SILENCE AND PATIENTS

RESISTING MEDICAL DISCOURSE IN BRONTE, WOOLF AND DRABBLE

By

BARBARA JEANNETTE McLEAN, B.A. M.A.

A Thesis

Submitted to the School of Graduate Studies

in Partial Fulfilment of the Requirements

for the Degree

Doctor of Philosophy

McMaster University

RESISTING MEDICAL DISCOURSE IN BRONTE, WOOLF AND DRABBLE

DOCTOR OF PHILOSOPHY (1993) McMASTER UNIVERSITY
(English) Hamilton, Ontario

TITLE: Silence and Patients: Resisting Medical Discourse in Brontë, Woolf and Drabble

AUTHOR: Barbara Jeannette McLean, B.A.
(Sir George Williams University)
M.A.
(University of Guelph)

SUPERVISOR: Professor Mary O'Connor

NUMBER OF PAGES: v, 314

ABSTRACT

This thesis investigates nineteenth- and twentieth-century medical discourse in treatises and texts written by doctors, and women's resistance to it in novels by Charlotte Brontë, Virginia Woolf, and Margaret Drabble. My analysis involves what is said and not said in medical texts; what other discourses influence medicine; the authority of the medical writer; and the power of the institution of medicine. I extend Foucault's theory of the formation of medical discourse by looking beyond madness to physical pathology, and by including issues of gender.

Women's novels, particularly in the nineteenth century, must do all the work of the larger canon of writing available to men. Until recently, women could not write back against medical discourse in text books or scientific journals: fiction was their primary genre. Patricia Yaeger suggests that much American feminist work has encouraged acceptance of 'the inevitability of women's disempowerment" rather than revealing "the woman writer's powers of protest and change." Building on Yaeger's work, I explore the discursive possibilities of Brontë, Woolf and Drabble rather than their limitations.

I investigate the narrative strategies which enable both an outward silence which sounds like acquiesence, and an inward voice which actively resists the social constructions

of medical discourse. The novels all feature doctors as imposing characters, all portray the power medicine wields, and all address the social implications of medical discourse on the construction of women. There is a progression in narrative methodology moving from apparent silent acquiescence to medical power in *Villette*, through couched derision against medicine in *Mrs Dalloway*, to open verbal resistance to medical authority in *The Millstone*. My analysis concentrates on the discourse of resistance formed by women writers against the discourse of medicine. This response slowly moves from an emphasis on silence towards the acquisition of voice.

ACKNOWLEDGEMENTS

My special thanks go to my supervisor, Professor Mary O'Connor, for her unfailing assistance and support, and for the encouragement she has given me to make my own discoveries. I would also like to thank my committee members, Professor Joan Coldwell for her kind help and support, and Professor James King for his excellent assistance and interest.

I also acknowledge Dr Thomas Wilson, for his dedicated technical help and personal encouragement, and my sisters, for inspiration and support.

TABLE OF CONTENTS

INTRODUCTION

I advise maidens who suffer from hysteria to marry as soon as possible. For if they conceive, they will be cured. (Hippocrates 460?-377? BC)

Woman is a pair of ovaries with a human being attached; whereas man is a human being furnished with a pair of testes. (Dr Rudolph Virchow 1821-1902)

The unpalatable truth must be faced that all postmenopausal women are castrates. (Dr Robert Wilson 1966)

I adore the heated capaciousness of women--women in whose penetralia is found the repository of existence. I would have them glory in that. (Dr Richard Selzer 1974)

For centuries, physicians have stridently been advising, analyzing, proscribing and describing women. In this thesis I interrogate and investigate nineteenth- and twentieth-century medical discourse in treatises and texts written by doctors, and women's resistance to it in novels by Charlotte Brontë, Virginia Woolf, and Margaret Drabble. This study is about both medical discourse, its specific authority and influence on women, and the response to it in women's writing.

I have chosen Brontë, Woolf and Drabble in this investigation because in their work they respond to particularly important historical events in both the professionalization of medicine and the implementation and authorization of specific medical methods and practices. Brontë's writing, in the second half of the nineteenth

century, occurs when medicine was beginning to form a professional institution, was creating its own regulatory body in Britain, and was organizing itself as a powerful authority. Woolf, writing in the early twentieth century, responds to the firmly established authority that medicine had achieved by that time, both legally and in the eyes of society. Drabble, writing in the late twentieth century, presents and reacts to medicine in a manner which suggests that the authority and power of medical discourse are about to change, that medicine is becoming subject to open criticism and is beginning to move towards accountability.

Any study of medical discourse must look to the important work done by Michel Foucault, particularly in *The Archaeology of Knowledge; Madness and Civilization: A History of Insanity in the Age of Reason; The Birth of the Clinic: An Archaeology of Medical Perception;* and *The History of Sexuality.* Foucault asserts that "it is in discourse that power and knowledge are joined together," that discourse is not static, but constantly open to change. Discourse involves "a multiplicity of discursive elements that can come into play in various strategies," and it is these strategies which we must reconstruct in order to understand power relations. According to Foucault's theory, we must look at

> things said and those concealed, the enunciations required and those forbidden...with the variants and different effects--according to who is speaking, his position of power, [and] the institutional context in which he happens to be situated-- (*History* 100)

An analysis of medical discourse, then, involves looking at what is said in medical texts, and what is left out; what other discourses intersect and influence medicine; the authority of the medical writer; and the power of the institution of medicine at the time.

In *The Archaeology of Knowledge*, Foucault uses medicine as an example of his theory of discourse formation. He states that what appeared to happen with the nineteenth-century creation of the institution of medicine was the presentation of

> a corpus of knowledge that presupposed the same way of looking at things, the same division of the perceptual field, the same analysis of the pathological fact in accordance with the visible space of the body, the same system of transcribing what one perceived in what one said (same vocabulary, same play of metaphor); in short, it seemed...that medicine was organized as a series of descriptive statements...(33)

Nevertheless, he argues that, conversely, like all discourses, medical discourse is created from not one entity, but from various and divergent elements: "the descriptive statement was only one of the formulations present in medical discourse" (33) which is in play with "observations mediated through instruments, the procedures used in laboratory experiments, statistical calculations, epidemiological or demographic observations, institutional regulations, and therapeutic practice" (34).

As well as mediating and being influenced by scientific observations and calculations, nineteenth-century medical discourse, according to Foucault, is affected by the discourse

of other important institutions in society, such as the law, religion, art and literary criticism. These discourses, he claims, intersect and interact in forming the definitions, the names, and the criteria for conditions such as madness.

Foucault's model, while excellent, overlooks the special status of gender.[1] Also, as presented in *The Archaeology of Knowledge*, and *Madness and Civilization*, the model considers mental illnesses almost exclusively--illnesses which come under the combined jurisdiction of medicine and law--and thus his model deflects the investigation of medical discourse away from the unique position medicine maintains with physical pathology. The neglect of gender, and the concentration on mental rather than physical illness, are issues which are intimately connected in two distinct ways. First, much of what is considered madness in both the nineteenth and twentieth centuries is gendered by medical discourse,[2] and second, many of the manifestations of mental illness are designated as physical by medical discourse.[3]

I extend Foucault's theory of the formation of medical discourse by looking beyond madness to physical pathology, and by including issues of gender. As Foucault makes clear, the judiciary, religion, art and literary criticism are some of the institutions which inform medical discourse:

> The relation between the filter formed by judicial interrogation, police information, investigation, and the whole machinery of judicial information, and the filter formed by the medical questionnaire, clinical examinations, the search for antecedents, and biographical accounts. The relation between the

> family, sexual and penal norms of the behaviour of individuals, and the table of pathological symptoms and diseases of which they are the signs. The relation between therapeutic confinement in hospital (with its own thresholds, its criteria of cure, its way of distinguishing the normal from the pathological) and punitive confinement in prison (with its system of punishment and pedagogy, its criteria of good conduct, improvement, and freedom). (44)

Discursive methods from law, religion, art, medicine, the family, and other institutions all contribute to what Foucault calls the formation of objects (44); what is depicted in art, for instance, is internalized by medicine and adds to the picture medicine paints in its own description of madness, but art also has its own direct influence on the public formation of what madness is.

In the realm of physical pathology, however, medicine is unopposed. Although I do not dispute the fact that medical discourse is formed and influenced by many institutions outside medicine, and that the discourses of such organizations as the judiciary and religion reinforce each other, I believe it is important to point out the specific hegemony medicine holds over illness of the body. When dealing with physical ailments, no other institution in modern Western society has the authority of medicine; its struggles are contained within the profession, and its discursive pronouncements are difficult to dispute. Thus, by virtue of its specialized knowledge, which until recently was unavailable outside the profession, medical discourse occupies a strong place of power.

Discourses of other institutions, such as religion, are appropriated by medicine. Religion and medicine connect, as Foucault points out, because of the shared function of clergy and physicians in "the consolation of souls and the alleviation of pain" (*Birth* 32). However religion, like nineteenth-century medicine, is a gendered institution, which excludes women from positions of authority and determines women's position in society. In its ability to pontificate, medicine, like religion, is able to contain women within a strict framework of what is deemed medically normal and socially acceptable.[4] Medicine and religion could also conspire to control the treatment of women, particularly with respect to obstetrics.[5] Although the discourses of religion and medicine interact, religious doctrine may be invoked or overruled by medicine because the doctor has the ultimate authority over the ailing body.

Likewise art is appropriated by medicine to portray physical pathology. Although depictions of madness and illness operate outside of medicine, art, in medical drawings and models, is central to the teaching and presentation of medical conditions within the profession, and thus has particular power in medical discourse quite apart from its public role. Once again, gender is crucial in this aspect of medical discourse; historical medical drawings and models impose specific ideologies on women. From the obstetrical drawings overseen by the surgeon William Smellie and those

drawn by the anatomist William Hunter in the eighteenth-century which depict women as antagonists to the process of birth,[6] to the gendered nineteenth-century wax anatomical models described by Ludmilla Jordanova in *Sexual Visions*, 1989, medicine has used art as a vehicle for presenting not just pathology, but for delineating and describing women both as objects and as passive sexual beings.[7]

By intersecting with other discourses, and absorbing discursive elements from other institutions into its own realm, medical discourse has the capacity to create and sustain power and authority, particularly, as I indicate, over the formation of the subject of the female patient. Assuming the judicial model of discipline and incarceration, medicine can impose punitive treatment and separation, not just for mental illness, as Foucault asserts, but also for physical manifestations of disease.[8] Using religious doctrine and pontification, medicine can make life and death decisions and impose its own ideology. Incorporating art and literary metaphor into its professional texts, medicine can influence the social construction of its patients, a fact that is particularly important for women, as will become evident in this thesis.

In *The Birth of the Clinic: An Archaeology of Medical Perception*, Foucault analyzes the importance of the medical gaze which in the nineteenth century was "justified by an institution...with the power of decision and intervention"

(89). In this text he extends his theory to physical pathology and delineates nineteenth-century medicine's emphasis on normality, a state which could be determined by medicine's intelligent perception of signs and symptoms. By neglecting gender in his assessment, however, Foucault does not recognize that normality is perceived differently depending on sex. Medicine, as I point out in chapter one, based its concept of normal on a masculine model. This crucial detail determined that women were defined as abnormal by nineteenth-century medical discourse, and thus were more likely than men to be diagnosed as ill.[9]

In his analysis of signs and symptoms, Foucault again leaves out the issue of gender, which I contend is crucial to the power of medical discourse over women. According to Foucault:

> Signs and symptoms are and say the same thing, the only difference being that the sign *says* the same thing that *is* precisely the symptom. In its material reality, the sign is identified with the symptom itself; the symptom is the indispensable morphological support of the sign. (93)

What Foucault does not address is that in medicine signs and symptoms are different. According to medical terminology, symptoms are experienced subjectively by the patient, and signs are outward manifestations of disease which are to be interpreted objectively by medical perception.[10] Symptoms need not be evident to the medical gaze, whereas signs ar available to medical perception and interpretation. Foucault optimistically suggests in this analysis that symptoms are

always accepted by physicians as real and that, according to the calculating gaze of medicine (as ascribed by medical discourse), can be read through signs. By failing to take gender into account, Foucault overlooks the negative attitude of male medicine to female experience.

Foucault gives us the history of dominant discourses but fails to provide us with a theory of discourses of oppressed groups such as women. There is a gap between women's experience and the discourse they have available to describe it. If the hegemonic discourses of patriarchal institutions such as medicine, the judiciary, and religion are the only discourses women have to define themselves, women's experience is then mediated through patriarchal structures. If women have no language of their own to discuss their experience, then they must fit their discussion of their symptoms into the discourse of medicine which defines them and interprets them. If women's symptoms do not fit the doctor's interpretation of the signs they manifest, there is a gap between what women experience and the language medicine uses to interpret their disease. The crucial problem is one of recognizing the limitations discourses about women impose on the expression of women's experience, and the recognition of who is reading the symptoms and the signs of illness in women.

As I show in my investigation, doctors often did not accept the symptoms women presented to them. When symptoms were not accepted as real, signs were often disregarded or

misinterpreted.[11] For women patients, therefore, signs and symptoms could be very different from each other. As my analysis of medical texts makes clear, medical discourse encouraged the questioning of women's credibility, which in turn discouraged the accurate interpretation of signs of their illness.

In my analysis of medical discourse, I explore the combination of power and knowledge that Foucault alerts us to, acknowledging that "where there is power, there is resistance" (*History* 95).[12] My focus, however, extends beyond Foucault's theory to the problem of gender in resistance.[13] Medicine is a patriarchal institution and, as Chris Weedon points out, a patriarchal relationship "refers to the power relations in which women's interests are subordinated to the interests of men" (2). Because medical knowledge is produced within a patriarchal institution, it is difficult for women to oppose it from their subordinate position. Significantly, Foucault also claims that

> discourse can be both an instrument and an effect of power, but also a hindrance, a stumbling-block, a point of resistance and a starting point for an opposing strategy. Discourse transmits and produces power; it reinforces it, but also undermines and exposes it, renders it fragile and makes it possible to thwart it. (*History* 101)

In my study I explore Foucault's concept of resistance discourses, but I focus on the specific struggles of women by examining strategies some women use to write against the power and authority of medicine.

Although Foucault does not address gender issues, his theories work well with feminist criticism[14] and share many of the same concerns.[15] Chris Weedon encourages feminist critics to use Foucault because his focus on history leads towards a theory which is "able to address the questions of how social power is exercised and how social relations of gender, class and race might be transformed" (20). By putting "experience into historical context," Weedon claims, that Foucault lets us determine that women's experience is formed by outside influences of "ideology and history and context" (125). Weedon's assertion raises again the question of whether women can have experience which is outside of the patriarchal discourses which they must use to describe it. Not only do we need to understand the formation of the female subject by discourse and power relations, we also need to find ways of recognizing resistance to the discourses which have disempowered women.[16]

With respect to medicine, although there is a large body of feminist criticism, little work has been done on women's resistance to medical discourse. There are numerous valuable studies of women and medicine, but they tend to concentrate on the problems of oppression and detail the structures in medicine which contain women;[17] they offer little analysis of ways in which women work against medicine's power.[18] Such works as *Complaints and Disorders: The Sexual Politics of Sickness* by Barbara Ehrenreich and Deirdre English, "'The

Fashionable Diseases'" by Ann Douglas Wood, and *The Nature of Their Bodies* by Wendy Mitchinson, are, however, extremely valuable in setting up the historical production of illness in women.[19] They identify an invalidation of women through the social construction and economic exploitation of illness. In these studies, with some variation, medicine is viewed as an enemy against women, and treatment is recognized as punishment.[20] As Ehrenreich and English point out, although the "doctors' view of women as innately sick did not, of course, make them sick, or delicate, or idle....it did provide a powerful rationale against allowing women to act in any other way" (22).

Using these historical medical studies as a base for my investigation, I extend their analysis of medicine and medical discourse to professional medical texts, and go on to reveal what Foucault calls "reverse discourse" (*History* 101)[21] in novels in which women writers fictionally represent medical oppression. The feminist histories of medicine are particularly important to my work as they align with the Brontë and Woolf novels in the maladies and treatments they represent and give a historical grounding for the resistance I detect.[22]

Feminist criticism of aspects of current medical practice and language are useful for my study of the extension of nineteenth-century medical discourse into the twentieth century, particularly with respect to my work on Margaret

Drabble. Many recent studies of medicine and women offer a reverse discourse by detailing problems with oppressive medical treatments and language and presenting a critique of medicine. Other texts, such as *Our Bodies, Ourselves,* 1971, and *The New Our Bodies, Ourselves*, 1992, concentrate on helping women empower themselves to maintain control in their dealings with the medical system.

Traditional medical histories typically valorize famous doctors of the past.[23] Nevertheless, when physicians and health care critics question medicine's methods they also offer a reverse discourse from which resistance can be established. Most of the criticism from within medicine is very recent, however, and is still considered to be radical by most of the medical profession.[24] Ann Dally, a contemporary British physician, in her 1991 book *Women Under the Knife*, gives both a biting critique of misogynistic surgical practices and a defense of surgeons whose main intention, she claims, was to alleviate suffering. As a practising physician, Dally attempts to denounce doctors' methods while defending their motivations, and her argument seems coloured by a conflict of interest. Although she does provide much damning information about the medical profession's treatment of women, she also critiques writers like Ehrenreich and English for writing histories of medicine which are "inaccurate through lack of medical knowledge" (xxii), thus reasserting the authority of medical discourse and protecting

the profession from external critique. Nevertheless, struggling discourses within medicine pave the way for resistance from inside and outside the profession.[25]

Medical language and narratives have often been examined and denounced as sexist,[26] elitist and distancing. Mary C. Howell, a physician, in her article "What Medical Schools Teach About Women," published in the prestigious *New England Journal of Medicine*, notes that medical school lecturers routinely refer to patients by the male pronoun unless they are "discussing a hypothetical patient whose disease is of psychogenic origin [in which case] the lecturer often automatically uses 'she'" (305).[27] By addressing the implications of gender inequities in medical language, Howell produces a contesting discourse within the institution of medicine.

Other critics have recently admonished doctors for using language which is so technical and specialized that patients cannot understand their own conditions. This criticism examines the antagonistic relationship which can build up between physicians and patients, and explicitly names technical language as a site of power in medical discourse. Diane Johnson, in her article "Doctor Talk," suggests that when doctors lost Latin as their elite language, they came up with a new secret code "to conceal the nature of our afflictions and the ingredients of cures" (396). By using a "strange argot of Latin terms, new words, and acronyms,"

physicians, according to Johnson, speak a confusing language which is "comprised almost entirely of numbers and letters" (397).[28]

Patients are even further distanced from medicine by a professional narrative which reifies the patient in the case history into a diagnosis. Kathryn Montgomery Hunter, in *Doctor's Stories: The Narrative Structure of Medical Knowledge*, critiques twentieth-century medicine for its dismissive manner of reducing the patient's experience of illness to "an objectified disease" (135) and recognizes the importance of the "possession of the story of illness [as being] 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" (13). By recognizing strategies of elitism and distancing in medical language and narrative, these critics also create a contesting discourse.[29] They do not, however, address the possibilities of how patients resist.

In my examination of nineteenth- and twentieth-century medical texts, my findings corroborate the existence of sexist, elitist and distancing medical language. Further, I find extensive evidence of the social construction of women. Some of the critics of modern medicine touch on this element, particularly Deborah Findlay in her examination of Canadian gynaecology texts and journal articles of the 1950s, and Diana Scully in her article, "A Funny Thing Happened On The Way To

The Orifice," which analyzes gynaecology texts published in the United States between 1943 and 1972.[30] The historical critics of medicine, however, while often suggesting that physicians had an important role in establishing health and behavioral norms for women, and focusing on nineteenth-century medicine's obsession with women's reproductive function,[31] do little textual analysis for evidence of medicine's discursive strategies.

There are critics who convincingly argue that science, particularly biology, plays a key role in the historical production of society's expectations of women. Maintaining that science has proclaimed an "objective, value-free stance" (Bleier 4), these critics point out that scientific discourse traditionally disregards the very possibility of bias. Thus, a woman was described in the nineteenth century on the basis of what was considered to be irrefutable scientific evidence; when woman is "defined biologically to be a mother and a wife" she is expected by society to be "nurturing, passive, dependent, weak, intuitive, non-intellectual, and asexual" (73). Women were studied in terms of their difference from men,[32] and nineteenth-century scientists "interpreted these differences as reasons to disqualify women on scientific grounds from participating in their world" (Hubbard 40).[33] This model of "pure objective evidence" is difficult to resist, and critics Ruth Bleier, Cynthia Russett and Ruth Hubbard concur that it is the model, rather than the

pronouncements which must be redefined. They agree that science is not, *de facto*, value free, that bias is inherent in scientists, and that gender bias was pervasive in nineteenth-century scientists which resulted in the positioning of "women and men not only as opposites," but as elements of a subordinate/dominant relationship (Bleier 197).[34]

The social definition of women is a problematic issue for feminist theorists and the question is central to women's ability to resist patriarchal discourse. Most agree that women have been historically defined by men, but there is some dissent as to whether women should take over the process of definition, or move away from it altogether. Cultural feminists such as Adrienne Rich and Mary Daly believe that women must create a reverse discourse in which the very qualities which science and medicine have used to subordinate women are re-evaluated as a source of women's power (Alcoff 300). Taking the same discourse which has been used to subordinate women, they reverse its meaning to valorize what they see as positive natural qualities. They see woman's nurturing capacity as an innate quality which, rather than keeping women from a position of power, can lead towards world peace. Annette Kolodny praises feminist critics who have alerted us to a feminist literary tradition, Patricia Spacks, Ellen Moers, Elaine Showalter, Sandra Gilbert and Susan Gubar, specifically because they help us to recognize and comprehend "the unique literary traditions and sex-related contexts out

of which women write." When Kolodny suggests that "the lying-in room, the parlor, the nursery, the kitchen, the laundry" ("Dancing" 155) are "sex-related contexts," she neglects to differentiate between what is imposed by sex and what is imposed by gender. In all but childbirth, the areas of the house Kolodny claims to be female relate to what is expected of women rather than what is determined biologically. Kolodny risks absorbing the male definition of women by not addressing the ideological issue of women's physical place. It is surely women's social and gendered construct, rather than her biology, which places her in the home. I concur with Alcoff that any attempt to delimit women to the ability to nurture, or to specific household tasks, invites an essentialist concept which threatens to "'tie' the individual to her identity as a woman" (305), restrict her, and limit her possibilities of resistance to the patriarchal system.[35] If, however, a woman embraces difference and "dodges all attempts to capture her" (Alcoff 307) in a definition, she will be able to break out of the hierarchical structure and resist it from her position outside.

In my analysis of resistance in the novels I present, I detect women characters struggling against the definition and subjectivity that medical discourse imposes. Rather than concentrating just on their marginality, I look for ways in which these characters transcend their oppression and form a tradition of working against it. Through the act of writing,

women authors resist their definition as dependent beings, for, as Myra Jehlen points out, the "proposal to be a writer in itself reveals that female identity is not naturally what it has been assumed to be" (79) by the patriarchal construct. Judith Kegan Gardiner sees a woman writer using a "process of testing and defining various aspects of identity" involving the author's "own self-definition and her empathic identification with her character" (187) which often "does not conform to the generic prescriptions of the male canon." Gardiner equates this non-conformity with what she calls "the fluid and flexible aspects of women's primary identities" (185), an explanation which reverts to the definition of an essential woman.

On the contrary, I would suggest that women's novels, particularly in the nineteenth century, must do all the work of the larger canon of writing available to men. Until recently, women could not write back against scientific or medical discourse in text books or medical or scientific journals: fiction was their primary genre.[36] Although Anita Levy, in her study, *Other Women: The Writing of Class, Race, and Gender*, is undoubtedly correct when she claims that nineteenth-century fiction naturalizes and popularizes "cultural categories imagined within the human sciences" (120), I believe the novel can also set up a strong opposing discourse to science and is therefore one appropriate place to search for women's written resistance to medical discourse.

SILENCE:

My analysis of medical writing indicates that medical discourse is a powerful agency which silences women by its definition and construction of gender. To speak out can be dangerous for women patients. As I discuss in the following chapters, when a woman speaks out she may find herself incarcerated or put to bed for hysteria, she might not be believed and therefore misdiagnosed and poorly treated, and in the nineteenth century, she was at risk of having her tongue surgically altered to silence her.

Women's silence is recognized by feminist analysis as both a debilitating impediment and a resisting strategy. Part of the cultural and historical definition of women is that they "should be seen and not heard" (Belenky *et al* 5), and when silence inevitably results, it is used against them as an indication of their "powerlessness, subjugation and inadequacy" (188). Many studies have been conducted which prove that women are silenced by men,[37] and contrary to cultural expectations, no studies give "evidence that women talk more than men" (Spender 41). The very fact that women write indicates that this imposed silence is overcome in literature, but the impediments they face to both writing and being published suggest that women are often discouraged from attaining voice as authors.[38] Despite these restraints, women

have used elements and aspects of silence within their writing to resist their oppressors.

Silence is used in disparate ways by women writers to resist various patriarchal structures including medical discourse. Subtextual messages can be determined from silences in the text in the sense of what is left out, what is not said. Reading between the lines, interrogating gaps and displacements, and interpreting ellipses and metaphors can all lead the reader to the veiled voice beneath the outward silence on particular issues or topics in a woman's text (Greene and Kahn 99-100). Women writers may disguise their resistance in the silence of the interstices of the text or through "the breaking of taboos and the exploration of...anti-patriarchal relationships" (99). Problematically, this use of silence is manifested in a strategy of covert writing and risks not being heard at all. The struggle against medical discourse in "The Yellow Wallpaper" by Charlotte Perkins Gilman, for instance, was not heard when it was first published. The story was received as a lone feminine "continuation of the genre popularized by Poe" (Kolodny "Map" 50). It was thus discarded, "quickly relegated to the backwaters of our literary landscape" (54) where for many years it could not resist anything at all.

Hidden resistance is superficially silent to the discourses which have power over women. Sandra Gilbert and Susan Gubar suggest that the very act of a woman writer confronting "her

own femaleness and the patriarchal nature of the plots and poetics available to her as an artist" may cause her to be "struck dumb by what seem to be irreconcilable contradictions of genre and gender" (71), and thus she buries her resistance in a palimpsest, "simultaneously conforming to and subverting patriarchal literary standards" (73). Such a palimpsest might never be uncovered by the reader; if resistance is very faint, it might never be heard at all.

Nevertheless, silence also has the potential to empower. According to Bauer and McKinstry, "speech is not always a sign of power, or silence a sign of weakness" (3). Rather, it is "the contexts of silence and speech [which] determine gender relations" (3). Silence can be used by the powerful as another form of domination, and as my research indicates, physicians sometime use silence as power. Whereas doctors are expected to diagnose (to know and to tell) and women patients are expected to listen (to learn and to follow advice) this can be reversed, as in the case of a ranting hysteric who is opposed by the icy silence of a calm practitioner.[39] Silence can also be used by the oppressed as a form of resistance. For "resistance can begin as private when women negotiate, manipulate, and often subvert systems of domination they encounter" (3).

Rather than looking for deeply covert and quietly hidden resistance in the silent spaces of a text, my method is to examine strategies which allow characters to react silently

in dialogue, but speak out in other narrative aspects of the novel. Patricia Yaeger suggests that much of the American feminist work has encouraged us to accept "the inevitability of women's disempowerment" rather than looking for "the woman writer's powers of protest and change." Building on Yaeger's work, I explore the discursive possibilities of Brontë, Woolf and Drabble rather than concentrate on their "limitations" (18). As well, I trace a progression in their works in which the silence in dialogue turns into voice; the resistance moves from the narrative engagement with the reader in Brontë and Woolf to a position directly between characters in Drabble. Yaeger's assertion that "women writers have incorporated men's texts into their own and entered into dialogues with these texts that these male writers have refused to initiate" (30) has particular significance for my investigation of medical discourse. The novel is the perfect place--perhaps until recently the only place--for women writers to speak back to medical texts and medical treatments, and if women characters cannot achieve any power or voice with physician characters in the dialogue of the text, they can and do resist in the silent narration of their inner thoughts. Silence, in this case, is an outward silence to the physician and the patriarch within the novel, paired with a contradictory response spoken directly to the reader. Yaeger suggests that the techniques available in a novel form what she calls a "multilanguagedness" in which the writer can "interrogate

and...challenge the very voices that tell her to conform" (59). This study investigates the narrative strategies which allow for the presentation both of an outward silence which sounds like acquiescence and the inward voice which actively resists the constraints and social constructions of medical discourse.

In chapter one I investigate Victorian medical discourse through the rise of the profession in the latter half of the nineteenth century. I examine the structure and boundaries of medicine as an institution and outline the rising authority of its discourse in the late decades of the century. I locate medicine's position as a powerful agent of scientific discovery and as a producer and enforcer of social mores, particularly for women.

My following three chapters deal with the presentation of medicine in fiction and the response to it in novels by women writers. Chapter two is an analysis of Charlotte Brontë's *Villette*, chapter three concerns Virginia Woolf's *Mrs Dalloway*, and chapter four looks at Margaret Drabble's *The Millstone*. All three novels feature doctors as imposing characters, all three portray the power medicine wields at the specific times they are written, and all three address and reflect the social implications of medical discourse on the construction of women. These novels represent a tradition in their employment of narrative strategies to resist the

authority of medical discourse. They form a progression in narrative methodology which moves from apparent silent acquiesence to medical power in *Villette*, through couched derision against medicine in *Mrs Dalloway*, to open verbal resistance to medical authority in *The Millstone*. My analysis, therefore, concentrates on the discourse of resistance formed by women writers against the discourse of medicine. This response slowly moves from an emphasis on silence towards the acquisition of voice.

My final chapter briefly investigates women in medicine, both real and in fiction, from the middle of the nineteenth century to the present. From Brontë's Shirley, who abhors patriarchal medicine and treats her own illness, through the physician Peggy in Woolf's *The Years*, to the psychiatrist Liz Headleand in Drabble's recent trilogy, I look at the struggle of women within a patriarchal institution, investigate their resistance to historic medical discourse, and look towards the possibility of change which their own evolving discourse promises to bring.

NOTES

1 In *Foucault and Feminism*, Diamond and Quinby address concerns that Foucault neglects to examine the gendered aspects of language and its relations to discourse and power which has a profound and negative affect on women, and Alcoff in "Cultural Feminism Versus Post-Structuralism: The Identity Crisis in Feminist Theory," notes that Foucault is "notorious for not including gender as a category of analysis" (310).

2 For a detailed look at ways in which medicine ascribes madness specifically to women, see *Women and Madness* by Phyllis Chesler 1972, and *The Female Malady* 1985, by Elaine Showalter.

3 As an example see Fritz Wengraf, *Psychosomatic Approach to Gynecology and Obstetrics*, 1953.

4 Janice Raymond, in her article "Medicine as Patriarchal Religion," in the May, 1982 issue of the *Journal of Medicine and Philosophy*, points out that medicine is like a "patriarchal church--that is centred on male myths, minister, and ministrations" (197). She claims: "Medicine is religious in the sense that it raises questions of 'ultimate concern' and meaning for women's lives, i.e., questions of bodily and spiritual integrity" (198-99), as well as using "apocalyptic images and warnings" (199) to make patients follow orders (particularly women, who, she notes "visit doctors almost twice as often as men" (198)). According to Raymond, medicine also claims that healing is restricted to those who attend qualified licensed practitioners, just as salvation in the Roman Catholic church is restricted to those who stay within the tenants of the church (209).

5 Decisions, for instance, of whether to save the child or the mother in a difficult birth were frequently taken by the physician rather than the clergyman. W.S. Playfair, in *A Handbook of Obstetrical Operations* 1865 describes the actions of a Dr Radford who would abort a woman once for a case of severe pelvic disproportion, "but if, in spite of due warning, a second pregnancy occurred, he would spare the life of the child, and subject the mother to the risk of Caesarian section" (8), an operation that carried a 70% risk of maternal mortality in the 1860s (Mitchinson 217). Radford may have been motivated by the religious doctrine of saving the soul of the infant. However, his method involves not only making a god-like decision, but imposing a dire penance on the woman for what he considers a sexual transgression--despite the possibility that her pregnancy could likely only have been avoided (in the days before birth control) by abstinence, a situation over which she may have had little control.

Playfair is not affected by such religious doctrine, and disagrees with Radford's actions. He encourages abortion in such cases to save the life of the mother. The issue of choosing whether to save the mother or the baby, although critical well into the twentieth century, is unlikely to arise with current medical technology. Lynne Tatlock, in her article "Speculum Feminarus: Gendered Perspectives on Obstetrics and Gynecology in Early Modern Germany" in *Signs* 1992, compares the management of obstetrics in 18th-century Germany by female midwives, who work for the birthing woman, and see their job as the deliverance of the mother, and male physicians, who focus on delivering the baby. She points out that male physicians may be upholding religious doctrine to save the soul of the child and sacrifice the mother (757).

6 Andrea Henderson, in her article "Doll-Machines and Butcher-Shop Meat: Models of Childbirth in the Early Stages of Industrial Capitalism" in *Genders*, 1991, describes the famous 18th-century creator of obstetrical forceps, William Smellie, and his depiction of birth as a mechanical process. He hired artists to create engravings which portrayed women only as bony pelvises: "rigid, mechanical objects that are discussed primarily in terms of the negative, obstructive role they tend to play in the delivery process." Henderson's point is that a woman, by this artistic depiction, has no role in the production of a child, but rather she appears "only as a machine--and an oddly inactive and poorly constructed one at that." Smellie's book of engravings, *Set of Anatomical Tables*, introduces to his medical readers the forceps he has invented which are depicted as "extensions of the male hand that themselves enclose the infant in order to free it from enclosure in the pelvis" (103). The birthing woman, in his artistic representation, is constructed only as an object of resistance to the process of medical delivery of the baby. In her analysis of the 18th-century anatomist William Hunter, Henderson points out that the women's torsos he depicts are cut off at the thigh in cross-section, with anatomical precision: their legs look like cuts of meat. Conversely, the babies in utero are presented as fully formed and beautiful: "these unborn infants tend to lack the distorted heads and limbs that we generally associate with babies even after birth" (109). What this presentation produces is a dehumanizing aspect to the mother, a "compensatory animalization [which] lends the maternal body a wild and grotesque quality that itself threatens the integrity and status of the child" (110). Both sets of engravings use art to depict women in opposition to the process of birth. They disempower women from their role as creators, they demote them to either a machine or a piece of meat, and they elevate the physician to the role of saviour of the precious and trapped baby.

7 Jordanova describes wax anatomical models used by anatomists and medical students which "lie [naked] on silk or velvet cushions, in passive, yet sexually inviting poses" (44) which are "adorned with flowing hair, pearl necklaces, removable parts and small foetuses" (45). These models, created specifically for medical training by medical artists, inscribe gendered qualities of sexual passivity to the female patient.

8 See Robert Brudenell Carter, *On the Pathology and Treatment of Hysteria* 1853, and S. Weir Mitchell, *Fat and Blood* 1877 for details of medical treatment of the physical aspects of mental illness in women.

9 Wendy Mitchinson, in *The Nature of Their Bodies: Victorian Women and Their Doctors*, 1991, claims: "physicians...used the male body and how it functioned as the norm by which to judge whether women were healthy or not" (12).

10 An example of a *symptom* would be the feeling of palpitations by a patient, which might be read by the physician through the *sign* of an irregularly beating heart.

11 In the July 22, 1993 issue of *The New England Journal of Medicine* Wenger *et al* address the continuing problem of the misinterpretation of women's symptoms. In spite of the fact that "heart disease is the most frequent cause of death among U.S. women, for whom it entails a worse prognosis than for men with both medical and surgical therapies [and that] the rate of early death after myocardial infarction [heart attack] is higher among women that among men," doctors continue to misperceive the importance of women's symptoms of chest pain:

> There is increasing evidence that women undergo intensive or invasive evaluations and treatments for cardiac diseases substantially less frequently that do men with symptoms of similar or lesser severity; this is particularly true for the evaluation of chest pain.

The article stresses the need to change "physicians' attitudes toward women patients and their symptoms" (247).

12 Jana Sawicki, in her article "Identity Politics and Sexual Freedom: Foucault and Feminism," encapsulates Foucault's definition of discourse "as a form of power that circulates in the social field and can attach to strategies of domination as well as to those of resistance" (Diamond and Quinby 185).

13 Although Foucault neglects gender, his theories can be used to explore this issue. As Chris Weedon notes:

> If Foucault's theory of discourse and power can produce in feminist hands an analysis of patriarchal power relations

> which enables the development of active strategies for change, then it is of little importance whether his own historical analyses fall short of this. (3)

14 Not all feminist critics agree. Nancy Hartsock, in "Foucault on Power: A Theory for Women?" feels Foucault's emphasis on resistance rules out the possibility for transformation. She sees women, through this theory, as always operating from a position of resistance rather than "creating alternatives" (172).

15 Diamond and Quinby, in their introduction to *Foucault and Feminism*, point out that both Foucault and feminism

> identify the body as the site of power....point to the local and intimate operations of power rather than focusing exclusively on the supreme power of the state....bring to the fore the crucial role of discourse in its capacity to produce and sustain hegemonic power and emphasize the challenges contained within marginalized and/or unrecognized discourses. And both criticize the ways in which Western humanism has privileged the experience of the Western masculine elite as it proclaims universals about truth, freedom, and human nature. (x)

16 This is an area in which Foucault needs to be extended, for, as Diamond and Quinby note:

> Although Foucault points to the ways in which rationalizing discourses suppress discourses of marginalized groups, and claims that such discourses are sites of resistance, his work only rarely attends to such discourses and virtually ignores those by women. (xvi)

17 John and Robin Haller give an excellent account of nineteenth-century medicine's inscription of women as intellectually impaired by their biology. Women's mental capacity was seen to be continually depleted by "the energy required for maternity and its attendant duties" (66). Menstruation, they point out, was believed to divert "blood as well as vital energy" and thus "any excessive brain activity by the woman brought inevitable suffering and degeneration to the reproductive organs" (59).

18 Mary Poovey, in "Scenes of an indelicate character: The Medical Treatment of Victorian Women," points out that because "the right to write about the body belonged to men at midcentury and to the medical expert in particular" (43), women were excluded from the debate about the use of chloroform as anaesthesia in childbirth.

19 For more historical studies on women and medicine see: J.A. and Olive Banks, *Feminism and Family Planning in Victorian England*, which investigates issues of population

control and contraception and the effect of medicine's involvement in female fertility on women; Jane B. Donegan, *Women and Men Midwives: Medicine, Morality, and Misogyny in Early America,* in which she gives an account of the takeover of midwifery from women by medical men and outlines the oppressive effects on women; Barbara Ehrenreich and Deirdre English, in *For Her Own Good: 150 Years of the Expert's Advice to Women* which gives details of specific controlling treatments of women diagnosed with gynaecological and nervous complaints; Mary Poovey, *Uneven Developments: The Ideological Work of Gender in Mid-Victorian England* in which she analyzes the fiercely debated social issues around the introduction of chloroform as anaesthesia for childbirth; *Suffer and Be Still*, edited by Martha Vicinus, which has helpful articles on the Victorian approach to menstruation by Elaine and English Showalter, and the medical/legal approach to Victorian prostitution and sexually transmitted disease by E.M. Sigsworth and T.J. Wyke; and *The Female Malady* by Elaine Showalter which deals extensively with the historical construction and treatment of nervous diseases in women.

20 Ehrenreich and English, and Wood are unequivocal in presenting an antagonistic relationship between women and their doctors, whereas Wendy Mitchinson, although she deals with the punitive aspects of medical care, is much more willing to recognize the positive advantages of medical advances over the years to women's health.

21 Chris Weedon notes that institutions like medicine "are themselves sites of contest, and the dominant discourses governing the organization and practices of social institutions are under constant challenge" as they struggle with "more than one subject position. While a discourse will offer a preferred form of subjectivity, its very organization will imply other subject positions and the possibility of reversal" (109). Reverse discourse is the "first stage in challenging meaning and power, it enables the production of new, resistant discourses" (110).

22 Recent studies which criticize medicine's treatment of women are useful to the understanding of the continuing power of medicine on social conditions. Hilary Graham, in *Women, Health and the Family* 1984, points out that women's illnesses are much more frequently diagnosed as neurotic than men's and that women are prescribed twice as many mood-altering drugs (78). What might be diagnosed as "'job burn-out' for men, may be identified as depression in women" (81). Helen Roberts, in *The Patient Patients: Women and Their Doctors*, notes that women are "dependent on medicine and doctors for the most basic control of their bodies" (5); they "go to the doctors more often than men, they take more medicines than men, and they spend more time looking after other people's health than

men do" (2). Elizabeth Fee, in *Women and Health: The Politics of Sex in Medicine* 1983, emphasizes that physicians disregard "the relationship of medical ideas to their social roots" (217) and interpret socially produced concepts of women as natural. She advocates "the re-inversion of this process--making the 'natural' reappear as 'social'" (217).

23 Patricia Branca, in her text, *The Medicine Show: Patients, Physicians and the Perplexities of the Health Revolution in Modern Society*, argues that medical histories detail medical discoveries without examining their sociologic impact and assume that "since the discoveries were designed for society they automatically had positive social effects" (90).

24 The leading medical journals in Britain and North America continue to use male-inclusive language. There are new journals dealing specifically with women's issues, such as *The Canadian Journal of Ob/Gyn & Women's Health*, but they are reluctant to print provocative or clearly critical material. A recent review by Simmons in the Canadian journal, *Family Practice*, of Dr John M. Smith's new book, *Women and Doctors--A Physician's Explosive Account of Women's Medical Treatment--and Mistreatment in America and What You Can Do About It* rejects the book out of hand because of the "writer's slanted point of view" (72) without ever addressing the reviewer's (or the journal's) bias.

25 Robert Mendelsohn M.D., in *Male Practice: How Doctor's Manipulate Women* 1981 is one of the few unequivocal critics writing from within the profession. His book is scathing in its exposé of the American medical system and offers no defense for medical misogyny which he claims subordinates and overtreats women.

26 See Emily Martin, "The Egg and the Sperm: How Science Has Constructed a Romance Based on Stereotypical Male-Female Roles" for an analysis of the sexist narrative of conception which embodies culturally constructed gender roles with the egg as alluringly passive and the sperm as lasciviously active.

27 A more blatant example Howell gives of sexist medical language is of a lecturer saying to medical students: "The only significant difference between a woman and a cow is that a cow has more spigots" (305).

28 Johnson also points out that medical shorthand is specific even to medical specialties. Not only might the patient misconstrue the term SOB (shortness of breath), but the letters ID might be read as identification to someone non-medical, "Intradermal to the dermatologist, Inside Diameter

to the physiologist, Infective Dose to the bacteriologist; it can stand for our inner self, it can mean *idem* (the same), or it can signify a kind of rash" (398).

29 Sue Fisher, in *In the Patient's Best Interest: Women and the Politics of Medical Decisions*, examines the medical interview and points out the imbalance of the power relationship between doctor and patient. Whereas in normal conversations both parties can contribute to a topic or change it, in medical interviews "[p]atients are expected to answer questions and to provide information asked for...they are not expected to expand, amend, or disagree with the topic under discussion" (80). Her research shows that "doctors, the persons with authority, correct patients' pronunciation of medical terms, correct their understandings of their medical problems, and have the last word on the definition of the problem[s]" (74).

30 Findlay's work examines social influences on medical knowledge of women, and Scully and Bart outline the sexist approach of gynaecologists who "have tenaciously clung to the idea of the vaginal orgasm as the appropriate response and labelled 'frigid' and immature those patients who could not experience it" even twenty years after Kinsey had "debunked the myth of the vaginal orgasm" (1047).

31 Ann Douglas Wood in "'The Fashionable Diseases': Women's Complaints and Their Treatment in Nineteenth-Century America," notes that medical studies consistently leave out important health concerns regarding diseases like cancer and tuberculosis, but "concentrate on every type of menstrual and uterine disorder conceivable" (3); Jean L'Esperance in "Doctors and Women in Nineteenth-Century Society: Sexuality and Role" points to medicine's concern with "every activity [a woman] engaged in which might interfere with her primary biological purpose" (116); and Ludmilla Jordanova in *Sexual Visions* asserts that "gender is a central medical metaphor" (144), and that women, with their reproductive capability, are considered closer to nature than men (21). Jordanova also notes the nineteenth-century concept of 'Woman' which "conveyed the idea that all women, irrespective of class, race, creed or age, did indeed share certain essential characteristics" (8), specifically reproduction.

32 Thomas Laqueur, in *Making Sex: Body and Gender From the Greeks to Freud* 1990, notes that "the standard of the human body and its representations is the male body" (62), and Teresa de Lauretis, in "Feminist Studies/Critical Studies: Issues, Terms and Contexts," asserts that

> all accepted definitions of cultural, social, and subjective processes start from the same assumption: that sexual difference is the difference from man, the

> difference of woman from man--man being the measure, standard, or term of reference of all legitimated discourse. (12)

33 Women were prevented or discouraged from intellectual pursuits because science decreed that "exercising the female brain could drain limited energy from her true roles of reproduction and motherhood" (Bleier 2).

34 Bleier claims that science is not a "static entity" but "is socially influenced and defined" (52). Scientific language, she asserts, has the power to "create a particular reality or view of reality that the writer holds and intends through writing to convey" (195). Russett examines the way in which nineteenth-century "science was able to provide a newly plausible account of [woman's] inferiority" (206), and Hubbard states that this era "produced the natural and social scientists and philosophers who generated most of our present political and scientific ideologies" (35) which "maintain sexual inequality" (17).

35 Laurie Finke, in *Feminist Theory, Women's Writing,* points out that only by accepting the concept that gender is socially constructed can we move away from the model which condones women's oppression as "'natural,' the result of universal and immutable 'differences' between the sexes" (3).

36 Elaine Showalter notes that women were also "excluded by custom and education from achieving distinction in poetry, history, or drama" (*Literature* 4).

37 See Dale Spender, *Man Made Language;* Cheris Kramer, "Women's Speech: Separate but Unequal;" Nancy M. Henley, *Body Politics: Power, Sex, and Nonverbal Communication;* David Graddol and Joan Swann, *Gender Voices*; and Jean Bethke Elshtain, *Public Man, Private Woman: Women in Social and Political Thought.*

38 See Virginia Woolf, *A Room Of One's Own,* and Tillie Olsen, *Silences,* for discussion on the difficulties for women to write, and Elaine Showalter, *A Literature of Their Own,* with regards to problems with publication.

39 Robert Brudenell Carter, in *On the Pathology and Treatment of Hysteria* 1853, advises physicians to leave a hospitalized hysterical woman patient alone for the first day or two of her treatment and not to "give utterance to a single expression" about her affliction during that period (109-10).

CHAPTER 1

"THE PRIESTS OF THE BODY"[1]

VICTORIAN MEDICAL DISCOURSE:

THE PROFESSIONALIZATION OF MEDICINE:

The middle of the nineteenth century marked a significant change in the way medical practice was perceived in Britain. Doctors became professionals, and their discourse gained a sense of authority which continues to the present time. Concomitant with the rapidly expanding body of scientific knowledge, there were steady improvements in the standards of qualification, examination, and regulation which contributed to the power of medicine as an institution, and strengthened its authority as a social and political body.

Doctors gained the power to pronounce on social situations at this time, and women were most often the objects of their advice. Thomas J. Graham, for instance, in *On The Diseases of Females; A Treatise Describing Their Symptoms, Causes, Varieties, and Treatment* published in 1861, takes a didactic professional opportunity to denounce the social habits of society women to the practitioners and medical students who read his text:

> Females who live in towns, and who have frequent opportunities of engaging in the public pleasures of gay and fashionable society, exposed to all the temptations incident to the possession, or accessibleness, of whatever means may be calculated

> to exalt the imagination, to inflame the passions, and by excessive or too frequent indulgences, to abuse the appetites, are in most cases the subject of precocious, profuse, and morbidly irregular discharges. (58)

Graham clearly believes that he needs no further justification or evidence for his pronouncements than his own valued opinion as a physician. He uses his position as a doctor and his experience with female diseases to threaten women against personal indulgence. If they take too much pleasure, illness will result, and it will be sure to be foul and have embarrassing effects. I maintain that the professionalization of medicine in mid-century contributed extensively to the role physicians play, even up to the present, in dictating social behaviour, particularly in women.

Until the 1850s, medicine was deeply divided into three separate groups, physicians, surgeons, and apothecaries, and their training methods and responsibilities were diverse. Physicians traditionally had the most power, as they came from the upper middle classes, were university educated in the classics, and attracted wealthy patients. By the 1840s, however, apothecaries, who had some autonomous authority to prescribe medicines and dispense drugs, were dissatisfied with their subordinate position and fought to extend their powers of practice. To this end they improved their training by extending apprenticeship requirements to a full five years (Youngson 13) and added a mandatory "half-year's experience in an infirmary, hospital, or dispensary" (Haley 5). Surgeons

sought to increase their professionalization by instituting qualifying examinations in London in December 1844 (Cartwright 54). After that time surgery, and medicine generally, began its move from an empiric art to a scientific practice (134).

The two most important scientific discoveries which facilitated the shift towards power in medicine were inhalation anaesthesia in 1847 and antiseptic surgery in 1871 (Youngson 212). These innovations, along with the medical regulation of water and food supplies, advances in home and hospital hygiene and sanitation, plus better nursing care, brought about vast improvements in patient health and a corresponding elevation of the social status of doctors.

The 1858 Medical Act changed the organization of medicine. From a group of disconnected practitioners with various levels of ability and qualification, doctors were divided into those who could meet a standardized set of requirements and those who could not. The former were elevated to membership in a professional association and were recognized to practice medicine. The Act placed the Royal College of Physicians, the Royal College of Surgeons, and the Society of Apothecaries,[2] which were the licensing corporations of medicine, under the aegis of a new ruling body called the General Council of Medical Education and Registration[3] (Cartwright 56). Association under one governing agency united the three recognized aspects of medicine into an exclusive and professional group with complete control over patient

treatment.

The professionalization of medicine under the General Council served to supervise and control the education and assimilation of members into the profession and to protect the public from the danger of unqualified practitioners. As a result of consolidating doctors and controlling their education, medical teaching improved and the public was treated with greater consistency and skill (Haley 5). Before the formation of the General Council, variation in education and practice was great, and the resulting patient care was disparate and variable. Care improved as standards of teaching were imposed by the newly formed Council.

Standardizing education, overseeing examination, and reforming the organization of medical licensing bodies all contributed to the rise in the efficacy and effectiveness of medical treatment. Patients benefited from higher standards of qualification, from better government control over who could practice medicine and how, and from the rising spirit of co-operation which prevailed among the medical specialties. Although the general public certainly acquired better medical treatment through the professionalization of medicine and medical training, improved care was not the only motivating factor which led to the Medical Act. Apothecaries, surgeons, and general practitioners (who combined the skills of apothecaries and surgeons) sought the changes to allow them the same rights of practice enjoyed by university-trained

physicians. Professional amalgamation ensured elevated status and increased authority for members of the medical trades and brought them to the level of entitlement enjoyed by physicians, while at the same time the regulations served to exclude peripheral medical practitioners, midwives, and quacks.[4]

The struggle for power within the profession assured the exclusive nature of medicine. While the Royal Colleges and the Society of Apothecaries fought bitterly amongst themselves for place in the hierarchy of medicine, they were unified in their agreement to keep unqualified practitioners out. The Hippocratic Oath, as Cartwright points out, has at its core "a promise to support members of the group, to confine teaching of the art to a closed circle, and not to reveal the mysteries to anyone outside that circle." Therefore, "the Hippocratic Oath ensured a 'closed shop'" (41). Through its exclusivity, as protected by the Medical Act of 1858, medicine gained considerable power to produce a selective and authoritative scientific and social discourse.

