or sobbing; and in others, producing very energetic involuntary movements, maintained during a considerable time, and occasionally terminating in a period of catalepsy or coma. The diagnosis (in so far as rules for it can be written down,) rests mainly upon the absence of epileptic characteristics, and the existence of some evident exciting cause, such as sudden fright, disappointment, or anger. (2-3)

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32 Carter, 3. Hereafter cited parenthetically in the text.
Like most nineteenth-century theorists of hysteria, Carter underscores the difficulty of assigning a diagnosis to a disorder that is defined negatively—by what it is not, e.g., epilepsy—and consists of a wide constellation of symptoms that vary between and within the same patient(s).

By Carter’s standards, Dorothea’s episode after seeing Rosamond and Will together is undoubtedly a hysteric paroxysm. Driving home from the encounter, Dorothea is stricken with a “self-possessed energy . . . that stimulated her beyond the susceptibility to other feelings. She had seen something so far below her belief, that her emotions rushed back from it and made an excited throng without an object. She needed something active to turn her excitement out upon. She felt power to walk and work for a day, without meat or drink” (597). Like Carter’s hysteric, Dorothea is overwhelmed by an inciting event that is profoundly upsetting. She is also overwhelmed by a crushing wave of emotions, which, significantly, have no outlet. Like the sexually repressed hysteric, Dorothea’s “throng” of feeling is stifled within her body. With this excess energy coursing through her nerves, Dorothea is highly susceptible to a hysterical paroxysm. And indeed, after talking with Mr. Farebrother—and becoming “alarmed at herself”—Dorothea returns home, where the “limit of resistance is reached . . . and the waves of suffering shook her too thoroughly to leave any power of thought. She could only cry in loud whispers, between her sobs” (604). These sobs shake Dorothea’s “grand woman’s frame,” and compel her to spend the night upon the “bare floor” (604).

At no point does Eliot explicitly identify Dorothea as a hysteric, but even without that narrative diagnosis any Victorian medical professional would have recognized Dorothea’s explosive feeling in the scene above as hysterical, not only because it was unusual and excessive for Dorothea, but also because any expression of extreme feeling in a woman would have been understood through the lens of hysteria. In addition, Dorothea manifests Carter’s dictate that
“emotion is a force adequate to the production of very serious disorders in the human frame” (25). Her circumstances also support Carter’s claim that women are more susceptible to hysterical fits of misdirected energy not only because they are more emotional than men, but because they are socially compelled to conceal their feelings. Like Dorothea, the hysteric lacks any outlet to “turn her excitement out upon.” Carter and his contemporaries hypothesized that because she was socially prohibited from purging her nervous energies, the hysteric’s energy became chaotically misdirected through the invisible sympathetic connections existing between, for instance, the breasts and the uterus—hence tender breasts during menstruation, mysterious mammary secretions during hysterical fits, or disordered menstruation in patients with breast cancer.

Unlike Carter’s hysteric, Dorothea does not exhibit unexplained “hysterical knee” spasms, nor does she secrete urine or experience unexplained heart palpitations. And yet Carter’s pathology is undeniably evident in Dorothea’s excessive feeling, in the impotence of that feeling, and in her subsequent fit of sobbing. Eliot quells any doubt about this diagnosis by pointedly referring to Dorothea’s episode as a paroxysm. It was “not in [Dorothea’s] nature, for longer than the duration of a paroxysm, to sit in the narrow cell of her calamity, in the besotted misery of a consciousness that only sees another’s lot as an accident of its own” (605). “Paroxysm” can be defined as “a violent attack or outburst of emotion or activity.” Given Eliot’s extensive reading in physiology, anatomy, and medicine, and also given the striking parallels between Carter’s understanding of hysteria and Dorothea’s fit, it would be naive to assume that Eliot intended for the word “paroxysm” to suggest any broadly characterized period of emotion or activity. Rather, in “paroxysm,” Eliot purposefully points to her heroine’s pathological state, and suggests that

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Dorothea’s experience is more specifically “an episode of increased acuteness or severity of a disease, esp. one recurring periodically in the course of the disease; a sudden recurrence or attack, e.g. of coughing; a sudden worsening of symptoms.” The word “symptoms” is key here because, as I have begun to suggest, Eliot imbues Dorothea with the pathological symptoms of hysteria that Carter outlines in his treatise on the disease. More than just the symbolic sexual repression that Matus identifies in Dorothea, Eliot quite literally diagnoses her heroine with hysterical symptoms. I have already indicated the first significant consequence of this diagnosis, namely, that it carries with it certain assumptions about the female body, its sympathies, and its status as an (invalid) object of knowledge. As a disorder that largely afflicts women and preys upon the female body’s sympathetic pathways, hysteria identifies the female body as unknowable, obscure, and thus pathological. Thus like Nancy Nash’s elusive tumor, Dorothea’s hysteria is in fact symptomatic of Eliot’s unease with the female body as an object of knowledge.

Unlike Nancy Nash, though, Dorothea is able to overcome her body’s physiological sympathy because she makes the difficult choice and effort to focus her energies on sympathizing with the Lydgates and their difficulties. The outcome of Dorothea’s hysterical fit therefore further valorizes the medical, ethical, and epistemological value of psychosocial sympathy. Medically, Eliot is quick to underscore that Dorothea possesses strength of will and body that far surpasses the typical hysterical. Luckily, Dorothea is “vigorous enough to have

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Ibid.

Typically, hysterics were thought to lack will power; rather than rationally processing emotion, hysterics succumbed to it. According to Carter, “even when an emotion is fairly established, its effects upon the muscular system are under the control of the will in some degree, and for a certain time” (21). Though he admits that will power alone is not enough to entirely prevent all hysterical outbreaks, Carter does argue that through will power one can better channel excessive feeling into appropriate—rather than pathological—physical outlets. Physiologically, hysteria was thought to literally degrade and weaken the nerves, making one more susceptible to fits after the first paroxysm. William Acton describes a similar erosion of the nerves that occurs
borne that hard night without feeling ill in body, beyond some aching and fatigue” (605). Though it is undoubtedly shaken by a paroxysm of sobbing, Dorothea’s body and nerves are apparently strong enough to bear the trial without lasting consequence. Part of the reason that Dorothea is able to recover physically is that she very quickly turns her thoughts to Rosamond in a profound extension of sympathy. Though she feels a deep and enveloping sorrow, Dorothea purposefully relives the encounter with Rosamond and Will, “forcing herself to dwell on every detail and its possible meaning,” and asking

Was she alone in that scene? Was it her event only? She forced herself to think of it as bound up with another woman’s life . . . All the active thought with which she had before been representing to herself the trials of Lydgate’s lot, and this young marriage union which, like her own, seemed to have its hidden as well as evident troubles—all this vivid sympathetic experience returned to her now as a power: it asserted itself as acquired knowledge asserts itself and will not let us see as we saw in the day of our ignorance.

(605)

Eliot is at pains in the passage above to underscore that knowledge is at stake in Dorothea’s effort to sympathetically “experience” Rosamond and Lydgate’s troubles. Dorothea’s search is one for “meaning,” and her sympathy is described as “acquired knowledge” that obliterates any previous ignorance. Of course, what’s most interesting in this scene is the fact that Dorothea’s sympathy is founded upon her “vivid,” but still subjective “representation” of the Lydgates’ marriage. In other words, her sympathy stems from her own biased and imaginative

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in patients who overindulge in sexual pleasure. Interestingly, Acton cites Paget, who concurs that the excessive stressed placed upon the spinal cord and nerves during sexual excitement and climax results in a loss or degeneration of nervous power. Acton, *Functions and Disorders of the Reproductive Organs in Youth, in Adult Age, and in Advanced Life, Considered in Their Physiological, Social, and Psychological Relations* (London: John Churchill, 1857), 36-37.
rendering of the events, and not from objective, empirical data. Because the narrative confirms that Dorothea’s assumptions about Rosamond and Lydgate are correct, we can presume that Eliot endorses Dorothea’s sympathy. This is apparent given that narratively it is Dorothea’s sympathy—her effort to reach out to someone suffering beyond the bounds of her own ego—that allows her to overcome the threat of hysteria. Psychosocial sympathy is what pulls Dorothea away from a self-absorbed misery that likely would have incited further hysterical fits. It also spurs the reconciliation between Rosamond and Dorothea, and ensures that Dorothea will learn the truth about her future husband. Epistemologically, Dorothea’s “vivid sympathetic experience” is tellingly equated with “power,” and is thus also implicitly and explicitly equated with knowledge. This “assertive” process allows her to “see” true reality, and strongly distinguishes her from Rosamond, who sees only with “pained confused vision” (609).36

This is a far cry from the dark obscurity signified through Nancy’s tumor and Dorothea’s hysterical fit. While the female body’s physiological sympathies remain shrouded in darkness and uncertainty, Dorothea’s mental acuity and sympathetic understanding allow her access to light, knowledge, and truth. Like her heroine, Eliot sees the problematic female body as a necessary sacrifice in the pursuit of rational masculine truth. Though this rational masculine truth is achieved through Dorothea’s keen understanding and, we might say, maternal sympathy,37 it is

36 Significantly, Dorothea’s first action after sympathizing with Rosamond is to open the curtains in her room, allowing light to spill in where it could previously only “pierce” the space. With her “curtains” open and light shining, Dorothea turns to observe several figures moving in a nearby field, and it is at this moment—one of compassionate observation and keen sympathetic understanding—that Dorothea feels “the largeness of the world” and understands that “she [is] part of that involuntary, palpitating life, and could neither look out on it from her luxurious shelter as a mere spectator, nor hide her eyes in selfish complaining” (606).

37 Matus argues that Eliot aligns Dorothea with maternity through her allusions to the Madonna, who, like Dorothea, represents a union between sexual and maternal energies. See Matus, “The Iconography of Motherhood: Word and Image in Middlemarch,” English Studies in Canada 17, no. 3 (1991): 283-300. We might also identify Dorothea’s sympathy for Rosamond as maternal
nonetheless privileged and supposedly superior to the “knowledge” derived from the hysteric’s body. The conflict between these two modes of knowledge is even more evident in Dorothea’s emotional response while meeting with Rosamond. She is overwhelmed by feeling, a fact that—given her previous hysterical fit—predisposes her to another, and another, and another, and so on. Yet rather than the slow erosion of Dorothea’s will power in the face of her intense emotion, and despite the fact that Dorothea’s “frame” is “as dangerously responsive as a bit of finest Venetian crystal” (609), Eliot’s heroine manages to direct her emotion outward. Even though her heart swells and she demonstrates the classic hysterical symptom globus hystericus in her initial inability to speak, Dorothea’s “emotion only passed over her face like the spirit of a sob” (609). This “spirit” opens Rosamond’s soul, which she had previously wrapped in “cold reserve,” and allows her to see that Dorothea’s intentions are purely benevolent.

What Eliot describes here is the hysteric’s struggle to channel excessive emotion properly. But unlike the hysteric, whose weakened will and weakened nerves put her at the mercy of every passing feeling or sensation, Dorothea’s intense effort to sympathize with Rosamond quells the physiological and “dangerous” force of her feeling. Rather than remaining trapped in the obscure pathways of her body as physiological sympathy, Dorothea’s hysterical feeling is translated outwards into a sphere of light, knowledge, and truth. Paradoxically, then, Eliot suggests a mode of knowledge that relies on (maternal) sympathy, and yet is supremely disembodied and even antagonistic to the female body—especially its physiological sympathies. Psychosocial sympathy, it seems, is the only healthy outlet for excessive feeling, since without that outlet physiological sympathy and hysteria destroy one’s nerves and willpower, not to mention the doctor’s ability to diagnose the condition. While women with exceptionally strong

because it is with “gentle motherliness” that Dorothea extends her “maternal” hands to Rosamond, thus prompting their understanding and reconciliation (Eliot, 609, 59).
physical frames can channel excessive feeling into psychosocial sympathy and knowledge, the rest risk losing truth and knowledge when they turn inwards towards their female bodies rather than outwards towards shared feeling with others. Thus in the hysteric’s capitulation to her physiological sympathies or in Rosamond’s inability to see past her own struggles, egoism and the female body emerge as potential prisons without possibility of knowledge.

The ethical implications of these prisons are made plain in the Lydges’ fate. After Dorothea’s departure, Rosamond quickly throws herself upon the sofa in “resigned fatigue,” and bewails to Lydgate that “if you go to talk to her so often, you will be more discontented with me than ever!” (614). Despite her exchange with Dorothea, here Rosamond reveals her profound inability to see beyond her own egoistic needs and desires. Tellingly, Eliot concludes this chapter by noting that Lydgate “accepted his narrowed lot with sad resignation. He had chosen this fragile creature, and had taken the burthen of her life upon his arms. He must walk as he could, carrying that burthen pitifully” (614). The “narrowness” of Lydgate’s future life and “lot” is a striking contrast to the “incalculably diffusive” (640) effect Dorothea is said to have on those around her at the close of the novel. It is also significant that Rosamond’s lingering egoism excludes Lydgate from the sphere of knowledge that is closely aligned with psychosocial sympathy. Though he originally intends to expand on the work of the “great seer” Xavier Bichat by exposing the “more intimate relations of the living structure” (142, 143), the “burthen” of caring for Rosamond ultimately forces him to research the more lucrative disease of gout. Spending the rest of his life between London and various “Continental bathing-place[s]” (637), Lydgate’s intellectual sphere is thus considerably narrowed as well, since rather than discovering
the most fundamental of living tissues, he instead investigates a non-life threatening disease that “strikes” the affluent as a result of over indulgence in food and drink.  

Thus far, I have argued that in Dorothea psychosocial sympathy acts as an epistemic and ethical tool. I have also suggested that in Middlemarch this tool is strongly opposed to the female body, which, along with egotism, is linked to darkness and the absence of knowledge. In the conclusion of this chapter, I’d like to suggest how this conception of knowledge, sympathy, and the female body pertains to Eliot’s description of Dorothea’s pregnancy and labor. If Dorothea’s “frame” is not fragile, but “grand”; if, by virtue of her profound sympathy and understanding with others she is able to evade continued hysterical fits and her body’s physiological sympathies; and if, therefore, Dorothea and her body are aligned not with dark obscurity but with knowledge, truth, and light, then it is especially striking that Eliot circumvents the reader’s ability to see and know Dorothea’s struggle in childbirth. Eliot’s elision of the birth has not garnered critical attention, most likely due to entrenched assumptions about Victorian prudishness. In addition, the critical disfavor aroused by the (allegedly) gratuitous portrayal of Hetty Sorrel’s pregnancy and birth in Adam Bede (1859) may have led critics to assume that Eliot was keen to avoid similar criticism in Dorothea’s case.

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38 Interestingly, Carter’s hysteria treatise identifies gout as a disease that, like hysteria, predominates among the “wealthier and more luxurious classes” (90). He also suggests that it might be a “predisposing” condition for hysteria, in that it “appears to produce an especial proclivity to hysteria affections of the muscular system” (90).

39 The most famous of these was an unsigned review in Saturday Review, in which the anonymous author censured Eliot’s habit of “dating and discussing the several stages that precede the birth of a child.” The “literature of pregnancy” exemplified by Adam Bede is declared “intolerable,” and the author demands that contemporary authors “copy the old masters of the art, who, if they gave us a baby, gave it us all at once” (76). Unsigned review, Saturday Review 8 (26 February 1859), quoted in David Carroll, George Eliot: The Critical Heritage (New York: Barnes and Noble, 1971).
These are plausible, but not sufficient explanations. In light of the narrative, physiological, and psychosocial sympathies that I have outlined in *Middlemarch*, and in Dorothea in particular, Eliot’s scant description of her birth and labor deserves a more thorough explanation. Unlike her portrayal of Dorothea’s hysterical paroxysm, Eliot relays the details of her labor obliquely, through the pretense of a letter delivered to Celia:

But that morning something exciting had happened at the Hall. A letter had come to Celia which made her cry silently as she read it; and when Sir James, unused to see her in tears, asked anxiously what was the matter, she burst out in a wail such as he had never heard from her before. “Dorothea has a little boy. And you will not let me go and see her. And I am sure she wants to see me. And she will not know what to do with the baby—she will do wrong things with it. And they thought she would die. It is very dreadful! Suppose it had been me and little Arthur, and Dodo had been hindered from coming to see me! I wish you would be less unkind, James!” (638)

In this description of Dorothea’s delivery, I see a conspicuous selection of one narrative possibility at the expense of another. Inherent in these narrative possibilities, I argue, are underlying assumptions about the female body’s relationship to knowledge and sympathy. In the scene above Eliot transfers the site of knowledge from Dorothea’s body and her intimate experience of it to Celia’s experience of receiving a letter. Even if the basic events remained unchanged, we might expect the narrator—not Celia—to relate Dorothea’s labor and near-death; this would have been more consistent with her central status in the novel. It would also have the added benefit of reinforcing Dorothea’s bodily strength, which Eliot previously correlated with her ability to experience psychosocial sympathy after her hysterical paroxysm. Like that scene, the treatment of Dorothea’s labor suggests the intricate relationship between sympathy and
knowledge, though in the latter case Eliot denies Dorothea sympathy by withholding knowledge about her body and struggle to give birth. Indeed, in Celia’s exclamation that her sister “has” rather than “has had,” Eliot seems to imply that there has been no birth whatsoever; apparently Dorothea’s son does appear “all at once.” One might argue that what Eliot has done here is to further affirm the necessity of psychosocial sympathy, since Celia is in part concerned for her sister, and that concern ultimately mends the rift between the Ladislaw and Chettam families. But Celia is no ethical paragon, and her response is largely a petulant chastisement of Sir James’s stubbornness as well as an egoistic comparison between Dorothea’s maternal inadequacy and her own superior skills.

Further, it remains unclear who attends Dorothea in her delivery and why she nearly dies. Given the higher puerperal death rate during the nineteenth century, Dorothea’s near death is perhaps unremarkable. However, this explanation fails to fully explain the offhanded description of Dorothea’s labor, particularly because *Middlemarch* is a novel that explicitly assesses the status of medicine in Britain during the nineteenth century, including specific facts about the shifting hierarchy between medical practitioners. *Middlemarch* also consistently evokes and explores the connection between knowledge and sympathy, as well as privileging the truth of psychosocial sympathy at the expense of the dubious physiological sympathies of the female body. In short, none of the explanations for the novel’s elision of pregnant and laboring

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40 According to Irvine Loudon, the puerperal death rate from the mid-nineteenth century to the mid-1930s was approximately four to five deaths per one thousand births. This varied significantly between different regions, and included those women who died during pregnancy, labor, or the lying-in period, which generally lasted from four to six weeks after birth. Loudon, “Deaths in Childbed from the Eighteenth Century to 1935,” *Medical History* 30 (1986): 1-41. According to a 2010 study by *The Lancet*, the maternal death rate in the United Kingdom from 1980-2008 was 8.2 deaths per 100,000 births. Margaret C. Hogan et al., “Maternal Mortality for 181 Countries, 1980-2008: A Systematic Analysis of Progress Towards Millenium Development Goal 5,” *The Lancet* 375, no. 9726 (8 May 2010): 1609-1623.
bodies are sufficient. At the very least, Eliot might have attributed Dorothea’s near-death to puerperal fever and/or given some indication of how she fared during her trial. Doing this would have been more fitting for Dorothea and Eliot’s characterization of her as a woman who is strong enough to overcome conditions that would overpower a weaker woman.

I am not suggesting that Eliot should have conveyed every minute detail of Dorothea’s labor. *Middlemarch* is far more than a “literature of pregnancy,” and to reduce it as such would be to miss the scope and significance of Eliot’s work. But it is fair to say that the absence of information on Dorothea’s labor is conspicuous. Indeed, the text doesn’t identify the attending medical practitioner in any of the deliveries in *Middlemarch*, including Dorothea and Celia’s childbirth and Rosamond’s miscarriage. Even without “excessive” detail, Eliot might have identified the caretakers in these cases without violating any social convention, and given that the novel identifies who presides over every other medical case, this is a striking omission that suggests a lot by what it doesn’t state explicitly. For example, though their elevated social status makes it unlikely, the novel’s omission prompts the reader to consider the possibility that a midwife looked after the three women during their pregnancies and labors; while there is no mention of any midwife in the novel, the complete omission of one would actually mirror how the novel effaces maladies and patients that are distinctly feminine.

As you can see, obstetric cases and female pathologies in Eliot’s novel are unnamed and treated by unknown practitioners. I have argued that this narrative obscurity identifies the female body as an epistemic obscurity. Like Nancy Nash’s wandering tumor, Dorothea’s labor is another instance of Eliot’s discomfort with the female body as a source of knowledge. Signifying

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41 Interestingly, at the time when Eliot writes *Middlemarch*, the likelihood that genteel women would have used the services of a midwife is quite low. At the time when the novel is set, however, between 1830-32, male doctors and surgeons were not yet considered the only option for obstetric care.
her heroine’s tribulation through absence and uncertainty, Eliot implies that the female body—
unlike Trumbull’s strong male constitution—is not open to be read, understood, and constituted
as knowledge, whether that knowledge is medical, e.g. the etiology of Dorothea’s condition, or
sympathetic, e.g. narrative exposition of the events and the consequent likelihood of the reader’s
sympathy. In spite of her vast capacity for knowing and understanding others’ minds, Dorothea’s
psychosocial sympathy remains tied to the prison of her female body. Ultimately she is able to
evade the hysterical egoism inherent in this body, but only through concerted effort. Argyros
reminds us that for Eliot sympathy is a deliberate and difficult act—an instance of what she calls
“psychoethical work.”42 In my reading of Middlemarch, I have attempted to show that for
women, sympathy is also physiological work, both on the part of the female struggling to quell
her body’s chaotic nervous sympathies, and on the part of Eliot, who struggles—
unsuccessfully—to shine knowledge and narrative sympathy on that body.

42 Alicia Christoff makes a related point, arguing that weariness is the constant companion of
sympathy in Eliot’s novel. For Christoff, this correlation indicates the significant work and
potential for error in imagining what another feels: “Middlemarch thematizes the necessity of
looking beyond the self as well as its difficulty, examining the insecure separation of the object
from the sympathetic subject’s conception of him” (146). Christoff, “The Weariness of the
Victorian Novel: Middlemarch and the Medium of Feeling,” English Language Notes 48, no. 1
CHAPTER THREE

Shared Feeling and the Re却ke of Naturalism in George Moore’s Esther Waters

For all his French sympathies Mr. Moore has read the English heart aright. He has seen the
springs that keep it wholesome, divined the consolations that keep it from being altogether
debased.

-G-Y, “Esther Waters”¹

…and all [Moore] writes with knowledge vivified by sympathy, and sympathy directed to the ends
of art. But in the name of art one is bound to add that here and there a truer sense of proportion
would have ensured a more powerful effect. There are many details that could well have been
spared—details which detract from the weight or prominence of larger interests.

