DOCTORS IN DIALOGUE: DOCTOR-PATIENT INTERACTIONS IN *VILLETTE* AND *MIDDLEMARCH*

by

Valerie Mitanoff

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ABSTRACT

Charlotte Brontë's *Villette* and George Eliot's *Middlemarch* encourage the reader to consider the interactions among a plurality of voices and perspectives. This dialogic framework, I will argue, contributes to our understanding of the doctor-patient relationships that occur in the texts: although their fictional practitioners interact with patients differently, both Brontë and Eliot suggest that open dialogue between doctors and patients is essential to the healing process. Specifically, doctors must engage with multiple perspectives and discourses in order to diagnose and treat their patients effectively. These writers examine the dialogic nature of nineteenth-century medical discourse as the voices of both doctors and patients destabilize scientific terminology, diagnostic categories, and treatments. By analysing the interactions between these competing voices, I endeavor to comment on the doctors' use of authority, and on the extent to which they choose to facilitate or frustrate dialogic interaction with their patients.

LIST OF ABBREVIATIONS

Mikhail Bakhtin—*The Dialogic Imagination*.....*DI*

Mikhail Bakhtin—*Problems of Dostoevsky's Poetics* .....*Dostoevsky*

Gillian Beer—"Circulatory Systems: Money, Gossip and Blood in *Middlemarch*".....*CS*

Gillian Beer—"Myth and the Single Consciousness: *Middlemarch* and *The Lifted Veil*".....*MSC*

George Eliot—*Middlemarch*.....*MM*

George Eliot—"Notes on Form in Art".....*Form*

Lilian Furst—*Between Doctors and Patients*.....*BDP*

Lilian Furst—"Struggling for Medical Reform in *Middlemarch*".....*SMR*

Lawrence Rothfield—"Medical" in *A Companion to Victorian Literature and Culture*.....*Medical*

Lawrence Rothfield—*Vital Signs*.....*VS*

Sally Shuttleworth—*Charlotte Brontë and Victorian Psychology*.....*CBVP*

Sally Shuttleworth—*George Eliot and Nineteenth-Century Science*.....*GENS*

Athena Vrettos—*Somatic Fictions*.....*SF*

Athena Vrettos—"From Neurosis to Narrative: The Private Life of the Nerves in *Villette* and *Daniel Deronda*".....*FNN*

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Chapter One: Introduction

Charlotte Brontë's *Villette* (1853) and George Eliot's *Middlemarch* (1872) explore the changing role of doctors during the nineteenth century. *Villette* features Dr. John, a young practitioner familiar with the materialist terminology that emerged during the nineteenth century, and *Middlemarch* presents Tertius Lydgate, a doctor who attempts to establish a medical practice using his newly acquired physiological knowledge and skills. These fictional accounts provide insights into the practice of medicine because they critique the doctors' scientific approach in context: both novels include several exchanges between doctors and fully represent patients who respond variously to the medical advice they receive.

In the following discussion, I will argue that Brontë and Eliot suggest the doctors' new physiological, clinical approach is on its own insufficient. In order to provide effective care, the doctors must be able to shift their points of view, to be both detached observers of the body and to engage sympathetically with their patients. Only by seeking their patients' perspectives through conversation can the doctors diagnose and treat the various psychological and social elements that contribute to the complex illnesses that arise in the novels.

The nature of doctor-patient interactions is consistent with the broader styles and structures of the texts, both of which encourage the reader to consider the relationships among a plurality of coexisting voices and perspectives. For example, Lucy Snowe, the first-person narrator in *Villette*, describes her illness using several discourses, refusing to allow either the doctor or the reader to reduce her experience to a single cause or meaning—in addition to its physiological symptoms, Lucy

understands her suffering in terms of its religious, emotional, and social significance. In her wider narrative, Lucy perceives characters from both detached and sympathetic perspectives while adopting "other" socially acceptable roles and voices to communicate her own desires to readers who can interpret the relationships among these multiple points of view. Similarly, *Middlemarch*'s narrator allows several voices to enter into her commentary as a means of describing a multitude of characters from a variety of contradictory perspectives; characters are presented from both ironic and sincere points of view, and are themselves integrated into the narrator's commentary through Eliot's use of free indirect style.

The work of Russian literary theorist Mikhail Bakhtin is relevant to the narrative styles Brontë and Eliot employ. Bakhtin uses the term "dialogical" to describe the "plurality of independent and unmerged voices and consciousnesses" (*Dostoevsky* 4) that coexist in many novels between characters, between characters and the narrator, and within the narrative voice itself. According to Bakhtin, these opposing voices remain unresolved, their differences sustained in an ongoing dialogue as they contradict, qualify, and influence one another. Because all dialogic utterances derive meaning from their relation to the voices with which they come into contact, readers must consider the significance of the interaction that takes place between them instead of attempting to resolve these divergent perspectives into a single interpretation or unified meaning.

The meanings produced by conflicting voices are specific to each text. In general, Eliot suggests that, in order to reach the fullest possible understanding of characters and events, multiple perspectives must be linked and compared. Only

when they engage in this process can members of a community take appropriate action to benefit others. Brontë develops her dialogic style, I will argue, as a response to her society's failure to acknowledge certain types of female experience. She employs many voices and discourses to communicate these unique experiences as well as to invite multiple interpretations, which in turn create an ongoing dialogue with a community of readers to whom she can look for sympathy and validation.

Just as the novels produce meanings by juxtaposing a multiplicity of conflicting perspectives, the voice of a single character is only complete when it enters into dialogue with another because "every word is directed toward an answer and cannot escape the profound influence of the answering word that it anticipates" (Bakhtin *Dialogic Imagination* 280). This type of mutual enrichment is particularly necessary in exchanges between doctors and patients. While patients generally benefit from their doctors' knowledge and skills, in *Villette* and *Middlemarch* the doctors also need to consider their patients' illness narratives before they can reach an appropriate diagnosis or course of treatment.

In this respect, Brontë and Eliot take issue with Bakhtin's comments on the distinct nature of professional discourse, which he describes as a closed system (*DI* 289). Professional discourses, he argues, exist independently of conflicting discourses for their meaning: "these generic and professional jargons are directly intentional—they denote and express directly and fully, and are capable of expressing themselves without mediation" (Bakhtin *DI* 289). Bakhtin claims that, by virtue of being a professional discourse, medical discourse does not necessarily assume the presence of the patient. Both Brontë and Eliot, however, insist that the doctor's

discourse is "always half someone else's" (Bakhtin *DI* 291); patients always respond to their medical treatment, either to their doctors directly or to their friends and readers. By doing so, they claim an authority based on their own knowledge and experience.

Although Brontë and Eliot emphasize the importance of dialogic interaction between doctors and patients, the scientific epistemologies that formed the basis of nineteenth-century medicine privileged a different approach. Scientific advances in pathology, germ theory, surgery, and experimental method resulted in a new kind of doctor. This practitioner had a greater knowledge of human physiology than did his predecessors, and therefore diagnosed his patients by observing their bodies from a detached, clinical point of view. In order to communicate his diagnosis, the nineteenth-century doctor frequently described the minute details of human physiology with a technical discourse from which most patients were excluded. This alienating methodology differed substantially from that used by traditional doctors, who shared a common language with their patients, and who were almost exclusively dependent on their patients' narratives.

Charlotte Brontë and George Eliot consider the implications of the doctors' scientific approach in combination with other circumstances: during the nineteenth century, relationships between doctors and patients were also complicated by the changing balance of power between them. Because of their improved skills and expertise, nineteenth-century doctors made claims to a knowledge-based medical authority, but in practice doctors' actual power over their patients was moderated by the willingness of their communities to recognize the value of their new medical

knowledge. The medical profession was not highly respected at the beginning of the nineteenth-century because practitioners could do little to help patients and generally possessed neither wealth nor family status, which were more accepted indicators of worth. As the century progressed, doctors' scientific credentials were gradually recognized and valued by the public; they were able to collect higher fees, and, consequently, their social status improved. Because Lydgate enters into the profession during the 1820s, he discovers his medical authority gives him little power over his upper class patients, who value only wealth and birth. Dr. John, who practices during the 1850s, is supported by his community's respect for scientific achievement in addition to his gender and bourgeois status.

In *Villette* and *Middlemarch*, Brontë and Eliot explore the extent to which doctors and patients negotiate this unstable balance of power. To provide good patient care, these writers suggest, doctors must share their power by recognizing their patients' claim to knowledge based on experience and then by incorporating these perspectives into a diagnosis and treatment regimen. Medical care can be compromised, however, when power relations are unbalanced and participants refuse to acknowledge and negotiate other claims to authority.

The ideas presented by these nineteenth-century women writers are affirmed and informed when they enter into dialogue with twentieth and twenty-first century studies on doctor-patient interactions. Although Dr. John and Lydgate are not fully representative of present-day doctors because they treat their patients primarily in the home and possess only a fraction of the diagnostic tools and treatments that physicians employ today, the fictional doctors are representative of the an emerging

scientific paradigm that remains the basis of modern (twenty-first century) medicine. Like Brontë and Eliot, recent scholars are concerned with patients' dissatisfaction with their doctors' detached clinical manner and exclusive use of technical terminology. While studies by these scholars do not use Bakhtinian terminology specifically, they too advise doctors to consider their patients' subjective experiences of illness by entering into dialogue.

Until this point, I have referred to physicians exclusively as male because there are no women doctors in the nineteenth-century novels. In twentieth and twenty-first-century scholarship, doctors are assumed to be either gender, and will be referred to as such for the remainder of this section. Gender can influence a doctor's approach to patient care, and it does in both novels as Dr. John and Lydgate interact with their female patients. Because the fictional doctors under discussion are men, however, the following summary of recent studies on doctor-patient interaction does not elaborate on female doctors specifically.

In *Doctors' Stories: The Narrative Structure of Medical Knowledge*, Kathryn Montgomery Hunter recommends that doctors and patients work together in order to construct a narrative that embodies both the patient's initial narrative of his or her illness and the doctor's diagnosis-driven interpretation (5). Ideally, doctors interpret their patients' narratives to fulfill the function of diagnosis and treatment, but return their patients' altered story without asserting their medical ownership: "this transformed account of illness must be reintegrated as an interpretation of events into the patient's ongoing life story—whether that story is one of health or illness, successful treatment, physical limitation, or approaching death" (Hunter 13). Doctors

who fail to represent both voices in their diagnosis and treatment, Hunter warns, create narratives patients find extremely difficult to accept:

> Returned to the patient in this alien form (as occasionally it is by a physician who either has forgotten the common language of illness or ignores the need to use it) the medical narrative is all but unrecognizable as a version of the patient's story—and all but useless as an explanation of the patient's experience. A silent tug-of-war over the possession of the story of illness is frequently at the heart of the tension between doctors and patients, for that tension is in part a struggle over who is to be its author and in what language, a struggle for the interpretation of life (and death) events. (Hunter 13)

A successful doctor-patient interaction is one in which this tension is sustained but negotiated effectively.

Several writers elaborate on the various types of discourse doctors encounter while engaging with their patients' perspectives. In "Listening, Empathy, and Clinical Practice" Dr. Jennifer Connelly argues that doctors "must diagnose the problem whether its origins are in disease, social relationships, socioeconomic distress, or lifestyle or behavioral characteristics. They must understand what the problem means to the patient" (174). Lucy M. Candib suggests that in addition to contributing to the diagnosis, the recognition of these social contexts validates, supports and empowers the patient: "I see the naming of social forms of oppression . . as an essential step for a doctor and patient to make together in order to recognize where her symptoms come from and what keeps them going. When the doctor accepts and uses language that acknowledges oppression that people experience, this usage supports the reality of the patients' experience of oppression" (137). In addition, literary theorist Elaine Scarry argues that doctors can soothe pain by considering the diverse discourses patients draw upon to describe it. Because pain is a state of extreme embodiment, it can be alleviated when sufferers share it with

others. Therefore, the, "the success of the physician's work will often depend on the acuity with which he or she can hear the fragmentary language of pain, coax it into clarity, and interpret it" (6).

Like Brontë and Eliot, recent scholars emphasize the capacity of doctor-patient dialogue to foster a sympathetic and caring relationship. Dr. Melvin Konner observes that "almost every patient needs to believe that his or her doctor really cares, at least a little; that the doctor's effort is a serious one, mobilizing powerful resources on the patient's behalf" (13). In *The Sickroom in Victorian Fiction: The Art of Being Ill*, Miriam Bailin turns to literature for a deeper understanding of effective communication between doctors and patients. She describes the sickroom as a haven in which patients re-establish experiences that may be lacking in their everyday social interactions by participating in genuine communication and close relationships with their doctors and nurses. Ideally, the doctor's interaction with his patient is "characterized by intimacy, informality, and shared meaning" (9).

In the following chapters I will explore the potential for dialogic interaction between doctors and patients in *Villette* and *Middlemarch*. Chapter One provides an overview of the changing status of doctors during the nineteenth century, including their newly emerging sources of authority and the strategies they employed for enforcing this power. In this chapter I also discuss the potential instability of early nineteenth-century medical authority when doctors were confronted with actual patients who expressed their own expectations to a financially dependent practitioner. Both novelists take doctors' contradictory and unstable status in Victorian society into consideration as they explore the potential for direct dialogic interaction between

practitioners and patients. Finally, I draw connections between the authors' personal experience with illness and medicine as it informs their fiction. In her letters, Brontë acknowledges the need for doctor-patient dialogue in the treatment process, while Eliot's essays reflect the compatibility between modern science and sympathy that Lydgate embodies in *Middlemarch.*

In Chapter Two, I will analyse Lucy Snowe's dialogic dependence on her community for her health and identity in Charlotte Brontë's *Villette.* In order to overcome illness, Lucy seeks to make her own voice heard, to have her experience validated by her community. In short, Brontë suggests that communication is an integral part of psychological medicine, but she has a pessimistic view of the nineteenth-century practitioner's ability to acknowledge the variety of discourses that are required to understand the full complexity of Lucy's illness. Lucy discovers that Dr. John uses his authority to silence and dismiss her; he fails to acknowledge the healing potential of open, sympathetic conversation despite Lucy's own dialogic efforts to engage him.

In Chapter Three I argue that George Eliot, like Charlotte Brontë, acknowledges the importance of dialogic relationships between the individual and his or her community and, by extension, between doctor and patient. When Lydgate's consultations are compared with Dr. John's, we find that the former has a greater capacity to care for and sympathize with his patients; he is capable of sharing his power, diminished as it is, by communicating his knowledge to his patients, by encouraging their voices, and by considering their narratives. Lydgate is therefore better able to diagnose and treat his patients effectively.

Chapter Two: Doctors and Patients in the Nineteenth Century

The balance of power between doctors and patients was unstable during the nineteenth century. Although doctors had many claims to authority in theory, in actual practice these claims were compromised by a highly competitive medical marketplace. In many cases patients had expectations that differed from their doctors' scientific approach, and tension arose as each party attempted to negotiate their positions. In this chapter I situate Brontë's Dr. John and Eliot's Lydgate in their historical contexts with emphasis on the complex power dynamics at play between practitioners and patients.

The following discussion begins with an outline of the factors that contributed to doctors' increasing claims to authority: advances in scientific knowledge enabled them to provide better care while the development of diagnostic technology gave practitioners greater access to the inner workings of their patients' bodies. In the second section I argue that, despite their accurate knowledge and technical capabilities, Victorian medical men found it difficult to establish successful practices because many patients subscribed to eighteenth-century discourses of illness, and the doctors' newly acquired skills went largely unacknowledged by their paying clients, who preferred traditional practitioners.

Thirdly, I draw connections between the characteristics of the fictional doctors in *Villette* and *Middlemarch* and the life experiences of their creators. Charlotte Brontë's exposure to both medical men within her home and popular scientific debates can be detected in *Villette*, where the author's frustration with and dependence on her physicians inform the narrator's ambivalent attitude toward

nineteenth-century medicine. George Eliot's experiences as a student of science, a nurse, and a patient, I suggest, are translated into a fictional doctor who entertains scientific interests as well as a capacity for caring.

The Rise of Modern Medicine and the Doctor's Claim to Authority

Medicine was a pervasive aspect of Victorian life because nineteenth-century patients saw several medical improvements. The smallpox vaccine was developed, anatomy and pathology were established as standard elements in medical school, and hospitals became more sterile and humane. For example, inhalation anesthesia eased the pain of many procedures while the development of germ theory curbed the spread of disease, eventually leading to the advent of antiseptic surgery (Rothfield *Medical* 173).

The nineteenth-century doctor's ability to diagnose and treat his patients was a result of specific scientific advancements that were made, for the most part, in France and Germany. The French physiologist Xavier Bichat (1771-1802) contributed to the increasing interest in human anatomy that occurred during this time by shifting his emphasis from organs to the minute study of tissues (Bynum 32). This shift in turn resulted in a more detailed and scientific understanding of disease. In *Middlemarch*, for example, Lydgate, who receives his medical education in France and follows in Bichat's footsteps as a physiologist and tissue researcher, is able to arrive at a precise diagnosis for the cause of Casaubon's "fit," which he attributes to "fatty degeneration of the heart" (*MM* 397).

These nineteenth-century changes and developments contrasted markedly with earlier approaches to medicine. During the eighteenth century, little was known

about the physiological functioning of the body, and surgery, performed without proper sanitation or anaesthetic, was rightly considered a brutal option only to be attempted as a last resort. Physicians, rather, tried to balance their patients' constitutions with externally administered remedies such as bleeding and cupping. Pills and potions of questionable effect were often prescribed to patients, who relied largely on their personal relationships with doctors for hope and comfort.

Because nineteenth-century doctors' growing scientific knowledge and technical capabilities improved their ability to treat patients, they made more valid claims to medical authority. However, in the early decades of the nineteenth century, young physicians found that, although they were better trained than their elders, their patients often preferred traditional medical men, soothsayers, and quacks. In order to legitimize their authority—for their own as well as their patients' benefit—nineteenth-century medical men pushed for professional licensing and educational reform.

In their movement toward reform, general practitioners disrupted the pre-existing medical hierarchy. Prior to the medical reforms of the 1830s, physicians occupied the upper strata of medical practitioners; they tended mainly to the rich and were licensed by the Royal College of Physicians after receiving their education from Oxford or Cambridge. The curriculum at these schools, however, was archaic: medical courses were taught in Latin, and students received no anatomical training. Consequently, physicians adopted the role of advisors who deliberately distinguished their activities from the messy and invasive activities of the surgeons (Furst *SMRM* 343). Apothecaries, who prescribed and sold medicine after completing an informal

apprenticeship, were considered tradesmen and were therefore situated at the bottom of the medical hierarchy. The surgeons occupied the most flexible medical category. They claimed anatomical knowledge, often distributed medicine, and appealed to the rising middle class because they were cheaper than physicians to consult.

Reform of this system was advocated largely by younger surgeons and apothecaries, who demanded professional recognition (Cartright 52). The Apothecaries Act of 1815, the first official reform toward modern systems of licensing, specified that all apothecaries must possess the License of the Society of Apothecaries (LSA); candidates were required to attend lectures on anatomy, botany, and chemistry, and to spend six months at hospital bedsides. At approximately the same time, the surgeons, who had already broken from the Barber Surgeons in 1745, formed the Royal College of Surgeons, which distributed its own memberships (MRCS). Many men became "general practitioners," capable of surgery and medicine, by acquiring both their MRCS and their LSA.

These medical reforms did not occur without conflict. The new generation of competent general practitioners "who provided a powerful stimulus to reform was at best tolerated, and more often distrusted as a threat to physician and apothecary alike for trespassing on their turf and subverting the conceptual order of the profession" (Furst *SMR* 345). George Eliot replicates these conditions in *Middlemarch*, where Lydgate is received with skepticism and hostility by the established medical community. Reformers like Lydgate, however, did not meet their opposition with complacency. Thomas Wakely, who founded the Lancet in 1823, created a forum to attack the old elitist medical order and quacks alike (Cartright 55). Surgeons also

established several medical societies; for example, the Provincial Medical and Surgical Association, founded in 1832 by Charles Hastings (1794-1866), later became the British Medical Association (BMA) in 1855. The BMA called for bans on unqualified medical men in favour of a single national register for qualified practitioners (Porter 354). These demands eventually came to fruition when the 1858 Medical Act was passed to establish a unified register of all approved practitioners and to formally acknowledge the hospital as the center of medical instruction (Rothfield *Medical* 172).