By improving health care education and delivery, the Medical Act also institutionalized an exclusive body which had sweeping powers of control over patients. Doctors, like the judiciary, had the power to lock up the sick, the insane, and the medically dangerous; with their exclusive powers of diagnosis entrenched in 1858, they were unopposed by any other institution in their ability to impose treatment. Ironically,

the improvements inherent in the formation of the General Council, as well as protecting patients from dangerous unqualified medical care, laid the groundwork for another kind of debilitating and punishing institution.

The extent of increased power afforded medical practitioners can be explained, in part, by a look at the state of medical practice previous to amalgamation. The "system of treatment, taught in all medical schools in the 1830s and 1840s, recommended copious bleeding, violent purgatives, and poor liquid diet for almost every kind of illness or malfunction" (Youngson 18). Before the recognition of disease-causing agents, such as bacteria and viruses, treatment was basically antiphlogistic, based on methods which were thought to counteract inflammation and fever, either by the application of a counter-irritant or by alteration of fluids. Such treatments were not only ineffective; they were often horrific.

Surgery was particularly gruesome before the mid-century. Perhaps one of the most moving accounts of a surgical experience before inhalation anaesthesia is by Fanny Burney in her diary, describing her mastectomy in 1811:

> ...when the dreadful steel was plunged into the breast--cutting through veins--arteries--flesh--nerves--I needed no injunctions not to restrain my cries. I began a scream that lasted unintermittingly during the whole time of the incision--& I almost marvel that it rings not in my Ears still! so excruciating was the agony. When the wound was made, & the instrument was withdrawn, the pain seemed undiminished, for the air that suddenly rushed into those delicate parts felt like a mass of minute but

> sharp & forked poniards, that were tearing the edges of the wound--but when again I felt the instrument--describing a curve--cutting against the grain, if I may so say, while the flesh resisted in a manner so forcible as to oppose & tire the hand of the operator, who was forced to change from the right to the left--then, indeed, I thought I must have expired. I attempted no more to open my Eyes,--they felt as if hermettically shut, & so firmly closed, that the Eyelids seemed indented into the Cheeks. The instrument this second time withdrawn, I concluded the operation over--Oh no! presently the terrible cutting was renewed--& worse than ever, to separate the bottom, the foundation of this dreadful gland from the parts to which it adhered--Again all description would be baffled--yet Oh Heaven!--I then felt the Knife <rack>ling against the breast bone--scraping it!--This performed, while I yet remained in utterly speechless torture, I heard the Voice of Mr. Larry,--(all others guarded a dead silence) in a tone nearly tragic, desire every one present to pronounce if any thing more remained to be done; The general voice was Yes,--but the finger of Mr. Dubois--which I literally *felt* elevated over the wound, though I saw nothing, & though he touched nothing, so indescribably sensitive was the spot--pointed to some further requisition--& again began the scraping!--and, after this Dr. Moreau thought he discerned a peccant attom--and still, & still, M. Dubois demanded attom after attom (612-3)

For all the horror of her operation, Burney was, at least, in her own house, and she did agree, resignedly, to the surgery. Others had little choice in their treatment; Youngson describes the frequent use of violent coercion in bringing patients to brutal surgical procedures in England (27). Before the advent of inhalation anaesthesia surgeons were more to be feared than respected.

By the time of the 1858 Medical Act, medicine had entered a new age of discovery and experimentation which had many positive effects on the treatment of patients and the prognoses of their illnesses. Surgery was routinely painless,

and with more time to work on an unconscious patient, the surgeon was more often successful. In 1848 the first Public Health Bill was passed which "empowered a central authority to set up local boards whose duty was to see that the new homes had proper drainage and that water supplies were dependable" (Haley 9), and physicians, as the defenders and protectors of public health, oversaw these boards in the capacity of Medical Officers of Health Medicine's power, with the shift from trade to profession, extended from exclusive rights to treat illness to the power to safeguard health, to manage childbirth, and to influence social behaviour. General improvements in medical care brought new respect from the public, and new authority for doctors.[5]

GENDERED SCIENCE:

"Let her trust her doctor, and all will be well" (Arthur Allbutt 21).

Although scientific discovery led to radical advancement in medicine, which provided new cures for illness, some of the changes led to perilous new treatments--particularly for women. Surgery was increased to such an extent after chloroform was introduced that some surgeons were criticised for having "operating mania" and younger surgeons were often accused of attempting to "'to carve their way into practice'" (Youngson 90). Women, whose medical complaints were so often thought to be connected with their internal reproductive

organs, became the frequent objects of this new surgical zeal.

Ann Dally, in *Women Under the Knife: A History of Surgery*, 1991, asserts that removal of the ovaries, or

> ovariotomy gradually became accepted as *the* operation by which a surgeon's skill and worth were assessed. Almost any description of a surgeon in the second part of the nineteenth century informs the reader of the date when he 'did his first ovariotomy.' Clearly it was regarded as an important milestone in a surgeon's career. (139)

Ovariotomy formed the basis for all abdominal surgery (135). Women were surgical guinea pigs; without the informed consent we now demand, they "submitted to the experiments that were necessary for progress" (142) and underwent hysterectomy and uterine 'repair' for conditions which were absolutely normal. The medical reasons given for mutilating surgery on women were various. Dally claims:

> Surgeons, who shared the prejudices of the age, began to apply their growing skill in excising women's reproductive organs for symptoms or complaints they did not understand and which often did not relate directly to the organ. Increasingly, they operated on women not only for gynaecological symptoms, but for conditions we would now regard as psychological. They justified this not through scientific evidence, of which none existed, but through prevalent beliefs and fantasies about women which they liked to think were scientific. (146)

Surgery was performed to combat masturbation and nymphomania (146), and healthy ovaries were removed not only to alleviate perceived gynaecological abnormalities, but also to treat "women who were 'insane', hysterical, unhappy, [or] difficult for their husbands to control, for example those who were unfaithful to their husbands or disliked running a household"

(148).

Women who were diagnosed as insane were particularly vulnerable to gynaecologic surgery after anaesthesia became available. "Many psychiatrists thought that all cases of female 'insanity' were sexual in origin and would be improved by 'extirpation' of the ovaries" (153), and between the late 1850s and "1906 about 150,000 women [in Britain] had had the operation....the average age was thirty" (156).

Surgery was used to provide direct control over women's voice and movement. To silence a "lady of voluble speech and evil tongue" a surgeon could perform

> the operation of 'glossodectomy' which...'means a surgical operation upon the tongue, whereby its abnormal volubility is tempered'. The aim of the 'glossodectomie' operation for talking too much was 'to modify the development of the lingual muscles' such as 'promotes rapidity of motion'. It was thought that 'the mere inability to speak much without languor often ensures peace when the desire of war is present.' The idea was to 'reduce a woman's power of utterance' to a normal state by partially dividing some of the muscles of the tongue....'The patient being under the effects of chloroform, a very fine knife is run quite through the tongue and rapidly withdrawn. The result is that certain muscular fibres are cut' the mobility of the organ is in some measure impaired,--to the extent, namely of making continuous and violent objurgation impossible, but not of interfering with temperate conversation. (Dally 158)

If a woman was found guilty of dancing too much, she could be diagnosed as having 'gyromania,' and treated surgically:

> a narrow knife was inserted and, after 'division of a few fibres of the glutei and gastrocnemii muscles [in the buttocks and calf], no more'. the patient was cured. She left the surgical home 'as complete an ornament to her sex as any charming woman can well be'. (159)

Actions which were deemed to be inappropriate in women could be modified or eliminated through surgery. Offending anatomy was cut and the behaviour was cured.

With professionalization, medicine acquired complete authority over illness and health, treatment and cure. Moving from a pre-Victorian position in which doctors could offer few treatment options, medicine gained the knowledge and confidence with professionalization to improve health care and thus practitioners could demand respect for their work. As respect grew, their power also grew. Doctors acquired the authority to make pronouncements on social as well as physiologic issues. They began to define examples of overindulgence in women, for instance, and to suggest the medical ill effects which could be expected from actions they did not sanction. With anaesthesia, medical pronouncement was able to move far beyond the area of advice on behaviour and into the invasive field of surgical modification of the body. The power of medical discourse extended from the consulting room to the operating theatre, from the home to the ballroom.

Critics Ruth Bleier, Cynthia Russett and Ruth Hubbard[6] have pointed out that nineteenth-century science considered women to be inferior to men. The gender bias of Victorian scientists influenced the medical treatment of women. Thomas J. Graham's 1861 text is a typical example of the gendered construction of female disease by medical discourse:

> There are three things which may be said to render females very prone to derangement of health, and which

> modify their disorders, namely, -1. *The greater sensibility and irritability of their frame. 2. The changes continually sustained by the uterus at and after puberty, and the peculiar function of reproduction which it is destined to perform. 3. The greater development of their capillary circulation. (xiii)*

Graham's statement suggests that all women are abnormal, and that ill health is an expected and inevitable state. His pronouncements were unverifiable by scientific knowledge available at the time, but the power of medicine allowed Dr Thomas Graham and other experts freely to entrench gender bias into medical practice.

The female reproductive system was always regarded as the obvious focus of difference between men and women, but now it also emphasized what made women similar to each other (Poovey *Uneven* 6). Individual 'women' became collective 'woman,' a term which attempted to contain all females of childbearing age. The distinguishing features between individuals and groups of women--the choice or facility to reproduce notwithstanding--were glossed over by a scientific and medical discourse which melted them down into one body, whose dominant feature was a uterus. Grouped this way, they were easy prey for scientific pronouncements which affected not only their biology, but their employment, their education, their cultural expectations, their entire lives. In essence, women got reproduction, men got the rest.

Women's nature was explained by Darwin's theories which were taken up by medicine. The evolutionary ladder had a rung

reserved for women, a rung always situated beneath the one at the top for men. In 1871 Darwin asserts:

> It is generally admitted that with woman the powers of intuition, of rapid perception, and perhaps of imitation, are more strongly marked than in man; but some, at least, of these faculties are characteristic of the lower races, and therefore of a past and lower state of civilisation. (*Descent* 326-7)

Using the dictum that "nothing can be understood without its history" (Levine 16), Darwin entrenched woman's subordinate position. Because of her past, which he interpreted as inferior, his theory restricted her to a future of submission to man. According to Darwin's reasoning,

> The chief distinction in the intellectual powers of the two sexes is shewn by man's attaining to a higher eminence, in whatever he takes up, than woman can attain--whether requiring deep thought, reason, or imagination, or merely the use of the senses and hands. If two lists were made of the most eminent men and women in poetry, painting, sculpture, music comprising composition and performance, history, science, and philosophy, with half-a-dozen names under each subject, the two lists would not bear comparison. We also may infer, from the law of the deviation of averages...that if men are capable of decided eminence over women in many subjects, the average standard of mental power in man must be above that of woman. (327)

Darwin conveniently omits the contribution of cultural influences to the production of greatness. He disregards the fact that women had little access to formal education--and no access to higher education--making their prowess at history, science and philosophy almost impossible. Darwin accepts history as truth, rather than as a narrative which is as selective as science both in bias and omission.

Women were told they were restricted by their reproductive

biology from transcending their nature as child-bearers and care-givers. Any attempt to stimulate the brain detracted from the physiologic nourishment of the life-giving reproductive forces and was therefore disastrous for women, for the race. Thomas J. Graham in 1861 writes:

> I believe that the marked influence of the womb on the brain may account for the greater number of instances of madness found in females than in males, it being computed that the proportion is, in this country, as five of the former to four of the latter.[7](3)

Women's reproductive capacity was also believed to prevent lucid thought, particularly during menstruation. According to James McGrigor Allan, a nineteenth-century physician, during menstruation women "'suffer under a languor and depression which disqualify them for thought or action, and render it extremely doubtful how far they can be considered responsible beings while the crisis lasts'" (Russett 30).[8] Men, however, not encumbered by their reproductive functions, were able to transcend the body and to harness and control nature, rather than just be a part of it.

Pregnant women were increasingly instructed by doctors to maintain a passive role in birth. In his 1889 birthing Handbook, Dr Arthur H. Allbutt asserts that "[h]aving got everything ready, the young woman should do nothing till her doctor arrives, and then she should place herself entirely in his hands,[9] looking upon him as her best friend for the time being." The woman is deemed to be young and is ordered, during her "confinement," to be idle and submissive. Her

actual best frierds are excluded by the physician: "The woman's husband and neighbours must be kept out of the lying-in-room. None but the doctor and nurse should be allowed in it" (19). The patient is told she must comply with the doctor or she will suffer: "if the woman does all she is told, the use of forceps in many cases gives great assistance, and shortens what would be a long tedious, and painful labour" (22).

Allbutt's paternalistic advice reinforces the image of woman as childlike and submissive and accentuates the power of medicine not only to ascribe women's subjectivity, but also mysteriously and magnanimously to deliver her from pain and suffering. By suggesting that not complying with medical advice will make a woman's labour more difficult, Allbutt contributes to the expectation of obedience in the female subject.

When women are told they will suffer physical pain if they resist medical advice, they are likely to acquiesce. By first frightening women and then holding the possibility of pain relief over them, doctors like Allbutt have the power to control not only women's actions in labour, but also their general behaviour, for when women are forced to put their complete faith in the men of powerful institutions like medicine and to distrust their own inclinations, they must relinquish any control they have over their health. When the doctor must be relied upon absolutely, the woman is compelled

to see herself as weak and unreliable. Thus medical discourse has the power to construct the female subject.

THE PENETRATING GAZE:

In the second half of the nineteenth century there was a revolution in science which produced significant discoveries in many areas of inquiry including genetics, pathology, and biochemistry. Where once medicine had little to rely on but the observance of gross anatomy combined with trial and error and conjecture, it could now apply the scientific concepts of detailed physical examination and microscopic visualization. New tools and new tests revolutionized the methods of diagnosis and improved the outcome for unwell patients. From merely treating symptoms, now doctors could isolate and name various diseases, prescribe more effective treatments, and provide more realistic prognoses. With physical examinations doctors could interpret signs (what they could perceive) not just symptoms (what patients described). There was a shift from a subjective presentation by the patient to the objective determination by the physician. With the doctor as subject and the patient as object, the power rested securely with the medical profession.

Scientists who introduced germ theory and cell theory posited the existence of microscopic organisms and structures within the body which caused and/or responded to disease. After the presentation of these theories by such men as Louis

Pasteur and Rudolph Virchow, physicians had new things to look for. To see these newly identified objects, they needed new tools. Suddenly the physician's gaze intensified.

Certainly the medical gaze had always been "central to the acquisition of valid knowledge of nature," to the observance of normal and abnormal, natural and unnatural:

> From classical times, science and medicine have been explicitly concerned with the correct interpretation of visual signs, and skill in those fields was pre-eminently seen as a form of visual acuteness. (Jordanova *Sexual* 91)

But where once medical professionals could see only slightly more than an untrained individual looking at an ill patient, now, with the aid of technical instruments, they could delve into the inner recesses of humanity. With the microscope, cells could be isolated and observed and bacteria seen and identified.

The new technology involved getting both closer and farther away from the patient. Dissection of the cadaver had been central to medical training in the nineteenth century, particularly for the surgeon, and it "became the symbolic core of scientific medicine--the place where signs of pathology were revealed to the medical gaze" (100). But while doctors inevitably unveiled the lifeless body, they had little access to living flesh. Physical examination as we know it was rare, and doctors relied wholly on verbal or even written descriptions of their patients' illnesses; only after the scientization of medicine were hands--and eyes--laid on. The

body was prodded, palpated, perused. It was squeezed, sounded, and surveyed. Skin was bared and the doctors' hands and eyes gathered new evidence from detailed observation of exposed flesh.

When microscopic examination was applied to medicine in the mid-nineteenth century, "previous concepts both of disease and of the human body [were] radically altered" (Cartwright 137). The concept that individuals were made up of recognizable microscopic particles--as was all matter--challenged the very basis of civilization. When added to Darwinism, the concept was a blow to religion and the basic concepts of the creation theory of humanity.

With microscopes doctors could peer into the depths of the human body with magic eyes. Foucault claims that in eighteenth-century France medical observation "was a gaze that was not content to observe what was self-evident; it must make it possible to outline chances and risks; it was calculating" (*Birth* 90). New instruments furthered the capabilities of vision and of calculation.

And while all patients were potential objects of this gaze, there was one area of examination that was to include women alone. In gynaecology, the general introduction of the vaginal speculum late in the century enabled the medical gaze to penetrate the female body in a new way. The word speculum has two meanings. It is an instrument for dilating the cavities of the human body--specifically the vagina; it is

also a mirror of polished metal. The word penetrate also has two meanings. To penetrate is to find access into or through; it is also to see into, to find out.[10] The penetration of the speculum enabled a doctor to view what had previously never been seen. As Irigaray reveals, the speculum is:

> as instrument to *dilate* the lips the orifices, the walls, so that the eye can penetrate the *interior*. So that the eye can enter, to see, notably with speculative intent. Woman, having been misinterpreted, forgotten, variously frozen in show-cases, rolled up in metaphors, buried beneath carefully stylized figures, raised up in different idealities, would now become the 'object' to be investigated (144-5).

The speculum brings light into new and previously dark territory, but when the doctor looks through it and discerns the contours revealed, he also sees himself reflected back in the polished mirrors of the blades of the instrument. Thus the power of this gaze is magnified, is doubled in fact by its own reflection. Two eyes become four eyes, and all are on the most intimate parts of the female body.

The inward invasion of the medical gaze is particularly significant as the interior of the female body was not even visible to its owner. When doctors acquired the power to examine the inner walls of the vagina and the cervix, they could see more, and thus they "now knew more about the woman's body than she did herself." Such penetrating vision necessarily strengthened the doctor's position of power and weakened the importance of "the patient's description of symptoms" (Mitchinson 247).

Victorian modesty figures in the introduction of modern female internal examination. Modesty was a subject of concern for doctors even before the advent of the speculum, as manual examination was used by some, and treatment was sometimes effected through the vagina even before visualization was possible. Doctors were aware of the indelicacy of such examinations and frequently tried to avoid them in unmarried women or adolescents (241).

If medicine overruled the modesty that women were socialized to feel about their bodies, the vaginal examination, if done often, was believed to lead to sexual excitement in the patient. Robert Brudenell Carter, in his 1853 text, *On the Pathology and Treatment of Hysteria*, writes:

> the indiscriminate employment of the speculum is both a disgrace to the medical profession, and a misfortune to the female sex, in a nation where chastity and modesty have been esteemed and practised amongst us....I have, more than once, seen young unmarried women, of the middle-classes of society, reduced, by the constant use of the speculum, to the mental and moral condition of prostitutes...asking every medical practitioner, under whose care they fell, to institute an examination of the sexual organs. (67-69)

According to MacNaughton-Jones's 1901 text, *Points of Practical Interest in Gynaecology*, "Next to masturbation, too frequent medical examinations are to be condemned, especially in that type of woman, of the neurotic temperament, who can ill conceal her feelings" (4). The fear of unleashing sexual desire in women may have been connected with a fear of giving up privileged knowledge. There were concerns that these examinations "led [women] to talk too freely about their own

organs" (Mitchinson 240)."

By the late 1800s, doctors knew far more about the body than ordinary citizens. Their education was specific, regulated, and intense. Clinical experience was imperative for a doctor to obtain a license to practice, and hospitals were growing into larger, cleaner, more technically innovative teaching institutions. Doctors could see more than ordinary citizens. Their gaze, trained to observe small changes and minor anomalies, was brought to a point of intricate acuity with complex instruments and tools. Physics and mathematics were factored into the reading of blood pressure, heart rhythms, body temperature. Scopes of all sorts allowed the medical eye to delve directly into the human eye, the human ear, the nether reaches of the patient. And training in the use of these instruments allowed the doctor to interpret what was seen either as healthy or as pathological, to name it as such, and to go on to devise treatment, to modify tissue, to attempt cures. No other group ever had such power over the body. Thus the voice of medicine was the voice of authority. What the doctor said increasingly became what the patient believed, what the patient did.

With their increased power, doctors published their opinions on social as well as strictly medical issues. Dr William Acton, in his 1875 text *The Functions and Disorders of the Reproductive Organs in Childhood, Youth, Adult Age, and Advanced Life Considered in Their Physiological, Social, and*

Moral Relations, reacts to an early wave of feminism by attacking women whose actions indicate their resistance to what he and others considered to be an essentially feminine nature:

> During the last few years, and since the rights of women have been so much insisted upon, and practically carried out by the 'strongest minded of the sex,' numerous husbands have complained to me of the hardships under which they suffer by being married to women who regard themselves as martyrs when called upon to fulfil the duties of wives. This spirit of insubordination has become more intolerable--as the husband's assert--since it has been backed by the opinions of John Stuart Mill (142)

Acton uses his position as a medical authority to attack the concept of women's rights[12] and to quash women's resistance. Although he draws on the reportage of "numerous husbands" and their assertions to present his views, it is his professional position which gives his pronouncements their power. His solution to the problem undermines the protesting women, the "strongest minded of the sex," by attacking them for departing from the socially constructed image of the subordinate woman:

> As opposed to these doctrines, I would rather urge the sex to follow the example of these bright, cheerful, and happily constituted women, who, instead of exaggerating their supposed grievances, instinctively, as it were, become the soothers of man's woes, their greatest gratification apparently being to minister to his pleasures, seeing that woman was created for the purpose of being a help-meet to her husband. (143)

Acton criticizes strong women for lacking instinct, a quality deemed feminine, and for not living up to their decreed purpose in life--to please men. In these passages Acton uses his privileged position as a medical doctor to address social

and political concerns and indicates his awareness of some women's resistance to the role his profession prescribes.

In his denouncement of women who do not submit cheerfully to their husbands' desires, Acton would have us believe that he is representing his sexually-deprived male patients. However, on the issue of legal annulment of marriage in cases of male sexual impotence, Acton also attacks women. He believes that women must be willing sexual partners, but if their husbands are incapable, they should then endure abstinence without complaint:

> In my opinion these suits for nullity of marriage are becoming much too common, and I hope the law will cease to countenance some wives in dishonouring instead of honouring the husbands they have sworn to cherish, and this the more especially as a worldly experience teaches me that a woman seldom brings these charges till she has formed another attachment. (247)

By using his professional power and knowledge of the body, and by incorporating his "worldly experience," which is, of course, the confidential knowledge he possesses as the medical confessor of numerous patients, he uses medical discourse in an effort to influence legal and political decisions--and to admonish and punish resisting women.

Doctors became even more than priests of the body.[13] They educated themselves, regulated themselves, and excelled in improving the general health and well-being of the population to the extent that they could speak with influence on not just the body, but on the mind, and on the prevailing social conditions which affected their patients. Their prescriptions

went beyond anodynes and antidotes, and they marched right into areas of social and moral concern. As doctors gained strength in voice, they began to impose their authority, and as women were the profession's primary patients, it is they who became both the primary subjects and the primary objects of this powerful new medical discourse.

TOWARDS RESISTANCE:

Disempowered by a patriarchal discourse which recognized and inscribed women as inferior to men, women had few areas of social discourse where they could speak back against medicine's pronouncements. Barred from universities until the 1870s, women could not work against discourses of power from within the professions, and, socially relegated to the home, they had little opportunity to address any public forum. But literature, as Virginia Woolf declares in "Professions for Women," had "very few material obstacles" for women:

> Writing was a reputable and harmless occupation. The family peace was not broken by the scratching of a pen. No demand was made upon the family purse. For ten and sixpence one can buy paper enough to write all the plays of Shakespeare--if one has a mind that way. (57-8)

It is to a few of those women I now turn, those who had minds that enabled them to write and that allowed them to declare their resistance to the discourses which threatened and oppressed them.

NOTES

1 Michel Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception* (New York: Pantheon Books, 1973) 32.

2 Physicians were university-trained gentleman whose background was in the classics and whose concentration was in the art of medicine. Their education "combined an almost medieval respect for tradition with an excessive admiration for the manners and attainments of an eighteenth-century gentleman" (Youngson 15). According to Cartwright, "the lordly physician could, and often did, receive his degree without examining a patient" (47). Surgeons, until 1745, were in the same guild with barbers. The barber-surgeon could cut your hair, lance your boil, bleed you, or, with varying degrees of success, remove a limb or a superficial lesion from your body. He did not practice surgery in the manner we now know it. In fact, "operative surgery had been almost entirely destructive until the end of the eighteenth century, undertaken only when all other attempts at cure or alleviation failed" (Cartwright 141), and Apothecaries were drug dispensing medics who "trained by apprenticeship alone, and their training was severely practical" (47). Apothecaries operated in shops selling directly to the public like contemporary pharmacists. As they were licensed to dispense drugs, patients did not need to see a physician or a surgeon before acquiring a prescription. "Apothecary shops carried hundreds of 'specifics,' drugs intended to attack particular varieties or symptoms of disease" (Haley 13), but because they were limited to treating with medicines alone, "pure apothecaries" could earn a living only in cities or large towns (Youngson 12). Until they were regulated, apothecaries ran the risk of being confused with quacks who prescribed all manner of bogus remedies.

3 This body still exists under the name of The General Medical Council.

4 Quacks are named for "*quacksalvers*, or people who applied salves of quicksilver (mercury)" (Shorter *Bedside* 69).

5 Cartwright points out that because the General Council "assumed the right to discipline, it was enabled to formulate an ethical code to which all registered practitioners must conform." The implementation of this ethical code provided patients with the sense that their welfare was safeguarded while at the same time it "raised the social prestige of the doctor in public estimation" (57).

6 See introduction.

7 Bucknill and Tuke in *A Manual of Psychological Medicine*, 1858, claim that in England and Wales at that time "we find the proportion [of insanity] among males to be one to 616, and among females one to 543" (47). This text is cited in *Morton's Medical Bibliography: An Annotated Check-list of Texts Illustrating the History of Medicine (Garrison and Morton)*, edited by Norman, the standard bibliography of medical history, as "the standard English work of psychological medicine" (4934).

8 Debate continues on the effects of women's reproductive cycles on mental behaviour and responsibility. The diagnostic and statistical manual of mental disorders (DSM-III-R), which is psychiatry's established diagnostic classification system, has recently listed pre-menstrual tension syndrome as a disease. According to Dr Rosemary Hutchison, in a current article in *Ontario Medicine,* "[p]re-menstrual tension syndrome, postpartum depression, and the psychological changes of the menopause are considered disease entities when, in fact, they are normal experiences--felt by more than 90 per cent of women during the course of their reproductive lives" (14).

9 Nurses are also groomed to prepare for the doctor and assume a subordinate role. In *Hints on Nursing* 1889, Mina Drew writes:

> Everything must be in order when the doctor pays his visit to the patient. There must be no fuss or confusion. All information as to the patient's symptoms must have been previously obtained by the nurse, so that the medical man may not be detained longer than needful. (24)

10 Oxford English Dictionary, New Edition, 1991.

11 Foucault writes that the repression of open discussion of sex began in the seventeenth century, when, in order to gain mastery over sex in reality, it was "necessary to subjugate it at the level of language, control its free circulation in speech, expunge it from the things that were said, and extinguish the words that rendered it too visibly present" (*History* 17). Foucault deduces that what really happened, was that sex was spoken about even more through the exclusive discourses of powerful institutions where it was used discursively as a element in the formation and control of subjectivity. In order to contain sex, it was carefully encapsulated in the confessional discourses of religion and medicine. Extending Foucault's theory to include gender, it is possible to speculate that if women began to talk to each other about sex they might then begin to define themselves as subjects, and the controlling ideology around sex would break loose from the bonds of professional discourse. Uncontained sex presented a frightening threat to the institutions,

specifically medicine, which played an important role in regulating sexual mores through the power of its discourse.

12 He also, of course, is attacking John Stuart Mill's 1869 treatise *On the Subjection of Women*.

13 Foucault uses the term "priests of the body" to describe the French ideal, during the years of the Revolution, of a nationalized medical system in which doctors would look after the body in the way priests looked after the soul (*Birth* 31), following Descartes's theory of the split between mind and body. In late Victorian England, with scientific discovery challenging religious concepts, the Cartesian split was itself in question, and thus when I use the term "priests of the body," I am referring to the power of physicians to take over from the power of religion and govern both body and mind.

CHAPTER 2

"HUSH I WILL *NOT*"[1] "BUT I DARED NOT CONTRADICT"[2]

ACQUIESCENCE AND RESISTANCE IN *VILLETTE*

Most readers of Charlotte Brontë's *Villette*, published in 1853, have concentrated on the romantic attraction of Lucy to Dr John Graham Bretton. However, critics neglect to point to the crucial fact that the characters' personal relationship is structurally informed by their professional association; John Graham Bretton is a doctor, Lucy Snowe is his patient. In choosing such a fictional relationship, Brontë is able to critique the power of Victorian medical discourse. As narrator, Lucy presents both the discourse of medicine through her account of Dr John's dialogue and actions, and also her resistance against his professional pronouncements in her own dialogue, internal monologue, and autobiographical writing.

Dr John represents the new breed of professional Victorian practitioner, both knowledgeable, and caring. Brontë does not dwell on the specific educational background of Dr Bretton. Scientific methodology is in its infancy, and Brontë does not show Dr Bretton using its instruments. His value is specifically in the *art* of medicine, in his constant "wish to heal - to relieve" (*Villette* 306). For all his positive attributes, however, Dr John exhibits the newly rising authority of physicians which ultimately overpowers and

silences women. For when medicine gained respect, as I have shown, it also gained power--the power to decree, the power to deny. And, while Dr John is a gentle man, he is not without what Lucy calls "his masculine self-love" (273) and his "pleasure in homage" (273), which is easily fulfilled and perpetuated by doting patients.

The doctor's power, and Lucy's attempts to resist his power, are presented in their dialogue. I examine their relationship from this aspect, on the level of the characters as doctor and patient, but I also investigate responses to medical discourse through an analysis of Brontë's narrative strategies. In her dialogue Lucy is truly silenced and seems to be disempowered. Conversely, through the various voices made possible by her narration of the novel, Lucy has the opportunity to speak back to the oppression of medical discourse in silent retort to Dr John, but volubly to the reader.

A number of critics agree that Lucy Snowe is an unreliable narrator. E.M. Forster, in *Aspects of the Novel*, is disappointed that Lucy conceals Dr John's identity as her childhood playmate Graham and claims it mars Lucy's character:

> She has seemed, up to then, the spirit of integrity, and has, as it were, laid herself under a moral obligation to narrate all that she knows. That she stoops to suppress is a little distressing, though the incident is too trivial to do her any permanent harm.

Forster's comments suggest, on the one hand, that Lucy has

cheated the reader through a misrepresentation of her honesty and, on the other, that little more can be expected of her. Although he claims Lucy is not harmed by her action (or lack of action), he does discredit Brontë for her "mistaken triumph" and what he calls her "slip" (93) in narrative strategy. Forster interprets Lucy's unreliability as a negative aspect of her character.

Other critics also view Lucy's narrative concealment as damaging. Charles Burkhart, in *Charlotte Brontë: A Psychosexual Study of Her Novels*, feels "the mischievous use of narrative viewpoint" is a "fault" (100); W.A. Craik, in *The Brontë Novels*, sees Lucy's narrative restraint as an inevitable result of her unfortunate temperament (161); and Earl Knies, in *The Art of Charlotte Brontë*, suggests that Lucy's lack of dependability gives the reader license to question her personal impressions as well as her presentation of facts. He feels that because she is unreliable, the reader can "entertain value judgements which differ from hers." Knies invites the reader to believe "the objective facts she presents," but to question Lucy's "subjective reactions" (179), thus undermining both her credibility and her right to her own emotional response.

Critics who equate Lucy's narrative unreliability with mental illness also do her a disservice. Harriet Björk, in *The Language of Truth: Charlotte Brontë, The Woman Question and the Novel*, calls Lucy morbid and hypersensitive (114), and

Pauline Nestor, in *Charlotte Brontë*, suggests that Lucy's "vague, distorted and unreliable" narrative is evidence of her "neuroses" (85). Athena Vrettos, in her recent article on *Villette*, goes so far as to claim that Lucy Snowe is "the hysteric first-person narrator" of the text, and that her "hysteria informs her acts of narration, and alternatively [the] narration expresses and embodies her hysteria" (552). By accepting Lucy's unreliable narration as the product of a disturbed mind, these critics unquestioningly accept the diagnosis of Lucy as mentally unbalanced and overlook the possibility that she is in full control of her narration.

There is some critical recognition that Lucy's narration is consciously calculated to conceal. Matthew Arnold, in a letter to Mrs Forster in April 1853, written shortly after *Villette* was published, complains, not of Lucy's hysteria, but of Brontë's "hunger, rebellion and rage" which "will be fatal to her in the long run" (Allott 93). Clearly, Arnold recognized that Brontë was reacting against oppressive conditions which force Lucy to withhold information and disguise her perceptions.[3] Although Arnold was obviously annoyed with Brontë's boldness, other more recent critics recognize that Lucy's narrative wavering is a sign of her precarious and vulnerable position as a plain, poor spinster in the nineteenth century.

Gilbert and Gubar claim that there is no narrative pattern for a woman like Lucy to follow. According to their argument,

the only roles available to her are "the little girl lost (Polly), or the coquette (Ginevra), or the male manqué (Madame Beck) or the buried nun (in the garden)." Since "none of these roles ascribe to women the initiative, the intelligence, or the need to tell their own stories" (419), Lucy has no choice, if she is to be heard at all, they claim, but to be evasive in her narration. Gilbert and Gubar excuse Lucy's unreliability, but they see it as a result of her oppression rather than as an instrument of her power. They unquestioningly accept the suggestion that Lucy has a "mental breakdown" (422) and see Lucy as a reticent and unfortunate victim who is a long way from "finding a voice" (419) because she has no positive narrative possibility.

Patricia Lorimer Lundberg comes closest to recognizing that Lucy's narrative is strategically designed to subvert her containment in the role of plain, poor, and hysterical spinster.[4] As she suggests, in the "absence of a public forum," women like Brontë can speak out "their texts through their narrator" (299). Rather than naming Lucy unreliable, Lundberg calls her a "complex narrator" (307), which accentuates her power rather than her instability. Lundberg recognizes that "the distancing narrator like Lucy Snowe has a critical narratee who the narrator suspects does not adhere in the same belief system; [and that] such a narratee is male" (299). By pointing out that Lucy is aware that she is speaking to an unsympathetic male narratee, Lundberg allows

for the possibility of a positive strategy in Lucy's use of narrative concealment.

Whereas Knies, when he suggests that "Lucy makes it possible for us to entertain value judgments which differ from hers" (179), indicates that it is the *reader* Lucy is addressing, Lundberg differentiates between the reader and the *narratee* who, according to Rimmon-Kenan, is "the agent which is at the very least implicitly addressed by the narrator" (89). Lundberg recognizes that Lucy's narrative is written as an autobiography for a narratee, within the novel written for the reader by Brontë.

The shift between what Lucy writes and how she writes it undermines the limiting classifications Gilbert and Gubar see as inevitable for Lucy. In fact, as Lundberg points out, Lucy is not a "voiceless victim isolated in a hostile environment," but, conversely, "the power of her narrative voice" and "her manipulation of the reader" (307) give her strength and credibility as a writer. By saying that she is a silenced victim of fate, but writing a strong-willed text of rebellion, Lucy indicates that there is a powerful role for her to play as a story-teller, and manipulating the reader is central to her narrative strategy.

None of the critics questions the medical pronouncements of Dr John or analyze the ways in which Lucy's narrative strategies resist his diagnosis of her as suffering from hysteria, nervous exhaustion, or mental imbalance. In spite

of the fact that her so-called hallucinations or illusions are ultimately proved to be real and there is no other convincing evidence of mental illness, critics openly accept Dr John's assessment of Lucy as unstable. Because it is generally suggested that we, as readers, cannot believe what Lucy is telling us, her resistance to Dr John's medical definition has not been detected. I contend that Lucy's withholding and manipulation of information is an intentional resistance to the overpowering aspects of her life, most particularly to the prevailing Victorian medical model which threatens, through the auspices of Dr John, to describe her as ill, to define her as hysterical, and to relegate her to medical dependency.

Not only do critics disregard the overpowering aspects of medical discourse embodied in Dr John, they also neglect to assess his form of treatment. Knies goes so far as to claim that none of the doctor's "actions show him to be anything but an admirable character," that Lucy's "mild condemnations seem to be completely subjective" (177) and are thus, he implies, of no value. In his assessment Knies accepts the findings of Victorian medical discourse which impose mental instability on women and deny them credibility. His interpretation of Lucy's narrative as unreliable carries over to his interpretation of her personality as incredible. Similarly, Björk feels "Dr John is depicted as an almost ideal doctor...a hard-working, and on the whole, efficient healer of the wounds of those who suffer in body and mind" (82). Björk's only

hesitation is that "his advice to the nervous Lucy is partly characterized as medical jargon," but she does not question either his diagnosis or his treatment.

Judith Williams actually agrees with the doctor's suggestion that Lucy has had a hallucination (111-112) and valorizes Dr John as freeing Lucy from her solipsism both by moving her to his home at La Terrasse to convalesce and by taking her on outings when she has recovered (91-2). Rather than recognizing his manipulative and damaging medical oppression of Lucy, Williams sees Dr John as "the beautiful object of earthly desire, and Lucy's relationship with him is a paradigm of the whole novel, which moves toward a realization that earthly desire is not attainable" (83). Williams completely disregards the possibility that Dr John and his profession present a monumental obstacle to Lucy's attainment of desire, recognition, or power.

There is some critical recognition that Dr John has undesirable qualities. Gilbert and Gubar, although they describe him as attractive, "the bright-haired English missionary" and "the carrier of the burden of English healing arts" (412), they also briefly note his "condescending" (426) attitude to Lucy. Burkhart detects Dr John's "spots of commonness...self-love, insensitivity, snobbishness" but sees him as "a large-natured and intelligent man" (111) who is "vital, forceful, real...stately, and firm." He perceives a "stately manliness" (112) about the doctor, while at the same

time recognizing, but not criticizing, his "blend of patronage, sadism and kindness" (115) in his dealings with Lucy.

Lucy has little opportunity to resist the authority of medicine. Medical discourse has decreed that unfortunate women like Lucy are the products of their nature, and until very recently, the critics have tended to agree. Craik suggests that her "sufferings (when she loves Graham) are no one else's fault" and that Lucy "cannot cry out on society for making her suffer" (164), and Burkhart sees her troubles as the product of inauspicious "bad luck that dogged her in girlhood [and which] would follow her through life" (102). My investigation suggests that Lucy's ills and problems are the products of society, and that her bad luck is based, not on natural phenomena, but on the patriarchal construction of what is deemed 'natural' for women. Dr John's depiction of Lucy as mentally unstable infringes on Lucy's actual sanity, and only her ability to write out her resistance to his suggestions enables her to overcome his damaging medical methods.

RESISTANCE AND ACQUIESCENCE:

Lucy's awareness of Dr John's faults indicates that she is prepared to resist his power, but because she is sexually and emotionally attracted to him, she is also prepared to acquiesce to his demands. She is caught between resistance

and acquiescence in her relationship with Dr John, and her dilemma ultimately threatens to debilitate her through physical and mental illness. On the level of dialogue with Dr John, Lucy occasionally attempts to reject his commands or advice, but most often her resistance is countered by his superior position and medical knowledge. Her acquiescence appears, throughout the dialogue, to be almost complete, but Lucy's narration makes it very clear that her outward acquiescence is often mirrored by an inward resistance.

Brontë first presents Dr John using his medical power at a purely social occasion, a dance. He demands obedience when he speaks professionally: "You are both standing in a draught" he tells Lucy and her student companion, Ginevra Fanshawe, "you must leave this corridor" (218). Although Lucy is at first prepared to resist by arguing: "There is no draught, Dr John," he is not to be contradicted: "'She takes cold so easily,' he pursued, looking at Ginevra with extreme kindness,'" as well as a highly charged sexual admiration. "'She is delicate; she must be cared for: fetch her a shawl'" (218). His gaze at Ginevra may be kind, but it is clearly motivated by his emotional interest, and his discourse to the slightly older, plainer Lucy is in the form of an order. His medical position effectively suppresses Lucy's resistance. Thus silenced, Lucy acquiesces and runs off at his command.

Physicians in Dr John's era were well versed in giving orders and encouraged to show strength in their dealings with

patients. Bucknill and Tuke, in their important 1858 text, *A Manual of Psychological Medicine*, claim that a physician, particularly one who is treating psychological conditions, must

> have a good backbone to his character, a strong will of his own, and with all his inflections be able to adhere, with singleness of purpose and tenacious veracity, to the opinions he has on sound and sufficient reasons formed of his patient, and the treatment needful to be pursued towards him. (500)

They suggest that authority can be conveyed by "exercising a supreme power, knowing everything, judging everything" (501). Dr Robert Brudenell Carter, in his 1853 text *The Pathology and Treatment of Hysteria*,[5] published the same year as *Villette*, encourages doctors to give their female patients orders "in such a manner as to convey the speaker's full conviction, that the command will be immediately obeyed" (119). Although Dr John has not been consulted for medical advice in this scene, he is so conversant with medical method that he assumes his professional capacity, takes charge of Ginevra's health, and orders Lucy to co-operate.

Where Lucy is quashed, Ginevra speaks out, and through her Brontë indicates that some overt resistance is possible--"'Permit me to judge for myself,' said Miss Fanshawe, with hauteur. 'I want no shawl'" --but only when the subject/patient is not emotionally attached to the doctor, and even then it is ultimately ineffective against medical authority. The doctor knows best: "'Your dress is thin, you have been dancing, you are heated.'" Three short direct sound

reasons, statements delivered in a manner to discourage a reply. The plucky Ginevra, however, will not be silenced: "Always preaching...always coddling and admonishing" (218). Nonetheless, perhaps in part responding to Dr John's disappointed reaction to her retort, Ginevra succumbs and submits to being covered when the shawl is delivered.

Dr John assumes the power, granted by his scientific training, to impose his views on women's health. To this day, "doctors have an institutionally based authority that patients lack" (Fisher 17). Dr John is allowed by his profession to comment on the thin, perhaps revealing, nature of Ginevra's clothing, or on the level of exercise she exerts at dancing, or on the condition of her skin, which we can assume from his words is now flushed and glistening. These comments would surely be impertinent from a suitor at that time, but because he is also a doctor, he assumes the liberty and the right to make pronouncements, to demand change. The medical gaze permits the sexual gaze. Since both sexual politics and medical politics posit the male as authority, the woman is compelled to comply.

Ginevra does not love Dr John, but because she knows that he loves her, she is in a position to react negatively to his medical intervention. Not so for Lucy. She is secretly smitten by the doctor and is willing to obey his professional orders to gain his favour. She perceives "that his heart was hurt" (218) at Ginevra's admonition, and because she wants to

please him she mimics his authority by covering Ginevra carefully with the shawl, saying, "She shall wear this if I have strength to make her" (218).

Lucy has come full circle from trying to resist the whole notion of Ginevra needing a shawl to acquiescing to the doctor's demands and accepting the role of forcing her to wear it. At this point in the narrative Lucy has no inner techniques to use against Dr John's patriarchal methods. Even though she has initially attempted to speak back tc his command, she ultimately gives in and joins him.

Brontë uses Ginevra here as a double for Lucy. Ginevra is pretty and financially secure. She has her choice of suitors in the marriage market. With such wealth, Ginevra can afford to be outspoken and brash. Lucy, who continually presents herself as plain, poor and disadvantaged, is forced by these circumstances to silence. Ginevra, at this point, speaks for her and accomplishes the resistance.

MELANCHOLY OR MAD?

Lucy is particularly vulnerable depression and illness, but she is well equipped with inner strength to fight such afflictions. In spite of her attempts to please Dr John, she is unlikely to submit "to exist in another's existence" (Gilbert and Gubar 404). Because of her experience of "homelessness, poverty, physical unattractiveness, and sexual discrimination" (402) she has difficulty controlling her

destiny, but despite these disadvantages, she stubbornly accepts the responsibility of supporting herself; she refuses the role of governess, meaning she must endure exile, interrogation, loneliness and privation to be a teacher. Lucy's circumstances leave her little opportunity for fulfilment; she is unable either to satisfy or give up her sexual desire and romantic idealism, and unable to substitute economic and social success in their place, but she is determined to retain her independence.

Unfulfilled, Lucy is destined to fall into melancholia, and through her close proximity to Dr John, to find herself in the role of his patient. As Showalter points out, "depression, illness, withdrawal, and complaint [are] feminine forms of protest" (*Malady* 65), which indicate resistance in themselves. Lucy's particular circumstances are unique, but she is clearly like so many nineteenth-century women who were "deprived of significant spheres of action and [were] forced to define themselves only in personal relationships" (64). For Lucy Snowe, whose relationships are tenuous and disjointed, that route to self-definition is truly a *cul-de-sac*. In situations like Lucy's, Showalter suggests:

> women become more and more dependent on their inner lives, more prone to depression and breakdown. Sickness presents a tempting escape from the contingency of the feminine role; it offers a respectable reason to be alone, and real, if perverse, opportunities for self-development. (64)

Lucy makes no headway with the female sexual role as a contender for Dr John, but her illness allows her to establish

a relationship with him on a professional level. As a woman earning her own living, however, Lucy cannot afford the luxury of taking to her bed.

Lucy resists illness valiantly: "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?" (*Villette* 231). Her "agonizing depression" is "succeeded by physical illness" which puts her "in a strange fever of the nerves and blood" (231). Once sequestered, she is deprived of sleep by a mind which rages "with an unutterable sense of despair about the future" (231). She can find no reason to "try to recover or wish to live," but finds "unendurable...the pitiless and haughty voice in which Death challenged [her] to engage his unknown terrors" (232), as she struggles to resist her malady.

Her despair complete but her mind lucid, Lucy boldly and firmly refuses medical care when it is suggested by the maid Goton. Lucy does not give us the dialogue, but merely reports in her narrative, "I thought no doctor could cure me." She distrusts medicine to help her, and her statement is an attack on the power of the profession; perhaps she also distrusts herself to be in the care of Dr John. When finally she is driven by her nightmares to get help, she rises, dresses, and takes herself out into the stormy night. She emphasizes--to convince both the reader and herself--that this is a deliberate and sane act: "I was not delirious: I was in my

sane mind....(I could not be delirious, for I had sense and recollection to put on warm clothing)." Instead of medical advice, Lucy seeks the solemn solitude "of a certain hill, a long way distant in the fields" where she would most certainly perish in the storm; she has persuaded herself that trading in her life for "affection and sorrow in Heaven" (232) is a rational choice. She actively avoids medical care and seeks a suicidal solace she can control.

Lucy wavers in her decision. Her direct statements of fact regarding the absence of delirium and presence of sanity are followed by hesitation, and thus her writing reflects her struggle between resistance and acquiesence. Parentheses enclose, and thus emphasize, her increasing indecision. The doubt in her diction is soon reflected in her action.

It is particularly significant that Lucy is drawn in by the ringing bells of a church along her route, and gives up her suicidal journey impulsively to seek spiritual rather than medical help. The act of confession, although rather like medical blood-letting in that it delivers Lucy of her evil humours and leaves her, if not well, at least "solaced," is less threatening and less controlling than a medical consultation. Priests have power over the soul, but doctors can incarcerate the body. Her desire for confession indicates her need to pour "out some portion of long accumulating, long pent-up pain into a vessel whence it could not be again diffused" (234). Decanted and contained, her suffering is

both acknowledged and secreted, and Lucy remains in control. By confessing to a Roman Catholic priest, for whose church she has little respect, Lucy cleverly avoids having to fall under his power. Her strength to resist religion, particularly Roman religion, is much greater than her power to resist medicine, and she believes the choice of a priest over a doctor will allow her to continue to rule her own body.

Lucy's reasoning in choosing confession, although basically sound, fails to take into account her severely weakened physical state, and the priest, concerned only about her soul, forsakes her bodily problems. The inadequacy of religion foreshadows for Lucy the inadequacy of medicine as she returns to the storm, swoons into unconsciousness, and feels herself "pitch headlong down an abyss" (236).

Lucy's withdrawal from consciousness marks her move from resistance towards that of acquiesence to the role of patient, and with it a dangerous loss of control over her individuality. Lucy is now weak beyond resistance. When she awakens, finding herself rescued and secured, she is confused about her whereabouts (she has been taken by Dr John to his chateau), but immediately recognizes and relishes her retained sanity: "I knew there could be no mistake, and that I was not sleeping, and I believed I was sane." Although she is clear about her mental state in her narrative, she submits quietly when a strange maid hands her a medicated drink: Lucy "swallowed it passively, and at once." The drug strongly

sedates her, and she does not fight it: "I lost the power to move; but, losing at the same time wish, it was no privation" (240). The acceptance of sleep signifies a willingness to live certainly, but also a voluntary submission to illness. When she next awakens she is unable to reconcile the strange familiarity of her surroundings with reality and so concludes "that [she] had...passed into an abnormal state of mind; in short, that [she] was very ill and delirious" (241). By succumbing to the role of mental invalid implied by Dr John's treatment, Lucy invalidates her belief in her own sanity.

For an instant she attempts to fight thoughts of insanity in favour of blaming "the fever [as] the real malady which had oppressed [her] frame" (244), but although her spirit of resistance is kindled, her rationality is no match for Dr John, who, in his capacity as physician, takes strict and total charge of her care. He orders her to bed when she looks pale (251); he "is master and must be obeyed" (253). Merely "judging from [her] look" he determines that she has "had a nervous fever" (254), and Lucy submits to his care absolutely, too weak to contemplate disobedience, too delighted with his attention to resist. When she is forced by his orders to stay in bed, she luxuriates in the knowledge that he has taken care to direct her action (or non-action). The moment of taking control of her body and recognizing her true affliction passes, her weakness is no match for his strength, and she acquiesces to his treatment.

Convalescing at Dr John's home puts Lucy in a position of complete compliance. Moving patients to the doctor's premises was crucial to Victorian medicine: Dr Robert Carter insists in his text that the physician must

> demand that the patient be placed under his roof, as only when there, can she truly be described as under his treatment. Ard if...not acceded to, he will act wisely in declining to interfere with an individual, who will probably damage his reputation, and who certainly will not add to it. (106)

The authority which is bestowed on medicine to make people well becomes mixed with the doctor's good name, standing, and economic potential. As long as Lucy is in Dr John's home, he has complete control over her actions and her recovery.