-George Cotterell, “New Novels”²

Both of these reviews underscore the complex relationship between knowledge and
sympathy in Victorian literature. Despite differing conclusions, both reviewers implicitly
acknowledge the moral and aesthetic consequences of a novel’s ability to balance knowledge and
sympathy: too much of the former, and a text becomes “debased”; not enough of the latter, and a
novel fails to attain the “ends of art.” For Cotterell, the novel and the knowledge it contains
represent a kind of Frankensteinian monster that requires sympathy in order to “come alive” or
be “vivified.” In his assessment of Esther Waters, G-Y praises Moore for mitigating his

Continental sympathies, and argues that this allows the novel to feed the deep “springs” of the English reader’s heart. Cotterell, on the other hand, argues that *Esther Waters* oversteps the balance of knowledge and sympathy with details that “detract” and from which the reader might have been “spared.” Along with the degrading effects of gambling and drinking, Esther’s pregnancy and childbirth are undoubtedly these kinds of details.

It is no coincidence that the objectionable material in *Esther Waters*, namely, the scene in which she delivers her son in a London maternity hospital, was criticized on the basis of its proportion of knowledge to sympathy. However, though he received criticism for his naturalistic portrayal of childbirth, Moore’s depiction of labor and birth is much more exceptional for the way it privileges how Esther feels. Moore accomplishes this through the use of free indirect style, as well as by privileging Esther’s experiences over the cold, harsh gaze of her doctors. Neither the author nor Esther’s doctors coldly dissect her, and instead Moore provides an intimate portrait of Esther’s subjectivity, one that compels the reader to feel for and with Esther. Esther is thus “vivified” through the sympathy of the author and reader rather than silenced by an author or doctors who would destroy her in order to know her; in this regard Moore’s novel represents a critique of the literary and gynecological methods that would otherwise reduce her to a social type or a medical case.

I’ll begin this chapter by assessing the role of genre in Moore’s novel, after which I’ll turn to two elements of the novel that garner frequent attention. These are Esther’s pregnancy and birth, and Esther’s class status, in particular the extent to which she functions as a social “type” rather than a relatable human subject. Genre is of particular concern for two reasons. First, as I will demonstrate throughout this chapter, the debates about realism and naturalism at the end of the century were, at the core, debates about how knowledge—how much and about
whom—impacted the author’s and reader’s ability to sympathize with fictional characters.

Secondly, Moore’s style was strongly influenced by other authors as well as a number of literary styles and movements. According to Moore himself, he was a “smooth sheet of wax, bearing no impress, but capable of receiving any; of being moulded into all shapes.” We might alternately identify Moore with realism, naturalism, aestheticism, or symbolism, and by tracing these different styles in Moore’s work it becomes more clear how point of view, shifts in narration, and narrative voice alter what we know about and how we feel for his characters. For this reason, Moore’s work is an ideal starting point for considering how literary genre and narrative style shape the relationship between sympathy and knowledge.

The most notable of these impressions was made by the French naturalist Émile Zola; this man’s influence spurred Moore’s career as a novelist and also earned Moore the scorn of Victorian literary critics, who quickly condemned him as the wrong kind of realist. Yet Moore was quickly captivated by the naturalist and his aesthetic. After reading “Le Roman Expérimental” in 1879, Moore felt as though he had experienced a blow on the head or “the pain and joy of a sudden and inward light.” As Moore put it, “The idea of a new art based upon science, in opposition to the art of the old world that was based on imagination, an art that should explain all things and embrace modern life in its entirety, in its endless ramifications, be as it

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were, a new creed in a new civilization [sic], filled me with wonder, and I stood dumb before the vastness of the conception, and the towering height of the ambition.”

Though Moore’s infatuation with Zola would be relatively short lived, the French author’s influence was not. As Carol Ohmann notes, “the influence of naturalism on his materials and methods appears, sometimes more, sometimes less, throughout the eighties and the early nineties.” At the height of his adoration of Zola, Moore wrote two texts that would have far-reaching consequences for his reputation, for the realist novel, and for its mode of publication. The first of these was his novel *A Mummer’s Wife* (1885), in which Moore chronicles the tragic downfall of Kate Ede, a Hanely dressmaker who leaves her husband for a traveling actor only to die alone and in poverty from alcohol-induced liver failure.

The second was his polemic against the circulating libraries, *Literature at Nurse, or Circulating Morals* (1885), which Peter Gay identifies as one of many liberal protests against Victorian censors and their “heavy-handed efforts to infantilize fiction.” In his pamphlet Moore rails against librarians Charles Mudie and W.H. Smith, arguing that their control of the market prohibited the novelist from truthfully depicting reality. Gay confirms as much, noting that

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5 Ibid., 94-95.
6 In *Confessions*, which was first published in 1888, Moore compares his former master’s work to “the dregs of yesterday’s champagne,” declaring that they are but “the simple crude statements of a man of powerful mind, but singularly narrow vision” (95).
9 Moore’s antipathy towards these men was sparked when Smith withdrew Moore’s *A Modern Lover* (1883) from circulation after two female readers objected to its depiction of a woman posing nude for an artist’s painting. Moore was particularly incensed by the librarians’ censorship of his novel because *The Spectator* had reviewed it favorably, even declaring that Moore depicts the offending scene with “skill and beauty.” The reviewer admits that Moore seems to admire Zola, though in his opinion Moore will never succeed in imitating Zola’s
Mudie and Smith inspired “a certain crippling self-censorship, an anxious anticipation of official action that markedly interfered with most writers’ intentions to say what they like about sensuality,” and argues that these efforts, in addition to editorial censorship, were part of the censors’ attempts to identify with, and act as the voice of, the Victorian bourgeoisie. According to Gay, however, instead of drawing out bourgeois ideals and values, Victorian censors drew a caricature of the prevalent bourgeois concerns with the mastery of passion and the segregation of clean from dirty thoughts; the boundary that the censors and their instigators drew around permissible expression was far too narrow, their threshold of disgust for the public airing of natural processes far too low, to be truly representative of their middle-class culture. They acted like an exigent, punitive cultural superego.

I refer to these texts because they were a fundamental part of end-of-the-century debates about the publishing business and the role of sympathy and truth in fiction. Moore wrote *A Mummer’s Wife* with the express intent of publishing it in a one-volume format, selling it directly to the public, and thus circumventing the circulating libraries. Following his success with this venture, he expanded his 1884 article “A New Censorship in Fiction” into *Literature at Nurse*, in which he bewails that Mudie, a mere “tradesman,” controls English fiction through his decision to circulate a book or not. When an individual purchases a book, Moore argues, that piece of literature must necessarily be “at once national and pregnant with the thought of the epoch in which it is written.” Books promulgated by the lending libraries, in contrast, consist of


10 Ibid., 364.

11 Gay recounts the career of Thomas Hardy, who was on numerous occasions persuaded by various editors to soften his treatment of sex. Often, Gay notes, editors claimed that it was not their delicate sensibilities that had to be protected, but those of their readers (412).

12 Ibid., 379.
sentimental and contrived plots that pander to Mudie’s tastes rather than observing modern life in its deepest and darkest manifestations. While Mudie offers novels that are filled with “the pretty schoolroom,” “water-colour drawings,” and a “piano tinkling away,” Moore asserts that the “dissection of a healthy subject” is the proper purpose of a novel and that “a religious or sensual passion is as necessary to the realistic novelist as a disease to the physician.”

Like Zola, Moore defines his era as a scientific one and invokes the medical examination as a metaphor for the novel. Moore compares the novelist’s task to a dissection, or what Zola called the act of dismembering and scrutinizing “piece by piece this human machinery in order to set it going through the influence of the environment.” Clearly, then, there is no mistaking the naturalistic undercurrent in Literature at Nurse. In addition to arguing that literature must embody the “spirit of scientific inquiry that is bearing [his] age along,” Moore suggests that the novelist’s task is to autopsy human passions just as a doctor performs an examination or postmortem. This vision of the novel is thus naturalistic in both its taboo subject matter as well as its approach to that subject, and it is precisely these two characteristics that Garnet Smith deplores in an 1888 article on the graphic and immoral content of the modern realist novel. For Smith, Zola’s debased characters constitute a literature of pathology, or a study of that which is diseased rather than “normal” or healthy. To “produce a novel of the prevalent type,” Smith

15 Though he refers to this type of novel as realist, his target is not the realist novel per se, but those novels that embody the “scientific doctrine of the milieu, the doctrine of the influence of the environment, the evolutionary theory that imperfection, unhappiness, and suffering are due to the fact that as yet the equilibrium between man and his surroundings is not complete. . .” (120). For Smith, these “realist” novels supplanted the romantic tradition, in which psychology and sentiment, rather than pathology and sensation, were preeminent. Smith, “Gustave Flaubert,” The Gentleman’s Magazine 265 (1888): 120-131.
writes, “it is but necessary to study the life of some poor creature under the ban of society or belonging to the degraded classes.” Most importantly, sympathy for this “poor creature” is prohibited: “above all, no sympathy must be displayed by the author; and it is this utter indifference, this lack of sympathy, which above all else renders the theory and its results so hateful and disgusting, and will prove its death blow.”

As Smith makes clear, a novel’s proportion of knowledge to sympathy was a strong source of anxiety, nevermore so than when the subject matter of the novel was someone or something defined as foreign. And while it would be overstating matters to suggest that Moore read widely in gynecology and used his fiction to evoke that field’s preoccupation with sympathy, knowledge, and the female body, he does make use of a gynecological metaphor in his excoriation of Mudie. I will cite it at length to illustrate its graphic nature and import:

Literature is now rocked to an ignoble rest in the motherly arms of [this] librarian. That of which he approves is fed with gold; that from which he turns the breast dies like a vagrant’s child; while in and out of his voluminous skirts run a motley and monstrous progeny, a callow, a whining, a puking brood of bastard bantlings, a race of Aztecs that disgrace the intelligence of the English nation. Into this nursery none can enter except in baby clothes; and the task of discriminating between a divided skirt and a pair of trousers is performed by the librarian. Deftly his fingers lift skirt and under-skirt, and if the examination prove satisfactory the sometimes decently attired dolls are packed in tin-cornered boxes, and scattered through every drawing-room in the kingdom, to be in

16 Ibid., 121.
rocking-chairs fingered and fondled by the “young person” until she longs for some newer fashion in literary frills and furbelows.17

Moore’s language inspires near visceral disgust, largely because he adopts a gynecological metaphor in order to illustrate the unnatural consequences of the circulating library system. Comparing Mudie’s patronage to breastfeeding; likening his empire to “voluminous skirts” that are ominously vast and filled with degenerate (and Aztec) offspring; suggesting that Mudie’s inspection is akin to examining a child’s genitalia: in these examples Moore draws on several taboo topics or images in order to convey his distaste for the circulating libraries. More specifically, these topics include breastfeeding, especially the controversial fate of the “vagrant’s child,”18 the cavernous female body, particularly if she is marked as racially, socially, or genetically Other, and the highly fraught physical examination, here coded as a male investigation underneath female “skirts” and “under-skirts.”

Moore draws on a kind of gynecological fascination that stems from a desire to examine and know the foreign female body. Although it was a relatively new and still somewhat taboo field, the passage above suggests that gynecology was not an obscure field with which few authors and readers were familiar. Rather, Moore’s description indicates that debates in gynecology permeated other disciplines and mediums, and were part of a dynamic network of ideas that circulated within the Victorian cultural consciousness. Literature at Nurse is also

17 Moore, Nurse, 18.
18 The fate of the “vagrant’s child” is significant because of the baby-farming episode in Esther Waters. In that scene, Esther is horrified to learn that Mrs. Spires, the woman whom she hired to look after her son Jackie while she works as a wet nurse, actually conspires with wealthy women to neglect and kill the babies in her charge. Paul Sporn traces this episode to an 1890 article written by one of the founders of the National Society for the Prevention of Cruelty to Children, and argues that Moore was well informed of the various social, political, and medical issues that he represents in his fiction. Sporn, “Esther Waters: The Sources of the Baby-Farm Episode,” English Literature in Transition, 1880-1920 11, no. 1 (1968): 40.
useful because it correlates the study of the female body with the epistemic value of sympathy. For example, in his argument against reading books from the lending libraries, Moore asserts that sympathy is lost when a reader fails to purchase a novel. In that case, “the bond of sympathy that should exist between reader and writer is broken—a bond as sacred and as intimate as that which unites the tree to the earth—and those who do not live in communion with the thought of their age are enabled to sell their characterless trash; and a writer who is well known can command as large a sale for a bad book as a good one.”

Moore argues that sympathy grows from the transference of knowledge. Information offered by the author, once taken up by the reader, constitutes a bond of which shared feeling is the result. Moore directly correlates this process of shared feeling to shared knowledge when he privileges those novels that are in “communion with the thought of their age.” Apparently, it is the novelist’s duty to remain abreast of the thought—e.g. science, medicine, philosophy—of his day, and it is the goal of fiction to express that knowledge in a medium, and a marketplace, that foster sympathy between author and reader.

In contrast to this process of shared knowledge and feeling, Moore defines the library book as a distinctly feminine threat to the sympathetic bond between author and reader. In addition to likening Mudie’s books to dolls in skirts, Moore identifies young women as the source of Mudie’s vast enterprise. Hence the infantile nature of English fiction in Mudie’s “nursery,” since the “young person” is prohibited from reading works that threaten her innocence. Because “the British mamma is determined that her daughter shall know nothing of life until she is married,” Moore argues, “English literature is sacrificed on the altar of Hymen.” Sally Ledger sees Moore’s argument for truth in fiction as part of the new realists’ effort to reclaim the literary marketplace from female readers and authors. According to Ledger,

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20 Ibid., 20-21.
Moore, George Gissing, and Jack London “had as their aim the creation of ‘‘‘new’ form of realism, (heavily influenced by the Zolaesque school of literary naturalism).” For this reason new realism “carefully announced itself as ‘serious’ literature rather than as entertainment, a type of fiction which would be beyond the ken of women writers, who supposedly specialised in the more confined domestic world of romance and marriage.”

To be fair, Moore’s primary objective was not to eliminate female authors and readers entirely, but rather to demand a literary marketplace in which the author could “write as grown-up men and women talk of life’s passions and duties” without concern for Mudie’s taste or those of his female readers. The alternative was to grant Mudie, who was a “fetter about the ankles of those who would press forward towards the light of truth,” the continuing power to shape English fiction based on his personal tastes and morals. The consequence, Moore suggests, is that the English novel will be infantilized, feminized, and incapable of successfully communicating knowledge and spurring shared feeling.

Just as a woman’s physiological sympathy prevented the doctor from diagnosing her, so too did the female reader disrupt the proper balance between knowledge and sympathy. They are divergent disciplines, but here we see literature and medicine articulating a shared concern about the way women—whether through textual choices or literal bodies—affect the status of knowledge through their ability to influence sympathy. For the gynecologist, the female body’s unexplained physiological sympathies, along with the difficulties of treating female patients, disrupt the doctor’s ability to reach an accurate medical diagnosis. For Moore, the knowledge that is supposed to be transmitted from reader to author is disturbed as a result of the female

\[21\] Sally Ledger, *Fiction and Feminism at the fin de siècle* (Manchester: Manchester University Press, 1997), 179.


\[23\] Ibid., 16.
reader’s restricted reading selection. In this way female readers hinder the reciprocal feeling that ought to accompany the sharing of textual knowledge. Thus even though they were engaging with different forms of sympathy and different kinds of knowledge, in literature, as in medicine, we see that gendered bodies can become problematic when they disrupt the “normal” or “natural” relationship between knowledge and sympathy.

In *Esther Waters*, the correlation between knowledge, sympathy, and the female body is evident in the moment when Esther realizes that she is “in trouble.” By contrast, Eliot’s *Adam Bede* and Thomas Hardy’s *Tess of the D’Urbervilles* (1891), two contemporaneous novels with heroines who become pregnant, elide the moment in which the heroine learns that she is pregnant. The first allusion to Hetty Sorrel’s condition in *Adam Bede*, for example, is the title to chapter thirty-five, “The Hidden Dread.” Eliot later provides more detail retrospectively, when Hetty is further along in her pregnancy and the narrator reflects that “after the first on-coming of her great dread, some weeks after her betrothal to Adam, she had waited and waited, in the blind vague hope that something would happen to set her free from her terror. . .”.24 In *Tess*, Hardy does not even describe the period of Tess’s realization and early pregnancy, but rather shifts the narrative forward to after she has delivered her baby. The reader only learns that Tess is a mother when the narrator voyeuristically observes her breastfeeding during a break from work. I use the word voyeuristically quite purposefully, since the narrator describes the field, the labor, and the laborers (including Tess) in some detail before revealing that one of the young women being watched is, in fact, Tess Durbeyfield.25 This narrative defamiliarization is a far cry from Moore’s intimate portrayal of Esther’s physical and emotional response to pregnancy. While *Adam Bede*

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does represent Hetty’s realization, Eliot’s chapter title and its intimations of something secretive or hidden suggest that—like the narrator of Hardy’s novel—Eliot’s narrator remains quite removed from Hetty in the moment that she realizes she is with child.

Unlike *Adam Bede* or *Tess of the D’Urbervilles*, Moore’s novel allows the reader to share in the moment that Esther realizes that she is pregnant. This privileges Esther’s perspective and experience of the events, as opposed to Eliot’s and Hardy’s novels, which rely on the narrator’s perspective and description of events. Esther’s realization occurs “one afternoon at the beginning of December,” when “Mrs. Latch had gone upstairs to lie down, and Esther had drawn her chair towards the fire”26:

> She did not think—her mind was lost in vague sensation of William, and it was in this death of active memory that something awoke within her, something that seemed to her like a flutter of wings; her heart seemed to drop from its socket, and she nearly fainted away, but recovering herself she stood by the kitchen table, a deathlike pallor over her face, with drops of sweat on her forehead. The truth was borne in upon her; she foresaw the drama that awaited her, from which nothing could free her, which she would have to live through hour by hour. And it seemed so dreadful that she thought her brain must give way. (85)

Rather than eliding the moment when Esther realizes her pregnancy, Moore gives a precise register of Esther’s psychological state as she processes her condition and its consequences. The

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narrator knows Esther’s conscious thoughts and memories as well as those that are subconscious or “inactive.”

The passage above stringently relays the physical experience of Esther’s realization. The narrator doesn’t tap into Esther’s active memories of the sexual encounter that causes her condition, or describe her calculating the dates of her missed menstrual cycle. But Moore does give a minute description of the physical sensations that incite and follow Esther’s epiphany, relating how her heart drops from its “socket,” how a deathly “pallor” sweeps over her face, and how her forehead becomes covered with beads of sweat. Moore doesn’t utilize the kind of scientific jargon that we see in Eliot, though he is still remarkably attentive to the medical symptoms of pregnancy and anxiety. While Eliot and Hardy relate only the fact of their heroine’s pregnancy, Moore shares the physical symptoms and subconscious memories that give rise to Esther’s realization—so much so that the reader experiences the epiphany along with her instead of being told about her condition much later and/or from an external perspective. Put simply, Moore expresses what and how Esther feels in a way that Eliot and Hardy do not. This is

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27 With a different narrator, this intrusion into Esther’s consciousness might be read as imperialistic or condescending. In the case of *Esther Waters*, however, the narrator is so consistently true to Esther’s perspective, that here I think the intrusion into Esther’s consciousness is more accurately described as sympathetic rather than condescending or heavy-handed. In contrast to Annette Federico, who argues that Esther’s voice competes with the narrator’s tone of objectivity, I agree with Siobhan Chapman that the relationship between Esther’s voice and that of the narrator is “harmonious” (320). Federico, “Subjectivity and Story in George Moore’s ‘Esther Waters,’” *English Literature in Transition* 36, no. 2 (1993): 141-157. Hereafter cited parenthetically in the text. Chapman, “‘From their Point of View’: Voice and Speech in George Moore’s *Esther Waters,***” *Language and Literature* 11 (2002): 320. Hereafter cited parenthetically in the text.

28 Moore may have been purposefully challenging elements of *Tess* that he disliked. According to Frazier, Moore was “involved in a passionate contestation of Hardy’s tale” during the summer in which he wrote *Esther Waters*, as evidenced by his choice of a mundane rather than romantic name for his heroine, the realistic rather than mythic proportions of his narrative, and his inclusion of Esther’s confession to Fred Parsons (whereas Hardy’s novel excludes Tess’s confession to Angel Clare). Moore’s antipathy towards Hardy was also provoked by the fact that
particularly evident when Moore writes that “something awoke within her, something that seemed to her like a flutter of wings.” While the “something” that awakens within her might be the awareness of her pregnancy, it also seems to refer quite literally to the awakening of life that is taking place within her womb. “Fluttering” is especially suggestive because it is a verb often used to describe the sensation of a baby’s movement in utero.

Admittedly, the passage above does exhibit a certain degree of naturalist determinism. Esther’s fate is one “from which nothing could free her,” and one that she will have to “live through hour by hour.” Emphasizing that she will suffer “hour by hour,” the narrator sounds more like a voyeur than a sympathetic friend. As the author of Esther’s story, it is completely within Moore’s power to alter the course of her life, but instead he abjures this option and declares that she is at the mercy of forces far exceeding his ken. This move distances the narrator and the reader from Esther, and makes both appear to be cold, neutral observers of her “drama” rather than sympathetic and engaged participants in her life.

In this respect Moore’s narrator closely resembles the naturalist ideal that Zola outlines in “Le Roman Expèrimental.” For Zola, the novel is akin to a scientific experiment. First, the novelist carefully observes the laws of nature, after which he is then ready to confirm those laws through experiment, where he sets “his characters going in a certain story so as to show that the succession of facts will be such as the requirements of the determinism of the phenomena under examination call for” (Zola 8). In lieu of a rat in a cage or a cadaver being autopsied, the author experiments on the human subject, especially her emotional and cognitive reactions to the laws of nature. A human being, Zola argues, is a “higher organism”; unlike non-living things, which are ruled by their “ordinary, external environment,” man is “set in an internal and perfected

his literary rival was romantically involved with Lena Milman, whom Moore courted assiduously for several months in 1893. Frazier, 228-230.
environment endowed with constant physico-chemical properties exactly like the external environment; hence there is an absolute determinism in the existing conditions of natural phenomena; for the living as for the inanimate bodies” (3). Just like his physical state, Zola argues, man’s mental state is ruled by the interplay of heredity and environment:

This is what constitutes the experimental novel: to possess a knowledge of the mechanism of the phenomena inherent in man, to show the machinery of his intellectual and sensory manifestations, under the influences of heredity and environment, such as physiology shall give them to us, and then finally to exhibit man living in social conditions produced by himself. . . (21)

Abandoning Esther to her inevitable fate, Moore echoes Zola’s determinism and suggests that Esther’s intimate experiences—thoughts, feelings, subconscious daydreams—are merely “machinery” that he has chosen to “exhibit” in his experiment upon her.

