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DIAGNOSING NARRATIVES:

ILLNESS, THE CASE HISTORY, AND VICTORIAN FICTION

by

Nicole Desiree Buscemi

An Abstract

Of a thesis submitted in partial fulfillment of the requirements
for the Doctor of Philosophy degree in English in
the Graduate College
of The University of Iowa

July 2009

Thesis Supervisor: Professor Garrett Stewart

ABSTRACT

"Diagnosing Narratives: Illness, the Case History, and Victorian Fiction" explores how the medical case study competes with patients' experiential accounts of disease in the development of popular nineteenth-century fictions. During most of the Victorian period, clinical medicine served as the primary producer of medical knowledge. At the same time, its objectification of the sufferer—epitomized by the case narrative, the most prevalent form of nineteenth-century medical writing—led to an increasingly distanced relationship between doctor and patient. I argue that the mid-century novel responds by featuring narrator-sufferers who co-opt aspects of the medical case in order to represent their own subjective experiences and rethink what constitutes medical knowledge. As the century came to a close, however, sciences of the laboratory, rather than the clinic, began to gain epistemological sway. In light of widespread skepticism regarding the possibility of translating discoveries made in the lab into effective bedside practices, I contend that popular novels and short stories now returned full circle to the clinical case approach as a valuable alternative to the laboratory. The result is late-century fiction structurally and thematically driven by the useful yet sometimes callous techniques of the diagnostician and his case method. I chart these shifts through an examination of works by Charles Dickens, Wilkie Collins, Mary Elizabeth Braddon, Robert Louis Stevenson, Bram Stoker, and Arthur Conan Doyle. My project illustrates the responses of these authors to prevailing power dynamics in the world of medicine and offers a new reading of the ways in which the Victorian preoccupation with disease shaped literary narrative.

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of the requirements for the Doctor of
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Graduate College
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Iowa City, Iowa

CERTIFICATE OF APPROVAL

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PH.D. THESIS

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This is to certify that the Ph.D. thesis of

Nicole Desiree Buscemi

has been approved by the Examining Committee
for the thesis requirement for the Doctor of Philosophy
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To the other fruits of my labor, Gianna and Bruno, I dedicate this dissertation.

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ABSTRACT

“Diagnosing Narratives: Illness, the Case History, and Victorian Fiction” explores how the medical case study competes with patients’ experiential accounts of disease in the development of popular nineteenth-century fictions. During most of the Victorian period, clinical medicine served as the primary producer of medical knowledge. At the same time, its objectification of the sufferer—epitomized by the case narrative, the most prevalent form of nineteenth-century medical writing—led to an increasingly distanced relationship between doctor and patient. I argue that the mid-century novel responds by featuring narrator-sufferers who co-opt aspects of the medical case in order to represent their own subjective experiences and rethink what constitutes medical knowledge. As the century came to a close, however, sciences of the laboratory, rather than the clinic, began to gain epistemological sway. In light of widespread skepticism regarding the possibility of translating discoveries made in the lab into effective bedside practices, I contend that popular novels and short stories now returned full circle to the clinical case approach as a valuable alternative to the laboratory. The result is late-century fiction structurally and thematically driven by the useful yet sometimes callous techniques of the diagnostician and his case method. I chart these shifts through an examination of works by Charles Dickens, Wilkie Collins, Mary Elizabeth Braddon, Robert Louis Stevenson, Bram Stoker, and Arthur Conan Doyle. My project illustrates the responses of these authors to prevailing power dynamics in the world of medicine and offers a new reading of the ways in which the Victorian preoccupation with disease shaped literary narrative.

TABLE OF CONTENTS

INTRODUCTION 1

CHAPTER

ONE THE "STRANGE AFFLICTIONS" AT THE HEART OF *BLEAK HOUSE*: ESTHER'S ILLNESS VERSUS THE REPRESENTATION OF DISEASE..........19

"the testimony on which human occurrences are usually received": Dickens and the Case 25
Esther's Outlook on Disease and Her Inroad into Illness..........30
The Interplay of Content and Structure:
The Relationship between Illness, Disease, and Dual Narration..........41
Realism and Esther's Interiority of Experience..........47
Communicating Illness 53

TWO "BUT FOR HIS ILLNESS": THE NARRATIVE NECESSITY OF INDIVIDUAL SUFFERING..........56

Thickening the Plot: Illness as Large-Scale Narrative Catalyst 61
The Case of Ezra Jennings..........68
    Constituting Illness: Miscegenation, Ostracization, and Disease..........70
    The Impetus to Action: Constructing Community Through Narrative ...77
    Jennings's Revision of Illness Through Personal Case History..........82
The Generative Potential of Illness: The Union of Plot and Character 88
"there was the mixture of some foreign race in his English blood": The Mingling of Medical Narratives and Literary Genres 92

THREE CASES POISONOUS AND PREVENTATIVE: FROM BRADDON TO STEVENSON..........95

"Philip Sheldon Reads The 'Lancet'": The Spread of Medical Information and the Threat of Reading in *Birds of Prey* and *Charlotte's Inheritance*..........100
Sensational Science 109
"If you knew as much of doctors as I do, you wouldn't be in any hurry to trust a friend to the mercy of one": Lying Doctors and Fictionalized Afflictions..........113
Thinking Ill of Himself: Hypochondria and the Laboratory in *The Strange Case of Dr. Jekyll and Mr. Hyde*..........122
Narrative Contagion and Narrative Containment: The Dangerous Story and the Preventative Case..........131
The Moral and the Medical: Shifting Narratives..........142

FOUR “YOUR CASEBOOK WAS EVER MORE FULL THAN THE REST”: MEDICAL REPORTING AS ANTIDOTE IN *DRACULA* AND THE SHERLOCK HOLMES TALES 145

The History of the Case in Holmes and *Dracula* 149
Keeping Up “Good Habits” and Making “Blunders”: Clinical Accumulation and Professional Failure 158
“Why Did I Hesitate to Write the Word?”: The Absent Illness Narrative in *Dracula* 170
Cataloguing Parts: Death and Distance as Explanatory in Sherlock Holmes 179
The Case Comes Into Its Own 189

WORKS CITED 193

INTRODUCTION

> Since much of the information thus obtained [through the doctor's questioning of a patient] is *liable to be uncertain*, it is well to qualify it in the record with *some such saving clause* as "the patient says."
>
> *Scheme for Case Reporting* (1887), emphasis added

> *The patient stated* that for some years he served in the army, that lately he had been working as a miner (after his death *it was ascertained from his friends* that he had been for some time engaged as a prize-fighter and that he had … received a severe blow beneath the belt).
>
> "Notes on a Case of Cancer of the Stomach" from *The Lancet* (1875), emphasis added

> *It seemed* that he was a butler, and used to be very intemperate, but had not been able to indulge during the last year, on account of poverty. He suffered first from stricture nine or ten years ago—the result, *as he supposed*, of gonorrhoea.
>
> "Two Cases of Retention of Urine" in *British Medical Journal* (1859), emphasis added

The depiction of patients as liars whose words could not be trusted in their own treatment was all too familiar in Victorian medical literature. Examples like the ones cited above from an instruction manual for taking medical case notes, *The Lancet*, and the *British Medical Journal* draw attention to the widespread perception of patients by the medical establishment as unreliable. They also serve as indicators of a more overarching change in the way that those experiencing disease and those treating it interacted in the nineteenth century. During much of the eighteenth century, patients actively participated in the treatment of their disorders, helping to define sickness based on the symptoms that they experienced rather than the causes of disease.

The introduction of clinical medicine near the end of this period, though, and its differentiation of signs objectively observed by a doctor versus symptoms reported by the patient initiated a shift in the dealings between practitioners and those they treated, which solidified

during the Victorian era. The perspective of the sufferer was given less and less weight in the production of medical knowledge as the nineteenth century progressed. This changing emphasis in the medical field evolved concomitantly with a growing focus on disease rather than the person suffering from it. As a result, two distinct articulations of sickness arose: the one provided by the sufferer and the one supplied by the doctor.[1]

"Diagnosing Narratives: Illness, the Case History, and Victorian Fiction" explores how the medical case study competes with patients' experiential accounts of disease in the development of popular nineteenth-century fictions. During most of the Victorian period, clinical medicine served as the primary producer of medical knowledge. At the same time, its objectification of the sufferer—epitomized by the case narrative, the most prevalent form of nineteenth-century medical writing—led to an increasingly distanced relationship between doctor and patient. I argue that the mid-century novel responds by featuring narrator-sufferers who co-opt aspects of the medical case in order to represent their own subjective experiences and rethink what constitutes medical knowledge. As the century came to a close, however, sciences of the laboratory, rather than the clinic, began to gain epistemological sway. In light of widespread skepticism regarding the possibility of translating discoveries made in the lab into effective bedside practices, I contend that popular novels and short stories now returned full circle to the clinical case approach as a valuable alternative to the laboratory. The result is late-century fiction structurally and thematically driven by the useful yet sometimes callous techniques of the diagnostician and his case method. I chart these shifts through an examination of works by Charles Dickens, Wilkie Collins, Mary Elizabeth Braddon, Robert Louis Stevenson, Bram Stoker, and Arthur Conan Doyle. My project illustrates the responses of these authors to prevailing power dynamics in the world of medicine and offers a new reading of the ways in which the Victorian preoccupation with disease shaped literary narrative.

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[1] For discussions of the move away from the eighteenth-century's patient-oriented medicine and the clinical objectification of the patient see especially Jewson and Foucault.

Instrumental to my consideration of the subjective and ontological components of sickness is a distinction between the concepts of "illness" and "disease" which originates in work currently being done in the fields of medicine, anthropology, and the medical humanities. Arthur Kleinman, a psychiatrist and anthropologist who deals with chronic illness, first differentiated between these two ideas. In *The Illness Narratives* Kleinman explains, "when I write the word *illness* in this book, I shall mean something fundamentally different from what I mean when I write *disease*. By invoking the term illness, I mean to conjure up the innately human experience of symptoms and suffering. Illness refers to *how the sick person*… perceive[s], live[s] with, and respond[s] to symptoms and disability" (3, my emphasis). Disease, on the other hand, "is what practitioners have been trained to see through the theoretical lenses of their particular form of practice…. The healer…interprets the health problem within a particular nomenclature and taxonomy, a disease nosology, that creates a new diagnostic entity, an 'it'—the disease" (5). Hence, "disease is reconfigured *only* as an alteration in biological structure or functioning" (5-6). In other words, disease is a biological disorder (identified by a diagnostician), whereas illness is the patient's distinctive experience of this disease. Illness's narrative qualities come to the fore here since, in essence, illness consists of the patient's personal story of her or his disease.[2]

I have found this distinction consistently useful in my conceptualization of the split that becomes so pronounced in the Victorian era between different ways of articulating sickness, but employing the illness / disease dichotomy also brings with it rhetorical limitations. Finding synonyms for "illness," which is a term employed throughout the field of Narrative Medicine to indicate the particularly sufferer-oriented aspects of sickness, has proved challenging. The most likely alternatives, such as "condition," "disorder," or even "ailment" or "malady," seem more

[2] Later writers, such as Hunt and Skultans, have continued to usefully employ this differentiation. More generally, I owe a debt to the wealth of recent work in the medical humanities related to the narrativity of the medical encounter. Without the valuable contributions of scholars like Trisha Greenhalgh, Brian Hurwitz, Cheryl Mattingly, Linda Garro, Rita Charon, and Martha Montello, I might never have considered investigating the narrative intersections between illness, the case history, and Victorian fiction.

closely allied with the alteration in biological functioning associated with disease than with the patient's experience of it. Even a term like "pain," though subjective in the sense that it is felt only by the sufferer, is nevertheless peculiarly tied to the somatic, and pain sometimes fails to describe aspects of disease-experience. "Dis-ease" captures some of the connotations of "illness," but, rhetorically, since the term "disease" is also important for my project, "dis-ease" risks sounding as repetitive as "illness" can become. Even a word like "malaise," which nicely alludes to the emotional aspects of living with disease, carries with it the unwonted connotation of an unimportant or diagnostically insignificant event. Anne Hunsacker Hawkins forges the term "pathography" from "pathology" and "biography" in *Reconstructing Illness*, but by this word she very specifically means published, book-length studies of illness by sufferers or their families. Difficulties notwithstanding, whenever possible, I have attempted to incorporate alternate phrases that capture the sense of "illness" as well. The most useful synonyms have been "experience of / encounter with disease," "patient's account," and "sufferer's narrative." In certain instances, "feeling unwell," "individual suffering," or "distinctive experience" have also served well as stand-ins.

Though the distinction between the terms "illness" and "disease" is a twentieth century one, the Victorians were deeply concerned with the lived experience of sickness. One prominent example of the Victorian preoccupation with illness rather than simply disease is Harriet Martineau's published meditation on her invalidism, *Life in the Sickroom*. In this much-read account, Martineau does not reflect on the condition she has so much as what it feels like to exist in such a state. For instance, Martineau frequently refers to pain, but she draws attention to her emotional experience of this phenomenon, not where the ache is located in her body. She elaborates on the despair and depression that usually accompany the advent of physical discomfort and the way that it feels new each time it returns, yet she adds that occasional severe pain sometimes provides relief from the often-interminable weariness of invalidism and a resultant renewed relish for life. Martineau also considers how aspects of her environment inflect

her experience, such as the kinds of sympathy that people offer her or the views available from her sickroom window.

Although Martineau's work is one of only a few book-length meditations on living with sickness, the personal experience of disease was a common topic of discussion within the Victorian population.[3] In his influential study on Victorian perceptions of health and sickness, Bruce Haley observes that "Their correspondence indicates that many prominent Victorians were, or thought they were, constantly afflicted" (12). Significant here are not just the widespread feelings of sickliness—which were pervasive with or without confirming diagnoses—but the fact that people were narrating these experiences. In chapters one and two, focused on Dickens's *Bleak House* and Collins's *The Moonstone*, I will explore how fictional representations of such narratives of illness helped to provide shape to the Victorian novel.

Both Athena Vrettos in *Somatic Fictions* and Peter Melville Logan in *Nerves and Narratives* address patients' accounts in the nineteenth century, but their focus is quite different from mine. In one section of her work, Vrettos argues that during the Victorian period, the body functions as a text to be read and that sickness thus becomes a language that reveals characteristics of the sick person. At the same time that the sick body is stepping in to speak where language has supposedly failed, though, Vrettos contends that there is an opposite impulse on the part of the sick to employ narrative to understand the sick body and reconstruct the self. Unlike my own discussions of illness, Vrettos's description of the function of the patient's narration is directly tied to her focus on a specific ailment. For Vrettos, narrative serves the patients she examines by concretizing the "corporeal uncertainty" (50) surrounding the question of whether a sufferer from neurotic disease is really sick. Logan is similarly engaged with the narrations of those with nervous disorders and the social critiques made evident through this

---

[3] Maria Frawley, in her excellent Broadview edition of *Life in the Sickroom*, includes excerpts from three other published works of "Sickroom Literature" (252), though she maintains that there were also a host of other accounts in the form of unpublished correspondence and diaries (27-8). The letters, prayers, and poems that she incorporates help to illustrate the Victorian interest in the *experience* of disease, distinct from its diagnosis.

fictional narration. His study focuses, though, on the hysterical body in the late Georgian period and its literature, only briefly looking forward to the Victorian period. While I do not dispute the special problems attending nervous disorders, my discussion of illness underscores its difference from disease rather than the significance of a particular disease in its development. In fact, while there is no question that Esther Summerson in *Bleak House* and Ezra Jennings in *The Moonstone* suffer from specific organic complaints, the particular ailments remain unnamed, shifting attention to their narratives of illness rather than the way that a specific disorder has colored that narrative.

While sufferer accounts emerged through published essays, within diary entries, and in letters between friends during the nineteenth century, the medical case was the primary means for documenting the disease component of this equation. At base, no matter what shape it takes, by “nineteenth-century medical case” I mean a diagnostic record of a single manifestation of a specific disease or injury. The method and audience of the case varied, though. Most cases made their way into writing at first through usually unpublished though often circulated case notes. These case notes consisted of the detailed documentation of information gleaned through questioning and physically examining the patient upon first encountering him or her, as well as initial diagnoses and treatments and the eventual outcome of these practices. Case notes were employed in hospitals most often by medical students serving as clerks and at the bedside by general practitioners.

Two other forms of the case were also prominent at this time, and due to their publication, they reached an even broader audience of medical professionals. These types of cases were the instructive examples that appeared within medical treatises and the lengthier histories found in professional periodicals such as *The Lancet* and the *British Medical Journal*. These published forms especially emphasize the case’s association with disease rather than illness. Though each recorded instance originates in an actual person’s unique experience and includes similar types of information to that outlined above, in both treatise and journal the narrative is there to facilitate understanding of a particular disorder, not a disordered person.

Case examples were usually somewhat briefer than their periodical counterparts, and they were generally arranged in groups with their overt purpose being the illustration of a larger principle related to the given condition under discussion.

Titles of cases appearing in venues like *The Lancet* or *The British Medical Journal* underscore the function of these narratives as charting a disease or injury's progress rather than a person's. Representative examples include: "Case of Diphtheria," "Report of a Case of Hypertrophy of the Kidneys in a Still-born Infant," and "Case of Fibroid Tumour of the Masseter Muscle."[4] In all of these instances, the title accurately directs the reader to the article's appropriately clinical focus: diphtheria, not the diphtheria sufferer, is paramount; revelations regarding kidney malfunction are the salient points in this infant's brief existence; and the fibroid tumour is more clearly associated with the part of the body in which it is housed than with the possessor of that body part. Death, when the end result of an ailment, is noted matter-of-factly in these types of records, and though it marks the halt of the sufferer's life, it is generally not the conclusion of the case history. Instead, these narratives close with "Remarks" (which sometimes include post-mortem exams) that enumerate what can be learned regarding the disorder in question from this particular manifestation.

While the case becomes particularly tied to clinical perceptions of the patient during the nineteenth century, the case study itself did not originate in this period. Indeed, Julia Epstein locates the origins of case writing as early as Hippocrates and the cases that he records in the *Epidemics*, and she notes that case literature of a sort existed throughout the Middle Ages and the Renaissance. In the seventeenth century, manuals about how to take patient histories began to appear in print (Epstein 35).[5] By the second half of the eighteenth century, the medical case was

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[4] These are actual case titles taken from reports written by Bryan in the *British Medical Journal*, and Oldfield and King in *The Lancet*, respectively.

[5] Epstein does note that there is a change in focus between these earliest cases and the nineteenth-century incarnation of the form. She explains that "In Hippocratic case-writing, diseases were understood to be symptom complexes and interactions between environment, individual, and situation…. By the nineteenth century, physicians gave a higher privilege to specificity and sought pathogenic agents" (29).

the most prevalent means for conveying medical knowledge.[6] As Susan Lawrence explains, the purpose of these eighteenth century cases, which began to appear more frequently in forums like the *Philosophical Transactions* (the official publication of the Royal Society) and then books and journals associated with specific medical societies or groups, was, at least in part, to create "new, *useful* information" (251). This focus on producing knowledge presages the nineteenth-century case's emphasis on building the store of facts regarding particular diseases or injuries.[7]

Although the case history may have been the most widely published type of medical writing in the second half of the eighteenth century, it was not until the periodical boom of the 1800s that the written case narrative became truly widespread. As work like Lawrence's demonstrates, medical periodicals certainly existed prior to the Victorian period. However, the nineteenth century witnessed the flourishing of an unprecedented number of such journals. *The Lancet* and the *British Medical Journal*, both of which still serve as key publications in the world of medicine, were launched during this time as were a host of other medical magazines aimed at both professional and non-professional audiences.[8] Though many of these serials did not enjoy runs as long-standing as behemoths like *The Lancet* or the *BMJ*, William Bynum and Janice Wilson make the staggering estimate that "479 medical periodicals [were] established in nineteenth-century Britain, an average of one about every twenty-seven days" (30). Case literature continued to make up a large part of these publications; the increase in periodical

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[6] In her survey of medical periodicals from 1757 to 1814, Lawrence estimates that "At least 45 percent of all articles … were centered on case reports" (276, n. 49).

[7] Though part of Kennedy's project is to illustrate that the "curious" carries over into the more clinical nineteenth-century case, she does distinguish eighteenth-century cases as being more overtly focused on "the physiologically singular … the psychologically strange … the rare … [and] the exotic" than their nineteenth-century successors (*Curious* 75). Lawrence nods to this dynamic in the eighteenth-century case when she explains that "To be of interest … [these earlier] case histories had to contribute observations beyond the usual routines of unproblematic practice" (295).

[8] *The Lancet* was founded in 1823, and the *British Medical Journal* (which now goes simply by *BMJ*) was established under the title *Provincial Medical and Surgical Journal* in 1840. After two more title changes, it adopted the name *British Medical Journal* in 1857. For more details see Porter's *Bodies Politic: Disease, Death, and Doctors in Britain, 1650-1900* and Bartrip's *Mirror of Medicine: A History of the British Medical Journal*.

venues thus meant that more and more doctors were circulating accounts of their encounters with particular diseases—and more and more readers were coming in contact with this information.[9]

The medical case was more widely disseminated during the nineteenth century than it had ever been before, but the importance of this form for this time goes beyond its prevalence on the page. As Foucault suggests in *The Birth of the Clinic*, classificatory eighteenth-century medicine conceptualized diseases in terms of ideal types, and, thus, specific cases were merely examples of an already comprehended disease process playing itself out. Part of what differentiates clinical medicine from the classificatory model that preceded it, though, is clinical medicine's ability to focus on individuals and particular instances of disease. Ironically, instead of leading to a fuller understanding of the subjective personhood of whoever is being attacked by disease, this medical recognition of the individual makes him or her available to the probing clinical gaze and subsequently greater objectification. This same irony exists at the heart of the nineteenth-century medical case which gives value to individual experience *by* subsuming it under the explanatory rubric of a specific disease-type, such as diphtheria, kidney malformation, or tumour. The Victorian case narrative was thus no longer simply a means for recording examples of different disease-manifestations; it was now a way of conceptualizing the sick person.[10]

This shift helps to make clear why Victorian writers would choose this moment to meditate on the case form; and, indeed, my contention is that the Victorian preoccupation with illness coupled with this change in thinking about patients impacted the development of the characters, narrators, and plots within the popular nineteenth-century fictions that I examine. I do

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[9] For more information on the explosion of medical periodicals during the nineteenth century, see Peterson's "Specialist Journals and Professional Rivalries in Victorian Medicine" and Bynum, Lock, and Porter's collection *Medical Journals and Medical Knowledge*.

[10] Foucault marks this shift by focusing on the clinical gaze and the way in which medical perception literally changed with the introduction of the clinic. While I am indebted to Foucault's work in this field, my emphasis is not on spectatorship so much as the separation of patient and doctor narratives that attended this change. Indeed, embodiment and questions of vision are sometimes implicit when I talk about a narrator describing an event from the outside or the inside, but I have attempted to place my primary emphasis on how this position affects the way that a speaker *talks about* sickness.

not mean to suggest that each of the literary works included here is overtly structured around or by a particular case study. On the contrary, while many of these authors allude to actual case histories, they also put pressure on the figurative resonances of the word "case" in the ways they choose to organize their works and challenge the traditional confines of the genre. In addition, the presence of narratives of illness alongside this clinically maturing form often impacts what is retained from the case and what is discarded. The concept of the case provides a container, in other words, that often gives shape to what is included within the narrative discourses of these literary works, yet this container is one that can be unpacked at will, yielding up various connotations useful for different authors.

In *Bleak House*, for instance, Dickens structures Esther's narrative on the case model in the sense that her account supplies an individual example that falls away from the more normative and over-arching third-person narrative, but he diverges from this form when he makes the focus of Esther's account her subjectivity rather than her objectification. As a result, illness, rather than disease, comes to the foreground and helps to shape the novel's dual narration, which moves back and forth between an exterior narrator and the interior, first-person ruminations of Esther. Later authors like Conan Doyle return to the clinical case model and uphold its merits in contrast to the new, even more suspicion-inducing laboratory sciences and their growing prestige. The Sherlock Holmes stories thus illustrate the benefits of a distanced perspective nevertheless still focused on a patient. As such, they more overtly follow the pattern of the type of case history that concludes with post-mortem exam, an objectifying model indeed, but one which provides closure through certainty and resulting knowledge to serve in the treatment of future cases.