The authority accorded to doctors by their growing professional legitimacy was reinforced by the consequences of several scientific developments that took place during the nineteenth century. For example, doctors trained in anatomy used an exclusive technical discourse, which functioned as a source of their scientific power. Because eighteenth-century practitioners had little accurate knowledge about the body, their discourse was not technical, and patients could participate in detailed discussions about their health; therefore, "the traditional doctor saw his patients often and knew their lives well" (Shorter 40). The highly specific physiological terminology developed during the nineteenth century, however, gave doctors the ability and power to name, define, and categorize using discourses that differed from the layperson's understanding of illness. Such is the case in *Villette* when Dr. John refers consistently to Lucy Snowe's "nervous system," a term that assumes a physiological basis for her psychological experiences. Shortly after Lucy's collapse the doctor inquires whether her "nervous system bore a good share of the suffering" (212), and then again emphasizes the physiological nature of her illness when he

assumes that "there must have been high fever" (215). Dr. John's use of these terms, however, is limited in comparison to Lucy's description of her own suffering, which is emotional and social in nature. Later, Dr. John assesses Lucy's encounter with the ghostly nun using technical psychological terminology: "I think it a case of spectral illusion" (290). This diagnosis not only distresses Lucy, who subsequently questions her mental stability, but limits the meaning of the nun, who otherwise functions on both symbolic and material levels. In *Between Doctors and Patients: The Changing Balance of Power*, Lilian R. Furst argues that technical discourse enforces medical authority because it "unites medical professionals and at the same time alienates the uninitiated so that access to this language becomes a tool of empowerment" (8). In "Medicine and Literature," Michael Neve also suggests that the doctor's medical terminology acts as a barrier to open communication between doctor and patient: "the medical language of the nineteenth century jettisoned this external and collectively comprehensible element [of the eighteenth-century], and headed into the dark cave of the previously unexplored internal body and its world . . . The patient became part of the doctor's conversation, not a part of his or her own" (1527-1528). By applying a technical discourse to the patient's experience and bod`y, the doctor takes control of the illness.

Nineteenth-century practitioners did not assert their authority through language alone: their increasing physiological knowledge coincided with diagnostic technologies that gave doctors more access to and, therefore, more power over their patients' bodies. Lydgate employs the stethoscope, a cutting-edge diagnostic tool within the context of Middlemarch, to diagnose Casaubon's heart condition. Lydgate

would have been introduced to the stethoscope in France, where the instrument's precursor had recently been discovered in 1816 by René-Théophile-Hyachinthe Laënnec (1781-1826) as he listened to a patient's heart through a tightly rolled piece of paper. Laënnec later improved upon his invention, describing the one-ear wooden instrument in his authoritative guide to diagnosing heart disease, *Traité del'auscultation médiate* [*Treatise on Mediate Auscultation*], published in 1819. In his guide, Laënnec documented the ways in which auditory symptoms made accessible by the stethoscope corresponded to internal pathology (Bynum 37-8). This diagnostic technology redefined the doctor-patient relationship: while the stethoscope provided the physician with deeper, more accurate access to the patient's body, it also allowed the doctor to remain more distanced than he would have been listening with his ear pressed directly against the patient's chest (Furst *BDP* 10).

The nineteenth-century doctor's ability to observe was also improved by the development of the microscope during the 1820s. Lydgate takes advantage of the microscope's powers to study human tissue, or, more exactly, to "pierce the obscurity of those minute processes which prepare human misery and joy, those invisible thoroughfares which are the first lurking-places of anguish, mania, and crime" (*MM* 163). Lydgate exemplifies the scientific doctor's highly visual methods as he uses his clinical eye to focus on both his patients' tissues and their behaviour. As with the stethoscope, the microscope allowed the doctor to access the body while remaining a detached observer, removed from the patient's subjective experience.

Medical conduct books openly acknowledged that this clinical detachment was a form of authority, particularly over women. In *The Pathology and Treatment*

of Hysteria (1853), Robert Brudnell Carter advises the doctor to remain in control of his patient by avoiding emotional attachment or spontaneous conversational exchange:

> . . . remove and leave her alone, do not give utterance to a single expression, either of sympathy or alarm . . . no inquiries being made about her health, and all complaints being interrupted, by the introduction of ordinary conversation topics. . . . A day or two should be allowed to elapse before any conversation is held with her on the subject of her ailments, as this time will allow the excitement of her nervous system to abate, and will moreover afford the opportunity of introducing the subject unexpectedly. (109-110)

When Carter warns his readers that "women have a morbid craving after sympathy," (110), he makes it clear he considers sympathetic engagement to be compromising, even dangerous for the doctor. In *Somatic Fictions*, Athena Vrettos notes that nineteenth-century medical professionals contrasted what they perceived to be women's "greater emotional response to scenes of pain and suffering and their sympathetic, and thus inherently weak sensibilities" (92) with the physician's own superior qualities such as "strength, self-control, detachment, critical distance, dispassionate judgement" (91). In *Villette*, the narrator receives treatment from a doctor who fits the masculine paradigm of self-control and detachment. As a sufferer of nervous disease, Lucy is not given the opportunity to discuss her health when and how she wishes; instead, Dr. John makes an effort to calm and silence his patient by deferring her medical interview until he chooses to initiate it (McLean 84).

Carter's approach to his hysterical female patient is also indicative of the nineteenth-century doctor's emphasis on authority in the rising field of psychology. Although psychology is not practiced exclusively by the medical men in either of the novels, several concerns particular to this type of medicine arise in *Villette*, where

Brontë frequently incorporates and criticizes nineteenth-century psychological theory and terminology. In addition to discussing specific instances of psychological medicine that arise during many medical consultations in *Villette*, I will maintain that, as general practitioners, both Dr. John and Lydgate encounter illnesses that are caused by a variety of factors; therefore, both doctors must consider multiple discourses and medical approaches to diagnose and treat their patients.

In general, the psychologist enforced his power over his patients with his scientific "certainty." He was, therefore,

> supported by developments in physiological research that designated the brain and nervous system as the site of mental life. No longer was the mind viewed as an immaterial or spiritual essence, but was placed firmly within the workings of the body. Increasingly, social problems and individual deviance were medicalized, traced back to a physiological base. The physician, in consequence, was raised to new eminence: the arbitrator of normality, and licensed interpreter of the hidden secrets of individual and social life. (Shuttleworth *CBVP* 42)

In addition to claiming knowledge of the physiological base of mental life, psychologists classified different types of mental illness that required specialized training to discern and detect. The designation of "moral insanity," for example, was introduced to England in 1835 by J. C. Prichard's *Treatise on Insanity*, the standard psychiatric text until Bucknill-Tuke's 1858 *Manual of Psychological Medicine* (Faas 45). To Prichard, moral insanity was a "morbid perversion of the feelings, affections, and active powers, without any illusion of erroneous conviction impressed upon the understanding: it sometimes coexists with an apparently unimpaired state of the intellectual faculties" (20). This definition gave greater currency to the psychologist, who was able to detect insanity in otherwise normal individuals. It also partially explains the tenfold increase in the asylum population by 1858 (Faas 43).

Monomania, an obsessive and more dramatic form of mental deviance, was another type of insanity that developed during the nineteenth century. The term was first defined by Jean-Etienne Dominique Esquirol (1772-1840) *in Des maladies mentales* (1838), and was later popularized in England by Prichard. Eventually, several other "manias" arose, each with their own signs and symptoms, each to be differentiated and diagnosed by skilled psychologists.

Many designations of insanity were specific to women. Esquirol assumed that women were more vulnerable to insanity, particularly religious and erotic melancholy. Bucknill and Tuke also allowed their social values to inform their medical verdicts: "when the carefully-nurtured and modest female demeans herself in a bold forward, and indecent manner," she can be diagnosed as mentally deranged (272). In *The Female Malady*, Elaine Showalter argues,

> Even when both men and woman had similar symptoms of mental disorder, psychiatry differentiated between an English malady, associated with the intellectual and economic pressures of highly civilized men, and a female malady, associated with the sexuality and essential nature of women. Women were believed to be more vulnerable to insanity than men, to experience it in specifically feminine ways, and to be differently affected by it in the conduct of their lives. (7)

Henry Maudsley, for example, ascribes feminine attributes to women suffering violent dementia. They did not "evince such lively exultation and energy as men, and they had quieter and less assertive delusions of grandeur comfortable with their gentler natures and the quieter currents and conditions of their lives" (461).

Both Brontë and Eliot recognize and challenge the legitimacy of the nineteenth-century psychologist's interpretive power over his female patients. Dr. John's "powers of discernment" can be attributed to new theories on the nature of

selfhood and insanity that arose in the nineteenth century. Sally Shuttleworth explains that "selfhood no longer resided in the open texture of social act and exchange, but within a new interior space, hidden from view, inaccessible to even the subject's own consciousness" (*CBVP* 9). After Lucy has encountered the ghostly nun, Dr. John uses his medical powers to detect her inner mental disturbance: "I look on you now from a professional point of view, and I read, perhaps, all you would conceal—in your eye, which is curiously vivid and restless: in your cheek, which the blood has forsaken; in your hand, which you cannot study" (288). Despite his claims to visual penetration and interpretation, Lucy becomes frustrated by Dr. John's inability to read her features correctly: "He did not guess at all I felt: he did not read my eyes, or face, or gestures; though, I doubt not, all spoke" (368). While Lydgate is a more astute and intuitive psychological observer than Dr. John, he too mistakes Rosamond's outer feminine beauty with inward docility and grace only to find that she is shallow, selfish, and stubborn. Unlike Dr. John's blunders, however, Lydgate's mistakes cost him dearly.

Doctors and Patients

Charlotte Brontë and George Eliot demonstrate that the doctors' medical skills are fallible, and, consequently, that their authority is open to question. Indeed, the medical interactions that occur in these novels reflect the conflicts between doctors and patients that existed in actual practice despite practitioners' claims to scientific knowledge and professional legitimacy. During the nineteenth century, the medical profession was not highly esteemed because patients were slow to acknowledge scientific advancements. For this reason, doctors were not particularly well

compensated and, therefore, achieved limited social status in communities where birth and wealth were valued over medical accomplishment.

In practice, doctors' economic standing and authority were further compromised by the competition they faced from other, more established practitioners. These circumstances made it necessary for them to win patients' approval in order to secure a modest livelihood (Furst *BDP* 351). What, exactly, was required of doctors in order to accomplish this is evident in Daniel Webster Cathell's *Book on the Physician Himself* (Philadelphia 1881). Unlike the conduct books and manuals that instructed the doctors on matters of diagnosis and control, Cathell's publication served as a practical guide which acknowledged the actual social and economic conditions aspiring young practitioners faced. Cathell advises doctors to meet their patients' social expectations: "A brusque, tornado-like manner, or eccentric rudeness is fatal to a physician's success," unlike a "simple, humane, gentle, and dignified manner and a low tone of voice" (45). According to this conduct book, it is not clinical skill and authoritative demeanor that determines success; rather, the practitioner's appearance, personality and willingness to sympathize sustained patient relationships.

Cathell never advises his colleagues to force their patients to follow a course of treatment; rather, he warns new doctors not to admonish patients for relying on useless remedies. Only by compromising, he cautions, can young practitioners avoid losing their patients to more permissive medical men. Doctors were obliged to cater to the expectations of their upper- and middle-class female patients in particular because these women made most of the decisions concerning the health of their

families. In *The Medical Profession in Mid-Victorian London*, Jeanne M. Peterson notes:

> A medical man should cultivate the social graces and a reputation for tact and sympathy. Robert Waring Darwin, the father of Charles Darwin, may be the classic case of the medical man who built his success on just such traits. He had little of what could be called a 'scientific mind' and he disliked much of medical practice. He had, however, the ability to gain his patient's confidence because of his personality and powers of insight into their problems. Women, particularly, found him sympathetic, and much of his notable and rapid success was attributed to his success in winning their trust. (129-30)

While medical men may have been trained as detached observers of events in the sickroom, they often engaged sympathetically with their patients.

Dr. John and Dr. Lydgate

The doctor-patient relationships in *Villette* and *Middlemarch* reflect these complex dynamics in the sense that both doctors make claims to medical authority and both are confronted by patients who have their own opinions and expectations. The outcomes of these interactions, however, depend on the extent of the doctor's authority as well as the manner in which he chooses to exercise it. These conditions are in turn defined by the structure and setting of the fictional communities in which the doctors practice.

Villette is set in 1850s Belgium, a scientifically advanced country, where medical advancements were more readily adopted than they were in England. In addition to his scientific studies, Dr. John's gender and bourgeois status are privileged by the members of his community, and this social acceptance reinforces his medical power. While Dr. John's medical and social authority is far from absolute with respect to patients like Mme Beck, who is a major source of his income, Brontë is

concerned with the doctor's relationship with the narrator, a plain, unconnected, non-paying patient. Because of Lucy Snowe's circumstances, etiquette requires that she try to avoid openly challenging the doctor's advice. Unfortunately, Dr. John frequently asserts his authority inappropriately by using a variety of techniques to silence and alienate his patient.

George Eliot wrote *Middlemarch* between 1869 and 1872, after scientific medicine had taken hold in England. The novel, however, is set in 1829, when medical reform was first being introduced. While Lydgate has claims to medical authority based on his knowledge and training, his patients privilege other medical discourses and do not invest the profession with much social status; consequently, Lydgate meets with patients who exert their financial and social power over him in ways that frustrate their dialogic relationship. When Lydgate's medical authority is respected by his patients, however, he uses it appropriately. Consequently, Lydgate is able to practice scientific medicine more effectively than Dr. John.

These fictional doctors differ from each other in ways that reflect the personal contexts from which Brontë and Eliot were writing. Lucy's complex experience of illness and troubled relationship with her doctor, I will argue, resembles Charlotte Brontë's battle with depression, criticism of her own medical treatment, and interest in popular psychological theories of the day. George Eliot's emphasis on the validity of Lydgate's scientific approach to medicine reflects the importance of science in Eliot's own life, including her studies of biology, physiology, and psychology. However, Eliot's experience as a nurse and patient also inform her novel—in her

characterization of Lydgate, Eliot, unlike Brontë, acknowledges the potential compatibility of sympathy and nineteenth-century medicine.

Throughout her life Charlotte Brontë was surrounded by illness. She grew up in Hawarth, a community with an extremely high mortality rate due to bad sanitary conditions: the average age of death was 25.8 years, and 41.6% of the population died before the age of six (Shuttleworth *CBVP* 22). Within the Brontë household, every member of the family suffered physical or psychological illness. In 1825, Elizabeth and Maria, Charlotte's two beloved older sisters, succumbed to the tuberculosis they developed while boarding at the notorious Cowan Bridge School. Branwell Brontë, the family's favoured only son, became addicted to alcohol and opium after a series of failures and disappointed expectations. Emily was Branwell's primary caregiver, but the entire household was subjected to his drunken and delirious late-night ranting. In a letter to Elizabeth Gaskell, Charlotte Brontë writes: "no sufferings are so awful as those brought on by dissipation; alas, I see the proof of this observation daily proved.—and—must have as weary and burdensome a life of it in waiting upon their unhappy brother. It seems grievous, indeed, that those who have not sinned should suffer so largely."[1] Shortly after Branwell's funeral in 1848, Emily became ill with consumption and died in April of 1849. Months later Anne also succumbed this infection. Devastated, Charlotte was left to care for her ailing father.

As a member of the Brontë household, Charlotte participated in many types of sickroom relationships. As a nurse, for example, she was pained by the suffering of others and recognized the importance of dialogue between caregiver and patient.[2] The Brontë sisters, however, responded variously to the medical attention they

received: even when Emily was desperately ill, she rejected all medical authority and intervention, refusing to complain or to accept consolation. Charlotte writes:

> I feel much more uneasy about my sister than myself just now. Emily's cold and cough are very obstinate. I fear she has a pain in her chest, and I sometimes catch a shortness in her breathing, when she has moved at all quickly. She looks thin and pale. Her reserved nature occasions me great uneasiness of mind. It is useless to question her; you get no answers. It is still more useless to recommend remedies; they are never adopted.[3]

Emily's silence makes Charlotte extremely anxious. Although she carefully observes her sister's physical symptoms, Charlotte discovers that her effectiveness as a caregiver requires that her concerns be addressed by the patient. Unfortunately, Charlotte remains ignorant about Emily's state of health and frustrated by her inability to comfort her sister. In contrast, when Anne was ill, the presence of doctors, as well as the patient's willingness to discuss and accept treatment, is beneficial to Charlotte. The Brontës called in two lung specialists for Anne: Dr. Teale from Leeds and the London-based Dr. Forbes, who attempted several remedies (Gerin 380). Charlotte writes: "There is some feeble consolation in thinking we are doing the very best that can be done. The agony of forced, total neglect, is not now felt, as during Emily's illness. Never may we be doomed to feel such agony again. It was terrible."[4]

When Charlotte herself was ill, she, unlike Emily, seemed to find comfort in articulating her illness. After the death of her sisters, Charlotte sank into a deep depression caused by her grief and isolation. In a letter to Elizabeth Gaskell, she wrote:

> I struggled through the winter, and the early part of the spring, often with great difficulty. My friend stayed with me a few days in the early part of January; she could not be spared longer. I was better during her visit, but had

> a relapse soon after she left me, which reduced my strength very much. It cannot be denied that the solitude of my position fearfully aggravated its other evils. Some long stormy days and nights there were when I felt such a craving for support and companionship as I cannot express. Sleepless, I lay awake night after night, weak and unable to occupy myself.[5]

Like Lucy Snowe, Charlotte is aware of the connection between her social conditions and her health; friendship, support, and employment are all essential to Brontë's physical and mental health. Her letter is representative of many in which re-works her own symptoms while contemplating the effectiveness of her treatment.

As a patient, Charlotte was irritated by the way her doctor exercised his authority. When Mr. Ruddock, a poorly qualified surgeon, began caring for Brontë, she vented her frustration with his refusal to listen:

> Mr Ruddock to my dismay—came blustering in on Saturday—I had not intended to let him know of my return till this week. . . . He was actually cross that I had not immediately written—he began about the quinine directly—I told him I thought it did not suit me—but he would not listen to reason—says it is the only thing to do me permanent good &c. however I procured a respite of a week—and meantime I go on with the hop-tea which as far as I know, agrees quite well. I said nothing about it to him—but I mentioned the potass—and he laughed it to scorn—I wish I knew better what to think of this man's skill. He seems to stick like a leech: I thought I should have done with him when I came home.[6]

Mr. Ruddock intrudes on Brontë uninvited, prescribes a medication without first consulting with her, and then dismisses her protests. Consequently, Brontë feels she must withhold information from the doctor and has difficulty removing herself from his care. While Lucy Snowe finds Dr. John more charming than Brontë finds Mr. Rudduck, there are distinct similarities between the practitioners: both exert their authority inappropriately by disregarding their patient's description of symptoms, pain, and response to treatment, and both use laughter to further silence their patients.

Brontë did not draw only on personal experience in her final novel—her interest in popular scientific debates can also be detected in *Villette*. The Brontës attended lectures at the Keighley Mechanics Institute, which offered information on magnetism, geology, galvanism, and, most relevant to *Villette*, self-help, or "self improvement and control through the acquisition of knowledge and the principles of science" (Shuttleworth *CBVP* 24). During Brontë's lifetime, both Tories and Whigs championed the idea that rigorous control of mind and body would offer "a passport to autonomous selfhood and economic liberty" (Shuttleworth *CBVP* 23). Shuttleworth argues that "the mind, like the body, or the social economy, was to be treated as a system to be guided, regulated and controlled. . . . In the mental, as in the social economy, the aim must be to obtain maximum efficiency, neither over-stretching, nor under-deploying the natural resources" (*CBVP* 232). In *Villette*, Brontë explores the consequences of rigid self-regulation. When Lucy suppresses her ambitions as well as her love for Graham in order to sustain her links to the community, the pain caused by her efforts at control is clear. After she has received Graham's first letter, she is tempted to write an expressive epistle in return, but "Reason" chastises her: "Do you meditate pleasure in replying? Ah, fool! I warn you! Brief be your answer. Hope no delight of heart—no indulgence of intellect: grant no expansion to feeling—give holiday to no single faculty: dally with no friendly exchange" (265). In this instance, Lucy finds an outlet for her emotions by writing two letters, one disciplined, and one giving free range to feeling. However, when Lucy finds no means of expressing these energies, she suffers a constrictive sense of burial and, later, illness.

Brontë was also interested in phrenology, which was introduced by Franz Joseph Gall in the 1790s. Gall's concern with the material functioning of the brain inspired him to map out twenty-seven physical faculties, each corresponding to features on the skull that could be interpreted to reveal the strength and weaknesses of a subject's character. Brontë visited a phrenologist with her publisher George Smith and was very impressed by the "accuracy" of his reading (Dames 367). Brontë's consequent endorsement of phrenology is evident in her novels when characters read each other's external features, and "powerful secrets and disfiguring pasts are replaced by instantly legible signs" (Dames 368). Interpretation, however, is complicated when characters like Lucy attempt to control and mask their facial features, while others, like Dr. John, fail to recognize old friends or to discern the nuances of expression.

In general, studies of doctors in fiction neglect to acknowledge Brontë's in-depth depiction of Dr. John as he treats his patients according to nineteenth-century theories of psychological illness; instead, they identify George Eliot's Dr. Lydgate as the pivotal fictional working doctor, or, as Patrick McCarthy describes him, the first "physician hero" (805).[7] The two doctors, however, can be considered counterparts in terms of patient care. That Brontë's Dr. John was a precursor for Lydgate can be inferred by Eliot's certain knowledge of *Villette*, as well as by the similarities between the two practitioners. We know that George Eliot enjoyed reading *Villette*: she writes that the novel is "a still more powerful book than *Jane Eyre*. There is something almost preternatural in its power."[8] Eliot was so struck by Brontë's work that, during a trip to Brussels, she took long walks to the park or the Basse Ville,

where she found her reminiscences of *Villette* most vivid (Haight 149). In "George Eliot's Debt to *Villette*," Charles Burkhart traces a direct link between the doctors by comparing their physiques and demeanor. In both novels, he notes, the doctors are large, dominant, masculine men who combine good manners with arrogance; both are poor judges of women, or "typical Victorian sexists in the role they exact from their women, that of mindless angel" (12). We can expand this comparison to include medical similarities: Brontë and Eliot explore the implications of the detached medical gaze and note the interaction between their doctors' personal interests with their professional role in situations where medical observation is inseparable from sexual interest. Lastly, both authors are interested in the importance of communication between doctors and patients in the healing process.