THE POWER TO NAME:

Brontë chooses this moment of illness to reveal Lucy's identity to Dr John Graham Bretton (the Graham of her adolescent acquaintance) and to confirm that Lucy has recognized him all along. She has never used her surname in his presence; she is called either 'Miss' or 'Miss Lucy.' It is not only Lucy's identity which is revealed, but a sense of her subjectivity. The reader has known that Dr John is really Graham grown up, but Lucy has never betrayed her recognition. She has maintained a coy silence. By guarding her identity, she has acquired a certain power over her situation: she has knowledge that he--for all his authority and training--lacks. As long as this knowledge is secret, it retains its power.

Brontë's method of narration allows the reader access to

Lucy's thoughts as narrator and as writer of the tale. She is the fictional autobiographer. Thus, we can interpret Lucy's reaction to the doctor by her naming of him both silently and aloud. By reading Lucy's thoughts, we can hear the resistance behind her silent responses to Dr John Graham Bretton.

The names they can now use for each other highlight the duality of their relationship--professional and emotional--and expose another nerve in their imbalance of power. With open identities, the characters acquire new choices. Dr John Graham Bretton can now be called John, Graham or Dr Bretton as well as Dr John, and Lucy Snowe regains her surname. Lucy begins to think of the doctor as 'Graham' at the precise moment before she reveals who she is. At this time she is still in the position of knowledge and power over *him*, but she now shares her knowledge with the reader. Her power shrivels as she self-effacingly absolves him for not recognizing her because "he has so much to do and think of" and she reverts to thinking of him as Dr John. When he pauses with the revelation, and "silently disposed of his paroxysm of astonishment" (249), she gains some ground and thinks of him as Graham. She revels in her superior knowledge, and this allows her to discard his title. Whenever she thinks of him in his professional capacity, or addresses him, however, she always uses 'Dr John.' He maintains professional power, but through her narrative Lucy has a choice in what to call him.

Dr John undermines Lucy's power in names by mixing up Lucy,

Miss Lucy and Miss Snowe in an apparently indiscriminate manner which crosses the barriers of their private and professional relationship. When he orders her to bed she is Miss Snowe, a patient. But when he says goodnight--lighting her way up the stairs--he cuts the formality and calls her Miss Lucy. He wavers among her three appellations in personal and professional situations, now calling her Lucy in a medical interview, then Miss Snowe in family banter about his mother. His assumed familiarity with her names disempowers Lucy and leaves her confused about the nature of their relationship: is it professional or personal?

With his medical knowledge Dr John imposes a professional relationship on Lucy, for he has the authority to diagnose her condition. When he asks if her nervous system is involved she cannot answer: "I am not sure what my nervous system is" (256). Medical knowledge is privileged; she is excluded from the language. Lucy is also reluctant to respond to Dr John's question because of her love for him, and she avoids answering until he has made his diagnosis. Certainly the level of honesty in this encounter is open to question, for it was considered "especially necessary" at the time that doctors "never...put a leading question, unless it be a misleading one" (Carter 75) to a woman suffering from a nervous complaint. No matter how the diagnosis is devised, however, doctors were powerful in their ability to "judge....they could name, describe and explain" (Dally 67), or, as in Lucy's case,

Dr John can name (personally and professionally), assume, and advise. Lucy may be withholding information to protect herself from the power of medicine to name her disease, categorize her personality, and reify her humanity.

THE POWER TO COMMAND:

Usually, it is the patient who approaches the doctor for diagnosis and treatment. The illness is experienced by the individual who assumes the role of patient in order to receive a diagnosis and treatment. Initiation of the medical relationship puts the person in some control and indicates willingness to become a patient. As Kathryn Montgomery Hunter tells us, the "illness belongs first of all to the person who is ill, and the patient's experience is the ineradicable fact of medicine" (13). Unfortunately, Lucy has no control in her professional relationship with Dr John; she has not initiated the original medical encounter.

Because Lucy is unconscious when she is taken for treatment, she has no choice of practitioner and no chance to tell her story. In fact, she hardly knows her story, or how she has managed to be in Dr John's care. In Hunter's words, it is "the physician's concern...to translate the subjective experience of illness into the recognizable discourse of medicine" (53), but for Lucy there is no translation: she is not allowed to review her experience.

Lucy acquires the facts of her illness from Dr John, it now

belongs to him, and she gets little opportunity to add any subjective material to his narrative. He recounts his chance passing of the church where Lucy has fallen, and his observation of the "priest lifting some object in his arms" (*Villette* 257). Dr John discovers Lucy, "perfectly unconscious, perfectly bloodless, and nearly cold." Lucy's response to his story is to hedge. Rather than contributing any information about her condition before her collapse--information she has already divulged to the reader in her narrative--she stays aloof and gives nothing away, asking him, "What does it all mean?" (258).

Lucy is not as ignorant of the events as she lets Dr John believe, but conceals her knowledge and manipulates the narrative. She shapes her history as a patient around his knowledge as a physician; she is planning what to tell, what to withhold. She may not know how she lost consciousness, but she has full recall of her illness and confession. When Dr John reveals that the priest has divulged information, she responds with a puzzled exclamation: "Things I had said? I wonder what things!" (258). What she really wonders is what the priest has revealed. She resists committing herself to a narrative of her illness; she waits until Dr John declares his own knowledge.

As long as Lucy is in control of the story, she is convinced her illness is physical. Fever, she tells the reader, is "the real malady" (244) and moreover, for the past

nine days she "had taken no solid food, and suffered from continual thirst" (244). It is *her* body, *her* illness, and when she is the narrator of its history, she feels confident in her knowledge of its etiology.

Lucy's control of information falters when Dr John refuses to allow her to disclose. When she gets no chance to give her story in dialogue with Dr John, she begins to doubt its veracity in her inner narrative. Dr John continually defers hearing her history. He pronounces that she has had "a fainting-fit, not necessarily dangerous," and as to "[w]hat brought it on," he declares he has "yet to learn [the] particulars" (247), but gives her no opportunity to provide them. By sending her to bed he silences her and dismisses any possibility of discussion: "As to last night's catastrophe, I am sure thereby hangs a tale, but we will inquire no further this evening" (251). It is a full two days before he lets her talk about her illness, and then it is introduced with the suggestion that it all revolves around her "nervous system" (256). By now, her fever abated, her appetite returned, Lucy is perplexed.

Once again, Dr John, by controlling the discussion of Lucy's illness, follows medical teaching of his time. Dr Carter's system "acts by wearing out the moral endurance of he patient" (108). He advises:

> --remove her 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 conversational topics. (109)...a day to 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. (110)

Dr John appears to be following the contemporary course of treatment closely in his manipulation of Lucy's case.

Because Dr John assumes that Lucy's affliction is related to nerves or mental instability, he does not bother to investigate other physical causes. He performs no physical examination whatsoever, asks no questions of her general medical history, nor of her present illness. Carter suggests that manifestations which mimic physical disease "all are intended to answer the same purpose, and to excite sympathy by an appearance of dangerous or uncommon disease" (72-3). Nervous women, according to Carter, seek "gratification of the morbid craving after sympathy" (76). Actual physical causes are rarely looked for, in fact are not mentioned at all by Carter, who believes that "a certain amount of emotion will produce an attack in almost any woman, however healthy" (92). Because Lucy is known to have a melancholic personality, few friends, and little support, Dr John never thinks of physical pathology. Her situation fits the criteria for a nervous condition, and he investigates no further.

According to Kathryn Hunter, writing about current medical practice, there is often still, over a hundred years later, a "silent tug-of-war over possession of the story of illness"

between the patient and doctor. Because the patient's story is "reinterpreted as a diagnosis" it is "transformed and medicalized" by the physician into something which "may be alien to the patient: strange depersonalized, unlived and unlivable, incomprehensible or terrifyingly clear." Even if the patient is allowed to detail the events of the illness, by the time it is transformed into medical language often "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 tension develops between patient and doctor about the narrative of illness "over who is to be its author" (13).

Lucy has no opportunity to contribute to her diagnosis, and thus loses whatever power she has over her sense of health and sanity. Basing his diagnosis completely on observation, the doctor pronounces "Hypochondria"[6] (*Villette* 257). This diagnosis completely discounts her history of fever and malnutrition, for it is a history she has not been allowed to disclose. Not only does he frighten Lucy with his off-hand diagnosis, he also completely absolves himself of offering treatment because his "art halts at the threshold" (257) of this affliction. Dr John appropriates Lucy's illness and then refuses to treat it, and Lucy, deprived of authorship in her medical story, is silenced, then left with a plot she cannot write.

Bucknill and Tuke, in their chapter on Melancholia, cite

Sydenham' as the best example for a description of hypochondriasis:

> An incurable despair is so thoroughly the nature of the disease, that the very slightest word of hope creates anger. The patients believe that they have to suffer all the evils that can befall humanity; all the troubles that the world can supply. They have melancholy forebodings. They brood over trifles, cherishing them in their anxious and unquiet bosoms. Fear, anger, jealousy, suspicion, and the worst passions of the mind, arise without cause. (166)

By affixing such a diagnosis to Lucy, Dr John silences any possible resistance. If she responds with anger, it will only prove his theory; if she becomes more depressed, he will also assume he is right. Her only recourse is silence, and indeed she writes, "Acquiescence and a pause followed these remarks." Rather than telling her story of real sorrow and physical stressors, which would explain the cause of both her sadness and her collapse, Lucy does not risk confronting Dr John and settles for a diagnosis which "bore the safe sanction of custom, and the well worn stamp of use" (*Villette* 257). Had Dr John chosen mania as his diagnosis instead of hypochondria, she would be at greater risk of being pronounced insane. Indeed the distinction is often not clear according to Bucknill and Tuke as "the symptoms *essential* to the disease [of hypochondriasis] border on insanity" and those which are "of frequent occurrence, are inseparable from unsoundness of mind. This is, in truth, a species of insanity" (166). Thus Lucy is in dangerous territory, and has no choice but to accept the doctor's haphazard findings, or risk being put away

as insane.

Dr John, although he claims he cannot treat her illness, patronizingly advises Lucy to seek "cheerful society...be as little alone as possible...[and] take plenty of exercise" (257). "Change of air - change of scene; those are my prescriptions" (259). She cannot possibly fill his prescription; she is alone and virtually friendless, she has no other means of support than her teaching, and her movements are restricted by the vigorous duties of the school which employs her. But his advice gives her false hope that he cares for her. She feels her only chance of friendship is through him, but he is too cavalier or callous to notice.

It is her need for friendship, in fact, which she now suggests has taken her out into the storm where she collapsed: "I wanted friendship, I wanted counsel. I could find none of these in closet, or chamber, so I went and sought them in church and confessional" (258). What she has found, through her illness, is a brief refuge with Dr John and his mother. a short respite from her bitter life, and for that, "instead of crying [her]self asleep - [she] went down to dreamland by a pathway bordered with pleasant thoughts" (261). Dr John's medical advice to Lucy is useless; his encouragement of false hope is cruel.

Lucy's inner rage at the doctor's ignorance of her feelings surfaces occasionally. At one pcint when she is very angry, she stomps out of the room "very much excited" and tells the

reader that "the sympathetic faculty was not prominent in" Dr John. She immediately reconsiders, however, and wants us to know that he is not "*un*-sympathizing, unfeeling: [but] the contrary" (264). Her resistance emerges and then wavers and then disappears.

Lucy wavers frequently:

> Reader, if in the course of this work, you find that my opinion of Dr John, undergoes modification, excuse the seeming inconsistency. I give the feeling as at the time I felt it; I describe the view of character as it appeared when discovered. (266)

After calling him "a kind, generous man" (264) who responds to every need, she accuses him of selfishness and vanity. Either he has two sides, or Lucy has two ways of seeing. Gilbert and Gubar might read this as evidence of what they diagnose as Lucy's schizophrenia (416), and it fits Sydenham's[8] description of hypochondriasis:

> Joy, hope, and cheerfulness, if they find place at all in their spirits, find it at intervals, 'few and far between,' and then take leave quickly. In these, as in the painful feelings, there is no moderation. All is caprice. They love, without measure, those whom they will soon hate without reason. (Bucknill 166)

Lucy's vacillating feelings represent a duality which I interpret as evidence of her struggle between strategies of acquiescence and resistance. Dr John calls her closer, then pushes her away. The power of medicine alone is difficult to resist; when it is compounded with an emotional attachment the difficulty is insurmountable.

MEDICAL CREDIBILITY:

Dr John's refusal to believe that Lucy has really witnessed

a stranger in the garret of the school is typical of the silencing and controlling power medicine has over women. Because Lucy is a woman, and a patient of Dr John's, and because she has suffered from what he has diagnosed as a nervous complaint, she can have no credibility with him. He will never believe the words of a nervous woman and concludes that she is suffering now not only from hypochondria, but also from hysteria.

According to Helen Roberts, "doctors have the power to define what is, and what is not, illness; what is, and what is not, appropriate behaviour in a patient" (2), and therefore they have the power to condemn or belittle a patient they disbelieve. A diagnosis of hysteria is a diagnosis of disbelief. Dr Robert Carter writes that women experience hysteria because they are "not only more prone to emotions, but also more frequently under the necessity of endeavouring to conceal them" (26). According to Carter,

> when sexual desire is taken into the account, it will add immensely to the forces bearing upon the female, who is often much under its dominion; and who, if unmarried and chaste, is compelled to restrict every manifestation of its sway. (33)

Dr John, aware of Lucy's emotional and sexual desire for him, no doubt assumes he has ample evidence for his diagnosis. Carter suggests that the most manipulative women are at the greatest risk. Not only are these women not believed, they are assumed to be incapable of truth, their symptoms "artfully produced...to excite sympathy" (72-3).

Dr John assumes that Lucy has invented a frightening situation in the attic to gain his attention. In fact, Lucy has entered "the deep, black, cold garret" (*Villette* 324) because there is nowhere else for her to read her letter from Dr John in private. To her horror, she soon becomes aware of an unlikely vision, and yet she is certain she sees it--so certain, that she speaks directly to the reader: "tell me I was nervous or mad; affirm that I was unsettled by the excitement of that letter; declare that I dreamed: this I vow --I saw there--in that room--on that night--an image like--a NUN" (325). Dropping the letter, she frantically runs for help and is 'comforted' by Dr John, who, without even considering her story, clearly disbelieves her.

Nevertheless, Lucy is excessively overwhelmed by Dr John's kindness at this time: "he was as good to me as the well is to the parched wayfarer--as the sun to the shivering jail-bird. I remember him heroic. Heroic at this moment will I hold him to be" (327). In his role as a physician, he is expected to take control of the situation because Lucy is distraught and terrified. Lucy, however, reads his attention as personal, not medical, and presents it as such to the reader. It seems clear that Dr John is using his medical power to tease Lucy, for his kindness is tempered by a cruel joke. When she cries at having lost his letter, which in the commotion has disappeared, the doctor produces the missive from his waistcoat pocket. "His quick eye had seen the letter

on the floor where I sought it; his hand, as quick, had snatched it up" (327). He has kept it hidden, in spite of her chagrin at its loss. His apparent kindness is quite false; his action is sadistic[9] for a friendship and inexcusable professionally.

What sort of malicious game is Dr John playing with Lucy? Is he her doctor or her lover? She is clearly in love with him and has been overcome by receiving a letter from him. She admits she may be reading thoughts into his letter, wondering if, to her "longing and famished thought it seemed, perhaps, kinder than it was" (324). But if the letter was really just an innocent and friendly note, why is Dr John so quick to conceal it before the others can observe? Why does he torture Lucy by keeping it hidden while she bemoans its loss, giving it up only when they are alone together? He may be sexually teasing Lucy, and encouraging her with ambiguities. If this is the case, he certainly does not want to be caught by Madame Beck, who has not only had a sexual interest in him herself, but who is important in supplying patients for his medical practice. His motives are never disclosed.

Dr John, as doctor, now takes complete control. He has power over Lucy's medical and emotional well-being. She is in awe of his medical power and is in the midst of a transference of all her affections towards him. Lucy is aware that she has been mistreated, but she does not let him know:

"Pleasure at regaining made me forget merited reproach for the teasing torment" (328). She is reluctant to speak to him at all, and when he urges for a description of what she saw declares: "I never will tell exactly what I saw...unless someone else sees it too, and then I will give corroborative testimony; but otherwise, I shall be discredited and accused of dreaming" (328). In spite of her position as a respected teacher, Lucy knows that her words will not be believed; as a woman, Lucy is not in possession of the power of truth. She is aware that if the diagnosis of hysteria is added to that of hypochondria, she will be even more disempowered, more disbelieved. With Dr John in control, silence is the safest route and gives Lucy some power over her situation.

According to Carter in the 1850s, women with hysteria are more to be punished than treated for inventing their false symptoms or illusions (76). After the patient has been subdued by the silent treatment outlined above, she is to be approached with the intent to degrade her character and mortify her into submission and health:

> any or every part of her past conduct, which can conduce to her humiliation and shame, must be brought fully before her, and its true stamp and character explained; this plan being continued until either the resources of the speaker are exhausted, or until, as will now and then happen, the patient exhibits signs of contrition and regret. (112)

When she submits and shows "any sign of penitence...the patient will require more tender treatment" (112).[10] The central component to this treatment is the assumption that the

patient's symptoms are false, that she is lying and incapable of truth.

Dr John's methods do not go so far as Carter's, although his earlier denial of Lucy's voice fits Carter's pattern perfectly. In Lucy Snowe's case, the doctor has not only the authority and power of his professional position, but also the leverage of a pseudo-lover to force Lucy to tell her story. She has retreated into silence to protect herself. Hysterics, she seems to know, are liars. Dr John makes her speak, and his methods are much craftier than Dr Carter's, for he has her emotional dependence to rely on. To persuade her to disclose what she has seen he uses the heavy hand of medicine:

> I will hear it in my professional character: 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 steady. Come, Lucy, speak and tell me. (382)

He implores her to trust him "as implicitly" as she trusted the priest: "Indeed the doctor" he says, "is perhaps the safer confessor of the two" (329). His discourse is not just authoritarian, but suggests that his medical gaze already gives him a dreadful insight into her condition and her desires.

The sexual component of Dr John's gaze cannot be ignored. The penetrating quality of his gaze threatens to expose Lucy's sexuality which she is obliged, by Victorian ideology, to conceal. Lucy is caught in a contradiction between her

emotions and her subjectivity. If Dr John has the power to enter and read Lucy's mind against her will, she may also see him as a threat to her body, but she cannot express her sexual fears or feelings because of the impositions of the very discourse which threatens to reveal them.

If Dr John cannot gain Lucy's confidence by professional persuasion, he is prepared to bribe her for the information. Falling back on his power over her emotionally, he threatens: "If you don't tell me you shall have no more letters" (*Villette* 328). Lucy first responds in good humour, laughing in order to resist his threat. When he warns he will "take away that single epistle: being mine, I think I have a right to reclaim it" (328), she has no more strength to resist; she is disturbed and silenced: "it made me grave and quiet" (328). Lucy's attempt to undermine the power of his discourse with laughter is thwarted: Dr John's bribe succeeds.

Once again, Dr John is following an accepted medical practice. Although bribes are not mentioned as such, Carter advises doctors to attain the co-operation of a patient by assuring her that

> with good conduct on her part, there is every prospect of her complete moral restoration; that the endeavours of her professional friend shall steadily be directed to the attainment of this object; and that he will abstain from exposing her, either to members of her own family or of his, so long as she manifests a sincere desire for amendment. (112)

Carter uses the tenets of his profession,[11] as bribing elements to force his patients to give up what he determines are their

hysterical reactions.

SILENCE AND REVELATION:

Silence is Lucy's initial mode of resistance to Dr John in the attic scene. She feels power in maintaining her secret, in resisting what Foucault calls the recodification of confession as a therapeutic operation (*History* 67) and in undercutting the power of the doctor's professional discourse. At the same time, Lucy's silence is the result of being disempowered; Dr John's threat leaves her nonplussed; she has no reply but silent gravity. The combination of his professional power, her love for him, and his appeal as a friend, eventually forces Lucy to submit to his questions. She has clung to silence until finally "won to confidence" (330), or more likely broken down by his persuasive methods, she tells him what she has seen.

His immediate (if ill-considered) reaction to her terror is that she has had a hysterical hallucination, "a case of spectral illusion ... following on and resulting from long-continued mental conflict" (330). Once the diagnosis of hysteria was made in the nineteenth century, it was considered crucial for the physician to adhere to it. Dr Carter suggests that "whatever the decision the medical attendant may arrive at, he should judge and act entirely upon his own responsibility" rather than getting another opinion. Seeking outside advice, "however valuable it might be with reference

to the particular question, would show, beyond a doubt, that he was really perplexed" (123), and it would never do to let the patient see that she has any power to puzzle the doctor. Under the guise of maintaining strict control over the patient, the doctor is encouraged to protect his form of treatment and his faith in the diagnosis.

Dr John is misguided in his interpretation of Lucy's reaction. What we later learn has been a real man disguised as the ghost of a nun is dismissed by the doctor as "all a matter of the nerves" (*Villette* 329). Lucy has relinquished control of her silence, has been caught like a defenceless rabbit by the snare of the confessor, and is now disbelieved. Forfeiting her silence puts her in a new position of servitude and gives Dr John more power than ever.

His diagnosis fills Lucy with "secret horror," and she "shudder[s] at the thought of being liable to such an illusion" (330). Lucy is right to be so upset, for as Bucknill and Tuke define it, an illusion occurs when a person perceives persons or things which "have no such external existence as they are then conceived to have" (133). In such an illusion, "the sensations are produced by the false perception of objects. If unable to correct or recognize them, when an appeal is made to reason, [the patient] is...insane." Adding the diagnosis of illusion to that of hypochondria further discredits Lucy's mental stability, for, according to Bucknill and Tuke, she "cannot have a false

belief (not simply a false induction, but) the result of disease, and unconnected with the senses without the mind itself being unsound" (135): "Hypochondriacs have illusions which spring from internal sensations. These persons deceive themselves" (150). Dr John's pronouncement undermines Lucy's own belief in her sanity, for her perception of the nun had "seemed so real" (*Villette* 330).

NARRATIVE RESISTANCE:

Nineteenth-century women were at the mercy of medicine for treatment for nervous afflictions, and Lucy begs her doctor for a cure, a preventative. Dr John's prescription is for Lucy to cultivate happiness. Her overt response indicates her disgust at the ineptitude of medical thinking and the "mockery" of its forms of diagnosis; she silently smothers her rage and only briefly asks him "Cultivate happiness!...do *you* cultivate happiness?" Her silent response, directed to the reader, subverts the doctor's advice. "Happiness is not a potato," she succinctly tells us, "to be planted in mould, and tilled with manure" (330). Cultivating friendship and happiness is not under the scientific realm of medicine, to be prescribed and swallowed like a tonic. She realizes that medicine has once again failed her. Not only has she been wrongly diagnosed, she has been blamed for her vision and admonished with a trite command to will herself to contentment.

By aiming her comments directly to the reader and not to Dr John, Lucy manipulates a silencing situation into an opportunity for response. In what Patricia Yaeger might call a moment of "oral glee" (239), Lucy actually turns Dr John's serious comments into a joke. Equating happiness with a potato undercuts both Dr John's advice and his offhand, heartless manner of prescription. By joking with the reader, Lucy, in spite of her seemingly dependent and dejected state, is able to represent herself as intelligent, witty, and, within her mind at least, outside the reach of the discourse of medicine.

Dr John's shallow advice is consistent with the thinking of Victorian doctors, who, according to Showalter,

> ...believed that in most cases insanity was preventable if individuals were prepared to use their willpower to fight off mental disorder and to avoid excess. Mental health was to be achieved by a life of moderation and by the energetic exercise of the will. (*Malady* 30)

Lucy knows that Dr John is wrong, both in his diagnosis and his treatment, but she is unable to challenge him outwardly: "Not one bit did I believe him; but I dared not contradict: doctors are so self-opinionated, so immovable in their dry, materialist views" (*Villette* 338). She is afraid to speak back aloud, but her reader hears her resistance in the narration. Despite her inward response, the doctor's patronizing disbelief has taken its toll and left her asking herself, "whether indeed [the vision] was only the child of malady, and I of that malady the prey" (333).

The doctor's authority, though inwardly doubted, is enough to shake Lucy's personal conviction, to silence her, and to cause her horror and confusion at the questioned stability of her own mental health. She has relinquished her silence to confide her vision to Dr John and has thus exposed herself to ridicule, disbelief, misdiagnosis and self-doubt. Her reward for compliance is the continuation of a sporadic and ambiguous correspondence in which Dr John extends his medical power into the realm of a controlling personal relationship which further acts on Lucy's mental health.

WRITTEN RESISTANCE:

In the exchange of letters with Dr John, Lucy regains a little of the power she lost by speaking, for she does have control over her responses. The first-person narration allows Lucy to share the duplicitous nature of her replies with the reader. What she does not write to *him*, she conveys by writing to *us*.

She is predisposed to read his letters as loving when they first arrive, not only because of her tender feelings for him, but because, as she says, "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" (*Villette* 335). She interprets his medical interest on an emotional level.

Although she is thoroughly intoxicated by the contents of

each letter when it arrives, she mellows with time to admit there are, in two of the four, but "three or four closing lines half-gay, half-tender, 'by *feeling* touched, but not subdued.'" She realizes she is deceiving herself about the nature of Graham's (as she once again calls him) feelings for her, but she cannot easily relinquish the fantasy she has of him as her lover. Her solution is to write two separate responses to each of his letters, "one for my own relief, the other for Graham's perusal" (334).

The first letter is written from her heart:

> two sheets were covered with the language of a strongly-adherent affection, a rooted and active gratitude....a closely-clinging and deeply-honouring attachment--an attachment that wanted to attract to itself and take into its own lot all that was painful in the destiny of its object; that would, if it could, have absorbed and conducted away all storms and lightnings from an existence viewed with a passion of solicitude--

The second and surviving letter is the daughter of "Reason [who would] leap in, vigorous and revengeful, snatch the full sheets, read, sneer, erase, tear up, re-write, fold, seal, direct, and send a terse, curt missive of a page" (335). The destroyed silent letter, thought but not spoken, written but not sent, is her private form of resistance to his ambiguous overtures; the extant letter, conceived in a violent rage of reason, is her public presentation of resistance. The anger and rage of the language in which Lucy describes the composition of the letter she sends is the language of revolt. Reason, far from being calm, is personified as leaping,

snatching, and sneering. Reason operates with vigour, and from revenge. Lucy knows she is being toyed with and abused, but her roads of resistance are limited to silent blind alleys, for even the knowledge of her reactions is kept from the other characters and is limited to the reader of *Villette*.

Dr John/Graham is playing two roles. He is both a professional counsellor and a loving confidant. That Lucy writes two different replies to his letters suggests that she is well aware of his two roles. No doubt the letter she ends up sending addresses 'Dr John,' and the one she destroys hails 'Graham.' He clearly plays along with her adoration; it is good for his ego, as she suggests, and he doubtless defines and defends his deceit as valid treatment for Lucy's depressive personality. Mixing professional and personal roles and taking advantage of the emotional attachment of the patient is the subject of much concern and discussion in contemporary society. It is now well recognized that patients are particularly vulnerable to advances from doctors, and any abuse of the powerful doctor-patient relationship in private encounter is met with strict legal ramifications and societal disapproval.

In 1853 when the novel was written, there were no laws restricting doctors from forming emotional or intimate relationships with patients. Lucy's vulnerability is, of course, further compounded by her solitary situation. Dr John

is the closest thing she has to family, country, and security. He does not make his role in her life at all clear. She has recuperated in his house, she is under his medical care--yet he governs her social life, taking her to a gallery, or a concert. He allows, even encourages, Lucy to confuse completely his social and professional roles.

Lucy, to have any fun and companionship with *Graham*, must acquiesce to the role of patient with *Dr John*, for only the sick Lucy really interests him, or arouses his sympathy. He is otherwise oblivious to her needs. Assuming the character of an invalid is economically dangerous for Lucy unless she can win Dr John as a husband who will support her, and that possibility always seems unlikely in the novel. If she cannot marry Dr John, Lucy cannot afford either the time away from teaching to be ill, or the self-doubt and pain of dealing with any form of madness. She cannot speak out, nor can she gain much resistance from her silence.

VOICE:

Brontë gives Lucy a voice by letting her narrate her own story. Lucy frequently addresses the reader directly--not Brontë, or an unnamed narrator--but Lucy as autobiographer. Her silence, whether attacked and broken down by Dr John as in the sighting of the nun, or subverted in the destroyed letters to him, is given volume in the ears of the reader. Lucy does not always recognize the importance of her silence

as a form of resistance to Dr John and his power, so overawed is she by his presence. But the reader, party to her internal rage, hears the roar of her silent resistance.

NOTES

1 Brontë *Villette* 267.

2 Brontë *Villette* 338.

3 Perhaps Arnold's annoyance comes from his realization that it is not Lucy's questionable narrative, but Brontë's beliefs, which are put forward in the novel. Rimmon-Kenan, in *Narrative Fiction: Contemporary Poetics*, writes: "A narrator's moral values are considered questionable if they do not tally with those of the implied author" (101). In *Villette*, Arnold seems to recognize, or fear, that Lucy's rebellious narration accurately reflects the moral values of the novel's author.

4 Patricia Yaeger, in *Honey-Mad Women*, also recognizes the positive and resisting aspects of Lucy's character. Her argument is based on Lucy's use of French as a second language "as a form of interruption, as a way of dispelling the power of the myth systems represented the text's primary language" (37). Although Yaeger does not address Lucy's narrative strategies as such, she encourages the search for "emancipatory moments"(69) in the text, rather than a preoccupation, so prevalent in the criticism, with the negative and sober aspects of Lucy's character.

5 Elaine Showalter briefly mentions this text in *The Female Malady*.

6 Hypochondria in the nineteenth century is defined as morbid depression, or pronounced melancholia.

7 Sydenham's Epistle Dedicatory, section 75, cited in Bucknill and Tuke, 166. Thomas Sydenham, who lived from 1624 to 1689 is referred to as the English Hippocrates. That Bucknill and Tuke still defer to him indicates how little this aspect of medicine had changed in two hundred years.

8 Thomas Sydenham, cited in Bucknill and Tuke.

9 Charles Burkhart notices the doctor's cruel behaviour over Lucy's letter, and describes it as "that blend of patronage, sadism and kindness usual in his dealings with her" (115), but Judith Williams claims Dr John is "probably only teasing" (95), thus forgiving the inappropriateness of his behaviour. I found no other critics who commented on this scene.

10 Carter's use of the word penitence is another indication of the cross-over between religious and medical discourses.

11 The Hippocratic oath, which has been the ethical guide of the medical profession since the late 5th century BC, includes the following promises:

> I will prescribe regimen for the good of my patients according to my ability and my judgment and never do harm to anyone...All that may come to my knowledge in the exercise of my profession or outside of my profession or in daily commerce with men, which ought not to be spread abroad, I will keep secret and will never reveal. If I keep this oath faithfully, may I enjoy my life and practice my art, respected by all men and in all times; but if I swerve from it or violate it, may the reverse be my lot.

CHAPTER 3

SINGING IN GREEK

DISGUISING THE TELLING IN *MRS DALLOWAY*

Virginia Woolf is much more forthright than Charlotte Brontë in her condemnation of medical power and authority, presenting her criticism of medical discourse directly to the reader in the narrative of *Mrs Dalloway*. Her two fictional doctors are armed with the jurisdiction of judges: they "differed in their verdicts (for Holmes said one thing, Bradshaw another), yet judges they were; who...saw nothing clear, yet ruled, yet inflicted" (Woolf *Dalloway* 164). Significantly, Woolf's characters are unable to discuss aloud their horror and anger at medicine; they disguise the telling. Whereas Brontë gives the reader the voice of Lucy Snowe in the first person, Woolf uses an omniscient narrator and the techniques of stream-of-consciousness and interior monologue. We have access not only to what little the characters actually say, but to the greater aspects of what they think of saying, what they are afraid of saying, and what they are prevented from saying. Like the birds who sing incomprehensibly "in voices prolonged and piercing in Greek words" (28), Woolf's oppressed characters disguise their thoughts in the telling. They have no access to each other's codes; they are unable to

decipher each other's outrage and it is left for the reader to decode the message.

In *Villette*, the conflict over medical authority and medical silencing is directly between Lucy and Dr John, and the reader recognizes it as such. Even though Dr John is not apparently aware of Lucy's resistance to his professional power, there is a banter set up which pits the two characters against each other and the conflict is shared. He orders, and she resists or acquiesces, depending on the circumstances. It is a volley of action and reaction between opposing characters.

Conversely, in *Mrs Dalloway* the characters rarely verbally intersect. The doctors, Sir William Bradshaw and Dr Holmes, are on a linear course, propelled by their authority, to predetermined conclusions. They display a sense of confidence in their diagnosis and treatment which reflects the patriarchal system of medicine which was entrenched in the late nineteenth century as outlined in chapter one. Whereas Brontë's Dr John maintains a multifaceted professional, emotional, and verbal relationship with Lucy Snowe, Woolf's doctors have no time or concern for dialogue; they pronounce. Disease has a designated order for these London practitioners: diagnosis, treatment, cure. As Mary R. Lefkowitz points out in *Heroines and Hysterics,* doctors traditionally work in the "whenever...always" (22) method, believing specific symptoms invariably require absolute prescribed treatments; they

perceive no need for discussion. For Holmes, 'whenever' he encounters a breakdown of the heroic male spirit, we feel he will 'always' bully and belittle; as for Bradshaw, 'whenever' he perceives neurosis, he will 'always' prescribe confinement, and both act on assumption rather than on careful communication with their patients.[1]

Critics who have looked at *Mrs Dalloway* and its doctors include Roger Poole, Elaine Showalter, and Stephen Trombley. Poole reads Woolf through her subjectivity, analyzing the doctors in *Mrs Dalloway* as fictional representations of her own physicians. Both Poole and Trombley question the very existence of Woolf's 'madness,' and interpret her presentation of doctors as an attack against the specific treatment she received. Trombley, particularly, goes into great detail about Woolf's actual physicians. Whereas Poole and Trombley read Woolf through the novel, my approach is to read the novel through the context of the power and authority of medicine historically, and through Woolf's presentation specifically of accepted contemporary medical practice. Showalter, in *The Female Malady*, examines the history of psychiatric medicine and critiques its treatment of women; she reads the doctors in *Mrs Dalloway* in the context of "the sadism of nerve therapies that enforced conventional sex roles" (*Malady* 193). My work differs in its focus on the system of medicine, be it psychiatric, physiologic, or gynaecologic, which acquires and imposes its professional authority on patients and on the

strategies writers like Woolf employ to resist such power.

Sue Thomas, in her article "Virginia Woolf's Septimus Smith and Contemporary Perceptions of Shell Shock" touches on the importance of contemporary trends in medical treatment, but only as they are outlined in the British Army "Report of the War Office Committee of Enquiry into Shell-shock."[2] Thomas makes the case that Woolf was influenced by this report in writing *Mrs Dalloway* (although she has no proof that Woolf was familiar with it) and that Woolf was angered by medicine's treatment of soldiers with shell-shock. I extend Thomas's investigation and reveal the pervasiveness of medicine's mismanagement of mental distress, particularly with regard to women. Shell shock is important, as Thomas argues, but is only one aspect of the medical profession's force of power over patients. I intend to establish the level of power and control medicine held over patients, including Woolf herself, to examine the wide social acceptance such power enjoyed, and to indicate the struggle that patients and their families--specifically women--underwent to resist this power.

Zwerdling situates Woolf's attack on doctors with a general political attack in the mixing of public and private life (31); Bowlby sees medicine as only one element of an institutionalized patriarchy Woolf conveys; and Phyllis Rose sees Sir William Bradshaw as part of a conspiracy of Victorian idealism.

Biographers acknowledge the connection between Holmes and

Bradshaw and Woolf's own doctors. Bell accepts the treatment Woolf was given because he believes there were no better treatments available, and he sees the disease as having control, rather than the doctors. Gordon reads Woolf's criticism of her physicians in Holmes and Bradshaw and agrees that her treatment by medicine was harsh. But she also defends the system, which includes force-feeding, asking the thoughtful question: "were doctors to let her starve?" (64). Love reluctantly accepts Woolf's personal treatment by medicine which she surmises "must have seemed logical enough at the time" (316-17), but Lehman and Spater and Parsons, although dealing with Woolf's illness, completely ignore her doctors or their treatments.

My approach will be to examine the connections between the discourse of Woolf's fictional doctors and the medical discourse of the time in texts and articles by leading neurologists and psychiatric specialists. The authority which medicine began to acquire in the mid nineteenth-century continues to allow physicians to rule their patients and influence society. Woolf understands this power and clearly presents it in the doctors in *Mrs Dalloway*. Her call for resistance is less evident, but it runs through the text beneath the dialogue. My intention is to let it surface.

In *Mrs Dalloway*, Septimus Warren Smith, a suicidal shell-shocked World War I veteran, is patronized by the Harley

Street nerve specialist, Sir William Bradshaw, and misdiagnosed by the GP, Dr Holmes: "one falsely clinical, the other clinically false" (Poole 185). Septimus is abused and forsaken by medicine, and his ultimate retaliation is to jump to his death from a window in his Bloomsbury lodgings. His wife Rezia, his sane caretaker, is bullied, disbelieved and dismissed by the doctors. She has the crucial role of monitoring her sick husband, but her opinion is denied, her voice silenced.

Rezia and Septimus also fail to communicate. Septimus, in his delusions, talks to the vision of his dead friend and listens to the pronouncements of the Greek-singing birds. Rezia scurries between Septimus and the doctors, trying to console, cajole and carry out instructions. But for all her skill at making hats, she is unable to connect the heads of Septimus and the doctors.

Woolf connects her characters through the reader, who alone has access to all the voices and thoughts. By her use of stream-of-consciousness, Woolf is able to express the various unsayables to the reader, to present the characters' inner--and silent--methods of manipulation, negotiation and resistance both to the spoken dialogue of others, and also to the hegemonic discourse of patriarchy, which is represented in *Mrs Dalloway* particularly by medicine. Whereas James Joyce uses a similar narrative technique to express what is socially inexpressible about sexuality and the body, Virginia Woolf

employs both stream-of-consciousness and interior monologue techniques to give voice to the politically unutterable for women. Only the reader, party to both dialogues and monologues, has the pieces of the puzzle.

Women, as we have seen, are not encouraged to have opinions, and are certainly discouraged from expressing them if they do. Only Lady Bruton approaches her political views openly and aloud in this novel, but, of course, they are not her own views at all--she is a pawn of the patriarchy endorsing emigration for "superfluous youth" (122). In spite of her "reputation of being more interested in politics than people; of talking like a man" (117), she is unable to express herself effectively:

> one letter to the *Times*, she used to say to Miss Brush, cost her more than to organize an expedition to South Africa (which she had done in the war). After a morning's battle, beginning, tearing up, beginning again, she used to feel the futility of her own womanhood as she felt it on no other occasion, and would turn gratefully to the thought of Hugh Whitbread who possessed--no one could doubt it--the art of writing letters to the *Times*. (121)

Fussy Hugh Whitbread, who "did not go deeply" but merely "brushed surfaces" (114), has the advantage over Lady Bruton because he is a man, and "Lady Bruton often suspended judgement upon men in deference to the mysterious accord in which they, but no woman, stood to the laws of the universe; knew how to put things; knew what was said" (121). Lady Bruton's opinions are empty shells; she feels they will be valid only "if Richard advised her, and Hugh wrote for her"

(121). Only with the help of men is she "sure of being somehow right" (121).

Woolf's style allows her female characters to negotiate with and resist the anxiety Lady Bruton expresses over her attempts to make political commentary and invoke influence. Although Lady Bruton (in spite of being a patriarch in petticoats), is clearly unsuccessful in her efforts and must rely on male manipulators (as well as editors) to cloak her not very original or enlightening thoughts with acceptable words, Woolf allows other women characters to express their thoughts directly through the stylistic devices with which she augments their inner voices. Woolf uses style as an expression of the politics of female marginalization.

Woolf's narrative choice indicates her realization that style has a political objective. Josephine Donovan, in her essay "Style and Power," establishes the connection between the two. Bakhtin, she writes,

> recognizes that literature exists in a political context and therefore literary devices reflect and refract the power differentials of the author's society. Style in this view is not innocent or neutral--ie purely aesthetic--but rather...a political expression. (Donovan 85)

Woolf is clearly aware that her use of the interior monologue and stream-of-consciousness techniques allows her to give political weight to women's voices which are outwardly silenced by those in power. Doctors in this novel do not allow dialogue; Woolf's style covertly imposes it.

Presenting women's concerns and fears directly through

their thoughts expresses their subverted resistance to the patriarchal oppression of medicine, and Woolf's use of subversion follows an established practice in women's writing. Donovan states that "women's political location in the unofficial margins...was the context that determined the epistemic choices early women novelists made in their writing" (87). Typically,

> their style, which was characterized by an ironic use of indirect discourse, the use of the 'plain style' in prose, the 'dashaway' epistolary mode, and paratactic syntax, reflected a political resistance to hierarchical subordination (87)

by a patriarchal culture. Woolf, writing back against the overwhelming power of medicine, extends traditional women's stylistic practices by what Donovan calls "resistance to the imposition of authoritarian official dicta" (87), particularly the maxims of medical discourse.

In *A Room of One's Own*, Woolf resists the authority of Professor von X, the author of *The Mental, Moral, and Physical Inferiority of the Female Sex,* not by debunking his data or his methods of research, but by drawing his picture. Instead of outwardly attacking his words, she subversively attacks his very being, depicting him as not

> attractive to women. He was heavily built; he had a great jowl; to balance that he had very small eyes; he was very red in the face. His expression suggested that he was labouring under some emotion that made him jab his pen on the paper as if he were killing some noxious insect as he wrote, but even when he had killed it that did not satisfy him; he must go on killing it; and even so, some cause for anger and irritation remained. (32-3)

By describing her drawing, she effectively deflates the authority of the Professor and resists his power over women. "Drawing pictures," she writes, "was an idle way of finishing an unprofitable morning's work. Yet it is in our idleness, in our dreams, that the submerged truth sometimes comes to the top" (33). Drawing in the margins of her notebook at the British Museum and speaking from the margins of authority at her lectures in the women's colleges at Cambridge (where a version of *A Room of One's Own* was first presented), Woolf recognizes the power of hidden thought to reach a truth. It is through the portrayal of inner thought that she subverts medical discourse in *Mrs Dalloway*.

Instead of using indirect discourse, Woolf has her characters respond to medicine's power through interior monologue mixed with narrative voice. Rezia is incensed at Sir William Bradshaw's treatment of Septimus and herself. Woolf presents the reaction to the doctor in a series of paratactic thought sentences which almost imperceptibly drift from the narrative voice to Rezia's own:

> Never, never had Rezia felt such agony in her life! She had asked for help and been deserted! He had failed them! Sir William Bradshaw was not a nice man.
>
> (109)

The narrator, and then Rezia, dismiss Sir William with a silent terseness which brilliantly subverts his exceedingly curt dispatch of patients.

Woolf's personal history of depression and suicidal

behaviour gives her an intimate acquaintance with the medical treatment of mental illness in the early twentieth century and informs her writing on the topic. She was subjected to the sort of rest cures for which Weir Mitchell is famous[3] and was denied access to her family and to her work. Like Mitchell's patients, she was not allowed an opinion on the management of her depression, nor was she entitled to read or write while she was incarcerated. In *Mrs Dalloway*, as Suzanne Poirier points out, Woolf "made her most open attack on the rest cure and its prescribers" (Poirier 34), which she understood from her own experience.

Even before she was sent for rest cures, Woolf had a long-standing distrust of medicine.[4] Her mother, Julia Stephen, was a relentless nurse, "a woman obsessed with dispensing charity, visiting workhouses, carrying on her increasingly frail shoulders a heavy mantle, scented with illness and death" (Leaska xxviii) who seemed always to Virginia to be forsaking her family while she nursed the sick (xxix). In 1895, at the age of forty-eight, when Virginia was only thirteen, Julia Stephen contracted influenza, presumably from one of her patients, and died from its *sequelae* (Bell 1: 39). Woolf's description of the family doctor retreating from the house after her mother's death is a melancholy depiction of medical impotence: "I saw Dr Seton walk away up the street with his head bent and his hands clasped behind his back" (Woolf, *Moments of Being* 98).

When Woolf's half sister, Stella Duckworth (by now Stella Hills) returned from her honeymoon in April 1897 with "a bad chill on her innards" (Woolf *A Passionate Apprentice* 77), Virginia Woolf once again watched helplessly as doctors did very little. "Dr S.[eton] declares her to be much better & going on well" (77). After a moment of concern, in which the doctor declares Stella has peritonitis and must be kept quiet and "straw put down on the road" (77) to keep the noise of passing horses down, the following days see Dr Seton as "very cheerful" (78), "perfectly happy about Stella" (79) predicting "[t]horoughly good straight forward recovery--absolutely no danger" (79-80), but by early June she is once again ill. Dr Seton is summoned and declares her better. He "was pleased--says he thinks he has stopped it in time....he hopes--he will not be positive, but still he very much hopes that the actual peritonitis has been avoided, & that soon she will be well" (96). By July, "Stella had had a little pain--but they thought the worst was over; & she was already better" (114). "Stella was better the nurse said. But it was not true--she was ill all day--[Dr] Broadbent came & saw both of us[5], & said she was getting on very well" (114). Two days later the doctors decided to operate on Stella, and the following day Woolf writes in her diary: "At 3 this morning, Georgie & Nessa[6] came to me, & told me that Stella was dead--" (114). Whether the doctors were incompetent or untruthful is difficult to decipher. What is known, however, is that Woolf

considered them so. In *Moments of Being* she writes of Stella:

> One fortnight was the length of [her] honeymoon. And directly she came back she was taken ill. It was appendicitis; she was going to have a baby. And that was mismanaged too; and so, after three months of intermittent illness, she died--at 24 Hyde Park Gate, on July 27th, 1897. (125)

Woolf's depiction of medical ineffectiveness is reflected in doctors in her fiction; doctors provide little help and less comfort. In *The Voyage Out*, while Rachael lies dying of fever, Dr Rodriguez

> appeared to think that they were treating the illness with undue anxiety. His visits were always marked by the same show of confidence, and in his interviews with Terence he always waved aside his anxious and minute questions with a kind of flourish which seemed to indicate that they were all taking it much too seriously. He seemed curiously unwilling to sit down. (338)

When Rachael's condition deteriorates, Rodriguez still insists: "It is not serious, I assure you. You are over-anxious. The young lady is not seriously ill, and I am a doctor....Everyone has confidence in me" (343). Of course the doctor is wrong, has done nothing, and Rachael is so gravely ill that a subsequent physician, Dr Lesage, cannot make her well. Lesage is "sulky in his manner and very short in his answers" (352) and seems to offer little treatment or comfort between the time of his arrival and Rachael's death.

In *The Years* Woolf presents another inadequate doctor. Dr Prentice is fetched when the dying mother, Rose Pargiter, has a fainting fit. After seeing her, Dr Prentice joins the family in the drawing-room:

> He shut the door quietly but said nothing.
> 'Well?' said the Colonel, facing up to him.
> There was a prolonged pause.
> 'How d'you find her?' said the Colonel.
> Dr Prentice moved his shoulders slightly.
> 'She's rallied,' he said. 'For the moment,' he added.
> (*Years* 33)

The doctor leaves. The family eats their dinner. Rose Pargiter dies.

The doctors Seton and Broadbent, and the fictional Rodriguez, Lesage and Prentice are remarkable for their apparent medical inadequacy and their misrepresentation of illness. In *Mrs Dalloway*, however, Holmes and Bradshaw stand out for their overt interference, control and appropriation of their patients. They reflect the distrust Woolf grew to have for physicians, but they also represent the power and control medicine had on patients, had on her.

When she wrote *Mrs Dalloway* (after her rest cures)[7] she determined to expose the system of medicine as she had experienced it herself, and entries in her diary at this time suggest that doctors were frequently on her mind. She refers to the "Dr chapter" (2: 299),[8] and while she writes it Woolf feels she is getting at the core of her soul: "I may have found my mine this time I think. I may get all my gold out....And my vein of gold lies so deep, in such bent channels. To get it I must forge ahead, stoop & grope. But it is gold of a kind I think" (2: 292). It is significant that she remembers her mother on the anniversary of her death, May 5, 1924, by recalling Dr Seton retreating from the house.

This passage is very similar to that quoted above from *Moments of Being*, but is noteworthy for its particular emphasis on the doctor:

> This is the 29th anniversary of mothers death. I think it happened early on a Sunday morning, & I looked out of the nursery window & saw old Dr Seton walking away with his hands behind his back, as if to say It is finished.....I was 13, & could fill a whole page & more with my impressions of that day. (*Diary* 2: 300)

She could fill a page, but she does not. She adds only a sentence describing her confusion at laughing inappropriately "behind the hand which was meant to hide my tears; & through the fingers saw the nurses sobbing" (301). The doctor is central in her mind.[9]

Doctors feature in Woolf's personal life around the writing of *Mrs Dalloway*, but not the doctors who dealt with her mental illness.[10] She is sent on a round of visits to various physicians when she has an obstinate but mild fever: "My temp. goes on, as usual, & Dr Hamill thinks that my right lung is suspicious. Fergusson says no. And perhaps I shall have to see Sainsbury to settle it" (*Diary* 2: 182).[11] The doctors, like Holmes and Bradshaw in *Mrs Dalloway*, disagreed on the problem, and it was no minor medical quibble, for if they were concerned about tuberculosis, Woolf might have been sent to a sanatorium. The final consultation suggests this concern as it involves "the semi-legal discussion over my body" (2: 189), but ends in

> a bottle of quinine pills, & a box of lozenges, & a brush to varnish my throat. Influenza & pneumonia

> germs, perhaps, says Sainsbury, very softly, wisely & with extreme deliberation. 'Equanimity--practise equanimity Mrs Woolf' he said, as I left; an unnecessary interview from my point of view; but we were forced into it by one step after another on the part of the bacteriologists. (2: 189)

Quite apart from her own medical troubles, her niece Angelica is struck by a car and lies injured in a London hospital during the composition of *Mrs Dalloway*. Once again a doctor's approach suggests incompetence:

> Then the young Dr came, & seemed silently & considerately but firmly to wish the mother to know that the case was hopeless: very grave; run over across the stomach. Yes there may have to be an operation. The surgeon had been sent for, & was now on the train (2: 299)

In fact, Angelica is not injured: "Nothing was wrong with Angelica" (2: 299); medicine is mistaken.

Medical metaphors occur in Woolf's diary entries while she writes *Mrs Dalloway*. She refers to "a dose of criticism..." (2: 248) and "this odd symptom; a conviction that I shall go on [writing the novel], see it through, because it interests me to write it" (2: 262), which suggests she is thinking medically. When the book is finally written, she realizes that it has been "finished without break from illness, wh. is an exception" (2: 317). Writing her experience with mental illness keeps her sane.

According to Quentin Bell, Virginia Woolf's nephew and biographer, she was frequently on what he calls "the verge of madness" (Bell 1: 162). During these periods, she suffered from "headaches--what she called numbness in the head--

insomnia, nervous irritation and a strong impulse to reject food" (1: 162), symptoms that Stephen Trombley[12] suggests are hardly worthy of the term madness (Trombley 9), but which I find repeatedly detailed in the medical literature of the day as typical of neurasthenia.