Several other recent critical works also investigate the intersections between the medical case and nineteenth-century British literature, but I diverge from these studies in both my inclusion of illness as a competing influence within Victorian fiction and in my characterization of the nineteenth-century medical case. Margaret Kennedy's as-yet-unpublished dissertation, *A Curious Literature: Reading the Medical Case History From the Royal Society to Freud* and

Janis Mclarren Caldwell's and Jason Tougaw's books, *Literature and Medicine in Nineteenth-Century Britain* and *Strange Cases: The Medical Case History and the British Novel*, all share similar emphases with my project. A pointed difference between these examinations and mine, though, is that while they do explore the impact of the case on nineteenth-century literature, they are all torn between illustrating this influence and demonstrating the literary or artistic nature of the medical case itself.[11]

While I agree that the narrative method of reporting the case can impart story-like qualities to these accounts, I am more interested in how the conventions and social conditions that led to the predominance of the case method within the nineteenth century shaped the narrative structure of a host of popular Victorian fictions than I am with demonstrating the literary qualities of medical writing.[12] Moreover, the desire evident in works like Tougaw's and Caldwell's to uncover the artistic or subjective in the medical case report, which often translates into pulling out traces of the patient and his or her personal story, risks eliding the mediation inherent within the case history's narration. Even when aspects of the sufferer's experience are explicitly included within this narrative, they are always colored by the medical practitioner's organization and presentation of the medical record; this structure is driven by the doctor's attempt to illustrate findings about specific diseases or injuries themselves or new medical

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[11] This latter project is in fact Kennedy's focus in her dissertation, which is mostly a study of the history of the case from the eighteenth century through Freud, with brief sections on convergences between the cases of different eras and literary works from these times. Several later articles which she has published attend more explicitly to actual works of literature, though the dual concentration that I highlight above is still present.

[12] Freud, and his absence from my project, bears mentioning here. Examinations of Freud's cases indeed conclude both Tougaw and Kennedy's works on the medical case, but this stems more from their emphasis on the literariness of the case than from Freud's connection to the nineteenth-century clinical case upon which I am focusing. In the service of demonstrating the case's more story-like qualities, in other words, Freud's elaborate, character-driven narratives provide the obvious culminating examples. For a study like mine, though, which concentrates on the nineteenth-century clinical case's organization around disease type and the impact of this structure on Victorian fiction, Freud's later innovations prove less pertinent.

practices related to these physical conditions. The patient's personal experiences, when present in the clinical case, thus emerge in service of this project. In addition, as my initial examples demonstrate, the medical impulse was often to see the information provided by the patient as running counter to the practitioner's efforts. Hence, the separation of particulars supplied by the patient from the doctor's language was not necessarily an acknowledgement of the patient's valid experiences so much as a qualification intended to distinguish these potentially untrustworthy details from the practitioner's assessments.

Part of what motivates the attempt to draw out the more personal side of the case stems from the fact that novels of the nineteenth-century, while increasingly incorporating what might be described as diagnostic viewpoints, are also, of course, invested in representing subjective human experience. The impulse to maintain the influence of medical thinking while accounting for this element of fiction leads, I would contend, to an emphasis on what Caldwell sees as Romantic and Tougaw characterizes as sympathetic components of case histories. I certainly concur that nineteenth-century literary representation encompasses more than just the objectifying perspective associated with the clinical gaze. What distinguishes my study, though, from previous investigations of the case is that I wish to draw attention to Victorian familiarity with actual experiences of illness, rather than simply the mediated patient history included in the medical case, as a source of influence.

A concentration on the first half of the nineteenth century, whether explicitly stated or not, also characterizes Tougaw and Caldwell's works. Although Tougaw states that he will "examine the mutual influence of the medical case history and the British novel during the nineteenth century" (1), he moves between both eighteenth- and nineteenth-century cases and novels. This leads Tougaw to conflate the medical reporting of the more patient-oriented eighteenth-century with the clinical case history of the nineteenth century.[13] As a result, we

[13] His emphasis on the doctor's concern for his patient as well as Enlightenment empiricism as the source for case-reporting indicates that *Strange Cases* is actually more about the pre-clinical case's impact on literature than the clinical case's influence. The coverage of his study supports this reading as he treats no Victorian works until his fourth chapter when he quickly addresses *The Moonstone* (1868), *In*

radically diverge in our understanding of this medical narrative's function during the Victorian period.[14] Since we differ in our assessment of the clinical case, I find it difficult to endorse his overarching argument regarding the impact of this medical writing on the nineteenth-century novel. Based on what he sees as the case's demonstration of "empirical acumen, on the one hand, and … humane sympathy … on the other," he asserts "that the influence of the case history on the novel is precisely the ability to give readers the experience of mixing categories of thought and feeling that the nineteenth-century zeal for classification had made to appear incongruous" (2). Victorian fiction often mingles objectifying exterior perspectives with the representation of sympathetic subjects, to be sure, but I propose that this is precisely why we must consider the impact of illness narratives in conjunction with the medical case on the shape of Victorian fiction. Caldwell more overtly pursues a project that covers what she terms the pre-Darwinian period (i.e., 1800 to 1859). While the only chapter that explicitly examines the case report is one about Elliot's *Middlemarch* published in 1871, Caldwell examines the period represented within the novel (the 1830s) rather than the period of its writing. As a result, she looks to case histories from this earlier time, which, I would argue, are still transitioning into their clinically mature form and still bear traces of the more patient-centered medicine of the preceding century.

Beyond attending to the relationship between the less-examined cases and literary productions of the mid- and later-nineteenth century, my project also seeks to fill a generic gap

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a Glass Darkly (1872), *The Strange Case of Dr. Jekyll and Mr. Hyde* (1886), and "Good Lady Ducayne" (1896). For a fuller discussion of how he does (and does not) engage the case when dealing with these works, see my note 15 within this introduction and note 24 in chapter three.

[14] Tougaw depicts the "strange cases" that cannot be solved or cured with the period's medical knowledge as typical of the genre, and he characterizes the medical case as caught between diagnosis and sympathy. While strange cases did still appear well into the 1800s, I disagree that this type of narrative represents the lion's share of such articles appearing in Victorian medical periodicals. Moreover, while we, as readers today, may feel sympathy for the patients represented within these cases, it seems naïve to characterize one of the case study's overt narrative features as an attempt to elicit said sympathy. On the contrary, I would contend that when attempts to garner sympathy are made, at least in the clinical, nineteenth-century case, these attempts are directed at the doctor who heroically battles against lying patients and the progress of disease.

left by studies that have primarily considered the influence of clinical medicine on realist literature. Though he does not target the case history in particular, Lawrence Rothfield's *Vital Signs* initiated a critical trend which ties the rise of clinical medicine in the nineteenth century to the development of literary realism during this same period. More recent work by Meegan Kennedy has elaborated on Rothfield's claims with a more specific focus on the case study as the source of a "clinical realist methodology" based in careful observation and employed by many Victorian writers ("Diagnosis" par. 9).[15] Though realism certainly flourished in the mid-nineteenth century at the same time as the medical case, the Victorian period was also an era in which a host of more popular genres began to emerge. With the exception of a first chapter on *Bleak House*, my dissertation focuses on the case history in relation to texts that fall into these more popular categories, such as sensation fiction, the fantastic or gothic fiction, and detective fiction. And, indeed, even though Dickens's novels might be characterized as examples of social realism, one of the aims of Chapter One is to illustrate how Esther's narrative of illness works in conjunction with the case form to introduce a less clinical strain of realism.

Rothfield and Kennedy present the co-opting of clinical discourse by literary authors of realism as an attempt on the part of those authors to reinforce their own authority by aligning it with this already established discourse. More often than not, the popular authors in my study did not bolster their credentials by adopting ways of thinking about people and disease already prevalent in clinical medicine, but, instead, by questioning or supplementing these epistemologies, thus showing themselves to be even keener diagnosticians than those charged with that duty. For instance, in *The Moonstone*, Collins rethinks the conventional organization of

[15] Tougaw also grounds his study in the convergence between "the twin epistemic agendas of medical empiricism and literary realism" (21). Though, as my earlier note indicates, Tougaw does address works of sensation and gothic fiction in his fourth chapter, his claims regarding the genre focus on the parallel between the sensational texts' ability to create altered states and Victorian medical debates regarding the generation of altered states through pharmaceuticals or mesmerism, rather than on the parallels between these fictional works and the case form.

the case by positioning his sickly practitioner's narrative of illness side-by-side with his medical case notes on a patient with a completely different disorder, in the process emphasizing what can be gained through documenting shared experiences of suffering rather than shared disease-types. Likewise, Mary Elizabeth Braddon defends her position as a popular writer by sensationalizing clinical medicine and its discourses in *Birds of Prey* and *Charlotte's Inheritance*, not by mimicking them.

To demonstrate the fictional progression from mid-century novels that adopt aspects of the case in order to represent illness to *fin de siècle* works that emphasize the benefits to be gained from practicing clinical recording, I have organized my dissertation chronologically. I begin by examining *Bleak House* (1853), the only arguably realist novel covered in my project. In "The 'Strange Afflictions' at the Heart of *Bleak House*: Esther's Illness versus the Representation of Disease," I counter readings of the novel that wish to exclusively associate Dickens's skill as a narrator with his clinical eye by showing that Dickens's desire to acknowledge both patient-oriented and clinical means of expression impacts his portrayal of the protagonist Esther Summerson and his structural choices. I argue that Dickens presents Esther's narrative contributions as a case example distinct from the more overarching, and exterior, third-person narrative, yet he alters generic conventions by relating Esther's case in her own voice and highlighting her distinctive subjectivity.

Moreover, I suggest that Esther's narration, and indeed the entire novel's recounting, is driven by and mirrors this character's central bout with infection. Her alternation between looking in on disease from the outside and ruminating on the experience from her unique stance once she is afflicted underscores the reshaping of self consequent on a sufferer's encounter with disease. The retrospective nature of her narration means that it is from this revised perspective that she recounts her portion of the novel. This literally central moment in the text in turn provides a model for the novel at large, which moves back and forth between a more diagnostic third-person narrator and Esther's first-person accounts. In contrast to the wealth of criticism on realism that wishes to ally this literary movement with the deployment of minute visual detail, I

propose that Dickens's emphasis on illness rather than simply disease results in a more introspective method of realistic representation than is usually acknowledged.

My second chapter, "'But for His Illness': The Narrative Necessity of Individual Suffering," turns to a work of sensation fiction: Wilkie Collins's *The Moonstone* (1868). My examination of illness within this chapter functions on two levels. First, borrowing from the terminology of narrative theorist Peter Brooks, I suggest that critically unrecognized instances of illness within *The Moonstone* in fact serve as narrative "motors" key to creating plot progression. Next, by concentrating on the sickly doctor's assistant Ezra Jennings, I draw attention to the ways in which sufferers retrospectively construct meaning in their stories of illness (just as Brooks suggests that we do when we read literary narratives) and illness's consequent revisability. Jennings's solitary experience of his malady (he is almost universally shunned due to an unnamed accusation against him and his mixed-race background) shapes his individual suffering. Hence, unlike Esther Summerson who struggles to make sense of the reshaping of identity resultant from her encounter with being unwell, Jennings chooses to rework his self-image and rewrite his illness. Jennings performs this revision of self and illness narrative in part by positioning his subjective ruminations side-by-side with his case notes on another sick character. Their physical complaints are quite different, yet Jennings unifies the two based on shared suffering rather than shared disease-type and consequently rethinks the organizational principles underlying the usually disease-oriented medical case.

Chapter Three, "Cases Poisonous and Preventative: From Braddon to Stevenson," maps the shift in public sentiments toward the clinic and the case narrative. Closer to mid-century, while clinical medicine still held sway over the explanation of disease and its processes, Mary Elizabeth Braddon employed her novels *Birds of Prey* (1867) and *Charlotte's Inheritance* (1868) to lodge an indictment against the potential misuse by medical practitioners of information gleaned from their professional libraries. In her depiction of the calculating Philip Sheldon, a surgeon-dentist who employs *The Lancet* to perpetrate two separate poisonings, she sensationalizes the detached objectivity of the nineteenth-century practitioner, questions the

ready availability of potentially dangerous information to any doctor with a subscription to this medical magazine, and overturns the paradigm of lying patient / truthful doctor reinforced within this clinical literature.

As the nineteenth century drew to a close, though, the newer sciences of the lab began to divest the clinic of its sole authority to account for the workings of disease. This shift in the creation of medical knowledge was accompanied by pervasive doubt among the British populace regarding the likelihood of converting laboratory discoveries into practical therapeutics. In response to this attitude, authors like Robert Louis Stevenson in *The Strange Case of Dr. Jekyll and Mr. Hyde* (1886) now return full circle to the clinical case method as a valuable alternative to laboratory sciences—while simultaneously broadening the application of its diagnostic protocols to the realm of the supernatural. In his novella, Stevenson presents the hypochondriac, Dr. Henry Jekyll, whose professional training in the lab allows him to pharmacologically transform amorphous misgivings about the natural divide within himself between good and bad into a physicalized evil. I argue that Edward Hyde is not simply malevolent, though, but an allegorical representation of disease; as a result, his creation dramatizes Victorian fears about the potentially poisonous laboratory. In the end, the tool most suited to stem the flow of contamination loosed by Jekyll's formulation of Hyde, is Jekyll's "full statement of the case." Within this case narrative, Jekyll finally proves himself a responsible practitioner by carefully analyzing his missteps for the benefit of future generations.

Ironically, *The Strange Case of Dr. Jekyll and Mr. Hyde* humanizes the doctor by showing him, like his patients, to be susceptible to harm. My final chapter, "'Your Casebook Was Ever More Full Than the Rest': Medical Reporting as Antidote in *Dracula* and the Sherlock Holmes Tales," continues to investigate the link between practitioner vulnerability and the promotion of the case method. Together, these works illustrate the merits of accruing case information: Holmes is repeatedly able to solve cases based on previously documented records, and the amassing of case notes on Dracula's earlier victims, Renfield and Lucy, facilitates the eradication of the vampire and subsequent return to health of his final victim, Mina. At the same

time, the susceptibility to error on the part of Sherlock, Dr. Seward, and Dr. Van Helsing demonstrates case documentation's role as a defense against inevitable medical fallibility.

Unlike earlier, when Dickens and Collins drew out the case's figurative valences in the service of representing illness, in Stoker's and Conan Doyle's works, this diagnostic genre supplies a more overt structuring influence. I contend that *Dracula* (1897) employs the multivocal notes of the medical casebook as a model and that the Sherlock Holmes stories follow the pattern of the type of published case history that ends with post-mortem exam.[16] The medical casebook's incorporation of multiple perspectives in the service of making an initially unintelligible phenomenon intelligible parallels *Dracula*'s journalistic drive toward understanding and eliminating the contaminating vampire's presence. Identifying the echoes of the case narrative that ends with autopsy within Conan Doyle's stories underscores the ways in which the satisfying Holmesian summation draws on the same techniques of objectification and emotional distance often demonized in this clinical writing. In both instances, these literary works build toward resolution by filling the gap left by absent illness narratives.

[16] I focus on Holmes stories published throughout the 1890s.

CHAPTER ONE

THE "STRANGE AFFLICTIONS" AT THE HEART OF *BLEAK HOUSE*: ESTHER'S ILLNESS VERSUS THE REPRESENTATION OF DISEASE

In 1973, Alex Zwerdling published the now oft-cited "Esther Summerson Rehabilitated," an article which attempted to counter what had been, until then, the common reading of *Bleak House's* Esther as a "monstrous failure" or "too often weak and twaddling" (qtd. in Briganti 205, qtd. in Collins 126).[1] The title of Zwerdling's article invokes two interrelated recuperations. At base, Zwerdling wanted to save Esther (and Dickens) from the dismissal to which she had been subjected by so many readers who characterized Dickens's depiction of her as flawed. Zwerdling's method of doing so involved another story of recovery, though, since he argued that Esther needed to be afforded a little critical slack because of the childhood trauma that she experienced in the home of her verbally-abusive godmother. Esther's value for Zwerdling thus rested in her role as an object of Dickens's diagnostic skill. He maintains:

> We are asked to look very much *at* Esther rather than *through* her, to observe her actions, her fantasies, even her verbal mannerisms with great attention. For Dickens' attitude toward her is essentially clinical, and the major aim of her portion of the narrative is to study in detail the short- and long-range effect of a certain kind of adult violence on the mind of a child. (429)

While this reclamation of Esther's value provides an intriguing explanation for her coyness and a welcome recognition of the consistency of her character when viewed in the light of trauma, I find that it falls short in telling the full story of Esther's role in *Bleak House* and in recognizing the complexity of Dickens's engagement with the medical. Even in the midst of its recuperative potential, in other words, examining Esther's narrative as nothing more than a study of this early

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[1] These contemporary assessments come from George Henry Lewes and Charlotte Brontë, respectively. Most criticism leading up to Zwerdling's contribution similarly viewed Esther's character and her portion of the narrative.

back story's aftershocks directs the reader exclusively to what is wrong with Esther, not what is productive about her narration.[2]

I too see Dickens's treatment of Esther as, in part, clinical, but I contend that he balances this external diagnostic framework with an attention to Esther's unique interiority. Zwerdling's conception of Dickens's clinical attitude is grounded in the assumption that Dickens presents Esther's separate narrative simply as an object of dissection à la Foucault and his notion of the medical gaze. I, however, propose that Dickens's presentation of an individual narrative distinct from the more over-arching third-person account echoes a very specific clinical genre—the medical case history—while his reliance on Esther's voice to relate these events, rather than the third-person narrator's, simultaneously places value on her *subjective* detailing of her experiences.

Moreover, I maintain that an encounter with sickness literally and figuratively central to *Bleak House*, rather than something that happened to Esther years before she took up the pen, is the originary trauma at the heart of this case study. I am referring to Esther's bout with and narration of first the disease that she sees the street-sweeper Jo and her maid Charley succumbing to and then her experience of illness once she contracts this infection herself. This episode, with its repeated alterations between sufferer and caregiver, is emblematic of Dickens's desire throughout *Bleak House* to acknowledge both doctor-oriented and patient-centered perspectives. Dickens's recognition of both of these outlooks is reflected in not only the content of his novel, but in its structure as well. As I suggest above, this structural influence appears in the shape of Esther's account, which both corresponds to the medical case narrative and alters its

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[2] Since Zwerdling's famous defense of Esther, a host of critics have participated in the project of recuperating Esther. The essential "trouble" with Esther seems to be the fact that she is both perceptive and active, on the one hand, while remaining coy and self-deprecating, on the other. As such, these studies have taken various tacks, ranging from those who focus on Esther's ability to act quickly and decisively even in the face of her apparent confusion (see Wilt, Pelatson, and Dever) to those who examine her evasiveness and the ways that it either creates the possibility for feminist agency or registers patriarchal oppression (see Michie, Budd, Graver, and Newsom). My reading attempts to make sense of this apparent paradox in Esther's character by examining the shaping influence of Esther's encounter with illness.

generic conventions; more broadly, it also informs the division of the novel into dual narratives, which parallel the movement between an exterior, diagnostic viewpoint and an interior, patient-based reflection.

Dickens never names the ailment from which Jo and then Esther suffer, directing our attention, I argue, toward illness, yet most medically-oriented *Bleak House* criticism focuses on disease to the exclusion of the more sufferer-oriented phenomenon. Contentions range from maintaining that these characters had smallpox (the more popular assertion) to suggesting that they in fact had contracted an infectious inflammation of the skin called erysipelas. The general trajectory of these arguments accordingly begins with a hypothesis about which disease had attacked these characters and ends with an extrapolation outward from this particular diagnosis that designates its larger social meaning.[3] These studies have provided useful examinations of Dickens's social commentaries regarding issues as diverse as class relations and sanitation reform, yet in the same vein as Zwerdling, their emphases on the social and symbolic meaning of disease often divorces their discussions from what can be gained by investigating the experiences of individual sufferers.

I am not suggesting that Dickens is ignoring disease in *Bleak House*. On the contrary, one of the notions that his novel undeniably illustrates is the potential danger and contagiousness of corporeal complaints. However, while Dickens highlights this type of communicability, he is also reflecting on the communicability of illness—or, perhaps more accurately, the difficulty in communicating illness, as opposed to its exclusively somatic counterpart. Dickens's elaborations on Esther's narrative of being unwell attempt, in other words, to counter the evident and

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[3] See, for instance, F.S. Scwarzbach, "The Fever of *Bleak House*"; Michael S. Gurney, "Disease as Device: The Role of Smallpox in *Bleak House*"; Gilian West, "*Bleak House*: Esther's Illness" (West's piece introduces the diagnosis of erysipelas); Mary Burgan "Contagion and Culture: A View from Victorian Studies"; and Natalie Bell Cole, "'Attached to life again': the 'Queer Beauty' of Convalescence in *Bleak House*." Other studies that do not diagnose a particular disease, but which deal with physical disease and its social meaning include F.S. Schwarzbach, "*Bleak House*: The Urban Pathology of Social Life"; Graham Benton, "'And Dying Thus Around Us Every Day': Pathology, Ontology, and the Discourse of the Diseased Body. A Study of Illness and Contagion in *Bleak House*"; and Laura Fasick, "Dickens and the Diseased Body in *Bleak House*."

unstoppable communicability of disease by making the sufferer's personal story of this complaint more communicable too.

Bleak House is medically-inflected to an extraordinary degree. In addition to Esther's battle with the infection that she contracts from Jo via her maid, Charley, ailments abound in this novel. Richard Carstone becomes infected, seemingly via Chancery, and subsequently dies; the Chancery-addicted Miss Flite is irreversibly mad; Gridley, the man from Shropshire who also has a suit in Chancery, dies of a sickness perhaps inspired by that court; the junk dealer Krook is an alcoholic who spontaneously combusts; the law-writer Nemo self-medicates with opium purchased from Allan Woodcourt until he overdoses; after giving birth, Caddy Jellyby sickens, and her baby never fully recovers; the child of the brick-maker's wife Jenny dies of some unnamed ailment; the death of Charley's father due to what seems to have started as a head cold orphans the young girl and eventually leads to her becoming Esther's maid; and, indeed, the only thing that saves Ada Clare from being exposed to Jo's contagious complaint is that she is up in her room with a cold on the night that Esther and Charley bring him home. This is in addition to the multiple references by the third-person narrator to a more generalized pestilence and infectiousness of the environment of London.

The plentitude of diseases suffered in *Bleak House* would have been unsurprising to a Victorian readership obsessed with their own health and sickness and unnervingly familiar with the sickroom. Dickens himself suffered from a variety of ailments even though he remained quite active, and he lost a well-loved sister-in-law and, later, a daughter to unnamed ailments. Dickens's interest in medicine and medical discourses of the period manifested itself in his personal acquaintance with a range of doctors and a liberally stocked library. Besides his well-documented friendship with the doctor John Elliotson, Dickens was in contact with the doctors Sir Charles Bell, Thomas Southwood Smith, and John Conolly.[4] The author also worked with a Dr. Ernest Hart on improving workhouse infirmaries, and Dickens had several inscribed copies

[4] For details, see David Waldron Smithers and John Gordon.

of works by other surgeons and physicians in his library.[5] These signed copies were in addition to the other medical works found in Dickens's collection, including treatises by the doctors mentioned above as well as a medical dictionary and a dictionary of practical surgery. Interestingly, Dickens himself was even cited in medical works of his time. His description of Smike's "hectic fever" in *Nicholas Nickleby* (1838-9) was reprinted word for word in both Aitken's *Science and Practice of Medicine* and Miller's *Principle's of Surgery*.[6]

One of the realizations that Dickens's acquaintance with all of this medical information would have made clear to him was the sad fact that many disorders during this time were not easily cured—the effortless movement of infection from Jo to Charley to Esther, coupled with the terminal nature of most of the ailments detailed in the novel, suggests that this is certainly the case with disease in *Bleak House*. And indeed, though the doctors in the novel are often presented as *good*, they are also presented as ineffectual in the face of disease. For instance, the unnamed practitioner who treats Esther and Charley is unable to stop the spread of their ailment. Moreover, though Allan Woodcourt is an ideal doctor in terms of bedside manner and quick thinking, and he ably treats the *injuries* of an entire shipwrecked crew and the domestically-abused Jenny, he is unable to alleviate Miss Flite's mental instability, prevent Nemo from becoming dependent on the opium that he prescribes for him, or save Jo.

In the face of this ineffectuality, it is easy to see why Dickens would have promoted the narration and communication of illness.[7] In light of the fact that curing disease was not always possible in either the fictional world of *Bleak House* or the real world of Victorian England,

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[5] For information on what was included in Dickens's library, see J. H. Stonehouse.

[6] See Smithers, p.6.