Like Brontë, George Eliot approaches her representation of Lydgate from her own experience as patient and caregiver. Eliot was familiar with doctors because she suffered from recurring toothaches, headaches, and bouts of depression. Her progress on *Middlemarch* was also stalled by an intestinal disorder that occurred in the autumn of 1871 (Ashton 313). In addition, Eliot spent a portion of her life nursing her ailing father, which was an experience that left her with an appreciation of sympathy and understanding in the sickroom. She describes this time as "the happiest days of life to me," days in which "my heart bleeds for dear father's pains, but it is blessed to be at hand to give the soothing word and act when needed."[9] For Eliot, nursing provides mutual satisfaction and the occasion for genuine communication; as she comforts her patient, she is simultaneously assured by "a thousand little proofs that he understands my affection and responds to it" (*GEL* 1:270). In *The Sickroom in Victorian Fiction:*

The Art of Being Ill, Miriam Bailin emphasizes the importance of sympathy for Eliot, who "found in the tender mercies of nursing a transcendent meaningfulness in the ordinary details of life and a simple stable relation between love and duty" (112).

In *Middlemarch*, however, Eliot is more ambivalent about care giving than either her own correspondence or Bailin suggests. She explores both the virtues and dangers of providing medical care when love and duty compel caregivers to look after ailing spouses, patients, and family members, despite the personal risk to themselves. Dorothea, for example, is forced to repress her own desires in order to look after her husband, Casaubon, who cannot be distressed because of his heart condition. Unfortunately, for Dorothea, "all existence seemed to beat with a lower pulse than her own" (*MM* 258). Similarly, Lydgate finds that his medical instincts and love for his wife compel him to care for Rosamond as a patient, or "an animal of another and feebler species," (*MM* 628) for whom he must sacrifice his own desires.

George Eliot also developed her ideas about medicine by socializing and studying. She and George Henry Lewes were immersed in the scientific community of nineteenth-century London and frequently visited prominent physicians and researchers. Eliot took a particular interest in the career of Dr. Clifford Albutt, inventor of the clinical thermometer, who had taken over a new infirmary at Leeds during the writing of *Middlemarch* (Haight 407). Albutt himself was convinced he was the source for Eliot's fictional doctor (Haight 447), but Eliot's own brother-in-law, Edward Clarke also resembled the young reformer. Clarke was generous to the poor, and, like Lydgate, was a very good surgeon with a membership to the RCS and a license from the Society of Apothecaries (Haight 407). Regardless of his warm-

hearted nature, Clarke was beset by difficulties. Like Lydgate, he found it difficult to earn a living as a young country surgeon and went bankrupt with a large debt, dying shortly thereafter (Haight 448).

Both Eliot and Lewes wrote prolifically on science and scientific theory. Lewes in particular encouraged the emergence of scientist-doctors who could devote their time to both research and patient care (McCarthy 812) and advocated for the scientific improvement of the medical profession in "Physicians and Quacks" (1862). Lewes' interest in medicine went beyond the role of the doctor; in "Problems of Life and Mind" (1878), he discusses the relationship between psychology and physiology in an attempt to establish connections between the physical and moral life of man. Eliot also took an active role in the scientific community. She and Lewes were interested in the positivist philosophy of Auguste Comte, as well as in Herbert Spencer's theories of social organicism. Both ideas appear in *Middlemarch* as Lydgate searches for the mind in matter, and the narrator draws elaborate connections between members of the community as though they were part of an interdependent biological system.[10]

Common elements of patient care that emerge in *Villette* and *Middlemarch* can be loosely traced to each writer's personal experiences. Both Brontë and Eliot stress the importance of communication in the process of fostering effective medical treatments and sympathetic relationships that benefit patients and caregivers alike. Unfortunately, Charlotte Brontë's doctor misused his authority while betraying the limitations of his medical skills. It is reasonable to suspect that these negative experiences informed her characterization of the fictional doctor in V*illette*, who

refuses to consider the narrator's input. In contrast, George Eliot's social status and scientific pursuits are reflected in her more positive portrayal of the doctor and the potential of scientific medicine in *Middlemarch*. For her, nineteenth-century science was compatible with a dialogic approach to medicine—Lydgate's research requires him to find meaning in multiplicity while his physiological training coexists with his capacity for dialogue and sympathy. In the following chapters I will explore the way in which power is negotiated between doctors and patients in order to determine the effectiveness of medical interactions in *Villette* and *Middlemarch*. By discussing these interactions, I will endeavor to define the benefits and failings of nineteenth-century medicine according to each writer with reference to the overall dialogic framework of the narratives.

[1] Charlotte Brontë, "To Elizabeth Gaskell" 31 Dec 1845, *The Life of Charlotte Brontë*, Elizabeth Gaskell. (London: Rutland, 1997) 480

[2] Because of her family's poor health, medical authority was reinforced by Patrick Brontë, who constantly observed and diagnosed his children's symptoms according to his meticulously annotated copy of Graham's Domestic Medicine (Shuttleworth *CBVP* 27).

[3] Charlotte Brontë, "To Elizabeth Gaskell" 29 Oct 1848, *The Life of Charlotte Brontë*, Elizabeth Gaskell. (London: Rutland, 1997) 276

[4] Charlotte Brontë, "To Ellen Nussey" 30 Jan 1849, *Charlotte Brontë: The Evolution of Genius*, Winifred Gerin. (New York: Oxford UP, 1987) 380

[5] Charlotte Brontë, "To Elizabeth Gaskell" 12 April 1852, *The Life of Charlotte Brontë*, Elizabeth Gaskell. (London: Rutland, 1997) 394

[6] Charlotte Brontë, "To Ellen Nussey" 16 February 1852, The Brontës: A Life in Letters, Ed. Juliet Barker. (New York: Overlook Press, 1998)

[7] When a doctor does play a central role in fiction prior to *Middlemarch*, McCarthy observes that his actual medical practice is usually overshadowed by other story interests due to a general snobbery toward medical men, who occupied the "anomalous social and professional status of medicine" (807). Lawrence Rothfield agrees that, given the prominence of medicine in Victorian life, there are few stories "centrally about doctors interacting with patients, struggling against diseases, illness, or injury, until the 1870s," and when doctors do appear in fiction, the plot centers on their social and cultural standing rather than their work or love life (*Med* 171). Lydgate differs, however, from these characters because his work is central to his life, as is his marriage. McCarthy argues that Lydgate's status as a medical reformer who avoided discredited methods in favour of physiologically based diagnoses endeared him to a more scientifically advanced readership in 1871 (807).

[8] George Eliot, "To Mrs Charles Bray" 15 Feb 1853, *Selections From George Eliot's Letters*, Ed. Gordon S. Haight. (New Haven: YaleUP, 1985) 51

[9] The George Eliot Letters. Ed. Gordon S. Haight 1: 283.

[10] See Sally Shuttleworth's *George Eliot and Nineteenth-Century Science* (Cambridge, 1984) where she argues that "the characters in *Middlemarch* cannot be abstracted out of the life processes of the town . . . individual identity is not only influenced by the larger social organism, it is actively defined by it" (142).

Chapter Three: "Not one bit did I believe him; but I dared not contradict:" The Limits of Doctor-Patient Dialogue in Charlotte Brontë's *Villette*

In *Villette*, Charlotte Brontë suggests that psychological health is dependent upon social integration. In a Bakhtinian analysis of this novel, I will argue that the first-person narrator strives to participate in her community and employs dialogic strategies in order to do so, often by adopting many different voices and discourses to better communicate her own intentions. When Lucy Snowe has no listeners to whom she can articulate her experience, she falls ill, discovering that she can find relief only in the healing capacity of conversation.

In her last novel, Brontë is critical of the nineteenth-century doctor's inability to communicate effectively with his patients. Dr. John uses his authority to silence and dismiss Lucy's attempts to describe her illness even though her narrative proves crucial to his understanding of the complex social factors that cause her physical and psychological distress. Because Dr. John fails to acknowledge the multiple discourses Lucy uses to communicate her illness, he fails to offer his patient either an insightful diagnosis or an effective remedy.

Lucy Snowe's Community

Critics have argued that Lucy Snowe shows disdain for those around her and attempts to isolate herself from others. In "Charlotte Brontë and the Pleasure of Hating", Christopher Lane argues that "hatred underwrites citizenship in Charlotte Brontë's fiction. None of her protagonists discovers what it means to be sociable without experiencing a . . . repugnance for other people. Such an aversion surpasses interpersonal conflict, proving endemic to her fictional communities" (199). Pauline Nestor emphasizes Lucy's dislike of the "swinish multitude." She argues that Lucy's

"response to threat is not a bonding together of women . . . but a self-protective acquisition of power, which sees Lucy insulate herself against others in the progress from nursery governess, to teacher, and finally to directress of her own school " (135). In "The Buried Letter: Feminism and Romanticism in *Villette*," Mary Jacobus suggests that Lucy deliberately evades the scrutiny of others: "Lucy's invisibility is a calculated deception—a blank screen on which others project their view of her" (44). When Lucy refuses to reveal her true identity to Graham Bretton after she has recognized him as her childhood friend, Jacobus suggests that "her strategic silence conceals the private life which Mme Beck's system of surveillance is at pains to detect;" Lucy then "casts herself as an onlooker, passive, yet all-powerful" (45) in her isolated detachment.

Contrary to these critics, I will argue that Lucy Snowe needs to interact with her community. I share Patricia Lorimer Lundberg's assertion in "The Dialogic Search for Community in Charlotte Brontë's Novels" that Brontë's narrators are dependent on their social environment for their well being and search for an understanding of their "experience through the narration of it to a resisting or receptive community of readers" (296). According to Lundberg, Lucy attempts to integrate herself into her fictional community dialogically; she "searches for selfhood in a Bakhtinian atmosphere" as she tries "on one self after another in relation to the otherness of those around [her], not submitting to the dominant other but rather searching for a non-subordinate and vocal position within the discourse community" (298). In this discussion I consider the interpretive significance of the different

"selves" and voices that Lucy adopts with respect to her illness and her community of readers.

Lucy is responsive to others, so while her evasive identity can help her achieve invisibility and detachment, as Jacobus suggests, her role as a "blank screen" also indicates the extent to which otherness, the perceptions of those around her, constitutes her identity. Lucy marvels inwardly:

> What contradictory attributes of character we sometimes find ascribed to us, according to the eye with which we are viewed! Madame Beck esteemed me learned and blue; Miss Fanshawe, caustic, ironic, and cynical; Mr. Home, a model teacher, the essence of the sedate and discreet . . . whilst another person, Professor Paul Emanuel, to wit, never lost an opportunity of intimating his opinion that mine was rather a fiery and rash nature—adventurous, indocile, and audacious. I smiled at them all. If anyone knew me it was little Paulina Mary. (386)

Lucy adopts all of these attributes in order to engage with the person to whom she is speaking. The reader finds her at times teasing, reserved, passionate, and sarcastic, and Lucy herself admits that her behaviour often corresponds to external expectation: "[Dr John] was the kind of person with whom I was ever to remain the neutral, passive thing he thought me" (169).

Lucy's assumption of various roles becomes significant when we consider the writing of Mikhail Bakhtin, where otherness is inherent in all objects and subjects by virtue of the various discourses and languages that perceive them:

> [Any] concrete discourse (utterance) finds the object at which it was directed already as it were overlain with qualifications, open to dispute, charged with value, already enveloped in an obscuring mist—or, on the contrary, by the "light" of alien words that have already been spoken about it. It is entangled, shot through with shared thoughts, points of view, alien value judgements and accents. The word, directed toward its object, enters a dialogically agitated and tension-filled environment of alien words, value judgments, and accents, weaves in and out of complex interrelationships, merges with some, recoils from others, intersects with yet a third group: and all this may crucially shape

> discourse, may leave a trace in all its semantic layers, may complicate its expression and influence its entire stylistic profile. (*DI* 276)

Like Bakhtin's novelist, Lucy understands that her identity is constituted by a multiplicity of meanings derived from a variety of pre-existing discourses: "For the writer of artistic prose . . . the object reveals first of all precisely the socially heteroglot multiplicity of its names, definitions, and value judgements. Instead of the virginal fullness and inexhaustibility of the object itself, the prose writer confronts a multitude of routes, roads, and paths that have been laid down in the object by social consciousness" (Bakhtin *DI* 278). Lucy and the characters who surround her literally adopt different names to suit different contexts: Lucy is Miss Lucy, the nursery governess, Miss Snowe, teacher and patient, while Dr. John is also Graham Bretton, Lucy's friend, and Isidore, Ginevra's lover.

At the same time, Lucy attempts to define her own unique voice. When M. Home offers her a position as Paula's companion, Lucy distinguishes her own identity from that of another: "I was no bright lady's shadow—not Miss de Bassompierre's. Overcast enough it was my nature often to be; of a subdued habit I was: but the dimness and depression must both be voluntary" (382). Similarly, after Paulina admits to discussing Lucy's personality with her fiancé, Lucy sternly replies, "Have the goodness to make me as little the subject of your mutual talk and thoughts as possible. I have my life apart from yours . . . I shall share in no man's or woman's life in this world, as you understand sharing" (520). Lucy requires that her identity remain separate from the perceptions of others as she attempts to shape her own narrative.

In short, Lucy Snowe's individual experiences emerge from a narrative that remains an essentially dialogic exploration of self. She learns, for example, to adopt socially acceptable roles and voices as a means of communicating with a fictional community in which the majority of characters privilege only the voices of women with beauty, wealth, or status. After securing employment as a nursery maid, Lucy is not at all surprised to discover that her social status and appearance make her all but invisible to the handsome young doctor: "He laid himself open to my observation, according to my presence in the room just that degree of notice and consequence a person of my exterior habitually expects: that is to say, about what is given to unobtrusive articles of furniture, chairs of ordinary joiner's work, and carpets of no striking pattern" (111). The plainest example of Villette's bourgeois value system is articulated by Ginevra Fanshawe as she describes Lucy's disadvantages: "I suppose you are nobody's daughter, since you took care of little children when you first came to Villette: you have no relations, you can't call yourself young at twenty-three; you have no attractive accomplishments—no beauty. As to admirers, you hardly know what they are; you can't even talk on the subject: you sit dumb when the other teachers quote their conquests" (167). Because Lucy is excluded from the dominant social scene, she must assume other, more visible and appropriate roles to communicate her feelings. Lundberg observes that "Lucy Snowe . . . seek[s] self by taking otherness on with [her] . . . cross-dressing . . . [She] attempts dialogue by becoming other" (297). Lucy engages dialogically in "the study of subjectivity through intersubjectivity, through the many voices of the varied groups in an open community" (Lundberg 298) when she adopts the role of a foppish suitor in the

school play to express her own desires. While Lucy assumes the part of a man vying for the hand of Genevra's character, she is sure to keep her female clothing underneath the male costume, and when she speaks her character's lines, she infuses them with her own expression. Looking out into the audience, Lucy sees Dr. John, who, in her eyes, becomes part of the drama. She considers him her rival for Ginevra's love, and in doing so, "recklessly altered the spirit of the role" to suit herself. The role is transferred onto the "real-life" triangle of desire between Dr. John, who loves Ginevra, and Lucy, who loves Dr. John and values Ginevra as a friend. Lucy's "double-voiced" approach communicates a meaning acceptable to a consensual and undiscerning audience, and a meaning for those with an understanding broad enough to discern an interplay of voices that reveal Lucy's feelings toward characters outside of the play.

Lucy engages in role-playing, not only to communicate her own desires through the voice of another, but also as a means of self-exploration. Helen Moglen describes the positive value of role playing: "in a new situation, assigned different roles by the teachers and students at Madame Beck's pensionnat, Lucy finds that instead of being deprived of an identity she has protected with such difficulty, she can define herself in a number of different ways, playing a variety of roles, responding to other people's expectations of her" (205). Ginevra "summons Lucy's independence by making her strong in her assertion of disapproval," (Moglen 205) while Madame Beck "challenges Lucy to assume roles which express her capacity for leadership, which evoke her Protestant 'individualism,' her fierce integrity, her pride" (Moglen 206).

Lucy also explores the opportunities that arise from her multiple, flexible identity. To Ginevra's perplexed inquires: "Who are you, Miss Snowe . . . But *are* you anybody? . . . Do—*do* tell me who you are!" Lucy describes her identity a process: "I am a rising character: once an old lady's companion, then a nursery-governess, now a school-teacher" (394). This process provides her with space to adapt, and, in this case, to assume more skills and compensation.[1]

In addition to adopting a plurality of roles and voices as a means of exploring her own potential, Lucy perceives others from multiple perspectives. In the following passage, Lucy engages sympathetically with Vashti:

> The strong magnetism of genius drew my heart out of its wonted orbit; the sunflower turned from the south to a fierce light, not solar—a rushing, red, cometary light—hot on vision and to sensation. I had seen acting before, but never anything like this: never anything which astonished Hope and hushed Desire; which outstripped Impulse and paled Conception; which, instead of merely irritating imagination with the thought of what might be done, disclosed power like a deep, swollen winter river, thundering in cataract, and bearing the soul, like a leaf, on the steep and steely sweep of its descent. (300)

Lucy's ability to feel with her "heart" allows her to experience the depth and complexity of Vashti's performance. She grants the actress access to her inner life and then charts the effect—what began for Lucy as mere "seeing" becomes a moving experience as she is momentarily transformed by Vashti's translation of emotion into physical power. A short time later, however, Lucy shifts her mode of perception to gaze analytically at Graham Bretton: "When I took time and regained inclination to glance at him, it amused and enlightened me to discover that he was watching that sinister and sovereign Vashti, not with wonder, nor worship, nor yet dismay, but simply with intense curiosity" (301). Lucy, who has the capacity to sympathize as

well as to entertain a more detached point of view, criticizes Graham for his singular mode of perception.

The wider framework of *Villette* can also be conceived as an oscillation between multiple perspectives in the form of a dialogue between Lucy's younger and older selves.[2] By telling her story from the perspective of her youth, the narrator recreates the intensity of her past to elicit understanding and sympathy. In several instances Lucy describes her psychological experiences, such as the delirium and anxiety she suffers during the long vacation, without mediation:

> About this time the Indian summer closed and the equinoctial storms began; and for nine dark and wet days, of which the Hours rushed on all turbulent, deaf, disheveled—bewildered with sounding hurricane—I lay in strange fever of the nerves and blood. Sleep went quite away. I used to rise in the night, look round for her, beseech her earnestly to return. A rattle of the window, a cry of the blast only replied—Sleep never came! (182).

As in the Vashti passage, the narrator uses fragmented syntax, exclamatory phrases, and numerous verbs to recreate the action of the moment.

At other times, Lucy emphasises her retrospective reflections. The tension between Lucy's younger and older perspectives is apparent when she interrupts her idealistic description of Graham's perfection with a more detached observation: "the colouring of his hair, whiskers, and complexion—the whole being of such a tone as a strong light brings out with somewhat perilous force (indeed I recollect I was driven to compare his beamy head in my thoughts with that of the 'golden image' which Nebuchadnezzar the king had set up)" (111). By parenthetically distancing herself from and, therefore, qualifying her initial, incomplete response, Lucy indicates that multiple perspectives are required to fully understand any character or situation. Lucy openly acknowledges this mode of perception after she describes both

Graham's professional generosity to the poor and his personal vanity: "The reader is requested to note a seeming contradiction in the two views which have been given of Graham Bretton—the public and private—the out-door and the in-door view . . . Both portraits are correct" (229).

Although Lucy attempts to engage with multiple voices and perspectives, her attempts to interact with her fictional community are generally frustrated. She meets with few characters who can acknowledge her unique experiences and eventually suffers illness as a result of this isolation. Just as Lucy encourages the reader to consider her narrative from multiple points of view, she requires her doctor to shift his perspective in order to diagnose and treat her.

The Mere Relief of Communication

Lucy's dependence on her community is apparent when she falls ill as a result of her isolation from her students and colleagues. Despite her efforts to integrate herself dialogically into her community, she "endures varying degrees of isolation, losing rather than gaining community" (Lundberg 298). During the school vacation, Lucy, who has no family to visit, is left alone at the pensionnat with only a speechless cretin. Lucy suffers both physical and psychological illness because of her social situation: "A goad thrust me on, a fever forbade me to rest; a want of companionship maintained in my soul the cravings of a most deadly famine" (181). Lucy's pain and isolation increase her sense of alienation from the outside world: "I felt too those autumn suns and saw those harvest moons, and I almost wished to be covered in with earth and turf, deep out of their influence; for I could not live in their light, nor make them comrades, nor yield them affection" (230).