Clearly, *Esther Waters* does bear traces of naturalism even as it details Esther’s intimate experiences with sympathy. Describing Moore’s process of revising the novel, Christine Huguet asserts that “between the draft stage and the second revised edition, one finds Moore all too often wavering between genuine sympathy for his unsophisticated heroine and the naturalists’ habit of belittling her.”29 Ohmann more thoroughly examines the tension between these two aesthetics—one objective and the other sympathetic—in *Esther Waters*, arguing that Moore’s working-class heroine is just one of the novel’s many Zolaesque characters. “In undertaking *Esther Waters,*” she writes, “Moore’s conscious intentions were recognizably naturalistic; he set out to cover an aspect of English life that he considered had not been ‘done,’ as Zola, for example, set out to

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‘do’ French miners in *Germinale.*” For Ohmann, Moore’s novel fails for just this reason, since she sees Esther as a clichéd type rather than a dynamic and rounded character. Further, her larger point is that Moore’s prose style is influenced by Esther’s status as social type. Like Esther, whom Ohmann deems “ordinary,” “typical,” and “representative,” Moore’s style is infused with “tired language” and “clichés,” which Ohmann sees as Moore’s effort to write “insensitive prose” from the point of view of his “insensitive protagonist.” Even when Moore is writing from an omniscient rather than subjective point of view, “the drabness of Esther’s sensibility has, as it were, overspread its boundaries; Esther’s language is pressed into service in fictional chores not even logically proper to it, much less aesthetically, and the results are what we have seen: the blanching reduction of experience to the typical or even the prototypical.”

It is true that the novel has naturalistic elements and that Moore made a number of insensitive comments about *Esther Waters.* For instance, he states that “a servant’s life, when looked at from a certain side, is very pathetic”; he compares the novel to taking a bath in the “simplest and most naïve emotions, the daily bread of humanity”; he asserts that unlike Eliot’s treatment of Hetty Sorrel in *Adam Bede,* his novel would truly demonstrate the “eternal instinct of motherhood”; and finally, he declares that Esther’s “is a heroic adventure if one considers it—a mother’s fight for the life of her child against all the forces that civilisation arrays against the lowly and the illegitimate” (*Esther Waters* 172). These remarks are often cited to prove that

30 Ohmann, 176.
31 Ibid., 179.
32 Quoted in David Skilton, introduction to *Esther Waters,* by George Moore (Oxford: Oxford University Press, 1999), xv.
33 Moore to Clara Lanza, 1889, quoted in Joseph Hone, *The Life of George Moore, with an Account of His Last Years by His Cook and Housekeeper Clara Warville* (Westport, CT: Greenwood Press, 1973), 161.
Moore’s characterization of Esther and the novel as a whole are cold, unfeeling, and more Zolaesque than Moore probably cared to admit.

What Ohmann does not address, however, is that Moore also wrote quite emphatically of the deep kinship he shared with the characters in *Esther Waters*. Moore writes of this affection at length in a letter to his brother Maurice: “I have been writing on this book for nearly three years and am still in love with it. Is it possible I am mistaken? It is immensely long. It contains a description of the Derby, 30 or 40 pages—no racing, only the sweat and boom of the crowd—the great cockney holiday. The people I love and understand—the dull Saxon. Flesh of my flesh, bone of my bone—how I love that thick-witted race.” Even though Moore’s trenchant wit is on full display here, these statements make clear that his attitude towards Esther is much more complex than Ohmann admits. Moore was, of course, a landed Irish gentleman and not a cockney servant, and yet when he declares that he is “in love,” it is clear that he admires both his novel and its subject matter. In addition, though he sardonically calls them “dull” and “thick-witted,” the phrase “flesh of my flesh, bone of my bone,” suggests that Moore did feel an affinity for his working-class subjects. I don’t want to overstate this affinity, given Moore’s less-than sympathetic remarks about Esther’s class and gender status, though it is fair to say that Moore’s feeling for Esther was far more nuanced than what we would expect from a naturalist author who is detached, objective, and scientific. As I began to suggest through the scene in which Esther realizes her pregnancy, the complexity of Moore’s attitude towards Esther is most apparent when he depicts Esther’s physical and mental experiences. In these scenes, Moore’s intimate and detailed descriptions convey sympathy for Esther, and also provide a fuller picture of how the novel diverges from the naturalist aesthetic.

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35 Quoted in Frazier, 227.
The birth of Esther’s son Jackie is most telling in this regard, since it dramatizes Victorian efforts to know the female body while also foregrounding the importance of Esther’s experience. The scene is, of course, noteworthy for its portrayal of labor and childbirth, a fact that Victorian reviewers consistently deplored. For instance, Malcolm MacColl argued that *Esther Waters* is, in fact, a moral book with a heroine whom he deems a “higher type of woman” than Hardy’s Tess Durbeyfield. However, MacColl stops short of endorsing Moore’s descriptions of inappropriate subjects, asserting that “it is a mistake in art to leave nothing to the imagination, and this is especially true when the subject is an unpleasant or terrifying one.”36 The subjects of Moore’s novel are apparently so unpleasant and terrifying that MacColl feels himself unable even to name them in his article, and instead he turns to a less egregious example from art to demonstrate why some subjects are best left to the imagination. In conclusion, MacColl regrets that though Moore is “so good an artist that he ought to be better,” he still commits an “error in supposing that he deepens the sympathy of his readers on behalf of his heroine by his crowd of unpleasant hospital details, for they are details which are likely to nauseate and repel.”37

What’s most interesting about MacColl’s argument is that he pits unpleasant details against readerly sympathy. In doing so, he confirms my argument that for the Victorians, the amount of information provided about a fictional character was directly proportionate to the reader’s ability to sympathize with him or her. Not only that, but given that MacColl’s complaint and Moore’s novel center around the heroine’s procreative body, it is clear that the female body represented a particular kind of case, or challenge, to this play between knowledge and readerly sympathy. However, where MacColl sees a conflict between the reader’s sympathy and the

37 Ibid., 493.
author’s presentation of “nauseating” details in *Esther Waters*, I argue that in Esther’s childbirth scene these details do in fact sharpen the reader’s sympathy. Though his depictions of unforgiving surgical tools and indifferent medical students do give the scene a naturalistic overtone, Moore ultimately undermines the naturalist aesthetic by describing the scene almost entirely from Esther’s point of view. This scene and the novel as a whole are narrated in the third person, and yet, as Siobhan Chapman points out, Moore “forgoes the possibilities afforded by a potentially omniscient narrator,” and instead, “the narrative is restricted almost exclusively to recounting Esther’s experiences” (309).

During the birth of her son, Esther’s feelings of fear and uncertainty are juxtaposed against her caretakers’ cold hunger for medical knowledge. For instance, Esther’s first introduction to the “eight or nine” medical students, midwives, and nurses that will attend to her is immediately followed by the most gruesome and striking element of the entire scene. After Esther fearfully exclaims, “‘What! in there? and all those people?’” Moore writes, “The screams she had heard in the passage came from a bed on the left-hand side. A woman lay there huddled up, and Esther was taken behind a screen by the sister who brought her upstairs, undressed, and clothed in a chemise a great deal too big for her, she heard the sister say so at the time; and as she walked across the room to her bed she noticed the steel instruments on the round table and the basins on the floor” (*Esther Waters* 122). Esther is horrified by both the sheer number of medical professionals, as well as their “care” for her fellow patient, who lies “huddled” and screaming as if she were a tortured animal for whom nobody cares. Also of note in this passage is the way Moore presents information as Esther becomes aware of it, so that the reader only learns about the screams in the hallway when Esther encounters and understands their source.
The same is true about Esther’s oversized chemise, which Moore depicts according to what Esther *hears* rather than using direct dialogue to cite what the sister *says*.

In contrast we might compare this scene to a similar hospital scene in Ernest Jones’s “The Young Milliner” (1852), in which a fallen woman, Anna, is being treating in a medical school hospital for lung failure. In that story, Jones uses the same kind of defamiliarization that I highlighted in *Tess of the D’Urbervilles*. Rather than describing why Anna ends up in the hospital, or even identifying the patient in the bed as Anna, Jones writes: “In the ward of the hospital, two men were standing by the bedside of a woman, who seemed plunged in a slumber of exhaustion. The one was a physician—the other a medical student.” 38 Clearly this is a far cry from Moore’s intimate portrait of Esther’s experiences in the hospital, since in this scene Anna is first presented as purely a medical case—indeed, merely a body that the doctor, his student, and the reader and author gaze upon. Another distinction between Anna’s case and Esther’s is the fact that Anna’s condition is initially described only through the dialogue of the doctor and student and not, as in *Esther Waters*, through the heroine’s thoughts and feelings. Like the practitioners in *Esther Waters*, the senior doctor in “The Young Milliner” is smug and condescending, as is evident when he coldly predicts Anna’s death and takes tobacco as he stands near her bedside. He also tells his student, a Mr. Weldon, to “take care to have her dissected with the greatest attention” since there are three other patients who might benefit from the knowledge gained at Anna’s autopsy. 39 Significantly, these other patients are described as “ladies,” while Anna’s status as a fallen woman presumably marks her as material for medical gain rather than compassion.

39 Ibid.
Unlike the senior doctor and the narrator in the scene, however, Mr. Weldon does exhibit sympathy for Anna. During her four months in the hospital, Weldon “had made [Anna] the especial object of his care. During her long illness, he had become intimately acquainted with the character of that young girl. He had learned to respect it—to admire—to love its excellence...He lavished on her all that his position and his science enabled him to bestow for her cure…” 40 Like Moore’s novel in its treatment of Esther, Mr. Weldon resists seeing Anna as an object of knowledge. In the quote above Jones suggests that Weldon’s compassion for Anna is what compels him to work harder for a medical cure; this, as I have begun to suggest, is strongly antithetical to a purely medical or naturalistic approach to the object of knowledge. While Mr. Weldon’s sympathy encourages his medical efforts, the naturalist or coldly objective physician does not share feeling with the object of his study, but rather, sees the destruction of said object as the necessary—and in some cases, desirable—outcome of epistemic pursuits.

Thus Weldon and Moore do what Jones cannot, that is, share feeling with the object of knowledge. Moore does this by placing the reader within Esther’s realm of subjective experience rather than giving an outsider’s transcription of events. We might say that unlike Esther, Anna is made into a case study—both by her physician as well as by Jones. As Nicole Buscemi notes, “Until the early twentieth century, the case history was generally narrated in the first person … but the difference is that the ‘I’ narrating this clinical account was a doctor describing a sick patient from his external perspective. As a result, the medical case study focused on an object rather than a subject—on a patient who is spoken about rather than speaking.” 41 This, then, is the most pressing difference between the medical scenes in Esther Waters and “The Young

40 Ibid., 66.
41 Nicole Buscemi, “Diagnosing Narratives: Illness, the Case History, and Victorian Fiction” (PhD diss., University of Iowa, 2009), 27.
Milliner.” Whereas Anna’s case is centered solely in the opinions and thoughts of her medical practitioner, Moore fashions Esther as more than a mere “case” by foregrounding how she perceives her condition and her treatment at the hospital.

In this way, Moore encourages the reader to sympathize with Esther, particularly when she fearfully undergoes an examination by one of the male medical students. In addition to seeming quite young, this medical student terrifies Esther because he appears less interested in her condition and more preoccupied with the candy he is eating and the German band playing outside the hospital. “Overcome with pain and shame,” and struggling to “rise from the bed” in an attempt to evade him, Esther exclaims, “‘Let me go! take me away! Oh, you are all beasts!’” (Esther Waters 123).42 In response to this plea the nurse coldly declares, “‘Come come, no nonsense!’ . . . ‘you can’t have what you like; they are here to learn’” (123). The contrast between Esther’s deep feelings of shame and fear and the nurse’s indifference could not be more striking. Rather than seeing Esther as a fellow human being who is merely trying to protect her dignity, the nurse reduces Esther’s concerns to a matter of vain preference, or what she “likes.”

What’s ironic about this scene is that Esther describes the medical professionals as “beasts” who greedily flock to more interesting cases once they (mistakenly) diagnose hers as an unexciting and “easy confinement.” Moore continues to characterize the students, nurses, and midwives as animals when he portrays their desire to know as part of an animalistic instinct for competition and dominance. Once again, Moore contrasts the animalistic behavior of the medical

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42 Moore notes that the student’s intent is to “try the pains,” i.e., perform an examination of Esther’s uterus. This paints the encounter as a physical and/or sexual assault in which Esther tries to protect herself from the student’s penetrating hands and eyes; it also indicates Moore’s familiarity with commonplace gynecology terms. This familiarity is again made evident in the way Moore begins the chapter after Jackie’s birth. Referring to the loosening of joints and tendons that occurs during pregnancy and labor, Moore begins the chapter by writing that “all her joints were loosened” (126).
professionals with how Esther feels. With pains that “creep up from her knees,” Esther waits as her attendants debate her case: “One of the young men said that her time had not come. The woman, with the sinister look that Esther dreaded, held a contrary opinion. The point was argued, and, interested in the question, the crowd came from the window and collected round the disputants. The young men expounded much medical and anatomical knowledge; the nurses listened with the usual deference of women” (124). Unlike the rest of the scene, we can presume that this is the narrator’s perspective, or a mixture of Esther’s and the narrator’s perspective, since the diction (e.g., “disputants,” “expounded,” “deference,” etc.) is more elevated than we might expect from her. In response to these interlocutors, Esther responds dramatically:

Suddenly, the discussion was interrupted by a scream from Esther; it seemed to her that she was being torn asunder, that life was going from her. The nurse ran to her side, a look of triumph upon her face, and she said, “Now, we shall see who’s right,” and forthwith went for the doctor. He came running up the stairs; silence and scientific collectedness gathered round Esther, and after a brief examination he said, in a low whisper: “I’m afraid this will not be as easy a case as one might have imagined. I shall administer chloroform.” (125)

Instead of gathering around her, Esther’s caretakers, or the “disputants,” gather around each other so they can better debate her medical condition. Part of the debate is clearly about gender and knowledge, since while the men “expounded much medical knowledge,” their subordinate female counterparts only listen, with the exception of the nurse who callously declares, “Now, we shall see who’s right,” when Esther’s condition is worsening.

In sharp distinction to the medical personnel’s callous indifference, the scene is laden with intimate details about Esther’s childbirth experience, including the sensation of pain
climbing up her body and her feeling that she is being torn apart. Esther’s feelings are consistently juxtaposed against the hospital staff’s indifference, as when Esther interrupts the medical debate with her piercing scream. The irony is, of course, that Esther’s condition ought to be the primary concern of the staff, though as Moore illustrates, they are purely interested in possessing the most knowledge about her medical status. Gathering around each other excitedly, arguing vociferously, and struggling for intellectual dominance, here the subjects of knowledge become “beasts” as they vie for the choicest cut of “meat.” In the absence of sympathy, it seems, the will to know can dehumanize both the subject and object of knowledge.

And yet, as I have begun to suggest, because Moore privileges her point of view and contrasts it favorably against that of the medical students, nurses, and midwives, Esther is in fact not dehumanized in this scene. It is Esther whom we might expect to most resemble the lump of diseased and decaying flesh that we see in a strongly naturalist work like *Nana*. However, instead of dissecting his heroine, Moore flays the scientific and unsympathetic methodology that is at the heart of the naturalist aesthetic. We see this again when Esther loses consciousness and the narrative abruptly ends, resuming only when Esther awakens from her ordeal. For Chapman, this mirrors “the way in which, in the novel in general, the narrative remains with events which Esther herself witnesses” (310). Technically, Esther does not “witness” the birth of her son, nor does she ask her attendants about the nature of her medical complication and what transpires while she is unconscious. As a result, the narrative remains silent on these details. But unlike *Middlemarch*, where the procreative female body is shrouded from the reader’s sympathy and rendered unknowable, this gap in the birth scene actually functions to reinforce the primacy of Esther’s point of view. Moore refuses to reduce Esther to a mere object of knowledge, e.g. a cadaver awaiting dissection, and instead ensures that we spend the majority of the scene with
her, learning what she learns and feeling what she feels. In this way, Moore condemns the hospital staff and their dehumanizing methods and levels a persuasive attack against the naturalist’s similarly degrading methodology.

In her article “Subjectivity and Story in George Moore’s Esther Waters,” Annette Federico points to several consequences that follow from Moore’s privileging of Esther’s point of view. One of these consequences is that the naturalistic elements of the novel are outweighed by what Federico calls its “deep commitment to the attributes of the nineteenth-century English story.” Following Raymond Williams’s theory of the nineteenth-century novel, Federico argues that these attributes include “sympathetic concern with the substance and meaning of community, human relationships, morality, the knowable and unknowable individual, and the historical imagination” (141). For the Victorians, “the issue is not so much about subject matter as it is about subjectivity: whose stories get told and whose stories get read, and by whom” (143). The notion that there is something “at stake” in the fictional subject serves as the foundation for Federico’s larger point, which is that Moore’s novel is ultimately an attempt to “dissolve cultural hierarchies and to change the literary marketplace by questioning received ideas about what subjects—and subjectivities—are appropriate for art” (141). In privileging Esther’s point-of-view, Moore eschews the naturalist aesthetic and in doing so prioritizes subjective experience over objectivity and authority: “for all its naturalistic observation, Esther Waters is still a claim for story over analysis, for empathetic connection over authority and control, and in this sense it is also embedded with values that nineteenth-century British culture labeled feminine—‘gentleness, flexibility, openness to others, friendship, love’” (153).

Federico’s point about the primacy of Esther’s experience is useful, and helps us understand how Esther’s procreative body is fundamental to the novel’s privileging of her
experience. It also leads us to see that in privileging Esther’s experience as a uniquely embodied female, Moore also privileges a mode of knowledge that is distinct from that of the naturalist author or the gynecologist. Moore does this by foregrounding Esther’s experiences rather than relying on the condescending “objectivity” of her medical caretakers as the prime source of narration and information. Thus, in contrast to the methods of knowledge demonstrated by the hospital staff, Moore offers Esther as an alternative epistemology, one that we might call experiential rather than objective. Furthermore, what this scene also indicates is how strongly Moore endorses his own, and the reader’s, “empathetic connection” with Esther, even though in his case it is at the expense of his “authority and control.” Rather than echoing how the naturalist author or the gynecologist might treat a figure like Esther, Moore extends sympathy to his character by allowing her to express her experiences. Esther refuses to become a reproductive body that is consumed in service of a novel or a medical case, and in this regard too Moore subverts the dehumanizing effects of the naturalist author and gynecologist.

Esther’s fight is evident when she stands up to a hospital subscriber who is greedy to hear her story but unwilling to write her a letter of admittance to the hospital. This woman, “an elderly lady who said she did not wish to judge anyone,” only gives letters to married women. Though Esther is of course unmarried, and tries repeatedly to leave, “the lady, although unswervingly faithful to her principles, seemed not indifferent to Esther’s story, and asked her many questions.” To these questions, Esther stoutly replies, “I don’t see what interest all that can be to you, as you ain’t going to give me a letter” (Esther Waters 119). In this scene Moore emphasizes the subscriber’s perverse desire to know Esther’s story even though she has no intention of giving her a letter. Though she doesn’t appear “indifferent,” she is not truly sympathetic to Esther’s plight because she is unable to view her as more than a cliché—i.e. a
fallen woman. Esther, however, refuses to be reduced to her condition as an unwed single
mother, and instead she asserts ownership of her story and defies those attempts to know her—
whether social, fictional, or medical—that ignore her agency and the primacy of her experiences.

During her interactions with Miss Rice, Esther again asserts her sense of how unique her
story is. Though she is initially reluctant to share her life story with her employer, protesting that
her “story is not one that can be told to a lady” (184), Esther and Miss Rice eventually develop a
meaningful bond that transcends the usual boundary between servant and employer.
Interestingly, it is when Miss Rice declares, “‘I think I’m old enough to listen to your story’”
(184), that Esther begins her tale. As a spinster whose “experience of life is limited to a tea-party,
and whose further knowledge of life is derived from the yellow-backed French novels which fill
[her] bookcases” (204), Miss Rice is the epitome of the late-Victorian female reader, to whom
Mudie and Smith pandered with sentimental novels. In the scene above Moore self-consciously
alludes to the readers that Mudie and Smith hoped to cultivate, and instead suggests that even a
pure and virginal woman like Miss Rice can benefit from hearing the story of Esther’s life,
assuming that she hears it without judgment or condescension. In this scene too, then, Esther is
not owned or controlled by another who attempts to know her and her story; rather, once again
Moore privileges her story by illustrating the contrast between Esther and Miss Rice’s lives.
After parting ways with Esther, Miss Rice’s “…thoughts went back for a moment to the novel
she was writing, so pale and conventional did it seem compared with this rough page torn out of
life” (245).

There are clearly naturalistic overtones to Miss Rice’s sentiments: her novel is a
feminine, white-washed version of a truly “realistic” novel, which would objectively transcribe
the “pages” of life regardless of how “rough” they are. And yet there is something suggestive
about Moore’s use of the word “rough”; instead of only indicating his demand for truth in fiction regardless of the consequences, what this seems to reiterate is that Esther herself is “rough,” that is, composed of jagged edges, feelings, thoughts, and above all, experiences. One might be tempted to argue that these feelings and experiences are still part of those conditions that the author/scientist manipulates in his experimentation upon Esther. But given the level of depth with which Moore shades Esther’s character, such a reading would be shortsighted. Instead, I argue, it is more accurate to acknowledge both the undercurrent of naturalism while also recognizing how Moore tweaks that aesthetic in order to legitimize Esther’s experiences and her ways of knowing.

Esther’s fate and the conclusion of the novel further undermine naturalistic narrative techniques, and underscore how, throughout the novel, Esther persistently claims the right to be an active agent in her life or, we might say, the author of her own story. We see Esther hinting at this when William Latch attempts to win her back despite still being married to another woman. Esther is quick to point out that he deserted her previously, which prompts the following heated exchange between the two: “‘You deserted me.’ ‘Why go back on that old story?’ ‘It ain’t a story, it’s the story of my life, and I haven’t come to the end of it yet’” (235). Unlike William, who is quick to reduce Esther’s experiences to “that old story,” Esther insists on the uniqueness of her story. While “men in Esther Waters often see women’s stories as either manipulative lies or tales already heard countless times from other women” (Federico 147), Esther claims her story’s “progress, its particularity, and its meaning for herself. The real ‘fight that isn’t over yet’ is for subjectivity in a society hostile to women’s stories” (Federico 148).

Moreover, Esther rightly stresses the importance of the end of her story. Unlike the characters in Zola’s L’Assommoir or Nana, Esther is able—through incredible hard work and
determination—to raise her son successfully and regain a secure position at Mrs. Barfield’s country estate. Though she sees *Esther Waters* foremost as a naturalistic novel, even Ohmann acknowledges that Esther’s fate signifies a move away from naturalism. For Ohmann, the conclusion of the novel dramatizes Esther’s flight from “contemporary life,” and her attempt to regain the peace and innocence of her lost youth. Unlike Zola, Moore writes “his happy ending,” and imbues it with values with which he “could sympathize.” ⁴³ Despite being a hybrid text that exhibits both naturalistic and sympathetic characteristics, *Esther Waters* upholds the significance of Esther’s embodied experiences and the insufficiency of naturalism’s cold objectivity.