[7] In addition, though Dickens was familiar with Victorian medicine and has been described as having a clinical eye by various scholars in addition to Zwerdling (see, for instance, Strachan, Burgan, and Schwarzbach ["Bleak House: The Social Pathology of Urban Life"]), his interests in less orthodox methods of treatment, such as mesmerism, suggest a dissatisfaction with the efficacy of traditional medicine and another possible reason for his interest in illness as opposed to just disease.

understanding the experience of illness would have provided an alternative avenue into easing, if not eliminating, suffering. Encouraging the narration of illness would have also been an advance toward rectifying another potential downfall of the increasingly clinical medicine of this period, namely, the diagnostic localization of patients under the rubric of a disease-type to the exclusion of their individual characteristics and voice. Since the *experience* of disease (i.e., the sufferer's illness) often leads to a reshaping of identity, this recuperation of the patient's voice serves another purpose as well: to increase awareness not just of the symptoms and progression of particular disorders, but rather of the unexpected and disconcerting nature of the self-examination and ensuing self-revision that illness itself enacts.

Allowing illness an equal amount of room as disease also impacts *Bleak House*'s realist narration. The project of realism is of course to faithfully represent human experience—the actual problems of human life, in other words—as opposed to romantic flights of fancy. Much realist criticism, though, only addresses one facet of this represented experience—that which can be conveyed through minute description, and thus, through a reliance on the visual. While I agree that Dickens does utilize this type of observational description in relaying some situations, what I suggest is that he also realistically represents another type of human experience—and another actual problem of life, particularly for the Victorians—through the character of Esther. This type of experience is tied to illness and interiority, and it cannot be conveyed through the strictly visual, or, sometimes, even nailed down through a (clinical) use of language. This representation focuses on the sufferer's unique subjectivity, yet it is equally true to human experience, and thus, equally realistic.[8]

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[8] The type of realistic representation that I am suggesting Dickens employs through the character of Esther should not be confused with the modernist representation of consciousness. For further discussion of this distinction see note 37, p. 50.

"the testimony on which human occurrences are usually received": Dickens and the Case

Though Dickens did not of course have access to the terminology of illness and disease employed by medical anthropologists today, what he did have access to were the discourses commonly associated with the distinct realms of disease and illness: namely, the case narrative, on the one hand, and the patient narrative, on the other. Dickens would have been familiar with the case form from clinical treatises in his own library like Elliotson's *Human Physiology* (1840)[9], and articles in Dickens's journal *Household Words* were peppered with miniature versions of the medical case. One of these cases even found its way into another prominent medical work of the day, W.B. Carpenter's *Mental Physiology*.[10] Introducing and manipulating the concept of the case afforded Dickens an avenue into a discussion of the distinctions between a more exterior, doctor-oriented focus on the somatic and a more interior, patient-oriented focus on individual suffering.

The medical case history provided Dickens with a form to both draw on and work against in his structuring of *Bleak House*. On the one hand, Dickens relies on the medical authority of the individual, illustrative case study to build his own ethos as the author of a realistic text.[11] As such, he sets up Esther's narrative as a case example in juxtaposition to the more far-ranging and

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[9] Though Elliotson's use of mesmerism (and in particular two mediums who later proved to be frauds) eventually led to his being forced to resign his professorship at University College Hospital, previous to this incident he was a renowned and well-respected physician who introduced the use of Laennec's stethoscope to British practice.

[10] The case example came from the unfortunately titled "Idiots Again," an article dealing with idiocy as a result of intermarriage that appeared in *Household Words* in 1853.

[11] In "Bodies, Details, and the Humanitarian Narrative," historian Thomas Laqueur identifies the emergence of what he terms "humanitarian narratives" during the eighteenth and nineteenth centuries. Such narratives are detailed reports of individual suffering which incite some kind of action, and they include "the realist novel, the autopsy, the clinical report, and the social inquiry" (177). I propose that Dickens's use of the case to build his ethos as a realistic writer participated, at least in part, in this larger cultural trend which made wrongs more real through concrete illustration.

inclusive narrative that also constitutes the novel. On the other hand, in constructing Esther's narrative, he alters the generic conventions of the case history in order to highlight the importance of *personal* experience—as opposed to the *observed* experience that characterizes the typical medical case narrative. This challenge ultimately leads to an emphasis on illness rather than disease in Esther's portion of the novel, and, subsequently, an illustration of realism's less clinical possibilities.

Within his very short preface to *Bleak House*, Dickens chooses to comment on only two things: examples of Chancery lawsuits that substantiate his claims about the court and actual cases of spontaneous combustion that demonstrate the possibility of this phenomenon. If Dickens wished to provide support for the possibility of spontaneous combustion—and we know that he did after being attacked by George Henry Lewes for including a case of spontaneous combustion in the middle of *Bleak House*—Dickens could have elaborated in his preface on the scientific principles behind this phenomenon. Instead of including this elaboration, though, he chooses to focus on individual cases to support this larger principle. He explains to the reader that "before I wrote that description [of spontaneous combustion] I took pains to investigate the subject. There are about thirty cases on record" (6), and he then goes on to detail two of them. Though she does not mention Dickens in particular, Margaret Kennedy notes in her work on the case history as a genre that "although it lacks the authority of logic or the force of numbers, the 'case' strengthens an argument through its narrative appeal" (*Curious* 5). The evidence of this narrative appeal had become obvious by the nineteenth century since the case study had become by that time the most common form of medical writing. Dickens's belief in the persuasiveness of the case as a form is driven home by his final description of case narratives in the preface to *Bleak House*. In defense of his reliance on these recorded examples to demonstrate the possibility of spontaneous combustion (rather than the corroborative "opinions of … distinguished medical professors" that he could have but did not incorporate), he heralds such reports as nothing less than "the testimony on which human occurrences are usually received" (7). According to Dickens, specific cases are necessary to lend credence; they are the very criteria by which people qualify

something as real rather than hypothetical. This, I would argue, is at least part of the reason why Dickens includes Esther's "case" alongside the third-person narrative.

In order to see how Dickens sets up Esther's narrative as a case, let us begin by looking at the earlier understandings of the word. According to James Chandler in his examination of the meaning and use of the concept of the "case" in the Romantic period, implicit in the word is the root sense of "'befallings,' configurations of circumstances identified as such in relation to some normative domain" (198). On a basic level, then, cases are fallings away from an established system or principle. In her work on the genre, Kennedy echoes this notion as she maps out a definition of the case in the medical field. She observes that a medical case "offers the interest of an anecdote within the schema of a classificatory system; whether an 'unusual case' or a 'typical case,' it registers as 'a case' precisely because it resists being subsumed within the system" (6). Esther's narrative falls away from a normative system or principle, not in the sense that she eschews her society's norms and principles—far from it in fact—but rather in terms of her *narrative's* very difference from the more far-ranging and systematically presented third-person narrative. Within *Bleak House*, rather than telling one clear story, the third-person narrative depicts from above the operations of a larger society, ranging from the interplay between the classes to the various environments within which this interplay occurs. There are a host of smaller storylines included within this third-person portion of the novel, but Esther's account alone breaks away from this overarching narrative to be offered up on its own. In juxtaposition to this systematic portrayal of England and English society, in other words, Dickens offers up Esther's narrative as a single case.

Instead of simply paralleling the form of the case study, though, Esther's narrative shifts the focus from object to subject. Until the early twentieth century, the case history was generally narrated in the first person, like Esther's narrative, but the difference is that the "I" narrating this clinical account was a doctor describing a sick patient from his external perspective. As a result, the medical case study focused on an object rather than a subject—on a patient who is spoken about rather than speaking. While neither of the cases that Dickens cites in his preface was

recorded during the nineteenth-century, they do share, and in fact exemplify, one of the key components especially characteristic of the increasingly clinical nineteenth-century medical case history. By merit of the particular medical phenomenon which they document, these eighteenth-century examples focus on the observations of an outside observer rather than the feelings or experiences of an afflicted individual. In doing so, these records serve as examples *par excellence* of the objectification possible in and in fact characteristic of many case narratives.

A closer look at one of the cases of spontaneous combustion that Dickens mentions in his preface makes this potentially objectifying nature of the case narrative clear. The most famous example of this phenomenon on record, and the one to which Dickens first draws the reader's attention, is that of the Countess Cornelia de Bandi Cesnate. Giuseppe Bianchini's description of the Countess's death by spontaneous combustion was reprinted in the *Philosophical Transactions*—the publication of the Royal Society and the primary site for publishing medical case histories in the eighteenth century—in 1745. The record begins, like most narratives of this type from both the eighteenth and nineteenth centuries, with the patient's age, a statement of her general health preceding her combustion, and an account of the events immediately leading up to her death.

After this patient history, we move to an observation of the Countess's body following her demise. The nature of this particular ailment leads to a radical objectification, one which makes the post-mortem description of the Countess not just objectifying (as we might expect when a now-dead body is being described) but, in fact, an account of nothing more than a pile of objects. Bianchini describes the discovery of the Countess's remains in the following way: "Four Feet Distance from the Bed there was a Heap of Ashes, two Legs untouch'd… with *their* Stockings on; between them was the Lady's Head; *whose* Brains, Half of the Back-part of the Scull, and the whole Chin, were burnt to Ashes; amongst which were found three Fingers blacken'd" (447-48, my emphasis). The Countess, once a woman, has now become nothing more than a heap of ashes, two legs, a head, and three fingers. The use of possessive pronouns within this passage drives home the absence of the Countess as a person from this case narrative. The

legs here possess stockings, not the woman who once wore them; the brains, skull, and chin belong to “the Lady’s Head,” not the Lady herself.

While Esther’s narrative, like the medical case, is differentiated by its resistance to being subsumed into the larger system of the novel, the difference between her account and the type of reporting detailed here is that Esther’s record focuses on her as the subject. She attempts to belie this by suggesting that she does not know why she has been asked to write and that her purpose is really to tell us about others, but like many of her other disavowals (such as her assertion that she is not really very perceptive) this one also proves untrue. The heading of “Esther’s Narrative” which precedes most of her accounts indicates both that these writings are narrated by Esther and that they are about her. The use of the genitive helpfully tracks the difference between these two instances. In terms of Esther’s record, the narrative tellingly *belongs to* Esther, whereas in this example of spontaneous combustion, the Countess de Bandi does not even own her stockings, much less her story.[12]

This shift is important not simply because it puts the emphasis on Esther as a subject, though. More specifically, in terms of the medical case, this shift charts a movement from focusing on disease to focusing on illness. As Kennedy observes regarding the case study, “Since the nineteenth century in particular, the phrase ‘a case of malaria’ implies a detailed narrative of an individual patient which focuses on his or her unique history while placing him or her within the broader context of a disease type” (6). What I would contend is that Esther’s personal narrative, while focusing on her unique, individual history, diverges from the part of the case narrative which insists upon cataloging the individual within the broader context of a disease type. In other words, Esther’s narrative illustrates the significance of illness within the novel, and

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[12] Though the British population was becoming increasingly skeptical about the possibility of this phenomenon by mid-century, Dickens would certainly not have been alone as a believer in spontaneous combustion. Both Trevor Blount and James Gamble argue that Dickens did indeed trust in its reality. For instance, even beyond his comments in the preface to and body of *Bleak House*, he continued to maintain in private correspondence with Lewes the existence of “scientific evidence” for his belief (qtd. in Gamble 15).

the interior perspective from which it is generated, as opposed to simply disease by itself, and the exterior perspective from which it is observed.

Esther's Outlook on Disease and Her Inroad into Illness

At the center of the novel in a chapter entitled "Nurse and Patient," Esther encounters and aids a dangerously sick street-sweeper named Jo. This encounter culminates in Esther's contraction of Jo's ailment and her own ensuing sick-bed experiences. It is at this point that Esther's narrative most clearly charts the distinctions between disease and illness and the unique characteristics of each, for within this middle section Esther moves from observing others suffering from this condition to actually experiencing it herself. As a result, Esther's encounter with this complaint reads as a movement from disease (a physical manifestation which she can only perceive from the outside) to illness (her own unique, and more interiorly perceived, experience of this malady).

Near the beginning of "Nurse and Patient," Esther hears through her maid Charley that there is a poor, sick boy in the neighborhood who may be in need of aid. So, Esther and Charley set out to find this young man and see what assistance they can provide. The two young women end up bringing Jo back to Bleak House, Esther's home, where Charley, with Esther's assistance, begins to nurse the young man. However, this particular positioning of nurse and patient does not last for long, for before the night is out, Jo has mysteriously disappeared. Shortly after this disappearance, Charley's health begins to fail, at which point Esther takes on the role of nurse to Charley's patient. Charley's battle with this significantly unnamed disease is long and difficult. However, she does finally begin to recover, at which point Esther herself begins to experience symptoms of coldness and weakness. Hence, as Esther weakens and Charley grows stronger, the roles of nurse and patient shift again, with Charley now playing nurse to Esther's patient.

By examining Esther's descriptions of both Jo and Charley when they are suffering from this malady, we can see the outside perspective from which Esther observes at first—before she herself has experienced this ailment—as opposed to her later, illness-driven, interior perspective. When Esther first sees the infected Jo, the only information with which she can provide the reader is that Jo is "a wretched boy, supported by [a] chimney-piece… cowering on the floor…. and as he tried to warm himself, he shook until the crazy door and window shook" (489). Compare this to the outside narrator's later depiction of Jo when we encounter him again in Tom-all-Alone's. Here the narrator tells us that "The boy… falls to… staring at the ground, and to shaking from head to foot until the crazy hoarding against which he leans, rattles" (715). The similarity of language used by the outside narrator and by Esther (the "crazy" structures, being supported against something and leaning, shaking and rattling) highlights at a glance the exteriority of Esther's perspective on Jo's suffering. What both of these descriptions also do is chart Jo's body—what it physically looks like when someone is suffering from this disease, rather than what it feels like. And tellingly, the unsoundness of Jo's physical surroundings, which are crazy enough that his shaking sets them to shaking as well, receive just as much attention as Jo himself.

When describing Charley, Esther is at first even less specific about Charley's condition than she is about Jo's. Her rather unhelpful initial account of Charley consists of "Charley fell ill. In twelve hours she was very ill" (499). She then later adds, "And thus poor Charley sickened, and grew worse, and fell into heavy danger of death, and lay severely ill for many a long round of day and night" (499-500). While Esther's "poor Charley" helps to demonstrate the compassion which this one character feels for the other, it is otherwise difficult to discern a difference between this portrayal and the descriptions provided elsewhere by our third-person narrator. Additionally, this latter account drives home the physicality of Charley's experience in Esther's eyes, for when Esther concludes by noting that Charley "lay severely ill," this word choice elicits an image of Charley's prone body quite literally *lying* there before Esther. The references to the progress of time in each passage are also suggestive, and they illustrate that

these accounts are really time-lines of the disease's progress in Charley's system rather than descriptions of Charley's experience of illness.

Even before we get to Esther's narration of her own individual suffering, there are moments in her relation of Jo's and Charley's torments when the distinctions between illness and its exclusively somatic counterpart make themselves evident. As Jo lies huddled on the hearth shaking away, he attempts to explain what he is feeling, and he tells Esther, "I'm a being froze… and then burnt up, and then froze, and then burnt up, ever so many times in an hour. And my head's all sleepy, and all a going mad-like—and I'm so dry—and my bones isn't half so much bones as pain" (490). The first part of Jo's statement that he is "a being froze… and then burnt up" resonates on two levels. On one level, the word "being" as participle tracks Jo's *disease* by highlighting its symptomology—which includes chills and feverishness—and his passive victimage—he is being frozen. On another level, though, "being" also works as a noun, as in "I am a being." In this capacity, we can see Jo's experience as not just a host of physical symptoms but as *self*-predicating as well—through this experience of disease, in other words, Jo is changed as a person. In this sense "being" emphasizes that the entire character of who Jo is has been impacted, and this "being" is a manifestation of his *illness*. In other words, "being" as participle tracks disease through its symptoms, while "being" as noun illustrates that illness incorporates the somatic yet goes beyond it.

The last part of Jo's statement further emphasizes the split between the physical ailment from which Jo suffers and his own distinctive illness, for Jo's "my bones isn't half so much bones as pain" simultaneously draws our attention to his physical body and denies this body's priority. The bones in and of themselves are not important; what takes priority for Jo here is this subjective sensation. Moreover, the highlighting of *bones* in particular is suggestive since the bones of a body are what define that body's structure. By describing his pain in this way, Jo, in essence, transforms physical structure into subjective sensation, negating the centrality of the corporeal to his experience of this malady and substituting for it his unique feeling.

Charley's initial comments after contracting this complaint similarly highlight the disjunction between disease and illness. Upon observing Charley shivering, Esther asks her maid if she is cold. Charley replies, "I think I am, miss… I don't know what it is. I can't hold myself still. I felt so, yesterday" (498). On the one hand, Charley's symptoms are clear to an outside observer—Esther relates that "I saw my little maid shivering from head to foot" (498). On the other hand, though, Charley herself cannot focus what she is feeling through the lens of symptomology; she cannot assert, for instance, that she is cold, and she does not know what exactly is ailing her. Charley cannot pin down her experience with language and give it a name, say that she is suffering from A or B. However, on another more interior level, she *does* know how she is feeling, enough so that she can recognize this feeling as recurring and add, "I felt so, yesterday." Charley recognizes her illness though she cannot describe her disease.

Esther at this point, however, remains grounded in the physical side of Jo and Charley's suffering and in her outside perspective. For instance, as Charley's condition worsens, the young girl's mind begins to wander. While this seems like a perfect opportunity to privilege Charley's unique experience of this malady—and to give Esther her due, she does *mention* that Charley's mind returned to her father's sick bed and to her siblings—the focus of Esther's ruminations is primarily on her ability to physically comfort Charley in the midst of these mental wanderings. Esther explains to the reader that "When [Charley] was at her worst… she still knew me so far as that she would be quiet in my arms when she could lie quiet nowhere else" (500). The emphasis here is not on where Charley's *mind* is wandering, but rather, on where her *body* is resting. Dickens similarly privileges this exterior perspective when Esther interacts with Jo. Immediately following the poor boy's vivid description of what it feels like to be ill, Esther dismisses Jo and his observations by directing all of her questions and comments regarding Jo to the woman whose home he is in—even though Jo continually attempts to respond to her queries. Esther's reliance on this outside perspective is driven home by her observation that Jo is "strangely unconcerned about himself, if I may say so strange a thing" (493). Her emphasis on the

"strangeness" of Jo's behavior demonstrates her inability to understand any of his feelings as he undergoes this experience.

As Esther moves away from witnessing others endure this infection and toward the understanding that comes as a result of suffering from this disorder herself, this ailment begins to register for her in a completely different way. A focus inward rather than outward characterizes her own experience of being unwell. The priority of physical observation is thus left behind, and this interior shift allows Esther to recognize, though with trepidation, the ways in which disease becomes reshaped when transformed into illness and, in turn, the ways in which illness exerts a reshaping influence on the self.

Shortly after watching Jo and Charley succumb to this contagion, Esther begins to feel the first signs of sickness herself. Right before we break off into chapter thirty-two—one of the third-person narrator's sections—Esther's minor initial symptoms abruptly take a turn and Esther dramatically announces in the very last lines of chapter thirty-one, "I cannot see you, Charley; I am blind" (504). The end of this portion of Esther's narrative is charged with Esther's literal and sudden incapacity to see outside herself, an incapacity which coincides with her own development of illness. What occurs *in between* Esther's exterior descriptions of Jo and Charley and her interior descriptions of herself is equally telling, for within this gap is the very case of spontaneous combustion upon which Dickens elaborates in his preface. The inclusion of this episode at this moment, in conjunction with the third-person narrator's relation of it, is important because it provides a narrative transition between Esther's two very different perceptions of the ailment from which she will very soon suffer herself.

How the scene of spontaneous combustion is conveyed to us parallels the shift that occurs between Esther's outside observations of Jo and Charley and her soon-to-be-described internal experiences, for this scene includes the *only* instance in the entire novel in which the outside narrator slips from a third-person voice into a first-person voice. We do not actually see the combustion occur, but we do witness the aftermath and narratively accompany the two young men who discover Krook's remains. This passage reads, "*They* [the two young men who

discover Krook] advance slowly, looking at all these things…. Here is a small burnt patch of flooring…; and here is—is it the cinder of a small charred and broken log of wood sprinkled with white ashes, or is it coal? O Horror, he IS here! and this, from which *we* run away… is all that represents him" (519, my emphasis). Within this passage the usually third-person narrator slips into the voices of two of his characters, only able to convey the true horror of the situation from their inside perspective.[13] While the narrator does provide a more interior perspective at this moment than his own, this slippage also draws attention to the fact that here, in the case of spontaneous combustion, the sufferer cannot speak for himself and the closest that this narrator can get to representing these experiences is to represent the first outside observers of this phenomenon and their reactions. In this sense, the true horror of this situation is perhaps that Krook, like the objectified Countess de Bandi Cesnate before him, cannot speak. By contrast, Esther's contributions are uniquely set up to allow us to see inside her experiences as a sufferer. Hence, by demonstrating a need that cannot in this instance be fulfilled but which Esther does supply in the following section, the representation of this case of spontaneous combustion serves as a narrative bridge between Esther's observations as caregiver and Esther's observations as sufferer, between Esther's impressions of the sick Jo and Charley and Esther's case study of herself—into which all her previous chapters of retrospective, first-person rumination seem now to be funneled.

The shift in perspective that characterizes Esther's case study of herself becomes clear from the beginning of her reflections on her own encounter with this ailment. She tells the reader that "In falling ill, I seemed to have crossed a dark lake, and to have left all my experiences, mingled together by the great distance, on the healthy shore" (555). This figurative lake to which

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[13] For simplicity's sake, I follow the critical commonplace of referring to the third-person narrator as "he." As far as I am aware, only two critics have attempted to suggest otherwise. Wilt suggests at one point that the unnamed narrator and Esther are "two phases of one being" (58) and that the unnamed narrator might thus be considered female, and Katherine Cummings in "*Bleak House*: Remarks on a Daughter's Da" makes a suggestive comment that Esther might actually be both narrators. In both of these cases, though, Wilt and Cummings suggest rather than demonstrate these points.

Esther draws our attention differentiates those moments when Esther observed Jo and then Charley succumbing to this infection—her exterior brushes with this disease when healthy, in other words—from her now-sickness-inflected interior ruminations. But it is not just the occurrence of seeing Jo and Charley battle with disease as an outside observer that Esther leaves on the distant, healthy shore; on the contrary, when Esther becomes ill, she moves away from "*all* [her] experiences." The distance of the healthy shore from Esther's current, sickly location results in all her previous experiences becoming blurry, and, thus, these incidents no longer hold the same place in Esther's definition of herself. Becoming ill has reshaped who Esther is in a way that echoes the changes in "being" that plagued Jo during his own illness. Moreover, the image that Esther employs explicitly describes the shift in her relationship to this ailment in terms of sight. As Esther notes, the lake that she has crossed is dark; hence, observation can no longer hold a privileged status in her attempts to understand what she is suffering from—it will not serve her as it did when she looked in on Jo and Charley's sufferings from the outside.

Esther's movement from witnessing disease to experiencing illness and the seemingly paradoxical self-distancing characteristic of this move become clearer still as Esther's individual suffering progresses. When Esther first encountered Jo in the throes of his own illness, Esther found it strange that he seemed "unconcerned with himself." However, the behavior that Esther found puzzling in Jo becomes natural to her once she is ill. During this time, Esther describes an attitude similar to Jo's, asserting that "in my weakness I was too calm to have a care for myself" (556). Having now experienced illness herself, Esther understands this formerly inexplicable feeling. Moreover, given the revision of self enacted by illness, Esther's lack of concern for herself makes sense. Much later in the novel, after encountering Woodcourt again, Esther refers to her pre-disease self as "my old self," and further suggests that she "felt for [her] old self as the dead may feel if they ever revisit these scenes" (708). Through illness, whether she likes it or not, Esther has been reborn, and her former self is as a result no longer who she is; it is thus this old, dead self for which Esther cannot care during the height of being unwell.

Throughout the narrative of her illness, Esther repeatedly acknowledges the difficulty of comprehending illness when you have not experienced it and have only looked in at it from the outside, while simultaneously suggesting the necessity of attempts to grasp individual suffering and to make it intelligible. For instance, on the one hand, she admits that "I suppose few who have not been in such a condition can quite understand what I mean" (555). While her avowal speaks to the trickiness of communicating the experience of being unwell—as opposed to disease which has been communicated from individual to individual quite easily with hardly any interaction between these people, and which, moreover, can be pinned down through language—the fact that Esther nevertheless tells us about her "sick experiences" (556) speaks to the need for efforts at communicating illness.