Lucy's experience coincides with Elaine Scarry's understanding of the link between pain and the sufferer's sense of disconnection from the outer world. Whereas most states of consciousness are directed outward, affirming the human capacity to move beyond the boundaries of the body and out into the "external, sharable world," the state of pain has no object: "physical pain—unlike any other state of consciousness—has no referential content. It is not of or for anything. It is precisely because it takes no object that it, more than any other phenomenon, resists objectification in language" (Scarry 5-6). Because of its unsharability, illness and pain cause isolation and alienation, both of which intensify the patient's suffering: "[pain] achieves its adversiveness in part by bringing about, even within the radius of several feet, this absolute split between one's own reality and the reality of other persons" (Scarry 4).

Scarry argues that the sufferer must therefore be able to share his or her pain with others to ensure some measure of relief: "When physical pain is transformed into an objectified state, it (or at least some of its adversiveness) is eliminated. A great deal, then, is at stake in the attempt to invent linguistic structures that will reach and accommodate this area of experience normally so inaccessible to language" (6). She recommends that the patient use metaphors that attribute his or her pain to a weapon or object in order to convey a purely subjective experience to another individual. Scarry also emphasizes the role of the listener, who must understand the sufferer's pain in order to help alleviate and diagnose the illness: "The success of the physician's work will often depend on the acuity with which he or she can hear the fragmentary language of pain, coax it into clarity, and interpret it" (6).

As Scarry suggests, Lucy finds that, because her psychological pain has no object, no physical form, it is almost impossible to articulate; her suffering coincides with a sense of emptiness and nothingness. She describes a dream that "remained scarce fifteen minutes—a brief space, but sufficing to wring my whole frame with unknown anguish; to confer a nameless experience that had the hue, the mien, the terror, the very tone of a visitation from eternity" (182). Later in the passage, Lucy struggles to find words to represent her experience: "indescribably was I torn, racked and oppressed in mind. . . . Galled was my inmost spirit with an unutterable sense of despair about the future" (183).

Lucy finds relief when she shares her pain with a sympathetic listener. When her anguish reaches a climax, she decides to wander through the countryside in search of comfort: "The bells of a church arrested me in passing; they seemed to call me in to the *salut*, and I went in. Any solemn rite, any spectacle of sincere worship, any opening for appeal to God was as welcome to me then as bread to one in extremity of want" (184). Although she is not Catholic, once inside, Lucy feels compelled to confess and discovers that "the mere relief of communication in an ear which was human and sentient, yet consecrated—the mere pouring out of some portion of long accumulating, long pent-up pain into a vessel whence it could not be again diffused—had done me good. I was already solaced" (234). Lucy derives a sense of release and relief from her confession, a sense that sharing her pain objectifies and then transfers her suffering to the body of another.

Lucy discovers healing potential in all instances of sympathetic conversation. When she is recovering at La Terrasse after her collapse, Lucy derives greater

comfort from her new-found friends, from her reintegration into a caring community, than she does from the medical attention she receives. Her relief is so overwhelming that she tries to quell her passionate need for conversation:

> Let me be content with a temperate draught of this living stream: let me not run athirst, and apply passionately to its welcome waters: let me not imagine in them a sweeter taste than earth's fountains know. Oh! would to God! I may be enabled to feel enough sustained by an occasional, amicable intercourse, rare, brief, unengrossing and tranquil: quite tranquil! (206)

Similarly, any type of social exchange with Graham in which he exhibits sympathy and kindness has the power to comfort Lucy. When Graham writes to her socially, as a friend, Lucy describes her brief respite from pain and unhappiness: "The present moment had no pain, no blot, no want; full, pure, perfect, it deeply blessed me. A passing seraph seemed to have rested beside me, leaned towards my heart, and reposed on its throb a softening, cooling, healing, hallowing wing" (284). Lucy praises the healing potential of sympathetic words when Graham comforts her after she loses his letters:

> He talked to me and soothed me with unutterable goodness, promising me twenty letters for the one lost. If there are words and wrongs like knives, whose deep-inflicted lacerations never heal—cutting injuries and insults of serrated and poison-dripping edge—so, too, there are consolations of tone too fine for the ear not fondly and for ever to retain their echo: caressing kindnesses—loved, lingered over through a whole life, recalled with unfaded tenderness, and answering the call with undimmed shine out of that raven cloud foreshadowing death itself. (286)

Here, Lucy uses a graphic weapon metaphor in an attempt to "invent linguistic structures" that convey psychological pain, an experience that is normally impossible to articulate (Scarry 6). Brontë suggests that the doctor can heal psychological distress far more effectively when he approaches the patient as a friend in conversation.

This type of relationship is accompanied by its own dangers, however. When doctors become too personal with their patients and the professional boundary is blurred, patients can develop unrealistic expectations, seeking levels of involvement that doctors cannot provide. While her interaction with the doctor may comfort Lucy, her need for friendship fosters a desire for his love that cannot be fulfilled within a professional relationship and, because she is eager to please and care for him, she becomes more vulnerable to his misused power. Conversely, when doctors experience closer feelings for their patients, they can develop needs of their own, which can in turn compromise their patients' best interests. It is for doctors and patients, therefore, to negotiate boundaries that determine the balance between friendship and professionalism.

Personal and professional boundaries were not the only source of instability between doctors and patients during the nineteenth century. The language used to describe illness at this time also reflected confusion about the links between the physiological, psychological, and social causes of disease.

"I am not quite sure what my nervous system is:" Discursive Instability and the Doctor's Authority

During the mid-nineteenth century, the functioning of the "nerves" and their related disorders was a topic open to debate. The terminology used to describe "shattered nerves," "broken health," "nervous collapse," all of which can be broadly understood as depression, reflected both the materialist assumption that all experiences could be reduced to a physical cause, as well as the cultural and ideological associations that linked nervousness with personality traits such as "edginess, agitation, and irritability" (Oppenheim 9). According to the materialists,

"most 'neuroses' were thought to stem from weak and delicate nerves, literally stretched or lax, overworked or over excited. It was only as the Victorian period waned that the question of psychological causation became more central to medical thinking" (Drinka 12).[3] This confusion stemmed from the enigmatic processes of the brain, whose dual function as coordinator of the nervous system and "organ of the mind made any precise discrimination between mental and nervous illness impossible for Victorians to establish" (Oppenheim 6).

According to historians, members of the nineteenth-century medical profession frequently admitted their uncertainty.

> Indeed, so entangled did the terminology of body and mind become that the British physician John Hughlings Jackson called for a moratorium on phrases such as "the psychology of the nervous system" or "the physiology of the mind" that seemed to confuse physiological process with emotional or psychological ones. These interpretive shifts and contradictory explanations attest to the precarious separation between mental and corporeal realms in Victorian medical thinking and suggest that in studying neurosis physicians were forced to develop new paradigms for defining health and disease. (Vrettos *NN* 554)

Aside from their discursive confusion, doctors were also unsure "whether to treat these illnesses with medicine aimed at restoring the body or with moral exhortations designed to rally the mind and return the will to its proper function" (Oppenheim 5).

But doctors weren't the only Victorians participating in the shifting paradigms of health and disease; patients also used the opportunity provided by this discursive instability to challenge medical authorities. Janet Oppenheim argues that,

> Much recent writing on medical history notwithstanding, doctors did not invariably play the role of powerful oppressor, and patients were not always the impotent victims of medical authority. Nervous patients were, in fact, notorious for consulting a string of medical practitioners is search of relief, both from psychological pain and from physical symptoms accompanying it. Their willingness to discard one doctor in favor of another strongly suggests

> that these men and women were not cowed by medical autocrats. Relations involving power are rarely unambiguous; Victorian medical men and their patients participated together in delicate, ongoing maneuvers to delimit their own spheres of influence in defining nervous maladies. (10)

Nervous patients reached for terminology to describe their own illnesses on their own terms.

In *Villette*, Brontë explores the instability of nineteenth-century psychological discourse through Lucy Snowe's illness narrative. Lucy, ambiguous about the role of the nerves in psychological suffering, refers to her "nervous system" as a means of linking her mental anguish to her physical body. As storms rage outside, she describes the physical pain of her psychological state: "beating rain crushed me with a deadlier paralysis than I had experienced while the air remained serene: but so it was, and my nervous system could hardly support what it had for many days and nights to undergo in that huge, empty house" (180). Lucy also locates her mental distress in physical symptoms: "At last a day and night of peculiarly agonizing depression were succeeded by physical illness . . . I lay in a strange fever of the nerves and blood" (182). Later in this episode, as her psychological suffering reaches its climax, Lucy describes her corresponding hands as "hot, feeble, trembling" (183).[4]

At other times Lucy differentiates between the nerves and the mind while simultaneously acknowledging their subtle interconnectedness. After experiencing visions of the happy Ginevra, connected to and loved by others, Lucy frets: "One day, perceiving this growing illusion, I said, 'I really believe my nerves are getting overstretched: my mind has suffered somewhat too much; a malady is growing upon it—what shall I do? How shall I keep well?'" (231). The workings of the mind,

although somehow connected to the body, require discourses and terminology beyond what is technically available:

> The world can understand well enough the process of perishing for want of food: perhaps few persons can enter into or follow that of going mad from solitary confinement. They see the long-buried prisoner disinterred, a maniac or an idiot!—how his nerves, first inflamed, underwent nameless agony, and then sunk to palsy—is a subject too intricate for examination, too abstract for popular comprehension. . . . Long may it be generally thought that physical privations alone merit compassion, and that the rest is a figment. (317)

Sally Shuttleworth notes that, when Lucy's attempts to trace her pain beyond the "available technical vocabulary, she reaches the limits of the expressible: the agony must remain 'nameless.' Unlike her biblical counterpart, Lucy knows better than to try and describe to others a form of experience that has never received social recognition or articulation" (*CBVP* 236). While Lucy is not denying her own belief in the material basis of psychological suffering, she emphasizes the mysteriousness and complexity of their connection, directing "an implicit rebuke to the medical establishment who believe that in naming the 'symptoms' of hypochondria they have somehow mastered the experience. Lucy is . . . denying Dr John's claim to authoritative knowledge" (*CBVP* 236). [5]

Lucy finds it necessary to draw on several discourses to articulate the complexity of her experience. In addition to describing the physiological manifestations of her illness, Lucy understands her suffering in religious terms: "That evening more firmly than ever fastened into my soul the conviction that Fate was of stone, and Hope a false idol—blind, bloodless, and of granite core. I felt, too, that the trial God had appointed me was gaining its climax, and must now be turned by my own hands, hot, feeble, trembling as they were" (183). It is possible to conclude from

this passage that Lucy disowns personal responsibility for her situation by attributing her suffering to a fated divine trial, but she also experiences her illness as deeply spiritual, even transcendent:

> Where my soul went during that swoon I cannot tell. Whatever she saw, or wherever she traveled in her trance on that strange night, she kept her own secret; never whispering a word to Memory, and baffling Imagination by an indissoluble silence. She may have gone upward, and come in sight of her eternal home, hoping for leave to rest now, and deeming that her painful union with matter was at last dissolved. (191)

Athena Vrettos suggests that Lucy's "nerves" are indicative of a heightened sensibility that enables her to interpret others through the "invisible and subjective truths" of feeling (*NN* 567). When Lucy sees the King of Labassecour, she looks at his troubled expression and reflects, "if I did not *know*, at least I *felt*, the meaning of those characters written without hand" (247).

Lucy also describes her psychological experiences in Gothic terms: her once familiar world becomes "other," or haunted as "the solitude and stillness of the long dormitory could not be bourne any longer; the ghastly white beds were turning into spectres" (183). Her sense of oppression is experienced as live burial: "I was sure hope would shine clearer if I got out from under this house-roof, which was crushing as the slab of a tomb, and went outside the city to a certain quiet hill, a long way distant in the fields" (184). The most overt manifestation of Lucy's Gothic illness appears in the form of a ghostly nun, who can be understood to symbolize the return of Lucy's repressed desires.

Lucy resists the doctor's restrictive use of physiological terminology, but he remains a strict materialist. Shuttleworth identifies Dr. John's diagnoses as representative of the physiological discourse within the nineteenth-century medical

community: "Dr. John actually presents a whole language of analysis and a theory of psychological functioning . . . he offers a materialist explanation based on the functioning of the nervous system." (Shuttleworth *CBVP* 220). Despite Lucy's insight into the complexity of her experience, she has difficulty challenging the doctor because he uses his authority inappropriately.

Brontë emphasizes the general acceptance of the doctor's authority within his fictional community. She sets the novel in Belgium at a time when physiologically based science was more advanced and accepted on the continent than it was in England. In fact, Dr. John's scientific research bolsters his social status by gaining him access to the elite community of Villette. Realizing her own exclusion from the doctor's claim to authority, Lucy describes scientific discourse as the exclusive property of men. During a gathering of the community's elite at the Hôtel Crécy, she differentiates between culturally ascribed male and female domains with respect to Paulina Home's accomplishments: "they clustered around her, not indeed to talk science, which would have rendered her dumb, but to touch on many subjects in letters, in arts, in actual life, on which it appeared she had both read and reflected" (363). And despite Lucy's countless references to up-to-date medical terminology to describe her own illness, she outwardly disclaims any such ability: "I never had a head for science, but an ignorant, blind, fond instinct inclined me to art" (230). Unfortunately, the doctor's conduct reinforces this paradigm when he uses his authority to assert his own discourse at the expense of his patient's voice. In the following discussion, I will outline the consequences of Dr. John's refusal to interact dialogically with Lucy.

The Doctor and His Patient

Dr. John's approach to patient care corresponds to twentieth and twenty-first-century studies on doctors who exercise their power inappropriately. In her sociological study of doctor-patient interactions, Sue Fisher observes that "during medical encounters, language use is structured by the authority of the medical role" (59), and it is usually "the doctor who asks most of the questions and initiates most topics" (Fisher 60). The physician can assert his authority by interrupting the patient and then by reasserting his own line of questioning in order to control the flow of information. This approach makes it difficult for patients to clarify misunderstandings, to articulate their concerns, and to make informed medical decisions.

Dr. John inhibits dialogic interaction by limiting his patient's opportunity to voice her experience and concerns on her own terms. When Lucy first emerges from her bedroom during her recovery at La Terrasse, the doctor initiates the encounter with an inquiry about her health without addressing the patient directly: "How is your patient, mama?" It is Mrs. Bretton who adds, "will she come forward and speak for herself?" (202). As the consultation progresses, Mrs. Bretton disrupts the structure when she recognizes Lucy as her long lost god-daughter, thereby enabling her to join the party as an old friend rather than as a patient. The group continues to converse on more social, casual topics until Dr. John adopts his professional role to end the conversation, and Lucy becomes a powerless invalid once again: "Miss Snowe must retire now . . . she is beginning to look very pale." He then asserts control over when and how Lucy will be allowed to speak about her health: "To-morrow I will venture

to put some questions respecting the cause of her loss of health. . . . As to last night's catastrophe, I am sure thereby hangs a tale, but we will inquire no further this evening" (206).

When Dr. John does ask Lucy questions "respecting the cause of her loss of health," they are generally closed and rhetorical. During their first interview, the doctor alludes to Lucy's condition: "'So you are come down,' said he; 'you must be better then—much better. . . . I trust you really do feel better'" (202). This line of questioning makes it more difficult for the patient to describe her illness on her own terms, and purposely so, for the patient's narrative may not fit into pre-established medical categories. When Dr. John asks, "Your nervous system bore a good share of the suffering?" (256), he is trying to appropriate her experience of illness, to describe it in the material terms that correspond to his medical discourse.

The doctor's diagnoses are also alienating and isolating. After Lucy has seen the nun in the attic, Dr. John insists that her "vision," is a product of a physiological malfunction: "This is all a matter of the nerves, I see" (289). He follows up by proclaiming: "I think it a case of spectral illusion: I fear, following on and resulting from long-continued mental conflict" (290). While Dr. John scorns the inappropriateness of her solitude in the garret—"that dungeon under the leads, smelling of damp and mould, rank with phthisis and catarrh: a place you never ought to enter" (289)—his diagnosis leaves Lucy feeling even more isolated, a victim of inner processes beyond her control: "I was left secretly and sadly to wonder, in my own mind, whether that strange thing was of this world, or of realm beyond the grave;

or whether indeed it was only the child of malady, and I of that malady the prey" (292).

In this consultation, Dr. John manifests his detached approach to the patient and his consequent inability shift his perspective, to be moved by his patient's pain. Earlier, he describes his use of the scientific, clinical gaze:

> I had been in attendance all day yesterday on a case of singularly interesting, and critical character; the disease being rare, and its treatment doubtful: I saw a similar and still finer case in a hospital at Paris; but that will not interest you. At last a mitigation of the patient's most urgent symptoms (acute pain is one of its accompaniments) liberated me, and I set out homeward. (213)

Dr. John remains a detached spectator to the patient's illness because he attends only to physical symptoms of the "case," which is valued for its rarity. Elsewhere, Lucy describes the doctor's philanthropic public persona: "I understood presently that—cheerfully, habitually, and in single-minded unconsciousness of any special merit distinguishing his deeds—he was achieving, amongst a very wretched population, a world of active good. The lower order liked him well; his poor patients in the hospitals welcomed him with a sort of enthusiasm" (228). However, Judith Williams argues that the doctor's limited clinical approach always underlies his benevolence and serves as his dominant mode in even personal situations:

> This detached, clinical attitude toward suffering, though necessary to Graham in his professional character, is out of place at the hearthside, and is of a piece both with his inability to see Ginevra as she really is and with his faulty memory of Lucy and of his own childhood. All of these characteristics are symptoms of a serious lack of inner vision, of true sympathy, and of imagination. His generosity and kindness are rational and not intuitive. . . . Furthermore, this kindness of Graham's—he achieves 'a world of active good' among the poor and sick—should be seen in context: he shares "rational benevolence" with the sinister Mme Beck." (94)

Again, Lucy recognizes Graham's lack of "inner vision" and "true sympathy" when he levels his rational, clinical gaze at Vashti: "Dr. John could think and think well, but he was rather a man of action than of thought; he could feel, and feel vividly in his way, but his heart had no chord for enthusiasm" (301). Unlike Lucy, who attempts to balance her faculties of intense feeling with those of her analytical mind, Dr. John fails to reap the benefits of either.

Dr. John's scientific detachment becomes harmful to his patient. After she loses her letter, Lucy thinks she is speaking to a friend, but soon discovers that the doctor has been hiding it in order to gage her feelings for him. With a detached air of curiosity, Dr. John alters the intentions of his clinical gaze to gratify his personal vanity. He asks: "Was it *my* letter, Lucy?" and then continues to probe for a validation of his own importance in her life: "I am sure you did not read it . . . or you would think nothing of it!" (327). The doctor is engaging in the worst of both worlds: his detachment makes him unsympathetic to his patient's pain while he lacks objective consideration required to make responsible decisions on her behalf.

After Dr. John realizes the extent to which his patient cares for him, he takes advantage of his newly acquired knowledge of Lucy's personal feelings to manipulate her into disclosing information that will aid in a professional diagnosis. First, in his professional character, he urges Lucy to reveal the cause of her fright. When she asks for assurance that he will not laugh, he threatens her: "If you don't tell me you shall have no more letters" (328). Lucy is distressed by Dr. John's threats and frustrated by his raillery.

Lucy responds only after Dr. John abandons both his professional claims to "read . . . all you would conceal—in your eye, which is curiously vivid and restless; in your cheek, which the blood has forsaken; in your hand, which you cannot steady" (328) and his mocking, manipulative tone. She is moved to speak to him, rather, when he appeals to her as a sympathetic friend: "He now looked like a friend: that indescribable smile and sparkle were gone; those formidable arched curves of lip, nostril, eyebrow, were depressed; repose marked his attitude—attention sobered his aspect" (330). When Lucy perceives that Graham is listening seriously, she is "won to confidence" and tells him her story. In "Listening, Empathy, and Clinical Practice," Julia E. Connelly explains the importance of listening in the medical interview:

> A physician who is a good listener encourages and enables his patient to speak the unspeakable, to search the depths of the soul, to put voice to the unconscious. . . . Listening helps patients tell their stories, and this telling in turn helps them discover their personal voice as they become aware of themselves, their wishes, and choices. (178)

Unfortunately, Dr. John does not reflect on his patient's perspective, nor does he help her communicate as a means of exploring her feelings.