Treated for madness and neurasthenia by the time she is writing *Mrs Dalloway*, Woolf uses the novel to confront the issues around mental illness as they applied to her. She is careful to approach the book with an intensity which will expose medicine as she has experienced it:

> But now what do I feel about *my* writing?--this book, that is, The Hours[13], if thats its name? One must write from deep feeling, said Dostoevsky. And do I? Or do I fabricate with words, loving them as I do? No I think not. In this book I have almost too many ideas. I want to give life & death, sanity & insanity; I want to criticise the social system, & to show it at work, at its most intense. (Woolf, *Diary* 2: 248)

She resists the temptation to lose herself in words; she directs herself to expose her ideas, to lay bare her interpretation of mental distress and its treatment. "I think it most important in this book to go for the central things, even though they dont submit, as they should however, to beautification in language" (2: 249). Writing about madness is trying and painful: "I am now in the thick of the mad scene in Regents Park. I find I write it by clinging as tight to fact as I can..." (2: 272), and that *fact* is drawn up from her own experience with mental illness and treatment. It is no easy task for her to confront these demons: "Of course the

mad part tries me so much, makes my mind squint so badly that I can hardly face spending the next weeks at it" (2: 248), but it is necessary for her to deal with medicine in order for her to dismiss it. An examination of the type of treatment she experienced in her 'mad' phases should indicate the extent of her concern.

NEURASTHENIA:

"the man who does not know sick women does not know women" (Mitchell *Doctor* 10).

Dr Silas Weir Mitchell (1829-1914) began his medical career as an army surgeon in the American Civil War. His interest in nervous diseases sprang from his experience with soldiers (Britannica 15: 617). It is somewhat ironic that he was to became a world renowned neurologist remembered for his rest cures for neurasthenia--not for soldiers, like Septimus Smith--but particularly for wealthy women. Mitchell's name not only appears in most of the feminist criticism of medicine,[14] but constantly recurs in psychiatric, gynaecologic and neurologic texts of the turn of the century. There is no doubt that he was considered the highest authority[15] on female neurasthenia on both sides of the Atlantic;[16] his rest cure was widely used in Europe, Britain and North America, and his work was translated into four languages (Poirier 15).[17] My research suggests that few practitioners put much thought into expanding on his ideas; rather, they followed his advice

unquestioningly, even though concurrent research by Charcot, Breuer and Freud suggested alternative treatments.

Mitchell prescribed seclusion and rest, as did Virginia Woolf's personal physicians and Sir William Bradshaw in *Mrs Dalloway*. As Dr William Playfair, Mitchell's British advocate, points out,[18] the concept of rest as treatment is not as new to medicine as are the strict regulations imposed by Mitchell's 'cure' on a patient's activity, food, and thought.

In 1877 Mitchell first published *Fat and Blood*, his full description of the treatment of neurasthenia. As a text-book advocating and describing isolation and rest as treatment, Mitchell's *Fat and Blood* begins with a particularly menacing title. Although it refers to the cause and treatment of neurasthenia, which according to Mitchell occurs chiefly in "women, who, as a rule, are thin and lack blood" (9), the title of the text deflects the medical reader from scientific analysis with its use of idiom.

The ambiguity of the title of this medical text was likely intentional, as Weir Mitchell was also a novelist and was familiar with metaphor. A book with an intriguing title was likely to have a readership beyond medicine, which would be desirable for Mitchell, a man described as "egotistical and self-centred" (Burr 156). Anna Robeson Burr, Mitchell's first biographer, uses these terms in a positive sense and praises his penchant for "exercising an authority that was almost tribal" (157). Mitchell was also capable of going to great

lengths to get what he desired, to "take hold of an idea...and push it through, because he wanted it" (160). The best way to sell his rest cure was to describe it directly to the market. *Fat and Blood*, no doubt partly because of its intriguing title, became popular outside the profession of medicine and was read by many who would become Mitchell's patients or by their relatives.[19]

Burr is careful to indicate that Mitchell did not anticipate an increase in patients with the publication of *Fat and Blood* and that "he used jestingly to declare that he reaped where he had not sown" (152).[20] However, this is not a typical medical text, but is aimed for a general market. There are very few statistics, almost no indication of follow-up, and little medical terminology. *Fat and Blood* is primarily an advertisement for Mitchell's rest cure. Burr calls the book a "direct appeal to the common-sense and intelligence of the layman at large" (152), and yet she quotes Mitchell describing *Fat and Blood* as "'the first effort in book form to spread the full knowledge of rest treatment before the profession'" (180), indicating his intention to provide a text for physicians.[21]

Fat and Blood changes subtitles in its various editions, from *and How to Make Them* in the first edition of 1877, to *An Essay on the Treatment of Certain Forms of Neurasthenia and Hysteria* in 1902.[22] The book raised concerns in the medical world and caused the profession to question Mitchell's

credibility, so he altered the title.[23] The bound volume, however, stands without the subtitle on cover or spine, and cries out from the stacks of medical texts as menacing and gothic. It was a brilliant tactic; by "1881, Mitchell's name was a household word" (Ball 122).

As Playfair points out, Mitchell's is "a complete scheme of treatment" (Mitchell 13). The sense of authority in Mitchell is quite clear; this is a treatment which must be carried out to the letter, by the patient and by the practitioner; there are to be no deviations. Because his treatment is based on complete power over the patient, it is not surprising that he admits it is "the half-ill who constitute the difficult cases" (45). For if a patient is dreadfully weak and sick she or he is unlikely to have a will to break: "As a rule, the worse the case, the more emaciated, the more easy is it to manage, to control, and to cure" (45). His language is the language of absolute authority, he must 'manage,' he must 'control.' When he finds this impossible, he feels "beaten by a patient who has an unconquerable taste for invalidism" (44), as if the patient is an enemy and the treatment is really a war between her (or very occasionally, him) and the doctor. It is not only the physical aspects of treatment which must be imposed, for in the case of selfish women, who draw in sympathetic nurses, "you must morally alter as well as physically amend, and nothing less will answer" (41). Mitchell's complete programme is completely tyrannical.

The treatment "consists in seclusion, certain forms of diet, rest in bed, massage (or manipulation), and electricity" (49). Patients must be removed from their homes to the doctor's nursing establishment in order to receive "daily visits of some length from the masseur, the doctor, and possibly an electrician" (51), thus establishing the well-known and accepted doctor-run system which is organized for the convenience of the profession rather than the patient. As well as catering to the physician's busy schedule, however, Mitchell's determination to move his patients enables him to force his patients to conform to his methods and to be under his complete power. His intention is to break "up the whole daily drama of the sick-room, with its little selfishness and its craving for sympathy and indulgence" (52), and he urges doctors not to "hesitate to insist upon this change" (52) of scene. If a move is impossible, Mitchell is reluctantly prepared to take over the patient's house, but not without imposed modifications: "change her room, and also have it well understood how far we are to control her surroundings and to govern as to visitors and the company of her own family" (52).[24] It is quite clear: according to Mitchell's dictum doctors must not hesitate; doctors must insist; doctors must change, control and govern. Doctors not only know what is best, suggests Mitchell, but they are empowered and even obliged to impose it.[25]

It is only women who can be completely managed in the rest-

cure system. Men, it seems, used to more autonomy in their lives, cannot tolerate being controlled and are thus treated somewhat differently. What was imposed on Woolf will not be endured by her character Septimus Smith; he kills himself to avoid it. Even in situations of "extreme neurasthenia in men accompanied with nutritive failures require as to this matter cautious handling, because, for some reason, the ennui of rest and seclusion is far better borne by women than by the other sex" (51). With little autonomy in any part of their lives, women were accustomed to following the advice of authorities, and it is likely that many of their neurasthenic symptoms were a direct result of their lack of power and control. A woman bears up because she has no choice. Mitchell expects a woman patient to make his task easier:

> With all her weakness, her unstable emotionality, her tendency to morally warp when long nervously ill, she is then far easier to deal with, far more amenable to reason, far more sure to be comfortable as a patient, than the man who is relatively in a like position. (*Doctor* 11)

If the doctor persuades the family that she is to be incarcerated, what voice has she to resist? If, diagnosed as hysteric or neurasthenic, she is generally assumed to be contriving, lying and deceiving as part of the illness, why would anyone attend to her thoughts about treatment? Women were ordered to rest homes, were taken to rest homes, were even anaesthetized and accompanied by doctors on trains to get them to rest homes two hundred miles away if that was what the doctor ordered (Mitchell *Fat* 13). Women have little or no

power of resistance to the treatment imposed.

Once in the care of the doctor, the patient is cut off from all familiarities: "it is desirable...to surround her with strangers and to put aside the nurse with whom she may have grown familiar" (53), and the doctor is to "forbid the receipt of any letters from home" (55). If letters do arrive they, "most important of all, should come to the nurse and by her be read to the patient" (56). Because control is so crucial for this treatment to work, Mitchell, showing his misogyny, claims that women doctors[26] fail because they are incapable of obtaining "the needed control over those of their own sex" (61). Clearly, patients are bullied into being well, and no doubt many comply in order to be set free.[27] This is not lost on Mitchell for he states

> when they are bidden to stay in bed a month, and neither to read, write, nor sew, and to have one nurse--who is not a relative,--then repose becomes for some women a rather bitter medicine, and they are glad enough to accept the order to rise and go about when the doctor issues a mandate. (62-3)

Although male patients may be given "time to attend to their affairs" (66), women, who presumably have no affairs or business, have even "letter-writing...usually forbidden" (65). Mitchell does not overtly suggest that the treatment differs by gender, but it is clear by these instructions that men are allowed some autonomy, and women are not.

The treatment is not only controlling, but degrading. In "extreme cases" the patient is forbidden "to use the hands in any active way except to clean the teeth" (66), must not leave

the bed, or even sit up:

> I arrange to have the bowels and water passed while lying down, and the patient is lifted on to a lounge for an hour in the morning and again at bedtime, and then lifted back again into the newly-made bed. In most cases of weakness, treated by rest, I insist on the patient being fed by the nurse...(66)

Apparent concern for the patient's eyes "makes it needful to prohibit reading and writing, and to have all correspondence carried on through the nurse" (67). Again, Mitchell uses the diction of force and power. He insists; he prohibits. But even Weir Mitchell seems surprised that he is able to control his patients so easily and reduce them to compliance and infantile complaisance: "I am daily amazed to see how kindly nervous and anæmic women take to this absolute rest, and how little they complain of its monotony" (68). First he degrades his patients into submission; next he criticizes their obedience. It is difficult to discern a genuine concern for his patients when his methods depend on reducing women to a completely dependent, child-like state.[28]

Mitchell encourages students and practitioners to revel in absolute power over the woman patient. He dubs his method a conspiracy (68), put into place to make his patients not only "contented," but "tractable" (68). Never is medical control to be relinquished. At one point he reduces his advice to: "The matter is simple, and I have no more to say" (*Doctor* 148). Defy him if you dare! Even the gentle massage aspect of the treatment is medically protected as "a remedy with capacity to hurt as well as to help, and should never be used

without the advice of a physician, nor persistently kept up without medical observation of its temporary and more permanent effects" (*Fat* 13). He encourages "force of character" (69) to deal with patients and advises the physician to "*seize* the proper occasions to *direct* the thought of his patients" (60; my emphasis). This "moral medication" is of "the higher sphere of the doctor's duties" (70) and sets him (for he has ruled out women practitioners as unsuitable) above all others in a god-like position. Only the doctor can be trusted with the patient's story:

> Above all, let him be careful that the masseuse and the nurse do not talk of the patient's ills, and let him by degrees teach the sick person how very essential it is to speak of her aches and pains to no one but himself. (70)

As a silencing tool, this direction is paramount. No one but the doctor is to be trusted with crucial medical information. He must have absolute power, not only over the treatment, but over all information. The potential for abuse is significant and frightening, for nurses and other workers are likewise instructed not to engage in serious discussion. The patient is completely at the mercy of the physician for sustenance, for treatment, for information of the outside world--for whatever the physician in charge deems appropriate.

One disturbing story that recurs in the literature about Weir Mitchell is his apparent manner of persuading a fully cured patient to rise from her bed. Anna Robeson Burr innocently refers to it as "the famous story--which went all

the rounds amid much laughter" (184):

> Dr. Mitchell had run the gamut of argument and persuasion and finally announced: 'If you are not out of bed in five minutes--I'll get in with you!' He there-upon started to remove his coat, the patient still obstinately prone--he removed his vest, but when he started to take off his trousers --she was out of bed in a fury! (184)

David Rein recounts the story in his biography *S. Weir Mitchell As a Psychiatric Novelist*, as does Donald Ball. According to Ball, Mitchell took a risk "when the occasion demanded it" (122) thus acknowledging that Mitchell could have been caught in a potentially "embarrassingly compromising *dénouement*" (122)--quite literally with his pants down. Mitchell is excused from this "somewhat unethical" (122) behaviour because, according to Ball's reasoning, "he was *compelled* to adopt a more menacing attitude towards his patient" (122; my emphasis) who was "intractable...who obstinately refused to obey his orders" (122). Ilza Veith, in her renowned text *Hysteria: The History of a Disease*, also refers to the disrobing of Weir Mitchell. She is not concerned by the question of judgement in his action, but describes him as "an extraordinarily charming man, erudite and entertaining, and doubtless most attractive to his female patients." She presents his action as an example of a "resourcefulness in dealing with [women which] was almost boundless." Veith goes on to suggest that although "this story may be apocryphal, since Mitchell does not relate it himself, it was well known during his lifetime and apparently

was never denied by him" (218).

There is great potential for physicians to abuse patients because of the position of trust they hold, the tradition of intimate physical examination, and the inevitable dependence of an ill individual on the healer. The fact that Mitchell neither relates nor denies this story suggests that it was told by someone else. Only the patient or a third party could have knowledge of the event. If the patient spread the story, it seems unlikely that it would have sparked so much laughter, for clearly she was incensed. Also, the laughter was presumably among physicians, who would not be likely to form the patient's audience. It also seems unlikely that Mitchell would have threatened to get into bed with a patient in the presence of a third party. The threat would work only if they were alone.[29] As Walter indicates, "Weir Mitchell, the master manipulator, placed great emphasis on seclusion" (Walter 135), and he insisted on a controlling secrecy with his patients. The combined circumstances of seclusion, secrecy and the doctor preparing to climb into bed with a patient suggest the possibility of abuse.

There is evidence that Mitchell was not as kind to women as his biographers suggest. Ilza Veith claims he had "a sympathy and even fondness for these unfortunate women" (219), but Mitchell's own words sometimes suggest a sinister dislike and cruelty. In a description of his treatment of a sixteen year old with hysterical paralysis of her arm, Mitchell

describes the patient as "rather wanting in signs of sexual ripeness" (Walter 139). His treatment involves raising her arm and then instructing her to keep it up. After the cure, Mitchell writes: "I sent her away with a lightly uttered word or two as to the use of the hot iron, if she again loses power" (139). His message is stay better or be punished.

Mitchell disregards a woman's own sense of her health or treatment. He has no qualms about tricking his patients, or ignoring their complaints:

> Very often I meet with women who cannot take iron either because it disturbs the stomach, causes headache, or constipates, or else because they have been told never to take iron. In the latter case I simply add five grains of pyrophosphate to each ounce of malt, and give it thus for a month *unknown to the patients*. (*Fat* 142; my emphasis)

When treatment with "iron gives headache....as a rule, I disregard all such complaints, and find that after a time I cease to hear anything more of these symptoms" (143). Either the symptoms disappear, or the woman's will to complain is broken. It is of no interest to Mitchell, and is never determined.

Sir William Osler,[30] in his seminal medical text *The Principles and Practice of Medicine*,[31] first published in 1892, plays down the need for absolute power over the patient by the physician, but ultimately he praises Weir Mitchell's treatment. Although Osler criticizes the early treatment of hysterics and points out that it "is pitiable to think of the misery which has been inflicted on these unhappy victims by

the harsh and unjus· treatment" (Osler 1120) that Carter and others practised, he ascribes the harshness to the "false views of the nature of the trouble" (1120). Thus, it is not the doctor's fault that they were cruel and unsympathetic to their patients, for they did not understand the true nature of the disease. Their ignorance, something usually not tolerated in physicians, in this case is their salvation.

Osler describes neurasthenia's symptoms and treatment in much the same manner as Mitchell and advises physicians that "the most important element in the treatment is moral control" (1121). Writing about hysteria and anorexia nervosa, Osler claims that Mitchell's rest-cure produces "remarkable results [which] are now universally recognized" (1121). Osler adds nothing new to the management of neurasthenia or hysteria. Although he does not overtly reiterate Mitchell's callous tone and controlling manner in his writing, neither does he criticize Mitchell's struggle for power over the patient.

After the turn of the century, there is some resistance in medical texts to following the "complete treatment" Mitchell prescribes. Professor Hermann Oppenheim's text, translated from the German by Dr Alexander Bruce as *Text-Book of Nervous Diseases for Physicians and Students*[32] and published in Edinburgh for use by British doctors and medical students, reserves the "Weir-Mitchell [sic] treatment" only for "cases which resist other measures" (Oppenheim 1108). He claims he "hardly ever prescribe[s] the Weir-Mitchell method in its

strict sense," and when he deems the conditions "favourable, the home comfortable, and the relatives judicious, [he] permit[s] the treatment to be carried on at home" (1145). Dr William White, in *Outlines of Psychiatry* (1915), after initially praising Mitchell's rest cure, goes on to contradict enforced rest by advising "awakening new interests and training [patients] gradually in healthy view-points, in continuity of effort, and in endeavouring to establish the habit of work" (White 236). Likewise Henry Foster Lewis and Alfred de Roulet, in their 1917 *Handbook of Gynecology*,[33] hedge on the precise following of the "complete treatment" considered so important by Mitchell and Playfair, recommending, instead, "some modification of the Weir Mitchell *rest cure*" (443).

The motivations for altering the treatment can, however, be read as suspect. Lewis and de Roulet, for instance, seem to want more to put their own stamp on the method than to improve the cure rate. Their language, with words such as 'neuroses' and 'psychic elements,' reflects the changing terms of psychiatry. The chapter title in their text is "Neuroses and Psychoses," which is updated from their predecessors' chapters on "Insanity," or "Hysteria and Neurasthenia." They encourage doctors to treat their patients according to principles rather than timetables, but the principles are all too familiar: "The main principle is *rest*....A secondary principle is *discipline*" (443), which is followed (as a late

third) by exercise. New names for the affliction, but the patient still must be moved "from scenes and influences which have probably contributed to her condition" (443) and sent to a "sanitarium" for scrutiny and recovery. The patient is still the victim of this treatment; there is no change in her loss of freedom or control, no advantage through the proclaimed modification of method.

White's text also seems to follow Mitchell's control model fairly closely, despite his insistence on the importance of work for the patient's recovery. He also shares Mitchell's misogyny, describing neurasthenics as "suspicious, carping critics, gossips and scandal mongers" (White 235). White also gives full instructions for force feeding, yet another medical method combining treatment and punishment:

> The esophageal route is always to be preferred. The patient is fed sitting up in a firmly constructed, straight-backed armchair, unless a greatly enfeebled condition renders the position on the back imperative. The operator stands behind and gently forces the mouth open with a soft wooden wedge introduced on the left side, then with the patient's head held under his left arm he holds the wedge with his left hand, which is steadied by placing his little finger under the patient's chin. The patient's head thus secured, the arms and legs held by nurses, if necessary, the esophageal tube is dipped in the milk to be given and passed. A funnel, preferably vulcanized rubber, is now inserted in the tube by a nurse and the food slowly poured in. (32)

It is hardly a surprise to read that "[s]ympathy is...not to be indulged in. The patient does not want it and it is not helpful" (41). Food is helpful, so patients must be forcibly held down and have wedges driven between their teeth to allow

it; sympathy is detrimental, so it must be withheld. This treatment, based on force and deprivation, attests to the power of medical authority. The nods White gives to the physician's attitude of "understanding" (41) and to using psychotherapy seem limited to male patients. He encourages his reader to

> take the patient frankly into his confidence and by pointing out the exact mechanism of his distress, by putting his finger accurately on the difficulty, so give the patient *his* opportunity to meet the problem in an efficient way. (35; my emphasis)

White believes that "the psychoses are about equally divided between the sexes" (27) but this does not imply that he accepts an equal measure of cause and effect. Rather, the "results of alcohol and syphilis and a more strenuous mental life in the male" (27) are presented as the equivalent to the mental stresses of "the dangerous periods in the female, the puerperium and the climacterium" (27). Men, according to this theory, acquire the causes of psychoses from outside sources, whereas women possess them naturally as a result of their biology. As well as raising problems of biological determinism, White's theory precludes the incidence of alcohol, syphilis and a strenuous mental life in women.

The concepts of psychotherapy and psychoanalysis, however, are beginning to appear in texts of this time. Lewis and de Roulet, as I mentioned, use some of the terms of these therapies, but give no details of their use and display no knowledge of their meanings. White understands psychotherapy

as the duty of the physician to discover the precise problem in the patient (35), and then to unveil it like a hidden gem that only science can discover. The physician remains completely in charge. Only the physician can interpret the patient's information. What is new, is that physicians are encouraged to share their privileged information with the patient, something Mitchell did not advise. Only Oppenheim considers "*Psychotherapy* [to be] the essential factor in the treatment. The physician must bring an intense and warm interest to bear upon his patient, whose confidence he must gain without losing the prestige of his authority" (1104).

Oppenheim's use of psychotherapy breaks new ground. He encourages an informal level of discussion and claims that "[u]nderstanding and tact on the part of the physician will gain the trust of the patient, who will lay bare to him his inner life and will confide to him his secret mental troubles, which must be removed if the disease is to be cured" (1104). This realization is critical in the approach to mental illness, for it assumes a *cause* for the disease and leads towards a subsequent *cure.*

Weir Mitchell's treatment and most of his physician fans and followers have treated only the *signs* of illness. Their case histories and descriptions are filled with what they have observed, rather than their patients' complaints. In fact, they discourage their patients from complaining, from talking about their *symptoms* at all. The basis for the treatment is

to cure the signs of illness. An emaciated woman is made fat; a lethargic woman is speeded up; a frowning woman is made to smile. The real root of the illness is not exposed. Only the external presentation is altered. and the patient is sent home fattened up with rosy cheeks. "She goes back to her home, like a graduate of a drug or alcoholic cure" (Lewis 443).

There is little wonder that Osler writes that Mitchell's "plan is more applicable to the lean than to fat, flabby hysterical patients" (1121). If a patient is already fat, she cannot be fattened more to look well. Force-feeding cannot be used. Only the anorectic patient can make a miraculous-*looking* metamorphosis; those whose "condition looks so alarming...when removed from their home surroundings and treated by Weir Mitchell's method, sometimes recover in a remarkable way" (1117). Fat and blood can be acquired by force-feeding. Women with anorexia stop eating and stop menstruating. They have neither fat nor blood, but Mitchell's rest cure treatment, as implied in the title of his book, gives them both.

The subsequent outcome of the women 'cured' by this form of treatment is unknown. Mitchell does not concern himself with follow-up studies. Cure is measured by a comparison of weight and colour on admission to those on discharge. Judging from Virginia Woolf's own recurring problems with anorexia and depression,[34] it seems the treatment realized superficial rather than lasting results.

All of these physicians adopted or modified the treatment of Weir Mitchell rather than embracing the new and revolutionary ideas of Freud. With Breuer, Freud had published *Studien über Hysterie* in 1895, which detailed the case of a patient who, under hypnosis, was able to recollect the circumstances surrounding the onset of hysteria and to describe and express the emotions which were felt at that time. From this work came Freud's theory of psychoanalysis which proposed the importance of the unconscious and its influence on the conscious mind. Oppenheim claims an interest in psychotherapy, but sees it in terms of teaching "the patient how to train himself properly, and convince him that great results can be attained by the distraction of his attention from his symptoms and by the gradual strengthening of his will-power" (1104). Rather than help the patient uncover some deep-seated cause for illness, Oppenheim seems to suggest, like Mitchell, that the patient must repress even further anything to do with his or her symptoms. He goes on to discredit the

> method of Freud and Breuer, which consists in awakening, during a hypnotic condition or in a confidential talk, the processes which have entered into the mental life and caused the disease, [which] has not been approved of by other writers, and [which] recent personal experience has led me to agree emphatically with those...who regard this kind of treatment as dangerous. (1104)

Oppenheim writes this after the 1908 first International Congress of Psychoanalysis, at a time when most Western countries had already established branches of the

international association. Freud had support. Oppenheim and others clearly regarded the treatment as aberrant, even harmful,[35] but was it a matter of lack of interest and investigation, or a stubborn adherence to tradition which caused them to discard Freud's ideas and methods? Whatever the motivation, treating only the signs of illness and glossing over the symptoms and causes did a great injustice and disservice to their patients, particularly when alternative methods were available.[36]

THE IMPATIENT PATIENT:

During the periods that Virginia Woolf was ill with headaches, anorexia, insomnia and nervousness, she was secluded, either in the country, or within the confines of Burley, a nursing home in Twickenham, cruelly dubbed by Bell "a kind of polite madhouse for female lunatics" (1: 164). Woolf, described by Bell as "an exceedingly difficult patient" (1: 164), was sent to Burley four separate times between 1910 and 1915, and each time she was subjected to complete intellectual isolation. Bell writes: "her letters, her reading, her visitors would all be severely rationed, she would be kept in bed in a darkened room, wholesome foods would be pressed upon her and she would be excluded from all the social enjoyments of London" (1: 164). Was this treatment or punishment for her alleged madness?

Clearly Woolf considered the panacea to be punitive. She

wanted to be at home and she wanted to work. When she was sent off to stay with her Quaker maiden aunt, Caroline Emelia Stephen, in Cambridge in 1904 to rest and stay quiet, she was terribly restless; she wanted only to be back in London. In a letter to Violet Dickinson she writes:

> it is a great hardship to me to have to spend two more long months wandering about in other peoples comfortless houses, when I have my own house [Gordon Square] waiting for me....London means my own home, and books, and pictures, and music, from all of which I have been parted since February now,--and I have never spent such a wretched 8 months in my life. (1: 147)

It is her physician, Dr George Savage, who controls her whereabouts: "that tyrannical, and as I think, shortsighted Savage insists upon another two [months in Cambridge]" (1: 147). His approval is needed for her every move, prompting her to write that

> really a doctor is worse than a husband! Oh how thankful I shall be to be my own mistress and throw their silly medicines down the slop pail! I never shall believe, or have believed, in anything any doctor says....They can guess at what's the matter, but they cant put it right. (1: 148)

Woolf accepts that she has had a breakdown, "hardly knowing what [she] did or said...for three months...more or less incapable of doing anything but eat and sleep...watched by three fiends of nurses" (1: 149). But as she regains her clarity, she struggles against "tnis eternal resting and fussing, and being told not to do this and that" (1:148), what she dubs "the endless bothers and delays of a nervous breakdown" (1: 148) imposed by medicine.

When she is sent by Dr Savage to Burley for the first time, in 1910, Woolf is horrified: "Ive no doubt it will be damnable, and the thought of the nurses and the food and the boredom is disgusting" (1: 428), but she is persuaded by her doctor that it is her only option for recovery: "I also imagine the delights of being sane again" (1: 428), and clings to Savage's promise that her treatment is to be a modified Weir Mitchell: "He says he wont insist on complete isolation [as he had when she was sent to her aunt in Cambridge], so I suppose I shant be as badly off as I was before" (1: 428). But it seems that she is denied any freedom and at times is prevented from writing or reading letters, just as Mitchell's strict treatment advises. When she is allowed to write to her sister, Vanessa, Woolf claims, "I meant to write several days ago....[b]ut in that too I was hoodwinked by Miss Thomas. I gather some great conspiracy is going on behind my back....She--(Miss T.) wont read me or quote your letters" (1: 430).

Woolf may well have experienced paranoia during her illnesses, but her sense of conspiracy seems real enough when we look at the rationale of the treatment. She is lured to the nursing home with promises of leniency, but is then admonished for taking "unheard-of liberties" (Bell 1: 164) for walking "in the garden clad only in a blanket" and breaking "rules about rest and food" (1: 164). Mitchell himself writes that the various aspects of the complete treatment "all

conspire" (*Fat* 68) to subdue the patient, but when "attempts were made to keep her in order" (Bell 1: 164), Woolf is at once terrified and bewildered:

> I really dont think I can stand much more of this....what I mean is that I shall soon have to jump out of a window....there is all the eating and drinking and being shut up in the dark. My God! What a mercy to be done with it! (*Letters* 1: 431)

FROM BURLEY TO BRADSHAW:

When Sir William Bradshaw proposes that Septimus "must be taught to rest" (*Dalloway* 162), Woolf depicts a power that she has experienced first hand, but one that Septimus has yet to comprehend: "'Must', 'must', why 'must'? What power had Bradshaw over him? 'What right has Bradshaw to say "must" to me?' he demanded" (162). In fact, as Woolf well knew, doctors had (and have) every legal right to isolate and incarcerate. After Virginia Woolf's suicide attempt in 1913, Leonard Woolf "went to look at asylums and was horrified" (Poole 144). In *Beginning Again* he writes:

> I told the doctors that I was prepared to do anything required by them if they would agree to her not being certified. They agreed not to certify her, provided I could arrange for her to go into the country accompanied by me and two (at one time four) nurses. (158)

Because Septimus is a danger to himself and "talked of killing [him]self....he was in their power! Holmes and Bradshaw were on him!" (163). Septimus, condemned like Woolf, would have to be committed.

DISEASES OF WOMEN:

Although she is prepared to make disparaging statements about the state of medical treatment in London in the 1920s in *Mrs Dalloway*, Virginia Woolf is hesitant to draw too close a parallel to her own situation, or to the situation of other women undergoing psychiatric care. She displaces her own experiences onto the male character Septimus Warren Smith. Allotting nervous collapse to a male subject legitimizes it to an audience which continues to distrust either the inherent mental stability of the average woman, or the genuine pathology of the female hysteric. Hysteria has been seen not only as a woman's disease, what Elaine Showalter calls "The Female Malady," but as a disease which is characterized by faked symptoms and lies. And as we have seen, women are not in possession of truth. According to Carter, hysterical "derangements are much more common in the female than in the male" (26), so much so, that "the existence of this disease was long doubted" (82) in men. And, although Carter admits that in the early 1850s "one or two well-marked cases have been treated in Guy's Hospital" (82), male hysteria is most definitely the exception, and its rarity gives it verity.

Hysteria is so specifically associated with women, and with women's physiology, that whole chapters are routinely devoted to its symptoms and treatment in gynaecology textbooks in the nineteenth and early twentieth centuries. Typically, texts begin with information on anatomy, run through menstruation

and ovulation, deal with anomalies and operative procedures, and close with what is dubbed 'hysteria and neurasthenia' in the nineteenth-century books, or 'neuroses and psychoses' in the early twentieth-century texts. Hysteria can still be found mentioned under sections on 'psychosomatic aspects of gynaecology' in contemporary medical text-books. As in the time of Carter, hysteria continues to be regarded as primarily a disease of women.[37]

According to Thomas Clifford Allbutt[38] and W.S. Playfair in their 1896 gynaecology text, *A System of Gynaecology by Many Writers*,[39] it is the "mobility of the nervous system, especially in the sphere of the emotions, which distinguishes the woman from the man, [and] influences the character and progress of all kinds of disease in women" (220). This 'mobility' of the nervous system is never fully explained.[40] Is it the feminine lack of muscular definition which makes women's nerves literally lax? Do they float around in the soft tissues of women's bodies and lack the good grounding of male toughness and strength to keep them in control? If it is not actually the nerves themselves, but the emotions which are so different, how do they explain the risk for women? Puberty, it seems, with its hormonal onslaught on the female frame and temperament is to blame for the mobile condition of the nerves. "Up to the time of puberty there is little if any marked difference between the sexes, either in health, in disease, or in any other condition" (Allbutt 220), but once

a young woman begins to menstruate, she is at terrible risk, out of control, and dangerous.

According to Allbutt, if she is "*judiciously managed*, she may be so *trained* that she will be able to meet successfully the strain on her nervous system during her future life" (220; my emphasis). The implication is that the advent of womanhood puts a woman at terrible risk of illness unless she is completely under the control of medicine. Not only is she to be controlled, like a potentially wild animal, she is to be controlled properly, for if she is "injudiciously managed... [it] will tell terribly on her" (220). Clearly, a woman cannot be left to her own devices to manage her budding fertility and adulthood. That she must be managed is a given; that she must be managed properly, according to the medical dictum of the time, is forcefully advised under threat of disaster. Left to her own devices at this time, a woman "will have no stamina, no power of resistance;[41] and she may become [a] wretched, broken-down invalid" (220).[42] Mitchell warns that puberty must be treated with great care and once menstruation begins "it should be the rule that at certain times temperate exercise, lessened walks, and no dancing, riding, rowing, skating, or swimming should be allowed" (*Doctor* 144). Once puberty occurs, according to Mitchell:

> the wise mother will insist on lighter [educational] tasks and some rest of the body at the time when nature is making her largest claim upon the vital powers. The least sign of physical failure should ring a graver alarm, and make the mother insist, at every cost, upon absence of lessons and reasonable

repose. (148)

Handled incorrectly, puberty can be disastrous, Mitchell claims, because "very little emotional disturbance will suffice to overcome the woman as it does not do the man, and that same disease which makes him irritable makes her nervous" (137).

J.C. Webster, in his 1898 text, *Diseases of Women: A Text-Book for Students and Practitioners*,[43] extends the period of danger to cover the complete child-bearing years. Although he disagrees with the view that "'women's life is a history of disease'" (Webster 135), he does cite French historian Jules Michelet's use of the phrase, and goes on to assert,

> it must be admitted that it is one of physiological unrest, except in youth and old age. When we remember the great disturbances which mark the advent and departure of the reproductive era of her life, the profound changes taking place during ovulation, menstruation, pregnancy, labour and lactation; the subtle and complex activities of her physical life in its various diastaltic functions, it is not remarkable that neuroses should manifest themselves particularly in relation to her reproductive mechanism. (135-6)

Women are only safe, therefore, from the mental stresses of their biology when they are not functioning reproductively. As the interval between menarche and menopause forms the greater part of any woman's life, the risk is absolute.

Webster's hysteric is slightly less nasty than Carter's. She is "purposeless, introspective and selfish" (137) compared to Carter's "wayward, irritable [and] capricious" (Carter 138), but she can also be jumpy. Referring to a "tendency to erratic and extravagant reaction to stimuli" (Webster 137),

he cites Féré's phrase dubbing the hysterical woman the "'frog of psychology'" (137).

Webster is clearly fascinated by animal analogies; he is the product of social Darwinism. His methods serve to discredit women, however, not only by associating them with reptiles and domestic mammals, but by suggesting that intimate contact with another being will permanently taint them. His argument centres around problems of neurotic gynaecologic pain. It is his belief that a disease, once cured, can continue to cause phantom pain (as in phantom limb syndrome) because of a biologic "power of impressing the nervous system" (132). The nerves, thus depicted, bear a resemblance to those described by Allbutt, for they are mobile and elusive, but Webster allots to the nervous system the magic capability to retain information and even genetic material. His proof lies in

> the case of a dachshund bitch which bore pups to a sheep-dog; in two succeeding years she bore them to a pure dachshund, but the offspring took after the sheep-dog as much as after the real fathers....if a ewe Leicester sheep [all white] breeds to a Shropshire ram [brown head and legs], she is never safe to breed pure Leicesters from afterwards, as dun or coloured legs are apt to come even when the sire is a pure Leicester. (134)

If this information were not so amusing, bringing images of sheep-dogs and Shropshire rams hiding behind barn doors or hopping over pens in the dark, it would really be terrifying. The assertion is that the female of the species can be polluted by a 'wrong' breeding, can retain disease or foreign

genetic material forever, whereas the male merely withdraws, and escapes unscathed.

With regard to medical discourse, I feel this is a vital example of the gendered thinking of male physicians. Webster does not leave it for his reader to make the leap to human beings. He goes on to cite cases of mixed breeding between races of different colours, observing "that children of white people had after shown traces of the negro character when the woman had previously had a child by a negro" (134). When we consider that this text is subtitled *A Text-Book for Students and Practitioners*, and forms the basis for the teaching of gynaecology to medical students, its pronouncements are terrifying. Webster was an authority. His credentials were excellent with an MD degree from Edinburgh and a Fellowship in the Royal College of Physicians. He taught medicine at both Edinburgh and at McGill. Webster had influence.

Like Carter, Webster makes moral judgements on women and encourages this action in his students. His descriptions of hysteric patients are evaluative and derogatory; he comments on the pettiness of women's complaints and on the demanding nature of the hysteric, quoting Oliver Wendell Holmes: "'she is a vampire who sucks the blood of healthy people about her'" (138). Webster emphasizes the deception of women patients, and he distrusts the veracity of their pain. However, he disagrees with gynaecologic surgery as a curative for mental stress: "The rash and wholesale manner in which, in

particular, removal of the appendages [ovaries] for the cure of pelvic pain has been carried out, cannot be too strongly condemned" (145). Webster is certainly more sympathetic to women than Carter, but he is hardly kind.

The argument for appropriating mental diseases as gynaecologic territory is still made as late as 1893 by Alexander Skene in his *Treatise on the Diseases of Women For the Use of Students and Practitioners*. First of all, like most practitioners of the time, he takes "it for granted that all will agree that insanity in women is often caused by diseases of the procreative organs" (930). Because the gynaecologist "has the advantage of knowing when his patients have uterine or ovarian disease...if insanity follows in any of his cases, he may be able to estimate the influence of the primary disease in causing the mental disorder" (932). Although we would disagree with his assertion that "acute disease of the ovary or uterus, or a displacement of either is sufficient to cause a mental derangement" (932), his initial emphasis on pathology in the organs is encouraging.[44] Unfortunately, he also claims that "the normal functional activity of the reproductive organs sometimes tends to undermine the brain and nervous system to an extent sufficient to lead to insanity" (934). In this thinking, apart from his limitation that it only "occasionally does so" (934), Skene seems to reflect archaic views and pass them on to twentieth-century practitioners.

Changes in thinking are slow to be accepted in the medical world. By 1917, when Henry Foster Lewis and Alfred de Roulet published their *Handbook of Gynecology For Students and Practitioners*, they also included a last chapter on Neuroses and Psychoses. Their claim that women "who have pelvic lesions are probably more likely to become insane than are women with normal pelvic organs" (444) sounds slightly tentative with its 'probably,' unlike the absolute and certain statements of their predecessors, and they offer no evidence to strengthen their conclusion. They seem to be afraid to go against the established belief, although they put little faith in it themselves. They reiterate the newly accepted thinking that there is no

> benefit or cure of insanity by *operations upon normal genital organs*. Formerly many normal ovaries were removed in hope that the mental condition, perhaps in some vague way dependent upon the genital function, could be cured or improved by removal of the essential female sexual organ. (444)

Slowly, the biological determinism of female insanity starts to be questioned.

Puberty causes insanity, reproductive organs cause insanity, pelvic lesions cause insanity, hysterectomies cure hysteria. From the medical texts, I get the distinct impression that puberty, particularly, is a special disease of young women, and that it does not even exist as a medical entity for young men. At a time when the male pronoun is used almost exclusively in scientific literature, puberty is singularly feminine. E.C. Dudley sums up the general thinking

in his 1899 text, *Diseases of Women: A Treatise in the Principles and Practice of Gynecology for Students and Practitioners:*[45]

> puberty...is a critical transition period; upon its normal course depends much of the after-health, comfort, and usefulness of the individual; its influences are fundamental, not only in the reproductive organs, but in the entire woman. (17-18)

There are no treatises or text-books on the diseases of men. There are medical texts and surgical texts and psychiatric texts and diseases of women texts. The clear message is that as soon as signs of womanhood appear, early in adolescence, all is fragile, all is threatened, and all can be lost. Before a woman has a chance to establish herself intellectually--even socially--as a member of society, her biology threatens to doom her to a life of mental instability and physical incapacity. Her illnesses result from her sex and are almost inevitable without proper 'management,' but at the same time, they are likely to be bogus, contrived, and self-centred.

Early psychiatric texts use specific discursive methods to treat women patients differently from men. Henry Maudsley, the famous British physician who edited the *Journal of Mental Science* and founded the Maudsley Hospital, published his influential book *The Physiology and Pathology of the Mind* in 1867.[46] As well as discussing women's weaknesses from natural, hereditary and cultural causes and insisting that "there is in woman, by virtue of her sex, a slightly greater

predisposition to insanity than in men" (208), Maudsley, in his written description of patients, displays his extreme gender bias. Male patients tend to be just that, male patients--unless, as Showalter points out, they happen to be from the lower classes, in which case they are described with contempt, regardless of sex (*Malady* 115). But what Showalter does not report is that women patients are described in terms of their physical beauty or its lack. In one particular paragraph Maudsley describes a male patient as simply a "man of epileptic visage" (Maudsley 354), whereas a woman is depicted as a "pale, delicate, fragile, blue-eyed young lady, æt. 25" (354). Perhaps her pallor and fragility might be relevant to her condition, but Maudsley does not use technical terms to describe them. If lack of strength is part of a diagnosis, more precise terms like weakness, debility or languor might be expected. Words like delicate and fragile, however, do not describe symptoms, but are personal value judgements Maudsley makes. Contributing to the Victorian ideology that women are naturally weaker than men, Maudsley medically constructs female patients with words which describe character rather than condition. In noting his patient's blue eyes, Maudsley adds a romantic element to his terminology. Eye colour has no influence on health or illness; he mentions it only as part of a narrative which describes his women patients as objects to be viewed in terms of beauty. Miss G. turns out to be "a fair young lady, with light eyes and hair"

(382), but a male patient is merely a "young man, æt. 24, [who] suffered from frequent and severe periodic pains in the head" (390). The text-book is riddled with depictions of men whose features are described only when relevant to their illness, but with assessments which are discerning and judgemental both of women's position as lesser beings in society and by their appearance. By his method of observation, Maudsley admits the quality of female beauty and the expectation of female weakness to the medical gaze.

Maudsley's observation is very important to the establishment of psychiatric medical discourse, particularly because he was so enormously influential. In "The Twenty-Fifth Maudsley Lecture" delivered by Dr Aubrey Lewis in 1951, Maudsley is still being lauded as the heroic founder of British psychiatry. Lewis presents Maudsley as "the brilliant iconoclast, the erudite reasoner who could expound lucidly the principles of physiological psychology, the sage, the far-sighted writer on clinical psychiatry." We are told that Maudsley's influence "was not limited to the narrow circle of psychiatrists and psychologists; Darwin, for example, quoted Maudsley frequently in the *Descent of Man* and in the *Expression of the Emotions*." His text, we are told, "forms the background for the tradition for medical psychology in Great Britain" (A. Lewis n. pag.). How many physicians learned to denigrate and objectify female patients from Maudsley's fanciful descriptions of women's delicateness,

their fair hair and fetching eyes? His work subliminally teaches medical students to look for signs of illness in their male patients, but to be sidetracked by ideological assumptions of weakness and beauty in women. In this way, women's mental illnesses are not just seen as such, but become enmeshed in the prevalent construction of women as objects, and doctors are encouraged to respond differently to women than to men. By mixing issues of beauty with issues of illness, psychiatry risks confusing diagnosis and treatment with social issues of gender.

When women are given license to complain at all, and as I have shown this is not often the case, they have little credibility. When they do attempt to state their case, but are silenced from complaint, medicine believes women are even more irrational and even less credible. According to Webster, if a woman "is checked or chided in any way, she takes offence, gets irritated, bursts into tears, or has an attack of pain, paralysis, or some other manifestation of the hysterical condition" (138). Women can gain no ground. They must either submit silently to treatment, or risk chastisement for resisting. Whatever they do they will not be believed, for their doctors are warned that "there is a tendency to tell untruths and practice deceptions" (138) which, according to the thinking of the time, is both natural and inescapable in women.

SHELL SHOCK:

In the post World War I period, the incidence of shell shock syndrome was first being recognized and legitimized as a nervous illness of service men. Thus Woolf's fictional presentation of Septimus Smith as a mentally unstable man was likely to provoke more credibility and concern than a disturbed female character. Public acceptance would no doubt stem from the fact that men enjoyed a predetermined credibility generally, rather than from any appreciable difference in their symptoms of hysteria. Although manifestations of shell shock were classically hysteric, medicine--in its acceptance of the Darwinian concept of the biological superiority of men[47]--dubbed the disorder "shell shock," "anxiety neurosis," or "war strain" (Showalter *Malady* 168), giving it valuable medical currency. The behaviour of afflicted men was not seen as the reprehensible result of their reproductive organs or sexual fantasies as it was in women; they were merely judged to be the victims of their own bravery. They were "wounded in mind" (168) instead of body. Showalter recognizes that the

> efficacy of the term 'shell shock' lay in its power to provide a masculine-sounding substitute for the effeminate associations of 'hysteria' and to disguise the troubling parallels between male war neurosis and the female nervous disorders epidemic before the war. (172)

Although women were actually expected to be mentally unstable, medicine had great difficulty accepting the

possibility of neurotic soldiers. Initially, shell shock was thought to be a direct result of "the physical force or chemical effects of a shell bursting at close range" (167), but when men who had no contact with explosions displayed similar hysterical symptoms, doctors had to reconsider the cause. Whereas medicine had no difficulty accepting the reproductive capacity of women as the cause of female hysteria, the profession resisted any attempts to relate male hysteria to biological etiology. Rather, "psychiatrists desperately sought explanations for their condition in food poisoning, noise, or [externally caused] 'toxic conditions of the blood'" (Showalter 170). Women were crazy and it made them sick; men, it seems, were sick and it made them crazy.

If a physical cause could not be found, then medicine invented a moral one. Needing to disassociate themselves from inferior, weaker men, medical professionals, such as Woolf's fictional Dr Holmes, began to see shell shock victims as "moral invalids" who were destined "to collapse in the face of the enemy." The lack of strict discipline and loyalty in a troop was thought to cause malingering and cowardice (*Malady* 170). According to the Victorian masculine ideal, men were not ideologically allowed to forfeit self-control or show fear (171). If they did became emotional, they were not normal; they were ill.

When shell shock was first recognized and written about, treatment was very similar to the Weir Mitchell method. Dr

E.E. Southard, in *Shell-shock and other Neuropsychiatric Problems: Presented in Five Hundred and Eighty-nine Case Histories From the War Literature, 1914-1918*, acknowledges that to Mitchell "the profession the world over has been indebted for the development of new views as to the nature of neurasthenia and hysteria and the new methods for combating these disorders" (vii). Describing the treatment at the Salpetrière in France in 1915, Southard writes:

> The isolation service of the neurological center is composed of 34 beds, arranged in two halls, with three extra rooms. Each bed is isolated. The régime in one of the rooms is more rigorous than in the other, and it is an advance for a patient to be moved from the first to the second room. The patient on wakening has no right to leave his box or communicate with his neighbors. He leaves only to be treated by hydrotherapy or electrotherapy. He takes his meals in isolation, receives no calls, and has no leave to go out. The physician sees the patient twice a day and carries on psychotherapy and motor reëducation, as well as special treatments.
>
> Women nurses care for the patients. A system of control and of progressive rewards has been installed, being a sort of metric evaluation of the process of cure. As the cure proceeds the patient's lot is progressively mitigated, or if he gets worse the regime is clamped down....The grade obtained by our scholar in psychotherapy is inscribed upon a slate. Finally, walks, concerts, visits and eventually permission to go out into the town are granted. (902)

As in Mitchell's treatment, punishment is an element in the cure. By adding rewards, the French practitioners reinforce the medical assessment of the disease as self-induced. These patients are graded on their improvement, suggesting that it is only lack of concentration and motivation which hinders their recovery.

Southard, however, is more interested in case histories than in treatment and, unlike Mitchell, is also extremely concerned about diagnosis and mis-diagnosis. Mitchell's work essentially begins after diagnosis; there is no suggestion that women brought in for treatment have ailments other than neurasthenia or hysteria. Although Osler concedes that the "physical examination is of the highest importance in excluding other diseases likely to be confounded with" (Osler 1127) neurasthenia, and Oppenheim warns that a diagnosis "should always be established *by means of exclusion*....as the disease is often associated with other affections, and specially with other organic diseases of the nervous system" (Oppenheim 1094), most text-books assume the complete and unquestionable veracity of diagnosis when applied to female neurasthenics. Only in Southard, who is dealing with male patients, did I find a complete list of diagnostic possibilities, with the following warning to physicians:

> You must pause to consider whether your putative case is not actually:
> A matter of spirochetes?
> The response of a subnormal soldier?
> An equivalent of epilepsy?
> An alcoholic situation?
> A result of neurones actually *hors du combat?*
> A state of bodily weakness (perhaps of *faiblesse irritable)?*
> A bit of dementia praecox?
> One of the ups an downs of the emotional (affective, cyclothymic) psychoses? (1)

Southard wants to be very sure that shell shock is not suggested until all other physical and mental and environmental causes can be ruled out. This can be attributed

to the disbelief that men could suffer the same hysteric symptoms as women, as suggested by Showalter, but also points to the reality that men were needed for the war effort. Soldiers had to be cured to go back to the front, to fight, and to die as heroes. If something other than shell shock could be found to cause their illness, the horrors of war could be set aside from the disease itself.

On the authority of professional medicine in the early part of the century, a woman who sees a vision is hysterical; but according to Dr Holmes in *Mrs Dalloway*, a Great War survivor who sees a vision has "nothing the matter with him" (27). Although Lucy Snowe's spectre eventually turns out to be real, and Septimus's vision is always known to be hallucination, the doctors they consult diagnose by gender rather than by personal history and physical examination. The mis-diagnoses are both extremely harmful. Lucy is practically driven mad by the suggestion that she is mentally unstable, and Septimus suicides. They are both subjected to interpretation on the basis of their sex. As a woman Lucy is disbelieved, and as a man Septimus is expected to overcome his illness, to buck up and stop frightening people with his careless remarks and delusions. Dr Southard criticizes doctors like the fictional Holmes who will not tolerate mental ills in strong men:

> I have even heard a physician well-trained in somatic lines say that Shell-shock did not exist because Shell-shock was nothing but neuroses, and neuroses were characterized by imaginary symptoms, -- accordingly neuroses being imaginary, do not exist! (833)

Southard believes in the veracity of the symptoms and the reality of neuroses in soldiers. He allows for shell-shock in men, but only after other pathology is carefully ruled out by detailed medical investigation.

Southard, and subsequently Dr W.H.R. Rivers, in *Instinct and the Unconscious: A Contribution to a Biological Theory of the Psycho-Neuroses*, published in 1920, allow for the existence of war-neurosis. But Rivers denounces the advice that Southard gives that patients "should endeavour to banish all thought of war from their minds" (187) and finally follows a Freudian approach in his form of treatment. Rivers believes that Freud's theory of the unconscious is useful to the physician and "provides him with a definite working scheme of influences...known to be active in the causation of mental disorders and of the bodily disorders which are traceable to mental factors" (168). He notes that

> patients had been repressing certain painful elements of their mental content. They had been deliberately practising what we must regard as a definite course of treatment, in nearly every case adopted on medical advice, in which they were either deliberately thrusting certain unpleasant memories or thoughts from their minds or were occupying every moment of the day in some activity in order that these thoughts might not come into the focus of attention. (198)

Rivers, unlike the other doctors I have cited and the doctors Virginia Woolf describes, is concerned about the symptoms and causes of his patients' illness. He works towards uncovering the root of the problem in the unconscious and leading his patients to face their torment and ultimately cure themselves

--something both Virginia Woolf and her character Septimus Smith are denied by their physicians.