In privileging Esther’s experience, Moore makes his heroine more than a cadaver, a rat in a cage, or any mere object of knowledge. He states as much in a provocative excerpt from *A Communication to My Friends*, where he describes his struggle to find the perfect name for his new novel:

> It seemed that difficulties and trouble insurmountable loomed up; I could perceive them faintly in the mist of the months, perhaps years, that I would have to devote to a work to be entitled—what? *Mother and Child*? No, that seems sententious; I would like a humble name, beautiful in its simplicity. A name will continue to beckon me all the way, and if I hit upon a good name it will lead me by the hand, and I shall follow, obedient as the child she carries in her arms. ⁴⁴

Moore’s devotion to *Esther Waters* is a sharp departure from naturalistic objectivity and unfeeling fictional experimentation. Moore is so devoted to his heroine, it seems, that he likens himself to a trusting child who is willing to follow his “mother” through months and possibly years of arduous work. In spite of his early adherence to Zola, and in spite of the naturalistic

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⁴³ Ohmann, 185.
undertones of his novel, Moore conceived of his heroine as much more than an object of knowledge for either the gynecologist or the novelist. Indeed, in the excerpt above, Moore twice describes himself as the object—rather than subject or creator—of his novel. Unlike Zola, Moore does not retain a vice grip on his heroine, her fate, and her every action; in fact, he tenderly holds her hand and allows her to lead him.

Thus rather than repeating the unfeeling and misogynistic configuration that we see in the naturalist novel or the gynecological treatise, Esther is painted with a degree of subjectivity that distinguishes her from a social, literary, or medical case. Moore envisioned his heroine as an agent, not an object, and while he does make Esther’s body an object of knowledge in her birthing scene, the sharp contrast between Esther and the hospital staff underscores the primacy of her experience and also subverts the doctors’ and students’ will to know. Likening the hospital staff to beasts, Moore castigates the doctor and the novelist who would dehumanize Esther in order to satisfy their hunger for knowledge. Paradoxically, the knowledge and information that we do receive is ultimately derived from Esther’s body and her experiences as a uniquely embodied individual. Even as he refuses to reduce Esther to a reproductive body fit for dissection, Moore also constructs a narrative that is intimate with and deeply sympathetic to the procreative female body. *Esther Waters* embeds its author, narrator, and reader within the body and mind of its heroine, and it is in this regard that Moore’s novel diverges from the naturalist aesthetic and instead acts as a site of shared feeling.
CHAPTER FOUR

Man-Midwives, Lady Doctors, and the Tenuous Balance of Knowledge and Sympathy in Victorian Medical Woman Fiction

The mania for removing the ovaries is a crying evil. To unsex a female does harm in a majority of cases.

-Dr. Daniel Clark, in Dr. James Russell, “The After-Effects of Surgical Procedure on the Generative Organs of Females for the Relief of Insanity”¹

Many of the most estimable members of our profession perceive in the medical education and destination of women a horrible and vicious attempt on the part of women to deliberately unsex themselves in the acquisition of anatomical and physiological knowledge. . . .

-Pierce Adolphus Simpson, “An Address on Post-Graduate Possibilities. Delivered at the Opening of the Medical Classes in the University of Glasgow, October 25th, 1887”²

This chapter takes as its starting point the question of why the male-dominated Victorian medical profession indicted both the gynecology patient and the medical woman as “unsexed.” The two are no doubt related figures, but their respective positions as the object and subject of knowledge makes the common charge of “unsexed” highly provocative. As historians of

medicine have noted, Clark is not alone in his assertion that ovariotomy—the surgical removal of one or both diseased ovaries—rendered a woman no longer womanly, but sterile, mannish, hairy, and unfeeling. It is for these reasons that early attempts at ovariotomy were deemed criminal, since unsexing the Angel in the House had repercussions that extended far beyond the domestic sphere. The medical woman, on the other hand, differed from the gynecology patient not only because she chose to study medicine, thereby unsexing herself, but also because her transgression stemmed from her possession of knowledge and not the absence of her ovaries. In one case the lack of particular bodily organs unsexes, while in another, it is the positive addition of knowledge that makes a woman unwomanly.

Ostensibly, what these two figures shared was their (allegedly) masculine appearance. Whether it was by growing facial hair after an ovariotomy or wearing a “divided” skirt and traveling to see patients late at night, the gynecology patient and medical woman undermined the biological basis of Victorian gender roles. More important for my purposes is the fact that these two figures also sparked conflict because they exceeded the proper boundaries of knowledge and feeling. For her part, the medical woman supposedly unsexed herself in the pursuit of medical knowledge; not only did the knowledge in itself unsex her, but the physical and mental effort to obtain it was widely thought to have effects that unsexed her literally and figuratively. The hysteric, by contrast, was unsexed by her repeated fits of excessive feeling. This excessive feeling—especially when it engendered somatic sympathy—prevented the male doctor from diagnosing and curing her condition; feeling and knowledge, in this case, were both disrupted.

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3 Since the ovaries were considered the “‘grand organs’ of sexual activity in women,” their “removal ‘unsexed’” her and threatened “the source and symbol of femininity itself.” Moscucci, 134.
4 It was argued that any kind of rigorous study degraded a woman’s delicate mental faculties and strained her nervous system, thereby rendering her reproductive system too weak to function properly.
The Victorians’ fear of unsexed women was thus, I argue, part of a more widespread cultural anxiety about women whose balance of knowledge (medical, sexual, or literary) and sympathy (textual, interpersonal, physiological) was supposedly flawed.

Because much of this dissertation focuses on women as the objects of knowledge—as gynecology patients or bodies to be “dissected” by the fiction writer—in this chapter I investigate instead how female subjects of knowledge influenced Victorian discourses about knowledge, sympathy, and female bodies. Here I follow Kristine Swenson’s lead in *Medical Women and Victorian Fiction*, where Swenson argues that there was a “much more complicated and reciprocal relationship between women and medicine in Victorian culture,” a relationship that even included female medical practitioners who “enforced or subverted the sciences of sex and race,” and participated “in the discourses that determined the limitations and opportunities of their own lives.” Swenson’s point is that women weren’t only the objects of knowledge, and in this chapter I highlight instances where the power dynamic between the male doctor and female patient was upset and/or reversed. For the sake of simplicity, I’ll use the general term “medical woman” to denote a number of female medical professionals that arose during the nineteenth century, including the female physician, surgeon, pharmacist, and alternative medicine practitioner. This category does not include the figure of the nurse because, as I will demonstrate, the nurse was thought to choose her work due to a sense of moral duty and maternal feeling. By comparison, the medical woman—as she was represented in the popular press, medical discourse, and the sub-genre of New Woman medical fiction—desired knowledge for its own sake. Like her male counterparts in the burgeoning fields of pathological anatomy, abdominal

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6 Ibid., 12.
surgery, and gynecology, the medical woman thirsted to know, to see, and to understand how the human body functioned both in normal physiological processes and in pathological conditions.

Foremost among the objections leveled against the medical woman was the argument that acquiring medical knowledge and practicing medicine would stunt or eradicate her capacity for sympathy. Confronted by rowdy male medical students, lectures on the genital organs, or the prospect of traveling long distances in inclement weather to treat patients, the medical woman, it was argued, would necessarily lose the delicacy of feeling that allowed her to intuit and patiently minister to her husband’s every need and feeling. In what follows I trace this opposition between knowledge and feminine feeling. In medical journals and in fiction, in texts written by men and those written by women, the medical woman incited anxiety and debate because she disrupted the proper balance between feeling and knowing. In addition to examining debates in *The Lancet* and the *British Medical Journal* and fictional representations of the medical woman in works by Margaret Todd, Arabella Kenealy, Charles Reade, and Arthur Conan Doyle, I will also explore the tension between knowledge and feeling in biographical accounts of medical women, especially Elizabeth Blackwell. By engaging three distinct genres (medicine, fiction, biography), it is my hope that we can more firmly grasp the nuances of fictional and medical representations of the Victorian medical woman. Ultimately, doing so will explain more fully how and exactly why the medical woman, the presumed subject of knowledge, came to inhabit a role that was not unlike that of the hysterical or ovariotomy patient.

The Victorian medical woman was, of course, part of a long tradition of women acting as caretakers and healers. As Lilian Furst notes, “women have traditionally been expected to tend
the sick as a normative part of their domestic obligations." Among the different kinds of female medical practitioners, Barbara Ehrenreich and Deirdre English count doctors, anatomists, abortionists, nurses, counselors, pharmacists, midwives, "wise women," witches, and charlatans. As they see it, "medicine is part of our heritage as women, our history, our birthright." The most relevant of these figures is the midwife, who attended most cases of childbirth until the early-eighteenth century. Because there were few regulations controlling the practice of midwifery, midwives often lacked formal training. What they did possess was a vast store of experiential knowledge that was gathered during their own experiences giving birth and also through witnessing friends’ and neighbors’ births. In fact, "right to the end of the seventeenth century personal experience of childbirth was considered an essential requirement for midwifery practice." And yet, by the end of the eighteenth century, the man-midwife or general practitioner had replaced the female midwife.

I mention the history of the midwife again because earlier debates over male versus female midwives served as the discursive setting for Victorian debates about male versus female physicians. Furthermore, the terms of the debates were very similar, since in both cases—the man-midwife and the female physician—the relationship between sympathy and knowledge was crucial to determining who should be allowed to provide medical care. The rise of the male midwife in the eighteenth century was part of a larger shift that transformed the domestic, secretive, and feminine ritual of childbirth into a medical procedure that required (male) medical

8 Ehrenreich and English, 3.
9 Ibid.
10 According to Moscucci, there was no regulation of British midwives until 1512. At this time a bill was passed that compelled midwives to seek a license for their practice by applying to the church. Moscucci, 43.
11 Ibid.
supervision. One major factor in this transformation was the professionalization of medicine and
the growing trust in the physician’s knowledge and skill. Unlike his female counterparts, the
man-midwife received professional training and formal education; his entrance into the birthing
room is thus said to represent the “medicalization” of childbirth and the larger historical shift
towards objective rather than subjective knowledge. According to Cody, “the key
epistemological or psychological shift at work here was the man-midwife’s ability to proclaim
true insight into reproduction by dismissing the lived, felt, subjective experience of mothers and
by foregrounding the observable, external, increasingly statistical, objective knowledge of
medical science.”12 Significantly, Cody also notes that knowledge alone was not sufficient to
overcome feminine modesty and the tradition that barred men from the lying-in chamber. Rather,
the man-midwife fashioned himself as a medical professional as well as someone who could
listen to his patients, draw out their concerns, and sympathize with their worries: “On the one
hand, [male midwives] presented themselves as possessing heroic, life-saving, masculine
strength and the intellectual insight to connect women’s reproductive bodies to national health
and political stability. On the other hand, they presented themselves as almost feminine in their
empathy for women and in their personal sensitivity to delicate mothers, fragile infants, and the
intimate, domestic sphere.”13

Unlike her male counterparts, the female midwife remained chained to her sex, since her
authority as a midwife was said to stem largely from her own experiences as a childbearing
woman.14 Proponents of female midwifery even drew on nature in order to prove that women

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13 Ibid., 12.
14 Cody cites an interesting broadside from the 1670s entitled *The Mistaken Mid-vwife, or Mother Mid-Night Finely Brought to Bed*. In this text, a childless midwife hides a pillow underneath her
were more suited to delivering babies. According to them, female midwives were preferable because they had a longer track record as midwives, because male practice would injure a woman’s delicate nature if not altogether halt the natural process of birth, and because woman’s nature—rather than artificial book knowledge—was epistemologically superior. Even physiological differences between the sexes were cited as evidence both for and against man-midwives. Female midwives contrasted the man-midwife’s large hands and cold steel instruments with their own soft, agile, and feeling hands. A woman’s hands were considered “the physical manifestation of her tenderness of feeling,” and “were simply a reminder of her innate ability to sympathize with the sufferings of other women.”

Male midwives also drew on the discourse of nature, though as I illustrated earlier they concluded that woman’s ability to feel and sympathize was excessive. Women had extremely sensitive nervous systems, they argued, and thus “they were excessively susceptible to the impressions of the sense and had difficulty, therefore, in distinguishing between what was real and what was not, a tendency that would have disastrous consequences in the birthing chamber.” Cody cites the eighteenth-century man-midwife John Leake, who declared women unfit for practicing midwifery because of their delicate bodily frames and inordinate passions; they were “by nature creatures of feeling,” and far too often they were prone to “feeling incorrectly.” The ideal birth attendant, according to the man-midwife, was one who combined “both scientific, objective insight” with “virtuous empathy.” In this way, the male practitioner “unsexed” himself, though he did so by claiming “a rational compassion that was uniquely clothing in order to give the appearance of pregnancy and therefore buttress her qualifications.

Cody, *Birthing the Nation*, 35.

Sommers, 93.

Ibid., 95.

Cody, “Politics,” 485.

Cody, *Birthing the Nation*, 155.
removed from any association with a specifically sexed body."\textsuperscript{19} In the terms that I have set up here, we might say that the man-midwife balanced masculine knowledge with feminine subjectivity, strategically managing both in order to counter his detractors and assert the legitimacy of his profession.

Like the man-midwife, the Victorian medical woman was similarly forced to balance claims of knowledge with concerns about feeling. She also resembled her predecessor in her ability to incite controversy: between 1865 and 1920 she was the focus of hundreds of essays, novels, cartoons, and correspondence appearing in medical journals, literary journals, and newspapers.\textsuperscript{20} Like that which was written about the New Woman, discourse on the medical woman often presented her in contradictory ways. She was portrayed “variously as a butt of satires, a villain of the sensation novel, a savior to countless numbers of English and Indian woman, an everyday student, an extraordinarily disruptive student, a social insurgent, a social reformer, a friend to women, a danger to women, an unsexed oddity, a woman who was unusually curious about sexuality, a threat to the medical profession, and a much-needed medical practitioner.”\textsuperscript{21} While I attempt to represent all the sides of the medical woman adequately, it is worth reiterating that she was a bundle of contradictions. What is consistent is that her relationship to sympathy and knowledge remained at the forefront of arguments both for and against her.

For critics of the medical woman, even the process of acquiring medical knowledge was problematic, since it exposed female medical students to the raucous and often inappropriate behavior of their male peers and professors. Florence Fenwick Miller, for example, describes

\textsuperscript{19} Sommers, 90.
\textsuperscript{21} Ibid., 8.
male students shutting doors in the women’s faces, taking their seats during lecture, and laughing obnoxiously in their presence. More famously, in 1870 male medical students threw mud and protested violently when Miller, Sophia Jex-Blake, and five other women attempted to enter the College of Surgeons at the University of Edinburgh for an anatomy exam. This so-called “riot” was an extreme example of the male students’ harassment, but it served as a reminder of the daily trials that would vex the female medical student and, it was warned, try her delicate feelings and likely leave her hard, coarse, and mannish.

Opponents of the medical woman were numerous and very vocal. For them, “mixed classes were a ‘violation’ of the relations of the sexes and thus a threat to the whole social system.” Rather than allowing the “revolting mixture of young male and female students in the study of anatomy, physiology, and pathology of the sexual organs,” one doctor suggests separate schools for female midwives, in which “no male students are allowed to enter.” In this way, he suggests, not only is the modesty of the women preserved, but so too are the “feelings of delicacy which pertain to Christian civilisation.”

More than the feelings of “Christian civilisation,” critics were concerned about the delicate feelings of the women themselves. In a letter to the editors of *The Lancet*, “Old Morality” outlines in detail what threatened the female medical student’s delicate feelings:

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23 Catriona Blake, *The Charge of the Parasols: Women’s Entry to the Medical Profession.* (London: The Women’s Press Limited, 1990), 117. Blake sees the question of mixed versus separate classes as central to debates on the medical woman. As she points out, there were male and female supporters and opponents to mixed medical classes, though the issue was largely mute because there didn’t exist “an equal number of places for female and male students in separate but equally well-equipped and staffed courses” (119).
Common decency seems utterly to forbid that a young girl, probably in her ’teens, unmarried of course, just fresh from a boarding school, should, in conjunction with male students, be dissecting the human subject, witnessing operations, and attending the out-patients’ practice of a general hospital, where, as a rule, nearly three-fifths of the patients are males, two-fifths of whose diseases are of such a character, the proper investigation and personal examination of which is totally unfit to be witnessed, much less practised, by women. What must the moral effect be on the minds of young girls of from sixteen to twenty years of age from such contact, involving as it does a knowledge of vice and its practices, such as a guileless girl should have no shadow of a suspicion of.\textsuperscript{25}

Though “Old Morality” appears most concerned about the “fresh” young girls who will be sacrificed in medical school, his letter betrays a deeper anxiety that women might replace men as the subjects of knowledge. Not only would the “guileless” female medical student become aware of the iniquities that drew men to hospital, but they would also be able to observe, treat, and dissect male patients. Instead of a huddle of male medical students surrounding the splayed and flayed female patient—as Moore dramatizes in *Esther Waters*—what “Old Morality” seems to fear most is a male patient being used by the female student in her pursuit of knowledge.

Whether it was coldly observing the male patient in his darkest hour or dispassionately dissecting his corpse as though it were a mere lump of fibers, muscles, and bones, in the female medical student “Old Morality” foresees woman treating man as he has become accustomed to “treating” her.

In addition to suffering the trials of male venereal patients, critics of the medical woman also contended that the social and learning environment of medical school would be jeopardized

\textsuperscript{25}“Old Morality,” “Female Medical Students,” *The Lancet* 94, no. 2405 (2 October 1869): 496.
by the presence of women. In fact, “Old Morality” hints that male medical students would have to curb their inappropriate jokes and behavior if women were allowed into medical school. After asking his readers to “recall to memory their student days, the moral atmosphere of the dissecting-room, and the other surroundings of their student life at hospital,” “Old Morality” questions if this atmosphere is appropriate for women. He is vague about what, exactly, makes the dissecting-room environment immoral, but his remarks portray medical school less as an intellectual coterie of disinterested physicians and more as a male fraternity house.

Of course, opponents to the medical woman could not openly admit that their primary concern was the security of their “old boys’ club” and their ability to make lewd jokes while lecturing on the female reproductive system. What they did argue is that the presence of women in medical schools hindered both teaching and learning. Sir George Burrows allowed women into his classes for a short time in the 1850s, and declared in *The Lancet* that he was “therefore not prejudiced against [women].” However, he ultimately determined that the mixing of the sexes was a “mistake socially and morally” because the presence of women “narrowed his teaching considerably, and was bad for students and the young women in many ways, and he came to the conclusion that the two sexes ought not to be educated together.”26 Like “Old Morality,” Burrows is purposefully vague about precisely what is sacrificed by the presence of female medical students, and it is therefore difficult to make absolute conclusions about why “Old Morality” and Burrows so vehemently oppose the coeducation of male and female students. I argue, however, that both articles identify female students as a threat to male camaraderie and

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professional privilege. As I will demonstrate next, whether they were excluded because their presence would threaten the “moral atmosphere” of the dissecting room, or because they would prevent the transfer of knowledge, feeling was consistently deployed as a reason for the exclusion.

For instance, in an 1875 discussion from *The British Medical Journal* on medical women, a “Mr. Turner” suggests that women err when they try to stand “on a footing of equality” with men. Women and men, he argues, should never be rivals because they possess opposing attributes and skills. Turner concludes that each sex “has its own excellences, and one is the complement of the other,” but he is not quite as generous when he assesses the physical limitations that prevent women from practicing medicine. For Turner, it is “perfectly sound physiological doctrine” that “the physical framework of woman is inferior in its capacity and power to the physical framework of a man. Her muscular apparatus is less powerful, her bones are more slender, her skull is smaller, [. . .] and her brain, also, is smaller and lighter.” As you can see, Turner equates physiological difference with intellectual and/or moral difference, and thus he declares that “lower brain-weight implies a smaller capacity for concentration of thought, for intellectual capacity, and for prolonged exertion, either mental or bodily.” Lower brain weight also accounts for what he calls “the preponderance of the emotional qualities in woman’s nature.” Though these emotional qualities give women “all those characteristics which we value so much in a wife and a mother, and which are also of the greatest importance in connection with

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27 One critic of the medical woman suggests an underlying monetary and professional rivalry when he concludes his argument against women in medical schools by declaring, “I am no alarmist, and least of all fear any rivalry in our profession from the opposite sex . . .” Of course, the author of this letter, F.G., suggest just the reverse, since his defensive posturing confirms the possibility that in the future male doctors might have to defend their jobs from women. F.G., “The Edinburgh University and Female Medical Students” *The Lancet* 94, no. 2403 (18 September 1869): 422.
the functions of a nurse,” they also “ill [adapt] her for the performance of those duties which are entailed upon those who enter into the profession of medicine.” Foremost among these duties, Turner cites “the clear exercise of the logical faculty,” since without it, medicine fails to be a science.28

There are several important points worth emphasizing here. First of all, it is noteworthy that Turner sees women as physically incapable of being physicians or surgeons. Here he echoes another of his colleagues, Dr. Andrew Wood, who angrily suggests that women ought to enter the law or the church rather than medicine. In those professions, “She will have no blood to encounter there. She will not have to exercise brute strength, such as a woman very seldom has, and which is required in many important operations. Fancy a woman called to reduce the dislocation of a hip-joint! Could a woman do that?”29 Wood’s incredulity is humorous in hindsight, but he wasn’t alone in thinking that women were incapacitated by their weaker muscles, smaller frames, and (supposedly) lighter brains.

Most relevant for my purposes are the conclusions that Turner makes regarding the interplay of a woman’s physical frame and her emotions. Not only does her physiology (smaller brain) make it difficult for her to concentrate on something for extended periods of time, but it also causes her an excessive amount of feeling. In this way, Turner’s argument comes very close to those that identified excessive feeling—and the communication of that feeling via bodily organs—as the culprit of hysteria. The medical woman, it seems, resembles the hysteric in that excessive feeling plagues them both. In the case of the hysteric, bodily organs transmit that feeling through the sympathetic (and pathological) channels in her body; in the case of the

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28 “Mr. Turner,” “General Council of Medical Education and Registration,” *The British Medical Journal* 2, no. 757 (3 July 1875): 10.
29 Ibid., 19.
female doctor, the feeling is first and foremost a barrier to logical and scientific thought, and secondly a condition that also threatens to render the doctor hysterical. We see this in Henry Curwen’s novel Dr. Hermione (1891), in which the female doctor protagonist abandons her medical degree and training upon her marriage to a soldier. Though she has been trained in Paris—where we would expect she had received the finest and most extensive medical training—after her marriage her sensitive feminine nerves deteriorate to the point that she becomes hysterical at the sight of her wounded husband. Thus not only is she unable to treat her husband like the medical doctor that she is, but her intense feelings render her a medical patient as well.30 According to Swenson, “nurses and women doctors who fall into ‘hysteric’ like this are favourite characters in antifeminist medical literature,” making hysteria shorthand for New Women who dared to achieve any education or profession as well as for those women who sought medical degrees and careers.31

And yet, though it prevents her from practicing medicine as a physician or surgeon, a woman’s innate emotionality does not prevent her from nursing. According to Turner, emotions are, in fact, requisite for mothers, wives, and nurses, or those roles in which a woman’s emotions “make her truly a helpmeet for man.”32 Clearly, Turner’s conclusions about female caretakers are skewed by his desire to protect male dominancy in medical knowledge. Although male physicians are more than happy to see feminine emotionality exercised through nursing—i.e. carrying out the doctor’s orders—they are less than enthused at the prospect of women giving orders themselves. What is also intriguing here is that Turner’s very different sentiments for the female physician and the female nurse are underpinned by his assumptions about women,

31 Swenson, 114.
32 “Mr. Turner,” 10.
sympathy, and knowledge. The nurse and the medical woman both evince excessive emotionality, though only the medical woman attempts to gain medical knowledge. The nurse, by contrast, attempts to know and feel what her patient feels in order to best care for him. We might say that the nurse pursues only interpersonal knowledge—that which can be gained through shared feeling—while the medical woman seeks out the objective medical knowledge that is traditionally reserved for the male sex.