Esther recounts her experiences in the hopes that this narration from her unique perspective will help to facilitate an understanding and awareness of illness, as distinct from disease, in those who have only an exterior outlook on illness. She concedes the potential incomprehensibility of this experience to those on the outside and that the relevance of its relation may be hard to discern when she explains that "Perhaps the less I say of these sick experiences, the less tedious and the more intelligible I shall be. I do not recall them to make others unhappy, or because I am now in the least unhappy in remembering them" (556). Esther is not sharing these recollections in order to garner sympathy from others or out of self pity. She maintains, in fact, that her description of her suffering is instead prompted by the belief that "it may be that if we only knew more of such strange afflictions, we might be better able to alleviate their intensity" (556). "Knew more of" on the one hand suggests understanding the quality of these experiences, what they are like; on the other hand, though, this phrase also suggests the importance of simply being aware of the existence of illness as distinct from disease. And the way that we can know more of these strange afflictions is through their narration, via the communication of illness as a story.

Furthermore, this latter statement about Esther's strange affliction places the emphasis squarely on illness rather than disease. "Affliction" is an illuminating choice of expressions

here—while it can certainly bear *connotations* of disease, Esther has employed a word whose *denotations*, at least according to the OED, never specifically involve disease. Instead, "affliction" is another name for "pain, calamity, grief, distress" or "sore pain of body or trouble of mind; misery." If Esther has smallpox, as many critics surmise, physical pain is certainly a component of her experiences, and thus, "affliction" can refer to her actual disease in this way, but it is telling that "distress," "grief," and "misery" are also called up by her use of this term. Esther's use of "affliction" to describe what she is going through, in other words, suggests that the physical aspect of her experience is only part of the story.

Esther's desire to alleviate the *intensity* of these afflictions and her use of the word "strange" to describe them further emphasize illness as opposed to disease. First of all, her statement regarding the purpose of her descriptions stems from a patient's, rather than a diagnostician's, point of view, for Esther's interest here is not in what caused her ailment or even how to cure it—which is where the focus would be if she were in the position of a doctor examining a complaint. Instead, Esther is interested in alleviating the intensity of the actual, and often unavoidable, experience itself. Second of all, when she describes her affliction as "strange," she must not be referring to the actual malady since *it* does not seem to be uncommon. On the contrary, three different characters become infected within the novel, and Harold Skimpole, a man who has not practiced medicine for years, can tell just by looking at Jo that he is contagious. Rather, the "strange" part of this affliction is the part unique to a patient experiencing the ailment. In addition, the use of "strange" speaks to the self-e*strang*ing qualities of illness already touched on. The allusion therefore suggests that part of what this awareness may be able to help alleviate is the unexpected and disconcerting nature of the self-examination and ensuing self-revision that the experience of being unwell enacts.

This is not to say that this new self abandons all earlier aspects of a sufferer's personality; on the contrary, part of what makes illness distinctive is its incorporation of an individual sufferer's traits. And, indeed, Esther's personal history does color her current experience. At one point she explains, "While I was very ill,…. [I felt myself to be] at once a child, an elder girl, and

the little woman I had been so happy as, I was not only oppressed by cares and difficulties adapted to each station, but by the great perplexity of endlessly trying to reconcile them" (555). Esther's biography, her own history, is still an integral component of her illness. For instance, her perpetual, and at this point still unrewarded, search for clues to her parentage is mirrored in her feverish hallucination of "labour[ing] up colossal staircases, ever striving to reach the top, and ever turned, as I have seen a worm in a garden path, by some obstruction, and labouring again" (555).[14] Even more than the stairs themselves, the image of the worm that Esther uses to describe herself is telling, for it lays stress on the way that Esther's sense of personal insignificance, fostered in her childhood by her strict godmother, inflects her fevered experiences.[15] Her idiosyncratic illness is in stark contrast to the corporeal disorder from which she suffers, which is more pervasive than distinctive; Esther's descriptions at this point in the narrative do not touch on disease-type so much as her unique experiences of this malady.

At the same time, while her previous experiences do help to compose her illness, her illness is causing a revision of self. After describing her previous selves and alluding to the "cares and difficulties" attendant upon each of these incarnations, Esther tells us that she is most "oppressed… by the great perplexity of endlessly trying to reconcile them." At base, this "them" refers to the cares and difficulties of each station and Esther's attempt to reconcile these concerns. On another level, though, what Esther is trying to reconcile is the existence of all of

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[14] Miriam Bailin also touches on Esther's fevered attempt to reconcile various versions of herself, and she suggests that this desire, along with Esther's delirious vision of motion without progress, parallels the shifting sense of worth that characterizes Esther's larger narrative of self discovery. Rather than reading this as a sign of Esther's unique experience of disease, though, Bailin investigates the way that this fever prefigures aspects of Esther's self discovery yet to come, such as her literal pursuit of Lady Dedlock with Inspector Bucket. In the following section, I too link Esther's illness to the larger narrative discourse, but my focus is on the novel's dual narration, rather than the frenetic narrative motion which characterizes Esther's discovery throughout the novel of her place in the world.

[15] In this respect, I take Zwerdling's point about the shaping influence of Esther's childhood misery in the home of her godmother, but Zwerdling's impulse to make these experiences the trauma around which Dickens organizes Esther's narration discounts the more immediate ordeal of disease through which Esther suffers.

these previous selves with one another, and, I would contend, with her newly-revised, illness-generated self.

Investigating one of the worst moments for Esther while she is afflicted helps to further illustrate the necessity of narrating illness, for this narration is in large part what prevents a sufferer from being subsumed under the rubric of a disease-type. After ruminating on her struggle to reconcile her conflicting views of self and their attendant concerns, Esther alludes to a moment in her experience even more awful than this initial effort. She cries,

> Dare I hint at that worse time when, strung together somewhere in great black space, there was a flaming necklace, or ring, or starry circle of some kind, of which *I* was one of the beads! And when my only prayer was to be taken off from the rest, and when it was such inexplicable agony and misery to be part of the dreadful thing? (556)

Esther's feeling that she is trapped on this ring as one of the many beads that constitute it helps to illustrate the horror that accompanies disease of losing both one's individuality and one's voice, of becoming simply another silent sufferer whose distinct experiences are discounted as one is fitted into a disease type.[16]

The flaming nature of the necklace which Esther describes reinforces this point, for these flames draw our attention back to the fire that the reader has most recently encountered in the text and the unique characteristics of that incendiary moment. Only pages earlier the junk-dealer

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[16] Several other critics have tied this scene to an assertion of individuality on Esther's part, though in very different contexts. In his deconstructionist introduction to an edition of *Bleak House*, J. Hillis Miller asserts that Esther's statement about the flaming necklace is an outcry against the forced alienation of individuals from themselves as naming forces them to become part of a larger system. Wilt argues that Esther's sick ruminations are suggestive of the fact that Esther is "experiencing the nightmare of solipsism" (78) that comes with the self's recognition of its separateness from the outside world.

Stewart also treats this scene, though his focus in on the ways in which Esther's fevered desire to be removed from this necklace participates in "one of the strangest and most persuasive configurations of fever in Dickens: the nightmare of severance," which he characterizes as "an image of suicidal escape" (191). In Stewart's reading, what makes this part of Esther's sickness "worse" is not her unrequited desire for removal in the moment of her fever so much as the fact that she now recognizes this wish for severance as self-obliterating. I concur that the obliteration of self is a key issue here, but I see this destruction as more figurative, as a fear of becoming nothing more than another example of an ailment along with the unwanted revision of one's previous conception of self, rather than as a wish for literal death.

Krook has died in the explosive case of spontaneous combustion that I previously examined. As I noted above, one of the peculiar contingencies of spontaneous combustion is that once aflame, a sufferer loses the ability to voice that suffering. Furthermore, this loss of voice is accompanied by a radical de-individuation. As Krook combusts, the sooty residue of which he now consists goes everywhere. When Mr. Snagsby the law-stationer takes the air before bed on the night of Krook's combustion, he repeatedly "sniff[s] and taste[s]" this air, which smells, as one of Krook's boarders notes, like burnt and not-quite-fresh chops. In the process, Snagsby literally ingests the bits of Krook which flavor the air. The law-clerk Mr. Guppy further spreads the de-individuated Krook about when he touches a windowsill coated with a "thick, yellow liquor" (516), and thus gets part of Krook's remains on his hands. In this way, Krook's combustion causes him to literally become one with his entire neighborhood; Krook's fiery demise, in other words, causes him to become completely undifferentiated and the opposite of individual. By using the image of entrapment in a "flaming" circle to describe the worst moment in her illness, Esther's adjectival choice connects her fears with this previous incident of combustion and highlights the individuality and voice denied Krook and desired by the ill Esther.

The Interplay of Content and Structure:
The Relationship between Illness, Disease, and Dual Narration

In addition to suggesting the need for the narration and examination of illness separate from disease, the scenes leading up to and encompassing Esther's bout with this ailment demonstrate the ways in which the roles of patient and caregiver, along with the perspectives attendant on each position, can repeatedly alternate. To whom the individual appellations in the chapter heading "Nurse and Patient" refer could be endlessly debated, for Esther moves within these sections from looking in on disease from the outside to experiencing her own illness from the inside. This literally central moment in *Bleak House* resonates on more than just a content

level, though. The alternation in perspectives illustrated during the course of Esther's encounter with this complaint also provides a template for understanding one of the most noteworthy aspects of the novel's structure, namely, its dual narration. The movement between third- and first-person narrators that organizes the larger novel follows the same shifting pattern documented in the sections on Esther's sickness, with the third-person narrator providing an exterior outlook on disease and Esther the narrator narrating from the interior position of an illness sufferer.

From the moment that the novel begins, the third-person narrator takes on the role of a doctor looking at Chancery court from the outside and diagnosing it as breeding contagion. Not only does this narrator associate the court with the miasmic fog that encircles it and causes "a general infection of ill-temper" (13)—he even goes so far as to pronounce the court itself "pestilent" (14). Later, as he looks in on Tom-all-Alone's, the dreadful abode of London's poor, he identifies "Tom" as both contaminated and infectious. The third-person narrator explains that "There is not a drop of Tom's corrupted blood but propagates infection and contagion somewhere. It shall pollute, this very night, the choice stream (in which chemists on analysis would find the genuine nobility) of a Norman house, and his Grace shall not be able to say Nay to the infamous alliance" (710). The social commentary that this narrator somewhat transparently makes in this statement is accomplished by tracing the etiology of disease, something which any diagnostician worth his salt would attempt to do.

It is also this third-person narrator who assigns Krook's cause of death. Immediately following the brief slip into the first-person voice that I have described above, this generally third-person narrator returns to his exterior perspective and asserts, "Call the death by any name Your Highness will, attribute it to whom you will, or say it might have been prevented how you will, it is the same death eternally – inborn, inbred, engendered in the corrupted humours of the vicious body itself, and that only – Spontaneous Combustion, and none other of all the deaths that can be died" (519). Our third-person narrator is the first doctor on the scene, viewing and examining the body long before any of the other "men of science and philosophy [who] come to

look, and… doctors… who arrive with the same intent" are allowed to see Krook, much less identify the ailment that has eliminated him (532). And it is this narrator who speaks in the voice of a doctor addressing a magistrate in charge of the inevitable inquest that will occur, and who diagnoses spontaneous combustion and describes the factors leading to this condition.

Before moving to a discussion of our other narrator, Esther, and the function that she holds, allow me to briefly distinguish between the two Esthers that we encounter in this novel: Esther the character and Esther the narrator. Esther's roles in *Bleak House* as character and narrator are not synonymous, particularly in terms of the knowledge that each has and the experiences that each has undergone. While Esther the character progresses from a child living with a hard-hearted godmother to a married adult, Esther the narrator only comes into existence in adulthood, and she has already experienced all of the events that she recounts before she ever begins relating her tale. These two figures only converge, in fact, as the novel closes, and Esther the narrator brings us to a description of Esther the character writing down this tale.

With that distinction in mind, Esther the narrator, then, speaks from the point of view of an illness sufferer from the moment she begins narrating her portion of the novel. Esther the character admittedly does not get sick until the middle of the novel, but Esther the narrator has already encountered Jo, nursed Charley, and caught the ailment that afflicted them both, and her belief in her literal and figurative defacement still marks her as she begins to narrate. After some time in the sick room, Esther works through her malady and regains her physical health. However, as my previous discussion has made clear, Esther's disease is not identical to her illness, which encompasses her belief in (and horror at) her changed self. In addition to the revision of self that occurs during the height of her infection, the new physical appearance that follows her recovery from this ailment changes her relationship to the world, further redefining who she sees herself as. When she encounters Woodcourt for the first time after her disease and tells him that she was quite sick, he asks her, "But *you* have quite recovered?" (706, my emphasis). Instead of simply replying in the affirmative, Esther returns, "I have quite recovered my health and my cheerfulness" (706). The fact that Esther does not simply reply that *she* has

recovered and instead specifies that she has regained her health and cheerfulness indicates the degree to which the restoration of physical health is just part of the story. The extent of Esther's illness far outreaches the extent of her disease, and her illness still plagues her long after her disease has passed. Esther's illness haunts her, in fact, until the very last moment of her narration when she ponders for the first time, inconclusively, I might add, the possibility that her "old looks" have returned (989). Hence, Esther the narrator's experience of illness never completely departs her, and her first-person contributions provide an interior, illness-based counterpoint to the more diagnostically inclined third-person narrator.

A careful examination of Esther the character's experience of illness thus helps to explain the narrative structure of the entire novel, for *Bleak House*'s alternating organization parallels Esther's own perspectival shifts as she encounters disease in Jo and Charley and then illness in herself. At first, Esther the character looks in on disease from the outside, much like the novel's third-person narrator, but then her contracting of this ailment affords her a unique inside perspective on the experience of illness, a perspective which is supplied throughout the novel by Esther the narrator's first-person accounts.

This is not to say, of course, that Dickens is thus privileging the narration of illness to the exclusion of disease. On the contrary, his inclusion of these two narrators side-by-side within the novel suggests the complementary nature of these two discourses—and the necessity of both in facilitating understanding of individual suffering and corporeal complaints. In another moment of interplay between content and structure, we can see this ideal of complementarity concretized in the marriage of the caring doctor Woodcourt and the still illness-shaped Esther.

On their own, each of these characters already begins to disrupt the division between objective doctor and subjective patient. As my descriptions of Esther's shifting perspective have made evident, Esther starts to challenge this simple breakdown through her original, exterior observations of the infected Jo and Charley. In addition, her method of inquiry regarding her own illness intersects with the modes of inquiry common to doctors at the time. The intended purpose of Esther's descriptions of her ailment obviously differs from the desired result in a

medical case narrative. While Esther's narrative promotes understanding of what illness consists of in an attempt to alleviate its intensity, the typical case history details a patient's encounter with a disorder in order to facilitate either the diagnosis or the elimination of the malady. Yet, Esther's description of her illness is quite analytic. In order to describe her subjective experiences, such as her feeling that she is an irremovable component of a flaming necklace, Esther carefully outlines both the progression of her experiences while she is ill and the details of this experience in a manner whose organization and rigorousness parallel the case narrative.

Woodcourt, in his role as empathetic doctor, also begins to bridge the gap between doctor as emotion-free, exterior observer of disease and patient as subjectively experiencing sufferer from illness. For instance, immediately after the law-writer Nemo dies, Woodcourt is called in to examine Nemo's body and determine his cause of death. The third-person narrator describes two rather disparate reactions on the part of Woodcourt to the dead man before him. Woodcourt's first reaction is to Nemo's physical state, and this portion of the narrator's description squarely situates Woodcourt in the role of detached doctor. The narrator begins by noting "the young surgeon's professional interest in death," which is evident in his examination of Nemo (168). This interest aligns Woodcourt with the exteriorly focused diagnostician; death as a category is important here, not the person who has died. However, the third-person narrator proceeds to remark that this interest is "noticeable as being quite apart from [Woodcourt's] remarks on the deceased as an individual." For instance, Woodcourt notes "not unfeelingly" according to the narrator, that he remembers "once thinking there was something in [Nemo's] manner, uncouth as it was, that denoted a fall in life," and he inquires as to whether anyone knows if this were true (168). Here we can see Allan Woodcourt moving beyond the potentially reductive diagnostic perspective in order to consider his deceased patient's unique traits and situation in life. This consideration of individuality begins to take into account not only the physical cause of Nemo's death but also the other factors contributing to the illness from which this fallen man suffered. I would suggest that what is perhaps "noticeable" here is the coexistence within this doctor of an interest in disease with an interest in illness.

The ultimate union of Esther and Allan provides more than just these nods to one realm or another, though. Instead, this marriage indicates the necessity of wedding these two medical perspectives and the potential gain that could follow from such a marriage, for it is only after Allan and Esther are united that Allan's most noteworthy traits as a doctor come to the fore. After revealing that she and Woodcourt are married, Esther describes their life together, and, in particular, she tells us of the aspects of Allan's reputation as a practitioner that she most admires and that are most admired by his patients. She explains to the reader, "I never lie down at night, but I know that in the course of that day he has alleviated pain, and soothed some fellow-creature in the time of need. I know that from the beds of those who were past recovery, thanks have often, often gone up in the last hour, for his patient ministrations" (988). Tellingly, Woodcourt's ability to cure or even diagnose his patients is never mentioned here. Rather than focusing on Woodcourt's facility in this realm, the emphasis is placed instead on his success in *soothing* the individuals that he treats. Allan's attention, in other words, is on his treatment of the patient, not the disorder. This focus is driven home by the second part of Esther's statement, in which she describes the reaction to Allan's ministrations when they are directed at someone past recovery. These "patient ministrations" (and I would note the double resonance of "patient" here, which invokes both Woodcourt's unhurried attitude and the fact that he is ministering to a *suffering person* rather than just a disease) are greatly lauded, and they speak to the idea promoted by Esther's earlier narration of her illness—that focusing on disease and the recovery from this complaint leaves much about a sufferer's illness unsaid.

Moreover, Allan's chief talent—the ability to *alleviate* pain—hearkens back to Esther's own words when she explained earlier why she took the time to narrate her illness. If you recall, Esther clarified her motivations with the statement that "if we knew more of such strange afflictions, we might be better able to *alleviate* their intensity" (556, my emphasis). Being married to Esther, Allan is now intimately acquainted with the strange afflictions—the illnesses—that transcend simple disease; and using his skill as a doctor coupled with the

knowledge he has gained as Esther's husband, the novel ends with the fulfillment—for Allan's patients—of Esther's motivating desire in narrating her illness.

Though the emphasis here is on Allan and what he does, Esther's role at this point is not a silent one. Remember, it is Esther who uses her narrative power as one of the two voices conveying the content of *Bleak House* to place this attribute of Allan's in a position of prominence right before the novel closes, thus highlighting through placement and description the type of doctoral ministrations that her earlier narration of illness promoted. Allan's skill as a practitioner provides the initial entry into the patient's chamber, but his marriage to and relationship with Esther inflect this treatment, giving it its emphasis on illness and the individual. The inclusion of the third-person narrator and Esther as narrator side-by-side echoes this message regarding the benefits to be garnered through the marriage of these two types of perspectives. While *Bleak House* begins with the third-person narrator and the basis of careful examination that his perspective introduces, the novel ends with Esther's contributions, which open up *Bleak House* into more than just diagnosis.

Realism and Esther's Interiority of Experience

Many studies of nineteenth-century realism critically tie the representation of reality in this literary form to a more diagnostic narrative perspective and, more broadly, to vision itself. I do not dispute that many realist texts depend upon a careful spinning out of physical details in their efforts to replicate reality, and I agree that Dickens often employs this method quite masterfully. However, just as close examination of *Bleak House* reveals Dickens's interest in illness rather than disease alone and the diagnosis of social ills, so too does an investigation of the novel uncover another method for realistic representation not grounded in the visual. My aim in this section is to illustrate how Dickens introduces this possibility through Esther's narration.

In his benchmark work on realism, Rothfield maintains that the clinical medicine practiced during the nineteenth-century influenced the shape of this period's developing realist literature and that a clinical eye thus characterizes the point of view that we consider indicative of this literature. Rothfield focuses specifically on Gustave Flaubert, Honore de Balzac, and George Eliot, but he asserts that his theories apply to other critical realists of the time, including Dickens. Rothfield suggests that certain ways of thinking about people and disease prevalent in clinical medicine were co-opted (consciously or not) by realist authors like those mentioned above and these ways of thinking then informed the narrative techniques employed by these writers.

While later studies of realism do not all explicitly rely on this explanation of realism's genesis[17], Rothfield's study has had lasting effects. Even critics such as Alison Byerly, whose investigations of realism are not grounded in the medical, belie through their rhetoric an underlying assumption regarding the clinical nature of realism. In her introduction to *Realism, Representation, and the Arts in Nineteenth-Century Literature*, Byerly begins by discussing the simultaneous Victorian appreciation of "art's mimetic capacity" and the accompanying fear that art forms like realistic fiction might provide a substitute for reality rather than simply reflecting it. What is most telling here are not Byerly's claims, though, but the way in which she couches them. In describing this Victorian fear, she explains that realistic art at the time had two possible functions: "it could act as either a powerful diagnostic tool or as a placebo" (1-2). Though Byerly's study goes on to focus on the role of represented art work in Victorian fiction, her

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[17] A monograph by medical professor Henry Harris following his Romanes Lecture in 1993, *Hippolyte's Club Foot: The Medical Roots of Realism in Modern European Literature*, also focuses on the relationship between medicine and realism in the nineteenth century. However, while Harris touches on the clinical detachment that he considers a definitive feature of the realist movement, much of his work details the medical backgrounds and reading habits of French, Russian, German, and other European authors often associated with realism or naturalism. Kennedy's recent article "Diagnosis or Detour?: The Uses of Medical Realism in the Victorian Novel" is more in line with Rothfield's study. She focuses on the ways in which Victorian writers incorporated methods of "clinical medical observation and representation" common within the medical writing of the time into their own fictional representations (par. 10).

choice of metaphors to describe what realism at its best might do (act as a "diagnostic tool") suggests the extent to which the clinical view promoted by critics like Rothfield has permeated current thinking about nineteenth-century realism.

Furthermore, Rothfield's study participates in a larger critical tradition, separate from but encompassing this medical explanation, that locates realism's attempts at creating *realness* in the visual. Works ranging from Ian Watt's *The Rise of the Novel* to Nancy Armstrong's *Fiction in the Age of Photography: The Legacy of British Realism* have contributed to the construction of this critical viewpoint over the latter half of the past century.[18] Peter Brooks's recent overview of nineteenth-century realism tellingly entitled *Realist Vision* illustrates the currency of this position. Brooks sets the stage for the rest of his work by asserting in his introduction that "realism more than almost any other mode of literature makes sight paramount—makes it the dominant sense in our understanding of and relation to the world" (3).[19] This critical emphasis on what one sees in defining what realism represents suggests that realist writers of the Victorian period relied exclusively on an exteriority of description akin to the more diagnostic perspective that I have outlined above.

As I have noted, I do not disagree that careful descriptions of details related to setting and physical appearance populate much of the realistic literature of the Victorian period. However, just as disease forms only part of the story in my above argument, so too does this explanatory model only account for certain types of realistic expression. While some of Dickens's *Bleak*

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[18] Other works participating in this construction include George Levine's *The Realistic Imagination: English Fiction from Frankenstein to Lady Chatterly's Lover*, John Rignall's *Realist Fiction and the Strolling Spectator*, and Marie Lathers's *Bodies of Art: French Literary Realism and the Artist's Model*.

[19] I should note that Brooks's opinion on Dickens's role as a realist writer is somewhat vexed because of the limited scope of his examination of Dickens. In his discussion of Dickens he focuses solely on *Hard Times*, and he maintains that this work is not part "of the canon of the realist novel… since it cannot be counted a persuasively full effort to represent industrial England" (53) due to its lack of attention to the dirtier aspects of its subject. At the same time, though, Brooks notes that *Hard Times* is "oddly different from any other of [Dickens's] novels" (40) and that it "seems to stand apart in his work" (53), thus opening the door for Dickens's inclusion within the realist canon.

House could certainly be said to fall into this visually-based category—in particular, those sections of his text narrated by his anonymous, third-person narrator—I would argue that there is another component to Dickens's realism often left uninvestigated and that an attention to the ways in which he alters and augments this clinical perspective—especially via the narration of Esther—reveals a new layer to his realism and, indeed, another way of conceptualizing realism in the Victorian period.