DOCTORS AND DISPLACEMENT:

In 1924, when *Mrs Dalloway* was written, the time was not yet ripe for women to speak out against medical authority, for women patients had no medical credibility. Silence still prevailed. Although Woolf's writing conveys her message against medical discourse to the reader, that message is not spoken aloud by her characters. What Woolf shows in *Mrs Dalloway* is that the pervasive sense of silence against medical authority is central--extending even to the male character who is afflicted. Woolf displaces her own illness onto Septimus; she bestows on him her symptom of hearing birds singing in Greek and her jump from a window in an early suicide attempt (Bell 1: 90). She has him suffer mis-diagnosis and no treatment by one doctor, followed by heartless diagnosis and ill treatment by another. Ultimately he succumbs to suicide, as does Woolf. But a female character, Septimus's wife Rezia, also suffers at the hands of medical authority, and she is also silent.

The silence of Woolf's characters is an outward silence. While they do not speak directly to the reader as Lucy Snowe does, their inner voices are crisp and desperate. As in *Villette*, the resistance to medical discourse lies in the submergence of the voice within the writing itself, but in *Mrs*

Dalloway the voice never wavers. Rezia, Septimus and Clarissa are absolute in their disgust for the medical profession, but their complaints, never allowed within and by the medical system, are sheltered in interior monologues, camouflaged by an outer silence.

The misguided Dr Holmes[48] uses shame and dishonour to force Rezia into silence about her husband's condition, claiming her concerns are unfounded; Septimus has "nothing whatever seriously the matter with him but was a little out of sorts" (25). Holmes refuses to take Septimus's problems seriously enough to give them medical consideration. There is no evidence that Dr Holmes performs any physical or laboratory examination, or takes a medical history. Holmes dismisses Septimus with non-medical language, with idiom. To be 'out of sorts,' according to the Oxford English Dictionary, is to be "not in the usual or normal condition of good health or spirits; in a low-spirited, irritable or peevish state." Holmes reduces the problem to a matter of common sense; Septimus is not acting in what Holmes considers to be a normal manner, therefore; he is a little low, a little down, a little disgruntled. There are two difficulties with Holmes's approach. First, it assumes that there is such a condition as a normal state of 'sorts' in which individuals follow natural patterns of behaviour. As Catherine Belsey notes, this sense of normal and natural is "not *given* but *produced* in a specific society by the ways in which that society talks

and thinks about itself and its experience" (3). In Western society medicine is responsible for the production of what is 'normal' and 'natural' in health and illness, and has little or no regard for the individual's own sense of normality. The problem Rezia detects with Septimus's actions is in relation to his former behaviour patterns rather than to a prescribed behavioral norm. Holmes disallows any consideration of individuality or difference. Second, Holmes lets his 'common sense' approach overrule his medical expertise. Because he is so sure from his brief observation that Septimus is just "a little out of sorts" (*Dalloway* 25), he feels no need to examine him or offer any sort of medical diagnosis or treatment. In Dr Holmes's society there is a 'common sense' ideological construct that men are strong and do not succumb to hysteria or mental breakdown. Therefore Holmes cannot see and will not look for contrary evidence. Dr Holmes's discourse indicates his dismissal of Septimus as unworthy of medical attention and silences Rezia by discounting her concern.

Rezia, made to submit to Holmes's bullying, is aptly named Lucrezia. The legendary Roman Lucretia is famous for protecting her father and husband from dishonour. When the evil Tarquin threatens to murder her with a slave and spread the lie that he found them in an adulterous relationship, Lucretia submits to rape rather than bring disgrace to her family. She then stabs herself to preserve the honour of her

father and her husband, in anguish after telling them of her ordeal. Lucretia becomes a model woman and reinforces the "stereotypes of women as masochistic, passive, and essentially victims" (Russell and Barnes 32). Woolf's Lucrezia does not kill herself in shame; but she outwardly succumbs to silence. In order to preserve her family's honour she cannot even tell them about her husband's illness: "she would never, never tell that he was mad!" (*Dalloway* 28). Woolf recognizes that male hysteria cannot be credited; the shame of male madness is in direct contrast with medicine's expectation of female insanity. Rezia feels she must not speak of her husband's affliction, but the enforced silence tears her apart:

> she could stand it no longer...and she could tell no one....She could tell nobody, not even Septimus....Dr Holmes said there was nothing the matter with him....It was she who suffered -but she had nobody to tell. There was nobody. (27)

For her knowledge of Septimus's hysteria, and for her implied contribution to it, Rezia is punished by not being able to speak aloud--her affliction thus mimics hysterical muteness.

Rezia can provide helpful information about her husband's condition, but no one wants to hear her opinion, and no one believes her story of her husband's suicidal ideation, his "headaches, sleeplessness, fears, dreams" (101). Dr Holmes "brushed it all aside [as] nerve symptoms and nothing more" (101). Repeatedly in the medical literature, doctors warn other doctors to discount the information of female relatives. Usually these are mothers rather than wives, because the

patients are so often female. Mitchell, in *Fat and Blood*, warns against

> the self-sacrificing love and over-careful sympathy of a mother, a sister, or some other devoted relative. Nothing is more curious, nothing more sad and pitiful, than these partnerships between the sick and selfish [patient] and the sound and over-loving [female relative] (40),

and Osler, encouraging "inquiry into the occurrence of previous manifestations and the mental conditions" of the patient, advises physicians that such "questions, as a rule, should not be asked the mother, who of all others is least likely to give satisfactory information about the patient's condition" (1120). Women are systematically ruled out as accurate historians, either of their own illnesses, or those of their loved ones.

Added to medicine's disregard and disbelief, is medicine's blame. Weir Mitchell frequently blamed his patients for causing their own illnesses, particularly if they suffered from anorexia. For example, he spoke heartlessly at the Annual Oration before the Medical and Chirurgical Faculty of Maryland in Baltimore in 1877 of one of his patients as if she were solely responsible for her unfortunate body and deserved his ridicule:

> She was five feet four, and weighed ninety-four pounds, and had as much figure as a hat rack, and had no more bosom than the average chicken of a boarding-house table. Nature had wisely prohibited this being from increasing her breed. (*Annual* 13-14)

Where it is acceptable for Mitchell to blame a woman patient for her condition and to use such comparisons as "hat rack"

and "chicken" for the female frame, it is more difficult for Holmes to blame Septimus, the distinguished soldier; so he blames his wife.

According to Holmes's flawed medical detective work, it is Rezia's fault that Septimus is acting oddly. She should "learn to cook porridge" (*Dalloway* 101); it is up to her to "make him notice real things" (29), to stop his odd behaviour. But when she tries to protect Septimus from Dr Holmes, who is clearly making things worse, she is violently thrust out of the way with what he terms "a friendly push before he could get past her" (102). Dr Holmes refuses to listen when Rezia says "'No, I will not allow you to see my husband'" (164) but barges in: "'My dear lady, allow me...' Holmes said, putting her aside (Holmes was a powerfully built man)" (164). Holmes's action is equivalent to Dr Weir Mitchell's propensity "to put aside any nurse with whom [his patient] may have grown familiar" (*Fat* 53), but with disastrous results. Holmes's authority and physical presence overpower Rezia, and his forced entrance induces Septimus to jump from the window to his death. There is no consolation for Rezia's having been right; instead, defending himself, Holmes calls the suicide "a sudden impulse" (*Dalloway* 165). His investigation into his patient's illness is totally inept; he is blithely unaware that his efforts have instigated Septimus's death: Holmes is no Sherlock.

The violence exhibited by Holmes in fiction and Mitchell

in practice reflects the disciplinary quality of the discipline of medicine. All meanings of the word discipline apply: a branch of instruction or education; instruction aiming to form 'proper' conduct; a trained condition; a system of rules for conduct; correction; chastisement: punishment inflicted by way of correction; an instrument of chastisement, a whip or scourge; and a medical regimen.[49] Foucault discusses the discovery in the classical age of "the body as object and target of power" (*Discipline* 136) and recounts the setting up of regulations by various organizations for "controlling or correcting the operations of the body" (136). These organizations, "the army, the school and the hospital" (136), are all branches of instruction or education which mould their inmates to a prescribed system of rules and training. When their inmates--recruits, students and patients--do not respond to training or treatment, they are subjected to discipline in the form of correction, chastisement, or sometimes medical regimen. Thus the disciplines dispense discipline.

When Holmes pushes Rezia aside, he is exercising the disciplinary punishment allowed him by the discipline of medicine. As Mitchell asserts, the physician needs "force of character...and should...seize the proper occasions to direct the thought of his patients" (*Fat* 69). The violence of such words as 'force' and 'seize' emphasize the acceptance of the use of discipline in medicine; indeed Mitchell insists that "[s]uch moral medication belongs to the higher sphere of the

doctor's duties" (70). Discipline is essential in a system which relies on an arsenal of weapons to defeat an enemy. In the case of illness, it is too often not just the disease, but the patient or the relative who becomes the doctor's enemy. When Dr Weir Mitchell admits "that now and then one is *beaten* by a patient who has an *unconquerable* taste for invalidism" (44; my emphasis), treatment is set up as a battle of wills, doctor against patient. According to Anna Robeson Burr, "[f]ew people could stand against that driving power" which Mitchell displayed; he "had no more sense of humour than a poker" (245). If Rezia cannot resist Holmes's push, it is not just because Holmes is a big man, but also because Holmes works within a tradition of power which accepts and valorizes the disciplining of women.

In frustration with Holmes, Rezia consults a Harley Street specialist: "Sir William Bradshaw; she thought his name sounded nice; he would cure Septimus at once" (*Dalloway* 92). Like Lucretia in the legend, she will tell the patriarch of her plight and he will avenge her; he will help. But once again it is not to be. As a foreigner, Rezia may be unaware of the significance of Bradshaw's "nice" name.[50] Like the British Railway timetable his name signifies (*Bradshaw's Railway Guide,* a time-table of all railway trains running in Great Britain, was named after its printer, George Bradshaw, and was in print from 1839-1961),[51] Dr Bradshaw presents a strict regimen of dispatch. But he trades in people, not

trains. Sir William Bradshaw intends to dispatch Septimus like clock-work to a rest home, to hide him away, to lock him up. He needs only "two or three minutes" (106) to make his diagnosis. He no doubt prides himself on being on time, detests being late.[52] Sir William appropriates Septimus like a porter who takes on baggage; he disallows his wife's care, and silences Rezia. "'Trust everything to me,' he said, and dismissed them" (109).

Medicine's power is tantamount in Sir William. He terrorizes his captive patients with a demonstration of his physical prowess at actions which are malevolently akin to rifle drill:

> huddled up in arm-chairs, they watched him go through for their benefit, a curious exercise with the arms, which he shot out, brought out sharply back to his hip, to prove (if the patient was obstinate) that Sir William was master of his own actions, which the patient was not. (112)

The military analogy is appropriate, for in his authority as a Harley Street Nerve Specialist he has the power to take over and alter people's lives. He regularly

> secluded lunatics, forbade childbirth, penalized despair, made it impossible for the unfit to propagate their views until they too shared his sense of proportion (110). Naked, defenceless, the exhausted, the friendless received the impress of Sir William's will. He swooped; he devoured. He shut people up. (113)

His intention to shut up Septimus also shuts up Rezia - it effectively silences her.

Woolf calls Bradshaw a "priest of science" (104), equating medical and religious pontification. This is an analogy she

reiterates in *Three Guineas*, when she suggests that the patriarchy will be threatened by the admission of women to its ranks: "it matters not to which priesthood; the priesthood of medicine or the priesthood of science or the priesthood of the Church" (146). It is a recurring theme, evident also in *Villette* and in Foucault's *Birth of the Clinic*. The doctor and priest share in the inner secrets of their charges; both may grant absolution of afflictions. And, illness, according to Woolf, "is the great confessional" (*Moment* 17).

For all his power, however, Sir William Bradshaw's medical "priesthood" disallows confession. "Never, never had Rezia felt such agony in her life! She had asked for help and been deserted!" (*Dalloway* 109). Her cry is not heard; her plea is not answered. Like King Charles I, who was muzzled by another Bradshaw[53] and denied the opportunity to speak in his own defence, Rezia is silenced. Septimus as patient, and Rezia as woman, are considered insignificant; their defence is discarded by the patriarchal law of medicine as embodied in Bradshaw.

Roger Poole, in *The Unknown Virginia Woolf*, points out the prevailing "refusal of the psychiatrist to *listen*. Not just the inability to hear or to attend, but the actual methodological decision *not to listen*" (124) to the patient.

> Two central assumptions of the discourse of power in psychiatry in Virginia Woolf's day would have been that the patient is talking unconnected gibberish and, as a corollary to that, that he or she does not have to be listened to. (Poole xvi)

This is the key to the treatment of both Virginia and Septimus; their doctors refuse to listen to them. At a time when psychoanalysis was gaining ground, patients' experiences and unconscious conflicts being explored by new forms of psychiatry, Woolf's doctors use archaic methods. Elaine Showalter, in her introduction to a recent edition of *Mrs Dalloway*, defends the treatment Septimus is given: "Although they are tactless, snobbish, patronizing, and obtuse, the doctors of *Mrs. Dalloway* are probably right in recommending rest and seclusion for Septimus" (xlii). First of all, Holmes does not make such a recommendation: he merely tries to shame Septimus into submission; and second, Bradshaw is clearly not right. The excellent vision of hindsight (through what doctors refer to as the retrospectroscope) proves that Bradshaw is wrong. His proposed treatment induces Septimus's suicide. Showalter claims that this form of treatment "was therapeutic to Woolf, and before the days of drugs, the best care available" (xlii). The rest cures may have contained Virginia Woolf while she got well, but they did nothing to prevent relapses and may very well have influenced her ultimate suicide. In her final letter to Leonard Woolf she writes: "I feel certain I am going mad again. I feel we can't go through another of those terrible times. And I shan't recover this time. I begin to hear voices, and I can't concentrate" (Trombley 265). Although the prospect of madness must have been terrifying in itself, there is evidence

to suggest that Virginia Woolf's altered states of mental health increased her creativity. In a letter to Ethel Smyth in 1930 she recalls that when she was "ill and suffering every form and variety of nightmare and extravagant intensity of perception" (4:231), she would make up

> poems, stories, profound and to me inspired phrases all day long as I lay in bed, and thus sketched, I think, all that I now, by the light of reason, try to put into prose (I thought of the Lighthouse then, and Kew and others, not in substance, but in idea)--...(231)

In "On Being Ill" in *The Moment and Other Essays*, Woolf claims that "illness is the great confessional" (17), and that "rashness is one of the properties of illness" (22), and that rashness is a positive quality. If illness made her rash and impetuous and let new and creative ideas surge forth in her mind, the treatment she was subjected to in previous bouts of 'madness' did everything to silence, deaden and repress her increased mental energy. She was forbidden to read, forbidden to write. Another submission to the detached and controlling medical treatment, in which she has no voice--in which she clearly has no faith--ultimately proved impossible to endure.[54]

Dr Holmes uses his medical power to bully Rezia, to physically push her aside, to denigrate her story; and his mis-diagnosis and brute treatment result in Septimus's death. Sir William Bradshaw imposes his professional authority to commit Septimus to incarceration and to exclude Rezia, telling her (as Dr Savage told Virginia Woolf, and as Weir Mitchell

told his patients) that she must stay away from her husband, for "the people we care for most are not good for us when we are ill" (*Dalloway* 107). Rezia is left silenced and disempowered, angry and frustrated, the secondary, and now widowed, victim of medical authority. If her story had been heard and believed, perhaps the outcome would be different, but instead, as she is a woman, she is disregarded, bullied and blamed.

Even the critics disregard and blame Rezia. She is mentioned infrequently, or, in Barbara Hill Rigney's assessment, is chastised because she "rarely allows [Septimus] the privacy which it costs him his sanity to achieve. Her ultimate betrayal is her allegiance to the doctors" (51). Rezia's so-called 'allegiance' is the necessary submission required of her by the authority, the authority which has a double power over her because of her sex and her foreign nationality. She cannot cure Septimus by herself, nor should she be expected to have this ability. She rightly seeks outside advice, no doubt scraping up what little money she has from her hat-making to pay the high Harley Street fee to Sir William Bradshaw. She has chosen to take Septimus to someone Clarissa recognizes as "a great doctor. A man absolutely at the head of his profession, very powerful" (*Dalloway* 202). Rezia is intrigued by English reticence: "'The English are so silent,' Rezia said. She liked it, she said. She respected these Englishmen" (98), and she feels comforted by Bradshaw's

quintessentially English name. She is not the betrayer in this drama; she herself is betrayed--by Holmes, by Bradshaw, by a society which is closed to foreigners, and ultimately by Rigney. Rezia does whatever she can think of doing to make Septimus well and to protect him; she packs up the razors so Septimus cannot get them. If she seems slow to "recognize Holmes and Bradshaw for the villains Woolf intends to portray" (Rigney 51), it is because of her isolation and her alienation from British patriarchal culture. Because Holmes is well mannered she assumes he is "such a kind man" (*Dalloway* 102), who speaks "in the most amiable way in the world" (104). Rezia has no experience with superficial English pleasantries and naively interprets Holmes's offhand invitation to tea as a sincere expression of his interest in helping Septimus. She cannot be blamed for submitting to the doctors because she is unprepared culturally to recognize their manner as condescending. Only after Bradshaw's dismissive appropriation of Septimus and Holmes's physical brutality is Rezia fully aware that she has been silenced and over-ruled by medicine. Like the tragic hero Lucretia who shares her name, Lucrezia strives to save her husband from dishonour, and despite her brave efforts she suffers.

Critics generally view Septimus's suicide as a positive experience. Suzette Henke claims that "'throwing it all away,' Septimus makes of his life an unspoiled, gratuitous offering" (126); J. Hillis Miller claims "Septimus chose the

right way" ("Repetition" 96); and James Naremore sees the death of Septimus as having "a partially redemptive" (106) quality in giving Clarissa "an acute sense of her unity with life" (106), and as "transformed from the ultimate separation into the ultimate union" (107), allowing Clarissa "to experience Septimus's death as it really must have been" (107). Indeed, Clarissa visualizes the death, but it is not an exalting experience for her as Naremore seems to suggest:

> Always her body went through it, when she was told, first, suddenly, of an accident; her dress flamed, her body burnt. He had thrown himself from a window. Up had flashed the ground; through him, blundering, bruising, went the rusty spikes. There he lay with a thud, thud, thud in his brain, and then a suffocation of blackness. So she saw it. (*Dalloway* 203)

It is a bleak depiction, a realistic depiction. Instead of celebrating death, Woolf's description reduces it to the horror of reality. Death leaves, Woolf writes in her diary, "an indelible mark...death & tragedy...once more put down his paw, after letting us run a few paces. People never get over their early impressions of death I think. I always feel pursued" (2: 299). Because Clarissa, like Woolf, endured the early death of her mother and sister, she seems unlikely to adopt a romantic attitude to a death she imagines in such gruesome detail.

Rigney claims that Woolf "does endow Septimus's death with a symbolic significance: it serves to effect the spiritual regeneration of Clarissa....allows her to reaffirm her life" (60). Through his death, according to Rigney, Septimus "has

achieved a sense of self, an integrity, in the face of those who would rob him of such assets. There is nobility in his defiance of the William Bradshaws" (61). For Septimus, it may be true, as Rigney suggests, that "insanity, after all, may be the only escape from society's own state of schizophrenia called normality" (63), and for Clarissa, his defiance gives her a new cause to fight for life, but surely it is not Woolf's message to valorize the victim so much as to denounce the doctors and to censure the system! In her diary, Woolf writes that she wants, in this novel, "to criticise the social system, & to show it at work, at its most intense" (2: 248). There is nothing noble and little 'sense of self' in the "horribly mangled" (*Dalloway* 165) and bloody body of Septimus lying impaled on the stiff and unbending iron railings of his meagre lodgings. There is nothing noble about the body of Virginia Woolf, surfacing blue and bloated weeks after she took herself into the grim muddy tidal waters of the River Ouse. "Death was defiance. Death was an attempt to communicate....There was an embrace in death" (204) thinks Clarissa, but only because there is a limited possibility for communication in a world governed by patriarchal controlling figures like Sir William Bradshaw and Dr Holmes, the "brute with the red nostrils [who] was snuffing into every secret place" (163). Holmes and Bradshaw are "capable of some indescribable outrage--forcing your soul, that was it....Life is made intolerable; they make life intolerable, men like

that" (204). It is the "men like that" who must change, and Woolf's writing serves to criticize them, to challenge the system which allows them, and to enlighten her reader in order to oppose and resist the power of such men.[55] Clarissa has been lucky to avoid them. When she leaves her party to go upstairs to be alone with the information of Septimus's death, looking out the window and connecting in a new way with the old woman in the house opposite, it is not because of the unifying power of death, as Able ("Narrative" 179-180) and Rigney suggest; it is the recognition that as women they share survival in the face of oppression. The "old lady stared straight at her! She was going to bed" (*Dalloway* 205). She still lives, has grown old, even with the forces of the patriarchal system against her. Clarissa recognizes that the old lady has resisted, just as she has. What had been Clarissa's "disaster--her disgrace....her punishment to see sink and disappear here a man, there a woman, in this profound darkness" (204-5) becomes her salvation, for she has survived it. Through Septimus's death Clarissa moves beyond embracing death for herself; she finds strength in life. In spite of the fact that Clarissa feels she "had schemed; she had pilfered. She was never wholly admirable" (205) in her own estimation: "She had escaped. But that young man had killed himself" (204). In not being able to resist the system, Septimus has relinquished it.

Resistance to medical power is overt in Woolf's writing.

Lyndall Gordon refers to the 'Dr Chapter' as "a manifesto against the medical profession" (64). Never once is the reader encouraged to sympathize with or admire the doctors; they are depicted as stupid and evil. Although Rezia is not empowered to speak aloud, her interior monologues make her position succinctly clear to the reader. She cannot speak aloud against the power of medicine, but her inner fury is foremost in her conscious thoughts. Clarissa instantly assesses Bradshaw as "obscurely evil" (*Dalloway* 204). Although "she did not know what it was about Sir William; what exactly she disliked" (202), she is not alone, for Richard too "agreed with her, 'didn't like his taste, didn't like his smell'" (202). They detect the rot in the system, they have discussed it, outside the dialogue of the novel, and the reader is given Clarissa's thoughts. But these thoughts only confirm what Virginia Woolf has made very clear through the entire narrative in the silent thoughts of everyone from Rezia to Septimus to Clarissa to Mrs Bradshaw to the narrator herself: medicine can be terrifying, and medical power can maim and kill.

Even the obscure Evelyn Whitbread adds to Woolf's message. She is never seen or heard from directly in *Mrs Dalloway*, but her husband Hugh tells Clarissa she is in London "to see doctors" for "some internal ailment, nothing serious." She makes a habit of illness, but seems to have little luck with cure: "Times without number Clarissa had visited Evelyn

Whitbread in a nursing home" (8), and once again Clarissa feels she will have to try to buy something to "make that indescribably dried-up little woman look, as Clarissa came in, just for a moment cordial; before they settled down for the usual interminable talk of women's ailments" (12). In the precursor to *Mrs Dalloway*, Woolf's short story, "Mrs Dalloway in Bond Street," Mrs Whitbread is named Milly and is not a chronic invalid, but is suffering, Clarissa deduces, from problems with menopause: "Milly is about my age--fifty--fifty-two. So it is probably *that*" (Woolf *Complete* 153). Milly's interlude of illness metastasizes into Evelyn's entire lifestyle. By increasing this character's medical dependency, Woolf makes a stronger case against medicine's power to control women. Evelyn is permanently shut away by medicine in the novel and cannot even appear as a character. She cannot disguise the telling, for she has no voice at all, but like the external silence which pervades this novel, her absence forms a medical presence.

Because the characters' resistance to medicine is subverted in interior monologue in *Mrs Dalloway*, it risks not being heard. In fact, it is glossed over by many critics as nothing more than a satirical complaint about a couple of nasty physicians. But the disconnected thoughts of the silenced characters form continuous peaks on a graph of this novel, all reaching up as if begging to be noticed and connected by the reader. Woolf writes the resistance; it is up to the reader

to recognize the telling.

NOTES

1 Mary R. Lefkowitz, in *Heroines and Hysterics* suggests:

> Beginning from clearly defined premises about the world and his art, the doctor speaks with assurance and authority in the face of danger. Therefore the doctor presents his conclusion in timeless terms, with abstract nouns; verbs in the present tense, or in conditional clauses of the 'whenever-always' type. By setting up a general model, he is able to treat his patients impersonally... (22)

2 The "Report of the War Office Committee of Enquiry into 'Shell-shock'" appears in *English Parliamentary Papers*, XII, 1922, cmd. 1734. Thomas points out that rest, as recommended by Sir William Bradshaw in *Mrs Dalloway*, was part of the treatment, as was persuasion and withholding of sympathy, as practised by Dr Holmes. Thomas offers no critique of the treatments, nor does she point out their contradictory nature.

3 According to biographer, Richard D. Walter, in *S. Weir Mitchell, M.D.--Neurologist: A Medical Biography,* 1970, "[b]y the mid 1880s, Weir Mitchell had become the most prominent neurologist in America" (141) chiefly for his rest treatment for nervous disorders. For detailed information on Weir Mitchell's life and work see Walter; *Weir Mitchell: His Life and Letters*, by Anna Robeson Burr, 1930; and "Silas Weir Mitchell (1829-1919)" by Donald Ball, in *Practitioner* 217 (1976): 117-124.

4 Stephen Trombley, in *'All That Summer She Was Mad'*, details the preponderance of medical tragedies in the Stephen family and suggests that medical incompetence was to blame in many of them (75-106).

5 Virginia is herself ill with the "fidgets" (Woolf *A Passionate Apprentice* 114).

6 Stella's brother George Duckworth, and Virginia's sister Vanessa Stephen.

7 Woolf was sent by her physicians for varying degrees of Weir Mitchell-type rest cures in 1904, 1910, 1912, 1913, and 1915 (Gordon 51-4).

8 This is a casual reference: "As for work, I have done the Dr chapter in the novel" (*Diary* 2: 299).

9 It is significant to note that although Woolf wrote entries in her diaries on May 5th in 1897, 1905, 1918, 1919, 1920, 1924, 1926, 1927 and 1937, only three of these mention

her mother's death. Of these, both the 1924 entry, when she was concentrating on doctors in *Mrs Dalloway*, and the 1937 entry, when she was working on *Moments of Being*, mention Dr Seton. The 1919 is as follows: "The smell of wreaths in the hall is always in the first flowers still; without remembering the day I was thinking of her, as I often do." (1: 269). This image appears in *The Years*:

> It smelt strongly of spring flowers. For some days now wreaths had been piled one on top of another on the hall table. In the dimness - all the blinds were drawn - the flowers gleamed; and the hall smelt with the amorous intensity of a hot house. (Woolf *The Years* 69)

It is also present in *Moments of Being*: "The hall reeked of flowers. They were piled on the hall table. The scent still brings back those days of astonishing intensity" (Woolf *Moments* 107-8). These two memories seem strongest for Woolf - the flowers, and the doctor, walking away from the case he could not cure. Only the doctor surfaces as she writes her doctor chapter in *Mrs Dalloway*.

10 Lyndall Gordon lumps all Woolf's doctors together as contributing to her portrait of Sir William Bradshaw. She refers to the "hopeless meddling of consultants" (Gordon 64), but as Stephen Trombley makes clear, it is more likely the influence of Sir G. H. Savage, Sir Henry Head, and Sir Maurice Craig, who all treated her for psychological problems, who contribute most towards Bradshaw.

11 Dr D.J. Fergusson was Woolf's Richmond doctor, Dr Philip Hamill was a Harley Street specialist, and Dr Harrington Sainsbury was a Harley Street heart specialist. (Woolf *Diary* 2: 17n, 189n, 170n)

12 Stephen Trombley, in his 1981 book *'All That Summer She Was Mad': Virginia Woolf and Her Doctors* (which takes its title from Quentin Bell 1: 90), examines the whole question of Virginia Woolf's mental state in the context of contemporary medical meanings of madness.

13 The Hours was the working title for *Mrs Dalloway*.

14 Charlotte Perkins Gilman mentions him in "The Yellow Wallpaper" which has sparked critical interest in Ehrenreich and English, Gilbert and Gubar, Mitchinson, and Showalter.

15 Mitchell was awarded honourary degrees from Harvard (1886), The University of Bologna (1888), Edinburgh (1895), Princeton (1906), The University of Toronto (1907), Jefferson College (1910), and Johns Hopkins (1912). In his obituary, the *London Times* praised Mitchell's approach to nervous diseases as

> pioneer work in a most difficult and treacherous field. He brought to it a steadfast courage and sympathy which in the end overcame all obstacles and gained for his system the recognition of medical authorities throughout the world. (cited in Burr 389-90)

16 *Morton's Medical Bibliography* (Garrison and Morton), which is the accepted medical bibliography of standard medical texts, lists seven of Weir Mitchell's publications, including his published accounts of the rest cure, "On rest in the treatment of nervous disease," (4553) and *Fat and Blood and how to make them*, (4554).

17 Donald Ball confirms that *Fat and Blood* was translated into German, French, Italian and Russian (121), and Mitchell, in the introduction to the 8th edition of *Fat and Blood* reports that "a translation of my book into French by Dr. Oscar Jennings, with an introduction by Professor Ball, and a reproduction in German, with a preface by Professor von Leyden, have placed it satisfactorily before the profession in France and Germany."

18 Cited by Mitchell in *Fat and Blood* (13) from Playfair: *The Systematic Treatment of Nerve Prostration and Hysteria*. London: 1883.

19 As Anna Robeson Burr notes, "warnings have ever been favorite reading of the American mother, who takes a melancholy joy in contemplating the dangers to her off-spring of over-weight and under-weight..." (151)

20 Mitchell profited well from his rest cure treatment, and soon gave up his general practice to consult exclusively on nervous diseases. In one year alone he made sixty-four thousand dollars. (Burr 121).

21 The scientific aspects of the text are sparse or shoddy. In *Fat and Blood* Mitchell refers to a study he made of weight determination on the Philadelphia police force to indicate summer weight loss, but his results are inconclusive: "As I have mislaid some of the sheets [of his research], I am unable to give it accurately, but I found that three out of every five had lessened in weight" (20). He writes about the connection between "the gain of fat...with an improvement in the color and amount of the red corpuscles" (16-17) without giving any specific measure of blood values. His judgement is extremely subjective, based only on what he observes in his patient's countenance. He refers to "cases desirable to fatten and redden" (35), "cases in which loss of weight and loss of color are noticeable" (36), "lacking in color" (38), and a patient whose "appearance was strikingly suggestive of anæmia" (132). Even when there is evidence of laboratory

investigation, Mitchell's description is vague: "her white corpuscles were *perhaps* a third too numerous" (146; my emphasis), and of a patient whose weight gain is noted numerically, the blood increased is observed as merely a "gain in color" (148). Only in the final pages of the book does Mitchell give laboratory analyses of blood values. Suddenly a book which is filled with idiomatic language is infused with "hæmoglobin...microcytes, megaloblasts, nucleated red cells, and...white corpuscles" (186) with assigned scientific number values.

22 The first and second editions are entitled *Fat and Blood, and how to make them.* The first edition was published in 1877, the second in 1878, and was reprinted in 1879, and 1881. Subsequent editions are entitled *Fat and Blood: an essay on the treatment of certain forms of neurasthenia and hysteria.* The third edition was published in 1884, the fourth in 1885, the fifth in 1888, the sixth in 1891, the seventh in 1898, and the eighth and final edition was published in 1902 and reprinted in 1905, 1907 and 1911. In 1905, however, the first edition with its original title was reprinted. Not only did the text go into eight editions with frequent reprintings, but the original title was still considered appropriate twenty-eight years after original publication.

23 In "The Evolution of the Rest Treatment" in the *Journal of Nervous Mental Disease*, 31: 1904, Mitchell writes:

> The one mistake in the book was the title. I was, however, so impressed at the time by the extraordinary gain in flesh and blood under this treatment and I made it too prominent in the title of the book. Let me say that for a long time the new treatment was received with the utmost incredulity. (372)

Mitchell is quite clear that he believes that his book was slow to be accepted because of the title alone. It is the one and presumably only mistake he acknowledges.

Donald Ball suggests the book "was viewed with some mistrust...by certain members of the medical profession" (121) because Mitchell was "a propagandist of highly unorthodox practices" (121).

24 The female pronoun is now used exclusively.

25 Burr recounts that Mitchell "kept an iron discipline in the sick-room, exacting complete obedience" (185). He obviously expected other doctors to follow this course for the treatment to be successful.

26 Mitchell's misogyny cannot tolerate any attempt at equality by women. He does not "think any educational change in generations of women will ever set her, as to certain mental and moral qualifications, as a equal beside the man"

(*Doctor* 138), and when she is successful, she loses her feminine appeal to men: "there are careers now sought and won and followed by her which for him inevitably lessen her true attractiveness, and to my mind make her less fit to be the 'friendly lover and the loving friend'" (139). It is little wonder he felt he could not advise women doctors to treat neurasthenia.

27 Ann Douglas Wood points out that Mitchell was "curing his patients...by subordinating them to an enlightened but dictatorial male will" (9).

28 Despite his abusive manner, Mitchell is regarded by his biographers as extremely sympathetic to women. Accepting that Mitchell associated women with weakness "till the association crystallized into a cliché" (Burr 373), Burr insists: "Nothing could be less true than to assert that Dr. Mitchell had a low esteem of women--the contrary was the case" but "his standard was extremely conventional; his ideal woman was the well-sheltered woman" (373). Donald Ball notes that Mitchell "was God's gift to women. Handsome, bearded with penetrating eyes and a persuasive manner...the secret of Mitchell's success with women was a fairly simple one; he understood them" (122). Mitchell claimed he never tired of sick women: "tired of sick women? Not I. Of women who are well? Of sick women never; they are doubly interesting" (Burr 279).

29 If, however, he was interrupted in a state of undress, the story takes on a much more sinister aspect. Might Mitchell have been caught in an unseemly position and turned the situation around to indicate his brilliance in dealing with an 'intractable' patient?

30 Osler, a Canadian, became Regius Professor of Medicine at Oxford in 1904. See R.L. Golden & C.G. Roland, *Sir William Osler: An Annotated Bibliography with Illustrations*, San Francisco, Norman Publishing, 1988, and Harvey Cushing's *Life of Sir William Osler*, OUP, 1925.

31 According to *Garrison and Morton*, "Osler's textbook was the best English work on medicine of its time" (Morton 2231).

32 According to *Garrison and Morton,* the "best edition is the English translation of the 5th German edition" (Morton 4582), which I have used, but there were also two American editions translated by Edward E. Mayer, and published by Lippincot in 1900 and 1904.

33 This text is cited in the *Index Medicus* Vol XV: August 1917, 567.

34 Woolf experienced frequent periods of self-starvation throughout her life, and her weight dropped to the point of amenorrhea in 1913. See Stephen Trombley's chapter on food in *All That Summer She Was Mad*.

35 Oppenheim refers here to the concern that hypnosis itself "may produce symptoms of grave hysteria" (1111).

36 I do not wish to imply that Freud's methods are the answer to the treatment of women with hysteria and neurasthenia. Freud's initial linking of hysteria with sexual abuse--the seduction theory--is extremely important, and if followed through, or taken up by other physicians, might have led to the recognition of the prevalence of incest and other forms of sexual abuse that are only now being acknowledged by medicine. For a discussion of Freud's seduction theory and his move away from it, see Charles Bernheimer's introduction to *In Dora's Case* 10-18.

37 The word hysteria is derived from the Greek *hustera*, meaning womb.

38 Allbutt became regius professor of physic at Cambridge in 1892, was knighted in 1907, and became a privy councillor in 1920. Two of his medical works are listed in *Garrison and Morton* (4778), (4779), and *A System of Gynaecology* is listed in the *Encyclopedia Britannica*.

39 This text went into three editions: 1896, 1899, and 1907.

40 There may be a connection to the "wandering womb" condition described by Greek physicians which was thought to cause hysteria.

41 Resistance to disease in this instance.

42 Allbutt warns against a young woman wearing stays and "bending the back in her education" (137) as it induces abnormal spine curvatures and reduced body strength. With studying, "digestion is impaired, flatulence arises, constipation is produced, the teeth become carious...the nerves are debilitated [and] menstruation is disordered." It is not work itself "which hurts, but perseverance in work after nature has hung out its danger signals" (223). He also advises: "Football and gymnastics, unless of the parlour variety, are quite unsuited to adult women" (251).

43 This text is cited in *Index Medicus* Vol XXI: No 2, June 1898, 123.

44 What was then considered to be displacement of the uterus, would not now seem pathological ·· most practitioners, but a normal variant of position.

45 This text is cited in the *Index Medicus* Vol XXI: No 6, October 1898, 418.

46 This text is cited in the *Index Medicus* Vol XVII: No 4, April 1895, 171.

47 See Ruth Bleier, *Science and Gender: A Critique of Biology and Its Theories On Women*. New York: Permagon Press, 1984.

48 It is curious to note that in Woolf's 1909 essay praising Oliver Wendell Holmes in the *TLS*, she writes: "Dr Holmes was primarily a medical man who valued sanity above all things....he liked his men to be strong and sanguine, and honoured the weakness of women...he loathed all gloom and unhealthiness" (Woolf *Granite & Rainbow* 238-9). What she valorizes in one Dr Holmes early in her career, she clearly despises in another, written after her extensive experience with mental and moral medicine.

49 See the Oxford English Dictionary, 2nd Ed. Complete Text, 1991.

50 Roger Poole points out that Maurice Craig, a doctor Woolf consulted, gave the 'Bradshaw Lecture' to the Royal College of Physicians in 1922. He suggests: "It is possible that some published report of this Bradshaw lecture gave Virginia the name of her fictional neurologist" (124).

51 See Oxford English Dictionary 2nd Ed. Complete Text, 1991.

52 Of course he is late for Clarissa's party, but Sir William has Mrs Bradshaw deliver the excuse that they are "shockingly late" (201) because of Septimus: "just as we were starting, my husband was called up on the telephone, a very sad case" (203). In this way, Septimus gets some retribution; his death detains Bradshaw.

53 John Bradshaw was the president of the High Court of Justice which tried King Charles I in 1649 (*Britannica* 3: 1009).

54 Sue Thomas, in "Virginia Woolf's Septimus Smith and Contemporary Perceptions of Shell Shock," *English Language Notes* (2) 1987: 49-57, points out that the treatment Septimus is offered is in keeping with contemporary medical practice.

My concern is that the practice itself is inappropriate and inadequate.

55 For a discussion of patriarchal violence and rape in *A Room of One's Own*, see Barbara McLean, "An Inviolate Space: Refuge From Rape in *A Room of One's Own*." *Room of One's Own*. Volume 15, Number 2, July 1992.

CHAPTER 4

"NO MORE PROTEST THAN...A CORPSE": SHELTERING IN SILENCE IN *THE MILLSTONE*

Medical bullying and silencing of women does not disappear as the years pass. It continues to be evident in both medical texts and fiction. In *The Millstone*, Margaret Drabble gives a horrifying account of how a callous state medical system treats an unwed mother. Virginia Woolf makes it clear that the private-patient Harley Street doctor, although superficially polite and dignified, has no qualms about asserting his authority. Drabble, whom Showalter calls "the novelist of maternity" (*Literature* 305), indicates that the sense of authority remains, but that health care delivered through the public system further denigrates the patient and further silences the victim, particularly if that victim is female and alone.

Women continue to be treated by medicine as lesser and weaker individuals than men and continue to be judged intellectually by their reproductive capacity. Drabble's *The Millstone* deals directly with issues of pregnancy and childbirth in the early 1960s, and this chapter investigates medical discourse on the subject, both in terms of obstetrics and gynaecology and through the continuing connections made by medicine between mental disfunction and reproduction.

More than a century after Brontë wrote *Villette*, Drabble continues the tradition of using silence in her female characters as a resisting strategy to the horrors of medicine. When Drabble's Rosamund suffers the offensive treatment of medicine on her own body she, like Lucy, is outwardly silent, and like Rezia and Clarissa she gives vent to her concern only inwardly in the narrative. When her baby is affected by medicine's authority, however, the method suddenly changes as she finds voice and breaks the pattern of silence as resistance. Rosamund, in demanding to see her sick child, has 'hysterics.' The difference is that now such a response, at least for Rosamund, an independent, educated, privileged and articulate woman, actually works. Instead of being locked up for her antics, she unlocks the barriers medicine has erected between her and her child.

To explain Rosamund's treatment by the medical system in *The Millstone*, I will look at teaching methods through medical text-books of the time. There is little doubt that Drabble's description of medicine is based on fact: what is more, she claims it to be so. In an interview with Nancy Hardin, Drabble says her description of medical scenes in *The Millstone* is "what life was like" (Hardin 290); "in the National Health episodes you see Rosamund coming up against a world which she is aware goes on....I wanted to make those documentary episodes real in their own right" (290). Drabble believes "the health system is a model of society as a whole."

"It's a very paternalistic system, which I don't think is endemic in a health service: I don't think it should be there at all, but it is there....In a way *The Millstone* was designed to show the holes in the system" (Interview).[2]

There is a paucity of critical writing on Drabble's work. She is a very successful and popular writer, which seems to separate her slightly from the realm of academic criticism. Although this is changing, and more articles and books are being published, the change is not dramatic. There is very little analysis of either feminism or medicine in Drabble. In a recent study published in 1991, Valerie Grosvenor Myer claims Drabble is "still occasionally dismissed as 'a woman's writer' (13), with her work denigrated as "Tampax literature" (11). Gayle Whittier agrees with Elaine Showalter's mother metaphor, referring to Drabble's works as "matricentral" (213), and Nora Foster Stovel suggests "the source of conflict in the contemporary novel may be maternity" (5). Stovel believes that "more than any other novelist, Drabble has recognized that motherhood raises serious ethical and metaphysical questions based on the essential conflict between egotism and altruism" (5). Stovel concentrates on Rosamund's growth through maternity in *The Millstone*, but she does not critique the oppressive medical process Rosamund experiences.

Gail Cunningham, in her article "Women and Children First: The Novels of Margaret Drabble," situates Drabble in the "honourable tradition of the Victorian novelist" (131) and

concentrates on what she calls "the more commonplace patterns of domestic life" (132) like "the interaction of parent and child" as central to Drabble's fiction. Cunningham argues that Drabble's feminism is situated historically, that "the most apparently emancipated behaviour is part of a tradition" (133), and that "Rosamund's position as unmarried mother and career woman, superficially a paradigm of modern feminism, is linked firmly with its nineteenth-century parallels" (133-4), quoting Rosamund comparing herself to a "'Bernard Shaw woman who wants children but no husband'" (134). Cunningham neglects to point out that for the odd Bernard Shaw woman who could survive social scorn as an unwed mother there were countless others who could not.[3] Rosamund is right to acknowledge the strides made by early feminists, but her treatment by the medical patriarchy indicates that women continue to be oppressed, particularly if they deviate from accepted social patterns. When Cunningham suggests that "the straightforward questions have to a large extent been answered" (134) for contemporary women, she denies the importance of the basic issues of women's inequality raised in *The Millstone*.

Although Rosamund is successful in her academic career in spite of having a baby on her own, Ellen Cronan Rose concludes that Rosamund holds "non-patriarchal values" (*Novels* 21). Rose believes that Rosamund is successful "because she puts mind over matter" (21). Feminism is not an issue for Ellen

Cronan Rose in *The Millstone*. Lynn Veach Sadler, in her 1986 overview of Drabble, points out the problems inherent in "the National Health Service and Pre-natal clinic" (26), but she ascribes little importance to the medical aspects of the novel. Rather, Sadler is concerned that "Rosamund is much like other Drabble heroines, emotionally flawed and struggling to be both a woman and a human" (27). Lorna Sage claims Drabble uses a "deliberate traditionalism" (91) in her work, which involves both a "cosiness" and a "consciousness of virtue" (94). In Sage's 1992 text, *Women in the House of Fiction*, she does not mention *The Millstone* in her assessment of Drabble's work, but refers to Drabble's "flavour of cosy masochism in her self-limiting choices" (96) which apparently precludes feminist analysis.

It is my contention that Drabble is a strongly feminist writer, and in *The Millstone* she presents a feminist critique of medicine. Her writing works to correct the stereotype of the unwell woman; medicine interests her:[4]

> I think I don't particularly go for the idea that women are always ill, and I know perfectly well why I react against it, it's because my mother was a hypochondriac...a tremendous hypochondriac who greatly enjoyed being ill....in my novels I try to give people an active life. (Interview)

Personal experience has influenced Drabble's interest in critiquing medicine. Before her father's death in 1982:

> He was taken ill in Holland and he was in a Dutch hospital for a month....that hospital was so much better than ours... the health care was excellent. The ease and access - you could ring up from England and speak to the doctor quite easily and they would

> tell you the truth. He had cancer. They described it; they said don't go and have the tests again in England, it's a waste of time. They provided the X-rays; they were absolutely first class. The hospital had a kind of jolly atmosphere, if you could say that. The foyer was pleasant, it was bright paint, you could sit and have a cup of coffee and a cigarette! There was none of this nonsense about never having a cigarette. There was no puritanism. And when he got back to hospital here we were right back to this old regime - sort of *them* and *us*. (Interview)

Drabble worries about the way physicians guard and disseminate their knowledge. She believes in the right of patients to know the truth about their conditions, but also in the right to be told with compassion:

> I certainly wanted to know about my son's heart condition. But I did not want to be handed a post card as I sat on a chair in a corridor. I wanted to be told by a specialist. There is sometimes a brutality which is just unthinking. (Interview)

Drabble admits it is her intention to make women aware of their socialization as unwell, and to point out their ability to be well and to overcome the expectation of illness (Interview). She also has a profound interest in medical topics:

> I'm a great reader of medical items in the newspapers, which is why they crop up in the novels. I'm particularly interested in rare disasters, rare medical disasters, and of course the papers love to write about them so I'm well supplied with these things. (Interview)

Drabble's fascination with medical matters and her commitment to isolating and changing social ills combine to form a succinct criticism of medicine. In *The Middle Ground*, Kate vows to do an article on the inhumane medical treatment Hugo receives when he goes to be fitted for a prosthesis (249).

Kate never writes the article, she does not need to, for Drabble portrays the problem directly to the reader, and critiques the medical system. "It's a question of the strong bullying the weak, I think, and it very often is a sex thing." Although she believes that in the health system "women aren't the only victims," that "also working class men and old men are bossed and bullied" she agrees that "women of all classes are bossed and bullied - it's true" (Interview).

Medical texts provide valuable evidence for Drabble's description of the workings of obstetrics and gynaecology in the 1950s and 1960s, both in Britain and North America.[5] Initially, my reaction to these medical texts was that their physician-authors were aware that someone like me might be reading them critically. That impression, however, was fairly short-lived. The outrageous opinions of the nineteenth and early twentieth centuries are toned down in the texts, which surely reflects the changes in women's role in society over time. What is surprising, and so distressing, is that the change is so small, that the concessions to women's ability, intelligence and integrity are so meagre. Each of the texts I look at deals with psychological aspects of obstetrics and gynaecology, most have specific sections or chapters on hysteria or neurosis, and all address psychosomatic complaints in women's medical conditions.[6]

THE BODY'S ENGINEER:

As Foucault suggests, with the decline in religion and the rise of science in the nineteenth century, doctors became the new priests of the body. The concept of doctors ministering to the sick, hearing confessions, and bestowing comfort and absolution maintained a religious-like fervour well into the twentieth century. The rise of science, however, included the rise of technology. In the twentieth century, technological advances overtook the art of medicine. According to Fritz Wengraf, in his 1953 text, *Psychosomatic Approach to Gynecology and Obstetrics*, "Where once the doctor was the body's priest, now he was the body's engineer. Thus the 'machine age' of medicine was born" (6). Engineers, like priests, acquire the power of specific and exclusive knowledge through their training. As technology gets more and more complex, engineers become isolated in their ability to understand the workings of machinery which elude the average person. By suggesting that doctors are party to the extra knowledge of technology, as well as to the god-like skills of the priest, Wengraf invests them with more power over their patients than ever before.

Technology has revolutionized medicine. Since the introduction of X-rays, faradization and electroconvulsive therapy early in this century to the general use of CT scanners, ultra-sonography, and *in vitro* fertilization at present, technology and medicine are rarely separate entities.

As technology and medicine merge, however, the patient's body separates, from a whole entity into a conglomeration of individual parts, each dealt with by a different specialist, each subject to a different form of engineering, or technology. This divisiveness further distances the doctor from the patient; she is at even greater risk of being notable as merely a uterus, a birth canal, and an apparatus for reproduction than she was in the nineteenth century, when the specialized fields of gynaecology and obstetrics were first delineated.

Medical technology, with its fragmentary approach, does not solve all the problems of human health and illness, and the advances in science have not proven Virchow's theory at the turn of the century "that the origin of all disease could be found in the disease cell" (Wengraf 6). After a great burst in technological activity, doctors began to realize, according to Wengraf, that no matter how sophisticated their diagnostic tools and curative devices, they could not ultimately eradicate all illness, or prevent all complications. Where it was once assumed, for instance, that the recognition and measurement of female hormones would fully enable medicine to cure problems with the menstrual cycle,[7] the actual discovery of hormone activity proved less than adequate in explaining all pathological conditions (Wengraf 8). If science and technology (which are by the 1950s considered to be so precise and accurate) cannot solve all the problems, the problems must

be beyond the very reach of medicine, religion, and engineering; they must be inherent in the patient herself. As Wengraf puts it: "the pressure of mounting evidence has forced gynecologists to consider not alone the genital organs but the woman herself" (8). Although this approach suggests a welcome move away from the fragmentation of the body, unfortunately it does so at the expense of the woman's perceived ability to control her bodily functions. If there is pathology which cannot be explained by technology, it must originate in the patient's mind. Medicine blames the victim.

PSYCHOSOMATIC APPROACH:

The psychosomatic approach, adopted after science and technology failed to solve all the problems in medicine, puts a new name on the diseases and problems which continue to defy professional investigation. In *Psychosomatic Approach to Gynecology and Obstetrics*,[8] Fritz Wengraf presents an updated response to conditions which would have been classed as hysteria in the nineteenth century, or neurasthenia in the early twentieth century. It is important to examine texts such as this to determine how the approach to women patients has changed in the century since Brontë wrote *Villette*, and to understand how treatments differ.