Lucy's desire for understanding and friendship is also frustrated by Dr. John's insistence on assuming his professional role during social occasions. In the following passage, Lucy describes his condescending attitude:

> I did not live on letters only: I was visited, I was looked after; once a week I was taken out to La Terrasse; always I was made much of. Dr. Bretton failed not to tell me *why* he was so kind: 'To keep away the nun,' he said; 'he was determined to dispute with her prey. He had taken,' he declared, 'a thorough dislike to her, chiefly on account that white face-cloth, and those cold gray eyes: the moment he head of those odious particulars,' he affirmed, 'consummate disgust had incited him to oppose her; he was determined to try whether he or she was the cleverer, and he only wished she would once more

> look in upon me when he was present': but *that* she never did. In short, he regarded me scientifically in the light of a patient, and at once exercised his professional skill, and gratified his natural benevolence, by a course of cordial and attentive treatment. (294-5)

The doctor's "medical" attention, however, does not last indefinitely. When Paulina Home dislocates her shoulder at Vashti's performance, his "medical interest" shifts to this new patient, who ultimately becomes his wife.[6]

Dr. John inhibits a dialogic relationship with Lucy by trying to appropriate her narrative without taking her perspective into account and by repeatedly diagnosing her in terms that invalidate her experience. Nonetheless, Brontë explores how Lucy "struggles to control her narrative," to take ownership over "*her* body, *her* illness" (McLean 82). Hence, there is what Kathryn Montgomery Hunter describes as a "silent tug-of-war over possession of the story of illness" (13). Lucy attempts to correct the doctor's diagnosis: when Dr. John asks her if her "nervous system bore a good share of the suffering," Lucy denies her familiarity with the term, choosing instead to describe her state as "dreadfully low spirited" (256). Instead of engaging in dialogue based on Lucy's answer to his question, the doctor detaches himself:

> Which disables me from helping you by pill or potion. Medicine can give nobody good spirits. My art halts at the threshold of Hypochondria: she just looks in and sees a chamber of torture, but can neither say nor do much. Cheerful society would be of use; you should be as little alone as possible; you should take plenty of exercise. (212)

Although the doctor assumes her experience is limited to physiological symptoms, he does attribute the cause of her illness to social factors in a limited way: he understands that Lucy's suffering is the result of her isolation and blames Mme Beck for her predicament. As a bourgeois male, however, Dr. John fails to recognize the larger implications of Lucy's situation. That Lucy depends on others for her well

being is a negative circumstance caused by her general marginalization as a woman without wealth, social status or family connections.[7] Her compromised position makes it unlikely she will find a suitable husband, and to remain unmarried makes it next to impossible for Lucy to obtain a home, financial security, or legitimate status within her community. Dr. John further betrays his lack of understanding when he recommends "cheerful society," six months of travel (214), and a general "change of air—change of scene" (215); while these things may help Lucy, none of them are practical because her social and financial limitations prevent her from going where she wants when she pleases. Because Dr. John lacks insight into the extent to which Lucy depends on others, he himself eventually neglects his patient, causing her illness to recur.

Dr. John also uses laughter to dismiss and silence his patient when she attempts to correct him. When he asks Lucy to name the culprit responsible for her isolation, she responds passionately:

> "Me—Dr John—me; and a great abstraction on whose wide shoulders I like to lay the mountains of blame they were sculptured to bear: me and Fate."
> "'Me' must take better care in future," said Dr John—smiling, I suppose, at my bad grammar."
> "Change of air-change of scene; those are my prescriptions," pursued the practical young doctor. "But to return to our muttons, Lucy." (214-15)

Lucy refers to herself as "me" to critique Dr. John's treatment of her as an object, only acted on and treated by others. He fails to recognize the significance of her response, and then dismisses her emotional and unconventional explanation by teasing her.

When Lucy tries to correct her physician a second time, he reconstructs her narrative: "instead of returning to the Rue Fossette, your fevered wanderings—there

must have been high fever—", but Lucy is quick to assert her own experiential authority by denying her delirium: "No, Dr John: the fever took its turn that night—now, don't make out that I was delirious, for I know differently" (215). Dr. John, however, dismisses his patient's protests with humour as he reasserts control over her narrative once again: "Good! You were as collected as myself at this moment, no doubt! Your wanderings had taken an opposite direction to the Pensionnat" (215).

Again, the doctor's laughter has the most destructive effect on his dialogic interaction with Lucy because it silences her: "I felt the raillery in his words: it made me grave and quiet; but I folded up the letter and covered it from sight" (288). When he tries to take the letter again, she "made no answer." His face becomes difficult for her to read or to trust: "Just now there was a new sort of smile playing about his lips—very sweet, but it grieved me somehow—a new sort of light sparkling in his eyes: not hostile, but not reassuring. I rose to go—I bid him good-night a little sadly" (288). McLean observes that Lucy uses silence as a means of resistance by withholding information to thwart the doctor's control over her illness. When Dr. John laughs, however, her silence "is the result of being disempowered," of having "no reply" (96).

Eventually Lucy turns away from the doctor in frustration, realizing that a dialogic relationship with him is impossible. She complies with his request by telling him about the light she saw in the attic, but inwardly rejects what he has to offer her:

> He was so obstinate, I thought it better to tell him what I really had seen. Of course with him, it was held to be another effect of the same cause: it was all optical illusion—nervous malady, and so on. Not one bit did I believe him; but I dared not contradict: doctors are so self opinionated, so immovable in their dry, materialist views. (297-8)

Lucy later rejects his habit of appropriating her voice and identity on a personal level as well. When he asks Lucy to be his messenger to Paulina, she becomes angry:

> With now welcome force, I realized his entire misapprehension of my character and nature. He wanted always to give me a role not mine. Nature and I opposed him. He did not guess at all I felt: he did not read my eyes, or face, or gestures; though, I doubt not, all spoke. (367-8)

While the doctor boasts of professional ability to read his patient's symptoms, he fails in Lucy's case, and she turns instead to other communities.

Conclusion

Over the course of her narrative, Lucy discovers that her fictional community is incapable of engaging with multiple perspectives and discourses dialogically. Ginevra, while proving an effective outlet for Lucy's sarcastic criticism of bourgeois ideals, maintains the status quo, unwilling to contemplate experiences that lay outside of it. Lucy reaches a mutual understanding with Mme Beck during the early days of her employment, but their relationship is based on stealth and surveillance instead of open communication. Mrs. Bretton, whose kindness provides Lucy with an acceptable social environment, is also representative of its limitations. When her Godmother asks about her health, Lucy holds back: "Further on this subject, I did not consider it advisable to dwell, for the details of what I had undergone belonged to a portion of my existence in which I never expected my godmother to take a share. Into what a new region would such a confidence have led that hale, serene nature!" (209). While Villette consists of different characters with different expectations of Lucy, they form a largely consensual community that does not understand her psychological and social experiences.

In the final chapters, Lucy manages to establish a dialogic relationship with one other character. Before he leaves on a journey to the West Indies on Mme Walraven's behalf, Lucy has the opportunity to express her concerns to M. Paul Emanuel. In the unfolding scenes, Lucy is moved by M. Paul's ability to speak, to communicate with her: "M. Paul talked to me. His voice was so modulated that it mixed harmonious with the silver whisper, the gush, the musical sigh, in which light breeze, fountain, and foliage intoned their lulling vesper" (565). Similarly, Lucy feels release and validation when she has the opportunity to express herself, unfettered, to a sympathetic listener:

> I spoke. All leaped from my lips. I lacked not words now; fast I narrated; fluent I told my tale; it streamed from my tongue . . . Still, as I narrated, instead of checking, he incited me to proceed; he spurred me by the gesture, the smile, the half-word. Before I had half done, he held both my hands, he consulted his face which tended neither to calm nor to put me down; he forgot his doctrine, he forsook his own system of repression when I most challenged its exercise. (567-8)

M. Paul is able to abandon his own discourses in order to offer understanding and validation to a speaker whose experience is different than his own.

M. Paul's return from his journey, however, is uncertain. Lucy describes a raging storm: "a thousand weepers, praying in agony on waiting shores, listened for that voice, but it was not uttered—not uttered till, when the hush came, some could not feel it: till, when the sun returned, his light was night to some!" (573). These foreboding words are then brightened:

> Trouble no quiet, kind heart; leave sunny imaginations hope. Let it be theirs to conceive the delight of joy born again fresh out of great terror, the rapture of rescue from peril, the wondrous reprieve from dread, the fruition of return. Let them picture union and a happy succeeding life. (573)

This ambiguous ending addresses two groups of readers: conventional readers like Charlotte Brontë's father, who felt the stormy resolution was too negative, and rebellious readers, who are able to consider harsher, more complex realities of women's lives and to read M. Paul's failure to return as a criticism of male-female relationships.

By constructing this type of narrative, Lucy creates, essentially, a heteroglossic community of readers that functions as an alternative to her fictional community. In "The Reflecting Reader in *Villette*," Brenda R. Silver describes the significance of Lucy's readers: "Lucy is deliberately creating not only a new form of fiction for women, but a new audience—part critic, part confidante, part sounding board—whose willingness to enter her world and interpret her text will provide the recognition denied to women who do not follow traditional paths of development" (92). Silver argues that Lucy creates this "reflecting reader" through "silence and revelation" as her narrative progresses. For example, Lucy begins to recognize and create her sympathetic readers by remaining silent after an eight-year lapse in her narrative:

> I betook myself home, having been absent six months. It will be conjectured that I was of course glad to return to the bosom of my kindred. Well! The amicable conjecture does no harm, and may therefore be safely uncontradicted. Far from saying, nay, indeed, I will permit the reader to picture me, for the next eight years, as a bark slumbering through halcyon weather, in a harbour still as glass—the steersman stretched on the little deck, his face up to heaven, his eyes closed: buried, if you will, in a long prayer. A great many women and girls are supposed to pass their lives something in that fashion; why not I with the rest? (37)

In this passage Lucy allows the traditional reader to assume conventional paths of experience for women because alternatives do not yet, for them, exist. At the same

time, Lucy raises questions about the nature of her relationship with her family by allowing her readers to "conjecture" without contradiction. Her silence is meant for the unconventional reader who is able to imagine alternative paths for women, and "the 'tinge of sarcasm' in this passage speaks to the reader who can perceive the dual roles Lucy needs to fulfill" (Silver 102). As her narrative progresses, Lucy also transforms many of her once critical readers into sympathetic accomplices through a process of "revelation": she reveals the nature of her psychological experiences and becomes confident enough to vent her frustration with both a doctor and a society unable to understand the complex social, physical, and emotional factors that constitute her suffering.[8]

Further, by leaving her narrative, including the ending, open to different interpretations, Lucy involves this community of readers in an ongoing dialogue, a dialogue from which she is often excluded in the community of Villette. Lundberg develops this idea:

> Brontë resists the conventional closure, creating an ongoing dialogue among readers over that very ending, a non-ending. The open-endedness of Villette is a primary feature of dialogism. The dialogue between the narrator and her constructed community of readers continues as a dialogue between Brontë's text and the community of actual readers. (308)

These actual readers offer various interpretations that continue to validate and create new possibilities for Lucy even after the narrative ends.[9]

After discerning conflicts among perspectives and searching out muted voices that "comprise the combined author-text-reader community" (309), Lundberg concludes that the ending is one of isolation: "Charlotte Brontë, through the experiences of her character Lucy Snowe, demonstrates that at least in the mid-

nineteenth century the woman who would be independent of male physical, emotional, and financial domination necessarily isolates herself from the only community available to her" (Lundberg 308). Indeed, Lucy's fictional community fails to accept or acknowledge certain aspects of her experience, and M. Paul's failure to return can be read as a critique of heterosexual relationships in a patriarchal culture, but Lucy's sense of satisfaction with her own accomplishments, financial independence, and social integration should not be diminished. She has acquired a home of her own and an autonomous job as a teacher, which gives her the opportunity for the financial and social growth she has craved throughout her narrative; again, Lucy leaves the reader with the sense that her character is a "process and an unfolding" (Eliot *MM* 140). Other critics agree: Nancy Sorkin Rabinowitz concludes that M. Paul has to die "to prevent her taking second place to him," but these circumstances allow for the alternatives Lucy creates for herself: "a new kind of solitude, one that is f founded on proprietorship and work" (252). Similarly, Diane Long Hoeveler and Lisa Jadwin explain Lucy's paradoxical description of the interval during M. Paul's absence as "the three happiest years of my life" (570) as a testament to the importance of her professional success:

> Lucy's happiness seems to have been more contingent on her establishment of her own school than on M. Paul Emanuel's love . . . Lucy's elliptical conclusion gives rise to the possibility that she is happiest as long as M. Paul Emanuel expresses his love in letters but remains far enough to keep from dominating her. These profoundly anti-patriarchal feelings, however, are unrepresentable. (133)

By the end of the novel, Lucy has negotiated satisfactory relationships with a very diverse community: she has oriented herself toward her students and guardians, toward M. Paul, whom she loves, and toward both sympathetic and critical readers.

By refusing to project a concrete reality from a single, authoritative source, Brontë suggests a means of understanding based on multiplicity that can be applied to her depiction of illness and nineteenth-century medicine. In *Villette*, the nun represents a significant link between the Lucy's illness and the interpretive paradigm of the text. Like Lucy's illness, which is described by multiple, irreducible discourses, the nun cannot be explained from any single perspective, by any one discourse. The apparition functions as a Gothic element of the narrative when Lucy wonders if she has seen the ghost of a nun who was buried alive in the pensionnat's garden for falling in love. With respect to Lucy's illness, the nun is determined by Dr. John to be "all a matter of the nerves" (289); his materialist, rationalist explanation is undermined by the reality of the androgynous "phantom," which is actually a disguised Colonel de Hamal who, by adopting this female role, gains access to the pensionnat to court Ginevra. The fictive reality of the nun, however, proves insufficient with respect to Lucy, who sees her only during moments of emotional upheaval, at which point the nun's meaning shifts from a plot device to a symbol of Lucy's emotional development more complex than Dr. John can grasp.[10]

Sally Shuttleworth summarizes the novel by linking the nun's role to Dr. John's function as a medical practitioner:

> As readers, interpreting the signs of Lucy's discourse, we are constantly tempted by the text into re-enacting the role of Dr. John, as we attempt to pierce through the external linguistic signs of the narrative to a concealed unity lying below. The text, however, frustrates all such quests for a hidden unitary meaning, deliberately undermining the social and psychological presuppositions which underlie such a quest. (221)

Brontë creates an interactive form of fiction that provides a compelling model for patient care. She demonstrates that dialogue is essential for an individual's health and

happiness in a community as well as within the context of doctor-patient interactions. Just as Lucy's narrative requires her reader to consider multiple discourses, meanings, and voices, to perceive from different perspectives, she requires the doctor to converse and sympathize with his patient, rejecting any singular notion of "reality" based exclusively on convention or science.

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[1] Several critics attribute multivoicedness like Lucy's to a distinctly feminist mode of writing. In her essay entitled "Dilemmas of a Female Dialogic," Diane Price Herndl summarizes this critical tradition:

> Not surprisingly, theorists have said that 'speaking from the place of the Other' makes a marked difference in the way women use language; this feminine language is said to be contralogic, 'not conforming to solid male rules of logic, clarity, consistency' (Gallop 274). In resisting the 'official' language of logic, women's language can become 'depersonalized' and 'pluralized' (Furman 50), and 'decentered,' 'polyphonic or dialogic' (Jardine 230). Because it is spoken from the 'place of absence,' a feminine language does not assume the authority of logical discourse and, therefore, escapes the hierarchy of the official language. . . . Feminist language, then, is marked by process and change, by absence and shifting, by multivoicedness. Meaning in feminine language is always 'elsewhere,' between voices or between discourses, marked by a mistrust of the 'signified.' (10-11)

Feminist writers and narrators challenge the concept of singular authority by disrupting any general consciousness and replacing it with a variety of irresolvable perspectives that inform and qualify one another; interpretation becomes a process, open to multiple possibilities. Lucy realizes that by engaging with the multiple voices and discourses offered by her community, she can insert her own unconventional voices into the community to create a plurality of meanings located "between voices or between discourses" that the reader must extract.

[2] Lundberg summarizes Lucy's strategy of communicating through multiple perspectives as one that includes the author as well: "Taken together, the novels illustrate narrative attempts to fashion fictional transformations of each of the narrators from an other into a self in heteroglossic conflictual community through the very act of the retrospective narration of earlier experience to an audience. In a similar way, the texts that Brontë creates seem like other selves that she tries on, to test their fit and

either to accept a self as her own or to reject or sabotage it to try on another more suitable to the perception of herself that she wants to communicate to her audience. In the same way that the narrator tries to connect dialogically with inscribed readers, the actual readers seek to connect dialogically with a text that can be read" (298).

[3] According to Janet Oppenheim in *Shattered Nerves* (Oxford: Oxford UP, 1991), the term 'neurosis' was applied to all psychological illnesses that nineteenth-century scientists had yet to understand but assumed would eventually be traced back to their physiological causes. These illnesses encompassed mania, dementia, melancholia, and hysteria (8-9).

[4] *In* "From Neurosis to Narrative: The Private Life of the Nerves in *Villette* and Daniel *Deronda*," Athena Vrettos argues that Lucy needs to find a physical form for a psychological experience that may not have a definite basis in the body. Her story is therefore an "act of narrative inscription that attempts to relocate and reshape a threatened corporeal experience in a linguistic artifact" (15).

[5] In *Middlemarch*, Dorothea's suffering reflects a similar confusion: "She besought hardness and coldness and aching weariness to bring her relief from the mysterious incorporeal might of her anguish" (Eliot *MM* 774). Eliot also connects the emotional to the material when Lydgate is looking at tissue through his microscope for "those invisible thoroughfares which are the first lurking-places of anguish, mania, and crime, that delicate poise and transition which determine the growth of happy or unhappy consciousness" (163). In Eliot's writing, the exact connections between the physical and the immaterial remain unknown in what Gillian Beer refers to as "a sense of something always there, quiet, beneath consciousness, a part of that resignation which oscillates with activity to compose our life. [Dorothea] felt a longing, if not for the transcendent, at least for the numinous, the incandescent, the mysterious" (*MSC* 91).

[6] Barbara Jeannette McLean notes that Dr. John also betrays his sexual interest in Ginevra through the guise of medical concern when he notes the danger of her thin, damp dress in the cold air (85).

[7] On other occasions, Dr. John ignores social circumstances altogether. At one point he advises Lucy to "cultivate happiness." She inwardly responds: "No mockery in this world ever sounds to me so hollow as that of being told to cultivate happiness. What does such advice mean? Happiness is not a potato, to be planted in mould, and tilled with manure. Happiness is a glory shining far down upon us out of Heaven. She is divine dew which the soul, on certain of its summer mornings, feels dropping upon it from the amaranth bloom and golden fruitage of Paradise" (290).

[8] It is important to note that Lucy's inscribed readers remain members of a heteroglossic community—she addresses both conventional and sympathetic readers throughout the text. Lundberg argues that reflecting readers exist only in texts in which the narrator, the narratee, and the actual reader belong to the same "monovocal and consensual interpretive community" (299). Lucy Snowe, however, "has a critical narratee who the narrator suspects does not adhere in the same belief system: often such a narratee is male" (Lundberg 299). She therefore anticipates different readers who relate to and refute the multiple perspectives that arise in a dialogic novel in which Brontë addresses herself through a community that includes herself, the author persona, Currer Bell, and the narrator's older and younger self (Lundberg 298-99).

[9] The novel's open ending also provides an opportunity for Lucy to share her authorial power. By withholding evidence from her readers, she protects her privacy while holding her audience in suspense. Her reticence, however, also gives her readers the power to create the story.

[10] Because Lucy first encounters the nun when she is alone in the garret reading Graham's letters, which evoke passionate feelings, and later, when she is burying the letters along with her hope of securing his love, critics argue that the nun is symbolic of repression. Kate Lawson gives voice to the common critical assumption that "ultimately, these feelings refuse to remain buried or cut off from consciousness and the internal struggle causes Lucy Snowe to become ill, the repressed desires return as symptoms, as the onset of illness" (54). One of these symptoms is the nun, who, according to Moglen, is "the perverse offspring of sexual desire and the repression which results from guilt and fear" (219). For Lucy, the nun can be understood as a reminder of her own, sometimes threatening, buried desires, as well as a frightening reflection of her buried life: a warning of an unfulfilled future if her repression continues.

Chapter Four: The Dialogic Doctor: Lydgate and his Patients in George Eliot's *Middlemarch*

In *Middlemarch* George Eliot urges the reader to engage in an interpretive process that takes multiple perspectives into account. The narrator shifts her focus from one character to another while her commentary presents these characters from several points of view. In the following discussion, I will argue that this process of interpretation is crucial to the successful practice of medicine. In order to treat his patients effectively, the doctor must consider his patients' perspectives and, like the narrator, approach his subjects from multiple points of view, alternating between detached observation and sympathetic engagement. In this chapter I suggest that Lydgate interacts effectively with his patients by considering their perspectives and by engaging with them sympathetically; he does not, however, apply these methods of interpretation to the world that exists outside of the sickroom. Instead, he fails to realize the extent to which his professional success depends on his interpretation of the relations between himself and other members of his community, and suffers great misfortune as a result.

George Eliot's Dialogic Text

Before discussing specific doctor-patient interactions, I will consider the role of the interpretive process in the text as a whole. The novel's structure, for example, corresponds to Eliot's conception of form as "the relation of multiplex interdependent parts to a whole which is itself in the most varied & therefore the fullest relation to other wholes" (*Form* 433). It therefore encourages the reader to find meaning in multiplicity because the narrative focus shifts between "multiplex interdependent parts," or characters, while tracing the relations between them to create the

community, or the "whole," using a variety of web and fabric metaphors: "I at least have so much to do in unraveling certain human lots, and seeing how they were woven and interwoven, that all the light I can command must be concentrated on this particular web, and not dispersed over that tempting range of relevancies called the universe" (*MM* 132). The reader is also urged to link characters by tracing the effects of their various actions on other characters, and, in books entitled "Three Love Problems," "The Widow and the Wife," and "Two Temptations," to compare and contrast characters who share similar experiences.