Bronwyn Rivers makes a related point in her work on mid-Victorian nursing heroines. According to Rivers, mid-century nursing reform drew from the image of the domestic angel in order to reframe the nurse as the epitome of femininity rather than a transgressive female in the public sphere. Prior to this, nursing in England was a “largely untrained and disorganized activity,” and nurses were portrayed as one of two types. The first was a loving mother and wife who not only cared for her family and close friends, but also nursed the sick through her personal philanthropy work. The second type, Rivers suggests, was best epitomized by Sairey Gamp in Charles Dickens’s *Martin Chuzzlewit* (1844), and was, by contrast, a drunken and corrupt figure who leached far more from her clients than she contributed in loving care. Beginning at mid-century, in tandem with the founding of Florence Nightingale’s Nightingale Training School for nurses in 1860, reformers began to purposefully refashion these images of the nurse.33

Part of this refashioning involved reframing nursing as a *lady’s* calling rather than work for low and working class women who, it was argued, sullied the image of the nurse with their alcoholism, promiscuity, and lack of education. The nurses who volunteered with Nightingale during the Crimean War, for example, were addressed as “Sister,” and wore white uniforms that resembled a nun’s habit. To counter the image of the promiscuous nurse, Nightingale argued for

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dramatic changes in hospitals and their management, including redesigning hospitals to lessen the number of hidden corners, closets, and bathrooms (where illicit liaisons might take place), keeping orderlies out of the nurses’ rooms, giving the nurses plenty of work to keep them busy, and remaining hyper vigilant of all encounters between men and women within the hospital.34 In seeking to lessen the stereotype of the drunken or promiscuous nurse, reformers attempted to strengthen the nurse’s moral credibility and to lessen popular uproar that Victorian women were not only venturing out of the household, but seeking a living as well.

To defuse the threat of this “new-style professional nurse” further, reformers underscored her “personal attributes rather than her technical skill.” In other words, women ought to be nurses because they are naturally caring and sympathetic, not because they possess unique technical skills or medical knowledge. As Rivers concludes, “in their focus on the personal attributes of the nurse, in their attempt to position their new recruits as ‘womanly’ women of the highest moral character, then, the nursing reformers were in fact co-opting the idealised morality and caring instinct of the domestic woman nurse. In this way that idealised figure was manipulated and undermined, as it shifted to encompass paid work outside the home.”35

I agree with Rivers’ conclusion, and I also argue that there is a reason the reformers’ argument succeeded in making nursing a socially acceptable profession for women. That reason is the pervasive relationship that the Victorians perceived between women, sympathy, and knowledge. To lessen the sting of women in the public sphere, reformers rearticulated the nurse’s relationship to knowledge and sympathy, making sure to assert the following: 1) the nurse’s

35 Rivers, 61-62.
feeling far outweighed her knowledge, 2) the knowledge she did acquire was interpersonal rather than objective, and 3) this extra feeling was natural for women.

We see the outline of this argument in Elizabeth Gaskell’s *Ruth* (1853), in that Ruth only becomes a nurse after she has learned how to negotiate and regulate feeling that is shared between different individuals. This is apparent in a poignant scene that occurs after Mr. and Miss Benson persuade Ruth to stay with them until Leonard is a year old. After making this decision, Ruth becomes less agitated about her future and is subject to “trains of reverie, and mournful regretful recollections which rendered her languid and tearful.” Significantly, “this was noticed both by Miss Benson and Sally, and as each had keen sympathies, and felt depressed when they saw any one near them depressed, and as each, without much reasoning on the cause or reason for such depression, felt irritated at the uncomfortable state into which they themselves were thrown, they both resolved to speak to Ruth on the next fitting occasion.”

Shortly thereafter, Sally catches Ruth sobbing over Leonard, and witnesses that he “contracts” his mother’s feeling: “. . .she saw the babe look back in his mother’s face, and his little lip begin to quiver, and his open blue eye to grow over-clouded, as with some mysterious sympathy with the sorrowful face bent over him.”

In this scene Gaskell portrays sympathy as a mode of feminine and maternal communication. While Mr. Benson might console Ruth when she cries or verbally expresses her despair, only Sally and Miss Benson are able to feel her depression even when she betrays few or no ostensible signs of it. Though she remains silent, Ruth’s feelings are transferred to Sally and Miss Benson, who are consequently thrust into the “uncomfortable” position of sharing Ruth’s

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37 Ibid.
depression.\(^{38}\) In this scene, sympathy is both feminine and embodied, because Ruth’s maternal tears (allegedly) have the power to bring bad luck upon Leonard. Here Gaskell hearkens back to the popular belief that the strong physical connection between mother and child gave them a similarly strong sympathetic bond. Hence midwives’ tales of mothers who imagine monsters while pregnant and subsequently give birth to deformed infants.\(^ {39}\)

Gaskell understands and underscores the power of shared feeling. Indeed, it is only after Ruth learns its power via Sally’s admonitions that she is able to nurse Leonard better and also become a sick nurse during the cholera epidemic. The lesson that Ruth learns through Sally and Miss Benson’s “keen sympathies” reveals that sharing feeling is necessary to care for and nurse others. It also suggests that they are particularly suited to those duties because they are female. Athenas Vrettos confirms as much in her work on illness in the Victorian period. For Vrettos, the nurse didn’t need verbal communication, since “certain kinds of illnesses” functioned “as strategies of communication.” The result was a “semiotics of emotional distress” in which the nurse became “the privileged interpreter of embodied emotions.”\(^ {40}\) Put simply, women can “read” and care for other bodies because they share feeling with them. Like Sally and Miss Benson, the nurse feels along with the patient and is therefore better able to care for him. Gaining knowledge of another’s feelings rather than facts about medical conditions, the nurse

\(^{38}\) This is also noteworthy because it suggests that Sally, Miss Benson, and Ruth exist in the same moral and class stratum. As I point out in my discussion of *Middlemarch*, sympathy was thought to exist only when the two (or three) parties are equals. Pointedly noting that the feeling is shared between Ruth, Sally, and Miss Benson, Gaskell thus makes plain that differences of class and/or social standing are of no consequence in the Benson household.

\(^{39}\) Enlightenment thinkers inherited and perpetuated this centuries-old explanation for the existence of monsters. According to Cody, “it had been long and widely maintained that ‘maternal imagination’ could alter the plastic form of a child in utero when a mother’s desires or fears overwhelmed her and her foetus.” Cody, *Birthing the Nation*, 120.

marks her “learning” as sympathetic, and not objective; feminine, and not masculine; feeling, as opposed to knowing.

Whereas Gaskell treats sympathy, knowledge, and female bodies only briefly, in Victorian medical woman fiction these issues consistently recur and are at the center of the medical woman’s struggle to obtain a degree and practice medicine. Todd’s novel *Mona Maclean, Medical Student* (1892) is important in this respect because Todd was herself a medical doctor and the close companion of Sophia Jex-Blake. Jex-Blake, as Virginia Woolf famously describes in *Three Guineas*, was at the forefront of the effort to allow women into medical schools, and led the group of seven women (the “Edinburgh Seven”) that attempted (unsuccessfully) to obtain medical degrees from Edinburgh University between 1869-1873. Woolf’s source of information was Todd’s biography of Jex-Blake, *The Life of Sophia Jex-Blake* (1918). *Mona Maclean* thus represents an “insider’s” perspective (albeit fictionalized) on the struggle for women’s medical education. Despite its frank portrayal of medical school, including human anatomy, animal dissections, and professional politics, critics received the novel with a surprising degree of approbation. Though he found it regrettably “full of” the “‘female medical’ movement,” William Wallace of *The Academy* admits that *Mona Maclean* “must be allowed to be a promising and, indeed, eminently ambitious story.” He detects that “Graham Travers” (Todd’s pseudonym) is but a “novice in literature” with “some philosophic and other problems to solve,” but Wallace is forced to admit that “in *Mona Maclean* [Todd] shows that she can write well, and that she can construct an ingenious plot.”

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41 Woolf devotes a fair amount of space to Jex-Blake’s biography because Jex-Blake’s “case is so typical an instance of the great Victorian fight between the victims of the patriarchal system and the patriarchs, of the daughters against the fathers. . .” Virginia Woolf, *Three Guineas* (Orlando, FL: Harcourt, Inc., 1938), 78.
Wallace gives high praise for a novel that a group of male medical students debating the medical woman reputedly deemed “the hysterical work of a sentimental female.”\textsuperscript{43} Wallace’s review also highlights the central conflict of the novel, and in fact, the central conflict facing any Victorian woman who attempted to pursue a medical career. Describing how Mona, at the conclusion of the novel, is united with Ralph Dudley in both a medical practice and in marriage, Wallace writes: “But it is not to be expected that every female medical student should be able to solve the two problems of her life so satisfactorily as Mona.”\textsuperscript{44} As you can see, Wallace identifies a conflict between the medical woman’s personal and professional desires. In my terms, we might say that the medical woman faced a conflict between her “feminine” feeling and her desire to obtain “masculine” knowledge. In Kochanek’s words, medical woman fiction consistently returned to a “common underlying narrative,” which “always concerned how a woman doctor resolved the tension between her gender and her profession.”\textsuperscript{45}

Swenson makes a related point by underscoring how gender politics shaped fictional representations of the female doctor’s private and public lives. For Swenson, medical woman fiction often romanticized the female doctor so as to negate her status as a professional and political threat. According to Swenson, “By subsuming the identity of the woman doctor within her professional role and then reducing that role to conflicts with potential suitors, these texts finally define her by her (defective) sexuality alone, rendering her less threatening professionally.”\textsuperscript{46} The contrast between the purely professional female physician and the romanticized doctress is most clearly showcased in Kenealy’s \textit{Dr. Janet of Harley Street} (1893).

\textsuperscript{43} Hilda Gregg, “The Medical Woman in Fiction,” \textit{Blackwood’s Edinburgh Magazine} 164 (July 1898): 108.
\textsuperscript{44} Wallace, 504.
\textsuperscript{45} Kochanek, 45.
\textsuperscript{46} Swenson, 107.
In this novel, Kenealy—who was herself a well-known physician and the author of *Feminism and Sex-Extinction* (1920)—tells the story of Phyllis Eve, a young girl who flees after her wedding because she realizes too late that her husband’s courtship niceties were motivated only by his debauched secret desires. Upon leaving her husband, Phyllis is lucky enough to encounter Dr. Janet Doyle, with whom she develops a mentorship that leads her to pursue a medical degree. However, just as the novel begins with a marriage, so too does it end with one, since Phyllis quickly becomes enamored with a Dr. Paul Liveing and marries him after the death of her first husband.

By bookending Phyllis’s medical career with her marriages, Kenealy suggests that it is merely an interlude before a more desirable marriage. In Phyllis, Kenealy confirms that the doctress’s career is always shadowed and superseded by her sexuality. This theme is also evident in the sharp contrast between Phyllis and her mentor Dr. Janet. While Phyllis is delicate, feminine, and never forgets the person behind each patient, Dr. Janet is tall, with masculine mannerisms, large hands, and a wide forehead. In her, Kenealy embodies a rational medical woman who cares for nothing but her cause and career and is therefore contrasted quite unfavorably with our heroine Phyllis.

A unique alternative to Kenealy’s conservative narrative is Conan Doyle’s “The Doctors of Hoyland,” which depicts a small-town physician, Dr. James Ripley, who finds himself and his practice assaulted by the presence of a competing female physician named Dr. Verrinder Smith. Despite his initial repugnance at his female rival, whom he deems “unsexed,” Dr. Ripley’s opinions undergo a change after a broken leg forces him into Dr. Smith’s care. Unlike Kenealy’s Dr. Janet, Conan Doyle’s doctress is intellectually adroit and emotionally caring. Not only has

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Dr. Smith received the Lee Hopkins prize for original research, as well as eminent degrees from Edinburgh, Vienna, and Paris, but she also demonstrates a gentle touch that betrays her sex. According to Conan Doyle, “under all her learning and her firmness ran a sweet, womanly nature, peeping out in her talk, shining in her greenish eyes, showing itself in a thousand subtle ways which the dullest of men could read.”

Conan Doyle’s story suggests that feminine feeling need not disqualify a woman from medical practice. It also indicates that the doctress need not be either a mannish brute or an emotional girl who chooses medicine only as a detour to marriage. Indeed, Conan Doyle gestures at the latter narrative possibility when, despite his initial misgivings, Dr. Ripley asks for Dr. Smith’s hand in marriage and is denied because she means to accept an opening at the Paris Physiological Laboratory. Regardless of her position in Paris, Dr. Smith rejects Dr. Ripley because she wants to devote her life to science; while there are “many women with a capacity for marriage,” there are “but few with a taste for biology.” Here we see a possibility that is not afforded in Kenealy’s novel, since in Dr. Smith Conan Doyle portrays a gentle, caring, and attractive woman who not only wins coveted awards and positions, but also refuses to give them up when an offer of marriage comes along. Where Kenealy sees feminine feeling as incompatible with medical practice, Conan Doyle hints that the two can in fact coexist. Since part of Dr. Smith’s efficacy in treating Dr. Ripley stems from her delicacy of feeling, Conan Doyle’s story even goes so far as to suggest that feminine feeling might aid medical knowledge.

In *Mona Maclean* Todd gestures towards something similar through her characterization of Dudley and Mona, whom she uses to suggest that the ideal physician is androgynous—both personally and epistemologically. Our first evidence of this occurs early in the novel, when

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48 Ibid., 292.
49 Ibid., 294.
Mona’s wealthy uncle, Sir Douglas Munro, interrogates her about the nature of her medical education. Through Munro, Todd gives voice to several arguments used both for and against the medical woman. After remarking that he does see the “terrible” necessity of female doctors, given that otherwise women are “pulled apart by a man,” Munro still concludes that it is an incredible sacrifice on the part of the doctor herself (particularly one who is related to him and attractive). Without exception, he declares, the female medical student must become “hard and blunted,” losing “everything that makes womanhood fair and attractive.” In response to these charges, Mona passionately wonders to herself how she can explain the “wonder and beauty” of medical science: “‘To be a true anatomist,’ she thought with glowing face, ‘one would need to be a mechanician and a scientist, an artist and a philosopher. He who is not something of all these must be content to learn his work as a trade’” (22).

The lack of communication between uncle and niece is paramount in the scene above. As readers of both characters’ spoken words and our heroine’s private thoughts, we know that Mona is drawn to medicine because it is awe-inspiring. Where Sir Douglas sees only unspeakable anatomy details and the butchering of human cadavers, Mona sees the wonders of the physical world. The divide between the two is highlighted first by Mona’s failure to share her thoughts with her uncle, and secondly, by her uncle’s indifference to his niece’s thoughtful and intelligent inner dialogue. “As a medical student,” Todd writes, “she had got beyond his range. As a woman, for the moment, she was beautiful” (22-23). Though Mona’s true philosophy of medicine remains a secret, Todd underscores that Sir Douglas is happy to bask in the glow of a pretty girl without really caring about what she might be thinking.

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A telling contrast to the stunted communication in the scene above occurs later when Mona meets Dr. Alice Bateson. Dr. Bateson is called in to treat Mona’s close friend Lucy Reynolds, at which time Todd engages the two women’s thoughts as if they could communicate wordlessly. After describing Dr. Bateson’s “girlish figure,” “earnest brown eyes,” and “resolute mouth,” Todd juxtaposes Mona’s thoughts with Dr. Bateson’s: “‘She means work,’ thought Mona. ‘There is no humbug about her.’ ‘The girl has some nous,’ thought the doctor. ‘She would keep her head in an emergency’” (177). The encounter between Mona and Dr. Bateson is structured similarly to the one between Mona and Sir Douglas. In both cases, Todd’s omniscient narrator examines Mona’s thoughts and those of her companions, though Sir Douglas doesn’t really think about Mona and instead just reflects on her pretty face. Dr. Bateson, on the other hand, quickly appraises Mona’s “head” or intellect, and the shared admiration between the two women is underscored by the way Todd pairs their thoughts as if they were telepathically communicating.

The difference between Mona/Dr. Bateson and Sir Douglas is that Sir Douglas sees medicine and feminine feeling as incompatible. By contrast, Mona understands that medicine need not be a degrading pursuit of knowledge that saps one of feeling, emotion, and humanity. For her, medical knowledge is only degrading when one fails to see the art, the beauty, and the wonderment of it. Given Mona’s privileged position in the narrative, it is fair to conclude that Mona’s is the stance on knowledge that Todd advocates. Subtly criticizing Sir Douglas as he dismisses our heroine’s choice of profession, Todd also critiques his strict opposition between knowledge and feminine feeling. The alternative view, Todd suggests, is that medicine can be a science and an art, a way of feeling and knowing.
We see this in Mona and Dr. Ralph Dudley’s apparent androgyny and also in their intense sympathy with one another. For example, Todd consistently takes pains throughout the novel to underscore how feminine Mona is. Unlike Dr. Janet, Mona is young and far from “mannish.” After her cousin Evelyn erroneously assumes that Mona does not care for clothes because she is a medical student, Mona declares, “I am afraid I do care about fashion, fashion quâ fashion, fashion pure and simple” (19). Likewise, when working in her cousin’s shop in Scotland for six months, Mona gains repute in the neighborhood for her good taste in bonnets and lace. Thus, though she possesses a keen mind and a bright medical future, Todd also endows her heroine with a multitude of feminine attributes. Like his future bride, Ralph Dudley also exhibits marked feminine and masculine attributes. Early critics of the novel noted as much, as is evident when Wallace declares that another one of Mona’s suitors, Mr. Dickinson, a.k.a. “the sahib,” is “indeed much more of a man in most respects than Dudley.”⁵¹ Even Mona remarks on Dudley’s effeminacy, telling Lucy Reynold’s father that the “friend” she met while working at her cousin Rachel’s shop was male but “nice enough to be a woman” (207).

Mona and Dudley’s shared androgyny accounts for the sympathy that they quickly develop with each other. Early on, Mona remarks that Dudley is “curiously simpatico” (126) and Dudley mentally compares Mona to “an outlying part of his own mind” (160). Dudley’s remark is particularly important for my work because it crystallizes just how significant sympathy can be. For Dudley and Mona, feeling and thoughts are shared freely. Later at Dudley’s poetry recital Mona compliments him on the vividness of his words: “‘In any case, you made it poetry for me. I saw the sunny, glowing street, and the blue sky overhead.’” To this, Dudley replies, “‘Did you? . . . ‘Truly? I am so glad. I had such a vivid mental picture of it myself, that I thought the brain-

⁵¹ Wallace, 504.
waves must carry it to some one”” (250). What’s interesting about this scene is the content of Mona and Dudley’s telepathic “conversation.” At the most basic level they are merely describing how they shared the experience of the poem. But Todd takes pains to emphasize the empirical nature of what Mona and Dudley share. Mona sees the “sunny, glowing street” that Dudley portrays, and Dudley’s recital is first and foremost his effort to convey his visual impression, or “vivid mental picture” of the scene depicted in the poem. Mona and Dudley do not share only abstract feelings or meaningless emotions, but rather, their sympathy allows them to communicate empirical data about the world around them.52 While one might argue that the “world” in this case is merely the fictional world of the poem, Todd’s description nonetheless underscores the empirical nature of the knowledge shared sympathetically between Dudley and Mona. In this way Todd’s narrative hints towards a kind of epistemological androgyny that erodes the otherwise strict boundaries between knowledge/sympathy and male/female.

The androgyny that Dudley and Mona exhibit in their gender traits and in their epistemological standpoints is dramatically opposed to Sir Douglas’s strict opposition between feminine feeling and knowledge. For Mona and her future husband, feeling need not be antithetical to empirical knowledge and, in fact, it might even assist one in acquiring it. We see this on multiple occasions when Todd describes how Mona and Dudley approach the study of medicine. Like Mona, Dudley does not view medical science as a strictly objective, cold, and

52 In his book on Victorian telepathy, Roger Lockhurst offers an interesting look into the relationship between telepathy and sympathy. According to Lockhurst, women were often perceived to be superior telepathic mediums because their delicate nervous systems made it easier for them to discern unseen communication, vibrations, and the even the presence of ghosts during séances. Not only did woman’s intrinsic sympathy allow other beings to enter her consciousness and communicate from beyond the grave, but it also signified “a quantifiable extension to the sympathetic social instinct,” though, as Lockhurst notes, this instinct became problematic when the female medium was too readily and too often permeated by others’ thoughts and words. See Lockhurst, The Invention of Telepathy 1870-1901 (Oxford: Oxford University Press, 2002), 218-219.
empirical task, as is clear when the narrator describes him observing members of the opposite sex: “. . .he found himself analysing them as calmly as if they were men. Yet ‘analyse’ is scarcely the right word to use, for Dudley read character less by deliberate study than by a curious power of intuition, which few would have predicted from a general knowledge of his mind and character” (142). I need hardly point out that intuition is not a traditional tool of empirical medicine or science. The *Oxford English Dictionary* defines intuition as “the action of looking upon or into”; more commonly, it refers to “the action of mentally looking at; contemplation, consideration; perception, recognition; mental view.”

This difference between “looking upon” and “mentally looking at” is an important one because while “looking upon” a patient might be a recognized practice in Western medicine, “mentally viewing” a patient is not. Unlike his purely rational and empirical colleagues, then, this passage underscores that Dudley is not a cold dissector of human bodies, but instead a physician who uses his feelings and intuition in his pursuit of medical knowledge.