Early texts dealing with hysteria and neurasthenia, such as Forbes 1834, Carter 1853, Graham 1861, Playfair 1865, Acton 1875, and Weir Mitchell 1888, skip the steps of diagnosis and

jump immediately into treatment; turn-of-the-century and early twentieth-century texts such as Osler 1898, Oppenheim 1911, Southard 1919, and Rivers 1920 & 1923, suggest the possibilities of making a differential diagnosis by ruling out other pathology before treating the ailment as psychogenic; and the texts of the mid twentieth-century, detailed below, alert doctors to *suspect* neurosis in a patient who presents with somatic symptoms. Troubled nineteenth-century patients who could not be diagnosed as having a specific physical ailment were automatically assumed to be hysteric, early twentieth-century patients were considered hysteric or neurasthenic until proven otherwise, and mid-twentieth century patients were considered potentially neurotic beneath their symptoms. For the latter group, with the help of gynaecology and obstetric text-books, the discerning doctor was trained to detect and reveal neuroses.[9]

One clue indicating a neurotic patient in 1953, according to Wengraf, was an overt interest in the operative procedures to be performed on her body. Although he suggests that surgeons can no longer "be taciturn, hasty, and condescending, thus impressing the patient with their importance, skill, and authority" (Wengraf 136), and that the patient "objects to this dependency and resents being considered merely the object of a prearranged deal between the referring practitioner and the surgeon" (136), he denounces the need for patients to understand the methods of their treatment. In the case of

hysterectomy:

> Some patients indicate their neurotic state by a detailed inquiry into the *immaterial details* of the operation, such as the question of local or general anesthesia, the use of suture material, the operative approach (e.g. an expression of preference for either the abdominal or vaginal route), and last but not least the amount of tissue to be removed from the genitals. (136; my emphasis)

What Wengraf dubs immaterial seems absolutely crucial for a woman's adjustment to mutilating surgery. The question of anaesthesia influences both potential risk and discomfort. The operative approach changes the physical outcome in terms of the resulting scar and the amount of recovery time, and the amount of tissue removed determines the extent of mutilation, which is surely a reasonable concern for any sane patient. By suggesting that these concerns are "immaterial details," Wengraf indicates medicine's continuing demand for silent submission, particularly from women patients. These are details for doctors, not patients. Such decisions will be made on the basis of scientific and technological information which is unavailable to the patient, and any patient who indicates an interest or a concern for such details is considered likely to be neurotic. Women must submit silently to the knife, or their sanity is suspect.

Wengraf deals specifically with the psychogenic elements of pregnancy. *Hyperemesis gravidarum*, or protracted vomiting of pregnancy, he writes, is thought by "practically every author and practitioner" to be caused by "a psychogenic factor" (177). Doctors responding to this belief have a

"tendency to use feigned operations and sham abortions" (178) as treatment. He cites E.P. Solomon, from a medical journal article in 1941,[10] who "claims success by the cauterization of the cervix. The bad odor, he says, does the trick" (179). Wengraf does not condone this treatment; neither does he criticize it on medical grounds. The concept of unnecessarily cauterizing a pregnant woman's cervix seems unconscionable. Not only would she be at increased risk of spontaneous onset of labour and miscarriage, but scarring could interfere with labour and delivery and be disastrous to both mother and child; an injured cervix would be likely to dilate ineffectively and the labour would not then be able to proceed normally. If this occurred, risk of fetal and maternal distress and infection would rise, and the delivery would have to be undertaken by caesarian section with its increased risks to both mother and child. These, however, are not Wengraf's reasons for denouncing such treatment. Rather, he considers it merely "poor management to respond to the alleged malingering of an 'hysterical woman' with a conscious fraud" (179). It is the management of the patient which concerns him rather than the methods of treatment used. Poor management brings poor results, and Wengraf discourages such sham operations on this basis. He implies that he would condone the treatment if it worked to halt the vomiting.[11]

The obstetrician, according to Wengraf, should "find the time to listen to a woman's fears and apprehensions" (181) in

pregnancy. But he does not go on to outline a professional relationship between intelligent beings. Rather, he suggests the doctor should "express himself in not too severe a tone but adopt the role of a father or friend" (180-1) so the patient will form a "willingness to submit to his mastery." If not patriarchal, the doctor is advised at least to be paternal. In fact the obstetrician is urged to "make up for the frustrations of the pregnant woman's past; he must substitute for the disappointing father; he must lessen the antagonism toward the mother," and also "allay the pains of labor before they are realistically experienced" (210). The doctor is to be confessor, engineer, and saviour all in one.

Clearly there is no room for a female obstetrician in this scenario. Even by 1953 no doctor is advised to assume the role of a mother with her patients. On the contrary, an obstetric patient who deviates from the male medical model is immediately suspect as neurotic, and her sexual fantasies are put into question: "If a pregnant woman prefers a female physician, her day dreams may portray the danger which allegedly emanates from the (seductive and handsome) male gynecologist (214)." There must be something psychologically wrong with a woman who would avoid a male doctor and go to another woman for obstetric care.

Wengraf asserts that the relationship between a woman and her doctor is based on "'transference,' meaning the sum total of a patient's emotional response to the physician" (253).

Since he assumes the transference includes "sensual elements" (211), he clearly expects every pregnant woman to be heterosexual, to prefer a male physician, and to accept a sexual component to her medical treatment. Wengraf believes the pseudo-sexual relationship is an asset:

> It is neither charlatanry nor crude empiricism to utilize a phenomenon which is so common and so spontaneously produced. Its effect may be a strong ally, lessening the danger of childbirth, rendering it a profound joy instead of an ordeal. (210-211)

He believes "the relationship of a woman to her obstetrician is lasting," and to a psychiatrist, such a "relationship serves as a gauge by which the strength of *any* affection is measured" (210; my emphasis). He implies that it is not only normal for a woman to fall in love with her obstetrician, but actually productive. He reassures his physician-readers that following the birth "this strong reliance upon the obstetrician will be purified of possible sensual elements" through natural amnesia, and "what remains will be a deep feeling of gratitude to one whose authority, skill, and concern helped her" (211). Wengraf allows for a "certain affinity of characters" (256), arguing that a "domineering, masculine woman will usually be on the lookout for a weak character; an outwardly passive personality will seek a strong, tyrannical physician," but the sexual element is essential. When a woman chooses a female physician, she may be indicating that she is neurotically afraid of men and the sexual threat they pose. Wengraf suggests a strong father

fixation, which will elicit "a strong positive attachment to the gynecologist, can be employed therapeutically by transposing this neurotic trend into a constructive tool to ease the fears and apprehensions of pregnancy and childbirth" (214). Such a father fixation may be neurotic, but it is judged as much more normal than a fear of men which might lead to the choice of a female physician. Wengraf valorizes the powerful and sexual relationship between male physicians and female patients, but mentions nothing about the impending possibility of sexual abuse.

In *Crossen's Synopsis of Gynecology* 1963,[12] a text published just two years before *The Millstone*, psychogenic disorders and their detection are given prime space at the beginning of the chapter on examination and diagnosis.[13] In this book, which is meant to be a quick guide for students or general practitioners rather than specialist gynaecologists and obstetricians, doctors are advised that "[m]any women seeking aid for female troubles are, instead, troubled females." Before detailing the methods of history-taking, examination, and diagnosis, the authors impress upon their readers the symptoms of hysteria and neurosis, which "consciously or unconsciously" frequently appear "as symptoms such as pain, frigidity, infertility, or menstrual disturbances" (Beacham and Beacham 77).

Once again, any deviation from the submissive patient model is to be seen as suspicious:

> In the history there are a number of symptoms and actions that enable one to suspect a large psychosomatic element. Alvarez states: 'The harder it is to get a clear history out of the person, the less likely she is to have organic disease'. These patients bring in many irrelevant facts which they have written down. Instead of answering the questions put to them they interrupt the physician in order to give their own diagnosis. (Beacham and Beacham 78)

Even by 1963, a woman patient must not deviate from the doctor-run interview. She must provide a clear detailed history (with no notes), and she must know what is relevant to her case without presuming to have an opinion on the diagnosis. If she interrupts, or offers suggestions, her condition suddenly loses medical credibility. As Findlay asserts in her dissertation *Women and Medical Knowledge in the 1950s: A Study of the Process of Social Construction*, "The assumption was that the woman was passively there, to be examined and monitored, and to be filled with the doctor's advice" (343). With such an expectation still in place, silence remains the only safe route.

Medicine in the 1960s continues to expect women to display neurotic and hysteric symptoms. In a differential diagnosis of these conditions, *Crossen's* gives a two page chart claiming that neurosis is twice as common in women as in men, and hysteria is "almost exclusively in women" (80). Almost anything that indicates an unwillingness to succumb to the power and authority of medicine is ruled to be indicative of psychosomatic illness "such as procrastination in seeking medical advice, self-treatment, vagueness and evasion, broken

appointments, medical shopping, misleading explanations [and] fear of personality study..." (78). All of these situations might well suggest an unsatisfactory doctor-patient relationship rather than a neurotic or hysteric individual, but the situation still seems to prevail that the doctor is always right, the patient wrong.

ROSAMUND'S BABY:

When Rosamund finds herself pregnant after one short and rather unsatisfactory sexual encounter, she enters into a medical system which is inherently unsympathetic to her. She is given no allowance for her intelligence; no one bothers to discover that she is an academic, writing her doctoral thesis. If she is assumed by the system to be ignorant, she is also influenced by this assumption, and finds herself wondering "if all the symptoms from which [she] suffered might not be purely psychological" (*Millstone* 35). When medicine expects women to suffer from psychogenic illness, even clever women like Rosamund are affected by that expectation and find themselves questioning their ability to recognize the reality of their physical condition.

Rosamund is a neophyte in matters medical. She has not visited a doctor since she was a child and has little idea of how to find one. Indeed, most healthy young women have little need to deal with medicine now until their reproductive organs demand it, and, with the medicalization of childbirth in our

culture, this becomes inevitable in pregnancy. Because she lives so close to Harley Street, the historical bastion of private and exclusive medicine in London, she is "terrified that [she] might walk into some private waiting-room by accident, and be charged fifty guineas for what [she] might and ought to get for nothing" (35). Judging by Virginia Woolf's experience, and that of her character Septimus Smith, Harley Street would not ultimately have served Rosamund any better than the National Health, but the question of finding a doctor is an important one. Rosamund is a student. Her friends are single and healthy. She has no contact with young mothers or the aged, the members of society who visit doctors most regularly, so she has no one to ask for advice on finding an appropriate physician. Although she realizes that "it did not seem a good plan to pick a surgery so evidently seedy that it could not exist but on the National Health...this was in fact what [she] did" (35).

The demoralizing aspect of the system Rosamund becomes part of is evident as soon as she arrives at the surgery. Typically doctor-run, these offices function without pre-arranged appointments, but on a first-come, first-served basis. Rosamund knows about this; she notes the hours and plans to arrive at opening time the following day:

> The surgery opened at five thirty, and I made a point of going along there quite promptly: I arrived at about twenty-eight minutes to six, thinking that I was in plenty of time, and would have to wait hardly at all. But when I opened that shabby varnished door, I found a waiting-room over-flowing with waiting

> patients, patiently waiting. There were about twenty of them, and I wavered on the threshold, thinking I might change my mind, when a woman in a white nylon overall came in and said irritably,
>
> 'Come on, come along in now and don't leave the door on the jar, it's on the bell, it makes a dreadful noise in the back.'
>
> Meekly, I stepped in and shut the door behind me. I had no idea what I ought to do next: whether I should sit down, or give my name to somebody, or what. I felt helpless, exposed, before those silent staring rows of eyes. (36)

Rosamund, a highly intelligent scholar heading for a professional academic career, is reduced to silence. She becomes meek, helpless and exposed; she can neither face up to nor back down from the squalor of the doctor's dismal waiting room. She is consumed by a system which imposes itself on the weak--and weakens the strong.

All of Rosamund's privileges of class, education, and knowledge disappear as she merges with the system. She is instantly shamed by the nurse for forgetting her National Health card, a situation she somewhat alleviates by the "extraordinary feat of memory" which enables her to give the number. Her prompt arrival results in a wait of "one hour fourteen minutes precisely," during which she is able to study her "companions in endurance" (37). So naive is Rosamund, that she has not even known to bring along a book.

When finally she gets to see the doctor, she is reduced to thinking her complaint is too trivial compared with the obvious misery around her, and has "doubts about presenting it at all." Instead of being comforted by the doctor, Rosamund instantly feels sorry for him. He looks so harassed,

and is so obviously overworked, that she condenses her story to save him time and aggravation. He takes no careful history and makes no physical examination. She told him, "I thought I was pregnant" but he takes no steps to confirm or deny her suspicion. His first question, in fact, has to do with her marital status, and when he finds that she is single, he shakes "his head, more in sorrow than in anger" (38). This is better than Rosamund expects; she is ready for him to be angry. She seems to expect the doctor to assume the right to chastise her for her condition, and she is prepared to accept that. By putting her in a position of supplication, by making her wait so long, and by exposing her to the ills of the "depressed and oppressed" (37) patients around her, the medical system has reduced Rosamund to a taciturn state, in which she sees herself as undeserving and problematic.

Pregnant women in the 1960s were not consumers of health care who could openly demand the service they wanted, or shop elsewhere. As Helen Roberts notes as late as 1985 in *The Patient Patients: Women and Their Doctors*:

> women are dependent on medicine and doctors for the most basic control of their own bodies. It often seems that the power of reproduction--of getting or not getting pregnant, staying or not staying pregnant, having a baby--is as much in the doctor's province as in the mother's. (5)

For women like Rosamund, twenty years earlier, the problems include being slotted into preconceived categories outlined by their physicians based on marital status, class, and education. G.F. Gibberd, in *The Queen Charlotte's Text-Book*

of Obstetrics, published in 1965,[14] advised his readers to consider "conception-out-of-wedlock...as a social issue and as a disorder in the individual" (464). Conditions for the child, he claims, are not only "seldom entirely favourable" but are "often such that intellectual and emotional growth of the child is blocked or distorted." Thus the admission by a patient like Rosamund of her unmarried state is sure to flash red lights of warning to the physician. Here is an irresponsible woman, who is risking the potential intelligence and well-being of her unborn child. It seems not to matter under what circumstances the woman becomes pregnant, because according to Gibberd: "It may be summed up in the aphorism that the unplanned conception is seldom unwanted." Contraceptive failures often "on enquiry, turn out to be the result of negligence in the woman." Gibberd believes inadvertent pregnancy is often intentional, and indulged in to injure others. He claims, without any reference to research, that in a

> remarkably high proportion of young unmarried mothers the 'accidental' pregnancy is in effect a form of attack on the girl's parents. She herself may bear more or less *inconvenience*, humiliation or sorrow--especially if the baby is adopted--but it is the parents who suffer more than she does in the way of feelings of disgrace or shame. (464; my emphasis)

By ascribing vengeful motives to unmarried pregnant women, medicine not only ignores the inadequacy of birth control, but it absolves the father of the fetus from any responsibility, and allows doctors to admonish the patient with impunity.[15]

Because of the what Gibberd calls the "over-booked clinic and the crowded surgery," it is difficult to "establish the truth about the patient and her background," but it "is the first objective." Such information, he assures practitioners and medical students, will be crucial in predicting the outcome of the pregnancy. He considers it elementary information that the "'career-girl' tends to the Atalanta type, and is thus more prone to difficulty and distress in childbirth and after it" (464). Knowing the background of the patient enables the physician to apply preconceived expectations to her. According to David Brown, in *Obstetrics for the Family Doctor*, published in 1966,[16] "We all recognize that the gipsy or country girl usually has a more straightforward labour than the university or society girl" (116). Again, neither of these physician-authors draws on any clinical or historical research to back up his findings. These facts are merely accepted as real and known. If an educated woman is expected to have a more difficult labour and delivery, this expectation will undoubtedly influence the physician's level of intervention and could negatively affect the outcome for the patient.

Being unmarried and being educated are both problematic. Unmarried mothers, according to Brown, are less reliable about their dates, and are often on a par with "the vague and sometimes simple personalities" (84). There is a fine line of discrimination drawn by this thinking, which suggests that

any deviation from the submissive, compliant married woman presents a dangerous commodity to the obstetrician. If unwed, a woman is considered less than intelligent, but if educated, she is bound to have a difficult labour and delivery.

Intelligence is a quality which is not ascribed by medicine to women in general, and not to pregnant women in particular. As I have earlier established, medicine historically determined that women's biology precluded education, and that education predisposed illness. Even by the middle of the twentieth century, according to medical literature, the intellectual capacity of pregnant women is impaired by their condition. Medical authors warn their physician readers that women are especially vulnerable to false information from questionable sources during pregnancy (particularly from other women), and patients' powers of discernment apparently disappear. Wengraf, writing on a woman's decision about whether to breast feed, suggests that it "is possible for almost anyone to alter her opinion for or against nursing--the expert's opinion can be modified by the maid's superstition" (224). Clayton, in *Obstetrics: by Ten Teachers*, which he co-edits with Fraser and Lewis, goes so far as to suggest that not only is the "physiology of the pregnant woman...different in great degree from that of her non-pregnant self," but that ensuing "physiological stresses may alter brain function" (294)[17] Being pregnant can apparently make a woman irrational and, according to these authorities,

she cannot be relied on to follow their expert advice.

Clayton's text includes a chapter on "Mental Illness and Childbirth" which begins with the statement: "The childbearing woman, at all stages of pregnancy, labour and in the puerperium, is under psychological and physical stresses" (295). Although this chapter eventually deals with problems of psychosis in pregnancy, it concentrates on the more minor psychological disturbances of neuroses, anxiety neuroses, and depression. Clayton's assumption that all women suffer psychological stress teaches medical students that the very condition of pregnancy precludes mental health.

Clayton considers all pregnant women to be ignorant about obstetrics and incapable of learning to understand:[18]

> They know nothing definite about the risks of pregnancy or labour or of what can be done to circumvent them; moreover they are too shy or too fearful of being found ignorant to ask what their symptoms portend. They will prefer to ask someone as ignorant as themselves and all too often this only heightens their fears. (294)

Writing in 1966, Clayton is not singling out a specific education level for the bewildered women he describes. He includes all pregnant females in one fecund mass of ignorance based on fear:

> It must be remembered that education, even to the university standard, does not give immunity to fear, and reading, attending lectures about childbirth and going to relaxation classes of one sort and another may sometimes be symptomatic of excessive apprehension. (Clayton 295)

Women seem naturally dull to Clayton, and any attempt they may make to sharpen their wits betrays not only their ignorance,

but their fear. Patients are not expected or encouraged to educate themselves on their condition. He clearly feels it is the physician's role to explain symptoms and to reassure (294), to maintain the power of knowledge and decision over the patient.

Clayton suggests that the altered psychology he detects in the pregnant woman predisposes her to bouts of hysteria. He advises uncomplicated "explanation and reassurance...to deal with" symptoms of hysteria:

> Nothing too elaborate should be told the patient, for patients with hysteria are usually of emotionally immature type and not too well endowed mentally, so explanations are difficult and not likely to be understood. Indeed more fears may be aroused by the explanations and simple *authoritative* suggestion is best. (297; my emphasis)

More than a century after Carter, Clayton still relies on the powerful authority of medicine to quiet the odd female patient who dares to speak out.

Part of this authority is wrapped up in keeping secret from the patient all medical information pertinent to her case. Rosamund discovers the concealing aspect of medical power early in her prenatal care, but resists it by learning silently and surreptitiously how "to read the notes upside down on the file that said Not to be Shown to the Patient" (*Millstone* 60). What Beacham and Beacham call "'resistance symptoms'" (78), such as withholding information or evading the physician's questions, are read as signs of psychosomatic disturbance in the patient, but the same tactics are

absolutely acceptable in the physician. Doctors are privileged to know everything about the patient, but this information can, and often is, guarded and withheld.

Denying the patient information, or giving misleading information, is commonly suggested in the medical texts. Clayton, after giving a detailed description of the danger and etiology of death from *hyperemesis gravidarum*, goes on to advise practitioners that the pregnant patient "must be made to understand that the condition will soon pass, and she will be cured with certainty" (216). In spite of the risk of spontaneous abortion, or the necessity for life-saving operative abortion, or even malnutrition and electrolyte imbalance leading to death, the potential gravity of the condition is kept from the patient. Cure is likely, but is never a certainty in these situations as Clayton would have every patient believe.

A pregnant woman is considered to be incapable of dealing with medical information and is judged to be "highly susceptible to suggestion" (Clayton 494). Because of this determination, all discussion "about correctness of dates, the position of the child, engagement of the head, the level of blood-pressure or any other factor which could be construed by the patient as meaning 'something is wrong' should be avoided" (493-4). If this information is normal and is not to be discussed, it suggests that the doctor wants the patient to know next to nothing about her case. If, alternately,

there are abnormalities in the case, they too would not be discussed with the patient, as she would be unable to comprehend, and so only would fret. Even fetal disaster is to be kept from the woman for as long as possible. According to the *Handbook for Obstetric House Officers*[19] 1968 by Fraser and Anderson, "cases of intra-uterine death should be referred to the consultant in charge. The decision to tell the patient and to induce or await the spontaneous onset of labour should be his alone" (16). It may be reasonable for the doctor in charge to do the telling, but to decide *whether* to tell? Surely every woman should have the right to know the state of her own and her child's health, and to share in the decision to begin labour and delivery of a dead baby.[20] This, however, was not the case in the 1960s. Even at the point of delivery women were to be kept in ignorance:

> If an abnormality of the baby is noted at birth or a neonatal death seems likely, then the husband should be interviewed first, the position explained and with his help the decision made as to how and when to inform the patient. (Fraser and Anderson 107)

It seems the doctor, who is continually referred to by the male pronoun, and the husband (always assuming there is a husband) are considered to be more capable of dealing with disaster than the mother herself, and she is to be left in the dark for a negotiable amount of time while they determine how to tell her about her baby. As long as the doctors own the information and control its dissemination, they are secure in their authority.

ROSAMUND'S WRONGS:

In *The Millstone* Drabble gives Rosamund characteristics which are bound to be interpreted as problematic by medicine. She is unmarried, she is educated and intelligent, and she is independent. Clearly, from the medical point of view expressed in textbooks of the time, these qualities are considered disadvantageous for success in obstetrics. Rosamund resists the status quo; what she is doing is regarded as medically and socially wrong. She realizes she will be "doubly, trebly outcast by [her] unmarried status, [her] education, and [her] class" (*Millstone* 60).

Gibberd's attitude, that unwed mothers often become pregnant to injure their parents, surfaces in *The Millstone* and explains Rosamund's doctor's questions about her parents. Her general practitioner is eager to know if Rosamund's mother and father are aware of her pregnancy, if they are sympathetic, and, taking note of her stylish address, if she lives with them. Although she is living rent-free in their flat, her parents are out of the country and oblivious; nonetheless, she insists they are fairly sympathetic, "not wishing to embark on explaining about their being in Africa" (38). With the admission of her marital and parental state, Rosamund is at risk of being slotted into the category of tyrannical daughter, experiencing an attack pregnancy against her parents at worst, and an uncaring irresponsible negligent young woman with no respect for her developing fetus at best.

Susan Spitzer, in her essay "Fantasy and Femaleness in Margaret Drabble's *The Millstone*," concurs with the medical assumption that unmarried pregnancy is necessarily doomed. According to her analysis:

> Rosamund's pregnancy, doubly heavy, one might say, since she is unwed, constitutes a considerable millstone[21] in the life of the young woman dependent, as she amply demonstrates, on no one but herself until visited by the event of 'weighty' significance. (87)

Spitzer is correct that Rosamund's pregnancy strips "her of her total self-sufficiency [and] makes it imperative for her to seek the aid of others" (88), but, although dependence is something Rosamund dislikes, she is completely capable of acquiring the help she needs without losing control of her life. Rosamund's marital state is quite irrelevant to her own dependence on others: she is in a financial and social position to organize help without having to change her professional or living status to any great extent. As Sadler writes, Rosamund's "privileged status allows her to get by with being an unwed mother" (32).

Rosamund's unmarried state is both obscured and heightened by the medical system. When she first meets the midwife, having been sent off for obstetric care to a hospital clinic by the general practitioner, she is addressed as "Mrs Stacey" (58). The midwife is "a pretty lady with smart ginger hair and small features and blue eyes" (58) who greets her warmly. Rosamund thinks she has "reached civilization at last" (58)

but feels compelled to tell the midwife: "I'm not Mrs Stacey, I'm Miss" (58). Facts are important to Rosamund; she spends her days in the British Museum Library looking up precise details for her thesis. To the midwife, however, this is irrelevant: "'Yes, yes,' she smiled, coldly and sweetly, 'but we call everyone Mrs here. As a courtesy title, don't you think?'" (59). Rosamund is not so sure. She is too polite to complain, or too intimidated to speak, and she is not really invited to answer the rhetorical question. Sitting in silence, she does "not think much of the idea" (59) of being misrepresented. She has no interest in being married; the pretence is insulting to her.

Because the midwife makes no distinction, it might seem that Rosamund's marital state is really irrelevant to the hospital. Rosamund discovers this is clearly not the case after her baby is born, when a large label is placed at the foot of her bed "with the initial U, which stood, [she] was told, for Unmarried" (104). I can find no record of hospitals actually labelling beds with signals of marital status, although Margaret Drabble asserts that "there are those who have it that they did...there was a mythology that they did that kind of thing" (Interview), but certainly the standard Antenatal Record forms used by physicians today in patients' charts continue to note marital status right after name, address, age, and significantly, education level.[22] In Rosamund's case, the U is ironic, for Drabble might well be

giving a nod to Nancy Mitford[23] whose distinction between 'U' (for upper-class) and 'Non U' concentrates on the differences in speech and behaviour patterns among the British classes. Rosamund is by no means a member of the aristocracy, but compared with the average unmarried mother as described in the medical literature, she is extremely well situated financially and intellectually. Drabble's use of irony helps to debunk medicine's construction of the unwed pregnant woman.

Clayton's determination that women are incurably ignorant about obstetrics is reflected by the medical system in *The Millstone*, and Rosamund is in danger of fulfilling their expectation. She detects her ignorance of the childbirth management system (rather than her condition) from the start. She covers up her lack of knowledge about "the Unmarried Mothers people in Kentish Town" (38) partly because she does not want to involve the doctor in her decision to keep the baby and partly to conceal her ignorance from him. She is appalled by her detachment from medical situations when she visits the clinic:

> Everyone else there had looked resigned; they had expected to wait, they had known they would have to wait. I was the only one who had not known. I wondered on how many other serious scores I would find myself ignorant. There were things that I had not needed to know, and now I needed to know them....I felt threatened. I felt my independence threatened: I did not see how I was going to get by on my own. (39)

Rosamund detects the expectation of ignorance and is immediately at risk of succumbing to it.

Rosamund consciously resists medicine's power of knowledge by disassociating herself from all the trappings of childbirth education. She does not succumb to a submissive position as patient, nor does she rely on medicine to explain the process and procedures of pregnancy and birth. Instead of choosing to learn more than the teachers, she opts out of the class altogether. Rather than lessening her fear, she concludes that avoiding childbirth education increases it, but she has made a rational decision to resist what is, in many classes, just another branch of medicine determined to influence the patient. Rosamund takes her chances on naivete:

> I was worried partly through ignorance, as I had deliberately found nothing out about the subject at all, and had steered clear of all natural childbirth classes, film strips of deliveries, and helpful diagrams, convinced that I had only to go near a natural childbirth class in order to call down upon myself the most phenomenally unnatural birth of all time. There was no point in tempting providence, I thought; one might as well expect the worst as one would probably get it anyway. (92)

Rosamund has little faith in the medical system of birthing; she takes a fatalistic approach.

Clayton might interpret this attitude as indicative of the typically odd thinking patterns of a pregnant woman. He believes a woman may even be aware of what he assumes to be an altered mental state during pregnancy: "She often realizes that she is irrational and yet is unable to change her psychology" (Clayton 294) which rules her actions in a manner completely out of control.

Rosamund is aware of this general perception, and she

notices some change in her attitude to her work during her pregnancy:

> I do not wish to suggest, as perhaps I seem to be suggesting, that the irrational was taking its famed feminine grip upon me. My Elizabethan poets did not begin to pale into insignificance in comparison with the thought of buying nappies. On the contrary, I found I was working extremely well at this time and with great concentration and clarity.....I did not go over from the camp of logic to the camp of intuition....(*Millstone* 68)

Rosamund's self-containment, silence, and resistance to the queries of the medical personnel she sees assure her of privacy and protect her from misinterpretation. By keeping her professional life and the changes in her mental acuity to herself, she successfully resists mental classification by her physicians.

Rosamund's effort not to share too much of her personal situation with the physicians protects her somewhat from their biased assumptions about prognosis. In this way she avoids being stereotyped as a probable obstetric failure. It is clear in *The Millstone*, however, that physicians have absolute control over the details of a patient's medical condition. Drabble addresses the manner of physicians not disclosing information when Rosamund overhears nurses discussing previous cases outside her labour room:

> one of them started to recount in vivid detail the story of a woman whose labour she had attended a month earlier, who had died because they discovered at the last moment that this that and the other hadn't been properly dealt with; 'it was awful,' this girl said, 'the way they kept on telling her it was all fine...(100-101)

Keeping up the pretence of control and normality seems to be a top priority in medicine no matter how grave the circumstances.[24]

Withholding information is inevitable in a situation which discourages questions. When Rosamund first returns to her newly acquired general practitioner, he informs her that he has found a bed for her delivery at St Andrew's Hospital. This is all the information he is prepared to give: "After telling me that he had made this booking, he then washed his hands of me with undisguised relief. 'You can go to the clinic at the hospital,' he said, 'and they'll look after you there'" (55). Rosamund is not at all satisfied. She has no knowledge of the routine which is to become her life, but she is silenced and dismissed by this doctor's manner, and finds herself unable to demand her right to know:

> 'Yes, of course,' I said, as though I understood the whole procedure, though I wanted to ask him a dozen things, about when to go, and where to go, and whom to ask for: but he was a busy man and there was a long queue in the surgery outside, so I got up to leave. (55)

Rosamund has not even been given the details of her appointment; she has to telephone the hospital herself to find out the appropriate day and time. As for her medical concerns, they are neither acknowledged nor addressed. Since the general practitioner will not deliver her baby, or give her antenatal care, he feels no obligation to enter into any discussion about her pregnancy. Clinic doctors, on the contrary, are encouraged in their manual, after lists of

instructions as to examination, history-taking and form-filling, to remember that "lastly the patient should have any questions answered" (Fraser and Anderson 6). It would be a strong woman indeed who could manage to come up with questions at the end of an arduous interview following an extended wait.

Luckily, Rosamund is a strong woman. Unlike Brontë's Lucy, and Woolf's Rezia, she is capable of negotiating the system, manipulating the inefficiencies of the clinic, and subverting the power medicine imposes. Her advantages over Lucy and Rezia are multiple. First of all, she is living and working in her native country, whereas Lucy is an English woman displaced in Belgium, and Rezia is an Italian woman displaced in England. Not only does Rosamund have the advantage of dealing in her first language, but her skill at that language is paramount. She is a scholar of English, a connoisseur of nuance. She also has privacy, security and independence, things both Lucy and Rezia lack. Rosamund has excellent lodgings, she has a grant and she is assured of a university lecturing job when her dissertation is completed.

Although the territory of medicine and hospital clinics is new to her, with familiar language and geography Rosamund feels secure enough to learn what she needs to know to get proper care. At first she does not realize why the general practitioner "expected gratitude" (*Millstone* 55) for finding her a bed, but she has the wherewithal to figure it out:

> later I thought of three possible reasons for his air of achievement. It was quite clever of him to have

> got me a bed at all, in view of the shortage of maternity beds, and very clever of him to have got me one so close, and in a teaching hospital with an excellent reputation. (55)

Because she did not even know the location of St Andrew's Hospital when the doctor first informed her, it is clear that Rosamund has done some research. She not only has discovered where it is, but has ascertained that it is a highly regarded teaching hospital. She knows what a teaching hospital is.

Rosamund has had little help in gaining knowledge about maternity care. She is about to leave the GP's office with her questions unasked when he calls her back and condescendingly asks, "Now then, you don't want to go without your letter of introduction, do you?" She tries to cover her ignorance, pretending "it had just momentarily slipped [her] mind" (55), and retrieves the envelope. Of course, true to the practice of secrecy, the envelope is sealed, and although she wonders what it says inside, she does not dare to look. What it possibly could say, since this doctor has neither examined her nor taken a proper history, is in question itself.

It is not just medical information which is sacrosanct. Even medical buildings are chartered and protected. Rosamund initially chooses her GP because of his door, which is unprepossessing, "shabby" and "varnished" (36), but despite its impoverished appearance, it is able to alert and annoy the occupants with its attachment to a warning bell inside. There is no discretion allowed. Likewise the hospital is

inhospitable:

> the central block appeared to be early eighteenth-century and had regularity if nothing else, but it was surrounded and overlapped and encroached upon by a hideous medley of neo-Gothic, nineteen-thirties, and nineteen-sixties excrescences, all of which had been added entirely at random...

But if the building is ugly and uninviting, its features are at least familiar to Rosamund. She identifies the periods in which it has been built; she recognizes the architecture. Her concern is how to get in:

> I was alarmed, not so much because the building was an eyesore, for my visual taste is very weak, but because I did not know how to get into it, nor which part to attack. There were innumerable doors and entrances, and I had a sense that the main door was certainly not the appropriate one. (56)

Like Alice in Wonderland, she is puzzled by all the doors; there are no visual clues to follow. But Rosamund knows about Alice; this is her country and her architecture. The familiarity of the setting gives her the confidence and presence of mind to determine that the main door might lead at least to a reception desk, which might provide the key. It does, and from there she is redirected down the street to the Out Patients entrance. In spite of her powers of deduction and her ability to ask directions, Rosamund is still baffled by the building:

> So I went out and found the Out Patients and entered the building once more. Here, as I had suspected, there was no reception desk and no indication of any direction: there was a door marked Haemotology [sic] and a lot of dark gloss cream corridors. I stood there irresolute, feeling acutely ashamed at my own ignorance...

Despite her methodological approach and her right to be there, Rosamund cannot break the code of the hospital; rather, it plunges her deeper into distrust of her own judgement and ability. Only when another woman arrives "very evidently pregnant" (56) does she get a clue. Reduced like Alice to childlike logic, she "put two and two together, and followed her" (57) into the medical labyrinth.

Once inside the building, Rosamund finds it daunting. Looking around at the "variety of human misery that presented itself" in the faces and swelling bodies of the waiting patients, she notes one particularly distressed individual sitting "with a look of wild-eyed dilating terror."[25] Rosamund wonders if, like her, "she was more frightened of the hospital than of anything else." The demoralizing atmosphere is so pervasive as to affect "those who had no evident complaints, and who might well have been expected to be full of conventional joy" but who "were looking cross and tired, possibly at the prospect of such a tedious afternoon" (57). If there is a proscribed method to deal with the mass of patients, it is a secret system. There are no numbers to call, no lists to check; patients "disappeared, in a completely mystifying order, to have their blood pressure taken, and to be weighed, and to see Doctor This and Doctor That and the midwife" (58). No one ever asks Rosamund her name or her business; only her natural savvy gives her the courage to search out authority and present her sealed

envelope. When her name is eventually called, she seems to "be expected to know by instinct where midwives [are]." For the first time Rosamund speaks "almost sharply" when asking for directions. The receptionist, surprised at Rosamund's ignorance, nonchalantly "point[s] to a door leading off the hall in the far right-hand corner" (58). There are no arrows, no signposts. Patients exist in Kafka-like confusion.

In spite of her fear of the daunting medical building and procedures, Rosamund learns how to resist the system by subversion, thus avoiding being labelled as psychosomatic for displaying the 'resistance symptoms' Beacham and Beacham delineate above. Her privilege gives her footing with the midwife's medical discourse: "I did not like her, but I felt on safe ground with her, as I did not feel with all those bloated human people outside. Safe, chartered, professional, articulate ground." But this articulate exchange is not a conversation, but an "interrogation," after which, in spite of having arrived before the clinic began, Rosamund is made to wait for the doctor "until the bitter end, when everyone else had gone." Although she is assured that she will "soon find [her] way around. People don't take long to find their way around" (59), Rosamund does more than that. Not only does she learn the routine and find the best way to fit into the system by arriving at the best time and "presenting [her]self for inspection, with the minimum necessary clothes' removal" (60), she also discovers "where to slip [her] attendance card

in the pile so that [she] would get called early in the queue," to "bully them about iron pills and vitamin pills, because they would never remember," and to read her chart upside down for glimpses of her progress. By making a sort of game out of her hospital visits, trying to "win occasionally on the odd point" (60), she keeps herself aloof from the power of medicine and subverts its authority through silent and crafty deception. Her subtlety allows her resistance to go undetected and therefore to continue.

Medical authority makes a formidable opponent. When Rosamund has her first ever internal pelvic examination, for which she has been made to wait all afternoon, she is outraged by the insensitivity she is shown:

> 'I could have put up with Doctor Esmond,' she says, 'who was a grey-haired old man with rimless glasses, but I was not prepared for being examined by five medical students, one after the other.' (59)

Without asking leave, the consultant uses Rosamund, a patient he has never before met, to train his male medical students in gynaecological examination. Clearly, the Consultant physician considers this his right, and Rosamund, disheartened by her bewildering hospital odyssey and wait, submits. Rosamund does exactly what is expected of her. She blocks her vision and holds her tongue. The medical system has effectively cut her off from any means of expression. The humiliation of being examined in so public a manner is no doubt exacerbated by the level of competence of the students. Beacham and Beacham write that sometimes "students gouge about

roughly in the lower abdomen in various directions in an effort to feel the fundus uteri with the abdominal fingers," which "is likely to make the examination a failure" (110). They makes no mention of what effect this is likely to have on the patient. Their concern is only with the students who will need "weeks and months of patient work and many careful examinations to be able to recognize normal conditions" (105). This knowledge "can be learned only through repeated bimanual examinations by the student himself, under competent instruction" (106), and only women's live bodies, it seems, can provide the models for the probing hands. But women's bodies are not detached from their brains. Rosamund, subjected to this treatment is silently horrified:

> I lay there, my eyes shut, and quietly smiling to conceal my outrage, because I knew that these things must happen, and that doctors must be trained, and that medical students must pass examinations....and I lay there and listened to them and felt them, with no more protest than if I had been a corpse examined by budding pathologists for the cause of death. But I was not dead, I was alive twice over. (*Millstone* 60)

Her resistance is in her ability to shut them out by closing her eyes, to be quiet, to smile, and to conceal her rage. She has no other way to oppose this intrusion than with her own dignity. Medicine wins the power points here.

Drabble's presentation of this scene, like Woolf's depiction of Holmes and Bradshaw, writes the outrage that the characters cannot speak. Rosamund is expected to conform, to submit, and then to progress quietly along the path of medicalized pregnancy as just one more swelling belly in an

endless series of fecund females. There is very little else one can do in such a situation. To jump down from the table, grab one's clothes and flee in a huff of indignation only prolongs the inevitable examination, although one might hope for better treatment after making a fuss. The risk, of course, is in being dubbed hysterical or neurotic, or just a problem patient, and having the treatment worsen. Margaret Drabble presents Rosamund's violation in such a way as to denigrate the doctor, the students and a system which allows them to behave with brutality. Rosamund's seemingly passive, but quietly seething, reaction resists the doctors in its apparent acquiescence and in its inner turmoil. If the obstetrician and his students do not see it, the reader definitely does.

Rosamund, by preserving her dignity and maintaining silence through the examination, numbs herself to the procedure. She lies inert, neither flinching nor physically resisting the doctors' physical intrusion on her body. But her silence is her shelter; she deliberately chooses not to protest. Her senses are not at all quiet--they are heightened, in fact, and race with added acuity--but she gives nothing of this away. She may lie like a corpse, but as she says, she is not at all dead. Two hearts beat in her body. She is twice as alive as any of the doctors around her. Just as the baby shelters in her belly, Rosamund shelters under the silence she chooses to adopt.

No one in *The Millstone* suggests that this form of obstetrical treatment is acceptable. Rosamund's sister Beatrice, writing to advise Rosamund when she first hears of the pregnancy, confirms both the nastiness of the treatment and the futility of complaint: "The whole business of being pushed around is quite horrid but one just has to grit one's teeth" (79). Rosamund's aloofness spares her the degradation of dependence on her caregivers, but at best she only gets "used to it" (60), and always leaves the clinic "with relief" (71) at surviving relatively unscathed. When she arrives at the hospital in labour, Rosamund "thought with some relief that this would be [her] last visit" (97) and revels in the realization "that at the least the clinic was over with all its eroding grind" (97).

Labour and delivery present their own particular problems. Not surprisingly, Rosamund is not expected to know or interpret anything accurately about her case. Although she has been instructed to time her contractions, her care-givers, who are trained to distrust the patient, disbelieve her results: "When I told them, they said Nonsense, but when they investigated they naturally enough found me to be right" (98). Her confidence remains. She is left alone to labour, but can overhear the nurses

> discuss their trade: They began mildly enough by inquiring how many had been born the night before, and what had happened to the little premature one that was failing earlier in the evening....they described cases of women who had lain in labour for unbelievable lengths of time, of one who had screamed solidly for

three hours...

And they also talk of the maternal death I mentioned earlier. The horror of patients in their care prompts one of the nurses to say: "'I'll be really glad to get out of this ward. I don't really mind the babies, but the mothers are enough to give anyone the creeps'" (100). This discussion is not only insensitive, it is dangerous, for Rosamund, experiencing a precipitate labour, is neglected. When she calls out and asks for medication, the nurses, without establishing Rosamund's progress in labour, refuse to help her: "'not yet, you've a long time to go yet, we have to leave something to give you later on'...and they turned and went back to their row of seats outside." Only when Rosamund begins to "moan rather violently" do they rush back in, and, in a flurry of confusion and argument, they manage to catch the baby who is born "quite uncontrolled and undelivered" (101). Rosamund manages to subvert the system of delivery quite spontaneously.

The physicians are not seen again until the post-partum examination. Fraser and Anderson in their *Handbook for Obstetric House Officers* suggest that this aspect of care is the drudgery of obstetrics for doctors: the "postnatal ward is not infrequently treated as the 'Cinderella' of the Obstetric Unit" (64), where budding young surgical heroes are wasted on mundane procedures and idle chatter. Indeed Rosamund is irritated by "a perpetual succession of medical students who kept taking [her] temperature and measuring

various parts of [her] with cold wooden rulers and making feeble jokes" (*Millstone* 104), who clearly would rather be somewhere else, doing more exciting procedures. Fraser and Anderson, although they have given license for doctors to feel disgruntled about doing post-natal care, attempt to rectify the situation by claiming that for the patient, this period is "the most important phase of her pregnancy and she must receive...the same meticulous attention and care which he [the doctor] gives to the antenatal and labouring patient" (64). Their words do not ring true, however, for they give no practical suggestions as to how young doctors or medical students might improve their bed-side manner or make their visits more meaningful.

When the Consultant arrives, "accompanied by his attendant students" (*Millstone* 110), Rosamund is once again treated as she was on first examination, but this time she is left with more power. In the interval she has been examined only by the gynaecologist as her pregnancy is uninteresting, "the most normal of cases, not worth the attention of his students" (71). Once again, however, they now "prodded [her] and questioned [her] and talked about [her], and [she] felt oddly offended, for [she] was beginning to feel whole again and resented their interference" (110). Rosamund gains in power, for her body has resisted the stresses of childbirth, and thus negotiated a triumph against medical expectation. Not only has she had a fast and uncomplicated labour and delivery of

a full term healthy infant, but in spite of the initial concern over her "narrow pelvis" (60), she has outwitted the learned gentlemen with her anatomy:

> the gynaecologist said to his students, 'Notice the resilience of the muscles here. This is the case that Hargreaves said would have an exceptionally small baby, but you see how wrong he was, it weighed a good six and a half pounds. He was taken in by the exceptional firmness of the muscle.'

Rosamund has fooled the profession, but the physician is quick to find the cause for error. After establishing that she was not a "professional dancer," he assumes that she "must have some athletic pursuits" (110). There must be a reason for this anomaly, a reason the patient has not divulged. It must be the patient's deception which has misled the physician. But Rosamund is not a dancer, not an athlete, and the gynaecologist must accept that she "must just be made that way" as he passes on to the next bed and the next object of medical scrutiny. Drabble gives Rosamund the muscular strength to resist medical expectation. It makes her glow "with satisfaction for half an hour afterwards" (110).

Susan Spitzer claims that Rosamund's quick and easy delivery and excellent recovery show that "the ultimate female act, bearing a child, has been downright *sterilized* in *The Millstone*," that "Rosamund has not really even had to come to terms with her body" and that her physical normality after birth indicates that "she has passed the greatest test of all: having a baby while struggling to pretend you're not a woman" (102). In fact, as Nora Foster Stovel points out, "the

experience of childbirth is so real to her that she is unwilling to have it transformed into fiction" (65) by her novelist roommate; pregnancy affirms rather than denies Rosamund's biological womanhood, but she does not have to fall into the gendered role of dependency and disease that society, and apparently Spitzer, expect. I believe that Rosamund, by refusing to succumb to the morbid medical view of pregnancy, overcomes the stereotype medicine ascribes of the totally dependant pregnant woman, who falls apart physically and emotionally during pregnancy, and who cannot survive labour and delivery without the intervention of physicians. Spitzer's assumption of somatic deterioration and necessary pain in pregnancy and delivery is by no means more womanly than Rosamund's experience; rather it is more pathological, and feeds into the medicalization and control of childbirth so encouraged by the system of obstetrics and gynaecology of the time. Spitzer mistakenly confuses Rosamund's uncomplicated labour and delivery with ambivalence to womanhood. Instead, Drabble indicates that, although women cannot completely control their bodies for easy and uncomplicated pregnancies and deliveries, there are ways to resist the authority of medicine, to subvert the system of obstetric care, and to maintain a measure of personal power and control. By presenting Rosamund's power, Drabble encourages empowerment for the women who read *The Millstone.*

TURNING UP THE VOLUME:

Although it is in Rosamund's nature to be polite and quiet, her baby's father, George Matthews, is even more taciturn. She has been brought up by parents who were "so nice, so kind, so gentle" (27). George, her one-time lover, is a BBC announcer she knows only vaguely. She suspects he is "a man much susceptible to the tender emotions of pity and sorrow" (24), but he will not talk about himself. He is anonymous, he will tell her "nothing at all" (26) but resists "the pressure of [her] interest with expert skill." Rosamund is intrigued by his silence, so used is she "to being given endless unsolicited confidences by those in whom [she] had no interest at all," and she "tried to match him in diffidence but, of course, could not manage it" (27). George's silent secrecy, however, strongly influences Rosamund's resultant reticence.

Because George has made no attempt to form a relationship, Rosamund realizes she will keep the knowledge of her pregnancy from him. At first she feels "compelled to see George" as she "had an excuse, now, for seeing him." Very soon, however, she "realized that [she] was going to see George now less than ever." Because she "could not face the prospect of speculation, anyone's speculation" (34), she decides to refrain from telling anyone about the pregnancy and, when it becomes obvious, who the father is. Her natural reticence is reinforced by her situation, and she adopts silence to protect

her sense of self.

This silence is difficult for Rosamund and occasionally threatens to break down:

> I thought of George, and sometimes I switched on the radio to listen to his voice announcing this and that: I still could not believe that I was going to get through it without telling him, but I could not see that I was going to tell him either. (61)

She will not do it, however, from a need to protect both herself and him. When Rosamund thinks of her baby as perhaps turning out like George:

> I...felt a dangerous impulse to ring him up and tell him that instant: I did not, of course, but that evening I switched on the radio, a luxury I had not permitted myself for some time, and listened to his voice. He sounded so civil and so innocent that once more I could not imagine that I could ever have dreamed that I might encumber him with embarrassment and anxiety. (80)

Her concern and good manners prevent her from bothering him.

It takes a great deal of aggravation for Rosamund to respond verbally. She speaks "almost sharply" (58) at her first hospital visit, but it is not enough for the receptionist to notice. During labour she is able to suffer silently the indignation of hearing the nurses' terrifying tales of trauma until "after a while the tone really became too extreme for [her] possible comfort" (100). In the throes of the transition stage of labour, her resolve breaks down; she can "take it no longer, and [she] heard [her] voice yell, from a long way away, 'Oh, for God's sake, pack it in, can't you?'" (101). The silence is beginning to break, the volume is up, but Rosamund can still override her rage with decorum.

When the nurses investigate her call, she merely "mildly" and politely asks for more medication.

SIREN IN THE SHELTER:

Silence has served Rosamund well in sheltering her from the rigours of antenatal care. She has managed to own her pregnancy and keep the father a secret. She has managed to keep her dignity despite the dehumanizing medical treatment; she has quickly and easily delivered herself of a beautiful baby. She has maintained her aloof sense of integrity, and she has quickly regained her trim body. Only once has she felt compelled to raise her voice, and convert silent resistance into verbal. But judging from the nurses' discussion, the more vocal patients are treated as a travesty. The woman who screamed for three hours, the woman who "scratched a nurse's face when she tried to give her an enema" and the woman "who had sworn at one of the black nurses and told her to get out" (100) do not fare well in the system. Verbal resistance, Rosamund learns, does not work.

Not long after her delivery from the confines of the health system, Rosamund finds herself in the clutches of medical power once again. Octavia, now some months old, is diagnosed with a heart defect and requires surgery. The first visit to the hospital is so intolerable that Rosamund claims she "cannot bear to write about" (120) it. We now see this novel as a diary, or a direct communication between Rosamund and the

reader. But she does write (or rather Drabble has her write), about her long wait, her eventual visit with the surgeon, of whom she "did not dare to ask what he did not tell...the X-ray department, a good mile away it seemed through dark corridors, and back again to...the surgeon." Rosamund's reaction is to resist what is happening by mentally silencing the physician, by blocking out his words. She is "in a trance, hardly listening to a word he was saying...the very words were enough to throw [her] into a panic, so [she] stopped listening, for [she] could see that he was not really attempting to explain" (121).[26] Her ire is up, her resolve down. Rosamund is suddenly "unable not to speak" and complains aloud at the surgeon's insensitivity to talk about the luck of the diagnosis. To the reader, Rosamund writes about the lack of "professional sympathy" which is replaced by "professional curiosity" about her baby who is "an odd case...a freak." When she sees her "retort received no response" she assumes "a voice of renewed humility" (122) and ultimately breaks into tears.

When Octavia becomes the object of medical power and isolation, Rosamund realizes that silent resistance to medicine is not enough. When it was Rosamund herself suffering the cold rules and regulations of hospital life, silence was a form of survival, but her love and concern for her baby daughter release her voice. Ellen Cronan Rose claims that Rosamund "does not even love Octavia except as an

extension of herself" (*Novels* 21), but I believe Rosamund's significant change in vocal response disproves this assumption. The love and protectiveness she feels for Octavia fire her passion, and heighten her resistance.