Realism attempts to accurately represent human experience and the problems associated with this experience, and Esther's narration in its elaboration of the human experience of illness illustrates an interior realism.[20] What is real here is Esther's description of what it *feels* like to be ill as well as her limited ability to recognize everything around her or, indeed, everything about herself, and her betrayal of personal characteristics equally through these gaps and misreadings as through her overt statements. This, I would suggest, is what motivates so much of Esther's seeming coyness throughout the novel, moments when she leaves something unspoken (such as her feelings for Allan) or represents herself in a way with which most readers would not agree (think of her assertions that she does not have a "noticing way"). The gaps in Esther's narration realistically illustrate traits of Esther's illness-inflected character more accurately than a full narration of how this experience of disease impacted her would do. The fact that she cannot speak them is a by-product of the illness itself, and leaving them unsaid more effectively conveys what illness is like and what its effects are than a detailed description would do.[21]

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[20] In "'Who is this in Pain?': Scarring, Disfigurement, and Female Identity in *Bleak House* and *Our Mutual Friend*," Helena Michie also briefly touches on Esther's narration of her illness in relation to the realist tradition. She suggests that Esther's description while ill of her younger and older selves coming together is a "modernist moment" in an otherwise "meticulously realistic novel" and that this moment "suggests the gaps in realism's ability to portray the female body and the female experience" (205). For my discussion of modernism in relation to Esther see n. 37.

[21] Though modernism takes this interior turn as well, it is in some ways as explicit as the visually based realism, the difference being that realism of this sort focuses on the details of physical environment and appearance while the modernism of authors such as Woolf and Joyce focuses on the intricacies of consciousness, the turns it can take and the associations it can make. What I am suggesting is conveyed by Esther is somewhere in between these two poles, and yet different from them both. Though Esther's narration realistically represents facets of her interiority, what we are seeing is not a stream of

The final moments of *Bleak House* provide an especially powerful example of this less clinical possibility for realism. The interchange between Allan and Esther that closes the novel and Esther's final thoughts on this discussion highlight both a method of representation based on observation and a method antithetical to a simple depiction of physical appearance. At the end of the novel, Esther reflects on her husband's love for her and how she could not imagine it being greater even if she had retained her "looks" following her bout with disease. Upon revealing this feeling to Allan, Allan surprises Esther, and, in turn, the reader, by suggesting that Esther has in fact recovered her beauty. Regardless of whether Esther's original looks have returned, though, this last section of the novel reveals much about the different ways of knowing and understanding presented in *Bleak House*. The couple's exchange and Esther's famously indeterminate last lines follow:

> "My dear Dame Durden," said Allan, drawing my arm through his, "do you ever look in the glass?"
>
> "You know I do; you see me do it."
>
> "And don't you know that you are prettier than you ever were?"
>
> I did not know that; I am not certain that I know it now. But I know that my dearest little pets are very pretty, and that my darling is very beautiful, and that my husband is very handsome, and that my guardian has the brightest and most benevolent face that ever was seen; and that they can very well do without much beauty in me – even supposing—. (989)

Whether Esther has regained her looks or not is a question that goes unanswered as the novel comes to a close, and I would suggest that answering this question is not really the point of these final moments. Instead, the fact that Esther does not tell us what she looks like now is the point. This concluding speech of Esther's blends the two methods of understanding and representing

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consciousness à la Joyce or Woolf, but rather the ways that her personality is shaped by her individual illness experience, and this is often conveyed via the more figurative or subjective personal descriptions of what it feels like to be ill that I catalogued earlier or by what Esther refuses to put into words.

reality illustrated throughout *Bleak House* and, in particular, in Esther's experience of disease and illness. On the one hand, in this passage Esther represents the world around her and the people who make up this world by describing what they look like from an exterior perspective, just as she did when she recounted Jo and Charley's battles with their maladies. Esther's children, her dear companion Ada, and her husband are described in terms of their physical attractiveness, and John Jarndyce's moral goodness is made clear not through his actions but through the brightness and evident benevolence of his facial features. On the other hand, though, Esther's ultimate representation of herself is grounded in anything but observation.

In these final moments, it is not the visual that defines how Esther feels about herself. As Esther acknowledges when queried by her husband, she does look at herself in the mirror on a regular basis, and yet, she still "did not know" (and is, in fact, still "not certain") that her prettiness had returned. Allan's initial statement in this passage provides a key to unlocking Esther's uncertainty here, for the language that Esther hears—coupled with the lingering residue of her illness—proves to be more self-defining than what she sees before her. Allan begins his reassurance to Esther of her physical beauty by calling her "my dear Dame Durden," one of the very endearments so consistently employed by John Jarndyce earlier in the text. Dame Durden, however, refers to a woman in an old English song who manages a farm and who employs five maids and five man-servants, all of whom end up mating, while she remains unpaired. Being regularly verbally connected to this woman with whom not even a man-servant finds worthy of mating by the two men who should be most sexually attracted to her helps to undermine any physical evidence that would have been otherwise revealed to Esther by an objective look in her glass.[22] In addition, this discussion of looking reveals the inadequacies of even a sharply trained clinical eye. In this passage, Esther reveals not only that she looks in her mirror, but that Allan "sees [her] do it." Allan has watched Esther look in her glass all this time, and he has never

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[22] Carla Briganti does a nice reading of Esther's nicknames in "The Monstrous Actress: Esther Summerson's Spectral Name," and she too notes that the nickname of Dame Durden depicts Esther as a "folklore mother figure" who is "pointedly excluded from a sexual life" (213).

discerned that she is wholly unaware of any returned beauty that she might have. He may have been able to observe the actual changes in Esther's physical appearance, but his clinical eye glossed over Esther's reactions to her own physicality.

Nailing down (or diagnosing) whether her beauty has returned is not the purpose of this passage, though. The actual beauty itself, whether it exists or not, is inconsequential in comparison to how Esther feels about the possible return of this beauty. Her unwillingness to resolve the questions the reader has regarding her appearance through physical description highlights the unimportance of this physical appearance in conveying who she really is and how she feels. Esther is still shaped by her illness, and she is unable to reconcile her husband's nicknames with his assertion of her regained prettiness. Thus, her indeterminacy of speech more clearly conveys her indeterminacy of feeling and shifting conception of self than any description of this uncertainty could do.

In terms of Esther's earliest experiences of illness, the visual also played a relatively minor role. At the outset of Esther's bout with her strange affliction, she became temporarily blind, which led to her turning inward and relating her interior subjectivity to us instead of relying on the types of physical observations which characterized her descriptions of Jo and Charley. This final passage echoes back to Esther's earlier blindness and similarly illustrates the *un*importance of the visual in representing and defining the realities not just of illness but also of Esther's personality and unique character traits. By ending her narrative with this dash in the middle of her sentence, Esther blinds us as well, and by preventing us from focusing on her external appearance, she opens us up to understanding more about her personality than simply knowing what she looks like could ever reveal.

Communicating Illness

As Dickens no doubt intended to illustrate (and as many critics have noted), disease in *Bleak House* eliminates differences. According to this train of thought, Dickens deploys infectious complaints in his novel to demonstrate the links that exist between the upper and lower classes and thus to campaign for greater care being taken of those who are not so well off. I would contend that his representation of illness, while highlighting the uniqueness of individual experiences, demonstrates a similar point. While disease may show the connectedness of the classes, illness, through its very distinctiveness, also highlights individual value. For instance, some of the most poignant scenes in the novel are those concerned with the perpetually put off street sweeper Jo as he suffers through the agony of his ailment. What is striking is not simply that he is set aside by many of the upper class characters around him—that is a feature common to his appearances throughout the novel—but that those who encounter him in his fever-ridden state universally dismiss everything from their perception of him but his physical condition.

Harold Skimpole, a doctor before he embraced his current foot-loose and fancy-free lifestyle, demonstrates the extreme of diagnostic indifference when he looks at Jo, detects that "There is a very bad sort of fever about him," and consequently advises that they "turn him out" onto the street (493). Esther and Charley show compassion for Jo by disregarding this recommendation, but, as I have shown, even Esther cannot initially look beyond the surface of Jo (or even her well-loved maid Charley's) sufferings. Dickens's depiction of Esther's bout with this malady and the unique transformations that accompany her own illness reveals the urgent necessity of tempering disease's ready communicability with the recognition and communication of illness.

Attempts to express aspects of being unwell and to reflect on this phenomenon's occasional incommunicability emerge throughout this dissertation, and the relationship between narrative and sickness within Victorian fiction proves an intricate one. Within *Bleak House*, Esther's narration of her encounter with disease tells us not only about the strangeness of individual suffering; this articulation also informs the novel's entire narrative discourse. My

following chapter on Collins's *The Moonstone* will demonstrate ways in which illness functions as a reconstruction and how it accrues meaning retrospectively much as literary discourse does. Collins's text also illustrates the plot-building potential of the repeated instances of illness that occur within Victorian fiction and which can create mysteries, detours, and, sometimes, resolution.

CHAPTER TWO
"BUT FOR HIS ILLNESS": THE NARRATIVE NECESSITY OF INDIVIDUAL SUFFERING

From its inception in the 1860s, critics of sensation fiction have connected this genre with issues of health. Writing in *The Quarterly Review* in 1863, H.L. Mansel scathingly condemned this new type of novel as "preaching to the nerves instead of the judgment" (357) and catering to "the cravings of a diseased appetite" in its readers (357). In the same year, *Punch* included a satirical advertisement for a fabricated periodical entitled "The Sensation Times, and Chronicle of Excitement." Among this journal's primary objectives were "Harrowing the Mind, Making the Flesh Creep, Causing the Hair to Stand on End, [and] Giving Shocks to the Nervous System" (qtd. in Hughes 3). Later critics have extended this analysis even further. For instance, in *Disease, Desire, and the Body in Victorian Women's Popular Novels*, Pamela Gilbert examines both the metaphors of disease surrounding the production and consumption of sensation fiction and the repeated appearance of disease as both topic and trope in the novels of M.E. Braddon, Rhoda Broughton, and Ouida. She argues that sensation fiction was seen as possessing the potential to both morally and physically (via the sensations created in the passive reader) infect its readers.

Wilkie Collins is often identified as one of the founders of this new school of fiction. (There is evidence to indicate that Collins might have even been the prime offender that Manse had in mind in his 1863 critique.) Collins suffered terribly from various ailments (which he often simply identified as gout) throughout most of his life, and concerns over poor health permeate much of his often-sensational fiction. In a section on *The Woman in White* in her book *The Sensation Novel and The Victorian Family Magazine*, Deborah Wynne contends that one of Collins's specific "technique[s] for generating 'sensation' was to unsettle his readers by focusing on… the vulnerability associated with poor physical and mental health" (38). In this reading, then, Collins would have employed descriptions of mental and bodily ailments in order to create

within his readers the very sensations of nervous shock and titillation most feared by critics of this emerging genre.

While I find Wynne's observation quite suggestive, I believe that we can push the function of these recurring descriptions of individual suffering in Collins's texts further. Focusing specifically on Collins's *The Moonstone*, I argue that rather than simply acting as a stimulus to create sensations in the reader, these instances of illness act as a stimulant for the entire forward movement of the novel's narrative. Experiences of being unwell, in other words, structure and drive the narrative of *The Moonstone* forward. More broadly, I maintain that illness is not simply a common and recurrent *topic* in Victorian fiction, but rather, an organizing principle within the Victorian novel.

I wish to make clear that I am isolating *illness*, as opposed to merely examples of disease, as providing this narrative force. Illness repeatedly emerges in Victorian novels spanning a variety of genres ranging from what we now consider "high literature" to sensation fiction to early New Woman novels. In fact, it is difficult to find a Victorian novel which does not contain prominent examples of this personal experience of disease. Take as a diverse sample Elizabeth Gaskell's *Mary Barton* (1848), Charlotte Bronte's *Shirley* (1851), Charles Reade's *Hard Cash* (1863), and Olive Schreiner's *Story of an African Farm* (1883). In all of these instances, and in many more, while later critics may have expended a great deal of energy trying to determine the specific complaints from which the characters suffer, the novels themselves focus upon the experiences of these ailments; these novels often go so far as to disregard even naming the disorders or to lump them into general categories like "fever."

I propose that in *The Moonstone*, and elsewhere in Victorian fiction, illness serves as the "motor" which pushes the narrative forward and causes components of the narrative—such as individual narrator's accounts and detours within the plot—to accumulate. In order to clarify this concept, allow me to refer to Peter Brooks's seminal work of narrative theory, *Reading for the Plot*. In this study Brooks argues that we must abandon the static, formalist perception of plot *structure*, and replace it instead with the idea of plot *structuration*, the dynamic process through

which a plot comes to have meaning. In the service of this process of structuration, Brooks calls our attention to "motors" of narrative, forces within narratives which drive our reading and the creation of plot forward. These motors are necessary for meaning-making since they are precisely what drive us to the end of a novel, and thus, to the point at which meaning can be retrospectively determined. Though he specifies desire as the basic drive "which is initiatory of narrative, motivates and energizes its reading, and animates the combinatory play of sense-making" (48), the actual driving force pushing the plot forward within each novel, and thus creating meaning within each novel, can take many forms. For instance, Brooks highlights "ambition" as a "dominant dynamic of plot" in many novels of the nineteenth century (39), and he further observes that

> many writers seized upon the engines and motors of nascent industrialism as central thematic and symbolic forces in their work…. Not only do these [engines and motors] in each case provide the thematic core of the novels in which they figure, they also represent the dynamics of the narrative, furnish the motor power by which the plot moves forward. (42-5)

Hence, these metaphoric motors within narratives (ranging in form from ambition to the more concrete locomotive train) are the very things that facilitate narrative development, and thus, ultimately, meaning-making. I put forward that *The Moonstone* reveals illness as another predominant motor of narration in the Victorian novel, one which goes unmentioned in Brooks's examination.[23]

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[23] In my thinking on this topic, I also owe a debt to D.A. Miller's *The Novel and The Police*. Since Miller is one of the few critics who discusses the consolidation of *The Moonstone*'s disparate narratives, his work jump-started my thinking about threads that might run throughout and unify the narratives of *The Moonstone*. Essentially, Miller argues that the type of policing that operates within the plot of the novel is also enacted in the form of the novel, which may initially seem to be subjective and made up of many voices, but which is really monologic, for there is "always… a master-voice that corrects, overrides, subordinates, or sublates all other voices it allows to speak" (54). While I would not go so far as to say that illness controls the narrative in the sense of an over-riding master voice, I would suggest that examples of this phenomenon unify the disparate narratives that make up the novel and shape the construction of *The Moonstone*'s plot.

Illness is a particularly appropriate mode for perpetuating and building narrative, for the experience of disease is not only *narratable* (as I discussed in my previous chapter on *Bleak House*), but *narrative* itself. Brooks observes that a number of "the most suggestive analysts of narrative" (such as Walter Benjamin, Vladimir Propp, Frank Kermode, and Jean-Paul Sartre) share a common premise regarding retrospectivity, meaning, and narrative, namely, the "conviction that the end [of any narrative] writes the beginning and shapes the middle" (22). This is also the case with being unwell. Since maladies are often constituted by a multitude of seemingly unrelated symptoms which patients may not initially perceive and since current understandings and experiences of one's ailment can inflect a patient's understanding of what has come before, medical anthropologists like Linda Garro observe that illness, rather than existing objectively like disease itself, is always a retrospective construction. Thus, illness, much like the other, more literary narratives that Brooks discusses in his book, is the sufferer's forward-moving story of his or her disease which only takes on meaning retrospectively.

In *Medicine, Rationality, and Experience*, medical anthropologist Byron J. Good elaborates on the narrative qualities of illness, specifically describing its "subjunctive" nature. Good explains that the "indicative prevails in the world of what in the West we call 'actual fact'" (205), whereas sufferer accounts, which are often open-ended and constituted by alternative plots and mysteriousness, are more subjunctive and, thus, open to revision (155-57). This provisional quality of illness, I would note, characterizes it as not only a narrative wherein meaning is assigned after the fact, but one which has the potential to be rewritten.

The generative nature of illness as a tool for building narrative manifests itself repeatedly throughout *The Moonstone*, but the revisionary potential of these experiences of disease is nowhere clearer than in the case of the novel's sickly doctor's assistant, Ezra Jennings. In considering *Bleak House*, we saw that one of the unavoidable and sometimes disconcerting consequences of suffering from illness was a re-shaping of the self. Part of the necessity of communicating the patient's story in *Bleak House*, then, was to uncover this revision. In *The Moonstone*, however, rather than his encounter with disease reworking a passive and potentially

unwilling self, the sick Ezra Jennings actively performs a change in self. Jennings's experience of his ailment is uniquely shaped by his marginalized status as a miscegenated and shunned figure. His loneliness and yearning for community help to constitute his particular illness, and these aspects of his individual suffering prompt Jennings to carve out a group for himself and transform himself into an accepted member of this group. Within the new context that Jennings creates, he is able to rewrite his experience of disease rather than being rewritten by it.

Furthermore, via the fluidity of illness, Collins is able to use Jennings as a tool to radically revise the organizational principles underlying the nineteenth-century medical case. Within the pages of his journal, Jennings charts both his own distinctive encounter with sickness and, from his perspective as a doctor, the nervous disorder undergone later in the novel by Franklin Blake, a lovelorn and well-liked young man who the doctor's assistant clears of suspicions in the theft of the Moonstone. The two men's actual physical ailments could not be more divergent—Jennings's disease seems to be centered on his internal organs, while Blake is suffering from a complaint of the nerves. In the service of rewriting his illness, though, Jennings repeatedly links his experiences of physical discomfort with those of Franklin Blake. Traditionally within medical treatises and journals, multiple cases were cited side-by-side only in the service of providing a broader understanding of a particular disease. Jennings's case notes, though, unite patients based on their subjective experiences of suffering, not the strict categorization of their diseases. Jennings's journal, which combines patient narrative with medical case notes, rethinks the methodology of the medical case.

The generative nature of illness thus motivates both plot and character development within *The Moonstone* while simultaneously challenging its more diagnostic narrative counterpart, the medical case study. Experiences of disease prove productive and offer textual force within the novel on a number of levels. Repeated instances of illness provide the necessary detours of the middle of *The Moonstone*, which simultaneously delay and, in doing so, augment the novel's plot and propel it forward. At the same time, individual suffering helps create the initial desire to narrate in the work's most overtly ailing of characters, Ezra Jennings. Then, once

Jennings's narrative has come to a close with his death, his individual account retrospectively instigates the compilation of all of the other records that eventually make up the larger narrative which is *The Moonstone*. Illness within Collins's novel thus drives the reader to the end of the novel while simultaneously creating a situation in which this later moment authorizes the beginning and the middle.

Thickening the Plot: Illness as Large-Scale Narrative Catalyst

The body of *The Moonstone* is permeated with subtle instances of individual suffering that often go unnoticed in an initial reading of the novel—even though each instance ultimately involves a necessary manipulation of the plot. In much the same way that symptoms only become clear as signs of a larger disease retrospectively, so too does the pattern of illness within *The Moonstone* only take on full significance through a retrospective reading back. It is only at the end that we can see that the repeated instances of being unwell which permeate *The Moonstone* have led to the accumulation of narrative within the novel and, through this process, promoted the forward movement of the overarching novelistic narrative of which these embedded illness-narratives are parts. Because *The Moonstone* carefully juggles the concepts of disease and illness in a manner which clearly highlights the distinction between the two and because of the prevalence and importance of the experience of disease in forwarding the plot of the novel, *The Moonstone* is a particularly helpful novel to look at in order to see the narrative-building potential of the personal encounter with sickness.[24]

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[24] I am not the first critic to investigate the forces that propel *The Moonstone* forward. John Reed argues that "[l]ove is the engine that drives events toward a solution of the mystery of *The Moonstone*" (94). To back up this claim, Reed insightfully observes that Franklin Blake's love for Rachel Verinder, Rosanna Spearman's love for Blake, and even Blake and Ezra Jennings's friendship all contribute to the unraveling of the mystery surrounding the Moonstone's theft. I would not disagree that these relationships and the actions taken by those involved in these relationships are necessary for the mystery's resolution. However, I would like to propose that occurrences of illness play an even more instrumental role in the perpetuation of the narrative than love by itself.

From the start, the experience of being unwell plays an integral part in creating the mystery that composes *The Moonstone*. The central mystery of the novel begins with the diamond's initial entrance into the Verinder household. This entry results from the clause in John Herncastle's will in which he leaves the Moonstone to his niece provided that her mother is still alive to witness the inheritance of the diamond. One might argue that revenge, or perhaps penitence, is thus the impetus for the Moonstone's arrival in Rachel Verinder's hands. However, in order for the Moonstone actually to arrive in Rachel's hands, rather than just be intended for them, John Herncastle must first die, and it is thus his death, rather than his intentions, which really spurs the Moonstone's entrance into the Verinder household. And, as we discover, it is sickness, rather than many other possible causes, that leads to John Herncastle's death.

Herncastle's careful and elaborate precautions in which he specifies that the Moonstone be cut into pieces if he meets a violent end ensure that this death does not result from foul play. The reader is also never informed of any accidents or mishaps befalling Herncastle leading up to his death. Instead, the narration of Gabriel Betteredge and Franklin Blake reveals after the fact that Herncastle died as a result of sickness. As early as the birthday party at which Lady Verinder refuses to receive Herncastle, a year and a half before his death, Betteredge observes that the Colonel looks "wasted and worn" (31). Then, according to Franklin Blake, Herncastle notified Mr. Bruff six months before his death to tell him "Sir,--They tell me I am dying" (36) and to request that Bruff help him to make out his will. At this same time, the Verinder household receives word that John Herncastle is "ill in bed" (32), the last news of his condition that they receive, in fact, before being informed of his death. In this way, Herncastle's physical ailment coupled with his illness (that is, his bitter and ostracized experience of this ailment—evidenced, for instance, by Lady Verinder's refusal to see him at the birthday party) mark the entrance of the Moonstone into the narrative surrounding the Verinder family.

As the story continues, and we get closer to the theft of the Moonstone, illness continues to propel the events of the narrative forward. Leading up to Rachel's birthday party, we learn that Franklin Blake has given up tobacco to please Rachel. As a result, "He slept… badly… and came

down morning after morning looking… haggard and worn" (55). Blake's physical deterioration coupled with an acknowledgement of his recent poor sleep culminate in Mr. Candy, the doctor, diagnosing Blake over dinner and proclaiming that "his nerves were all out of order, and that he ought to go through a course of medicine immediately" (69). Thus, Blake's nervous disorder (coupled with his obstinacy) leads Mr. Candy with the help of Godfrey Ablewhite to secretly administer opium to the unknowing Franklin Blake. While Candy may understand the nervous disease from which Blake suffers, he has no grasp of Blake's distinctive encounter with this malady. And it is precisely Blake's illness (which intertwines both the experience of physical discomfort and the experience of worry over the diamond and the Verinder family's safety) that leads the young man to remove the diamond from Rachel's room and that thus transforms the mystery of the Moonstone's origins and John Herncastle's motives into the mystery of the Moonstone's theft, the resolution of which provides the plot for the rest of the novel.

At this point in the narrative, though, the potential still exists for the events of the narrative to come to a crashing halt and for the mystery of the Moonstone's theft to be quickly resolved. This possibility for speedy resolution of the conundrum lies in the prospect of Mr. Candy returning to the Verinder household in the morning and explaining that he had given Blake a dose of opium to soothe his nerves and to help him sleep. However, Candy does not come to the Verinder household the next morning to share this revelation because overnight he "had caught a chill… and was now down with a fever" (95). The doctor catches this fever not simply because it is raining when he leaves the party in his uncovered gig, but because his experiences and understanding of physical complaints lead him to believe that he is impervious to disease himself, "that a doctor's skin is waterproof" (75). Hence, Candy's particular beliefs and experiences as a doctor play a primary etiological role in the development of his ailment.

Candy's illness, shaped by both his beliefs and his behavior, turns out to be the very thing which prevents him from revealing his deception of Franklin Blake and stopping the narrative of the mystery in its tracks. Ezra Jennings makes this function of Candy's individual suffering in

the perpetuation of the narrative particularly clear in his later discussions with Franklin Blake. As he explains to Blake,

> *but for [Candy's] illness*—he would have returned to Lady Verinder's the morning after the party, and would have acknowledged the trick he had played you. Miss Verinder would have heard of it, and Miss Verinder would have questioned him—and the truth which has laid hidden for a year would have been discovered in a day. (381, my emphasis)

And if the truth of Franklin Blake's motivations had been discovered in a day, then most of the twists and turns that compose the central mystery of *The Moonstone* would never have even taken place—Rachel Verinder would never have felt the need to keep her secret and rebuff Blake for as long as she did; Rosanna Spearman would never have felt the need to cover for the already-vindicated Blake; and Ezra Jennings would never have been needed to prove Blake's innocence. While the location of the Moonstone would still have been in question, Rachel's ready forgiveness of Blake when the opium trick is finally revealed and Bruff and Betteredge's immediate agreement that Blake cannot be held responsible for his actions under the influence of the opium suggest that Candy's revelation would have eliminated the possibility of blaming Blake for the missing Moonstone. Moreover, the true thief might have been revealed earlier in the story had Rachel not been so certain of Blake's guilt—she does not follow the popular opinion that Godfrey Ablewhite had something to do with the theft of the diamond following his and Luker's encounters with the Indians simply because, at this point, she "know[s] the hand that took the Moonstone" (208) and nothing else, and she thus "knows" that Blake is responsible.[25] Thus, in much the same way that seemingly unrelated symptoms can delay the decision to take steps like seeing a doctor, so illness also augments the larger narrative by causing delays in the narrative and directing the paths of individual narratives.