Dudley makes a related point about the value of emotion when Mona helps him attend to a young woman giving birth. Significantly, Dudley makes the following remarks just after he and Mona playfully banter about the respective roles of the nurse and physician. Because Mona has promised to keep her status as a medical student a secret while staying with her cousin in Scotland, Dudley has no idea that his female helpmeet is in fact not a subordinate, but his medical school peer. Telling Mona that she need not feel guilty for laughing (unrelatedly) right after she has attended on Maggie, the poor and unmarried new mother, Dudley argues that emotion has a place alongside their medical and philanthropic duties. “‘Do not the laughter and jesting, like the flowers and the sunshine, show that the heart of things is not all tragedy?’ . . . ‘I

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think it is a great mistake to encourage mere feeling beyond the point where it serves as a motive. As we say in physiology that the optimum stimulus is the one that produces the maximum contraction; so the optimum feeling is not the maximum feeling, but the one that produces the maximum of action” (336). At first glance, Dudley’s comments appear to diminish the practical value of feeling by portraying it as an oft-misused vehicle for action or stimulus. But at the heart of Dudley’s sentiments is his view that feeling is valuable, in this case as an incitement to action or contraction. For Dudley, feeling needs to be proportionate to the action that follows it. Though there is the possibility that it might become excessive, Dudley maintains that feeling is a vital component of human action and physiology. Combined with his practice of intuiting facts about the world, Dudley’s remarks about feeling in this scene emphasize that he is not the cold, rational empiricist that we see in an anatomist like Dr. Benjulia from Wilkie Collins’s *Heart and Science* (1882). Instead, Dudley—like Mona—professes the value of feeling in life and in science. Like the androgyny they both exhibit personally, Dudley and Mona’s approach to medicine suggests that the best epistemological methods might be androgynous as well.

In her review of medical woman fiction, the Victorian critic Hilda Gregg cites the ending of *Mona Maclean* as an ideal blend of masculine and feminine and personal and professional. Gregg sees Todd’s novel as an apt gift to any female medical student, because “once begun, the book itself would carry on its reader to the end, there to show her what is surely the ideal medical career—the joint exercise of their profession by a husband and wife.” Gregg’s point is an important one because she hints how the ending of Todd’s novel attempts to unite not only Mona and Dudley’s hearts, but their epistemological positions as well. As Gregg suggests, Todd is not

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54 Gregg, 109.
solely concerned with the successful conclusion of the marriage plot, but is instead emphasizing that the best approach to medicine is one that incorporates both the “masculine” and the “feminine,” knowing and feeling. Indeed, at the conclusion of the novel, Todd confirms that this uniting of male/female and knowing/feeling is the result of shared sympathy. Describing Mona and Dudley’s happiness upon their marriage, Todd writes “. . .for these two it was one of those rare days when the cup of pure earthly happiness brims over, and merges into something greater. Every simple act of life took on a fresh significance now that it was seen through the medium of a double personality” (459).

Two things are of especial note here. First is Todd’s emphasis on marriage as a vehicle for seeing things anew. Second and even more important is the phrase “medium of a double personality.” What Todd describes here is the process of truly seeing as another person does. In marriage, Mona and Dudley gain the ability to see from their partner’s perspective; while she doesn’t explicitly label this as sympathy, that is nonetheless what she describes. Combined with her persistent reminders of Mona and Dudley’s intense sympathetic bond throughout the rest of the novel, this scene proves that the union between Dudley and Mona is romantic, professional, and epistemological. Sympathy here is both an indicator of the shared androgyny between Mona and Dudley as well as a reason for their successful marriage and medical practice.

Regrettably, Mona’s choice to marry her lover and medical partner was not one that, historically, the Victorian medical woman was allowed. Gregg shrewdly pointed out in her criticism that the fictional Mona Maclean was “somewhat unduly perfect,” and there is no doubt that Mona’s real-life counterpart would likely have felt that the demands of a medical career precluded the possibility of romance. Medical school was challenging for any student, but female students in particular faced difficulties that male students did not, including: discrimination from
male students, professors, and university administration, being compelled to hire chaperones for some university lectures, difficulty gaining access to certain lectures at all (whether due to a professor’s personal bias or a university policy about lectures to which women shouldn’t be exposed), and an even greater financial burden because costly private tutors had to be hired to compensate for those classes that were deemed off-limits. In the unpublished memoirs of Dr. Dorothea Clara Nasmyth, her son James describes the practical difficulties that his mother encountered while studying Physiology at Somerville College, Oxford: “So Dorothy was the only woman in her class. The men were too shy to speak to her and she was too shy to speak to the men, which was embarrassing and made things difficult in the practical course of scientific study. She could not ask her neighbour where the many bits of equipment were stored, or for the loan of a match to light the Bunsen burner. For weeks she exchanged no word with a fellow student.” While Nasmyth went on to obtain her medical degree from the University of London in 1909, it is fair to say that many would-be medical women were stymied by the challenges they met at every step of their struggle to study and practice medicine.

Dr. Elizabeth Blackwell neatly summarized the obstacles that were unique to female medical students, writing in her autobiography that she had no medical friends because an “invincible, invisible barrier” separated her from her classmates. Blackwell’s journey as a physician illustrated that for the Victorians, feminine feeling was crucial to the debate about women obtaining medical knowledge. For example, Blackwell initially “repudiated” the idea of become a doctor because she “hated everything connected with the body,” “could not bear the sight of a medical book,” and was so “ashamed of any form of illness” that she would sequester

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herself when sick because she was convinced that “subjection to disease was contemptible.”

Despite her vehement objections, Blackwell reconsiders when she witnesses first-hand how the embarrassment of seeing a male physician prevented a close friend from receiving treatment for uterine cancer. According to that friend, who remains unnamed in Blackwell’s autobiography, being treated by a female physician would have spared her of her “‘worst sufferings,’” which stemmed from being treated by men with “methods of treatment” that were “a constant suffering to her.”

In addition to sympathizing with her friend’s suffering at the hands of a male doctor, Blackwell’s strongest impetus to study medicine was her desire to avoid emotional entanglements with the opposite sex. Since childhood, she recalls that she had always been “susceptible” to the “disturbing influence exercised by the other sex.” This “influence” incited numerous “acute attacks” that recurred whenever she became emotionally intimate with someone with whom she imagined sharing a “life association.” In her autobiography, Blackwell explains how these complicated romantic feelings and “attacks” persuaded her to become a doctor: “I felt more determined than ever to become a physician, and thus place a strong barrier between me and all ordinary marriage. I must have something to engross my thoughts, some object in life which will fill this vacuum and prevent this sad wearing away of the heart.”

I don’t mean to suggest that Blackwell was motivated solely by her personal desire to avoid marriage, but her statement illustrates that the Victorian medical woman’s feeling was fundamentally (and often antithetically) linked to the question of her medical knowledge.

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57 Ibid., 27.
58 Ibid.
59 Ibid., 28.
In addition to her reasons for studying medicine, Blackwell’s approach to medical science also reveals just how complicated it was for the Victorian medical woman to balance feeling and knowledge in medicine. On one hand, Blackwell’s medical approach was largely moral; while other medical women clung to science and medical knowledge to buttress their credentials,\textsuperscript{60} Blackwell was one of a group of female medical professionals who envisioned the female doctor first and foremost as a moral healer. According to Blackwell, the physician must have a “clear perception of right and wrong, and a high standard of faith and conduct,” since moral “growth” directly inspires intellectual growth. Therefore, because women are more thoroughly governed by what is “right,” they are especially suited to a career in medicine. As she puts it, “Moral perception becomes reason, as the intellectual faculties grow; and reason is the true light for all. It is in this high moral life, enlarged by intelligence, that the ideal of womanhood lies. It is through the moral, guiding the intellectual, that the beneficial influence of woman in any new sphere of activity will be felt.”\textsuperscript{61}

Blackwell made these somewhat idealistic statements late in her career when she spoke to the London School of Medicine for Women as a well-established lady physician. In contrast, remarks she makes earlier in her struggle show a woman forced to manage the expectation of feminine sympathy alongside her pursuit of medical knowledge. Speaking with her sister Emily

\textsuperscript{60} Mary Putnam-Jacobi was one such woman. Blackwell mentored her early in her career, but Putnam-Jacobi quickly realized that for Blackwell, science would always be secondary to religion. In a long letter to Blackwell in 1888, Putnam-Jacobi admits that it is Blackwell’s mind “that conceived the idea of women physicians in modern life,” and yet she still alleges that Blackwell has “always disliked, ignored and neglected medicine.” By contrast, Putnam-Jacobi had been drawn to medicine out of her love for science and had committed herself to study in Paris since at the time it was the only place a woman could receive a rigorous scientific education. See Julia Boyd, \textit{The Excellent Doctor Blackwell: The Life of the First Woman Physician} (Stroud, UK: Sutton Publishing Limited, 2005), 196-197, 264.

\textsuperscript{61} Elizabeth Blackwell, “The Influence of Women in the Profession of Medicine,” \textit{The Sentinel} 12, no. 2 (1890): 15.
in front of the New York Infirmary in 1863, Blackwell asserts, “there is not in the whole extent of our country, a single medical school where women can obtain a good medical education.”  

Blackwell next addresses the claim that women are particularly suited to medicine because their work as mothers and wives prepares them to care for families as the family doctor. While she sees some truth to this argument, Blackwell cautions that

> medicine is a science as well as an art; it needs knowledge as well as feeling. Let us give all due weight to sympathy, and never dispense with it in the true physician; but it is knowledge, not sympathy which can administer the right medicine; it is observation and comprehension, not sympathy, which will discover the kind of disease, and though warm sympathetic natures, with knowledge, would make the best of all physicians, without sound scientific knowledge, they would be most unreliable and dangerous guides.

As you can see, Blackwell’s emphasis changes significantly in these two excerpts. Though at the close of her career she essentializes woman’s claim to medicine by asserting that they know best what is “right,” the remarks she makes at the beginning of her career paint a very different picture. More specifically, I argue, they showcase a woman who is still struggling to achieve equal footing with her male counterparts, and who is therefore reluctant to support any argument that relies on assumptions about feminine feeling and sympathy and would deny women knowledge because of these assumptions.

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62 Elizabeth and Emily Blackwell, *Address on the Medical Education of Women, Prepared by Drs. E. and E. Blackwell, Read Before a Meeting Held at the New York Infirmary, December 19, 1863* (New York: Baptist & Taylor, Book and Job Printers, 1864), 8. Blackwell does go on to admit that there are schools wherein women can get a medical education, though she argues that their education at these institutions is below par because they are under-supported with libraries, scholarships, dispensaries, clinics, and professional guidance.

63 Ibid., 9.
Like *Mona Maclean* and the contemporary debates on the medical woman that I have presented, Blackwell’s remarks indicate how central feminine feeling was for a woman seeking medical knowledge. To address a woman’s knowledge, it was necessary to consider her feeling; thus, while woman’s “natural” sympathy was invoked by both proponents and opponents of the medical woman, what remains constant is the fact that you simply couldn’t have one without consideration of the other. To ask what a woman should know was inextricably linked to the question “What, how, and with whom should/does she feel?” In this regard, the medical woman is no different from the gynecology patient, since in both cases womanhood is yoked to feeling, and sympathy in particular. Ultimately, this connection has consequences that reach far beyond the question of Victorian gender ideologies, since—as I have suggested—women and their sympathy also retained dramatic effects on the production and status of medical knowledge.
Though it goes unnoticed in the critical literature on Victorian vivisection and gynecology, these two movements, which arose at approximately the same historical moment, drew from a shared repertoire of medical and scientific discourse. According to Richard French, the effort to abolish experimentation on animals during the last three decades of the nineteenth century “transcended the issue of vivisection” and actually “arose from, and served as a palpable focus for a disparate array of social, cultural, and political forces.”¹ In this chapter I argue that one of these forces was the rise of gynecology as a medical specialty. Scholars have noted that the antivivisection movement drew parallels between gynecology patients and vivisected animals at a time when both were used for experimentation and to develop new surgical techniques. However, in this chapter I give a more thorough examination of this comparison and suggest that the vivisected animal and the hysterical were linked because their bodies were thought to deceive and hinder those who tried to know it. Not only did the vivisected animal and the gynecology patient exhibit symptoms of sensations and pathologies that were allegedly not “real,” but in both cases sympathy threatened to derail the effort to know and cure these bodies.

In the first section of this chapter I contextualize the comparison between women and animals within mid to late-Victorian evolutionary biology, illustrating especially how difference between the subject and object of knowledge was thought to complicate the subject’s effort to

know its object. Next, I move on to medical and scientific texts and demonstrate how they represent both the vivisected animal and the hysterical as a wealth of symptoms and sensations without any definitive cure or source of disease. Finally, I move to critical and literary representations of vivisection and gynecology patients in the period, in which we see that critics and authors with very different allegiances shared not only a sense of how deeply related the vivisected animal was to the gynecology patient, but also a realization that multiple forms of sympathy shaped the acquisition of knowledge. In correlating women and dissected dogs, Victorian authors, medical professionals, and antivivisectionists underscored how the effort to obtain knowledge about the female or animal body was directly shaped by the sympathies of the subject and object of knowledge. Whether they were dissecting the viscera of the family pet or exploring the abdomen of the female body, scientists and medical men struggled to reconcile the need for knowledge with the sympathy felt for and by the object of knowledge. Examining these cases in tandem reveals not only that the Victorians saw sympathy as a central part of any epistemic project, but that certain bodies—especially those of women—posed a formidable challenge to such projects.

While the Victorians were by no means the first to compare animals and women, Victorian theories of evolutionary biology did incite and further fuel discourse about the link between humans and animals by “provid[ing] a scientific foundation for interspecies

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comparisons.”3 Victorian work done in fields as various as biology, geology, and natural history made it clear that scientific conclusions about apes, for example, might have consequences for humans as well. On one hand, interspecies similarity allowed scientists to justify their work by arguing that vivisection directly benefited medical science and mankind. On the other hand, the “evolutionary continuity between species that helped to inaugurate the emergence of this professional physiological regime also could be seen as implicitly challenging the ethical foundations of vivisection.”4 In other words, if humans and animals do share a common biological origin, then vivisecting animals differs from dissecting a live human not in kind, but merely by degree. Vivisected animals have to be similar enough to humans in order to provide the maximum benefit to humans, and yet that similarity is what makes the practice of vivisection ethically questionable. As such, the Victorians anxiously tried to determine which species were similar enough to humans to warrant protection from vivisection; horses, dogs, and cats were the special targets of much antivivisection sympathy, while frogs garnered little sympathy from either physiologists or their antivivisection foes.5

Given their supposed status as lesser-developed versions of the male species, it is not surprising, then, that women were the point of comparison between humans and animals. Like children, they possessed smaller frames, smaller craniums, and smaller brains; these things predisposed them to lack the reason and intellect of their male counterparts. For sexologist

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4 Ibid.
Havelock Ellis, the female’s more developed “primitive nervous centres” also made her highly susceptible to fits of emotion. In contrast to these “primitive” dispositions, Ellis argues that men possess a more sophisticated nervous system, one that allows them to reason carefully and act judiciously. In addition to the evolutionary proximity between animals and women, gynecology and vivisection were linked in the Victorian period because it was in these two fields that doctors began making major developments in surgery. For critics of vivisection, the zealousness for dissecting animals directly translated into the fervor to perform ovariotomy on human patients. Fueled by the desire for knowledge, surgeons recklessly excised their patients’ ovaries without recognizing that “unsexing” a woman had vast social, mental, and moral consequences. Antivivisectionists also deplored ovariotomy because, according to Mary Ann Elston, rabbits were often used in “preparatory experimental work” by eminent surgeons like Sir Thomas Spencer Wells.

The vast difference between the educated male gynecologist or scientist and his canine or female patient made it remarkably difficult for him to quantify what pain the patient felt during examination and experimentation. In debates about gynecology and vivisection, a central concern is the challenge of accurately pinpointing the felt experience of pain. In this regard the debates revolved around the issue of sympathy, since in both cases writers asked how to sympathize with another whose utter foreignness prohibits one from knowing and sharing their emotional, physical, or mental state. The surgeon Stephen Paget outlined the issue in “Vivisection: its Pain and its Uses,” by first encouraging his readers to consider how their lifestyle already causes pain or death to animals. This was a common refrain among vivisection

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supporters, as they saw hunting with dogs, shooting, or wearing exotic bird feathers as more inhumane than vivisection and yet socially sanctioned. The economist and philosopher William Stanley Jevons stated the case directly by asking “on what sociological or psychological grounds can we explain the fact that a comparatively small amount of pain inflicted for the lofty purpose of furthering science and relieving the ills of mortality should excite such intense feelings of disgust, while the infliction of almost infinitely greater amounts of pain in mere trivial amusement seems to excite no corresponding feeling at all?” If only the opponents of vivisection were to “make a careful survey of their furniture, clothes, and ornaments, their food, amusements, and habits of life for a year,” Paget argues, they might be better able to make an informed decision about the amount of suffering inflicted by vivisection.

Paget also explains how arguments for and against vivisection drew on the practice of consulting one’s own experience of something in order to assess it: “If we reflect on the evidence on which we believe that, from any given injury or disease, anyone must suffer less or more pain, we find that we are generally guessing, or saying to ourselves, ‘It must be so,’ without any clear evidence that ‘It is so.’” What is most interesting about Paget’s comments is the implicit yet pervasive distinction that he makes between feeling and knowing. For example, Paget immediately suggests the importance of rationally considering our feelings when he implies that it is necessary to “reflect on the evidence on which we believe….” Belief here needs to be subjected to the scrutiny of reflection and evidence, the alternative being that we allow ourselves to be guided by the things that we “sa[y] to ourselves” rather than by actual facts. For Paget,

10 Ibid., 921-22.
making decisions in this way is erroneous not only because it denies reason at the expense of feeling, but because we can never fully know what another feels. “At most, if we have ourselves had any injury or disease, we may believe that another in the same condition would suffer just as we did.” But, Paget declares, “few beliefs would be more fallacious”; even the most minutely described experience of disease or illness will be experienced in wildly different ways by different people.\textsuperscript{11}

The trouble here is the difficulty of difference, that is, knowing something about someone or something that is different from one’s self. In a telling footnote to his article, Paget suggests as much when he admits,

\begin{quote}
We do not know what sufferings attend an animal being hunted to death; but, as we are in the habit of judging of the pains of animals by our own feelings, I may mention the following fact. During the Franco-German war, a soldier, being pursued by the enemy, made almost superhuman efforts to escape … and got safe to camp. …The man was many months before he recovered from the shock.\textsuperscript{12}
\end{quote}

Paget does not draw any further conclusion from this example, but it is telling that there is once again a tension between evidence (it took the soldier a long time to recover from the shock) and what he is proposing to know (how a rabbit suffers after being hunted for sport). Impeding the direct correlation between evidence and knowledge is the incommensurability of the different experiences, especially given that the soldier and the rabbit don’t belong to the same species.

Paget’s analysis relies on the assumption that there are “lower” and “higher” species on the evolutionary hierarchy. We see this when he declares that “the general sensibility to pain is far greater among the more than among the less cultivated races of mankind; that savages, as

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\begin{itemize}
\item\textsuperscript{11} Ibid., 922.
\item\textsuperscript{12} Ibid., 940.
\end{itemize}
they are called, endure with comparative indifference inflictions which to most persons of the higher races would be terrible.” This is due in large part, he asserts, to the fact that “mental cultivation continued through many generations has not only increased the general keenness of our senses … it seems to have increased equally our sensibility to pain and our power of directing our attention to it.” With greater evolutionary development comes greater sensitivity to pain as well as a disposition to focus on that pain, and therefore human beings are capable of feeling things that lower animals do not feel—even when they experience the exact same physical sensation.

Paget’s argument can’t help but leave a sour taste in the mouths of those searching for concrete conclusions based on observable facts. The difference of feeling between humans and animals might be used to justify the practice of vivisection, but Paget emphasizes that the cost of that justification is the possibility of knowing how a dog feels when its nerves are dissected. This is clear in the preceding excerpt when Paget frankly admits that “we do not know” what an animal feels as it is hunted, and yet we are still “in the habit of judging of the pains of animals by our own feelings.” Elsewhere in his essay Paget is adamant in his support of empirical research and scientific methods, and thus his reliance on an empirically null “habit” provides another telling indication of the intimate correlation between knowledge and sympathy in the vivisection debates. It also sheds light on the way that varying degrees of difference—whether based in race, species, gender, etc.—influenced that correlation. Put simply, sympathy and knowledge were intimately tied in Victorian vivisection debates, and presumed differences between animals and humans shaped and were shaped by this correlation.

13 Ibid., 922.
Jevons further elaborates on the epistemological pitfalls of sympathy by outlining the fundamental components of cruelty, which he calls a “highly complex notion” that consists of “several distinct elements involved together in a most subtle manner.” Jevons categorizes cruelty based on the actual pain inflicted on another, the motive for inflicting the pain, the degree to which the action is routine and familiar, and “the manner in which the pain is expressed and the circumstances of its infliction impressed upon the imagination.” Most relevant for my argument is the importance Jevons accords the imagination. After describing the case of a man who recoiled from shooting birds because the birds’ writhing “impress[ed] upon him the sense of pain” in a way that the flopping of a fish did not, Jevons declares that cruelty “does not necessarily involve the infliction of any appreciable pain; it may consist in the production of expressions which merely suggest the ideas of pain. The psychological element of cruelty may, then, become so important as itself to constitute cruelty almost entirely.” It is for this reason that the English are able to tolerate hunting animals even as they deplore the vivisection of animals: “It is not the knowledge, in a logical sort of way, that pain is needlessly and wantonly inflicted upon the lower animals which excites popular indignation … Cruel actions, according to popular esteem, are simply those which bring the fact and intensity of pain too much before the imagination.”

Jevons is not arguing that there is no such thing as cruelty, but he does suggest that those things that are deemed cruel by “popular esteem” are largely the product not of facts or knowledge, but of our own overactive imaginations. For Jevons, vivisection is objectionable not because physiologists are inflicting horrendous pain on research animals, but because the British

14 Jevons, 677.
15 Ibid.
16 Ibid, 678-679.
imagines that they are. Unlike the flopping of a captured trout, the bird, the dog, and the horse are all able to express—or appear to express—the experience of pain, thus encouraging a similarly uncomfortable experience in the mind of the viewer. We abhor the pain of vivisection, he argues, because our imagination compels us to feel the pain that we presume the animal feels as well. Key here is the fact that this pain is presumed and not known: we see the dog making expressions that we associate with a particular feeling and thus we assume that the dog is experiencing it. When we feel the pain of the vivisected dog, we are not acting on empirical knowledge of the animal’s experience. Rather, we act upon either our assumption of what they feel based on their expressions, or we act, as Paget suggests, based on how we felt in a similar situation. In either case there remains an epistemological gap between the evidence and the conclusions drawn from it. At the heart of this gap is the difficulty of bridging the difference between the self and others and thus the difficulty of sharing feeling through sympathy. Knowledge of what other people are feeling is impossible and therefore not valid grounds for rejecting vivisection.