Rosamund is deceived at the hospital into thinking she will be able to visit her child after surgery. Initially, "they said to come back in the morning, as she was still unconscious and not to be disturbed" (*Millstone* 128). This seems reasonable to Rosamund until she wonders and worries how Octavia will react when she wakens. The following morning, when Rosamund arrives to visit, she is told she may not. When she enquires why,

> The lady in white embarked upon a long explanation about upsetting children, upsetting mothers, upsetting other children, upsetting other mothers, justice to all, disturbing the nurses' routine, and such topics....'What about visiting hours?' I said, and back came the civil, predictable answer.
>
> 'I'm afraid that for such small infants we don't allow any visiting time at all. We really do find that it causes more inconvenience to staff and patients than we can possibly cope with. Really, Mrs Stacey, you must understand that it is of no practical use to visit such a young child, she will settle much more happily if she doesn't see you. You'd be amazed to see how soon they settle down. Mothers never believe us, but we know from experience how right we are to make this regulation.' (129)

The original delay of overnight is now lengthened to a fortnight.

Rosamund, told of the extended delay as she is leaving the ward, "half turned to retort, but had not the energy" (130); she initially decides silently to accept the regulations. She tries to work, to rationalize the situation, but she "had only

to think of [her] baby's small lonely awakening" to convince herself that she must see her. She returns to the hospital and confidently demands to see the child. When she is turned away by nurses, she calmly says: "'I don't really care...whether I'm allowed to visit or not. If you'll tell me where it is, I'll get there by myself, and you needn't even say you saw me.'" The "timid, undetermined note in [the responding nurse's] voice" who denies the visit makes Rosamund feel "mean to pursue [her] point" (131). She is still controlled, calm and civil, and uses gentle argument to try to persuade the nurses to let her in.

At this point, decorum breaks down, the nurses' "voices hardening from personal timidity and embarrassment into the weight of authority. They had that whole building behind them, they knew, and I had nothing behind me but my intention." But for once Rosamund has every intention of winning, none of backing down or resisting in dignified silence, in spite of the fact that "every impulse...tells [her] to give up at the first breath of opposition." The child has changed life irrevocably for Rosamund: "It was no longer a question of what I wanted: this time there was someone else involved. Life would never be a simple question of self-denial again" (132). Her voice emerges.

She begins expressing herself with difficulty, demanding to see "Sister, or Matron, or whatever she's called. Go and fetch her for me" she says, "Or I'll wait here till she comes"

and plunks herself down firmly on the desk. As yet Rosamund is only speaking "crossly, [and] suffering greatly from this as yet mild degree of self-assertion" (132). But when the Sister arrives, speaking first "snappily," then "fiercely" (132-3), and tries to usher her out, Rosamund "felt happier" and "felt free to assert [her]self." She demands to see Octavia and threatens to "wander round upsetting the whole...hospital until" (133) she finds her. The Sister is unmoved and proceeds to take hold of Rosamund and push her out the door. Now the silence is repressed and the siren comes from its self-imposed shelter:

> I started to scream. I screamed very loudly, shutting my eyes to do it, and listening in amazement to the deafening shindy that filled my head. Once I had started, I could not stop; I stood there, motionless, screaming, whilst they shook me and yelled at me and told me that I was upsetting everybody in earshot. 'I don't care,' I yelled, finding words for my inarticulate passion, 'I don't care, I don't care, I don't care about anyone, I don't care, I don't care, I don't care.'
>
> Eventually they got me to sit down, but I went on screaming and moaning and keeping my eyes shut; through the noise I could hear things happening, people coming and going, someone slapped my face, someone tried to put a wet flannel on my head, and all the time I was thinking I must go on doing this until they let me see her. Inside my head it was red and black and very hot, I remember, and I remember also the clearness of my consciousness and the ferocity of my emotion, and myself enduring them, myself neither one nor the other, but enduring them, and not breaking in two. (134)

From resisting through silence, Rosamund has come full circle to resist medical method and regulation through voice. According to Stovel, Rosamund's "hysteria represents the turning point in her development, the ultimate battle between

the two sides of her nature, her rationality and her passion" (69), and her passionate acquisition of voice gains her mastery over medicine. She is not dragged off and locked up, although even her pre-screaming manner is dubbed "hysterical talk" (*Millstone* 133). Somewhere through the commotion she eventually hears "she can see the baby, someone try and tell her," and she "instantly stopped and opened [her] eyes and beheld the stricken, confused silence around" (134) her. Rosamund's voice has won. Medical authority backs down.

Rosamund strikes a heavy blow to the doctor and nurse. Mr Protheroe, the surgeon, "looked agitated and white with anger" (134) and "Sister was sitting in a corner and crying into a handkerchief, the nurses were looking stunned, and there were a couple more men also looking angry" (134-5). Rosamund recognizes at once that this has been a power game between the medical characters: "it had been played out between the Sister and the others, quite clearly, and she had lost and was now suffering her defeat" (135). Rosamund, the patient, the patient's mother, is initially the pawn, but her vocal resistance lets her checkmate.

Rosamund now has the hospital in her control. She comes and goes at will; she cares for her baby. Only one other mother shares her privilege, one who is going through her second encounter with infant surgery, one who already knows the ropes from a previous experience and has the foresight to have "them give it me in writing" (137) that she could visit

before she allowed her child to be admitted. This woman confirms the fear that an overt action like Rosamund's could be dangerous. When told of Rosamund's screaming, she says: "'I was always afraid...that if I made a real fuss they wouldn't let me in anyway, because they'd say I was in too bad a state to see the children. I was afraid they'd put me in bed too'" (138). Resisting vocally is potentially dangerous, for it might well trigger powerful medical action against the woman. Rosamund takes the risk and it works.

SPEAKING BACK:

Margaret Drabble is committed to moving women towards wellness. Her depiction of Rosamund's survival of the system relatively unscathed is an inspiration to resist a medical system which is intent on its own ends and often loses sight of the patient, particularly the woman patient, who, unlike Rosamund, is often defenceless and unresisting. In Rosamund, Drabble strives to correct the notion of women as ill; Rosamund fights back, through her pregnancy and her baby's illness, through her confrontations with the health system, and through her tenacity in labour and delivery, despite her lack of support. Drabble's inscription of Rosamund's power over the body leads to the possibility of power over the system and moves towards correcting the stereotype of the unwell woman in literature.

NOTES

1 *The Millstone,* 60.

2 Personal taped interview with Margaret Drabble, London, England, September 18, 1991.

3 Elizabeth Gaskell's *Ruth* (1853), as just one example, who manages to conceal her unmarried state, ultimately dies nursing her sick seducer. There is no escape for the unwed mother in most of Victorian literature.

4 In a personal letter to me, dated August 29, 1991, Drabble offered to "spend an hour...talking about health matters, provided my own dental surgery and my aunt's cataract operation scheduled for next month all go according to plan" - she was clearly taken with the subject of medicine.

5 I examined a cross section of gynaecology, obstetric and psychiatric texts from Britain and the United States. *Garrison and Morton*, the accepted bibliography of medical history, cites only those texts which announce new discoveries, or are historically important as general texts, and they give no standard general texts published after 1910. I chose, therefore, to review texts which were current at the time *The Millstone* was published, and remain on active medical library shelves. Texts which are considered to have historical value are shelved in Medical History sections of health sciences libraries. The approaches I found in the texts I studied are remarkably similar: whether British or American, all are written by men, all addressed psychological issues in obstetrics or gynaecology, and many devote separate chapters to these issues.

6 Deborah Ann Findlay's dissertation, "Women and Medical Knowledge in the 1950s: A Study of the Process of Social Construction" gives an excellent background into the construction of the pregnant woman by medicine in Canada in the 1950s.

7 Findlay writes: "Hormones were postulated as affecting both the soma and the psyche...at times, this was taken to imply that psychological gender traits were caused by the designated female hormone, estrogen" (291). When this theory was undermined by actual hormone measurement, the hypothesis had to be changed, but rather than look for another possible physical cause for symptoms, Wengraf encouraged doctors to accept psychogenic causes. His advice leads doctors back to the nineteenth-century approach and blames a woman's psyche for her gynaecological irregularities.

8 Wengraf, a Neuropsychiatrist at Beth Israel Hospital in New York, writes that this text is "designed to supplement texts on gynecology and obstetrics...without using the highly technical terminology of psychoanalysis that so often discourages and even antagonizes specialists in these fields" (ix). Although it is an American book, his conclusions are relevant to the British situation as Wengraf argues that the conditions he describes are influenced by the "mores of the prevailing Anglo-Saxon culture" (x) of his patients.

9 The medical concern with psychiatric symptoms in pregnant patients is summed up by Sir Andrew Clayne in the chapter entitled "Psychiatry and Obstetrics" in his 1963 text *Obstetrics*: "Minor psychiatric symptoms are common during pregnancy....[i]n general, women during gestation tend to show psychological regression" (1217).

10 E.P. Solomon. "Vomiting of early pregnancy." *Kentucky Medical Journal*. 39:58, 1941.

11 There was a common expression in obstetric training in the 1960s that "if you end up with a healthy mother and a healthy baby it doesn't matter what you did" (Wilson Interview). In this type of thinking the patient's attitude is of no consequence.

12 *Crossen* is a synopsis of gynaecology, rather than a standard textbook. It is intended to impart to medical students

> Knowledge of the general principles and salient features...necessary to a rounded medical education which enables intelligent cooperation in the handling of patients....to supplement the large textbook with a pocket outline, for study at odd moments and memorization of the leading points in gynecologic examination, diagnosis, and treatment (7-8)

and as a "guide to the understanding of the pelvic disturbances" (8) encountered by practising physicians.

13 This section of the text is subtitled: "Psychosomatic Aspects of Gynecology." As late as 1976, obstetric and gynaecologic texts continue to deal with this issue. The *Combined Textbook of Obstetrics and Gynaecology* by James Walker, Ian MacGillivray, and Malcolm C. Macnaughton published in 1976, includes a chapter entitled: "Psychological, Psychosomatic and Psychiatric Aspects" (582-615).

14 This is a standard British obstetric teaching and reference text covering all aspects of normal, abnormal and operative obstetric care. There are chapters in this text devoted to both "Emotions and the Maternal Role" (41) and

"Vomiting" (10), which deal with what the authors consider to be psychosocial aspects of pregnancy.

15 Elizabeth Goodall RN, a nurse who trained at the Wolfson School of Nursing at Westminster Hospital in London between 1969 and 1972, recalls that unmarried women in labour were treated without analgesia, whereas married women were given the pain relief they required. It was done to "teach them a lesson." (Personal interview, April 1993).

16 This is a text written by a consultant British obstetrician to be used as a quick reference by family physicians. Brown suggests that "busy doctors have no time to read through pages of varying opinions on the management of different obstetric problems--No, they desire only one good, safe and reliable answer to each problem. This has been one of my principal aims" (ix).

17 This is a large British obstetric reference and teaching text, dealing with normal and pathological obstetrics, published in London in 1966.

18 Such generalizations are frequently made in obstetric texts about pregnant women or 'the pregnant woman,' as if they never differ as individuals.

19 A House Officer in Britain is roughly equivalent to a medical Intern in Canada.

20 It is interesting to note that in a recent case in Ontario, a doctor was found guilty of professional misconduct for failing to advise his patient of risks in a pregnancy which resulted in the intra-uterine death of the fetus. The case description chastises the physician for failing to inform his patient of the death of her baby. Instead, he sent her to hospital and left it for the physician there to tell the patient. *Report of Proceedings Discipline Committee of the College of Physicians and Surgeons of Ontario*. March 1991, 31-33.

21 In the introduction to the 1970 English school edition of *The Millstone*, Drabble writes:

> The millstone of the title has a double significance--in one sense it is the baby itself, which is a source of pain, expense and social disgrace to its mother, but in another, far more significant sense the word refers to the verse in the Bible where Christ says that those who harm little children should have millstones tied round their necks and be sunk in the bottom of the sea. (xii)

Rosamund never harms her child; her fight to be with Octavia in the hospital is to protect her from the harm of neglect.

22 See Antenatal Record: Ontario Ministry of Health in conjunction with the Ontario Medical Association 374-64 (87-03).

23 From *Noblesse Oblige*, published in 1956.

24 Drabble's concern about doctors not being truthful echoes the experience of Woolf with Stella's doctors, and her scene in *The Voyage Out* in which Dr Rodriguez insists Rachael's fatal illness is not serious.

25 Valerie Grosvenor Myer points out the "surprising use of the gynaecologically suggestive word, 'dilating'" (43), which indicates, perhaps, Rosamund's unconscious anticipation of her impending labour.

26 Margaret Drabble was told of her own child's heart defect by a message given to her on a postcard (Interview). Shoddy medical communication is certainly one of her concerns.

CHAPTER 5

RESISTANCE FROM WITHIN

FEMALE PHYSICIANS

In this chapter I look at women physicians. From their inception in nineteenth-century Britain, to their position in current medical practice, women doctors have a history of struggles against the patriarchal profession of medicine. In order for women to gain a place in the powerful institution of medicine, they have had to negotiate, manipulate and subvert a system which was (and sometimes still is) antagonistic to their participation. My investigation includes an analysis both of the words of women doctors who have been successful in entering the predominantly male domain, and of the representation of female practitioners in fictional characters in the works of Brontë, Woolf and Drabble.

Medical discourse, as outlined and investigated in previous chapters, is a powerful, patriarchal institution. The inclusion of women in the profession has not had an immediate or revolutionary effect either on the discourse, or on its power over patients. The first woman to practise medicine in Britain was registered with the General Council in 1859.[1] Since that time the number of women in medicine has slowly but steadily increased,[2] but it is my contention that, in spite of

many intentions and attempts to oppose the patriarchal controlling qualities of medical practice, many women have found it necessary to bury their resistance and adopt the patriarchal professional method in order to survive in the system. Merely allowing women into the profession, it seems, does not necessarily change the method of health care delivery.

PIONEER DOCTORS:

Elizabeth Blackwell (1821-1910), who was the first female doctor to be entered on the British medical register,[3] was motivated to enter medicine specifically to help women.[4] She was convinced that it was crucial for women patients to have the option to be examined and treated by women, particularly for gynaecological conditions which she considered to be "a horrible exposure; indecent for any poor woman to be subjected to such torture" (Blackwell *Pioneer* 58). She was, however, forced to go to Paris to train alongside midwives for knowledge and clinical experience in obstetrics and gynaecology, since in London, at St. Bartholomew's Hospital, "every department was cordially opened to [her] except the department for female diseases" (140). Not only did the Professor of Midwifery and the Diseases of Women and Children disapprove "of a lady's studying medicine" (140), he particularly disapproved of her entering the study of diseases and conditions of her own sex.[5] The very subject which had

motivated her to become a doctor was effectively denied to her.

Pioneer women doctors faced great obstacles to acquire their training. After Blackwell made many futile attempts to persuade a number of American universities to accept her as a medical student, she was advised by one supportive physician to undermine the system: "to disguise her sex, cut her hair off and dress as a man, and study medicine in Paris" (xi). Her determination and her strong ideological beliefs enabled her to continue applying, and in 1849 she graduated in medicine from Geneva, Western New York State at the age of twenty-eight. After graduation she was treated poorly by the other residents who were, of course, all men. "When I walked into the wards" she writes, "they walked out. They ceased to write the diagnosis and treatment of patients on the card...thus throwing me entirely on my own resources for clinical study" (*Pioneer* 65). And when she went to Paris to further her studies, she found the physicians there "determined not to grant the slightest favour to a feminine M.D." (101). Blackwell had entered the institution of medicine, but she constantly had to negotiate her way through a hostile labyrinth.

In the early 1860s another pioneer, Elizabeth Garrett, was compelled by professors to "prove [her] power of endurance etc., *before* any time was spent upon direct medical studies," and in her determination to enter medical school she submitted

to "spend six months as a hospital nurse at once as a test" (E. Bell 51). After this effort, when she still could not get accepted as a student, she was counselled to employ "patience and caution and the abundant use of discretion...[and] the use of 'feminine arts' to win her purpose" (53). She was thus required to prove endurance on the one hand, but show subservience on the other.

When the male medical establishment denied women entrance into specialized areas of the profession by restricting their post-graduate clinical training, women doctors fought back by starting their own schools. Elizabeth Garrett opted out of the hostile system and formed St Mary's Dispensary for Women and Children in 1866 as a treatment and training centre for women. It still exists, but in 1917 was renamed the Elizabeth Garrett Anderson Hospital. Another pioneer, Sophia Jex-Blake, founded the London School of Medicine for Women (later named the Royal Free Hospital) to train graduates in every aspect and field of medicine, and until 1908 it was the only British institution to offer post-graduate training in medicine to women (140).

By forming their own medical schools and hospitals, women doctors were able to manipulate the system to fulfil their needs and address issues critical to women's health. But they did not command the same respect and autonomy as their male colleagues in the profession.[6] When Blackwell went back to the United States and tried to set up a hospital for women and

children "conducted entirely by women" (*Pioneer* 168) she was told by male colleagues that

> no one would let a house for the purpose, that female doctors would be looked upon with so much suspicion that the police would interfere;' that if deaths occurred their death certificates would not be recognized; that they would be resorted to by classes and persons whom it would be an insult to be called upon to deal with;[8] that without men as resident physicians they would not be able to control the patients; that if any accident occurred, not only the medical profession but the public would blame the trustees for supporting such an undertaking; and, finally, that they would never be able to collect money enough for so unpopular an effort. (169)

After a short and difficult period in the United States,[9] Blackwell returned to England to take up the position of Chair of Gynaecology in the newly created London School of Medicine for Women.

In an all-female medical school and hospital, women had the power to resist the methods of the patriarchal institution and to set up a reverse discourse to male medicine. Blackwell urged female medical students "to remember that medicine is necessarily an uncertain science" (*Influence* 18) and advised "scepticism in relation to the imperfect or erroneous statement of what is often presented as truth" (20). She also cautioned them against accepting "the government and instruction of men as final" (19) for "conclusions formed by one half of the race only, must necessarily require revision, as the other half of humanity rises into conscious responsibility" (20).

Her remarks encourage women medical students to resist the

teachings of patriarchal medicine and to question the accepted notion that medicine is an objective science. Blackwell clearly believes that women, as "the other half of humanity," have a different agenda in medicine and must resist and revise medical thinking from a new female perspective. Not only is she interested in offering women patients the opportunity to be cared for by other women, but she also believes in better care for babies and better health education for mothers.[10] As a woman, Blackwell brings specifically female concerns to medicine.

The influence of women like Blackwell, Garret and Jex-Blake was significant, but limited. Women physicians were initially restricted to training in London, and unless they had private means and could afford to manage with few patients, they were obliged to practise in large cities. They were excluded from membership in the British Medical Association until 1892 (E. Bell 138), and the Royal College of Physicians would not accept a woman to be "eligible as a fellow of the College...entitled to take part in the government, management and proceedings...and hold any office" (136) until 1925. Early women doctors had new ideas and new strategies to bring better health care to women. They were gaining a voice to speak back to patriarchal medical discourse, but as yet they were not well heard.

DR KEELDAR:

Brontë's *Shirley* was written in 1849, and set in 1811-12, well before the registration of the first woman doctor in Britain. Nevertheless, *Shirley* anticipates the need for women in medicine and the desire of at least one woman patient to avoid treatment by patriarchal medicine. Brontë offers not only a critique of authoritative medical discourse, but an alternative to it. Shirley, by treating her own illness and refusing to consult any qualified male practitioner, resists the power of medical discourse and empowers herself as a healer. Quite before the availability of women doctors, Shirley Keeldar maintains medical control over her body and heals herself.

Apart from Shirley's own medical mishap, Brontë paints a small but vivid picture of medical authority and ineptness. When Caroline Helstone falls ill with fever, and the doctor (probably an apothecary) is unable to make her well, a physician is called for in the hope that his superior education will bring better results. Brontë undermines the physician's power and ridicules his manner by condensing his visit, advice and method into a single sentence:

> [The physician] was an oracle: he delivered a dark saying of which the future was to solve the mystery, wrote some prescriptions, gave some directions--the whole with an air of crushing authority--pocketed his fee, and went. (332)

Diffusing the power of medical discourse with her narrative mockery, Brontë not only resists the physician's power, she

completely dismisses it. She isolates his "air of crushing authority" within dashes and reduces it to a subordinate clause.

When Robert Moore is shot and injured, the surgeon MacTurk[11] is summoned and attempts to maintain complete control over the patient by assigning his own nurse. Mrs Yorke and Hortense disallow this intrusion, however, and promising to follow the surgeon's orders, they insist on nursing Robert themselves. Unfortunately, although "they executed the trust to the best of their ability...something got wrong: the bandages were displaced, or tampered with; great loss of blood followed" (564). Brontë now gives an account of the irascible surgeon who is tyrannical in his authority, terrifying in his power: "He was one of those surgeons whom it is dangerous to vex: abrupt in his best moods; in his worst, savage" (564). Feeling justified to vent his anger against inept nursing, MacTurk uses his authority to spray a shower of invective over all within earshot.

Again Brontë ridicules medicine. In her description of MacTurk's violent verbal reaction she subverts his authority by mocking his behaviour and disarming his words:

> On seeing Moore's state, he relieved his feelings by a little flowery language, with which it is not necessary to strew the present page. A bouquet or two of the choicest blossoms fell on the unperturbed head of one Mr. Graves, a stony young assistant he usually carried about with him; with a second nosegay he gifted another young gentleman in his train--an interesting fac-simile of himself being, indeed, his own son; but the full corbeille of blushing bloom fell to the lot of meddling womankind, en masse. (564)

Brontë brilliantly scorns his attack by using flower imagery to describe his foul language. Her use of a pleasant and peaceful metaphor completely undermines the surgeon's vicious words, mocks the power of medical discourse, and makes MacTurk look a fool.

When Shirley is threatened by a potentially lethal personal medical situation, Brontë gives her full power over both medical treatment and medical decision. Bitten by a dog which is acting strangely and is said to be rabid, Shirley takes immediate action to protect herself from infection and tells no one of the incident. Brontë recounts the event in dialogue between Shirley and Louis three weeks later.[12] Shirley confides in Louis both to alleviate his fears for her health, since her worry has caused her to become thin and withdrawn, and to enlist his help should it be necessary if she develops hydrophobia and becomes mad. Until she tells Louis, Shirley retains all knowledge of her predicament.

After asking Louis to promise to remain calm, Shirley quietly tells the tale of being bitten in the arm by a neighbour's dog and of then being told the dog was "raging mad" and was about to be shot. Louis is astounded that Shirley "told no one, sought no help, no cure" (510). Shirley describes her action:

> I walked straight into the laundry, where they are ironing most of the week, now that I have so many guests in the house. While the maid was busy crimping or starching, I took an Italian iron from the fire, and applied the light scarlet glowing tip to my arm: I bored it well in: cauterized the little wound. Then

> I went upstairs. (510)

When Louis says he will "inquire whether the dog was really mad," Shirley commands: "Tell nobody that she bit me." She then gives specific instructions to Louis as to how to manage the situation should she develop signs of rabies. As well as wanting his protection from the smothering attention of her uncle, Mr Sympson, and Henry, Shirley is particularly adamant that Louis shield her from the medical profession:

> Lock the chamber-door against the surgeons--turn them out, if they get in. Let neither the young nor the old MacTurk lay a finger on me; nor Mr Graves, their colleague; and, lastly, if I give trouble, with your own hand administer to me a strong narcotic: such a sure dose of laudanum as shall leave no mistake. *Promise to do this.* (512)

Shirley's instructions are clear. She has doctored herself, but if her treatment has failed she will allow no outside medical interference. She enlists Louis to intercede only if she loses her faculties and cannot protect herself from medical intervention.

Although Brontë does not dwell on medicine in *Shirley*, it is clear from her presentation of the doctors in the novel that she is critiquing their methods and undermining the power of their discourse. In the absence of women doctors, Brontë gives Shirley the presence of mind and the courage to attempt to burn the virus from her flesh with a red-hot iron and to arrange for her treatment--outside the bounds of medicine--if she is struck down. She enlists Louis's help because he is calm, trustworthy, and in her power, but through him she also

arranges that if "female help is needed, call in my housekeeper, Mrs. Gill: let her lay me out, if I die" (512). Her injury and its potential *sequelae* are under her own control. By avoiding patriarchal medicine, Shirley heals herself.

DOCTOR AS AUTOCRAT: OCTAVIA WILBERFORCE (1888-1963):

By the time Octavia Wilberforce entered the profession in 1913, although women doctors had established a few of their own hospitals, they were still situated on the margins of a patriarchal institution. Although many women may have wanted to alter the methods of medical authority, in order to survive and excel in their profession, women doctors like Wilberforce were forced to adopt a patriarchal manner and approach. Instead of creating a new discourse to oppose medicine's authority, they adapted themselves to fit into the existing discourse. To prove their worth as doctors, women had to prove not only that they could perform like men,[13] but also that they were willing to adopt masculine discursive methods.

Wilberforce willingly adopted the discourse of patriarchal medicine. In a conversation with the dean of The London School of Medicine for Women, the surgeon Miss[14] Aldrich-Blake, Octavia asked: "don't you think that it's part of the equipment of a woman doctor to be an out and out autocrat?" to which Aldrich-Blake replied "Yes, I suppose it is. You see, all women love power and usually they have to get it by

mean ways, but as a doctor you can be quite open and honest in your commanding" (75). Admitting to gender differences risked admitting to inferiority, and to resist the opposition of medical patriarchs like Sir Almroth Wright,[15] Wilberforce denounced any difference between the sexes. To do this she adopted patriarchal methods and attitudes.

Women were obliged to forsake their femininity in order to prove their ability in medicine. Octavia Wilberforce's family, horrified at the "unsexing" (48) of women in medicine, were vicious in their attempts to dissuade her from entering medical school. She reports:

> The anti-doctoring, anti-woman stream was continuously poured on my unoffending head...I have been hearing a great deal about women lately. No sense of honour, no sense of humour and a very great deal more to the effect that they are a miserable infliction on the world, and that every normal girl in a room containing fifteen women and one man would wish to attract and talk to the one man. (50)

Wilberforce's family members believed that to be a woman doctor, one must be abnormal and unwomanly.[16] This viewpoint, which reflected much of society's reaction to feminism and women's suffrage at the time, forced women in medicine to adopt patriarchal discourse and methods to survive in the profession.

Wilberforce, committed to being "of use to the community" (58),[17] overcame considerable obstacles to obtain training. Her father disapproved of women doctors, would not support her, and cut her out of his will (66). Because she was female (and the unwanted eighth child), she had not been properly

educated. It took her three years to pass pre-medical exams, and by the time she graduated from medical school she was thirty years old.[18]

In her midwifery training at the Rotunda Hospital in Dublin, Wilberforce was privileged to assist a Consultant surgeon, and her attempts to adopt the male model proved successful:

> By the end of yesterday's operation Jellett had forgotten he'd got a girl helping him - and that's what I'd always hope any male colleague would feel if I were working with him....I do want to achieve the same with his Assistant Masters here too. It all helps to consolidate women's position in Medicine....we've got to consolidate our position as *medical* colleagues, and not go sliding back into 'girls' and personalities. I personally think it easy to achieve the former, so I hate when people go and put the clock back. (99-100)

By denying her womanhood, Wilberforce is accepted as a doctor.

An incident in Dublin crystallized Wilberforce's views on medicine and the sexes. Dr Simpson, a male physician, responded to the news that a mother gave birth to a dead baby with, "Serves her right, she should have come into hospital." The patient's female doctor was furious: "Oh you are a brute, *I wish you men could have babies for a year or two.*" Wilberforce reacted with anger at her female colleague for suggesting that the doctor's sex could be an issue in treating a patient. She implored her not

> *ever* to make a remark like [that]. It's not the thing. If you go in for Medicine you've simply got to forget the differences in sex, else you'll make the whole work impossible. I can't tell you how damaging to women's doing Medicine is a remark as personal as that--it affects the whole foundation of things and is

> the worst possible taste. (99)

Wilberforce accepts and even defends Simpson's anger: "Now Simpson made that remark because he was furious at the baby dying. He minds terribly when they do. But he's Irish and says things like that without altogether meaning them literally." Wilberforce was prepared to adopt the patriarchal stance, even if it meant supporting a brutal attitude towards a female patient. She believed sex-based criticism "harms the status of medical women so much" (99), and that the status of medical women depended on defending and adopting male medical discourse.

Octavia Wilberforce, who practised in Brighton, is perhaps best known in literary commentary for her role in Virginia Woolf's last days. The two were distant cousins, but became closer friends when Wilberforce began sending milk from her Jersey cows to the Woolfs in December of 1940. Wilberforce describes the Woolfs as "thin and half-starved and if ever anybody ought to benefit from my herd it should be those waifs. Waifs I'm sure they are about food" (167). Woolf was also intrigued with Wilberforce,[19] but disparagingly refers to her in her diary as "Leech Octavia" (5: 342), and "old Octavia...with her market womans basket" (351).[20] Wilberforce, in spite of her admiration for Woolf and her commitment to helping her, ultimately follows the pattern of patriarchal medicine in her care.

By trying to fatten Woolf with her Jersey milk, butter, and

cheese, Wilberforce mimics the approach of Woolf's early doctors. She writes in her autobiography that Virginia "looks thinner and thinner" (172) and that in spite of her "milk ministrations ...Virginia looks a better colour but is still as thin as a razor" (173).

On March 26, 1941 Leonard Woolf requested that Wilberforce visit Virginia professionally. Wilberforce agreed to treat Virginia Woolf, but in her autobiography the doctor states: "I feel that I can do more to impress her professionally in my own surroundings; easier to get across when I'm in charge of the environment" (180).[21] Like so many of the physicians examined in this study, Wilberforce insisted the patient should come to her: Woolf's fear of doctors, and of incarceration, considering her past experience, was well founded. When she implored Wilberforce not to order a rest cure, Wilberforce felt thwarted: "*Blast*, say I to myself" (181).

Since 1927 Wilberforce had run a nursing home at Backsettown for professional women. "The aim was to restor normal vigour to over-fatigued women through rest in congenial surroundings, a good vitamin-enriched diet, and ultra-violet radiation when necessary" (Jalland xii).

Wilberforce considered ordering a rest cure for Woolf's condition: "At the one moment I'd almost a thought of Backset for her" (Wilberforce 181). Rather than promising not to send her away, Wilberforce looked

> her confidently in the eye: 'What I promise you is that I won't order you anything you won't think it reasonable to do. Is that fair?' She agreed. And we went on with the exam.--she protesting at each stage like a petulant child! (181)

By using the word "order" Wilberforce does not submit to Woolf's request. Her promise is vague. Wilberforce also insisted--"I continued to drive home my points"--that Virginia Woolf undertake "[n]o writing or criticism for a month. She has been too much nurtured on books. She never gets away from them. Let her be rationed and then she'll come good again" (181-2). Milk prescribed, rest looming, and work denied. The treatment plan is hauntingly familiar to those of Woolf's past.

Octavia Wilberforce maintained control over the medical decisions, just as she had been taught to do by the patriarchal system. Her methods were those of patriarchal medicine, and despite her sex, her advice and her discourse differed little from those of her male colleagues. Unfortunately, Wilberforce was unsuccessful in her treatment, and Virginia Woolf returned home and drowned herself the following day. There is no reason to believe that Wilberforce in any way contributed to Woolf's ultimate decision to commit suicide, but her methods were unable to prevent it.

MISS MARGARET PARGITER:

As well as writing about patriarchal physicians in *The Voyage Out*, *Mrs Dalloway*, and *The Years*, Virginia Woolf also created a female doctor, Peggy, in *The Years*. Although Woolf might have been expected to model Peggy after her own women doctors, she did not yet know Octavia Wilberforce, and Peggy bears little resemblance to her physician at the time, Dr Elinor Rendel.[22] Woolf's personal comments about Rendel, in her letters and diary entries, concentrate on the doctor's controlling manner,[23] whereas her fictional portrait of Peggy deals with the difficulties of being both a doctor and a woman. Peggy is continually struggling to conflate her scientific interests with her womanly inclinations. She cannot find a comfortable niche. Woolf depicts Rendel, however, as well situated in the patriarchal space.

Woolf recognizes the need to create a new place for the woman doctor. Not content with the male model that functions through a controlling power and authority, Woolf investigates the possibilities of incorporating gender differences into professional practice. When Peggy, who is not a surgeon, enters her aunt Delia's party and gives her name to the maid to be announced as "Miss Margaret Pargiter" (Woolf *Years* 281), she is able to put her profession aside and introduce herself as a woman, not a doctor.[24] It is unthinkable that Sir William Bradshaw, when presenting himself, would have deleted "Doctor" before he was knighted: surely the title "*Mr*" disappeared the

day he qualified in medicine as he is a psychiatrist, not a surgeon.[25]

Peggy tries to combine being a doctor with being a woman, but is never quite satisfied with either role. When she tries to analyze the relationship between the two she is invariably interrupted or distracted:

> As she waited [for her call to go through] she looked at her hands holding the telephone. Efficient, shell-like, polished but not painted, they're a compromise, she thought, looking at her finger-nails, between science and....But here a voice said 'Number, please,' and she gave it. (263)

There is no designated place for a woman doctor. According to the discourse of medicine, being womanly would disqualify Peggy from being scientific. Feminine hands have no recognizable place in the medicine of the time; they are a compromise between science and something that is not yet nameable.

When Woolf depicts Peggy putting on her make-up--accentuating her femininity--Eleanor's banter relentlessly interrupts the description, which suggests Peggy's discomfort about her appearance. After briefly looking in the glass herself, Eleanor

> gave way to Peggy and waited.
> 'I wonder if this was the room...'she said.
> 'What room?' said Peggy abstractedly: she was attending to her face.
> ...where we used to meet,' said Eleanor...I wonder if Kitty will come tonight,' she mused.
> Peggy was gazing into the glass and did not answer.
> 'She doesn't often come to town now. Only for weddings and christenings and so on,' Eleanor continued.
> Peggy was drawing a line with a tube of some sort round her lips.

> 'Suddenly you meet a young man six-foot-two and you realize this is the baby,' Eleanor went on.
> Peggy was still absorbed in her face.
> 'D'you have to do that fresh every time?' said Eleanor. 'I should look a fright if I didn't,' said Peggy. (276)

Although she is a doctor and a scientist, Peggy does not neglect her appearance or deny her womanhood, but the disjunction in the scene indicates that she is not comfortable applying the mask of femininity.

Peggy is caught between the Victorian and modern worlds. She sees her aunt Eleanor as comfortable, part of "A wonderful generation...Believers" (266), but she looks towards a future of "living differently, differently" (314). Although Peggy is apparently "short-sighted" (265), she can focus into the distance to a time of change. She believed "it was her line to disabuse her elders of their belief in science, partly because their credulity amused her, partly because she was daily impressed by the ignorance of doctors - " (264). Unlike Octavia Wilberforce, Peggy Pargiter daringly questions the objectivity of science and the infallibility of physicians.

Peggy also denounces the discourse of the patriarchy. When a young man comes up to talk with her at the party, she can only notice how self-important he is:

> I, I, I - he went on. It was like a vulture's beak pecking, or a vacuum-cleaner sucking, or a telephone bell ringing. I, I, I....
> He noted her lack of sympathy. He thought her stupid, she supposed.

But when she gives an excuse, the man is surprised and intimidated by her importance:

> 'I'm tired,' she apologized. 'I've been up all night,' she explained. 'I'm a doctor - '
> The fire went out of his face when she said 'I'. That's done it - now he'll go, she thought. He can't be 'you' -he must be 'I'.

Peggy is not insulted by his reaction but pleased: "She smiled. For up he got and off he went" (290). Peggy is not prepared to flatter and flirt with men, nor is she prepared, like Octavia Wilberforce, to act like a man. On the contrary, Peggy is hostile: "The vanity of men was immeasurable" (318).

Woolf shows Peggy as an unhappy woman working in a patriarchal profession. She seems to fit neither the world of women nor the world of doctors as they are constructed in her time. When she lashes out at her brother, North, about his predictable future of marrying and having children and writing little books "instead of living...living differently, differently" (314),[26] she is trying to reach what he eventually recognizes as a place "quite true...it was about other people; about another world, a new world..." (340). Peggy is never able to articulate what she wants or needs. She has no language to do so.

Woolf suggests that the language must still be invented. The old words cannot bend to the times. When Edward, the true Victorian, speaks in Greek, he will not translate for his nephew North to understand: "it's the language" (333) he says. When the younger Pargiters are called upon to make a speech at the party, they are unequal to the task: Lady Lasswade calls on Peggy: "'Speak for the younger generation'...'But I'm

not the younger generation'" (339) Peggy says, and North and Maggie also refuse to make a speech.

The caretaker's children, brought up by Delia for cake, also will not talk. "'The younger generation,' said Peggy, 'don't mean to speak'" (344). In fact, the younger generation, as embodied in these two timid characters, embrace a new and unintelligible language in the form of song:

> Etho passo tanno hai,
> Fai donk to tu do,
> Mai to, kai to, lai to see
> Toh dom to tuh do -

"Not one word was recognizable," and their song was frightening, "so shrill, so discordant, and so meaningless." Their presentation of "distorted sounds" (345), which is recognized by Maggie as "[e]xtraordinarily" beautiful (346), hints that the new generation will invent the language needed to lead the characters out of the old Victoriar order, and into a new world.

Only the invention of a new language, a new discourse, can take Peggy beyond the patriarchy, and into a world where she can be comfortable and productive as both a woman and a doctor. Virginia Woolf does not take us to that world, but in *The Years* she anticipates that it is possible.

PATRIARCHAL APPRENTICESHIP: WOMEN DOCTORS TODAY:

In an editorial in a current issue of *The New England Journal of Medicine*, Marcia Angell, M.D. suggests that the most important step to improve women's health care

> is to continue to bring women into the upper echelons of academic medicine. If women are the teachers of the next generation of doctors and the senior investigators in the next generation of clinical research, women's health will finally get the attention it deserves... (272)

Although putting more women in powerful positions in the profession will undoubtedly improve the quality of women's health care, only a change in medical discourse will alter the way the profession regards and treats women. In the concluding section of this chapter I look at ways in which today's female physicians either adopt or resist the continuing patriarchal discourse of medicine, and I examine some of the signs of future change.

Dr Corinne Devlin, a Consultant at McMaster University Medical Centre, met with considerable opposition when she decided to train in obstetrics and gynaecology in the mid 1960s. She was able to enter medicine; medical schools at that time had a quota for female students of from ten to twenty-five percent (Smedstad 171). Surgical specialties, however, had few women residents. Even if she had been accepted into surgical training, Devlin pondered, "if I am a general surgeon I wonder if men will refer [their patients] to me?"[27] If other physicians, most of whom were male, did not send her patients, she realized she would have no work at all. Thus she reasoned:

> I could do a surgical speciality and if...primary care physicians didn't see the merit and refer patients to me, I think I have enough rapport with women that they

> would come to me as a consultant obstetrician gynaecologist.

Once she made the decision to study obstetrics and gynaecology, Devlin had to overcome the resistance of the profession. "Western[28] had an unwritten policy that they didn't take women residents in obstetrics and gynaecology because we weren't able to do it." She was told the work was "too arduous" for women, and that "it required not just intelligence, but stamina, and that usually doesn't come packaged in women." She was also advised that "women [patients] would prefer to go to a male physician for obstetrics and gynaecology."

> I was told repeatedly that I had chosen unwisely because the vast majority of women would not be able to trust another woman....Why would you ever want to look after women as patients, and why would they want to go to you?

Devlin believes the opposition to women gynaecologists and obstetricians, which has continued since women first became doctors, "has to do with the status of women in the minds of everyone, including some women, that a woman is really a family member, and a role, versus ever an adult." Devlin also points out that it is considered "natural for men to relate to women's sexuality and reproductivity," and of course the corollary to this is that it is *unnatural* for women to do so.

To survive the arduous training, Devlin had to deal with overt misogyny. There were no other female residents, there were no female academic obstetricians and gynaecologists at

the University of Western Ontario, and no accommodation was made for her needs as a woman in the programme. She shared a duty room with three other residents, all male, and she was denied "all the informal opportunities to learn, the change room, the fishing trips. There was no camaraderie." Devlin claims she "apprenticed in a patriarchal institution." A hundred years after Elizabeth Blackwell broke through the restrictions and made a place for women in medicine, little had changed. Medical discourse was still overwhelmingly male. To succeed in medicine, women doctors had to deny or ignore that they were women when they were working.

DR E. HEADLEAND, HARLEY STREET:

In *The Radiant Way*, *A Natural Curiosity*, and *The Gates of Ivory*, Liz Headleand adopts rather than resists many of the trappings of the traditionally male profession. Nevertheless, she also follows the female tradition in medicine: her education is paid for by "the Alethea Ward Scholarship in Natural Sciences (an annual college award specifically designated by Dr Ward, 1853-1935, for female students of medicine...)" (*Radiant* 86). Liz combines the methods of male medical discourse with something new, something less sure and less emphatic, but, although Liz progresses slowly through the trilogy towards the hint of a new form of medical discourse which is less authoritative and more open to question and discussion than what we have seen, she never breaks down the

discourse of patriarchal medicine.

Like all the women doctors I have looked at, Liz is ambitious, but her aspirations are for herself rather than for the community. She seeks social elevation and personal success, not a change in medical philosophy or treatment. The "ill-born, ill-bred, brilliant Liz Ablewhite" (118), recognized that in the "1950s, one of the surest ways forward for an intellectual young woman from the provinces, for a socially disadvantaged young woman from the provinces, was through Oxford, through Cambridge" (86). Her ambition and tenacity eventually lead Liz from Cambridge to London, and from Fulham to Harley Street, the most eminent address for British physicians. Living and working on Harley Street gives Liz full membership in the medical elite and establishes her acceptance of personal privilege over resistance. Only by adhering to the patriarchal discourse of medicine could she achieve such social and financial success. Through medicine she has raised her social class. Even after many years she

> found satisfaction in giving her address. Each time a shop assistant or a clerk or a tradesman wrote down Dr E. Headleand, Harley Street, the same thrill of self-affirmation, of self-definition would be re-enacted. Liz Ablewhite of Abercorn Avenue[29] had become Liz Headleand of Harley Street, London W1. Nobody could argue with that, nobody could question it, it was so. (18)

Liz gains personal success by adopting traditional medical methods, and initially she never questions the need to resist its discourse.

Liz has acquired all the trappings of authoritarian

medicine. Her psychiatric practice is primarily private; she isolates herself from the public patients depicted in *The Millstone* who silently suffer as they wait hours to see the doctor. Her "patients were, largely, middle class or upper middle class (for she had become fashionable): they included...lawyers, priests, politicians" (107), and thus she is able to disassociate herself from the problems in the medical system. She is secure financially, for she "is not threatened by cuts in public spending, by the decline of the National Health Service, by the new and growing emphasis on privatization" in the Thatcher government. She believes

> that the private sector must encourage experiment, excellence, variation of treatment: naturally, some of her most interesting patients are from the private sector. The son of a cabinet minister, the adopted daughter of a millionaire, the (presumed) grandson of a philandering painter. She does not feel that she is betraying the public cause when she treats these patients. She believes she is offering therapy to those in need. Which, of course, she is. (181)

Her approach sounds similar to that of Sir William Bradshaw, another doctor who worked his way up into the ruling classes. Harley Street doctors treat those patients who can pay for the privilege, and their security as leaders in the system of authority precludes any personal need to resist.

Drabble is disturbed by the division of medicine in Britain between public and private practice, and offers Liz as an example of the problem. Drabble believes

> that the health service is a model for society as a whole, that unfortunately at the moment the articulate middle classes get the best out of it, and those for whom it was created--which is all of us--many don't

get what they want.

Drabble finds it "distressing" that the "holes in the system are getting larger" (Interview), and that the differences between private and public medical treatment in Britain are growing. In Liz, Drabble creates a character who slowly begins to question the problems of privileged medical discourse from within the profession. Although Liz has adopted the role of a traditional patriarchal physician, she does make some minor concessions to the lower classes. Unlike Bradshaw, who would see only patients who could pay his fee, Liz also sees "a random selection of first referrals, from the public sector" (*Radiant* 107), and she "believes in the National Health Service, in public welfare..." (181). Although she outwardly represents the medical elite, by seeing both public and private patients, Liz indicates that she is gradually moving towards a different method of medicine.

When her marriage breaks up, Liz sells the Harley Street house and moves to a small maisonette in St John's Wood, and with the move her manner and discourse begin to change. Although she never outwardly questions or resists the power and authority of her own medical methods, Liz "liked her new house, and looked back on the solid Harley Street mansion with a slight shiver of distaste" (257). No longer do we hear about the private patients. Now she talks about shared treatment and group therapy, techniques which begin to diffuse the ultimate power of the lone physician. She also admits to

making a mistake, which is something patriarchal medical discourse does not allow:

> we've had this disaster with a patient, he'd got this thing about having AIDS - he used to think he'd got cancer, but then he decided it was AIDS. We thought nothing of it, and went on with group therapy as usual, and now it turns out he really *has* got AIDS and all the group are furious with us, and have lost faith in our diagnostic powers completely, and I must say I can't blame them, but how could we have known? He was a classic depressive hypochondriac, poor chap, and now he's got this dreadful dreadful illness. (287)

Liz not only admits the mistake, she recognizes her failure to the patient and to the whole group of patients by the misdiagnosis. In this passage Liz acknowledges both her responsibilities and her patients' rights. Although she uses the typical impersonal plural to describe the clinicians--"our diagnostic powers"--she uses the first person when she talks about blame. She is prepared to own the blame, to take some personal responsibility for a mistake.

Drabble never creates a new mode of medical discourse through Liz, but she does begin to direct her away from the patriarchal psychiatric model. By the final novel in the trilogy, *The Gates of Ivory*, she is no longer Dr E. Headleand, Harley Street, but "Liz...healer of hurt minds" (5). Drabble sees Liz

> as a fairly free person...I think by now she has become a fairly free agent. And I think I'm making clear that she's not allied, I mean she's basically a Freudian, but she's not a sort of hard line Freudian. She's a therapist rather than an analyst...she's a pluralist: she does what she thinks will work, which is what good therapists do. Therefore she isn't really signed up along any particular male-dominated ideology. (Personal Interview)

As a pluralist, Liz begins to question the essentialist doctrines of patriarchal medical discourse. Her move away from Harley Street and its methods puts her in a position to inspect its rigid rules and allows her to approach treatment from new perspectives. Liz, says Drabble, is "an original thinker" (Interview) by the end of *The Gates of Ivory*. Liz opens up some cracks in the traditional system of medicine, and her actions suggest that changes need to be made, but she does not lead us to a new form of medical discourse.

POST PATRIARCHAL DOCTORS:

There are signs of change. Medical schools are admitting more women, more medical schools now have committees dealing with women's health issues, and more women are on faculties in medical schools than ever before. Women's health centres exist now in Canada, the United States, and Britain, which are staffed exclusively or primarily by women and use techniques of examination and treatment which empower women to take responsibility for their own health care. Slowly the discourse is changing, but women's issues are still on the margins of medical care. Many individual doctors, like Corinne Devlin, have no need for the heavy handed authoritarian discourse of the past. Approaches such as family-centred maternity care encourage women to share in their treatment options.[30] But these options are now available only at certain select hospitals, and not all

doctors agree with them. Patriarchal medical discourse remains powerful.

When medical discourse fully evolves to include and address the issues of women and other marginalized groups, medical care will change. At present, there are organizations working to evaluate and alter medical discrimination against women.[31] The reverse discourses within the medical profession are resisting the power and authority of the traditional practitioners and creating the opportunity for many new discourses to appear.

NOTES

1 The General Council of Medical Education was caught off guard when the first qualified woman, Elizabeth Blackwell, who had graduated in medicine from the University of New York at Geneva in 1849, presented herself for enrolment on the British Medical Register on January 1, 1859.

2 According to Drs Kari Smedstad, and May Cohen, in their article, "Women in medicine: an overview of practice," by "1980, 42.8% of medical students enroled in Canadian universities were women," and by "the year 2000, an estimated 40%-50% of the practising physicians in Canada will be women" (171).

3 Blackwell managed to negotiate her way into the exclusively male system by arriving in England as a duly qualified practitioner. The Council recognized degrees from abroad, and Blackwell was a British citizen, born in Bristol. When she applied for registration, it was found she could not be refused.

4 Blackwell recounts that a friend, dying of a painful disease, "the delicate nature of which made the methods of treatment a constant suffering to her," suggested she should become a doctor: "why not study medicine? If I could have been treated by a lady doctor, my worst sufferings would have been spared me" (*Pioneer* 21).

5 Blackwell was not the only woman barred or discouraged from treating other women. Mitchinson cites Theodore Thomas in his 1868 *Practical Treatise of the Diseases of Women*, claiming categorically that women "had little place in medicine and certainly not in the new specialty of gynaecology" (27), and L'Esperance claims The Obstetrical Society obstinately clung to the view, well into the twentieth century, that "midwifery...was the branch of medicine for which women were the least fitted" (143).

6 Blackwell, writing in 1895, had great hopes that "when the novelty of the innovation [of women in medicine] is past, men and women will be valuable friends in medicine, but for a time that cannot be" (*Pioneer* 140).

7 The term "female physician" was a euphemism in the nineteenth-century for women abortionists (*Pioneer* 24), and a hospital staffed by and for women might have been suspected as a site for illegal abortion, a procedure, incidently, which Blackwell opposed.

8 Blackwell was unlikely to be concerned about her patient's class or social standing. She was, for example, particularly sympathetic to women with sexually transmitted diseases: "Most [are] unmarried, a large proportion having lived at service and been seduced by their masters..." (*Pioneer* 64).

9 In 1857 Blackwell established The New York Infirmary for Women and Children.

10 Blackwell writes: "our medical profession has not yet fully realised the special and weighty responsibility which rests upon it to watch over the cradle of the race; to see that human beings are well born, well nourished, and well educated" (203). She also claimed: "Mothers beg me for instruction in health" (*Pioneer* 181), and in 1870 she published *How to Keep A Household in Health: An Address Delivered Before the Working Women's College*, in London.

11 It is interesting to note that MacTurk is also the name of a real doctor who treated Charlotte Brontë (Maynard 71).

12 Shirley was right to be concerned even three weeks after her attack. According to *Control of Communicable Diseases in Man*, although symptoms of rabies can manifest in as little as five days or as long as a year or more, the period of incubation is usually two to eight weeks (Benenson 354).

13 In 1913, there "were nine hundred women qualified in England as against thirty thousand men. Many of the former were abroad. The ones at home were engaged chiefly in public work and did not have private practices" (Wilberforce 51).

14 As a surgeon, Aldrich-Blake would be called Miss rather than Doctor. Surgeons in Britain, even to the present day, revert to the appellation Mister or Miss after they have completed their surgical specialty training. The title is usually uttered with a distinct note of deference.

15 Sir Almroth Wright (1861-1947), was professor of experimental pathology at the University of London, and principal of the institute of pathology and research at St. Mary's Hospital. He actively campaigned against women's rights, and in 1913 he published *The Unexpurgated Case against Woman Suffrage*.

16 Octavia Wilberforce's mother argued against both personal and professional aspects of becoming a doctor:

> you would ruin your chance of a woman's only real happiness--being a mother. I should be very sorry about that and I feel sure you would regret it later. You would only be allowed to attend women, and in the country it

would only be very ordinary ailments like colds. It would be a very dull life. (Wilberforce 52)

17 Her mother suggested: "If you feel you want to do good, you can do more good by living at home and making your parents happy than in any other way" (Wilberforce 53).