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[25] Incidentally, the relationships mentioned above (Rachel and Blake's, Rosanna and Blake's, and Jennings and Blake's) are the very love relationships that Reed highlights as facilitating the forward movement of the narrative, and they would have had a very different development or been wholly unnecessary had illness not stepped in and created the need for them.

Illness not only contributes to the creation of the mystery that comprises much of *The Moonstone*; indeed, it also plays a key role in resolving this enigma. Candy's secret, hidden for so long, must finally be revealed in order to reach this resolution. And it is Candy's fevered experience of disease, coupled with Ezra Jennings's documentation of this experience, that leads to the eventual revelation. The delirium from which Candy suffers erases the usual barrier between inner, personal thoughts and experiences and outer appearance, for Candy's delirium causes him to speak aloud whatever thoughts or concerns are currently passing through his mind. Since Ezra Jennings is in the midst of a work on the brain and nervous system during the period of time in which he treats Candy, he spends his evenings "tak[ing] down the patient's 'wanderings,' exactly as they fell from his lips" (370). These fevered ramblings provide a retrospective explanation of how Blake could be the unaware culprit in the theft of the Moonstone. In fact, they disclose just about everything that Blake needs to know to understand his involvement:

> First, that [Blake] entered Miss Verinder's sitting-room and took the Diamond, in a state of trance, produced by opium. Secondly, that the opium was given to [Blake] by Mr. Candy—without [Blake's] own knowledge—as a practical refutation of the opinions [regarding the inefficacy of medicine] which [he] had expressed to him at the birthday dinner. (381)

Thus, via Jennings's recording of Candy's inner-most thoughts while he is sick, Candy's illness leads us back to an earlier part of the narrative and contributes to the resolution of the mystery surrounding the diamond's theft.

Moreover, Jennings's own distinctive encounter with disease also plays a role in this resolution after the initial revelation is made based on Candy's ramblings. Jennings suffers from "an incurable internal complaint" (375), and he has only been able "to resist the disease by such palliative means that [he] could devise. The one effectual palliative in [his] case [being] opium" (375-76). It is this *personal knowledge* of the effects of opium that allows him to recognize not simply that Candy had given Blake opium, but even more importantly, what actions Blake could have taken while under the influence of this drug. The importance of Jennings's own personal

knowledge, rather than just medical knowledge, in the recognition of what has transpired becomes particularly clear when Blake expresses confusion at "the effect of the laudanum…. [He] thought the influence of opium was first to stupefy you, and then to send you to sleep" (387). In order to clear up Blake's misconception, Jennings cites his own experience of the drug which he uses to medicate himself. He emphatically responds to Blake's query by stating "I am, at this moment, exerting my intelligence… in your service, under the influence of a dose of laudanum, some ten times larger than the dose Mr. Candy administered to you" (387). In this way, Ezra Jennings's relation of Candy's fevered experiences combined with his own individual experience of his complaint are necessary to build toward a narrative conclusion.

The next step in the narrative involves the proposal and enactment of a "bold experiment" (384), through which Ezra Jennings hopes to clear Franklin Blake of any guilt in the theft of the Moonstone and to discover the Moonstone's hiding place. He plans to enact this vindication by causing Blake to repeat the theft while again under the influence of a dose of opium, thus demonstrating Blake's unconsciousness of the original larceny. One of the requirements of the experiment is that the conditions of the night of the Moonstone's actual robbery be duplicated as closely as possible. This duplication includes the physical condition of Franklin Blake. Ezra Jennings assures Blake that in order for the experiment to work, they "shall have to put [him] back again into something assimilating to [his] nervous condition on the birthday night" (385). However, the somatic component of Blake's condition is only part of the equation—it accounts for Franklin's earlier disease, but not his previous illness. As Jennings himself later explains, "I told Mr. Blake from the first, that our complete success in this matter depended on our completely reproducing in him the physical *and moral conditions* of last year" (424, my emphasis). Franklin's personal experience of his disorder, the narrative context within which his disease occurs, in other words, must also be replicated in order to fulfill all of the experiment's goals.

The first step, reproducing the physical ailment, advances relatively easily. The presence of the nervous condition results in Franklin repeating enough of his actions from the night of the

original theft to clear him of accountability in the stealing of the Moonstone, and thus, to allow his reunion with Rachel and his further innocent investigations into the Moonstone's whereabouts. However, while Franklin's former disease has been replicated, his illness has not been, and, consequently, Blake's behavior under the influence of the opium does not lead to the revelation of the Moonstone's current location. Although his old illness is not reproduced and the experiment is not completely successful, Franklin's current experience of his nervous condition does serve another purpose in the text. His *present* unique encounter with this disorder leads to one last delay in the text, one last accumulation of narrative, in other words, before we finally arrive at the end of the novel and learn the secret of the Moonstone.

Hence, we can see that illness plays a vital role in the narrative's development from the beginning of the novel when the Moonstone enters the Verinder household to the moment when the means of the Moonstone's original theft are revealed and the ending is delayed one more time. The novel's punctuation by illness begins with the sickness-related death of John Herncastle, and it continues through Blake's experience of his original nervous disorder, Candy's experience of his fever and delirium, Jennings's suffering-derived knowledge, and Blake's experience of his final, induced nervous disorder. Together, these personal encounters with sickness continually facilitate and augment the larger narrative of *The Moonstone*, building the mystery at the heart of the novel and completing this creation by contributing to the eventual resolution of this mystery.

The integral function of individual suffering within *The Moonstone* is telling in terms of more than simply this single novel, for I would suggest that this detailing of illness's import has revealed not just a motivating force within this work but, in fact, another motor of narration within the Victorian novel and short story. Critics of *The Moonstone* have expressed an interest in the various medical sciences at play within the novel, but no one has focused specifically on the overwhelming number of illnesses that fill the pages of this work or the possible function of

all of these experiences of disease within the novel.[26] If illness serves such an essential purpose in this text where it has remained seemingly unimportant for years, one can only imagine the depth of its involvement in the structuration of a host of narratives within which living with sickness more blatantly figures—as well as in those texts where its impact seems initially minimal.

The Case of Ezra Jennings

Illness's role as a prominent motor of narration within the Victorian novel is unsurprising given the British population's preoccupation with their health at this time. A host of maladies ran rampant during the nineteenth century, often, as I detailed in my chapter on *Bleak House*, without the possibility of being checked by medical intervention. As a result, subjective encounters with pain and discomfort became dynamic forces in the lives of many Victorians.[27] This catalytic effect of illness within daily life is key to Collins's portrayal of Ezra Jennings, a character whose participation within the mystery surrounding the Moonstone is driven by his

[26] Critics such as Deborah Wynne and Tabitha Sparks have focused on Collins's interest in the topic of health, but they have emphasized Collins's novels which more overtly deal with sickness or infirmity such as *The Woman in White* and his later *Heart and Science* and *Poor Miss Finch*. In his study "Science and The Moonstone" Ira Bruce Nadel addresses the topic of medicine in *The Moonstone*, but it is within a larger attempt to tackle all of the sciences that Collins touches on in the novel. Following Nadel's exhaustive study of the sciences represented in Collins's novel, few critics of *The Moonstone* have taken on this larger topic or the subtopics included within it. Notable exceptions include Ronald Thomas who investigates the rising field of forensic science in relation to imperialism in *The Moonstone* in his "Minding the Body Politic: The Romance of Science and the Revision of History in Victorian Detective Fiction" and Jenny Bourne Taylor who devotes a chapter in her book *In the Secret Theatre of Home: Wilkie Collins, Sensation Narrative, and Nineteenth-Century Psychology* to examining *The Moonstone* in light of various contemporary theories of the unconscious.

[27] This couldn't be truer than in the case of Collins himself, especially during his composition of *The Moonstone*. He wrote (or, rather, dictated) "The Narrative of Miss Clack," the section of *The Moonstone* certainly most divergent from the other sections in tone, while prostrated by pain as a result of rheumatic gout. This "severest illness from which [Collins]… ever suffered"—as he describes it in his 1871 preface to a new edition of the novel—was further shaped by his mother's simultaneously being on her death bed, factors which probably resulted in his rather surprising depiction of Lady Verinder's heart disease and death.

distinctive experience of disease, a circumstance which ultimately helps to shape the entire narrative of *The Moonstone* itself.

In the character of Ezra Jennings who is both doctor and patient, *The Moonstone* encourages an acknowledgement of both medical and patient perspectives as *Bleak House* did, but for different reasons. While in *Bleak House* this acknowledgement pointed to a recognition of the disconcerting revision of self that could occur in illness, in *The Moonstone*, Ezra Jennings's combination of these two perspectives allows him to actively rewrite his illness and write himself out of marginality—as well as rethink the idea of the medical case altogether.

Ezra Jennings's centrality in the resolution of the mystery of the Moonstone's theft is certainly no mystery in *Moonstone* studies. Many critics have noted the importance of his experiment, his deciphering of Candy's ramblings, and his own opium addiction in helping to solve the case, and it has become a commonplace in criticism of *The Moonstone* to identify Jennings with Wilkie Collins.[28] If Jennings's sickliness is ever noted, it is generally to reinforce this last point—namely, the similarity between him and the perpetually sick, opium-addicted Collins. However, though some critics may identify the two with one another, there are key differences between the English novelist and the mixed-race, shunned Jennings. Ezra Jennings, like Collins, may spin out narrative after narrative, yet it is Jennings's marginality and related

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[28] For examinations of Jennings's experiment and his deciphering of Candy's ramblings see especially Nadel, Bourne Taylor, and Allan. Nadel asserts that Jennings is best able to unravel the mystery of the Moonstone because of his reliance on the scientific method, and further, that he provides the clue to the mystery when he deciphers Candy's ramblings. Bourne Taylor examines the theories of the unconscious that Jennings's engages in support of his experiment. Through the lens of Derrida and Lacan, Allan investigates indeterminacies in the novel as well as scenes of writing—in particular, Jennings's rewriting of Candy's unconscious ramblings.

For a discussion that moves beyond merely noting biographical similarities between Jennings and Collins, see Murfin who uses Jennings's recreation of the birthday night during his experiment in order to suggest that Jennings is an authorial figure and who maintains that what he produces during the course of this experiment could represent the larger novel. Also see Heller who suggests that while revolutionary impulses are marginalized in *The Moonstone*, a double voice emerges through "irony and indirection" (256)—an assertion which leads her to connect Collins to the self-censoring Ezra Jennings.

yearning for fellow-feeling—a fact of his life which I argue makes up a large part of his illness—that inspires him to marshal a host of narratives, including letters, cases, and his journal, to re-create himself and to fashion a community within which this new self fits. Ultimately, this allows him to rewrite the narrative that is his illness as well. Ezra Jennings's reconstruction of his suffering in turn parallels the retrospective construction of the entire novel. Jennings's reshaping of his disease experience thus provides us with both an instance of the revisionary potential of illness and a model for understanding how meaning accumulates within *The Moonstone*.

Constituting Illness: Miscegenation, Ostracization, and Disease

A close examination of Ezra Jennings's character and role in society reveals the range of components that help to compose and shape his illness and which distinguish it from simply being identified with the disease from which he suffers. Jennings does have a tangible ailment—the "incurable internal complaint" (375) that I mentioned earlier. And, since Jennings has been forced to move "from the use of opium to the abuse of it" in order to treat the intense pain resulting from this disease, "his nervous system is shattered" in addition to the original problem (376). In short, he truly is "a dying man" (376). However, Jennings never names this "incurable internal complaint," a particularly significant omission since he is himself a doctor's assistant and, thus, is familiar with diagnosis and medical terminology. His decision here and elsewhere not to medicalize his ailment places the emphasis on his experience of the disease, rather than on the disorder itself.

In addition to the actual "disease that is in [him]" (396), Jennings's mixed-race heritage figures him as diseased from the start. In his *Colonial Desire: Hybridity in Theory, Culture and Race*, Robert Young cites various views from the eighteenth and nineteenth centuries which associated the offspring of mixed race unions with sickness. As he points out, "threats of adulteration and contamination with respect to racial mixing can be found in France and England

in the eighteenth century. Knox [an Edinburgh anatomist and racial theorist writing in the 1850s and early 1860s] cites Livy… warning of the 'contagion' associated with 'the enticing delights of Asia'" (104). This view of the products of miscegenation as contaminated or diseased was not limited to Knox or Livy. Instead, an increasingly common theory in the Victorian period held "that the descendants of… inter-racial unions quickly betrayed evident signs of degeneration" (Young 102). Though there is no evidence in the text to indicate an etiological connection between Jennings's mixed-race origins and the corporeal complaint from which he suffers, observers constantly associate his appearance of miscegenation with his sickliness.

The physical descriptions of Ezra Jennings within *The Moonstone* make this association between sickness and miscegenation clear. For instance, when Franklin Blake sees him for the first time, he is mesmerized by Jennings's appearance and describes it at great length. The description swings back and forth between highlighting characteristics that intimate foreignness and characteristics that imply unhealthiness, almost conflating the two in an attempt to demonstrate what is shocking about Jennings's appearance. In order to convey the extent to which Jennings is figured as almost diseased by nature, I will quote Blake's description at length. Blake tells us that

> Judging him [Jennings] by his figure and his movements, he was still young. Judging him by his face, and comparing him with Betteredge, he looked the elder of the two. His complexion was of a gipsy darkness; his fleshless cheeks had fallen into deep hollows, over which the bone projected like a penthouse. His nose presented the fine shape and modelling so often found among the ancient people of the East…. His marks and wrinkles were innumerable…. [His] eyes [were]… of the softest brown… and deeply sunk in their orbits. Add to this a quantity of thick closely-curling hair, which, by some freak of Nature, had lost its colour in the most startlingly partial and capricious manner. Over the top of his head it was still of the deep black which was its natural colour. Round the sides of his head—without the slightest gradation of grey to break the force of the extraordinary contrast—it had turned completely white. (319)

In this passage, Blake seamlessly moves between physical characteristics evocative of disease ("fleshless cheeks," "marks and wrinkles," sunken eyes) and those suggestive of miscegenation or the presence of foreign blood ("gipsy darkness," the shape of his "Eastern" nose, "closely-

curling hair"). The inclusion of characteristics related to Jennings's background side by side with characteristics related to an actual disease hint at the extent to which the story of Jennings's diseased state (i.e., his illness) consists of more than just the disease itself. His illness is both his physical ailment and the physical and environmental context in which he experiences this ailment.

This physical context, characterized by his "gipsy complexion," is closely tied to the environment of solitude within which Jennings experiences his disease, for when Blake inquires of Betteredge why Jennings is "so unpopular," Betteredge explains, "Well, Mr. Franklin, his appearance is against him" (320). Betteredge's choice of words here is telling in its linking of the physical with the environmental. On the one hand, Betteredge's statement literally refers to Jennings's body and how the look of this body has impacted Jennings's acceptance. On the other hand, though, the circumstances surrounding Jennings's arrival—his *appearance on the scene*—are also against him since there is "a story" circulating about town that Candy took him as an assistant in spite of his not having solid references (320). As Betteredge's use of the word "story" indicates, this information falls more into the realm of gossip than fact, yet it is Jennings's otherness, typified by his unique physical appearance, that facilitates the easy acceptance of this story by the members of the town. In fact, though Betteredge shows a clear dislike of Jennings, the only descriptors that he attaches to Jennings within this entire section refer not to his behavior, disposition, or competence, but to his "piebald hair" and "gipsy complexion" (320).[29] The appearance of impropriety associated with Jennings is thus connected to the way he looks, and his negative appearance on both of these levels factors into the distaste with which he is constantly greeted and the subsequent shape that his individual suffering takes.

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[29] An almost opposite process takes place in reference to the novel's most seemingly upright, English character, Godfrey Ablewhite. Though Ablewhite is a liar, a womanizer, and the true thief of the Moonstone, his appearance of propriety (which is connected to his "beautiful red and white colour… smooth round face…and… lovely long flaxen hair" [54]) shields him from suspicion even when circumstances seem to be most against him.

The specific group within which someone exists invariably contributes to that person's encounter with disease. Medical anthropologists have explored this phenomenon in a variety of cultural settings, and Linda Garro concludes from her observations that these population-specific beliefs "serve as resources [for the sufferers] in reconstructing the past" and, thus, their illnesses (75).[30] Just as specific cultural backgrounds help to shape the ways that people experience being unwell, so too does a lack of community membership impact the development of illness. Within *The Moonstone* Ezra Jennings is ostracized and most decidedly not a clear member of any social circle, and he is thus forced to suffer through his ailment alone. This dis-connect from those around him becomes an integral part of his experience of his malady and, consequently, informs his actions throughout the text.

Jennings's lack of membership in the various communities with which he comes in contact is repeatedly reinforced throughout the novel. For instance, his distance from the society of his up-bringing becomes evident when he explains to Franklin Blake, "I was born, and partly brought up, in one of our colonies. My father was an Englishman; but my mother—" (366). We cannot, admittedly, say with certainty whether Jennings was accepted by any of the populations within the colony in which he was born, in part because we never actually know which colony

[30] In Garro's contribution to *Narrative and the Cultural Construction of Illness and Healing,* "Cultural Knowledge as Resource in Illness Narratives: Remembering through Accounts of Illness," she examines occurrences of diabetes on an Anishinaabe reservation in Canada and the "cultural understandings… about illness and diabetes" specific to this community, such as the belief in the over-consumption of store-bought, prepared foods, rather than weight-gain, as primary etiological factor in the development of diabetes. Similarly, anthropologist Vieda Skultans, in her essay "Anthropology and Narrative" in *Narrative Based Medicine: Dialogue and Discourse in Clinical Practice*, describes her work in Latvia, explaining the ways in which illness for members of the Latvian population is constituted in part by factors such as "the perceived shortcomings of the Soviet regime in post-war Latvia" (230). Byron J. Good and Mary Jane DelVecchio Good provide a further recent examination of the impact of specific cultural backgrounds on the experience of illness in their article in *Social Science Medicine*, "In the Subjunctive Mode: Epilepsy Narratives in Turkey." While attention to the cultural context informing medical interventions and patients' experiences has garnered special attention in medical anthropology in recent decades, attention to this type of context can be traced back at least as far as Claude Levi-Strauss's *Structural Anthropology*, in which he examines practices such as shamanistic healing and treatment in the Cuna culture.

his mother is from.[31] However, though we cannot be sure of how Jennings was treated, the fact that he has left his colonial birthplace together with the diction that he uses to describe his origins make clear that he has dissociated himself from this possible community. Not only does he refer to the colony as one of "our" colonies, implying his identification with his English rather than colonial ancestry, but in fact the only parent whose origins he even willingly acknowledges is his English parent. In addition, he does not say, "my father was A *and* my mother was B," a grammatical choice that would have put the two nationalities on equal footing. Rather, he chooses to use "but" to introduce his mother's never-explicitly-acknowledged, but certainly-not-English background, suggesting its inferiority to the English heritage introduced in the first clause, and thus, its unacceptability to Jennings.[32] The way that Jennings believes that his mixed-race background will appear to others thus works together with his actual physical appearance of miscegenation to distance him from a group within which he might be able to more meaningfully (or, at any rate, differently) experience his disease.

Although Jennings associates himself with the English, it becomes abundantly clear throughout the novel that almost every English population that he encounters rejects affiliation with him. For example, in his initial description of Ezra Jennings, before we ever realize the integral role that the doctor's assistant will play in the novel, Betteredge states that "nobody knew much about him [Jennings] in our parts. He had been engaged by Mr. Candy, under rather peculiar circumstances; and, right or wrong, we none of us liked him or trusted him" (146). Betteredge's "us" seems to include just about everyone that he comes in contact with, for later in the novel, he asserts that "*Nobody* likes him… and *he hasn't a friend in the place*" (320, my emphasis). Betteredge's assessment is particularly damning considering his position in English

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[31] As Lionel Caplan explains in his *Children of Colonialism: Anglo-Indians in a Postcolonial World*, "[t]he manner in which mestizo groups engaged with others and among themselves depended to a large extent on how hybridity was construed in any particular colonial setting. Local circumstances ensured that each experienced its equivocal position in very particular ways" (8).

[32] For further discussions of the novel's colonial context, most of which focus on the Indians who search for the Moonstone, see for example Crooks, Miller Frick, Pionke, Roy, and Sabin.

society. As dedicated house-steward to the Verinders, Betteredge is uniquely acquainted with both the serving classes and the aristocracy, making his pronouncements of dislike all the more sweeping. Though Mr. Candy himself accepts Jennings enough to engage him as his assistant, Candy's extended sickness reduces him to a mere shadow of his former self and a rather poor companion. In addition, as Betteredge's earlier comment insinuates, Candy's initial acceptance of Jennings does not extend to the rest of Candy's household. Franklin Blake observes that Candy's

> pretty servant girl—who was all smiles and amiability, when I wished her good morning on my way out—received a modest little message from Ezra Jennings… with pursed-up lips, and with eyes that ostentatiously looked anywhere rather than look in his face. The poor wretch was obviously no favorite in the house. (364)

Jennings's ostracization is so pervasive that even those lowest in the hierarchy of the English household display no reservations about openly expressing disdain for him. We might not be that surprised to discover that no strong connection exists between the servants of the house and Dr. Candy's assistant, but what is surprising is that Jennings's own British family seems to have rejected him. Jennings himself tells Franklin Blake that "[t]here is much that I might say… about the merciless treatment of me by my own family" (374), indicating his distance from his English relatives. Jennings's existence within a society in which every avenue of fellow-feeling has been closed off to him contributes to his illness's development just as surely as recognized affiliation would promote an understanding of his complaint inflected by that group's beliefs.

Moreover, the members of Jennings's profession also look down upon him, a factor which may also play a role in his reluctance to medicalize his own ailment. When he proposes an alternate treatment for the slowly worsening Candy, the two other doctors also treating Candy's fever categorically refuse to even consider Jennings's idea. Upon deciding to attempt his method anyway, "[t]he two physicians took up their hats in silence, and left the house" (368). In addition, all of Jennings's employers previous to Candy have let him go the moment the never-disclosed accusation against him has come to light—without caring to help defend his name. Potential patients even recoil from Jennings, as he makes clear when he laments that "nobody who can

help it will employ *me*” (393). Jennings’s outward show of miscegenation and his resulting marginality help in large part to constitute his particular encounter with disease.

The impact that solitude has had on the shape of Jennings’s illness becomes clear in his accounts of his suffering. When Jennings initially converses with Franklin Blake, he divulges little personal information. There are two topics that he feels he must mention to Blake, though: first, the unfounded accusation against him and the constant movement that this accusation has necessitated and, second, the reality that he is a dying man. The close proximity of Jennings’s descriptions of his loneliness and then his disease begins to suggest the interrelatedness of these two facts of Jennings’s life. The motivation that Jennings reveals as fueling his continued endurance of suffering makes this connection even more blatant. Jennings explains that he “should have let the agony of it [his internal complaint] kill me long since, but for one last interest in life” (375). This interest in life is providing enough money to make the woman who he once loved independent. Jennings left this woman when the accusation against him came to light and he acknowledges that he “shall never see [her] again” (375). The nature of Jennings’s agony itself—his individual suffering—is thus wrought with loneliness since the prolongation of his pain stems from this broken bond.[33] In addition, the unremitting nature of Jennings’s anguish—intimated by his repeated references to pain within his journal—would serve as a constant reminder of his solitary status. This initial loneliness is only compounded by his everyday experiences of ostracization.

Jennings’s dreams further illustrate the way in which his experience of disease is tied up with his friendless existence. In addition to the physical torture noted above, Jennings’s use of opium, which he takes as a pain-reliever and to protract his existence, has led to his nights being “nights of horror” (376). In one of his first journal entries, he writes, “Rose late, after a dreadful

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[33] While I am referring explicitly to Jennings’s physical pain here, this physical pain is clearly connected to his emotional pain as well since he not only undergoes this pain, but *decides* to undergo it. He continually makes this decision because of his feelings toward the lost love for whom he intends to provide.

night; the vengeance of yesterday's opium pursuing me through a series of frightful dreams" (392). The content of these frightful dreams is significant, for they consist of a multitude of people who have passed out of Jennings's life forever, including "the phantoms of the dead, friends and enemies together" and "the one beloved face which I shall never see again…glar[ing] and grinn[ing]" at him (392). He adds, "A slight return of the old pain, at the usual time in the early morning, was welcome as a change. It dispelled the visions—and it was bearable because it did that" (392). This "old pain" can be read as both somatic and emotional since one of the painful realizations that must return to Jennings each morning along with physical discomfort is his friendless state. Jennings's illness thus consists of a vacillation between being haunted by nightmarish incarnations of those he was connected with in the past but whom he will see no more and awaking to a life of bodily hurt which he must face on his own.