By considering separate characters in terms of their relationships with one another, the reader is engaging in a "dialogic" process. According to Mikhail Bakhtin, dialogism is discursive interdependence: "every word is directed toward an answer and cannot escape the profound influence of the answering word that it anticipates" (*DI* 280). A word or discourse does not derive meaning in isolation, but from its interaction with other discourses. All words, therefore, are essentially shared with another: "the word lies, as it were, on the boundary between its own context and another, alien, context" (Bakhtin *DI* 280). In *Middlemarch*, Eliot creates what Bakhtin would describe as a "polyphony" or a "plurality of independent and unmerged voices and consciousnesses" (*Dostoevsky* 4) with respect to the characters and narrator, whose perspectives, like language, become meaningful only when the reader considers the interactions between them. Characters from different professions, age groups, genders, and social groupings of provincial society are represented as they conflict with and influence one another. As is consistent with Bakhtin's description of a novelist, Eliot's writing reflects that "the unity of a literary

language is not a unity of a single, closed language system, but is rather a highly specific unity of several 'languages' that have established a contact and mutual recognition with each other" (Bakhtin *DI* 295).

George Eliot provides a wide range of reasons for taking this approach; for her, to consider multiple perspectives is to fulfill a moral obligation. By attempting to view the world from the perspectives of many characters, the reader can foster a measure of sympathy for each, transcending the needs and limits of self to reach a depth of understanding required to form fair, benevolent assessments of others. In the following example, the narrator shifts her focus abruptly from Dorothea's promising and passionate perspective to the inner world of her less attractive husband:

> --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. In spite of the blinking eyes and white moles objectionable to Celia, and the want of muscular curve which was morally painful to Sir James, Mr. Casaubon had an intense consciousness within him, and was spiritually a-hungered like the rest of us. (*MM* 261)

Despite Casaubon's unprepossessing appearance, his needs are equivalent and real. The tension produced by the shift from Dorothea to her husband is the focus of Peter K. Garrett's analysis of *Middlemarch* in *The Victorian Multiplot Novel: Studies in Dialogical Form*. He argues that Eliot's novel can be considered dialogic in terms of its dual structure because it sustains an ongoing conflict between the individual development of a single protagonist, who is the focus of the first book, "Miss Brooke," and the need to "transcend the limitations of the individual point of view and envision the life of the whole community" (22). By tracing the development of Dorothea's character as a "later-born" Saint Theresa (Eliot *MM* 3), Eliot encourages

the reader to become attached to a sympathetic character, to enjoy a traditionally linear progression of her personal growth; alternately, the transition from a single to a multiplot structure, while a "disturbing loss," develops other possibilities, leading " to an increase of narrative range and variety, of moral and aesthetic complexity" in a world where "Dorothea cannot retain a central position because she cannot be another Saint Theresa" (Garrett 155).[1]

The narrator cautions the reader that any one point of view is limited, distorted by egoism:

> Your pier-glass or extensive surface of polished steel made to be rubbed by a housemaid, will by minutely and multitudinously scratched in all directions; but place now against it a lighted candle as a center of illumination, and lo! The scratches will seem to arrange themselves in a fine series of concentric circles round that little sun. It is demonstrable that the scratches are going everywhere impartially, and it is only your candle which produces the flattering illusion of a concentric arrangement, its light falling with an exclusive optical selection. These things are a parable. The scratches are events, and the candle is the egoism of any person not absent—of Miss Vincy for example. (*MM* 248)

Although this passage refers specifically to Rosamond Vincy, the metaphor can be applied to the narrator as she attempts to compensate for the limitations inherent in her own subjective point of view by considering the inner lives of many characters from multiple perspectives. She likens herself to a scientific observer who finds that "in watching effects, if only of an electric battery, it is often necessary to change our place and examine a particular mixture or group at some distance from the point where the movement we are interested in was set up" (*MM* 373-4). The narrator also "zooms in" on characters: "even with a microscope directed on a water-drop we find ourselves making interpretations which turn out to be rather coarse; for whereas under a weak lens you may seem to see a creature exhibiting an active voracity into which

other smaller creatures actively play as if they were so many animated tax-pennies, a stronger lens reveals to you certain tiniest hairlets which make vortices for these victims while the swallower waits passively at his receipt of custom" (*MM* 55). The number of possible interpretations is limited only by the number of "lenses" one brings to bear on any given situation, and the narrator becomes adept at changing these lenses: she describes both larger community structures, such as monetary exchange, and the complex inner lives of individual characters.

In addition to shifting her vantage point, the narrator allows different voices and perspectives to enter into her commentary. In "*Middlemarch*'s Dialogic Style," Rosemary Clark-Beattie argues that two main voices enter into an ongoing debate. The "common sense voice" is the "dominant voice of Middlemarch society, the comfortable, complacent voice of middle class England," but "because it is the voice of society, it is also open to question" (203); the "man of the world persona" is therefore "frequently an ironic posture" (203). The "poetic voice" offers an alternate worldview based on universal ideals such as the desire for sympathy and "the longing of the more noble characters for a world in which heroic action is possible" (201).

A single character is often described by both of these voices. In the Prelude, the narrator describes Dorothea using a "poetic voice:"

> Here and there is born a Saint Theresa, foundress of nothing, whose loving heart-beats and sobs after an unattained goodness tremble off and are dispersed among hindrances, instead of centering in some long-recognized deed. (*MM* 4)

When the deflated reality of nineteenth-century society is brought into contact with more noble yearnings, the poetic paradigm dominates in its criticism of the every day. This description, however, is contradicted by the pragmatic tone of the worldly voice,

which, in this case, conveys the potential for excess in Dorothea's religious ardour within the context of provincial England: "Riding was an indulgence which she allowed herself in spite of conscientious qualms; she felt that she enjoyed it in a pagan sensuous way, and always looked forward to renouncing it" (*MM* 10). Dorothea's idealism becomes absurd when it is too far removed from the checks and balances of daily life in passages where the "common sense voice" checks the potential of the poetic voice to express an absolute standard of truth. (Clark-Beattie 205). Throughout the novel, the reader's perception of most characters alternates between sympathetic and critical judgement with respect to the patterns created by these voices.

This oscillation becomes even more complex when a character's voice enters into the commentary. Free indirect style requires that "the narrator, without absenting himself entirely from the text, communicates the narrative to us coloured by the thoughts and feelings of a character" (Lodge 49). Because the character's discourse is no longer seen from the "outside," objectified by quotation marks, the "interpretive control of the author's voice" is diminished: the two voices are brought into fuller contact, into more rigorous and equitable dialogue, "and the reader's work increased" (Lodge 50). In effect, free indirect style opens the text up to an interpretive process Derek Oldfield describes as a " zigzag" (67) in which the reader's opinion shifts as he or she considers the nuances of irony that emerge from the conflicting voices found in the narrator's commentary. This zigzagging, Oldfield argues, can also be applied to a larger oscillation within the novel "between an emotional identification with a character and an obliquely judicious response to their situation" (81).

Rosemary Clark-Beattie describes how George Eliot uses free indirect style to create different levels of sympathy for and distance from her characters: "if free indirect style is to be exploited for its potential irony, the prose marks the gap between narrative analysis and the character's thoughts by emphasizing the qualities of direct speech; if it is to convey a more profound sympathy between the point of view of the character and the point of view of the narrator than is available through epic monologue, the prose de-emphasizes the marks of direct speech" (Clark-Beattie 211). Lydgate, for example, is presented both ironically and sympathetically as the narrator weighs his "spots of commonness," against his capacity for noble action. In the following passage Lydgate's colloquial language is emphasized to expose the folly of his conventional ideas about marriage.

> Certainly, if falling in love had been at all in question, it would have been quite safe with a creature like this Miss Vincy, who had just the kind of intelligence one would desire in a woman—polished, refined, docile, lending itself to finish in all the delicacies of life, and enshrined in a body which expressed this with a force of demonstration that excluded the need for other evidence. (*MM* 153)

Lydgate's personal assumptions are distinct from the narrator's: the comfortable, conventional tone is set with "certainly," and then followed by the colloquial terms in which Lydgate thinks of Miss Vincy, "who had just the kind of intelligence one would desire in a woman." This generality distances the reader from Lydgate's point of view because it exposes the basis of Lydgate's ideas about marriage as his society's mistaken assumptions about feminine values (Clark-Beattie 213). When Lydgate is on the verge of losing his professional standing, however, his voice becomes closer in style to the narrator's poetic voice:

> There was a benumbing cruelty in his position. Even if he renounced every other consideration than that of justifying himself—if he met shrugs, cold glances, and avoidance as an accusation, and made a public statement of all the facts as he knew them, who would be convinced? It would be playing the part of a fool to offer his own testimony on behalf of himself, and say, 'I did not take the money as a bribe.' The circumstances would always be stronger than his assertion. And besides, to come forward and tell everything about himself must include declarations about Bulstrode which would darken the suspicions of others against him. (*MM* 695-6)

According to Clark-Beattie, "the marks of direct speech are not strong enough to create the soliloquy quality of epic monologue," and therefore "have the effect of identifying the point of view of the narrator with that of her character. . . The technique expresses sympathy" (210). Lydgate is capable of thinking in a style that approaches the narrator's learned, poetic voice in terms of tense, syntax, and diction. Consequently, readers associate the doctor with the narrator's capacity to entertain noble thoughts and clear insights, and they become more sympathetic to his point of view.

This passage also elicits sympathy because both Lydgate and the reader are participating in a similar interpretive process. Garrett notes a direct link between reader and character within the dialogic structure of the novel: "The multiple and shifting focus of George Eliot's narrative works to undermine egocentric illusions, but at the same time her focus seeks centers of consciousness which can enact a process of interpretation like the reader's" (148). Both Lydgate and the reader must consider the perspectives of multiple characters while alternating between detachment and sympathy. In the passage above, which takes place as Lydgate discovers that he depends on the opinions of others for his identity, the doctor contemplates his predicament from the community's point of view. This process is a key theme in

Middlemarch: "Who can know how much of his most inward life is made up of the thoughts he believes other men to have about him, until that fabric of opinion is threatened with ruin?" (*MM* 677). Rosemary Clark-Beattie argues that, ideally, living in Middlemarch is a consciously dialogic process of negotiating self and other:

> The character acts, discovers through his actions that the world is not what he had supposed, revises his expectations, acts again in the hopes of better achieving his desires, and so on. . . . Gradually, his vision of the real comes to approximate the true order of the world in which he acts. (205)

Dorothea is the character who best learns to interpret other perspectives to the advantage of those around her. In the opening chapters of *Middlemarch* she misinterprets her future husband when, instead of considering the consequences of this difference, Dorothea projects her own desires: "She filled up all blanks with unmanifested perfections, interpreting him as she interpreted the works of Providence, and accounting for seeming discords by her own deafness to the higher harmonies." (*MM* 68). On their honeymoon in Rome, however, Dorothea discovers her mistake, proving herself capable of recognizing Casaubon's otherness, of feeling "the waking of a presentiment that there might be a sad consciousness in his life which made as great a need on his side as on her own" (*MM* 197). When she truly attempts to imagine his perspective, it becomes "feeling," or sympathetic knowledge:

> We are all of us born in moral stupidity, taking the world as an udder to feed our supreme selves: Dorothea had early begun to emerge from that stupidity, but yet it had been easier to her to imagine how she would devote herself to Mr. Casaubon, and become wise and strong in his strength and wisdom, than to conceive with that distinctness which is no longer reflection but feeling—an idea wrought back to the directness of sense, like the solidity of objects—that he had an equivalent centre of self, whence the lights and shadows must always fall with a certain difference. (*MM* 198)

While her more accurate, evolving interpretation yields disappointing revelations, Dorothea gains the ability to understand her husband more fully, and although she is not uncritical of Casaubon's shortcomings, she is able to use this knowledge to offer him comfort and support. Dorothea's response to Casaubon's perspective, however, requires that she sacrifice her own happiness because she must keep the peace in a marriage with a man who cannot acknowledge her own "equivalent center of self."

Toward the end of the novel Dorothea fully enacts this process to benefit other characters. Determined to help Lydgate gain control of his dilemma, Dorothea resolves to comfort and advise his wife. Upon her arrival at Lydgate's home, however, Dorothea is hurt by the appearance of Will flirting with Rosamond. Despite her personal anger and pain, Dorothea manages to interpret the larger situation from different perspectives in an imaginative process that seeks to recognize otherness: "Was she alone in that scene? Was it her event only?" (*MM* 740). She then draws on her own experience as a starting point for sympathetic understanding:

> All the active thought with which she had before been representing to herself the trials of Lydgate's lot, and this 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. She said to her own irremediable grief, that it should make her more helpful, instead of driving her back from effort. (*MM* 740-1)

Ultimately, Dorothea is able to transcend her own interests and to partially reconcile Lydgate with his wife.

In the remainder of this chapter, I want to look more closely at the extent to which this type of dialogic approach can literally improve a character's health. Lydgate, I will argue, is careful to consider the patient's perspective while shifting

between sympathy and analytical observation as a means of providing effective care. According to Eliot, however, nineteenth-century scientific thought is not only compatible with dialogism in medical consultations, but is applicable to everyday interactions. Unfortunately, the doctor fails to acknowledge the significance of the multiple discourses and points of view that confront him in the wider community because he does not understand the extent to which he is dependent on his friends and colleagues before he has made several crucial mistakes. In the following discussion, I outline other types of discourses to which Lydgate is exposed.

Medical Discourse in Middlemarch

In the community of Middlemarch, different voices and discourses are always in contact, conflicting with and influencing one another. Scientific discourse is but one of these discourses, and is itself divided. As the traditional, eighteenth-century approach to medicine practiced by the established medical community comes into contact with the new, nineteenth-century scientific approach Lydgate introduces, the reader is able to discern both the advantages and the disadvantages of each.

According to Eliot, traditional, eighteenth-century medical discourse did not represent a unified profession; rather, a variety of doctors are represented in Middlemarch, each occupying a different position in the medical hierarchy, and each administering different types of treatments. Dr. Sprague and Dr. Minchen are certified physicians located on the upper rungs of the medical hierarchy and therefore tend mainly to the rich. Although their anatomical learning is limited, these physicians emphasize their role as wise advisors. Patients respect Dr. Sprague's opinion for carrying most "weight" and Dr. Minchen for having more "penetration"

(147). The surgeons, Mr. Wrench and Mr. Toller, care for members of the middle class, the Vincys being among Mr. Wrench's patients. Both of these surgeons lack the accurate physiological knowledge that Lydgate possesses and practice instead according to an eighteenth-century model of the body. Thus, Wrench tends to his patients with a "strengthening treatment," while Toller reaches out to other types of constitutions with his "lowering system" (133). Mr. Gambit, the apothecary, prescribes pills and gives advice to the lower classes, like the grocer, Mr. Mawmsey.

In general, the traditional practitioners' lack of accurate knowledge determined the nature of their relationships with their patients. Because they had no training in pathological physiology, traditional practitioners failed to understand the nature of the underlying diseases that produced their patients' symptoms and could provide little in the way of prognosis or effective therapy (Shorter 43-44). These symptoms were largely assessed, not by any elaborate form of physical examination, but by the patient's own description of them (Shorter 44). Because patients had equal access to the non-technical terminology used by doctors, they were active participants in their medical care, often developing their own theories and remedies based on what they considered to be a rational extension of eighteenth-century medical discourse.

Practitioners were obliged to take their patients' voices into account because eighteenth and nineteenth-century medical men were financially dependent on the strength of their practice in communities where competition from other doctors was particularly intense, the medical profession was not uniformily respected, and fees were often low and difficult to collect. In *Middlemarch*, Lady Chettam describes the

practitioner's diminished social status when she announces that she expects her doctor to be "more on a footing with the servants" (*MM* 84). Instead of submitting to the doctor's orders, Lady Chettam decides whether his advice is valuable: "I assure you I found poor Hick's judgement unfailing; I never knew him wrong. He was coarse and butcher-like, but he knew my constitution" (*MM* 84). Unlike Brontë, Eliot explores the implications, both beneficial and detrimental, for the doctor who is compelled to acknowledge and negotiate with his patients.

One of *Middlemarch*'s plots focuses on the reaction of the previously stable medical community to Lydgate's new scientific approach. Educated in Edinburgh and Paris, Lydgate has accurate, in-depth knowledge of human physiology; theoretically, he focuses more on his patients' bodies and less on their subjective account of illness than do eighteenth-century practitioners. Lydgate uses a stethoscope to detect symptoms that are informed by his physiological understanding of the heart and lungs, and diagnoses Fred in the "pink-skinned stage of typhoid fever" (*MM* 244) where Mr. Wrench saw only "slight derangement" (*MM* 243). The novel demonstrates that, ultimately, both eighteenth and nineteenth-century discourses are necessary to diagnose, treat, and satisfy patients. Scientific discourse cannot be effective unless complemented by a sympathetic approach to patients and their narratives while eighteenth-century practitioners must be informed by physiologically based knowledge.

According to Eliot's fiction and non-fiction, nineteenth-century science is not exclusively focused on human physiology; it in fact requires the researcher to consider a variety of perspectives and discourses. In her essays, George Eliot argues

that scientific research requires the doctor-scientist to approach his subject through a mode of detached empirical observation as well as to draw on his own subjective experience, intuition, and imagination in order to perceive otherness. In "*Middlemarch* and Science: Problems of Life and Mind," Michael Y. Mason notes that both Eliot and George Henry Lewes departed from John Ruskin's conception of realism because it was based on unqualified empiricism in which the eye of the scientist was to function like a camera (Mason 152). Instead, Lewes held an enlarged view of the scientist's subjective perspective in empirical observation, a role that derived from William Whewell, who dominated the field of the philosophy of scientific method after publishing "The Philosophy of the Inductive Sciences." Mason summarizes:

> For Whewell laws involve concepts 'superinduced' in the facts, and these concepts originate in natural tendencies of the mind. The laws fits the facts but are not in the facts, to be brought out by abstraction; they are readings of the facts under a description that is logically connected with innate ideas about equality, space, time, force and so on. . . . It is thus the necessity of thought that make laws binding. (158)

Lewes develops these ideas in "Foundations of a Creed," where he argues that the imagination is a necessary component of scientific research and must be cultivated by the researcher's subjective, even passionate, involvement in his studies.

In *Middlemarch*, Eliot elaborates on the dialogic nature of scientific thought. Lydgate acknowledges the importance of his own voice, his own imagination in scientific discovery. In the following passage, he compares the scientific imagination to that which is responsible for mediocre art:

> But these kinds of inspiration Lydgate regarded as rather vulgar and vinuous compared with the imagination that reveals subtle actions inaccessible by any sort of lens, but tracked in that outer darkness through long pathways of

> necessary sequence by the inward light which is the last refinement of Energy, capable of bathing events in the ethereal atoms in its ideally illuminated space. He for his part had tossed away all cheap inventions where ignorance finds itself able and at ease: he was enamored of the arduous invention which is the very eye of research, provisionally framing its object and correcting it to more and more exactness of relation. (*MM* 154)

In addition, Lydgate realizes that physiology is the study of systems and process, that all tissues and organs are connected and interrelated; therefore, he must seek an "exactness of relation" between singular components that cannot derive their meaning without others. [2]

Lydgate's research also requires that he shift his perspective to one of emotional involvement. When he chooses his profession, the narrator describes Lydgate's immersion into his medical studies as a religious conversion. After Lydgate reads about the working of the heart, "the moment of vocation had come, and before he got down from his chair, the world was made new to him by a presentiment of endless processes filling the vast spaces planked out of his sight by that wordy ignorance which he had supposed to be knowledge. From that hour Lydgate felt the growth of an intellectual passion" (*MM* 135). The doctor does not take a measured and detached approach to medicine; rather, he is passionately involved in his study of physiology, which carries over into and benefits his medical practice.[3]

The Dialogic Doctor

Because both Dr. John and Lydgate practice modern, scientific medicine, feminist critics generally collapse these two doctors in terms of their motives, techniques, and effectiveness to uniformly criticize the manner in which they wield their medical authority. In *The Madwoman in the Attic*, Sandra Gilbert and Susan

Gubar argue that "like Dr. Frankenstein and Dr. John and all the other doctors who haunt the works of women writers from Charlotte Perkin Gilman's *The Yellow Wallpaper* to Sylvia Plath's *The Bell Jar*, Lydgate threatens to usurp control of women's bodies and therefore endangers their deepest values" (508). Similarly, in "From Neurosis to Narrative: The Private Life of the Nerves in *Villette* and *Daniel Deronda*" Athena Vrettos contrasts Dr. John's inability to identify and sympathize with psychological pain with Lucy Snowe's sensitivity in the sickroom; this opposition between the detached, authoritative male doctor and sympathetic female patient remains consistent in her analysis of *Middlemarch*. In *Somatic Fictions*, Vrettos contrasts Dorothea's sympathy, her capacity to share physically in the pain of another, with Lydgate's tendency to remain untouched. After he misjudges Madame Laure, he "resolves to stick to scientific modes of vision and affirms the 'proper' critical stance of the physician . . . the sickroom is a drama that he can control" as a detached spectator *(SF* 106-7).