18 Most students graduated in their early twenties (Wilberforce 51).

19 In a letter to Vita Sackville-West, Woolf writes: "I rather think I've a new lover, a doctor, a Wilberforce, a cousin--ah! does that make you twitch!" (6:462); and to Ethel Smyth she writes: "I have a far away lover, to match your translator--a doctor, a cousin, a Wilberforce, who lives at Brighton" (6:465).

20 Octavia Wilberforce was six years younger than Virginia Woolf.

21 Although Wilberforce describes feeling ill herself at the time, getting out of her own sick bed to see Woolf, it seems clear that her motivation for insisting the patient be brought in extends to her method of authority in treatment.

22 Frances Elinor Rendel (1885-1942), the daughter of Lytton's [Strachey] eldest sister Elinor, studied history and economics at Newnham College, Cambridge, and worked until 1912 for the National Union of Women's Suffrage Societies; she then qualified as a doctor, and after war service in Roumania and the Balkans, set up as a General Practitioner in London. She became VW's doctor when the latter moved to Tavistock Square in 1924 (Woolf *Diary* 3: 46n).

23 Woolf says very little about Rendel in her diaries and letters, but the two recurring topics refer to frustration at being kept waiting by the doctor, and being ordered to rest and not see anyone. Finishing *The Waves*, Woolf writes: "was ruined by Elly, who was to have come at 9.30 sharp but did not come till 11" (*Diary* 3: 9, and in a letter to Ethel Smyth she claims: "The dr. came, 6 hours late of course...The truth is doctors know absolutely nothing, but as theyre paid to advise, have to oblige" (*Letters* 5: 307). Woolf writes to Vita Sackville-West of "being rather strictly looked after...by Leonard and Ellie Rendel (the dr.) and so can only write these scraps" (*Letters* 4: 8), and "I am not to see anybody...it aint allowed [by Dr Rendel]" (10). To Vanessa she complains: "Elly is rather severe, and I've only seen Helen, who is thought less exciting than Mary" (15), and the following year she writes to Clive Bell: "I have been in bed a week with influenza, and [Dr] Elly [Rendel] proposes to keep me on the sofa another week" (139).

24 Peggy's brother North, although he has just returned from farming in Africa, gives his name as *Captain* Pargiter (*Years* 292).

25 As an example of reverse discourse, surgeons in Britain have managed to elevate the title Mister, which began as a slight to the barber surgeons, to a position of extreme respectability.

26 In her diary, Woolf writes:

> I dont think I have ever been more excited over a book than I am writing the end of [*The Years*]...I wrote like a--forget the word--yesterday; my cheeks burn; my hands tremble. I am doing the scene where Peggy listens to them talking & bursts out. It was this outburst that excited me so. (4: 241)

27 All quotations are from a personal Interview with Dr Devlin on March 8, 1993.

28 The University of Western Ontario, London, Ontario.

29 It is interesting to note that the Pargiters lived in the fictional Abercorn Terrace in *The Years.* In both books the Abercorn address was deleterious to women practising medicine. In *The Years*, the family house represents the repression of women by the Victorian patriarch; in *The Radiant Way*, the address denotes "suburbia...insignificance and social fear" (18).

30 At McMaster University Medical Centre, the only two rules for women in labour wanting to bring props with them to the hospital are "no animals, and no open flames" (Devlin). Dr Devlin would like to rescind the rule about animals.

31 The National Institutes of Health (the main federal government funding body for medical research in the United States), established in 1990 the Office of Research on Women's Health to address discrimination against women in medical research. In 1991 they appointed a woman director who has "launched the Women's Health Initiative--a massive 15-year study of 160,000 women" (Angell 329).

CONCLUSION

Mixing power with knowledge, the discourses of institutions have far reaching effects on society. In this study I have attempted to show that medical discourse, particularly from the time medicine became a professional institution in the middle of the nineteenth century, has contributed to the construction of the female subject and that women writers have used narrative strategies of silence to resist its controlling aspects.

Women have been deemed by scientific discourses as inferior to men. Described as more fragile physically and mentally, particularly because of their reproductive capacity, women have generally been excluded from positions of power in society until recently. Because of their lower status, women historically have also been denied full membership in patriarchal institutions and thus have not been able to speak back openly to the controlling aspects of the discourses of power.[1]

Foucault has alerted us to the intersections of the various discourses of powerful institutions. Religion, the judiciary, art and medicine all influence and reinforce each other on central issues, and women's subordinate position, as I have shown, is reflected in all their discourses. The importance of medicine, however, lies in its power over life and death issues. Religion speaks to the afterlife of the soul, the

judiciary has punitive powers over earthly transgressions of the body, and art reflects both. Medicine, however, involves exerting direct power over the actual workings of both the mind and body.

Medicine has extensive power to heal, to prevent disease, and to improve the quality of life. Nevertheless, the power of medicine, when it is misunderstood or misguided, extends also to withholding treatment, misusing treatment techniques, and causing injury rather than cure. Because of the exclusive nature of the profession, the erroneous suggestion of infallibility in its members, the secrecy of its language and the controlling power of its discourse, medicine, as an institution, is difficult to oppose.

The shifts in medical discourse have been slow to come and often slight in nature. My analysis of medical texts indicates that professional thinking towards women did not appreciably change until quite recently and that current modifications continue to be opposed by many members of the predominantly patriarchal institution. The propensity for medicine to describe women in relation to a male model of normality has encouraged the interpretation of women as abnormal. From the nineteenth-century belief that women would injure their reproductive systems by too much intellectual stimulation to the current dismissal of women's heart disease symptoms as neuroses, medicine has encoded its misconceptions about women into its etiology of their health problems.

The difficulties for women to resist medicine's construction of their subjectivity are complicated both by the discourses available to women and by the consequences of the resistance itself. By using patriarchal discourses, women are disadvantaged in describing their symptoms to physicians, and yet there are no other languages available. Medicine describes women's symptoms from its own professional determination of the signs of illness rather than from an understanding of women's experience. The difficulty in communication is further complicated by physicians' expectation of nervous disease in women.

If women resist the treatments medicine offers, they are in danger of being diagnosed and treated as mentally deranged. The outcome of such a diagnosis could be as drastic as surgical removal of the reproductive organs in the nineteenth century, or mood-altering drug therapy at present.[2] Thus women have had to negotiate a treacherous path to resist medical discourse.

Counter discourses have come out of the women's movement since the 1960s in the form of health collectives and health issue publications. Reverse discourses are also beginning to appear within medicine itself, but as women were excluded from the profession initially and discouraged from openly resisting until recently, resistance has often been undertaken and disguised in other forms, particularly through fiction. By using silence as a narrative strategy, Brontë, Woolf and

Drabble all oppose the controlling aspects of medicine which have imposed a restricting subjectivity on women. Their characters use their inner voices to speak back to physicians when outward speech is dangerous or impossible. By mediating their concerns about the controlling aspects of medical discourse through their fiction, these writers are free to voice their objections, and by having their characters share their thoughts, Brontë, Woolf and Drabble indicate that women do resist the power of medicine, if only in the silence of their own minds.

The progression in the resisting voice of women characters from Brontë to Drabble indicates that women are beginning to acquire both the language and the freedom to resist openly. For Lucy it is dangerous to speak; if she discloses her vision she will be diagnosed as hysterical. For Rezia, speech is unprofitable; it is discounted by the doctors, and it will only bring shame if she discloses her husband's illness. Rosamund initially retreats into silence for privacy and as protection from medical degradation, but acquires full voice when she is provoked. It is important to note, however, that over a hundred years after *Villette* was published, the issue of being put to bed by doctors for making a fuss is still a concerning issue in *The Millstone.*

Medical discourse has the power to override women's issues even when women are admitted to the profession. Traditionally, women have had to adopt the patriarchal and

authoritarian discourse of medicine to achieve success in the field. Although women need to be accepted as equally capable as men, because of their history of oppression they also have access to different approaches to power and authority which could be incorporated into medical method and language. If the discourse is allowed to modify to include new methods of sharing power and knowledge with patients, the controlling aspects of medicine will be diminished, and women (as both doctors and patients) will be able to approach their subjectivity with a sense of ownership.

As yet, a post patriarchal medical discourse has not been fully developed. Fiction has not yet provided a model for a new medical discourse, and reverse discourses within medicine are only just beginning to be heard in prestigious professional publications. But cracks and breaks in the traditional discourse of medicine are forming, criticism is evident in areas both outside the profession (in organizations such as the Boston's Women's Health Collective) and within, and the power of both the institution of medicine and its discourse is being questioned. There is not yet a solution to the oppression of traditional medical discourse, but there is increasing recognition of the problem. Foucault optimistically insists that discourses are always open to change and modification, and the discourse of medicine shows signs of responding to the pressures of resistance.

NOTES

1 In medical publishing, editors can be very cautious about challenging the traditional discourse. According to Sharon McCann, the editor of *The Canadian Journal of ObGyn & Women's Health Care*, articles for this publication, which deals only with women's health issues, must be presented in "an objective, inoffensive manner...this is the way of medical literature." In order to "reach a specific audience" she claims, "you have to speak the same language." In this case, medical discourse does not allow resisting discourses.

2 According to Dr Rosemary Hutchison, in *Ontario Medicine*, July 1993: "Women are twice as likely to be prescribed psychotropic drugs as males" (14).

BIBLIOGRAPHY

Abel, Elizabeth. "Narrative Structure(s) and Female Development: The Case of *Mrs. Dalloway*. *The Voyage In: Fictions of Female Development*. Hanover: UP of New England, 1983. 161-185.

___. and Emily K. Abel, eds. *The Signs Reader: Women, Gender and Scholarship*. Chicago: U of Chicago P, 1983.

___. Marianne Hirsch and Elizabeth Langland ed. *The Voyage In: Fictions of Female Development*. Hanover: UP of New England, 1983.

___. *Writing and Sexual Difference*. Chicago: U of Chicago P, 1982.

Acton, William. *The Functions and Disorders of the Reproductive Organs in Childhood, Youth, Adult Age, and Advanced Life Considered in Their Physiological, Social and Moral Relations*. Sixth Edition. London: J.& A. Churchill, 1875.

Alcoff, Linda. "Cultural Feminism versus Post-Structuralism: The Identity Crisis in Feminist Theory." *Feminist Theory in Practice and Process*. Ed. Micheline R. Malson, Jean F. O'Barr, Sarah Westphal-Wihl and Mary Wyer. Chicago: U of Chicago P, 1989. 295-326.

Alland, Alexander Jr. *Human Nature: Darwin's View*. New York: Columbia UP, 1985.

Allbutt, H. Arthur. *The Wife's Handbook: How A Woman Should Order Herself During Pregnancy, in the Lying-in Room, and After Delivery. With Hints on the Management of the Baby, and on Other Matters of Importance, Necessary to be Known by Married Women*. 10th Edition. London: R. Forder, 1889.

Allbutt, Thomas Clifford, and W.S. Playfair, eds. *A System of Gynaecology by Many Writers*. London: MacMillan and Company Ltd., 1896.

Allott, Miriam, ed. *Charlotte Brontë: A Casebook*. London: Macmillan, 1973.

Angell, Marcia. "Caring For Women's Health - What is the Problem?" *The New England Journal of Medicine*. 329.4 (1993): 271-2.

Bailin, Miriam Lynn. *The Consummation of Debility: Illness and Convalescence in Victorian Fiction.* DAI. Ann Arbor, MI: 1988.

Bakhtin, M.M. *The Dialogic Imagination: Four Essays.* Trans. Caryl Emerson and Michael Holquist. Ed. Michael Holquist. Austin: U of Texas P, 1990.

Ball, Donald. "Silas Weir Mitchell (1829-1919)." *Practitioner.* 217 (July 1976): 117-124.

Banks, J.A. and Olive Banks. *Feminism and Family Planning in Victorian England.* Liverpool: Liverpool UP, 1965.

Barker-Benfield, G.J. *The Horrors of the Half-Known Life: Male Attitudes Toward Women and Sexuality in Nineteenth-Century America.* New York: Harper & Row, 1976.

Bauer, Dale M. and Susan Jaret McKinstry, eds. and Introduction. *Feminism, Bakhtin, and the Dialogic.* Albany: State U of New York P, 1991.

Beacham, Daniel Winston, and Woodward Davis Beacham. *Crossen's Synopsis of Gynecology.* 6th ed. Saint Louis: C.V. Mosby Company, 1963.

Benenson, Abram S., ed. *Control of Communicable Diseases in Man.* Washington: American Public Health Association, 1990.

Belenky, Mary Field, Blythe McVicker Clinchy, Nancy Rule Goldberger, Jill Mattuck Tarule. *Women's Ways of Knowing: The Development of Self, Voice, and Mind.* New York: Basic Books, 1986.

Bell, E. Moberly. *Storming the Citadel: The Rise of the Woman Doctor.* London: Constable & Co. Ltd., 1953.

Bell, Quentin. *Virginia Woolf.* Vol. 1 & 2 Frogmore, St. Albans: 1976.

Belsey, Catherine. *Critical Practice.* London: Routledge, 1980.

Bjork, Harriet. *The Language of Truth: Charlotte Bronte, the Woman Question, and the Novel.* Lund: Gleerup, 1974.

Blackwell, Antoinette Brown. *Sexes Throughout Nature.* New York: Putnam's Sons, 1875.

Blackwell, Elizabeth. *How to Keep a Household in Health: An Address Delivered Before the Working Women's College.* London: Victoria Press, 1870.

___. *Pioneer Work For Women.* 1895. London: J.M. Dent and Sons, 1914.

___. *The Influence of Women in The Profession of Medicine: Address Given at the Opening of the Winter Session of the London School of Medicine for Women.* London: George Bell and Sons, 1889.

Bleier, Ruth. *Science and Gender: A Critique of Biology and Its Theories On Women.* New York: Pergamon Press, 1984.

Bloom, Harold, ed. *Virginia Woolf's Mrs. Dalloway.* New York: Chelsea House Publishers, 1988.

Boston Women's Health Book Collective. *The New Our Bodies, Ourselves.* New York: Simon & Schuster, 1992.

Bowlby, Rachel. *Virginia Woolf: Feminist Destinations.* Oxford: Basil Blackwell, 1988.

Braceland, Francis J. Introduction. *A Manual of Psychological Medicine.* By John Charles Bucknill and Daniel H. Tuke. New York: Hafner Publishing Co., 1968.

Branca, Patricia, ed. *The Medicine Show: Patients, Physicians and the Perplexities of the Health Revolution in Modern Society.* New York: Science History Publications, 1977.

___. *Silent Sisterhood: Middle Class Women in the Victorian Home.* London: Croom Helm, 1975.

Brock, W.H. "Medicine and the Victorian scientific press." *Medical Journals and Medical Knowledge: Historical Essays.* Ed. W.F. Bynum, Stephen Lock and Roy Porter. London: Routledge, 1992. 70-89.

Brontë, Charlotte. *Shirley.* 1849. Oxford: Oxford UP, 1981.

___. *Villette.* 1853. Harmondsworth: Penguin, 1979.

Brown, David. *Obstetrics for the Family Doctor.* London: Pitman Medical Publishing Co. Ltd., 1966.

Buchan, William. *Domestic Medicine: Or, A Treatise On the Prevention and Cure of Diseases by Regimen and Simple Medicines.* New York: George Lindsay, 1812.

Bucknill, John Charles, and Daniel H. Tuke. *A Manual of Psychological Medicine.* 1858. New York: Hafner Publishing Co., 1968.

Bullough, Vera, and Bullough, Bonnie. *Sin, Sickness and Sanity: A History of Sexual Attitudes.* New York: New American Library, 1977.

Burkhart, Charles. *Charlotte Brontë: A Psychosexual Study of Her Novels.* London: Victor Gollancz Ltd., 1973.

Burr, Anna Robeson. *Weir Mitchell: His Life and Letters.* New York: Duffield and Co., 1930.

Bynum, W.F., Stephen Lock, and Roy Porter, eds. *Medical Journals and Medical Knowledge: Historical Essays.* London: Routledge, 1992.

Canguilhem, Georges. *The Normal and the Pathological.* 1966. Trans. Carolyn R. Fawcett. New York: Zone Books, 1989.

Carter, Robert Brudenell. *On the Pathology and Treatment of Hysteria.* London: John Churchill, 1853.

Cartwright, Frederick F. *A Social History of Medicine.* London: Longman, 1977.

Chesler, Phyllis. *Women and Madness.* New York: Doubleday, 1972.

Clayne, Sir Andrew, and Aleck Bourne. *Obstetrics.* 3rd ed. London: William Heinemann Medical Books Ltd., 1963.

Clayton, Stanley G., Donald Fraser, and T.L.T. Lewis., eds. *Obstetrics: by Ten Teachers.* London: Edward Arnold (Publishers) Ltd., 1966.

Corea, Gena. *The Hidden Malpractice: How American Medicine Mistreats Women.* New York: Harper & Row, 1985

Craik, W. A. *The Brontë Novels.* London: Methuen, 1968.

Cunningham, Gail. "Women and Children First: The Novels of Margaret Drabble." *Twentieth-Century Women Novelists.* Ed. Thomas F. Staley. London: Macmillan, 1982. 130-152

Dally, Ann. *A Doctor's Story.* London: MacMillan, 1990.

___. *Women Under the Knife: A History of Surgery.* London: Hutchinson Radius, 1991.

Daly, Mary. *Gyn/Ecology: The Metaethics of Radical Feminism.* Boston: Beacon Press,1978.

Darwin, Charles. *The Descent of Man, and Selection in Relation to Sex.* Vol. 2. London: John Murray, 1871. 2 vols.

David-Ménard, Monique. *Hysteria From Freud to Lacan: Body and Language in Psychoanalysis.* Ithaca: Cornell UP, 1989.

De Courtivron, Isabelle. "Androgyny, Misogynv, and Madness: Three Essays on Women in Literature." *DAI.* Ann Arbor, MI: 1974.

DeLamotte, Eugenia C. *Perils of the Night: A Feminist Study of Nineteenth-Century Gothic.* New York: Oxford UP, 1990.

De Lauretis, Teresa. ed. *Feminist Studies, Critical Studies.* Bloomington: Indiana UP, 1986.

___. *Technologies of Gender: Essays on Theory, Film, and Fiction.* Bloomington: Indiana UP 1987.

Devlin, M. Corinne. MD, FRCS(C), FACOG. Personal interview. 8 March 1993.

Diamond, Irene, and Lee Quinby, eds. *Feminism and Foucault: Reflections On Resistance.* Boston: Northeastern UP, 1988.

Dinnerstein, Dorothy. *The Mermaid and the Minotaur: Sexual Arrangements and Human Malaise.* New York: Harper and Row, 1976.

onegan, Jane B. *Women & Men Midwives: Medicine, Morality, and Misogyny in Early America.* Westport, Connecticut: Greenwood Press, 1978.

Donovan, Josephine. "Style and Power." *Feminism, Bakhtin, and the Dialogic."* Ed. Dale M. Bauer and Susan Jaret McKinstry. Albany: State U of New York P, 1991. 85-94.

Dorland's Illustrated Medical Dictionary. 24th edition.

Dowling, David. *Mrs. Dalloway: Mapping Streams of Consciousness.* Boston: Twayne Publishers, 1991.

Drabble, Margaret. *The Gates of Ivory.* Toronto: McClelland & Stewart, 1991.

___. Introduction. *The Millstone.* Ed. Michael Marland. Harlow: Longman, 1970. vii-xiii.

___. Letter to the author. 29 August 1991.

___. *The Millstone*. 1965. Harmondsworth: Penguin, 1968.

___. *A Natural Curiosity*. Toronto: McClelland & Stewart, 1989.

___. Personal interview. 18 September 1991.

___. *The Radiant Way*. Toronto: McClelland and Stewart, 1987.

Drew, Mena. *Hints on Nursing*. London: R. Forder, 1889.

Dudley, E.C. *Diseases of Women: A Treatise in the Principles and Practice of Gynecology for Students and Practitioners*. Philadelphia: Lea Brothers & Co., 1899.

Eagleton, Mary, ed. *Feminist Literary Theory: A Reader*. Oxford: Basil Blackwell, 1986.

Eagleton, Terry. *Literary Theory: An Introduction*. Minneapolis: U of Minnesota P, 1983.

___. *Marxism and Literary Criticism*. Los Angeles: University of California Press, 1976.

Ehrenreich, Barbara and Deirdre English. *Complaints and Disorders: The Sexual Politics of Sickness*. Old Westbury, New York: The Feminist Press 1973.

___. *For Her Own Good: 150 Years of the Expert's Advice to Women*. Garden City, New York: Anchor Press/Doubleday, 1978.

Elshtain, Jean Bethke. *Public Man, Private Woman: Women in Social and Political Thought*. Princeton: Princeton UP, 1981.

Fausto-Sterling, Anne. *Myths of Gender: Biological Theories About Women and Men*. New York: Basic Books Inc., 1985.

Fee, Elizabeth, ed. *Women and Health: The Politics of Sex in Medicine*. Farmingdale, N.Y.: Baywood Publishing Co. Inc., 1983.

Felman, Shoshana. "Women and Madness: The Critical Phallacy." *Diacritics*. 5 (1975): 2-10.

___. *Writing and Madness*. Ithaca NY: Cornell UP, 1985.

Figes, Eva. *Sex and Subterfuge: Women Novelists to 1850*. London: MacMillan, 1982.

Findlay, Deborah Ann. "Women and Medical Knowledge in the 1950s: A Study of the Process of Social Construction." Diss. McMaster U, 1990.

Finke, Laurie A. *Feminist Theory, Women's Writing.* Ithaca: Cornell UP, 1992.

Fisher, Sue. *In the Patient's Best Interest: Women and the Politics of Medical Decisions.* New Brunswick, New Jersey: Rutgers University Press, 1986.

Forbes, John, Alexander Tweedie, and John Conolly, eds. *The Cyclopaedia of Practical Medicine: Comprising Treatises on the Nature and Treatment of Diseases, Materia Medica and Therapeutics, Medical Jurisprudence, etc. etc.* Vol III JAU-SMA. London: Sherwood, Gilbert and Piper, 1834.

Forster, E.M. *Aspects of the Novel.* New York: Harcourt, 1927.

Foucault, Michel. *The Archaeology of Knowledge.* Trans. A.M. Sheridan Smith. London: Tavistock, 1972.

___. *The Birth of the Clinic: An Archaeology of Medical Perception.* Trans. A.M. Sheridan Smith. London: Tavistock, 1973.

___. *The History of Sexuality.* Trans. Robert Hurley. New York: Vintage Books, 1980.

___. *Madness and Civilization: A History of Insanity in the Age of Reason.* Trans. Richard Howard. New York: Vintage, 1973.

___. *Power/Knowledge: Selected Interviews and Other Writings 1972-1977.* Trans. Colin Gordon, Leo Marshall, John Mepham, Kate Soper. Ed. Colin Gordon. New York: Pantheon Books, 1980.

Fraser, A.C. and Mary Anderson. *Handbook for Obstetric House Officers.* London: Edward Arnold (Publishers) Ltd., 1968.

Gardiner Judith Kegan. "On Female Identity and Writing by Women." *Writing and Sexual Difference.* Ed. Elizabeth Abel. Chicago: U of Chicago P, 1980. 177-191.

Gibberd, G.F. *et al.* *The Queen Charlotte's Text-Book of Obstetrics.* London: J.& A. Churchill, 1965.

Gilbert, Sandra M., and Susan Gubar. *The Madwoman in the Attic: The Woman Writer and the Nineteenth Century Literary Imagination.* New Haven: Yale UP, 1979.

Gilman, Charlotte Perkins. *The Yellow Wallpaper.* Old Westbury: The Feminist Press, 1973.

Goellnicht, Donald C. *The Poet-Physician: Keats and Medical Science.* Pittsburgh: U of Pittsburgh P, 1984.

Goodall, Elizabeth. RN. Personal interview. April 1993.

Gordon, Lyndall. *Virginia Woolf: A Writer's Life.* Oxford: OUP, 1984.

Graddol, David and Joan Swann. *Gender Voices.* Oxford: Basil Blackwell, 1989.

Graham, Hilary. *Women, Health and the Family.* Brighton: Wheatsheaf Books, 1984.

Graham, Thomas J. *On the Diseases of Females; A Treatise Describing Their Symptoms, Causes, Varieties, and Treatment.* London: Simplin, Marshall and Company, 1861.

Greene, Gayle, and Coppelia Kahn, eds. *Making a Difference: Feminist Literary Criticism.* London, Methuen, 1985.

Haley, Bruce. *The Healthy Body and Victoria Culture.* Cambridge, Mass: Harvard UP, 1978.

Haller, John S. Jr., and Robin M. Haller. *The Physician and Sexuality in Victorian America.* Urbana: U of Illinois P, 1974.

Hardin, Nancy S. "An Interview with Margaret Drabble." *Contemporary Literature.* 14.4 (1973): 273-295.

Hartsock, Nancy. "Foucault on Power: A Theory for Women?" *Feminism/Postmodernism.* Ed. Linda J. Nicholson. New York: Routledge, 1990.

Hemlow, Joyce. *The History of Fanny Burney.* London: Oxford UP, 1958.

Henderson, Andrea. "Doll-Machines and Butcher-Shop Meat: Models of Childbirth in the Early Stages of Industrial Capitalism." *Genders.* 12 (1991): 100-119.

Henke, Suzette A. "*Mrs Dalloway:* the Communion of Saints." *New Feminist Essays on Virginia Woolf.* Ed. Jane Marcus. London: Macmillan, 1981. 125-147.

Henley, Nancy M. *Body Politics: Power, Sex, and Nonverbal Communication.* Englewood Cliff, New Jersey: Prentice-Hall, 1975.

Herndl, Diane Price. "The Dilemmas of a Feminine Dialogic." *Feminism, Bakhtin, and the Dialogic.* Ed. Dale M. Bauer and Susan Jaret McKinstry. Albany: State U of New York P, 1991. 7-24.

Herrmann, Anne. *The Dialogic and Difference: "An/Other Woman" in Virginia Woolf and Christa Wolf.* New York: Columbia UP, 1989.

Hirschkop, Ken, and David Shepherd, eds. *Bakhtin and Cultural Theory:* Manchester: Manchester UP, 1989.

Howell, Mary C. "What Medical Schools Teach About Women." *The New England Journal of Medicine.* 291.6 (1974): 304-307.

Hubbard Ruth. *The Politics of Women's Biology.* New Brunswick, New Jersey: Rutgers UP, 1990.

Hunter, Kathryn Montgomery. *Doctor's Stories: The Narrative Structure of Medical Knowledge.* Princeton: Princeton UP, 1991.

Hutchinson, Rosemary. "MDs too quick with crazy dame label." *Ontario Medicine.* 13 July 1993: 14.

Irigaray, Luce. *Speculum of the Other Woman.* 1974. Trans. Gillian G. Gill. Ithaca, NY: Cornell UP,1985.

Jacobus, Mary, Evelyn Fox Keller, and Sally Shuttleworth, eds. *Body/Politics: Women and the Discourses of Science.* New York: Routledge, 1990.

Jalland, Pat. Introduction. *Octavia Wilberforce: The Autobiography of a Pioneer Woman Doctor.* By Octavia Wilberforce. London: Cassell, 1989. ix-xxvi.

Jehlen, Myra. "Archimedes and the Paradox of Feminist Criticism." *The Signs Reader: Women, Gender & Scholarship.* Ed. Elizabeth Abel and Emily K. Abel. Chicago: U of Chicago P, 1983. 69-94.

Johnson, Diane. "Doctor Talk." *The State of the Language.* Eds. Leonard Michaels and Christopher Ricks. Berkeley: U of California P, 1980. 397-400.

Jones, Ann Rosalind. "Writing the Body: Towards an Understanding of l'Ecriture Feminine." *The New Feminist Criticism.* Ed. Elaine Showalter. New York: Pantheon Books, 1985. 361-377.

Jordanova, L. J., ed. *Languages of Nature: Critical Essays on Science and Literature.* New Brunswick, New Jersey: Rutgers UP, 1986.

___. "Natural Facts: A Historical Perspective on Science and Sexuality." *Nature, Gender, and Culture.* Ed. Carole P. MacCormack and Marilyn Strathern. Cambridge: Cambridge UP, 1980. 42-69.

___. *Sexual Visions: Images of Gender in Science and Medicine Between the Eighteenth and Twentieth Centuries.* Madison: U of Wisconsin P, 1989.

Kehde, Suzanne. "Voices from the Margin: Bag Ladies and Others." *Feminism, Bakhtin, and the Dialogic.* Ed. Dale M. Bauer and Susan Jaret McKinstry. Albany: State U of New York P, 1991. 25-38.

Kellar, R. J., ed. *Modern Trends in Obstetrics.* London: Butterworths, 1963.

Kermer, Charmian. *No Time For Women: Exploring Women's Health in the 1930s and Today.* London: Pandora Press, 1985.

Knies, Earl A. *The Art of Charlotte Brontë.* Athens: Ohio UP, 1969.

Kolodny, Annette. "Dancing Through the Minefield: Some Observations on the Theory, Practice, and Politics of a Feminist Literary Criticism." *The New Feminist Criticism: Essays on Women, Literature, and Theory.* Ed. Elaine Showalter. New York: Pantheon Books, 1985. 144-167.

___. "A Map for Rereading: Gender and the Interpretation of Literary Texts." *The New Feminist Criticism: Essays on Women, Literature, and Theory.* Ed. Elaine Showalter. New York: Pantheon Books, 1985. 46-62.

Kramer, Cheris. "Women's Speech: Separate but Unequal." *Language and Sex: Difference and Dominance.* Ed. Barrie Thorne and Nancy Henley. Rowley, Masachusetts: Newbury House Publishers, Inc., 1975. 43-56.

Kucich, John. *Repression In Victorian Fiction: Charlotte Brontë, George Eliot, and Charles Dickens.* Berkeley: U of California P, 1987.

Landry, Donna. *The Muses of Resistance: Laboring-Class Women's Poetry in Britain, 1739-1796.* Cambridge: Cambridge UP, 1990.

Laqueur, Thomas. *Making Sex: Body and Gender From the Greeks to Freud.* Cambridge, Massachusetts: Harvard UP, 1990.

Leaska, Mitchell A. Introduction. *A Passionate Apprentice: The Early Journals 1897-1909* . By Virginia Woolf. Toronto: Lester & Orpen Dennys, 1990. xv-xlv.

Lee, So-Hee. "Madness, Marginalization and Power in *Mrs. Dalloway.*" *English Language and Literature* 36.4 (1990): 691-712.

Lefkowitz, Mary R. *Heroines and Hysterics.* London: Duckworth, 1981.

Lehman, John. *Virginia Woolf and Her World.* London: Harcourt Brace Jovanovich,1978

L'Esperance, Jean. "Doctors and Women in Nineteenth-Century Society: Sexuality and Role." *Health Care and Popular Medicine in Nineteenth Century England: Essays In The Social* History of Medicine. Ed. John Woodward and David Richards. London: Croom Helm, 1977. 105-127.

Levine, George. *Darwin Among the Novelists: Patterns of Science in Victorian Fiction.* Cambridge, Massachusetts: Harvard UP, 1988.

Levy, Anita. *Other Women: The Writing of Class, Race, and Gender, 1832-1898.* Princeton: Princeton UP, 1991.

Lewis, Aubrey. Introduction. *The Pathology of Mind: A Study of its Distempers, Deformities and Disorders.* By Henry Maudsley. London: Julian Friedmann, 1979. N. pag.

Lewis, Henry Foster, and Alfred de Roulet. *Handbook of Gynecology For Students and Practitioners.* St. Louis: C.V. Mosby Co., 1917.

Lewis, Jane. "The Medical Journals and the Politics of Public Health 1918-90." *Medical Journals and Medical Knowledge: Historical Essays.* Ed. W.F. Bynum, Stephen Lock and Roy Porter. London: Routledge, 1992. 207-227.

Lewis, T.L.T. *Progress in Clinical Obstetrics and Gynaecology.* London: J.& A. Churchill Ltd., 1965.

Longshore-Potts, Anna. *Discourses to Women On Medical Subjects.* San Diego: 1897.

Love, Jean. *Virginia Woolf: Sources of Madness and Art.* Berkeley: U of California P, 1977.

Lundberg, Patricia Lorimer. "The Dialogic Search for Community in Charlotte Brontë's Novels." *Journal of Narrative Technique* 20.3 (1990): 296-317.

Lyons, Albert S. & R. Joseph Petrucelli II. *Medicine: An Illustrated History.* New York: Harry N. Adams, 1978.

MacCormack, Carol P. "Nature, culture and gender: a critique." *Nature, Culture and Gender.* Ed. Carol P. MacCormack and Marilyn Strathern. Cambridge: Cambridge UP, 1980. 1-24.

MacNaughton-Jones, Henry. *Points of Practical Interest in Gynaecology.* London: Bailliere, Tyndall and Cox, 1901.

Malleson, Andrew. *Need Your Doctor Be So Useless?* London: Allen and Unwin, 1973.

Malson, Micheline R., Jean F. O'Barr, Sarah Westphal-Wihl, and Mary Wyer, eds. *Feminist Theory in Practice and Process.* Chicago, U of Chicago P, 1986.

Marcus, Jane, ed. *New Feminist Essays on Virginia Woolf.* London: Macmillan, 1981.

___. *Virginia Woolf: A Feminist Slant.* Lincoln: U of Nebraska P, 1983.

Marder, Herbert. *Feminism and Art: A Study of Virginia Woolf.* Chicago: U of Chicago P, 1968.

Marks, Elaine, and Isabelle de Courtivron, eds. *New French Feminisms.* 1980. Brighton: Harvester, 1981.

Martin, Emily. *The Woman in the Body: A Cultural Analysis of Reproduction.* Milton Keynes: Open University Press, 1989.

___. "The Egg and the Sperm: How Science Has Constructed a Romance Based On Stereotypical Male-Female Roles." *Signs.* 16 (1991): 485-501.

Martin, Philip W. *Mad Women in Romantic Writing.* Sussex. The Harvester Press, 1987.

Martin, Robert Bernard. *The Accents of Persuasion: Charlotte Brontë's Novels.* New York: Norton, 1966.

Maudsley, Henry. *The Pathology of Mind: A Study of its Distempers, Deformities and Disorders.* 1895. London: Julian Friedmann, 1979.

___. *The Physiology and Pathology of the Mind.* New York: D. Appleton and Co., 1867.

Maynard, John. "The Diagnosis of Charlotte Brontë's Final Illness." *Biography* 6.1 (1983): 68-75.

McCann, Sharon. Letter to the author. 19 August 1993.

McKeown, Thomas. *The Role of Medicine: Dream, Mirage or Nemesis?* London: Basil Blackwell, 1979.

McLean, Barbara. "An Inviolate Space: Refuge From Rape in *A Room of One's Own.*" *Room of One's Own* 15.2 (1992): 35-43.

Mendelsohn, Robert S. M.D. *Male Practice: How Doctors Manipulate Women.* Chicago: Contemporary Books, Inc. 1981.

Michie, Helena. *The Flesh Made Word: Female Figures and Women's Bodies.* Oxford: Oxford UP, 1987.

Miller, J. Hillis. "Virginia Woolf's All Souls' Day: The Omniscient Narrator in *Mrs. Dalloway.*" *The Shaken Realist: Essays in Modern Literature.* Ed. Melvin J. Friedman and John B. Vickery. Baton Rouge: Lousiana State UP, 1970.

___. "*Mrs. Dalloway*: Repetition as the Raising of the Dead". *Virginia Woolf's Mrs. Dalloway.* Ed. Harold Bloom. New York: Chelsea House Publishers, 1988. 79-101.

Mitchell, S. Weir. *Doctor and Patient.* Philadelphia: J.B. Lippincott Co, 1888.

___. *The Annual Oration before the Medical and Chirurgical Faculty of Maryland.* Baltimore: 1877.

___. *Fat and Blood: An Essay on the Treatment of Certain Forms of Neurasthenia and Hysteria.* 8th ed. Philadelphia: J.B. Lippincott Company, 1902.

Mitchinson, Wendy. *The Nature of Their Bodies: Women and Their Doctors in Victorian Canada.* Toronto: U of T Press, 1991.

Moers, Ellen. *Literary Women.* Garden City: Doubleday, 1976.

Moi, Toril. *Sexual/Textual Politics: Feminist Literary Theory.* London : Methuen, 1985.

Moore, Madeline. *The Short Season Between Two Silences: The Mystical and the Political in the Novels of Virginia Woolf.* Boston: George Allen & Unwin, 1984.

Myer, Valerie Grosvenor. *Margaret Drabble: A Reader's Guide.* London: Vision Press, 1991.

Myerson, Abraham. *The Nervous Housewife.* Boston: Little, Brown, and Company, 1927.

Naremore, James. *The World Without a Self: Virginia Woolf and the Novel.* New Haven: Yale UP, 1973.

Nestor, Pauline. *Charlotte Brontë.* Totowa: Barnes & Noble, 1987.

Newton, Judith Lowder. *Women, Power and Subversion.* New York: Methuen, 1985.

Nicholson, Linda J., ed. *Feminism/Postmodernism.* New York: Routledge, 1990.

Norman, Jeremy M., ed. *Morton's Medical Bibliography: An Annotated Check-list of Texts Illustrating the History of Medicine (Garrison and Morton).* Fifth Edition. Aldershot: Gower Publishing Co., 1991.

O'Connor, Mary. "Subject, Voice, and Women in Some Contemporary Black American Women's Writing." *Feminism, Bakhtin, and the Dialogic.* Ed. Dale M. Bauer and Susan Jaret McKinstry. Albany: State U of New York P, 1991. 199-217.

Olsen, Tillie. *Silences.* New York: Delacorte Press/Seymour Lawrence, 1965.

Oppenheim. Professor H. *Text-Book of Nervous Diseases for Physicians and Students.* Trans. Alexander Bruce. 5th ed. Edinburgh: The Darien Press, 1911.

Osler, William. *The Principles and Practice of Medicine: Designed for the Use of Practitioners and Students of Medicine.* Third Edition. Edinburgh: Young J. Pentland, 1898.

Paul, Janis M. *The Victorian Heritage of Virginia Woolf: The External World in her Novels.* Norman, Oklahoma: Pilgrim Books, 1987.

Playfair, W.S. *A Handbook of Obstetric Operations.* London: Henry Renshaw, 1865.

Poirier, Suzanne. "The Weir Mitchell rest cure: doctors and patients." *Women's Studies.* 10 (1983): 15-40.

Poole, Roger. *The Unknown Virginia Woolf*. 1978. New Jersey: Humanities Press International, 1990.

Poovey, Mary. '"Scenes of an Indelicate Character": The Medical "Treatment" of Victorian Women. ' *The Making of the Modern Body*. Ed. Catherine Gallagher and Thomas Laqueur. Berkeley: U of California P, 1987. 152.

___. *The Proper Lady and The Woman Writer*. Chicago: U of Chicago P, 1984.

___. *Uneven Developments: The Ideological Work of Gender in Mid-Victorian England*. Chicago: U of Chicago P, 1988.

Poynton, Cate. *Language and Gender: Making the Difference*. Oxford: Oxford UP, 1985.

Raymond, Janice. "Medicine as Patriarchal Religion. *Journal of Medicine and Philosophy*. 7.2 (1982): 197-216.

Rein, David M. *S. Weir Mitchell As a Psychiatric Novelist*. New York: International UP, 1952.

Richardson, Ruth. *Death, Dissection and The Destitute*. London: Routledge & Kegan Paul, 1987.

Rigney, Barbara Hill. *Madness and Sexual Politics in the Feminist Novel: Studies in Brontë, Woolf, Lessing and Atwood*. Madison: U of Wisconsin P, 1978.

Rimmon-Kenan. *Narrative Fiction: Contemporary Poetics*. London: Methuen, 1983.

Rivers, W.H.R. *Instinct and the Unconscious: A Contribution to a Biological Theory of the Psycho-Neuroses*. Cambridge: Cambridge UP, 1920.

___. *Psychology and Politics: And Other Essays*. London: Kegan Paul, Trench, Trubner & Co., Ltd., 1923.

Roberts, Helen. *The Patient Patients: Women and Their Doctors*. London: Pandora Press, 1985.

Rodgers, James. "Sensibility, Sympathy, Benevolence: Physiology and Moral Philosophy in *Tristram Shandy*," *Languages of Nature*. Ed. L.J. Jordanova. New Brunswick, New Jersey: Rutgers UP, 1986. 121.

Rose, Ellen Cronan. *Critical Essays on Margaret Drabble*. Boston: G.K. Hall & Co., 1985.

___. *The Novels of Margaret Drabble: Equivocal Figures.* London: Macmillan, 1980.

Rose, Phyllis. *Woman of Letters: A Life of Virginia Woolf.* New York: Oxford UP, 1978.

Rothfield, Laurence. *Vital Signs: Medical Realism in Nineteenth-Century Fiction.* Princeton: Princeton UP, 1992.

Rothman, Barbara Katz. *In Labor: Women and Power in the Birth Place.* New York: Norton, 1982.

Russell, Diane H. and Bernadine Barnes. *Eva/Ave: Women in Renaissance and Baroque Prints.* Washington: National Gallery of Art; New York: The Feminist Press CUNY, 1990.

Russett, Cynthia Eagle. *Sexual Science: The Victorian Construction of Womanhood.* London, Harvard UP, 1989.

Ruthven, K.K. *Feminist Literary Studies: An Introduction.* Cambridge: Cambridge UP, 1984.

Sadler, Lynn Veach. *Margaret Drabble.* Boston: Twayne Publishers, 1986.

Sage, Lorna. *Women in the House of Fiction: Post-War Women Novelists.* New York: Routledge, 1992.

Satow, Roberta. "Where has all the Hysteria Gone?" *Psychoanalytic Review.* 66 (1970-80): 463-78.

Sawicki, Jana. "Identity Politics and Sexual Freedom: Foucault and Feminism." *Foucault and Feminism.* Ed. Irene Diamond and Lee Quinby. Boston: Northeastern UP, 1988. 177-191.

Scully, Diane, and Pauline Bart. "A Funny Thing Happened on the Way to the Orifice: Women in Gynecology Textbooks." *American Journal of Sociology.* 78 (1973): 1045-1049.

Sharrock, Roger. "Our Health Is the Disease, or the One and the Many." *Agenda.* 23 (1985): 97-102.

Shorter, Edward. *A History of Women's Bodies.* New York: Basic Books, 1982.

___. *Bedside Manners: The Troubled History of Doctors and Patients.* New York: Simon & Shuster, 1985.

Showalter, Elaine. *The Female Malady: Women, Madness and English Culture, 1830-1980.* 1985. New York: Viking Penguin, 1987.

___. *A Literature of Their Own: British Women Novelists From Bronte to Lessing.* Princeton: Princeton UP, 1977.

___. ed. *The New Feminist Criticism.* New York: Pantheon Books, 1985.

___. ed. *Speaking of Gender.* New York: Routledge, 1989.

___. and English Showalter. "Victorian Women and Menstruation." *Victorian Studies.* 14 (1970): 33.

Sicherman, Barbara. "The Uses of a Diagnosis: Doctors, Patients and Neurasthenia." *Journal of the History of Medicine.* 32 (1977): 33-54.

Sigsworth, E.M. and T.J. Wyke. "A Study of Victorian Prostitution and Venereal Disease." *Suffer and Be Still: Women in the Victorian Age.* Ed. Martha Vicinus. Bloomington: Indiana UP, 1973. 77-99.

Simmons, Michael. "Book on doctors and female patients opts for soap opera tactics." Rev. of *Women and Doctors--A Physician's Explosive Account of Women's Medical Treatment--and Mistreatment in America and What You Can Do About It,* by Dr John M. Smith. *Family Practice* 14 June (1993): 72-73.

Skene, Alexander J.C. *Treatise of the Diseases of Women for the Use of Students and Practitioners.* New York: D. Appleton & Co., 1893.

Smedstad, Kari, MB, ChB, FRCPC, and May Cohen, MD, CCFP, FCFP. "Women in medicine: an overview of practice." *The Canadian Journal of Ob/Gyn & Women's Health Care.* June (1991): 171-2.

Southard, E.E. *Shell-Shock and other Neuropsychiatric Problems: Presented in Five Hundred And Eighty-nine Case Histories From the War Literature, 1914-1918.* Boston: W.M. Leonard, 1919.

Spacks, Patricia Meyer. *The Female Imagination.* New York: Knopf, 1975.

Spater, George and Ian Parsons. *A Marriage of True Minds: An Intimate Portrait of Leonard and Virginia Woolf.* London: Jonathan Cape, 1977.

Spender, Dale. *Man Made Language*. London: Routledge & Kegan Paul, 1980.

___. *Mothers of the Novel: 100 Good Women Writers Before Jane Austen*. London: Pandora, 1986.

Spitzer, Susan. "Fantasy and Femaleness in Margaret Drabble's *The Millstone*. *Critical Essays on Margaret Drabble*. Ed. Ellen Cronan Rose. Boston: G.K. Hall & Co., 1985. 86-105.

Spoerl, Linda Bell. "The Methods of Madness: Insanity as Metaphor in Five Modern Novels." *DAI* Ann Arbor MI: 1984.

Stafford, Barbara Maria. *Body Criticism: Imaging the Unseen in Enlightenment Art and Medicine*. Cambridge, Massachusetts: The MIT Press, 1991.

Stovel, Nora Foster. *Margaret Drabble: Symbolic Moralist*. Mercer Island, Washington: Starmont, 1989.

Tambling, Jeremy. "Repression in Mrs Dalloway's London." *Essays In Criticism*. 39.2 (1989): 137-155.

Tatlock, Lynne. "Speculum Feminarum: Gendered Perspectives on Obstetrics and Gynecology in Early Modern Germany." *Signs*. 17.4 (1992): 725-760.

Thomas, Sue. "Virginia Woolf's Septimus Smith and Contemporary Perceptions of Shell Shock." *English Language Notes*. 25.2 (1987): 49-57.

Todd, Janet. *Feminist Literary History*. New York: Routeledge, 1988.

___. ed. *Gender and Literary Voice*. New York: Holmes & Meier, 1980.

Transue, Pamela J. *Virginia Woolf and the Politics of Style*. New York: State U of New York P, 1986.

Trombley, Stephen. *All That Summer She Was Mad: Virginia Woolf and Her Doctors*. London: Junction Books, 1981.

Ussher, Jane M. *The Psychology of the Female Body*. New York: Routledge, 1989.

Veith, Ilza. *Hysteria: The History of a Disease*. Chicago: U of Chicago P, 1965.

Vicinus, Martha, ed. *Suffer and Be Still: Women in the Victorian Age*. Bloomington: Indiana UP, 1972.

Vrettos, Athena. "From Neurosis to Narrative: The Private Life of The Nerves In *Villette* and *Daniel Deronda*." *Victorian Studies*. 33:4 (1990): 551-579.

Walker, James, Ian MacGillivray, and Malcolm C. Macnaughton. *Combined Textbook of Obstetrics and Gynaecology*. 9th Ed. Edinburgh: Churchill Livingstone, 1976.

Walter, Richard D. *S. Weir Mitchell, M.D.--Neurologist: A Medical Biography*. Springfield, Illinois: Charles C. Thomas, 1970.

Waugh, Patricia. *Feminine Fictions: Revisiting the Postmodern*. London: Routledge, 1989.

Webster, J.C. *Diseases of Women: A Text-Book for Students and Practitioners*. Edinburgh: Young J. Pentland, 1898.

Weedon, Chris. *Feminist Practice and Post-Structuralist Theory*. Oxford: Basil Blackwell, 1987.

Weil, Andrew. *Health and Healing: Understanding Conventional and Alternative Medicine*. Boston: Houghton Mifflin, 1983.

Wells, Judith Lee. *Madness and Women: A Study of the Themes of Insanity and Anger in Modern Literature by Women*. DAI, Ann Arbor, Mi. 1977.

Wenger, Nanette K., MD, Leon Speroff, MD, and Barbara Packard, MD PhD. "Cardiovascular Health and Disease in Women." *New England Journal of Medicine*. 329.4 (1993): 247-256.

Wengraf, Fritz. *Psychosomatic Approach to Gynecology and Obstetrics*. Springfield, Illinois: Charles C. Thomas, 1953.

White, William A. *Outlines of Psychiatry*. 5th ed. New York: The Nervous and Mental Disease Publishing Company, 1915.

Whittier, Gayle. "Mistresses and Madonnas in the Novels of Margaret Drabble." *Gender and Literary Voice*. Ed. Janet Todd. New York: Holmes & Meier, 1980. 197-213.

Wilberforce, Octavia. *The Autobiography of a Pioneer Woman Doctor*. Ed. Pat Jalland. London: Cassell, 1989.

Williams, Judith. *Perception and Expression in the Novels of Charlotte Brontë*. Ann Arbor: UMI Research Press, 1988.

Wilson, Thomas N. MD, CCFP, MHSc. Personal interview. 29 August 1993.

Wittig, Monique. "One is Not Born a Woman." *Feminist Issues.* 1 (1980): 1103-1111.

Wolff, Janet. *Feminine Sentences: Essays on Women and Culture.* Berkeley & Los Angeles: U of California P, 1990.

Wood, Ann Douglas. "'The Fashionable Diseases': Women's Complaints and Their Treatment In Nineteenth-Century America." *Clio's Consciousness Raised: New Perspectives on the History of Women.* Ed. Mary S. Hartman and Lois Banner. New York: Harper Torchbooks, 1974. 1-22.

Woolf, Leonard. *Beginning Again: An Autobiography of the Years 1911-1918.* London: Hogarth Press, 1964.

Woolf, Virginia. *The Diary of Virginia Woolf.* Vol. II. Harmondsworth: Penguin, 1981.

___. *Granite & Rainbow: Essays by Virginia Woolf.* New York: Harcourt Brace Jovanovich, 1975.

___. *Melymbrosia.* Ed. Louise DeSalvo. New York: New York Public Library, Astor, Lenox and Tilden Foundations, 1982.

___. *The Moment and Other Essays.* London: The Hogarth Press, 1947.

___. *Moments of Being.* 1976. Frogmore, St. Albans: Triad/Panther Books, 1978.

___. *Mrs Dalloway.* 1925. Harmondsworth: Penguin, 1964.

___. *A Passionate Apprentice: The Early Journals 1897-1909.* Ed. Mitchell A. Leaska. Toronto: Lester & Orpen Dennys, 1990.

___. "Professions for Women." *Virginia Woolf: Women and Writing.* Ed. Michèle Barrett. New York: Harcourt, 1980. 57-63.

___. *A Room of One's Own.* 1928. Harmondsworth: Penguin, 1945.

___. *Three Guineas.* 1938. London: The Hogarth Press, 1991.

___. *Virginia Woolf: The Complete Shorter Fiction.* Ed. Susan Dick. London: Triad Grafton, 1991.

___. *The Years.* 1937. Harmondsworth: Penguin, 1968.

Yaeger, Patricia. *Honey-Mad Women: Emancipatory Strategies in Women's Writing.* New York: Columbia UP, 1988.

Youngson, A.J. *The Scientific Revolution in Victorian Medicine.* London: Croom Helm, 1979.

Zwerdling, Alex. *Virginia Woolf and the Read World.* Berkeley: U of California P, 1986.