The Impetus to Action:
Constructing Community Through Narrative

In his study of medical knowledge and the experience of disease, *Medicine, Rationality, and Experience*, medical anthropologist Byron Good describes illness's potential for being rewritten. As opposed to "facts," which are aligned with the objective assertiveness of the indicative, sufferer's narratives are more conditional, more contingent on circumstances and available to revision. Good argues that this "subjunctive" quality is present within these narratives in order to the leave open the possibility of cure. I would contend, though, that this openness to revision can exist even in the face of death and without any possibility of physical cure present. With his medical background and knowledge, Ezra Jennings is not anticipating a solution to his medical problem. As death closes in for Ezra Jennings, the subjunctive possibilities of his narrative are slowly closed off, and his final opportunity to rewrite himself and his experiences approaches. This impending end to the possibility of future changes is what

provides Jennings with the impetus to retrospectively reconstruct his role among his peers and, ultimately, his illness itself.

The narratives that Jennings creates and conveys play an integral role in the reconstruction of self that Jennings performs. Narrative is functioning on several levels at this point in the novel: Jennings's illness (that is, the narrative experience of his disease) prompts his initial yearning for community; this narrative consequently spurs the creation and use of further narratives which Jennings employs to rewrite his character and facilitate the construction of the desired relationships. His ability to then experience his disease within a group (and, specifically, a collection of fellow sufferers made up of himself and Franklin Blake) allows him to retrospectively reconstruct the narrative that is his illness.

As Jennings's disease worsens, his marginal status becomes more painful to him, and his desire to create associations intensifies. Jennings makes this clear in his journal when he tries to account for his interest in Franklin Blake. He wonders,

> is there… something in him [Blake] which answers to the yearning that I have for a little human sympathy—the yearning which has survived the solitude and persecution of many years; *which seems to grow keener and keener, as the time comes nearer and nearer that I shall endure and feel no more*? (393, my emphasis)

In other words, as Jennings's sickness progresses and death approaches, he feels an ever-greater need to redefine himself and to fit in with those around him, and his relationship with Franklin Blake holds the promise for fulfilling that need.

That Jennings believes his friendship with Franklin Blake is the key to creating community (and eventually revising the way he experiences his malady) becomes clear through his commentary on his new friend. First of all, Franklin intrigues Jennings because he demonstrates the potential for belonging. Jennings elaborates on this possibility when he tells Blake,

> There is no disguising, Mr. Blake, that you interest me…. A man who has lived as I have lived has his bitter moments when he ponders over human destiny. You have youth, health, riches, *a place in the world*, a prospect before you. You, and such as you, show me the sunny side of

> human life, and reconcile me with the world that I am leaving, before I go. (376, my emphasis)

In this way, simply observing Franklin Blake, a man who both has “a place in the world,” and who has not recoiled from or shunned Jennings (unlike almost everyone else Jennings encounters), gives Jennings the opportunity to imagine another kind of life typified by health and a place in society. This interest in Blake, though, goes beyond simply being allowed to see an example of happy and healthy association with a group. Rather, the assistance with which Jennings provides Blake allows Jennings to move beyond observation and to participate in, at least for awhile, the “sunny side of human life” that this other man represents. As Jennings notes, “[i]f I can do you this little service, Mr. Blake, I shall feel it like a last gleam of sunshine, falling on the evening of a long and clouded day” (391). Indeed, his interaction with Franklin does begin to lighten his burden and to present him with another possibility for how to live and, through this experience, the tools necessary to come to terms with his disease. In his journal, Jennings describes the effect of his new relationship with Blake: “Mr. Blake has given me a new interest in life” (393). This new interest in life should not be construed as some sort of belief in the literally curative powers of Jennings’s relationship with Blake; nowhere in the text does Jennings suggest that his internal complaint is dissipating, and he seems well-aware throughout that he shall soon die. On the contrary, Jennings’s interest rests in the ways that this relationship will allow him to reshape himself and the story of his sickness. Jennings transforms this new-found awareness into an active pursuit of a place in Franklin Blake’s world.

A wide array of narratives provides the means by which Jennings fulfills his dual desires of refiguring himself as smart, thoughtful, and kind and altering his sense of belonging (both of which will contribute to the eventual reshaping of his illness). First of all, he uses the story of the birthday night, derived from Candy, but which he helps to create, to facilitate Franklin Blake’s interest in him. This narrative allows him to propose the experiment that I detailed earlier. While exoneration will be one consequence of the experiment, a furtherance of Jennings’s relationship with Franklin will also result.

Another purpose of this experiment is to reunite Blake and Rachel Verinder, and to that end, Jennings writes to Rachel to tell her of the experiment after her one-time beau has agreed to undertake it. Again, this letter, like the narrative that he employs to win Blake's affections, helps Jennings to both facilitate the reunification of Franklin and Rachel's broken relationship and to become part of the community which Franklin and Rachel represent. That his letter-writing contributes to his acceptance by Rachel becomes clear when she arrives on the night of the experiment. Upon hearing Jennings in the hallway, Rachel "came out eagerly to speak to [him] in the corridor. [They] met under the light of a lamp on a bracket. At the first sight of [him], Miss Verinder stopped, and hesitated." However, she "recovered herself instantly," and her next words are "I can't treat you like a stranger, Mr. Jennings…. Oh, if you only knew how happy your letters have made me" (410). Rachel's initial reaction to Jennings's appearance, coupled with her following assertion, illustrates that Jennings has managed to win Rachel over primarily by writing her a letter in which he has defined himself as the one who will make her reunion with Blake possible. In his first encounter with Rachel, the body of the text that Jennings has written serves as a substitute for his own physical body; this narrative body then provides the context within which Rachel is able to dismiss Jennings's unusual physical appearance as inessential to his character. Narrative thus proves the perfect tool for circumventing the impressions generally produced in those meeting Jennings for the first time.

More than any other document, Jennings employs his journal to take control and create personal connections for himself. He does this first of all by using it as a forum to describe his new state of belonging. Within the pages of his diary, Jennings relates tales of his acceptance and by so doing he solidifies these new social bonds through narrative documentation. For instance, Jennings spends a great deal of time describing the growing closeness of his relationship with Franklin Blake. The moments when Blake takes Jennings's side over Bruff or Betteredge's demonstrate this closeness well. When Bruff sends Blake a letter protesting the experiment, Jennings "asked Mr. Blake if his friend's protest had shaken him" (397) with a bit of trepidation. However, the growing bond between Franklin and Ezra is obviously strong, for Blake "answered

emphatically, that it had not produced the slightest effect on his mind," at which point, Jennings feels "free… to dismiss Mr. Bruff from consideration" (398). The two are also united in their amusement at Betteredge's protest against the experiment and insistence on taking notes of everything that Jennings says so as to remain a "blind agent" in the proceeding (398). Blake, for instance, cuts Betteredge off in the middle of his request to be allowed to "wash [his] hands… of certain responsibilities" by interjecting after "wash my hands," "You may decidedly…. I'll ring for the waiter" (400).

In addition to this growing camaraderie, Jennings describes the way in which Franklin begins to rely on him for advice, observing that Blake "consulted me, with some nervous impatience and irresolution, about a letter… which he had received from Sergeant Cuff" (402). After counseling Blake as to the appropriate course of action, Blake "promised to follow my [Jennings's] advice" (403). Jennings also makes a point of documenting all of the activities that he and his new friend undertake together, noting, for example, that "Mr. Blake and I took a long drive in an open carriage. We both felt beneficially the blessed influence of the soft summer air. I dined with him at the hotel" (406). By actually writing down such descriptions of these everyday interactions with Blake within the pages of his journal, Jennings is in effect concretizing his membership in a group.

Moreover, Jennings's journal also illustrates the progress of his relationships with Rachel, Bruff, and Betteredge. In much the same way that Franklin Blake comes to rely upon Jennings's advice, Jennings observes that according to Mrs. Merridew, Rachel "declines to be guided by any opinion but mine" (401). Also, after she meets Jennings in person for the first time, Jennings notes that Rachel answers his statements "as she might have answered a brother or a father," while "[h]er fingers trifled… with a flower which I [Jennings] had picked in the garden, and which I had put into the buttonhole of my coat" (411). Rachel's toying with the flower in Jennings's buttonhole is especially telling in terms of the success of Jennings's redefinition of self. Jennings's physical presence earlier in the story was precisely what told against him according to Betteredge, yet Rachel's actions suggest a comfortableness on her part

with being in close physical proximity to Jennings and thus a shift in perceptions regarding the sickly doctor's assistant.

Bruff and Betteredge are a bit more difficult to win over, but by the conclusion of the experiment both men have also expressed their respect and admiration for the doctor. Betteredge's conversion comes earlier than Bruff's, for before Blake even rises from his bed for the first time and Jennings is still warning Bruff and Betteredge to remain completely silent, "Betteredge dropped to the lowest depths of familiarity with me [Jennings], without a struggle to save himself. He answered by a wink!" (418). Then, after the completion of the experiment both Betteredge and Bruff apologize for their earlier, distrustful treatment of Jennings. Bruff states, "I beg your pardon, Mr. Jennings, for having doubted you. You have done Franklin Blake an inestimable service" (424). Again, by explicitly including within his journal the above-cited descriptions of the meetings and events in which Rachel, Bruff, and Betteredge demonstrate familiarity and admiration for Jennings, Jennings is able to successfully rewrite himself into the role of friend and confidant.

This revision of self is inextricably tied to his illness in terms of both cause and effect. On the one hand, the impulse to embark on such a self-revision is predicated on his solitary experience of disease and the pain that this experience causes him. His initial suffering provides the motivation and thus opens the gateway to this breakthrough in self-definition. On the other hand, though, this forging of new relationships ultimately allows Jennings the opportunity to rework the very illness which prompted his creation of community.

Jennings's Revision of Illness Through Personal Case History

Jennings retrospectively rewrites his own illness by employing the methods of the traditional case study in reference to Franklin alongside his own personal reflections on his experience of his disease. In order to convince Blake of the efficacy of the proposed experiment

and that opium could work in the way that he describes, Jennings draws Blake's attention to two very different types of case narratives. The introduction of these narratives simultaneously implements the form of the medical case and posits the possibility of personal case study.

The first narrative is a more traditional case example presented by Dr. John Elliotson in his *Human Physiology*, and it relates the story of a man who misplaced a package under the influence of alcohol and was then only able to find it again under this same influence. This case is traditional in the sense that it appears in a comprehensive and widespread guide to the human body and mind written by a medical doctor and fellow of the Royal Society. The roughly eleven-hundred-page *Human Physiology* contains multiple case examples described from an outside perspective (i.e., not the patient's) and employed to illustrate larger tenets about specific bodily functions. Not as much time is spent developing the history of individual cases as would happen in a single case study appearing in a medical journal, for each case here is described only in so far as it relates to the bodily function or disease currently being discussed by the author. Elliotson is very clear about this organizing principle, stating at the beginning of the section within which the case excerpted by Jennings appears, "I will relate a number of examples of sleep-waking to show the various amount and extent of activity in this condition" (630). The patient's feelings about the cited experiences are generally not present, especially in the example mentioned in *The Moonstone*, for this particular case has gone through even more medical mediation than most, first being described by a Dr. Abel, who relates it to a Dr. Combe, from whom Elliotson finally quotes it.

The second case narrative cited by Jennings, on the other hand, is Thomas De Quincey's *Confessions of an English Opium Eater*. Though this is not a medical case study in the strictest sense, within *Confessions* De Quincey does provide a case history of himself and his experiences with opium. He begins with a description of his history preceding his opium use and the factors that led to it, and he follows this with the details of when and how much opium he imbibed and its effects. The inclusion of De Quincey's case narrative is significant, for it raises the possibility of personal examination and documentation of one's own ailments—a more interior case study

of oneself, in other words. De Quincey explains how his knowledge differs from that presented in traditional medical literature. He declares, "I speak from the ground of a large and profound personal experience, whereas… those who have written professionally on the *materia medica*, make it evident, by the horror they express of it [i.e., opium use], that their experimental knowledge of its action is none at all" (203-204). De Quincey's personal case study is grounded in experience, rather than outside observation, and according to him, this method for garnering information has led to a more accurate and thus valuable assessment of opium and its effects.

Moreover, De Quincey dismisses the traditional aligning of cases based on disease type in favor of pairing cases based on shared suffering. He compares his taking of opium with Coleridge's and maintains that their individual decisions to turn to opium to combat overmastering pain (though stemming from different ailments) unite their two cases. In fact, De Quincey boldly declares in reference to his and Coleridge's experiences, "And vainly, indeed, does Coleridge attempt to differentiate two cases which ran into absolute identity, differing only as rheumatism differs from toothache" (5). Though the difference between rheumatism and toothache might initially seem great, according to De Quincey the individual disease itself is not nearly as important in categorizing suffering as the sufferer's personal experiences of this disease such as pain.

The coupling of the ideals reflected in each of these works inflects Jennings's ministrations as a doctor throughout the novel. Jennings does value careful observation (for instance, he keeps up a vigilant watch at the bedside of Mr. Candy throughout his sickness), but as Jennings's appearance-based reception by his peers illustrates and he recognizes, observation alone is not sufficient for making judgments. Jennings's diagnostic methods are tempered by his knowledge of illness. As such, in addition to observation, Jennings also values the patient's discourse—most of his descriptions of Blake in his journal have less to do with how Blake looks, for example, than with what Blake relates about how he is feeling. In many ways, Jennings's life's work is about re-enfranchising the patient. One of the main contentions of the book he is working on is "to doubt whether we can justifiably infer—in cases of delirium—that the loss of

the faculty of speaking connectedly, implies of necessity the loss of the faculty of thinking connectedly as well" (369). Jennings's premise highlights what the patient still possesses (that is, connected thoughts) in the face of the current medical beliefs about patients' minds in this condition (their disconnected speech indicates disconnected thinking)—it focuses on their self-possession, not on what they have lost. Listening to his patients' narratives forms a large part of Jennings's medical practices.

The possibility of personal case study paired with a more traditional case note-taking and the recognition of illness as opposed to simply disease informs Jennings's most important act of narration, that is, the narration of his journal. It is this narrative act that most clearly allows Jennings to revise the story of his own suffering within the context of his new relationship with Blake. Once he has embarked upon the experiment with Blake, the descriptions of Jennings's illness in his journal occur within the context of the community constituted by him and the now also sick Blake. During the process of restoring Blake to his nervous condition of the previous year, Jennings begins to align his suffering with Blake's, repeatedly pairing personal descriptions of his own pain and discomfort with his case notes detailing the progress of Blake's condition. After describing the "dreadful night" populated by "frightful dreams" that I examined above, Jennings moves from his own experiences to Blake's. He explains that "My bad night made it late in the morning, before I could get to Mr. Franklin Blake. I found him stretched on the sofa, breakfasting on brandy and soda-water, and a dry biscuit" (392). He then records that Blake, too, spent a "miserable, restless night" (392). Following this comparison of their conditions, Jennings asserts, "I left Mr. Blake… feeling the better and the happier even for the short interview that I had had with him" (393). Jennings began this journal entry mired in the nightmares that revolved around his solitary status. With the advent of Blake's discomfort and restlessness, though, Jennings is no longer alone in his suffering. And this coupling of his own horrible experience with Blake's changes Jennings's outlook on his life and the way that he experiences his ailment.

Hereafter, many of Jennings's journal entries consist of his case notes on Blake side-by-side with ruminations on his own illness. For instance, on the twenty-first of June, he writes,

"Mr. Blake has had the worst night that he has passed yet. I have been obliged, greatly against my will, to prescribe for him…. As for myself, after some little remission of my pains for the last two days I had an attack this morning… that… has decided me to return to the opium" (405). Through these descriptions, and others like them, Jennings continues to draw parallels between the two men's experiences. Both of them are suffering, enough so that each is forced to turn to the palliative effects of medication. The descriptions thus allow him to revise his experience of disease since he is now undergoing it within a group as opposed to the solitude in which he has been forced to suffer up until this point. This connection between his new friendship and the experience of sickness becomes even clearer in Jennings's next journal entry, where he explains that both he and Blake slept better the following night and which he thus begins by stating, "*Our* prospects look better to-day" (405, my emphasis). Jennings's use of the phrase "Our prospects" to begin this entry is apt, for the two men's illnesses are, in fact, now linked. The progress of Blake's illness is key to his exoneration, his continued relationship with Jennings, and Jennings's vindication in the eyes of those around him. At the same time, Jennings's continued perseverance in the face of suffering is requisite for the completion of the experiment that will lead to these results. By placing the experience of his disease within the context of his relationship with Blake—that is, the new community that he has retrospectively solidified through his written accounts of everything that they share—Jennings has successfully begun to rewrite the narrative of his suffering.

Jennings's relationship with Blake not only allows him to resituate his experiences of his disease, but, in fact, to redefine the purpose behind his sustained suffering and thus the meaning of his illness. Before meeting Blake, Jennings continued to endure pain in order to provide a small inheritance for a past love with whom he had forever broken. His pain was thus grounded in loneliness. After meeting Blake and learning of his situation and his resulting alienation from Rachel, Jennings's endurance takes on a different tenor. Now, instead of simply providing money for someone he will never see again, he realizes that he can be "the means of bringing these two young people back together again" even though his "own love has been torn from" him

(394). His encounter with Blake allows him to re-ground his suffering in the service of unification rather than separation. The centrality of this purpose to Jennings's newly revised experience of his malady becomes clear in his June eighteenth entry as he describes a choice that he must make and the motivation underlying his decision. He writes,

> More of that horrible pain in the early morning; followed this time by complete prostration, for some hours. I foresee, in spite of the penalties which it exacts from me, that I shall have to return to the opium for the hundredth time. If I had only myself to think of, I should prefer the sharp pains to the frightful dreams. But the physical suffering exhausts me. If I let myself sink, it may end in my becoming useless to Mr. Blake at the time when he wants me the most. (396-97)

Jennings chooses which symptoms of his disease to suppress and which side-effects to undergo based on what will allow him to help Blake the most. Hence, the very nature of Jennings's suffering is now shaped by his communion with Blake and his desire to participate in the reunification of Blake and Rachel. Jennings's anguish has finally become meaningful; he suffers in the ways that he does so that he can help to create a bond.

The relief provided by the revision of his illness within the context of the society that he has formed for himself becomes particularly evident near the end of Jennings's journal excerpt included in the novel. When Jennings begins to grow melancholy thinking on "the gentle eyes which had once looked love at *me*" and thus on his loss of the one close relationship of his "youth" that he ever even hints at, he soothes himself by "turn[ing] to his Journal for relief" (426). This statement is soon followed by a description of the kind and loving sentiments expressed by Rachel Verinder and Franklin Blake before they must leave for London, which Jennings asserts "will help me through what is left of the end of my life" (426). Jennings's journal entries conclude with emphatic thanks for the happy participation in community that he has finally been afforded before his death. He proclaims, "God be praised for His mercy! I have seen a little sun-shine—I have had a happy time" (427). Earlier, Jennings observed that Franklin interested him because he "show[ed] [him] the sunny side of life" (376). Jennings has finally moved beyond observing others' sunny lives, though, and has "seen a little sun-shine" himself, thus providing him with the "reconcil[iation] with the world that [he is] leaving" (376) that he so

desired earlier. By helping to mend the bonds between Franklin and Rachel, a step which allows him to form a connection with these two, Jennings has taken control of the subjunctive potential underlying illness and rewritten his experiences into a form with which he can finally be satisfied.

Moreover, by describing these two cases together (cases, remember, in which the diseases suffered by each patient are quite different) Jennings explodes the idea of the traditional case study. First of all, through his recounting, Jennings transforms his singular experience into a shared experience. And second of all, with Jennings and Blake (as with De Quincey and Coleridge), the similarity uniting their cases is not a shared disease-type, something which could lead to more than one case being recounted in an article in a medical journal, but, rather, shared suffering. With the understanding of a doctor and the experiences of a patient, Jennings is able to use his journal to demonstrate the alienation attendant upon being a lone sufferer and to remove himself from the realm of singular case and place himself within a larger collection of fellow-sufferers, thus, effectively rewriting his illness after the fact.

The Generative Potential of Illness: The Union of Plot and Character

As I detailed near the beginning of this examination of *The Moonstone*, a host of often-minute illnesses serve as "motors" of narration within this novel, facilitating plot development and making the forward momentum of the novel possible. This generative potential of illness manifests itself on the level of character as well in the case of Ezra Jennings. The loneliness at the heart of Jennings's earlier conception of his individual suffering is, after all, what initially prompts him to begin the process of self-revision and community-building that culminates in his relationship with Franklin Blake, his movement away from marginality, and his newly revised narrative of illness. These two creative strains—both involved in engendering narrative, whether

it be the narrative thread of *The Moonstone* itself or the narrative that is illness—come together in Ezra Jennings's final act. With this ultimate deed, which involves preserving his account of the interactions between him and Blake and passing this account on to Franklin at the moment of Jennings's death, Jennings not only solidifies his newly minted narrative of his encounter with disease, but he also provides the foundation for the creation of the entire novel.

That Jennings intends the rewritten narrative of his suffering to be the final received version of his experiences becomes clear after his death, for the only information about himself that he leaves behind are the pages from his journal included within *The Moonstone*. Jennings's choice to save only these writings at the moment of his death serves as a final attempt to concretize the revised definition of self and story of his disease-experience that he has worked so hard to create during his time with Franklin Blake. On the one hand, then, Jennings's preservation of just these documents signals a closure to his narrative, an end to subjunctivity. On the other hand, though, Jennings's passing on of these papers to Blake illustrates the continued generative potential of illness. Following Jennings's death, the process of retroactive meaning-making which his previous actions set in motion persists, for his method of narration retrospectively leads to the creation of yet another community, the one composed of the many first-person narrators that populate this novel.

In order to complete the rewriting of his identity as a recognized friend and confidant to others, Ezra preserves for others only the excerpt from his journal included within *The Moonstone*, only, in other words, those "pages relating to the time when you [Blake] and he [Jennings] were together" (456). Jennings requests that the rest of his writings, which consist of "a little bundle of old letters… his unfinished book… [and the rest of] his Diary—in many locked volumes" (456) be interred with him. Significantly, all of the narratives that he wishes to have destroyed are the ones that document his loneliness—*old* letters that at best could only remind a reader of what Jennings had lost, the book "addressed to the members of [his] profession" who consistently shunned him and which he knew would "certainly never be published" (369), and the Diary in which he documented his "hard life" (457). Thus, by saving

this journal excerpt and having it transmitted to Franklin Blake after his death, Ezra Jennings retrospectively concretizes through narrative the alternate trajectory that he created for himself in his last days, the trajectory in which he was appreciated and valued as an important member of a welcoming group within which his illness took on new meaning.

Furthermore, Jennings's creation of narrative and society for himself extends, via this saved excerpt from his journal, far beyond his death. Rather, his death as a result of intense sickness spurs the creation of an even larger narrative collective made up of the novel's first-person narrators. What I am getting at here is that by sending Franklin Blake the excerpts from his journal that deal with the Moonstone, Ezra Jennings's character is actually the one who anticipates and prompts the project of creating a collection of first-person accounts of the Moonstone's history in relation to the Verinder family. According to Franklin Blake, it is he and Bruff who initiate the construction of what is contained in *The Moonstone* and propose its form. Blake states that

> Mr. Bruff thinks as I think, that the whole story ought, in the interests of truth, to be placed on record in writing…. The memories of innocent people may suffer, hereafter, for want of a record of the facts to which those who come after us can appeal…. And I think… Mr. Bruff and I together have hit on the right way of telling it… the idea is that we should all write the story of the Moonstone in turn—as far as our own personal experience extends, and no farther. (8)

While Blake and Bruff may be responsible for actually requesting and collecting the different narratives that make up the Moonstone, Ezra Jennings's last wishes actually suggest this plan at the time of his death—almost a year before Blake and Bruff propose it. Jennings's death-bed request is that Candy "Give those [pages from Jennings's journal that relate to the Moonstone and Blake] to Mr. Franklin Blake. *In years to come*, *he may feel an interest in looking back* at what is written there" (456, my emphasis). Candy conveys this information to Blake in a letter dated September 26, 1849. According to Betteredge, Blake does not propose that Betteredge write his first-person account until May 21, 1850 (7). Blake and Bruff's idea that participants in the mystery of the Moonstone provide first-person accounts explaining their first-hand knowledge of the mystery and that these accounts might be helpful to future generations tellingly

echoes Jennings's earlier observation that a first-person account of the vindication of Blake might be helpful to Blake in the future.