Though she is an unlikely complement to Paget and Jevons, Francis Power Cobbe’s writing on emotions also illustrates the close connection between sympathy, knowledge, animals, and gynecology. In “The Education of the Emotions,” Cobbe calls emotions “the most largely effective springs of human conduct. . .”17 They are derived from “the pressure of their natural stimuli,” i.e. first-hand experiences that cause one to feel a certain way, and they can also be incited “second hand,” through “the contagion of sympathy with the emotions of other men.”18 The “lower animals” share this susceptibility to sympathy, and whether it is communicated with

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18 Ibid.
“electric velocity” or “slowly and imperceptibly,” sympathy occurs when “one man conveys to another as if it were a flame, the emotion which burns in his own soul.”\textsuperscript{19} Using fire as a metaphor for sympathy, Cobbe portrays shared feeling as a rapidly spreading “contagion.” In this respect, her theory of sympathy strongly echoes gynecological theories of the embodied sympathy experienced by hysterics, and further demonstrates how difference in the Victorian period—for instance between the vivisector and his “pet” or between the gynecologist and his patient—was crucially linked to the (im)possibility of gaining knowledge of another’s experience and feelings. Like Jevons, Cobbe is highly attentive to the epistemological aspect of shared feeling, though as a social reformer she is most concerned with the possibility that sympathy might be the means of “infecting” healthy people with others’ unhealthy ideas, attitudes, or behaviors. While Cobbe takes for granted that sympathy can transmit real knowledge of another, Jevons retains a deep skepticism that this “knowledge” is real and accurate. However, in both cases it is clear that sympathy is an epistemological conundrum that is deeply connected to differences among humans and between humans and animals.

Thus far I have argued that Victorian antivivisection literature focused on difference as a crucial component of interpersonal sympathy, which in turn was a key factor in the production of medical and scientific knowledge. In large part I have identified how this difference was addressed in the case of inter-species comparisons between humans and animals. Now I’d like to indicate more directly how this focus on difference was also an effort to assess differences between the sexes, particularly as they were evinced between the gynecologist and his patient; doing so will show how antivivisection literature mirrored concerns that were also being explored in Victorian gynecology. Not only was the gynecology patient aligned with the

\textsuperscript{19} Ibid.
vivisected dog in her total subjugation to the rational doctor/scientist, but in both cases sympathy was a key part of justifications for and against resorting to “the knife.”

The possible connection between the vivisected animal and the gynecology patient is an implicit theme that pervades much Victorian antivivisection literature. Few savvy physiologists were willing to make the comparison, though antivivisectionists did suggest that the doctor’s penchant for “cutting” might extend beyond animals used for experimentation. Coral Lansbury attests as much, arguing that in fact much antivivisection ire was displaced anger that women felt upon being treated like clinical material by their physicians and surgeons. Working-class women in particular—as we saw in Esther Waters—could expect to be “bound to an elevated table, ankles in stirrups, while ebullient medical students examined them.” For these women, the antivivisection movement allowed them to “gratify impulses they would not have been able to recognize in themselves, or even have wished to acknowledge. They declared themselves to be outraged by the experiments they read about and saw illustrated … but all too often it was not the plight of the animals which stirred them to such anger, but their own.” Animals thus acted as “surrogates for women who read their own misery into the vivisector’s victims.”

20 Coral Lansbury, “Gynaecology, Pornography, and the Antivivisection Movement,” Victorian Studies 28, no. 3 (Spring 1985): 416. Lansbury also points out that there were “uneasy” similarities between devices used to immobilize women for sexual acts and pornography and those used by the gynecologist during an examination. Lansbury, The Old Brown Dog: Women Workers, and Vivisection in Edwardian England (Madison: The University of Wisconsin Press, 1985), 99.

21 Lansbury, Dog, 128. According to Lansbury, a possible source of the comparison between women and the dissected animal lies in the metaphors that Claude Bernard utilized in his seminal work, An Introduction to the Study of Experimental Medicine (1865). In that highly influential work, Bernard’s language “made the translation from animals to women inevitable. He described nature as a woman who must be forced to unveil herself when she is attacked by the experimenter…” (Lansbury, Dog, 162). Similarly, in his essay on vivisection Leslie Stephen writes, “Science progresses by interrogating Nature; but it is not every question which elicits a valuable answer. Nature is coy. You must know what to ask and how to ask it, or you might as
Physician Elizabeth Garrett Anderson explicitly linked the gynecology patient and the vivisected animal by comparing childbirth to vivisection. Garrett Anderson makes the comparison in order to more clearly delineate what makes certain types of pain cruel. Though childbirth invariably “causes the mother severe and prolonged pain,” Garrett Anderson states, “we do not think of it as cruelty” because it has a beneficent purpose. Likewise, the practice of vivisection consists of giving pain in order to stem the suffering of others. It is not Garrett Anderson’s intent to suggest that childbirth is akin to vivisection; however, the fact that the comparison between vivisection and childbirth arises at all is proof of the fact that the scientific treatment of animals was closely associated with the medical treatment of women.

Garrett Anderson also touches on how difficult it is to know the content of another’s experience, particularly when that Other is different from one’s self. In “the case of animals,” Garrett Anderson argues, “spiritual contact and the influence of mind upon mind” are much more “imperfect than they are between man and man… .” It is this lack of sufficient “contact” between the minds of animals and humans that antivivisectionists overlook in their presumptions that research animals suffer under the yoke of the inhuman vivisector. Garrett Anderson confirms that this is an epistemological problem with sympathy and argues that “It is also probable that the sympathy which is born in imagination is not specially developed by concentration of mind on the search for the facts of physiology. …The power of realizing mentally that which is not under direct observation is imagination, and it is not cultivated with at all the same assiduity as the power of observing.”


22 Garret Anderson, 149.

23 Ibid., 151.

24 Ibid.
Put simply, animals and humans are too different to imagine each other’s minds accurately, and even if they could, imagination—and the potential sympathy that arises from it—is epistemologically inferior to empirical methods like direct observation. Describing how all sensation is lost when the head of an animal is cut off or the upper spinal cord is destroyed, Garrett Anderson notes that “An impression made upon sensory nerves is conveyed towards the brain, but when its upward progress is stopped by the spinal cord having been severed, or the brain destroyed, the sensory impression is conveyed or ‘reflected’ through the cord to the motor nerves, and movements result which seem to the onlooker to indicate pain, though they are really entirely automatic and apart from consciousness.”25 Garrett Anderson’s choice of words here is interesting, particularly her description of “sensory impressions” being “reflected.” As I noted in my introduction, “reflected feelings” is precisely the term that Carter uses to describe how the hysteric’s body transmitted her excessive feeling to individual bodily organs and systems; this seeming coincidence, I argue, begins to make clear the parallels that existed between the vivisected animal and the hysteric.

In its ability to mask its true condition with deceptive external symptoms, the body of the dissected animal is strikingly similar to that of the hysteric. In both cases, the body “lies” by manifesting symptoms that misrepresent its true condition. The hysteric exhibits tics or spasms in her legs and arms, though in fact these symptoms are not the site of disease, but rather the result of sympathy that transmits pathologies to multiple parts of her body. Likewise, though it appears to twitch in violent pain, Garrett Anderson avers that the dissected frog does not experience suffering, namely because its brain and/or spinal cord have been crushed, leaving only the appearance—and not the actual experience—of pain. At no point does Garrett Anderson directly

25 Ibid., 152.
link the animal to the human female, and yet her arguments for vivisection outline the same controversial pathology that was allegedly also at work in the female body. Even while their viscera were laid bare by the gynecologist or vivisector, both the hysterical and the dissected frog exhibited symptoms that could not be tied to a single organ or any physiological cause. Not only was the etiology of their symptoms obscure, but in both cases the symptoms also disturbed the “normal” relationships and pathways between bodily organs and systems.

What the vivisected animal and the hysterical share, then, is the fact that their bodies are physically invaded in all respects, and yet epistemically they remain impenetrable. The vivisector might examine every single nerve and fiber of the frog’s musculature just as the gynecologist might surgically observe all of the hysterical’s reproductive organs; despite these efforts, which at that time marked the apex of modern surgery, medicine, and science, the frog and the hysterical retained a process or system of functioning that simply could not be comprehended. Upon dissecting the frog or the hysterical’s body, the surgeon could discern that something was there, present and causing certain effects, yet still he was unable to say exactly what it was or how it worked. This, you can imagine, would have been particularly vexing at a time when gynecology, abdominal surgery, and physiology were relatively new professions in which the practitioners were already struggling to assert their knowledge and authority. As a result it is no wonder that efforts to understand the frog’s twitching or the hysterical’s spasms caused so much confused discourse, since a ghost might have been as plausible an explanation for the symptoms that were evidenced during experiments and observations on these two figures. Despite being able to see the hysterical’s arms spasm uncontrollably, or visually witnessing that the frog’s leg twitches while its nerves are being cauterized, the gynecologist and the physiologist could not finally
confirm why these reactions occurred, what they indicated at a physiological level, or how a foreign being might experience them.

It is, I argue, their status as supremely foreign beings that dramatically heightened the anxiety around the gynecology patient and vivisected animal. As I have suggested throughout this dissertation, Victorian doctors and scientists were well aware (if only implicitly) of the way difference—for example between two beings—influenced sympathy, which then influenced the pursuit of knowledge. As a result, when the Victorian gynecologist or vivisector confronted his “patient,” what he truly saw was a person, a being, a thing that was terrifying in its otherness.

Though their bodies were socially marked as objects of knowledge, the bodies of the hysteric and the vivisected animal refused to be known, either literally or psychosocially. Because he could not see or know where disease originated from in the hysteric and because he could not finally determine what feeling, if any, generated spasms in the legs of decapitated frogs, the gynecologist and vivisector likewise could only see a vast cavern of obscure uncertainty in the minds of their “patients.” It is difficult, indeed, to determine whether it was epistemic uncertainty that vexed the gynecologist or vivisector more, or if the realization that a similarly dark cavern existed in the minds of their “patients” proved more unnerving. In either case it is clear that the extent of the disturbance cause by both figures bespeaks not just the undermining of empirical medicine or science, but the troubling possibility that the minds of some, or worse, all, can never be known and shared.

One proponent of vivisection, Gerald F. Yeo, underscores the obscurity of others’ experience, and—like Garrett Anderson—argues that empirical observation of the vivisected animal belies its true condition. For Yeo, “Pain is essentially a peculiar phase of consciousness, and when consciousness is wanting there can be no pain … though there may be a variety of
reactions ... these so-called reflex reactions not only take place without the individual being conscious of any suffering, but they are even more marked when the influence of the brain-centres is removed.” In other words, “the spasms of agony become all the more intense, in proportion as the individual is less able to feel pain.” 26 Yeo’s point is that antivivisectionists, being untrained in physiology, wrongly react to the appearance of pain even when the animal (allegedly) feels none. What this seems to suggest is that the proper training in physiology allows one to know more accurately the feelings and experience of an animal being vivisected.

In spite of his confident declarations, however, what’s implicit in Yeo’s remarks is the vast difficulty of ascertaining what another feels and experiences. Yeo gives no concrete evidence that the destruction of the brain (and by extension, the cessation of consciousness) impedes all sensation, largely because he does not have such proof: Victorian physiologists were deeply conflicted about how the stimulation of the brain influenced the body’s sensations; thus the frequency of experiments involving amputated frogs’ limbs: in these experiments and others, Victorian physiologists desperately sought to grasp how the brain and the spinal cord transmitted information to the frog’s body—even when, for example, these parts had been amputated. Regardless of Yeo’s assertions to the contrary, then, we see in his work and that of his colleagues’ the same uncertainty that is also prevalent in Victorian gynecology. In both cases the investigator falls far short of determining what the objects of knowledge feel.

This shortcoming is apparent in vivisection debates over the use of curare, or curari, a botanical anesthetic that was originally developed by indigenous tribes in South America and used for hunting. Curare gained widespread attention in the nineteenth century after Claude Bernard realized that it did not necessarily kill an animal, and could be used to paralyze it

temporarily. For the vivisector, this was important not only because it left the normal physiological processes of the nervous system undisturbed, giving physiologists a better understanding of them, but also because it prevented the animal from jerking or twitching during the experiment.27 This is why, according to Stewart Richards, “curare exerted a special fascination over physiologists…”28 For opponents of vivisection, this was the ultimate outrage, since not only was the vivisector inflicting torture and ending the lives of innocent animals, but through the use of curare they also made the animals suffer in mute terror, unable to express the agony that they endured. As Richard Hutton notes, the “fashion” of downplaying the pain of the animal was a direct result of the use of curare, “a poison which, by paralyzing the motor nerves, prevents all the usual signs of agony,” and “stills” the “contortions” of those bodies being examined.29

Ultimately, the physiologist did not know if the vivisected terrier cried from felt pain, just as the gynecologist did not know if the hysterics’ paralyzed limbs were truly (rather than just psychically) incapable of moving. In both cases, the objects of knowledge provoked epistemological uncertainty about their felt experience, and significantly, in both cases that uncertainty was inextricably linked to sympathy, whether it was sympathy for the animals’ suffering, or sympathy between the hysterics’ womb and breasts. Given this, it is not surprising that gynecology and the vivisection movement were also linked through the charges of hysteria that proponents of vivisection made against antivivisectionists. One particularly vociferous

27 Traditional anesthetics, in contrast, were known to lower blood pressure and body temperature, thus making it difficult to distinguish normal physiological processes from those that are caused by the use of anesthesia. Stewart Richards, “Vicarious Suffering, Necesssary Pain: Physiological Method in Late Nineteenth-Century Britain,” in Vivisection in Historical Perspective, ed. Nicolaas A. Rupke (London: Routledge, 1990), 136.
28 Ibid.
physiologist, Elias von Cyon, made very clear that the antivivisectionists’ sympathy for animals exceeded healthy levels:

I regard as honest enemies those who, through want of occupation, through an eccentricity amounting to disease, or through hysterical sentimentality, have associated themselves with this movement in the belief that they are doing a work of piety and charity. Is it necessary to repeat that women—or rather, old maids—form the most numerous contingent of this group? Let my adversaries contradict me, if they can show among the leaders of the agitation one young girl, rich, beautiful, and beloved, or one young wife who has found in her home the full satisfaction of her affections?30

I quote from Cyon at length because his words succinctly illustrate how gynecological theories—in this case of hysteria—became interpolated within a wide range of separate fields and discourses. In this case, Cyon draws on an understanding of hysteria as a disease of sentimentality, and asserts that this same pathology is manifested in the behavior of antivivisectionists and their demographic makeup.

The antivivisectionist, like the hysteric, feels too much and for the wrong things. Without an appropriate outlet for her feeling, such as a husband and children, that feeling becomes pathological and makes one susceptible to both fits of hysteria as well as hysterical fits of sympathy for mere dogs and cats. It is worth reiterating that Cyon draws on an understanding of feeling that is distinctly medicalized, in the sense that even an “eccentricity” like sympathizing with animals is “diagnosed” and considered a symptom of a deeper and more troublesome pathology. In his critical response to Cyon’s article Hutton fails to critique Cyon’s distinction between appropriate and inappropriate feeling—in other words, acceptable versus unacceptable

sympathies. Hutton is responding to Cyon’s claim that in Catholic countries, and especially in convents within Catholic countries, women find a healthy object for their feelings rather than expending their energies on trivial campaigns such as antivivisection. Hutton, on the other hand, doubts that Catholicism deters women from joining the antivivisection movement “because it affords full satisfaction to the legitimate cravings of the human heart, or because it invents an artificial satisfaction for the morbid cravings of the human heart.” 

The terms “legitimate” and “morbid” are Hutton’s, not Cyon’s, and suggest that despite the critiques Hutton levels against Cyon, he too is working from the assumption that feelings are either acceptable and healthy, or unacceptable and “morbid.”

The distinction between healthy versus unhealthy feeling is also evinced in discourse about the New Woman, who—like the gynecology patient and the antivivisectionist—opposed experimentation upon animals and was similarly criticized for the supposed morbidity of her desires. This is apparent in Sarah Grand’s novel *The Beth Book* (1897) and its critical reception. Like Grand’s earlier novel, *The Heavenly Twins* (1893), *The Beth Book* is a lengthy critique of male sexual and social privilege. Early in her life, Grand’s heroine, Elizabeth Caldwell, finds herself stifled by her mother’s self-sacrificing femininity. In the hopes of securing some degree of personal freedom, Beth agrees to marry Dr. Daniel Maclure, though very quickly she realizes that her husband is a lewd and lustful man whose work is actually the management of a Lock Hospital for women infected with venereal disease.

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32 Of course, I realize that the New Woman at the fin de siècle was not a uniform and static category. However, because there were a number of New Woman authors who professed their opposition to vivisection, and for the sake of simplicity, here I will use the term “the New Woman.” Likewise, when I suggest that the gynecology patient opposed vivisection, I do so to indicate that this was true very broadly, and certainly not in every patient’s case.
Grand’s argument is that men should conform to the same standard of sexual purity as women. What’s interesting for my purposes is the fact that the “final straw” that rends Beth and Dan’s marriage is her discovery that he is a vivisectionist. Beth makes this discovery late one night after her husband has left the house and she has retired to read one of his “shilling shockers.” This novel, Grand writes, works Beth into such a nervous state that she begins to jump at the slightest sound—including sounds that are coming from her husband’s laboratory. When Beth determines that these sounds are the painful cries of some creature, she overcomes her fears and finds a small brown terrier in her husband’s laboratory. The dog remains alive despite being partially dissected, a fact that Beth very quickly remedies by giving it a lethal dose of a narcotic she locates in the laboratory.

Throughout this scene and the one that follows it—in which Dan confronts his wife for interfering with his research—Grand takes pains to underscore the level headed rationality that governs all of Beth’s actions. Though at the beginning of the scene she appears to be a frivolous and silly wife who becomes frightened while reading a sensational novel, Grand actually uses that cliché to showcase how Beth instinctively puts aside her own fears because she senses that the noise she hears represents the suffering of another creature. Beth isn’t hysterical with sympathy for the dog, and neither is she indifferent to its suffering in light of her own reluctance to explore her large dark house after reading a thrilling novel. Rather, she clearly recognizes that something or someone needs her assistance, and she calmly goes about rendering it. And, though the events give her “great compassionate heart” quite a trial, they also make Beth feel “stronger for a brave determination and more herself than she had done for many months.”

34 Ibid., 475.
The same strong will is apparent again when Dan angrily rebukes Beth for euthanizing the dog. Throughout this encounter Dan repeatedly attempts to paint Beth as illogical and hysterical. For instance, though Beth speaks very calmly and even chides Dan for yelling by “gently” saying, “Please—I am not deaf,” Dan still declares that Beth’s negative opinion of vivisection is due to the nervous shock she received from seeing the suffering terrier: “I don’t wonder you’re shaken, poor little girl, and it’s natural that the shock should have made you unreasonable and uncharitable—unlike yourself, in fact, for I never knew a more reasonable woman when you are in your right mind, or a more charitable.”35 When Beth remains unconvinced about her husband’s supposedly altruistic motives for performing vivisection, Dan warns, “Now, look here, Beth, don’t be rabid…”36 Beth is clearly not “rabid,” nor is she unreasoning or out of her “right mind.” In fact, as Dan carefully puts to Beth all of the common defenses for vivisection—e.g. the use of curare as an anesthetic, the benefit to humanity from knowledge gained by vivisection—Beth responds quite clearly with logical counterarguments, stating, for example, the fact that curare does not lessen the pain of the animal, but merely makes the job of the vivisector easier.

As you can see, Grand is rehearsing popular arguments for and against vivisection. While Beth’s antivivisection stance is articulated calmly and coherently, Dan’s defense of vivisection not only likens women to dogs (by calling Beth rabid), but it also links that animality to their supposedly excessive feeling and lack of reason. Like the hysteric, Beth’s behaviors and opinions are pathological because they give undue preference to feeling—in this case for a dog—rather than to reason. This is why some vivisection proponents argued that only those with “fairly balanced minds, with at least an average both of humanity and of capacity for judgment in

35 Ibid., 478.
36 Ibid.
cases in which deep feeling may be stirred” should be trusted to determine the ethicality of vivisection.37 “Deep feeling” is antithetical to clear judgment. It is this assumption that links the antivivisection movement, the New Woman, and burgeoning gynecology discourse, since each of the problematic figures associated with these movements—the vivisected dog and the hysterical female antivivisectionist, the vociferous and independent New Woman, and the hysterical gynecology patient—is labeled problematic because of their ability to disrupt the production of knowledge with some form of sympathy.

Of course, Grand does not endorse Dan’s condemnation of Beth, and instead offers him up as a kind of sacrificial lamb that allows her to reinforce her ideological commitment to Beth, the New Woman, and the antivivisection movement. For New Woman critic Ann Heilmann this is obvious at the level of narrative and marks a shift in Grand’s work. For Heilmann, Grand’s earlier works, including Ideala (1893) and The Heavenly Twins, are marked by distinctly masculine and interrogatory narrative interjections: “Both texts present their (predominantly female) readership with a hall of mirrors in which New Woman protagonists are reflected through the prism of male eyes by narrators whose reliability readers are implicitly called upon to question, given the considerable emotional investment they have in the heroine and her story.”38 In The Beth Book, by contrast, Heilmann argues that Grand “articulates an unmediated female point of view: a perspective born out of the exorcism of authoritative discourses in the preceding texts.”39 I agree with Heilmann’s claim that Grand foregrounds Beth’s voice, and I’d also add that this is particularly important because Beth’s husband is a doctor and thus traditionally given the power to tell women’s stories through case studies. In spite of Dan’s

37 Paget, 929.
39 Ibid., 46.
repeated attempts to diagnose Beth’s behavior as pathological, Grand’s narrative remains with Beth’s perspective and endorses it as a superior and more accurate source of information.

An interesting counterpart to Grand’s self-consciously polemic novel is Conan Doyle’s short story “A Physiologist’s Wife” (1890). Conan Doyle was, of course, himself a physician, having studied medicine at the University of Edinburgh under Joseph Bell. Along with “The Doctors of Hoyland,” the short stories collected in *Round the Red Lamp: Being Facts and Fancies of Medical Life* give a useful, albeit fictionalized perspective on Victorian medical education, professional politics, and advances in medical, scientific, and physiological knowledge. In “A Physiologist’s Wife” Conan Doyle describes the attempt, by Physiology Professor Ainslie Grey, to secure a wife. This proves challenging because Grey is consumed by his research and seemingly incapable of experiencing emotion. From his consistently cold interactions with others to the “terra-cotta busts of Claude Bernard and John Hunter” that adorn his mantelpiece, Grey represents “the very type and embodiment of all that was best in modern science.” He even approaches marriage and love with a rational eye, declaring that marriage to a research scientist must be the highest “mission for a woman of culture.” He also refers to his desire for a wife as a vascular disturbance and suggests that in getting married he will “submit to the common lot of humanity.” More than an emotional and physical companion with whom he can be intimate, what Grey really envisions in a wife is in fact a research “helpmate.”