These critics do not acknowledge that, although Lydgate has scientific knowledge and training, as a young new doctor in a community that values wealth and status over medical skill, he has limited social power. I argue that when patients do acknowledge and defer to Lydgate's medical authority, he exercises it effectively. Far from remaining detached, Lydgate helps his patients by treating them with respect and compassion.

The limitations of Lydgate's medical authority are apparent when he converses with Lady Chettam. Middlemarch's upper class women enjoy discussing their minor maladies and expect that their medical men take the time to understand

their constitutions. Lydgate must therefore listen to the ladies discuss their health without offending them:

> Mr. Lydgate had the medical accomplishment of looking perfectly grave whatever nonsense was talked to him, and his dark steady eyes gave him impressiveness as a listener. He was as little as possible like the lamented Hicks, especially in a certain careless refinement about his toilette and utterance. Yet Lady Chettam gathered much confidence in him. He confirmed her view of her own constitution as being peculiar, by admitting that all constitutions might be called peculiar, and he did not deny that hers might be more peculiar than others. He did not approve of a too lowering system, including reckless cupping, nor, on the other hand, of incessant port-wine and bark. He said 'I think so' with an air of so much deference accompanying the insight of agreement, that she formed the most cordial opinion of his talents. *(MM* 85)

Because of her wealth and standing in the community, Lady Chettam's social power overrides Lydgate's medical authority, which results in an unbalanced and therefore unproductive dialogue. While this one-sided type of communication is of limited use in terms of medical care, it is in Lydgate's interest to create friendly contacts within the community.

Conversely, when Lydgate does not pay close attention to his patients' voices and expectations, his reputation and medical practice suffer. In *Middlemarch*, a patient's silence does not indicate powerlessness or acquiescence; rather, it frequently indicates stubborn disagreement on which the patient later acts. For example, Lydgate inadvertently fails to take his patient's understanding of medicine into account when he makes a flippant remark to Mr. Mawmsey by way of explaining his strategy for drug reform. When Mawmsey questions Lydgate about his new drug policy, the doctor was "injudicious enough to give a hasty popular explanation of his reasons, pointing out to Mr. Mawmsey that it must lower the character of practitioners, and be a constant injury to the public, if their only mode of getting paid

for their work was by making out long bills for draughts, boluses, and mixtures" (*MM* 417). He jokingly adds, "To get their own bread they must overdose the King's lieges; and that's a bad sort of treason, Mr. Mawmsey—undermines the constitution in a fatal way" (*MM* 417). Mr. Mawmsey laughs at the joke, and Lydgate assumes that all is well. The reader, however, sees the consequences of the patient's silence. Mr. Mawmsey, in fact, does not understand Lydgate's allusion to the "king's lieges," and in his confusion concludes that the new doctor thinks all drugs are useless. Further, when Mawmsey's own system of thought is disclosed, the reader realizes how much Lydgate has assumed, and the implication of his drug position takes new meaning. An asthma sufferer with a childbearing wife, Mr. Mawmsey has had ample experience with medical men and takes pride in being a good provider for his family when he receives a long doctor's bill for pills and medicines. Regardless of whether the drugs are effective or not, Mr. Mawmsey likes the sense of control he derives from measuring their effects, and enjoys engaging in a dialogue with his regular medical man, Mr. Gambit, who uses conversation as his primary source of treatment. Mr. Mawmsey disapprovingly tells his family and friends about Lydgate's disdain for drugs, and, consequently, many members of the community form their own negative opinions of the new doctor. Not only does Lydgate's inability to consider the merit of certain discourses, namely, the obsolete scientific discourses used by his colleagues, negatively impact his patient, but the doctor's general misunderstanding of his role within the wider the community harms his practice. [4]

In other cases, when both the doctor and patient participate in the consultation, Lydgate's capacity to engage beneficially in dialogic interaction

becomes apparent. During his consultation with Casaubon about the severity of his heart condition, the doctor actively encourages his patient to speak openly. After Casaubon has completed a lengthy and convoluted preamble, Lydgate asks a question only to "help forward Mr. Casaubon's purpose, which seemed to be clogged by some hesitation" (*MM* 396). Casaubon admits he knows his heart condition is serious and asks Lydgate to give him a candid prognosis so he can make important life decisions based on the information: "I appeal to you for an exact statement of your conclusions: I request it as a friendly service. If you can tell me that my life is not threatened by anything else than ordinary casualties, I shall rejoice. . . . If not, knowledge of the truth is even more important to me" (*MM* 396-7). Lydgate respectfully gives the patient hope by admitting his own fallibility: "my conclusions are doubly uncertain—eminently difficult to found predictions on" (*MM* 397). He then provides Casaubon with an "exact" statement of his condition:

> I believe that you are suffering from what is called fatty degeneration of the heart . . . a good deal of experience—a more lengthened observation—is wanting on the subject. But after what you have said, it is my duty to tell you that death from this disease is often sudden. At the same time, no such result can be predicted. (*MM* 397)

Lydgate offers both scientific specifics and hope, an approach that Dr. Melvin Konner approves in *Medicine at the Crossroads: The Crisis in Health Care*. Konner argues that doctors must strike a balance between what information is most useful to a particular patient, and what could be devastating enough to threaten the benefits of hope or placebo (24). He recommends that the doctor determine the appropriate disclosure by collaborating closely with the patient (27). In this instance, Lydgate urges Casaubon to speak so that he can assess his patient's personality and wishes,

then provides a "fairly succinct but compassionate account of the truth" (Konner 27), with which his patient can organize the remainder of his life.

Lydgate is also able to suppress his negative personal feelings in order to listen and respond carefully to his patient's concerns. On a personal level, Lydgate can be arrogant: "Lydgate's conceit was of the arrogant sort, never simpering, never impertinent, but massive in its claims and benevolently contemptuous" (*MM* 140). This aspect of Lydgate's personality manifests itself as he approaches Casaubon, who is inwardly grappling with the realization that the end of his life is near: "Lydgate, who had some contempt at hand for futile scholarship, felt a little amusement mingling with his pity. He was at present too ill acquainted with disaster to enter into the pathos of a lot where everything is below the level of tragedy except the passionate egoism of the sufferer" (*MM* 396). Although Lydgate initially fails to use his imagination to understand Casaubon's inner life, the doctor nevertheless puts his own feelings aside to engage in a productive conversation. In this respect Lydgate is unlike Dr. John, who disrespects and dismisses his patient to indulge his personal vanity. Barbara Hardy is one of the few critics to acknowledge Lydgate's capacity for compassion: "The conversation between doctor and patient, in which Lydgate tells Casaubon the diagnosis and prognosis, is marked by the mobile registrations of complex feeling. . . . This rash immature amusement is a silent one, and it is a sensitive sympathy which urges his question" (6).

Similarly, after Lydgate has been ruined by his association with Bulstrode, he overcomes his personal repulsion in order to treat the stricken man: "Lydgate, who himself was undergoing a shock as from the terrible practical interpretations of some

faint augury, felt, nevertheless, that his own movement of resentful hatred was checked by the instinct of Healer which thinks first of bringing rescue or relief to the sufferer, when he looked at the shrunken misery of Bulstrode's livid face" (*MM* 683). Lydgate is compelled to support Bulstrode as they walk arm in arm from the town meeting although it seemed "he were putting his sign-manual to that association of himself with Bulstrode, of which he now saw the full meaning as it must have presented itself to other minds" (*MM* 685).

Lydgate's dialogic approach to medicine also encourages his patients to discuss the merits of their treatment, which helps them better integrate their medical condition into their lives. When Lydgate advises Casaubon to relax and engage only in restful activities, his patient argues that these options are unsuitable for a man of his disposition. Instead of reinforcing his banal prescription, Lydgate addresses his patient's concerns by admitting the shortcomings of this conventional suggestion: "'I confess" said Lydgate, smiling, "amusement is rather an unsatisfactory prescription. It is something like telling people to keep up their spirits. Perhaps I had better say, that you must submit to be mildly bored rather than to go on working" (*MM* 269). Lydgate rejects the status quo, whereas Dr. John recommends that Lucy "cultivate happiness," and seek cheerful society without first taking her social limitations into consideration. When Lucy does challenge the pragmatism of his advice, the doctor defends the status quo without acknowledging the validity of his patient's misgivings.

After Casaubon's death, Lydgate again departs from an exclusively physiological approach to medicine when he is called to advise Dorothea in her state of grief. Lydgate arrives at Freshitt, where Dorothea is staying with her sister, only to

find that the former is extremely agitated. The doctor does not know that Celia has just informed Dorothea of the codicil in Casaubon's will preventing his widow from marrying Ladislaw, and like Dr. John, first diagnoses her distress by assessing her outward symptoms: "I fear you are not so well as you were, Mrs. Casaubon: have you been agitated? Allow me to feel your pulse" (*MM* 461). After Celia informs the doctor that her sister wants to return to Lowick to look through her husband's papers, he addresses his patient's psychological needs intuitively:

> Lydgate did not speak for a few moments. Then he said, looking at Dorothea, "I hardly know. In my opinion Mrs. Casaubon should do what would give her the most repose of mind. That repose will not always come from being forbidden to act." (*MM* 462)

Far from imposing his medical authority as a means of control over Dorothea's body, Lydgate gives her family the following advice: "Let Mrs. Casaubon do as she likes . . . She wants perfect freedom, I think, more than any other prescription" (*MM* 462). After giving careful thought to the context of Dorothea's life, "he felt sure that she had been suffering from the strain and conflict of self-repression; and that she was likely now to feel herself only in another sort of pinfold than that from which she had been released" (*MM* 462). Rather than attempt to relieve his patient's psychological pain with conventional recommendations of rest and travel, Lydgate considers the various non-medical factors that contribute to her distress and advises her to act.

Earlier in the novel, Lydgate's capacity to engage sympathetically with his patients is apparent when he consults with Dorothea about the state of her husband's health. At the outset, Lydgate takes a detached, scientific approach to his female patient, who

> was usually by her husband's side, and the unaffected signs of intense anxiety in her face and voice about whatever touched [her husband's] mind or health made a drama which Lydgate was inclined to watch. He said to himself that he was only doing the right thing in telling her the truth about her husband's probable future, but he certainly thought also that it would be interesting to talk confidentially with her. A medical man likes to make psychological observations, and sometimes in the pursuit of such studies is too easily tempted into momentous prophecy which life and death easily set at naught. Lydgate had often been satirical on this gratuitous prediction, and he meant now to be guarded. (*MM* 269-70)

Because of past misjudgments, Lydgate initially attempts to remain detached from Dorothea's suffering. While a student in Paris, Lydgate spent his free time in the theatre, enraptured by a stunning actress, Madame Laure. One night, in the course of the drama, Laure actually kills her husband during a murder scene. Lydgate finds himself propelled from spectator to participant as he "leaped and climbed, he hardly know how, on to the stage, and was active in help, making the acquaintance of his heroine by finding a contusion on her head and lifting her gently in his arms" (*MM* 142). Like Dr. John, whose attraction to Paulina Home is reinforced by his medical attention when he rescues her from a burning theatre, Lydgate finds that his medical intentions combine with his love for the actress during her moment of crisis. Later, Lydgate's feelings for Laure grow into "personal devotion, and tender thought of her lot" (*MM* 142), but he is utterly disappointed to discover that his lover had intentionally killed her husband. Therefore, when Lydgate confronts Dorothea, he makes an effort to view her as Dr. John watches Vashti, with "a smile so critical" (Brontë *Villette* 342). Lydgate discovers, however, that he is incapable of remaining so when Dorothea appeals passionately to his wisdom:

> Oh, you are a wise man, are you not? You know all about life and death. Advise me. Think what I can do. He has been labouring all his life and

> looking forward. He minds about nothing else. And I mind about nothing else—. (*MM* 272)

The doctor is deeply touched by his patient's entreaty:

> For years after Lydgate remembered the impression produced in him by this involuntary appeal—this cry from soul to soul, without other consciousness than their moving with kindred natures in the same embroiled medium, the same troublous fitfully-illuminated life. (*MM* 272)

Lydgate's reaction proves that his dialogic approach to his patients goes beyond tact and politeness. When necessary, he has the ability to connect emotionally with his patients, to respond with sympathetically to their pain.

Lydgate's instinctive capacity to sympathize also factors into his relationship with his wife. Dorothea Barrett describes the correspondence between Lydgate's vocation and his personal relationships: "In George Eliot's characters, love and work are equal expressions of one personality, and the same characteristics are manifest in both halves of the individual's life; . . . Lydgate's warmth affects both his love life and his professional life" (128). When Rosamond becomes ill after Ladislaw reprimands her, Lydgate reacts instinctively:

> The perception that she was ill threw every other thought into the background. When he felt her pulse, her eyes rested on him with more persistence than they had done for a long while, as if she felt some content that he was there. He perceived the difference in a moment, and seating himself by her put his arm gently under her, and bending over her said, 'My poor Rosamond! Has something agitated you?' Clinging to him she fell into hysterical sobbings and cries, and for the next hour he did nothing but soothe and tend her. (*MM* 734)

As a doctor, Lydgate responds immediately to Rosamond's distress by taking her pulse and then by trying to alleviate her suffering with tenderness. His ability to sympathize is also revealed when he is struck by his wife's pain: "He did wish to spare her as much as he could, and her tears cut him to the heart" (*MM* 558).

Initially, however, Lydgate assumes that his personal and professional life occupy two separate spheres. As a young bachelor, Lydgate believes that his married life will be an idyllic escape from the cares of the world with an "accomplished creature who venerated his high musings and momentous labours and would never interfere with them; who would create order in the home and accounts with still magic, yet keep her fingers ready to touch the lute and transform life into romance at any moment; who was instructed to the true womanly limit and not a hair's-breadth beyond" (*MM* 153).

Unfortunately, Lydgate realizes that his career is profoundly influenced by his marriage only after he has chosen an unsuitable wife:

> To Lydgate it seemed that he had been spending month after month in sacrificing more than half of his best intent and best power to his tenderness for Rosamond; bearing her little claims and interruptions without impatience, and, above all, bearing without betrayal of bitterness to look through less and less of interfering illusion at the blank unreflecting surface her mind presented to his ardour for the more impersonal ends of his profession and his scientific study, an ardour which he had fancied that the ideal wife must somehow worship as sublime, though not in the least knowing why. (*MM* 551)

Not only are Lydgate's attentions diverted from his career to Rosamond's personal needs, but his medical instincts also become a burden. When Rosamond is unhappy or in pain, Lydgate suppresses his own needs to respond as a doctor, leaving him trapped in the one-sided position of caregiver to his life-long patient: "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" (*MM* 787).

More specifically, when the natural "warmth" he feels for many patients is intensified by sexual desire and reinforced by the bonds of marriage, Lydgate becomes susceptible to Rosamond's selfish domestic power. He discovers that his

claims to medical and intellectual authority are irrelevant in his relationship with his wife because they are incompatible with her social agenda: "There was gathering within him an amazed sense of his powerlessness over Rosamond. His superior knowledge and mental force, instead of being, as he had imagined, a shrine to consult on all occasions, was simply set aside on every practical question" (*MM* 543). Lydgate realizes that to exert his power more forcefully would serve the destructive purpose of making their inseparable lives even more unbearable. Although she plays the role of patient, Rosamond has control over the dialogic doctor because, in the context of marriage, her selfishness overwhelms Lydgate's natural instincts: "The need for accommodating himself to her nature, which was inflexible in proportion to its negations, held him as with pincers" (*MM* 656).

Lydgate attempts to engage his wife dialogically, but her refusal to participate results in disaster. The doctor uses his imagination to understand the world from Rosamond's perspective: "He told himself that it was ten times harder for her than for him: he had a life away from home, and constant appeal to his activity on behalf of others" (*MM* 627), and then entreats his wife to make this exercise easier for him by communicating openly:

> You and I cannot have opposite interests. I cannot part my happiness from yours. If I am angry with you, it is that you seem not to see how any concealment divides us. How could I wish to make anything hard to you either by my words or conduct? When I hurt you, I hurt part of my own life. I should never be angry with you if you would be quite open with me. (*MM* 627)

Unfortunately, Rosamond does not acknowledge their interdependence in terms that benefit her husband. When Lydgate entreats her both as a doctor and a concerned husband not to go horseback riding while she is pregnant, Rosamond his warning,

falls off the horse, and miscarries. In addition, Rosamond runs up an unmanageable debt while furnishing their home and refuses to curb her expectations even after her husband attempts to explain their limitations. Then, despite the fact that Lydgate disavows his wealthy family connections, Rosamond writes to his uncle, Sir Godwin Lydgate, asking in vain for financial assistance. Lydgate is furious, but begs for some kind communication: "You have always been counteracting me secretly. You delude me with a false assent, and then I am at the mercy of your devices. If you mean to resist every wish I express, say so and defy me. I shall at least know what I am doing then" (*MM* 625).

Lydgate's mistakes thus far are indicative of his failure to apply the same scientific rigour and thoughtfulness with which he approaches his patients and research to the events and relationships he encounters in the wider community. His scientific imagination "reveals subtle actions" by tracking them "through long pathways of necessary sequence" (*MM* 154), and yet Lydgate is blind to the causes and potential effects of his actions on several occasions. In the course of socializing in Middlemarch, the doctor is charmed by Rosamond Vincy's beauty and accomplishments, and he indulges in what he assumes to be a harmless flirtation for his own entertainment. Lydgate " felt no agitation, and had no sense that any new current had set into his life. He could not marry yet; he wished not to marry for several years; and therefore he was not ready to entertain the notion of being in love with a girl whom he happened to admire" (*MM* 153). Nonetheless, Lydgate is swept up in a chain of events like a "current" he does not perceive or resist. Not only does Rosamond plan to marry Lydgate, but when other Middlemarchers have noticed their

association, they begin to nudge the relationship forward: Mrs. Plymdale tells Mrs. Bulstrode that various members of the community are under the impression that Lydgate and Rosamond are engaged (*MM* 277). Mrs. Bulstrode, doubtful that this is the case, questions her niece directly. When Rosamond is unable to confirm the rumour, Mrs. Bulstrode takes action by drawing Lydgate's attention to the actual consequences of his behaviour: "Gentlemen pay her attention, and engross her all to themselves, for the mere pleasure of the moment, and that drives off others. I think it is a heavy responsibility, Mr. Lydgate, to interfere with the prospects of any girl" (*MM* 279). Lydgate makes half-hearted effort to avoid Rosamond, but a subtle series of circumstances continue to propel him into an unpremeditated engagement. When faced with a teary-eyed Rosamond, Lydgate is "warm-hearted and rash:" "an idea had thrilled through the recesses within him which had a miraculous effect in raising the power of passionate love lying buried there in no sealed sepulchre, but under the lightest, easily pierced mould" (*MM* 282).

In addition to the "endless processes" (*MM* 135) that constitute his study of biological functions, Lydgate's scientific research requires him to "demonstrate the more intimate relations of living structure" (*MM* 139). Still, the doctor does not contemplate the relationship between his personal and professional life before choosing a wife. [5] Before his engagement, the narrator notes that Lydgate brings "a much more testing vision of details and relations into this pathological study than he had ever thought it necessary to apply to the complexities of love and marriage, these being subjects on which he felt himself amply informed by literature, and that traditional wisdom which is handed down in the genial conversation of men" (*MM*

154). Nor does Lydgate see the significance of the connections between himself and the wider community. Upon his arrival in Middlemarch, Lydgate decides to do business with Bulstrode despite his personal dislike for the man. The doctor convinces himself that their relationship is for the greater good of the new infirmary, which Lydgate hopes will function as a fever research hospital. He does not, however, realize that this purely "professional" decision, in combination with his careless treatment of his colleagues, will ultimately damage both his medical practice and his personal life. The seeds of this problem become apparent when Lydgate attends a community meeting to decide between Tyke, Bulstrode's personal favourite, and Farebrother, Lydgate's friend, for the new hospital chaplain. Dr. Minchin and Dr. Sprague were "ready to combine against all innovators, and against non-professionals given to interference" (*MM* 170), while Mr. Wrench and Mr. Toller thought "Lydgate was a jackanapes, just made to serve Bulstrode's purpose" (*MM* 171).[6] Nonetheless, Lydgate rashly decides to vote for Tyke, which reinforces his ties to Bulstrode. The medical men spread their negative opinions of the new doctor throughout the community, and Lydgate's reputation is eventually damaged by these careless relationships: Bulstrode grants Lydgate's request for a loan after the doctor as treated Raffles, whose subsequent death and connection to Bulstrode implicates Lydgate in what seems to be a bribe. By this time the community has been conditioned to think ill of Lydgate and Middlemarchers quickly accept these rumours. The doctor's career and marital happiness are shattered as a result.