Early in the story, it appears as though Grey is lucky enough to find such a partner in the widowed Mrs. O’James, who is herself well-read and versed in contemporary science. Their marriage is short-lived, however, when it is revealed that the new Mrs. Grey is in fact still legally

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41 Ibid., 115-118.
42 Ibid., 115.
married to her husband’s colleague, Dr. James M’Murdo O’Brien, who was actually courting Grey’s sister Ada under the assumption that his first wife had died. Conan Doyle’s plot is somewhat contrived, but what remains clear throughout the story is the irrevocable opposition between feeling and rational knowledge. For example, when M’Murdo O’Brien calls Ada an angel because she reminds him of the church organ and the incense burned there, Grey responds by suggesting that both M’Murdo O’Brien’s love for Ada and his belief in God are “Sensuous—purely sensuous … Vague hereditary tendencies stirred into life by the stimulation of the nasal and auditory nerves.”\(^{43}\) He also reacts with absolutely no emotion when he learns that his wife was and is still married to M’Murdo O’Brien. When Grey overhears M’Murdo O’Brien persuading Mrs. Grey to abandon her new husband, she replies quite emphatically that Grey “will not mind much,” if she leaves him because “he has no heart.”\(^{44}\) Later, when Mrs. Grey begins to apologize to Grey, he stops her and expresses his theory that she and her first husband are not to blame, but merely acting out the impulses of “hereditary and engrained tendencies,” that is, their evolutionary biology. For Grey, “condolence or sympathy would be an impertinence” since he could so easily merge his private griefs in broad questions of abstract philosophy.\(^{45}\)

As you can see, it would be a drastic understatement to say that Grey is a dispassionate person. Rather, Conan Doyle goes to great lengths to underscore that Grey is so completely devoid of feeling and so entirely obsessed with his research that even the most heart wrenching of scenarios is still not enough to induce sympathy for him. To put it plainly, Grey has no feelings and thus isn’t capable of inciting or sharing sympathy with another. The search for

\(^{43}\) Ibid., 129.
\(^{44}\) Ibid., 138.
\(^{45}\) Ibid., 139.
physiological knowledge, it seems, is inversely proportionate to the sustenance of human feelings. The conclusion of the story morbidly, ironically points to this as well. Following Mrs. Grey’s departure, Professor Grey slowly begins to lose his strength and vigor, until one morning he simply falls into an “eternal sleep.” It is worth noting, however, that before his death, Grey retains an obsessive interest in his research, even treating his own case as objectively as if it were another’s. Upon his death, Grey’s physicians debate how to fill in the cause of death on Grey’s death certificate. “It is difficult to give it a name,” remarks one physician. To this, the other replies, “If he were not such an unemotional man, I should have said that he had died from some sudden nervous shock—from, in fact, what the vulgar would call a broken heart … Let us call it cardiac, anyhow.” These remarks are morbidly funny because they juxtapose a cold medical diagnosis alongside a lay, non-technical, or emotional explanation of Grey’s death. It is humorous to consider that Grey died simply of a “broken heart,” given that he had no heart, and it is particularly funny to hear the suggestion come from another rational physician who resorts to diagnoses of “sudden nervous shock” or a “cardiac” ailment.

For Conan Doyle, Grey is the archetypal physiologist whose cold, detached rationality strongly opposes others’ sentimentality and feeling. In addition to this opposition, however, Conan Doyle also aligns these two variables, i.e. rationality and feeling, with gender traits, as is obvious in Professor Grey’s misogynistic opinions on the female intellect. Grey expresses these opinions early in the text when he observes that his maid Sarah is excessively chatty. According to Grey, “The first great advance of the human race … was when, by the development of their left frontal convolutions, they attained the power of speech. Their second advance was when they

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46 “He was much interested himself in his own case, and made notes of his subjective sensations as an aid to diagnosis. Of his approaching end he spoke in his usual unemotional and somewhat pedantic fashion” (143).
47 Ibid., 143.
learned to control that power. Woman has not yet attained the second stage.\textsuperscript{48} Grey’s comment is not unusual in itself, as it simply echoed Victorian theories that women and children were less evolved than men. However, given the pervasive opposition that Conan Doyle constructs between knowledge and feeling in the text, Grey’s misogynistic declarations can be seen as furthering that opposition by associating women with feeling and men with knowledge. In other words, in portraying Grey as a cold, über-rational physiologist who is also misogynistic, Conan Doyle indicates that Grey’s gender, his chosen career, and his lack of feeling are all related in their opposition to the emotionality that the female characters in the novel exhibit. While Conan Doyle’s short story does not explicitly take up the theme of vivisection, it does maintain the dichotomy between feeling and rational knowledge that I have identified throughout Victorian debates on vivisection. It also hints that, like the dog who is vivisected in pursuit of knowledge, women are often the unfortunate objects of the physiologist’s cold, unfeeling gaze.

There is perhaps no better example of the physiologist’s cold observation of women and animals than Collins’s novel \textit{Heart and Science: A Story of the Present Time}. Unlike his sensation novels \textit{The Moonstone} (1868) and \textit{The Woman in White} (1860), \textit{Heart and Science} is a polemical text that argues against the practice of vivisection. Much to the dismay of Algernon Swinburne, in \textit{Heart and Science} Collins betrayed his genius and instead listened to a demon who whispered, “Wilkie! Have a mission.”\textsuperscript{49} More than just persuading his readers that vivisection is immoral, the stated mission of \textit{Heart and Science} is to “trace, in one of [his] characters, the result of the habitual practice of cruelty (no matter under what pretense) in fatally

\textsuperscript{48} Ibid., 113-114.
deteriorating the nature of man….”50 The character is Dr. Nathan Benjulia, and the “habitual practice of cruelty” is the vivisection of animals for physiological research. As I will suggest, however, Collins’s work is more than a piece of antivivisection rhetoric. Rather, *Heart and Science* is a self-conscious meditation on knowledge itself, in particular how the will for knowledge, when unaccompanied by feeling, necessarily causes moral degeneration. Even more radically, *Heart and Science* undermines the validity of empirical science, and instead privileges sympathy as a tool for obtaining medical knowledge.

The denunciation of empirical science is formally registered in the novel’s punishment of the characters who support it, namely, Dr. Benjulia and Mrs. Gallilee. Ironically, Benjulia meets his demise after suffering a nervous breakdown that Ovid incites by refuting Benjulia’s life’s work. It is a poignant indictment of his medical practices that Benjulia burns to death within the very space that he formerly used to dissect, torture, and incinerate living animals.51 Similarly, Mrs. Gallilee’s descent into madness suggests that rather than treating patients with nervous disorders, the purely rational and unfeeling scientist renders herself susceptible to them. In contrast, though Ovid himself suffers from a nervous debility before leaving for Canada, he not only recovers while caring for his Canadian colleague, but he is also able to formulate a cure for Carmina’s condition. Yes, this cure is largely facilitated by the manuscript that his dying Canadian colleague bequeaths him, but it is worth reiterating that Ovid is only rewarded with the manuscript after he has “soothed” the remaining hours of his friend’s life.52 This underscores that

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50 Wilkie Collins, *Heart and Science: A Story of the Present Time*, ed. Steve Farmer (Ontario: Broadview Press, 1996), 38. All further references to this text will be made parenthetically.
51 While Collins makes no mention of Benjulia burning dogs alive, doing so was a common physiological experiment, as it allowed scientists to make conclusions about how extreme heat—in the case of fever, for instance—affected the body’s systems.
52 It is also worth pointing out that good bedside practice, and not vivisection, leads the Canadian doctor to his discovery.
Ovid’s scientific methods are sympathetic while those of Benjulia are purely objective. Ovid successfully learns about and treats patients based on feeling, while Benjulia cares only for nerves, tissue, and pathologies. Thus the narrative is founded on the privileging of feeling as a mode of gaining medical knowledge, while the unfettered thirst for scientific gain is condemned.

One interesting aspect of the opposition between the feeling and unfeeling characters in the novel is the fact that they are not traditionally gendered. In Heart and Science, men can fall victim to nervous disease, and women—even mothers—can become infected with the pathological desire for scientific knowledge. Men are not the sole possessors of knowledge, and neither do women act only as the objects of it. These transgressions of traditional gender norms are important because they illustrate the novel’s significant interest in understanding the intersections between knowledge, feeling, gender, and vivisection. They also present a more complex and realistic portrait of gender and knowledge instead of relying on the binary opposition that usually equates women with feeling and men with knowledge. While I have highlighted this binary opposition at work in other novels and in other sections of this dissertation, in Heart and Science gender does not mandate whether one evokes more “heart” or “science.” For Collins, gender does not determine one’s ability to know or feel, and is in fact secondary to the moral qualities associated with either their instinct to sympathize with others or their greed for knowledge.

The significance of feeling and the relative insignificance of gender in determining moral worth are apparent early in the novel when Carmina is disturbed by a stray dog being run over and when Benjulia upsets Ovid by stepping on a beetle. In the first case, Carmina expresses a poignant sadness about the dog’s death, and is also described as possessing a mysterious or unseen quality that drew the dog to her in the first place. According to Collins, “Every now and
then, the sympathy of [the dog’s] race led these inveterate wanderers to attach themselves, for
the time, to some human companion, whom their mysterious insight chooses from the crowd”
(57). This is a bit disingenuous, given that elsewhere Collins accentuates Carmina’s every good
grace. Here, however, he downplays her uniqueness in order to underscore that the dog senses
Carmina’s sympathy through its “mysterious insight.” This scene is a crucial component of
Collins’s antivivisection rhetoric, as it correlates Carmina’s feeling for the dog with her
privileged status in the novel. Carmina is our heroine because she feels sympathy for the dog and
for all creatures. For my purposes, this scene is significant because it presents an argument about
feeling and knowledge, since this stray dog senses and thus knows that Carmina will show him a
sympathetic hand rather than a wrathful one. The dog’s “epistemic methodologies” are starkly
contrasted with Mrs. Gallilee and Benjulia’s empirical science, and yet technically the dog’s
feeling knowledge, if I might call it that, is more accurate than the alternative.53

Rather than suggesting that sympathy is only a feminine trait, Collins underscores Ovid’s
sympathetic nature when his colleague Dr. Benjulia steps on and kills a beetle. Just before this,
Benjulia insults Ovid by calling Carmina a “misbegotten child,” with “an inhuman indifference
in his tone as he said this, which it was impossible not to resent, by looks, if not in words” (102).
This “inhuman indifference” is what causes Ovid to stop suddenly when Benjulia squishes a
beetle on the road:

[Ovid] started, and seized Benjulia by the arm. “Stop!” he cried, with a sudden outburst
of alarm. “Well?” asked the doctor, stopping directly. “What is it?” “Nothing,” said Ovid,
recoiling from a stain on the gravel walk, caused by the remains of an unlucky beetle,

53 The dog does meet its end because it attaches itself to Carmina, though I see this as a narrative
device that serves Collins’s larger purpose of illustrating how sympathetic Carmina is when the
dog is struck by a cab.
crushed under his friend’s heavy foot. “You trod on the beetle before I could stop you.”

Benjulia’s astonishment at finding an adult male human being (not in a lunatic asylum) anxious to spare the life of a beetle, literally struck him speechless. His medical instincts came to his assistance. “You had better leave London at once,” he suggested. “Get into pure air, and be out of doors all day long.” He turned over the remains of the beetle with the end of his stick. “The common beetle,” he said; “I haven’t damaged a Specimen.”

(103)

I quote from this scene at length because in it Collins lays the framework for many of the novel’s fundamental arguments. In the first place, this scene highlights Ovid’s sympathy for all creatures—including insects—and strongly suggests that he does not inflict cruelty on animals as a means of gaining medical knowledge. In the second place, the scene deliberately connects Benjulia’s pursuit of knowledge with his cruelty to animals, since Benjulia’s sees his “medical instincts” as an antidote or explanation for Ovid’s pathological feeling.

Finally, this scene sets up the symbolic imagery associated with Benjulia’s walking stick. Benjulia prods and metaphorically dissects the beetle with his stick, and concludes that the beetle is a “common” one rather than a useful “Specimen.” This distinction is an important one, as it underscores that Benjulia’s only interest in other creatures is as objects for scientific study. When he laments that the beetle is “common” and also later when he negligently cares for Carmina in the hopes of gaining a case for further study, Benjulia makes clear that the care of any living thing is always secondary to the advancement of medical knowledge. In addition, the way that he uses his stick to inspect the beetle is eerily similar to the way he “tickles” Zo Gallilee by methodically placing his fingers at the base of her neck as he stoically watches her physiological
response (96). Benjulia tickles Zo purely out of scientific curiosity, just as he turns the beetle over only to determine its genus and type.

For Lansbury, Benjulia’s treatment of Zo represents a sexualized form of the violence he inflicts upon his research subjects. According to Lansbury, Collins doesn’t allow Benjulia to “see the connection between his vivisections and his tickling of little Zo,” though the fact that they are related is made clear and left for the “reader to decipher.”54 Lansbury points out that tickling was a synonym for flogging or intercourse, and also declares that “we have met the stick before in all its manifestations of whip and male organ.”55 In other words, when Benjulia says goodbye to Zo by thinking “‘I should have liked to tickle her once more’” (321), he is in fact bidding goodbye to an “aspect of his sexual life.”56

In contrast to Lansbury, I see any sexualization of Benjulia’s treatment of Zo as incidental, and stemming from the fact that, like the brown terrier in *The Beth Book*, Zo is a suitable object for scientific research. In their deviance from the physiological norm of the adult white male, women, children, and animals were more likely to find themselves the target of the physiologist’s knife.57 In addition to the scientific curiosity that Benjulia exhibits when he “tickles” Zo, he also appears to truly care about her and suggests as much by making her the sole benefactor of his will. Thus, rather than a perverse sexual interest in the young girl, I argue that Benjulia’s treatment of Zo is actually part of Collins’s attempt to humanize the vivisector. As he writes in a letter to Power Cobbe, Collins wanted to “present [Benjulia] to the reader as a man not infinitely wicked and cruel, and to show the efforts made by his better instincts to resist the

54 Lansbury, *Dog*, 137.
55 Ibid., 140.
56 Ibid.
57 Collins’s novel does not, of course, suggest that Benjulia vivisects women or children, though he does indicate the parallel between animals, women, and children by frequently likening Zo and Carmina to animals. See, for example, Collins, 53 (Carmina) and 65 (Zo).
inevitable hardening of the heart, the fatal stupefying of all the finer sensibilities, produced by
the deliberately merciless occupations of his life."58 Zo condenses this struggle in miniature, and
acts as a symbol of the fact that Benjulia conceives of feeling as wholly antithetical to the pursuit
of knowledge. Collins’s argument in the rest of the novel—and the reason for Benjulia’s
downfall—is that sympathy, rather than being an obstruction to knowledge, is in fact a necessary
tool for it.

As I have already pointed out, the sympathy that Ovid shows his Canadian colleague is
what allows him to formulate a cure for Carmina’s nervous disease. In addition, when the
Gallilee’s maid Marceline recounts why she decided to aid Mr. Gallilee in absconding with Zo
and Maria, Collins writes that “Zo’s narrative of what had happened, on the evening of Teresa’s
arrival, had produced its inevitable effect on the maid’s mind. Strengthening, by the sympathy
which it excited, her grateful attachment to Carmina, it had necessarily intensified her dislike of
Mrs. Gallilee—and Mrs. Gallilee’s innocent husband had profited by that circumstance!” (293).
What Collins depicts here is the interdependence between sympathy and knowledge. Marceline
feels sympathy for Carmina after learning from Zo how she is treated upon her arrival in the
Gallilee house, and that sympathy in turn shapes how she perceives Mrs. Gallilee. Upon entering
Mrs. Gallilee’s room to confess her crime, Marceline observes her mistress without the aid of
sympathy: “Prepared to see a person with an overburdened mind, the maid (without sympathy, to
quicken her perceptions) saw nothing but a person on the point of taking a nap” (294).

What’s most interesting about this scene is the disjunction between what Marceline sees
and what Collins portrays. Given what we know about Mrs. Gallilee, we are not inclined to feel
sympathy for her, and are instead inclined to think, somewhat uncharitably, that she is leisurely

58 Qtd. in Collins, 370.
reclining for a nap rather than succumbing to a nervous breakdown. And yet she *is* mentally deteriorating, as Collins suggests when Marceline speaks to her and Mrs. Gallilee is so confused that she asks “Is that my maid?” (294). The narrative dissuades the reader from feeling sympathy for Mrs. Gallilee, and yet here it highlights how our lack of sympathy—and Marceline’s—might prevent us from understanding the severity of Mrs. Gallilee’s condition. For Collins, sympathy is not an impediment to objective observation and scientific knowledge, but is instead a tool through which we can more clearly see and know the world around us. Mrs. Gallilee does little to deserve sympathy, and still in this scene the fault lies with Marceline because her lack of sympathy distorts her knowledge of her surroundings. Sympathy in *Heart and Science* is a prophylactic against the demoralizing practice of vivisection, but it is also a necessary attribute for anyone who pursues knowledge. Without sympathy, Collins argues, we can’t see, since it is sympathy alone that allows us to accurately assess and know the world around us.
In her novella *The Lifted Veil* (1859), Eliot offers a darker, more sobering vision of sympathy. In that text, Eliot imagines a young clairvoyant named Latimer, for whom “mental closeness” with others is not an impetus for good moral behavior but rather an unwelcomed glimpse inside the narcissistic and selfish minds of others. Latimer gains the ability to see into the future as well as the minds of others after awaking from an unspecified illness and convalescence. Soon after he realizes these newfound skills, however, Latimer makes clear that even the most intimate knowledge of others’ minds is not enough to overcome his innate selfishness and disregard for others. Remarking that his “superadded consciousness” was “wearying and annoying enough when it urged on [him] the trivial experience of indifferent people,” Latimer then describes the “pain and grief” of hearing the thoughts of those close to him. Instead of witnessing thoughts of compassion, what Latimer’s “microscopic vision” unveils is “all the intermediate frivolities, all the suppressed egoism, all the struggling chaos of puerilities, meanness, vague capricious memories, and indolent make-shift thoughts” of the people around him.¹

Clearly, this is a far cry from the ethical ideal of sympathy, and goes a long way towards explaining why, for the Victorians, sympathy was of such great importance and also such a threatening prospect. What if, Eliot asks, upon learning what others are thinking and feeling, we are in fact less likely to behave compassionately? What if seeing inside the minds of others

doesn’t compel us to feel with them but instead compels us to draw further into our own narcissistic misanthropy? This possibility is quite frightening in itself, but Eliot’s novella suggests another, and equally worrisome, consequence of Latimer’s “double consciousness.”\(^2\) This phrase, “double consciousness,” is a significant one, and one that Latimer himself uses to describe his condition. The phrase is important for my purposes for its connotations of mental illness, since during the nineteenth century “double consciousness” was a phrase used to describe a variety of mental disturbances, including hysteria and what we now call “multiple personality disorder.”\(^3\)

Eliot alludes to Latimer’s “double consciousness” as a potential mental disorder at a number of points in the text, including when Latimer attempts to understand his new abilities. After his second “vision” Latimer begins to get concerned and wonders what his visions mean: “I was cold and trembling; I could only totter forward and throw myself on the sofa. This strange new power had manifested itself again. . . . But was it a power? Might it not rather be a disease—a sort of intermittent delirium, concentrating my energy of brain into moments of unhealthy activity, leaving my saner hours all the more barren?”\(^4\) As you can see, Eliot is undoubtedly alluding to those explanations of “double consciousness” that envisioned it as a mental pathology. In addition to suggesting that Latimer could be suffering from a more specific mental disorder, however, what Eliot alludes to here is the danger that sympathy itself, when excessive, might induce a kind of insanity. Latimer suggests as much when he describes just how it feels to “hear” what everyone around him is thinking and feeling. According to Latimer, it is like a

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\(^2\) Ibid., 21.
“stream of thought” that “rushed upon [him] like a ringing in the ears not to be got rid of...It was like a preternaturally heightened sense of hearing, making audible to one a roar of sound where others find perfect stillness.”

Despite the positive role that sympathy plays in the rest of Eliot’s oeuvre, there can be no doubt that here, in Latimer’s case, sympathy is a risk factor for mental derangement. Sensing a roar of constant sound when all else is quiet; hearing the constant sound of “ringing” in one’s ears: clearly these are not beneficial “side effects” of Latimer’s condition, and it is unlikely that they would encourage moral behavior in anyone. While I will not give an extensive analysis of *The Lifted Veil* here, Eliot’s novella is an important touchstone for understanding why sympathy was a central concern for the Victorians and why it was invoked across various disciplines as a source of concern. In the preceding chapters I have outlined how various modes of sympathy, whether psychosocial or physiological, shaped and were shaped by the effort to gain knowledge about the female body. In my analysis of *Middlemarch*, I highlight Eliot’s conflicting views on sympathy and argue that the female body’s sympathies are deemed a threat to both medical knowledge as well as moral behavior. In my chapter on *Esther Waters*, I show how Moore’s privileging of Esther’s unique voice and embodied experiences subvert the naturalist aesthetic and encourage sympathy for his heroine. In contrast to chapters one and two, chapter three takes on the historical figure of the medical woman, and questions how the relationship between women’s bodies, knowledge, and sympathy was influenced by the presence of female doctors acting as the subjects, rather than the objects, of knowledge. Lastly, in chapter four, I assess the parallels between the rise of gynecology and the antivivisection movement, suggesting that these

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5 Ibid., 18.
two movements drew from a common cache of images, theories, and assumptions about those bodies that are deemed appropriate for dissection.

All of these texts, whether gynecological or scientific or literary, evoke sympathy, knowledge, and the female body in very different ways and with very different purposes. But what they do share is the underlying assumption that sympathy, knowledge, and the female body are inextricably linked. What is also evident in all of the texts that I have presented here is the fact that, for the Victorians, feminine sympathies, in all of their forms, were often a troublesome obstruction to knowledge. While Eliot is able to represent and deal with this difficulty figuratively through her narrative, the female body’s sympathy was much more than a figurative problem for the Victorian gynecologist. For him, feminine sympathies were a literal obstruction that prevented him from tracing the source and different facets of disease. More importantly for his patients, these presumed sympathies came to define and determine how women were cared for during the most vulnerable periods of their lives. Unlike a literary character such as Dorothea Brooke, the patients that prompted the gynecological texts that I have surveyed here weren’t able to overthrow their pathological sympathies by reaching out and offering sympathy to a rival or friend. Instead, they were subjected to a remapping of their bodies, such that bodily connections, pathways, and processes were reconceptualized based on their alleged bodily sympathies.

As I have suggested in this dissertation, however, knowledge itself was also reconceptualized as a result of these developments in Victorian gynecology. Not only did the eighteenth-century theory of physiological sympathy reappear as an explanation for women’s bodily complaints and as a determinant in gaining more knowledge about the female body, but these gynecological theories also shaped how the Victorians conceived of sympathy between individuals. As in gynecological theories, the ability to feel with someone else became closely
linked to the ability to know him or her. In both the case of the gynecology patient and sympathy between two individuals, then, sympathy was problematic because it remained an epistemic uncertainty. In this way knowing the female body and knowing the contents of another’s mind were similarly theorized as problems with sympathy and with the ability to know. To put it simply, what this demonstrates is just how foreign the female body was to the Victorian medical profession, and to society as a whole. Though they idealized feminine feeling and virtue, for the Victorians the female body remained an unknown Other that, like the process of sympathy itself, remained obscure and threatening for science, for medicine, and for society.
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