Lydgate's capacity to interpret his environment with respect to his scientific methodology is indeed found wanting, but the doctor's character gradually undergoes

a "process and an unfolding" (*MM* 140).[7] By the end of the novel, Lydgate develops a new depth of feeling as he discovers that he is capable of interacting dialogically with Dorothea. After Lydgate's reputation has been damaged because of his business dealings with Bulstrode, Dorothea proclaims her belief in Lydgate's character and offers to heal his reputation (and his health) by listening to his story sympathetically, and then by repeating his narrative to other, misinformed, members of the community.[8] Dorothea urges Lydgate to speak: "Tell me, pray…then we can consult together. It is wicked to let people think evil of any one falsely, when it can be hindered" (*MM* 717). When Lydgate shares his story with Dorothea, he discovers the healing potential of unfettered, dialogic communication:

> The presence of a noble nature, generous in its wishes, ardent in its charity, changes the lights for us: we begin to see things again in their larger, quieter masses, and to believe that we too can be seen and judged in the wholeness of our character. That influence was beginning to act on Lydgate, who had for many days been seeing all life as one who is dragged and struggling amid the throng. He sat down again, and felt that he was recovering his old self in the consciousness that he was with one who believed in it. (*MM* 717)

In this passage Lydgate realizes that his well being can be shattered or soothed by another person's perception, that when one is willing to listen, sympathize, and validate, he can "recover" self in all its "wholeness" and complexity. Eliot's ideal is the collaboration of two perspectives working in sympathy for a common purpose. Lydgate abandons his pride, his isolated self and "gives himself up, for the first time in his life, to the exquisite sense of leaning entirely on a generous sympathy, without any barriers of proud reserve. And he told her everything, from the time when, under the pressure of his difficulties . . . gradually, in the relief of speaking, getting into a more thorough utterance of what had gone on in his mind" (*MM* 718). An

understanding listener allows the speaker to express himself more thoroughly, and to benefit from an expression that is invested in someone else.

The importance of conversation forms a framework for the practice of medicine in the novel. Lydgate treats his patients successfully by encouraging them to speak, and by considering their experiences and discourses before drawing on his own medical knowledge. As a result of his dialogic approach, Lydgate proves himself capable of forming relationships based on respect and compassion with patients like Casaubon, and those based on sympathy and friendship with patients like Dorothea, to whom he responds with real feeling. Consequently, Lydgate is able to determine the social and psychological causes of his patients' suffering and to suggest treatments that correspond with their lifestyles.

When *Middlemarch* is compared to *Villette*, it becomes apparent that Eliot and Brontë do not share the same outlook on the role of nineteenth-century medicine. According to both Lydgate and *Middlemarch*'s narrator, nineteenth-century science is compatible with dialogism: to perform his scientific research Lydgate must observe relations between different components of biological systems in a vocation that requires his imagination and emotional involvement. These traits carry over into Lydgate's medical practice, where he demonstrates the compatibility of modern medicine and sympathy, and, further, into Eliot's "Study of Provincial Life," in which the narrator suggests that scientific method is universally applicable to both art and life. Lydgate, while flawed, elicits the reader's sympathy as he confronts disappointment, and, to a certain extent, his own shortcomings. Whereas Lydgate endures a slow, painful process to develop his interpretive skills, Brontë's fictional

doctor proves himself incapable of any such growth. Brontë, like Eliot, emphasizes the healing capacity of conversation, but in *Villette*, nineteenth-century medicine is practiced as strict, cold materialism by a doctor who is immersed in the physiologically based psychological terminology of the 1850s to the exclusion of all other perspectives. Whereas Lydgate's newly acquired medical skills can correct and complement elements of eighteenth-century medicine to benefit patients, Brontë demonstrates how Dr. John's scientific terminology worries and isolates his patient, how his clinical detachment frustrates her craving for friendship and sympathy, and how he chooses to use his largely unchecked power inappropriately. In *Villette*, nineteenth-century medicine as it is practiced by Dr. John fails: personal and professional boundaries are not negotiated effectively, and the doctor does not acknowledge or respond to his patient's perspective—authority cannot be shared successfully in the context of doctor-patient interactions.

[1] Garrett writes that Eliot's dual structure sustains the tension between these two lines of development; therefore, he concludes, her novel is " not the realization of a secure and comprehensive vision but a continual, shifting, unstable and unpredictable confrontation between single and plural, individual and social, particular and general perspectives" (22). Because these meanings remain unresolved, the "Victorian multiplot novels also come to 'mean' themselves, to present not a direct vision of the world but a dramatization of the process and problems of making sense of it" (22).

[2] This imaginative approach to science applies particularly to advances that were occurring in the nineteenth century. After the invention of the microscope, scientists were able to see the smallest units of tissue, the cell. Objective reality was visible, but a shift in perception was required in order to name these tiny structures and to conceptualize their relevance to the pre-existing theories of physiological structure. As Lydgate looks through his microscope, he is actually looking for (and at) the cell, which was to be conceptualized in Germany during the 1830s by Mathias Schleiden and Theodor Schuann. The reader of 1872 would have realized Lydgate's goals, as well as his shortcomings.

[3] Lydgate articulates the need to constantly shift his perspective using another physiological heart metaphor. He understands "there must be a systole and diastole in all enquiry," and "a man's mind must be continually expanding and shrinking between the whole human horizon and the horizon of an object-glass" (602). The scientist must approach his object of study first from a distance, often in terms of generalities, then more specifically under a microscope; on another level, Lydgate gets close to his patients in a sympathetic, passionate, or "heart-felt" way.

[4] William Deresiewicz characterizes the Middlemarch community in terms of nineteenth-century theories of organicism as "the functional interorganization and interdependence of parts within a whole, be they organs within a body or individuals within a society" (731). He argues that this type of structure is resistant to abrupt change because its interdependent parts, or, in this case, organized hierarchies of citizens and professionals, shift one small unit at a time as they absorb, transmit, and sustain a low level of conflict. While frustrating for Lydgate, Deresiewicz suggests that this stability is not altogether negative because it "sustains ordinary people in their basic relations and needs" (728). Mr. Mawmsey's situation demonstrates that scientific medical reformers like Lydgate "may embody and seek to dispense the benefits of a higher stage of human development, but ordinary people, even those with 'feeble minds,' have a legitimate claim to being left as they are" (Deresiewicz 729).

[5] Alan Mintz argues that this mistake is caused by Lydgate's failure to take other scientific discourses into consideration. Specifically, Lydgate is interested in organic structure to the exclusion of Farebrother's natural history: "Lydgate refuses to acknowledge that there might be even partial truth in the older system of knowledge. . . . Lydgate's dismissal of the enterprise of classification, with its careful determination of boundaries and its straining to comprehend the multiplicity of phenomena within a coherent system, has dire consequences for his life" because he repeatedly fails to apply to the "nonvocational sectors of his life the same rigor of observation he applies to his scientific work" (93). "He is, in other words, an inadequate classifier of the phenomena of experience, and his inadequacy will eventually be his undoing. He fails as a taxonomer of his own life. What does not fit is simply not scrutinized, and he is intent to leave it that way" (94). When his scientific judgement relaxed, he slips into commonness; by appealing to conventional assumptions, he fails to classify Rosamond.

[6] Lydgate makes no attempt to humour or negotiate authority with the other doctors. When he corrects Mr. Wrench's misdiagnosis of Fred Vincy's typhoid fever, for example, Lydgate neglects to smooth the situation over with the older practitioner. Because of his tactlessness, Wrench "reflected, with much probability on his side, that Lydgate would by-and-by be caught tripping too, and that his ungentlemanly attempts to discredit the sale of drugs by his professional brethren would by-and-by recoil on himself. He threw out biting remarks on Lydgate's tricks, worthy only of a quack, to get himself a factitious reputation with credulous people. That cant about cures was never got up by sound practitioners" (*MM* 247). Indeed, his arrogant dismissal of and open challenge to his colleagues has negative consequences for Lydgate.

[7] Lydgate learns to "read" by making analogies, drawing comparisons, and negotiating the tension between generalizations and exceptions:

> His mind glancing back to Laure while he looked at Rosamond, he said inwardly, 'Would she kill me because I wearied her?' and then, 'it is the way with all women.' But this power of generalising which gives men so much the superiority in mistake over the dumb animals, was immediately thwarted by Lydgate's memory of wondering impressions from the behaviour of another woman—from Dorothea's looks and tones of emotion about her husband when Lydgate began to attend him—from her passionate cry to be taught what would best comfort that man for whose sake it seemed as if she must quell every impulse in her except the yearnings of faithfulness and compassion. (*MM* 556)

Garrett argues that "Lydgate partly grasps, partly distorts the significance of these comparisons: he senses the common, potentially deadly egoism of Rosamond and Laure but fails to recognize the 'spots of commonness' in himself which led him to prefer such women. Yet he can draw on the lesson of the earlier encounter which showed the inadequacy of his preconceptions" about Dorothea (150). Although Lydgate's ability to read his circumstances is limited, he nonetheless creates a sympathetic bond with the reader through a common process of interpretation which "is not aimed at any final truth but, like the lives of the characters themselves, remains open to change and development" (Garrett 150).

[8] In "Circulatory Systems: Money, Gossip and Blood in *Middlemarch*." (*Arguing with the Past.* New York: Routledge, 1989), Gillian Beer argues that gossip is essential to a character's identity, value, and fate in the novel. Like blood and money, "gossip is a medium of transaction and once it has been generated, it is hard to control its consequences" (101).

Chapter Five: Conclusion

Throughout this discussion I have emphasized the importance of conversation in *Villette* and *Middlemarch*. In both novels the act of expressing pain, of narrating one's story, is in itself a source of great relief: Lucy Snowe experiences self-expression as a physical and psychological release, and the validation she receives from understanding listeners alleviates her sense of isolation. While *Middlemarch* is very unlike *Villette* in terms of its structure, which includes a large number characters connected through multiple plot lines, Eliot's depiction of the power of conversation is remarkably similar to Brontë's. Characters must communicate openly with one another to sustain caring relationships, which in turn ensure their success and happiness. Dorothea and Lydgate, for example, discover the importance of dialogue when they suffer emotionally, physically, and financially after marrying uncommunicative partners. When Dorothea and Lydgate attempt to understand each other, however, they are able to experience what the narrator describes as a sort of emotional healing: "The presence of a noble nature, generous in its wishes, ardent in its charity, changes the lights for us: we begin to see things again in their larger, quieter masses, and to believe that we too can be seen and judged in the wholeness of our character" (*MM* 717).

Because conversation facilitates healing, it is a crucial component of patient care. In particular, patients' participation in medical interactions can inform the doctors' diagnoses as well as their suggested course of treatment in texts where illness is caused by a variety of non-physiological factors. In both novels, which are aptly named after places, community plays an important role in the health of each

character, as well as in the role of the doctor. Lucy Snowe's health depends on her ability to form relationships with others, and she relies on the doctor to integrate her into this social environment, to be a friend. In *Middlemarch,* the complete isolation that Lucy experiences cannot exist. Every character is linked to another: each individual thought, word, and action reverberates through the complex social network of the community as it impacts other lives and voices. Characters therefore experience psychological and physical illness as a result of the connections they form with others. Bulstrode, for example, suffers when the community discovers the lies he has told in his past: their accusations "rushed through him like the agony of terror which fails to kill, and leaves the ears still open to the returning wave of execration" (*MM* 682). The doctor himself is made ill by his association with Bulstrode. Dorothea is shocked by "the change in his face, which was strikingly perceptible to her who had not seen him for two months. It was not the change of emaciation, but that effect which even young faces will very soon show from the persistent presence of resentment and despondency" (*MM* 716). Illness also strikes Dorothea as "waves of suffering shook her too thoroughly to leave any power of thought" (*MM* 739) after she believes she has discovered an amorous connection between Ladislaw and Rosamond. Because social circumstances cause both psychological and physical suffering, the doctors' success depends on their ability to encourage their patients' perspective and to incorporate social, psychological, and spiritual discourses into their diagnoses and treatments.

Dr. John and Lydgate respond to these circumstances quite differently. Brontë is critical of the capacity of nineteenth-century medicine to fulfill this

function: her fictional doctor is unreceptive to Lucy's experience of illness, which lies outside of material functioning, conventional narrative structures, and mainstream social experience. He has the tendency to assert his own clinical methods and scientific terminology while silencing his patient's voice, and, as a result, Lucy is misdiagnosed, untreated, and left feeling alienated from her community. Eliot is more positive about the potential for the nineteenth-century practitioner to engage productively with his patients. Although he too is a scientific practitioner, Lydgate listens to and sympathizes with his patients, shares his knowledge, and collaborates with them before arriving at a diagnosis and course of treatment.

Brontë and Eliot explore several aspects of nineteenth-century medicine—the doctor's physiological focus, technical discourses, clinical detachment, and increasing medical power—that are relevant to current concerns about patient care. Not only do these writers anticipate the implications of scientific medicine, but they depict models of patient care that are remarkably consistent with the recommendations of twentieth-century scholarship. These similarities suggest that the practice of medicine requires modes of doctor-patient interaction that are continuous throughout time, regardless of specific scientific advancements and social changes. Both nineteenth-century novelists and twentieth-century doctors and sociologists advise doctors to foster friendly, sympathetic relationships with their patients, and to use their authority to provide them with comfort, hope, and validation. In addition, these sources urge doctors to encourage their patients' voices and to allow multiple discourses to enter into the consultation before forming a diagnosis.

The fictional depictions of doctor-patient interactions also emphasize elements of medical relationships that are difficult to explore in other formats. In addition to depicting the scientific transitions and social instability particular to nineteenth-century medical practice, Brontë and Eliot present medical consultations within the thematic and structural context of their novels. Illness embodies the major themes of community and self-expression, and doctor-patient relationships contribute to the novels' general concerns with interpretation. More specifically, the way in which narrators, characters, and readers interpret the events of the texts forms a paradigm for the approach doctors must take to their patients.

In the novels, interpretation figures as the process of putting different, contradictory structural elements, voices, and perspectives into contact with one another. Both writers resist finality in favour of continually weighing contradictory elements as a means of understanding the ever-changing lives of their characters. Consequently, these texts are open to multiple interpretations and enter into dialogue with the reader, whose subjective point of view produces meaning. Because they remain unresolved, Peter K. Garrett argues that "Victorian multiplot novels also come to 'mean' themselves, to present not a direct vision of the world but a dramatization of the process and problems of making sense of it" (22). While Brontë's novel does not include multiple plots, she too demonstrates that multiple voices and perspectives are required to appreciate the full complexity of her characters, and she explores the significance of the community of readers she engages in dialogue by doing so.

Just as the dialogic structure of their novels challenges the concept of a singular narrative authority, both writers suggest that, while patients need their

doctors' expertise, there is no one authority within medical consultations—each patient's voice and experience is crucial to arriving at a correct diagnosis and course of treatment. To treat patients effectively, doctors, like readers, engage in an ongoing process of interpretation that includes a variety of discourses and perspectives. When we consider the texts individually, we can draw even more specific conclusions about the nature of the interpretative process in doctor-patient interactions.

In *Villette*, Lucy withholds information from both the doctor and the reader, and by doing so suggests that there are limits to what a doctor—or reader—can know about any given patient or character. Initially, Lucy withholds information about her identity from Dr. John, and even neglects to tell the reader when she recognizes him as Graham Bretton. She does not reveal the true nature of her feelings for Graham and, later, M. Paul until they are very well developed. For example, although M. Paul has been leaving gifts in Lucy's desk over a long period of time, she does not divulge this information to the reader until well into her narrative: "Now I knew, and I had long known, that that hand of M. Emanuel's was on the most intimate terms with my desk; that it raised and lowered the lid, ransacked and arranged the contents, almost as familiarly as my own" (398). Lucy teases M. Paul himself by refusing to disclose the intended recipient of the watch chain she is making, and then, to infuriate him, pretends that she has neglected to bring him a birthday present. While Lucy eventually reveals many of her secrets to readers and characters, she remains elusive about her appearance, the specifics of her past, and M. Paul's return. To consider the various discourses and voices Lucy employs in her narrative is to learn more about her, but when readers are purposefully denied access to crucial details of her life and

character, they are encouraged to recognize the limits to which any individual can be known, medically or otherwise. Lucy's elusiveness opens the text to multiple interpretations and dialogue, but it also pushes readers away, making them critical of her tendency to deceive.

George Eliot draws slightly different conclusions about the nature of interpretation. In *Middlemarch*, the narrator adopts scientific methods to study the organic structure of the community; she uses scientific metaphors that involve pier glasses, chemical reactions, microscopes, and telescopes to describe her scientific mode of perception, which in turn parallels Lydgate's approach to his scientific research. The doctor's systolic and diastolic shifts in perspective and imaginative study of relations are reenacted by the narrator as she moves from character to character, examining both their outward relationships and their inner thoughts. For Eliot, scientific method rejects any one authority or perspective—it is the interpreter's failure to engage in this ongoing process that she criticizes, not the method itself. For Charlotte Brontë, however, nineteenth-century science is but one of many discourses. It does not necessarily acknowledge other voices and, when used exclusively, has the potential to harm patients.

In their fiction, both writers also explore the consequences of the doctors' medical authority with respect to the interaction between their personal intentions and professional discourse. Dr. John's medical concern becomes indistinguishable from his sexual and personal interest when he worries over Ginevra's health, teases Lucy with her letters, and becomes engaged to his patient, Paulina Home. Lydgate's romantic interests are also inseparable from his medical concern when he rushes to

the aid of a distressed actress, as well as when he tenderly responds to Rosamond's tears.

Brontë depicts a doctor who asserts his medical and social power continuously—he remains reserved and unsympathetic even in his personal relationships. Dr. John's fiancée realizes she must write carefully controlled letters to avoid alienating her future husband: "I wrote it three times—chastening and subduing the phrases at every rescript; at last, having confected it until it seemed to me to resemble a morsel of ice flavoured with ever so slight a zest of fruit or sugar, I ventured to seal and despatch it" (436). Lucy in turn notes that Dr. John remains insensible to her pain as well as her personal feelings for him: "the sympathetic faculty was not prominent in him. . . . Expect refinements of perception, miracles of intuition, and realize disappointment" (264). It later becomes apparent that Lucy's feelings for the doctor make her particularly vulnerable to his authority because she craves his approval. When she challenges him harshly during a personal discussion about his delusions toward Ginevra, Lucy immediately regrets angering him and vows to "expiate my culpable vehemence, or I must not sleep that night. This would not do at all; I could not stand it" (221). Dr. John remains detached and, when he does allow his personal interests to infiltrate medical encounters, they tend to serve his own vanity rather than the patient's best interests.

Lydgate, by contrast, manages to control the negative elements of his character in order to form respectful professional relationships, even friendships, with his patients. He possesses a natural warm-heartedness as well as the ability to share his authority, to better delineate personal and professional boundaries. Whereas

Brontë demonstrates the dangers of the doctor's unchecked, misused authority and clinical detachment, Eliot explores the potentially negative consequences of the doctor's sympathy and diminished, shared power. In their Introduction to *Feminism, Bakhtin and the Dialogic,* Dale M. Bauer and Susan Jaret McKinstry describe the benefits of dialogue between the public and private spheres. Recognition between the two realms is rare, but a dialogic approach is uniting: "The public sphere becomes alienated, atomized; the private sphere, a compensatory, but inadequate sphere. Feminists turn to Bakhtin's notion of the word and dialogue in order to break down this separation of public rationality and private intersubjectivity" (1). Because the "larger issue is the failure of a masculinized or rationalized public language (what Bakhtin would call the authoritative voice) that is split off in cultural representations from the private voice (Bakhtin's internally persuasive language) . . . a feminist dialogics would bring these two languages together in dialogue" (2). Eliot's fiction, like Brontë's, assumes contact between the professional or authoritative voice and the private voice. Despite speaking with a voice of professional authority, Lydgate often becomes emotionally attached to his patients and their pain, which makes him vulnerable to the private realm. Lydgate's wife becomes his patient, and he often attempts to give medical advice in the home. Not only does Lydgate, as a doctor and a husband, cast aside his own interests in order to tend to his wife's needs, but he also discovers that his professional authority is useless. In *Middlemarch*, Rosamond's private, feminine domain is not a "compensatory," sphere, healing and comforting in opposition to the harsh rationality of the masculine public sphere. Rather, Lydgate's medical voice, which itself embodies contradictory qualities of tenderness and

authority, meets the "silent obstinacy" of Rosamond's private domain. Eliot dialogize the feminine when she suggests that Rosamond, trained in the domestic arts, uses her feminine qualities of politeness and her fondness for intimate social gatherings to further her own plans within the public sphere of the community. Rosamond wears her acquiescing politeness as a mask to hide her true designs for social status; she operates by forming social connections with Lydgate's family and by manipulating the "public" financial affairs of her household. As a doctor, Lydgate finds himself mastered by the paradoxical combination of Rosamond's will and her weakness.

In their novels both Brontë and Eliot convey a similar model of patient care but have different opinions of the nineteenth-century doctor's ability to provide it. Brontë is not satisfied with nineteenth-century medicine or practitioners and constructs her narrative as an alternative to the doctor's inappropriate use of his authority. Lucy shares her authorial power with the reader through a narrative structure that requires the reader's point of view while challenging the power of nineteenth-century medicine to observe every aspect of her life and character. Unlike Dr. John, who does not grow, feel deeply for others, or strive for noble goals, Lydgate is presented sympathetically. He is not without his faults but suffers because of them, and the reader sympathizes with the pain the doctor feels when he is forced abandon his dreams. Lydgate corresponds with George Eliot's more positive view of nineteenth-century medicine because he combines his anatomical training with a willingness to listen to his patients' concerns and feelings; he shares the power his

medical knowledge affords him by providing patients with the information they need and by collaborating with them to arrive at appropriate diagnoses and treatments.

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