Indeed, Blake himself holds Jennings's excerpt up as a model when he introduces it later in *The Moonstone*. As Blake concludes his first narrative contribution, he leads into Jennings's journal by saying, "[t]he events of the next ten days—every one of them more or less directly connected with the experiment of which I was the passive object—are all placed on record exactly as they happened…. In the pages of Ezra Jennings nothing is concealed, and nothing is forgotten" (392). This description of an account that stays exactly within the bounds of what happened at the time of the mystery and that relates all of the relevant points regarding this time almost perfectly coincides with the type of narrative that we discover Franklin Blake has instructed the other narrators to adopt. At the end of his first inclusion, Betteredge explains to the reader that he cannot take the reader "up into those regions of superior enlightenment in which I sit myself… [because] I am forbidden to tell more in this narrative than I knew myself at the time…. I am to keep strictly within the limits of my own experience" (190). Jennings's contribution to the larger narrative, recorded in the moment of the mystery itself, by its nature tells nothing more than he knew at the time of the mystery and is definitely confined to his own personal experience. Thus, Betteredge's elucidation of the instructions that he must operate under in constructing his contribution indicates that Blake essentially tells the other writers to create accounts like Jennings's (a narrative, remember, that Blake had access to at this point)—even if Blake does not use these exact words to convey this meaning.

In this way, Jennings anticipates the idea that narratives explaining the mystery of the Moonstone would be helpful later, as well as the form in which these accounts would be best expressed, and, at the moment of his death, he authorizes the larger narrative of *The Moonstone* with his own. Hence, although Jennings's contribution appears near the end of the novel, his narrative (which documents and solidifies his acceptance by others as well as the resulting revisions of his illness-narrative) significantly contributes to the construction and meaning of the stories that compose the beginning and middle of the novel.

The disease from which Jennings suffers may be destroying his body, but the subjunctive nature of his illness proves ultimately generative. As the above examination has illustrated, Ezra Jennings's individual suffering leads to the production of both community and narrative. Jennings's initial solitary experience of his ailment prompts him to generate social bonds for himself, which leads to a subsequent regeneration of the broken tie connecting Franklin Blake and Rachel Verinder, a regenerated version of Jennings's illness, and, ultimately, the creation of the linked narratives which compose the text of *The Moonstone*.

"there was the mixture of some foreign race in his English blood": The Mingling of Medical Narratives and Literary Genres

The inclusion within Ezra Jennings of both foreign and English blood plays no small role in the way that he is originally perceived by the other characters within the novel and by the reader. However, his initial castigation followed by his later valorization overturns the easy identification made by many of the characters of whiteness with rectitude. Jennings's character participates in a more subtle combination of the personal and the medical case to similar effect. Jennings's narrative practices, stemming as they do from both his mixture of blood and his amalgamated role as both doctor and patient, promote a mixing of narrational methods, a movement between careful observation from an outside perspective and a more subjective inside knowledge. This mingling of styles ultimately results in a challenging of the traditional case form and the methods underlying its organization. As a result, the priority of somatic definition in categorizing patients' and their experiences is questioned. Jennings's pairing of he and Franklin Blake based on suffering rather than disease-type highlights the limitations of definitions based only on the physical.

The trickiness of genre definition when discussing *The Moonstone* only reinforces these ideas. Earlier in this chapter, I drew on the valances of sensation fiction to introduce the

discussion of illness within this novel. While *The Moonstone* is undeniably a work of sensational literature, its strict categorization as sensation fiction does not tell the entire generic story. Like other sensational novels such as *Lady Audley's Secret*, *The Moonstone* has also been identified after the fact as detective fiction. Indeed, T.S. Eliot famously maintained that *The Moonstone* was "the first and greatest of English detective novels" (525). This combination of genres is particularly telling in terms of the blending of the medical and the personal that we see in Jennings's journal (the very piece of writing, remember, that leads to the composition of the larger novel), for detective fiction is aligned with the clinical, with a diagnostician / detective resolving a mystery, whereas sensation fiction is so named because of its connection to the experiencer of sensation him or herself, the patient / reader. Generically, *The Moonstone* remains unresolved at the nexus of detection and sensation. Like Ezra Jennings, who is both doctor and patient, and his journal, which is both personal story and clinical accounting, this novel is mixed, and its makeup cannot be pinned down. *The Moonstone*'s placement somewhere between the genres of sensation and detection underscores the rich possibilities inherent in the drawing together of narrative forms.

Collins's text illustrates the possibility of employing clinical reporting to rethink the way we understand patients' distinctive, and often uncategorizable, experiences. Narrative, for Collins, is a powerful tool: though Jennings ultimately dies, the stories that he weaves fulfill a positively transformative function. Narrative is no less powerful in the chapter to come, but Mary Elizabeth Braddon paints a bleaker picture of medical writing's potential for creating change. In *Birds of Prey* and *Charlotte's Inheritance*, with which Chapter Three begins, Braddon hyperbolically demonstrates the possible threats stemming from the impersonal and widespread dissemination of medical literature. The compassionate Ezra Jennings combines personal and clinical recording to help others and to rewrite his illness, but, as Braddon cautions, less scrupulous practitioners might be equally able to employ the materials included within their professional libraries in the service of opposite ends. In the wrong hands, the mastery of medical

knowledge can lead to harm, not good—and the formulation of illness where no ailment existed before.

CHAPTER THREE
CASES POISONOUS AND PREVENTATIVE: FROM BRADDON TO STEVENSON

As the 1880s dawned, the cultural environment surrounding medicine and its practice began to change. One sign of this shift was the focus of the Seventh International Medical Congress, convened in London in 1881. As medical historian W.F. Bynum explains, "Like a rite de passage, this ceremony definitively ushered medical science onto the international public stage" (142). This highly publicized event heralded an emerging concentration later in the century on "science" in medicine—on the lab, that is, rather than the clinic. This is not to say that traits like scientific objectivity and experimentation were absent from clinical procedures previous to the 1880s. Indeed, it is the very detachment inspired by such methods that authors like Dickens and, as we will soon see, Mary Elizabeth Braddon target as potentially problematic in their featured practitioners. However, the possible disconnect between discoveries of the lab and the treatment of patients—the patient might have been objectified by the case, but the lab threatened to move attention even further away from individual sufferers, concentrating instead on the test tube and the Petri dish—spurred a skepticism of its own regarding the efficacy of the lab's findings.

In this chapter, my pairing of Braddon's *Birds of Prey* and *Charlotte's Inheritance* from the 1860s with Robert Louis Stevenson's 1886 *The Strange Case of Dr. Jekyll and Mr. Hyde* maps the transition in thinking from medical literature as threat to clinical case narrative as useful counterpoint to the new, and even more suspicion-inducing, laboratory sciences. Near the middle of the century, Braddon identifies the widespread availability of potentially dangerous information in the impersonal format of the medical periodical as the root of the unscrupulous doctor's power to manipulate and even "infect" his patients. By the end of the century, though, Stevenson identifies the doctor as equally, if not more, susceptible to contagion than those he treats. And amid the structural impact of Jekyll's final narrative, Stevenson presents the medical

case study as a vehicle for the responsible doctor to analyze and spread useful information regarding previous cases, thus pinpointing the medical case as serving a preventative, rather than contaminating, function.

In addition to their allusions to medical literature, Braddon and Stevenson both reflect on Victorian anxieties regarding the interrelatedness of the mind and the body and the creation of disease. Frequently recurring epidemics of cholera, influenza, and typhus plagued London and its surrounding areas from the 1830s through the 1860s, and the city suffered from exceedingly poor sanitation. Fueled by factors such as these, the fear of contagion through physical proximity to disease-causing agents was widespread in Britain by the latter half of the nineteenth century. At the same time, most Victorians steadfastly believed that physical and mental states could influence one another. This prospect manifested itself in arenas ranging from the developing medical field of psychophysiology to the belief in the physical hazards of certain reading habits. For instance, in J. Milner Fothergill's 1874 *The Maintenance of Health: A Medical Work for Lay Readers*, he maintains that "Uncleanliness of mind and body act and react … and perfect health of one is incompatible with an unhealthy state in the other" (qtd. in Haley 23). While Braddon meditates on the corruptibility of medical professionals and their potential exploitation of this mind-body link in the solidifying of their influence over patients, the latter-century Stevenson directs attention to the harm that practitioners could do to themselves through a combination of the tools of their authority and their own mental hang-ups.

From their differing standpoints in time, Braddon's novels and Stevenson's novella investigate issues ranging from the possibility of contagion via narrative and the impact of this etiology on individual's illnesses, to the role of medical practitioners and medical writing in creating or curbing disease, to the connection between medicine and morality at mid-century and the century's end. Braddon and Stevenson employ their non-realistic genres of sensation and gothic horror, respectively, to hyperbolically draw attention to real Victorian concerns.

At the outset of *Birds of Prey*, the serial novel which initiated Braddon's editorship of *Belgravia* magazine, Braddon introduces us to a surgeon-dentist named Philip Sheldon. The

narrator ironically explains, “Of course he was eminently respectable…. A householder with such a door-step and such muslin curtains could not be other than the most correct of mankind” (7).[34] Sensation novels of the 1860s have long been critically recognized as vehicles for revealing the disparity between respectable façades and seedy interior truths, and Braddon’s underexamined work *Birds of Prey* and its sequel *Charlotte’s Inheritance* are no exception: by the close of the second novel, the seemingly upright Sheldon has been revealed as a liar, a cheat, and a killer.

The revelations that occur in *Birds of Prey* and *Charlotte’s Inheritance*, though, go beyond the attacks on middle-class respectability or the repressive mores of Victorian society, which critics often attribute to sensation novels. Instead, Braddon uses these two works to target the potential duplicity and often unquestioned authority of the medical profession and its discourses. Braddon couples this criticism with a defense of her own writing of sensational literature and the female readership supposedly imperiled by this fiction. In order to mount this dual assault and vindication, Braddon employs a surprising tactic: she acknowledges both the potential danger of reading and the immoral nature of sensational behavior. *Birds of Prey* and *Charlotte’s Inheritance* locate the threat of reading within medical literature instead of novels, though. In addition, the sensational activities that Braddon highlights are carefully planned murders committed by a rational doctor rather than the impetuous actions of a passionate woman. Braddon thus utilizes *Belgravia*, a periodical venue for “light” literature, to question the

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[34] All of my citations come from recent reprints of *Birds of Prey* and *Charlotte’s Inheritance* published by Hard Press. There are currently no critical editions of either of these two novels, and I have chosen to quote from the Hard Press version of the text, rather than the original 1867 and 1868 editions of the texts published by Ward, Lock, and Tyler in London due to the availability to other scholars of these more recent versions. These Hard Press reprints (along with reprints published by Kessinger Publishing in 2004, BiblioBazaar in 2007, and IndyPublish in 2007) reproduce the Project Gutenberg transcriptions of these two novels. The Gutenberg texts are transcriptions of the stereotyped editions of these two works published by John and Robert Maxwell, which match the original stereotyped editions published by Ward, Lock, and Tyler. Publication dates are not listed for any of these stereotyped editions, but this is not surprising given that stereotyping is a process which reproduces the layout of a novel via a mold made of the original standing type; since the resulting text is a reprint rather than a new, revised edition, new publication dates are often not listed in the publication information.

power dynamics set up and reinforced by prominent and "serious" medical journals such as *The Lancet*.

Braddon employs the character of Philip Sheldon in his role as medical professional to question the quality and availability of Victorian medical literature and the belief that doctors should be implicitly trusted. In the process, she disarms popular concerns regarding women's susceptibility to their reading and the genre of sensation fiction by offering an alternative, and even more sensational, possibility for narrative contagion that involves a seemingly more objective reading population—male, medical practitioners and their professional reading. In turn, this sensational depiction of the deceitful Sheldon questions the trope of truthful doctor / lying patient common in the medical literature of the day. Moreover, through her depiction of the diseases that Sheldon is able to simulate because of his reading, Braddon illustrates the consequences for the uninformed and unquestioning patient in the increasingly clinical landscape of nineteenth-century medicine. *Birds of Prey* and *Charlotte's Inheritance* together dramatize the ways in which misdiagnosis or ineffective treatment can place the weight of responsibility for continued suffering on the shoulders of the sufferers themselves rather than their practitioners.

In *The Strange Case of Dr. Jekyll and Mr. Hyde*, the highly suggestible and often hypochondriac Robert Louis Stevenson crafts Dr. Henry Jekyll, a figure who mistakenly believes that he suffers from a more than ordinary inner division between his good and evil urges. Jekyll turns to the laboratory to repair this supposed imperfection, with the end result being the release of Edward Hyde. Jekyll's initial hypochondriac musings are thus transformed into a physicalized evil. The character of Hyde serves as more than simply an externalization of Jekyll's wicked impulses, though; I argue that we must see Hyde as an allegorical representation of disease itself. Jekyll's reliance on laboratory science and his misguided assumption that his medical expertise will provide him with the ability to cure what he believes ails him work together in the formulation of the metaphorical malady that is Hyde.

Though Jekyll's actions are indeed questionable—particularly since they contribute to the deaths of at least two people (Sir Danvers Carew as well as his colleague Dr. Lanyon)—

Stevenson's novella is not simply an indictment of the medical profession's hubris or moral corruptibility. On the contrary, *The Strange Case of Dr. Jekyll and Mr. Hyde* also invokes sympathy for the doctor-figure since the very symbols that grant him authority, such as access to the laboratory in Jekyll's case or patient confidences in Lanyon's, are what makes him particularly vulnerable to contagion. Moreover, Stevenson illustrates through Jekyll's final "Statement of the Case" that the responsible doctor does have at his disposal at least one particularly powerful tool for curbing future missteps: the medical case study. By passing along analyses of information gleaned in a particular case, this type of medical literature functions to stem the flow of contamination in Stevenson's novella rather than facilitate contagion.

Braddon and Stevenson's reflections on similar issues during the 1860s and then the 1880s make them perfect candidates for mapping shifts in the cultural climate surrounding medicine, doctors, and medical writing from near mid-century to a time verging on the century's close. Together, Braddon and Stevenson's works illustrate changes between seeing the clinical detachment of medical writing as opening the door to immoral behavior and envisioning this method as the chief tool of the responsible doctor and the means to prevent disease. The movement that they chart also helps to explain why earlier novels like *Bleak House* and *The Moonstone* might focus on a recuperation of the patient's narrative (in light of the sometimes unwarranted power granted to medical professionals through their exclusive knowledge of medical literature), while later works such as Conan Doyle's Sherlock Holmes stories and Stoker's *Dracula* would hold up the case form as the most effective means for achieving narrative resolution and medical cure.

"Philip Sheldon Reads The 'Lancet'": The Spread of Medical Information and the Threat of Reading in *Birds of Prey* and *Charlotte's Inheritance*

Birds of Prey and its sequel explore the sensational behavior and actions of three "birds of prey," villainous men whose exploits range from deceit and fraud to murder. My examination of Braddon's work focuses on the first and most insidious of the predators to whom we are introduced, a calculating surgeon-dentist named Philip Sheldon. In the first book of *Birds of Prey*, entitled "Fatal Friendship," the cash-strapped Sheldon uses information gleaned from *The Lancet* to poison his friend Tom Halliday under the guise of treating him for a head cold so that he can marry Tom's wife and inherit Tom's money. Later, in *Charlotte's Inheritance*, when Philip discovers that Charlotte Halliday, Tom's daughter and now Sheldon's step-daughter, is set to inherit a large sum of money, he perpetrates a similar crime, poisoning her while he ostensibly bolsters her health.

Near the beginning of *Birds of Prey*, Braddon challenges both the discourses through which the medical profession established its authority and the popular belief that women were especially at risk of becoming contaminated through unregulated reading. She creates this indictment by setting up a prominent medical journal as the primary tool by which Philip Sheldon is able to commit his crimes. In order to plan his poisoning of Tom Halliday, Sheldon examines issues of *The Lancet*, one of the main British medical publications during the Victorian period. His reading of this well-known medical journal is foregrounded by the title of the second chapter, "Philip Sheldon Reads The 'Lancet,'" as well as Sheldon's lengthy, late-night perusal of volumes of this periodical near the chapter's end.

Braddon's incorporation of *The Lancet* into her novel serves a dual purpose: she critiques the quality of the information available in this impersonal format *and* the implicit assumption that medical professionals reading *The Lancet* are morally qualified for unlimited access to such information. As Lorraine Daston points out in her article "Objectivity and the Escape from

Perspective," the nineteenth century was a time of a greatly increased spread of information in the natural sciences, including medicine. However, this dispersal of information occurred through impersonal forums such as journals rather than through the personal friendships that predominated in previous centuries. Braddon had intimate knowledge of the perils of such impersonality from her experiences in the publishing world. Both Braddon's life and her writing were ceaselessly and viciously attacked by critics in a host of magazines, ranging from *Blackwood's* to the *Pall Mall Gazette*. As a result, defenses of Braddon and her work became a regular part of *Belgravia*. As Jennifer Phegley has noted, one of the main tactics that Braddon condemned in her responses to these critics was "the shroud of anonymity that enabled such cutthroat critical practices" (122). Braddon's concerns about the potential damage incurred through the impersonality of the periodical press even come up in *Charlotte's Inheritance* when Braddon describes the obstacles met by one of the novel's heroes, an up-and-coming writer named Valentine Hawkehurst. Though Hawkehurst is a hard-working and popularly appreciated young writer, he is constantly attacked by critics who are depicted as "*nameless* assailants *hidden* behind the hedges" (328, emphasis added). Braddon countered the hidden dangers associated with this namelessness by having critics writing in *Belgravia* forego anonymity.

Braddon's appraisal of Sheldon and his reading of *The Lancet* play on similar themes. However, her evaluation here focuses not on the anonymity of the writers but instead on Sheldon's anonymity as a reader in the newly-available sea of medical information and the potential hazards resulting from this accessibility. Because Sheldon is able to look to *The Lancet* in order to carry out the poisoning of Tom and then Charlotte, he, like the critics castigated by Braddon, is able to remain a shielded and "nameless assailant." Braddon's critiques of Sheldon are thus aimed at the ease with which he is able to misuse the information he impersonally gleans from the pages of this medical journal. While Sheldon would certainly not have asked a friend or fellow doctor how to poison Tom Halliday, after an evening spent anonymously flipping through *The Lancet*, he is easily able to acquire this information.

Sheldon would have had plenty to read regarding poison in *The Lancet*. Just a quick look through issues of this periodical from the 1840s reveals that most volumes included anywhere from three to twelve articles on poisoning. One essayist from 1850 explains this preoccupation with poisoning as stemming from causes like "the wholesale system of poisoning by arsenic, which has now become so prevalent" ("On the Prevention" 551). Throughout the century, the fear of poisoning as a form of murder was widespread. In large part, this fear stemmed from a series of trials, beginning in the 1840s, of women who poisoned their husbands. Though the number of spousal murders of husbands by their wives was dwarfed by the number of husbands committing such crimes, the method of the wives' attacks (and the fact that wives would dare to kill their husbands) captured the media's attention and the public's imagination (Robb 176-77), leading to the impression that there was indeed a "wholesale system of poisoning" plaguing their nation. Though media attention primarily focused on the women who employed this method, as the historian George Robb notes, "in spite of popular prejudice, it was men who were most knowledgeable about poisons," and "a number of husbands accused of poisoning their wives were druggists or physicians" (182). Braddon was aware of the reality of the male, medical professional as poisoner. In fact, later in *Birds of Prey* when Philip Sheldon's brother, George, attempts to obliquely warn Charlotte's fiancé about Philip's deceitfulness (he never goes so far as to voice his suspicions that Philip poisoned Tom), George exasperatedly exclaims:

> You are inclined to believe in Phil rather than to believe in me, and you will be so inclined to the end of the chapter. You remember that man Palmer, at Rugely, who used to go to church, and take the sacrament? … Why, people believed in him, you know, and thought him a jolly good fellow, up to the time when they discovered that he had poisoned a few of his friends in a quiet gentlemanly way. (327)

Rather than being a fictional creation of Braddon's, William Palmer of Rugely was a notorious Victorian murderer who had been convicted in 1856 of killing his friend John Parsons Cook and who was suspected of killing many others. He was also a surgeon, and the facts suggest that he

poisoned his friend Cook with strychnine as he ostensibly treated him.[35] In her depiction of Philip Sheldon and his reading of *The Lancet*, Braddon is thus targeting the double-standard that erroneously suggests that women (who have lesser access to the relevant information about poisoning than their male counterparts) pose a greater threat, while she also voices her suspicions regarding the knowledge available to the not-always-trustworthy medical man.[36]

Many of the articles on poisoning in *The Lancet* are full of particulars about specific means of poisoning that an unscrupulous reader could use to his advantage. For instance, one doctor in 1851, after relating in detail a case of poisoning which he treated, laments that this case demonstrates that some poisons can take much longer to set in than was previously realized. He fears that this fact will lead many people who might not have poisoned someone to do so because it will now be easier to escape detection ("Medical Society" 410-11). The irony here, of course, is that through his detailed relation of this case, this doctor has provided the precise information necessary for someone, such as another doctor reading *The Lancet*, to do exactly what he fears. Braddon herself highlights this irony in *Charlotte's Inheritance* when the specific articles used by Sheldon to poison Tom Halliday are discovered. The first article is entitled "On the Fallibility of Copper Gauze as a Test for the Detection of Arsenic," and the narrator makes the potential danger of such an article in the wrong hands quite explicit. The passage reads:

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[35] While there are certainly similarities between the case of William Palmer and the character of Philip Sheldon—both men were deeply in debt, a chamber-maid complained of feeling sick after tasting broth that Palmer sent up for Cook just as Sheldon's housekeeper feels ill after tasting beef-tea intended for Tom (an incident I will address later in this chapter)—the differences between the two cases are equally significant. While Palmer was a notorious gambler and womanizer, Sheldon maintains both a respectable façade and a clinical detachment from those surrounding him. These two characteristics, as I will later suggest, are at the heart of Braddon's critique of Sheldon as medical professional. For more information on William Palmer, see *The Queen V. Palmer: Verbatim Report of the Trial of William Palmer* and the William Palmer website maintained by Dave Lewis.

[36] Though he does not examine *Birds of Prey* at length, in an essay entitled "Laws, the Legal World, and Politics," John R. Reed briefly mentions three famous Victorian doctor-poisoners—William Palmer, Thomas Smethurst, and Edward Pritchard—and he notes that "The character Philip Sheldon in Mary Elizabeth Braddon's *Birds of Prey* (1867) could have been based on any or all of these practitioners" (168). While I agree that Braddon was aware of these poisoning practitioners, I would like to suggest that her portrayal of Philip Sheldon goes beyond simply retelling the story of any one of these doctors.

> And yet, even in this dry as dust title of a scientific communication from a distinguished toxicologist there was some sinister significance. It was the letter of a great chemist, who demonstrated therein the fallibility of all tests in relation to a certain poison. It was one of those papers which, *while they aid the cause of science, may also further the dark processes of the poisoner*, by showing *him* the forces *he* has to encounter, and the weapons with which *he* may defend himself from their power. (242, emphasis added)

While articles on poison and poisonings were quite common in the popular press due to public interest in the poisoning murders mentioned above, it is significant that Braddon is not highlighting a mass media article, but, rather, one that is directed toward a specialized, professional audience. Moreover, this potentially dangerous article is, as the narrator goes on to describe, "one of a series on the same subject, or range of subjects" that appear in this journal (242). Dealing as it does with technical topics like chemical testing, the type of information that Braddon highlights as alarmingly accessible would prove threatening only when wielded by someone with the specific scientific knowledge necessary to sort through this information and determine its value. Braddon's focus on a journal primarily available to male, medical professionals, coupled with the narrator's repeated use of the pronouns "him" and "he" to describe the potential poisoner, suggest that it is the male professional, not the downtrodden wife, who is most in jeopardy of succumbing to the temptation of employing "the dark processes of the poisoner."

In addition to engaging debates regarding the nature of poisoning as a crime, through her use of *The Lancet*, Braddon is also able to upend prevalent nineteenth-century fears about women, contagion, and their reading of sensational literature by illustrating the contaminating potential of scientific reading for a predominantly male readership. Kate Flint's comprehensive study, *The Woman Reader, 1837-1914*, persuasively demonstrates the overwhelming concern during the Victorian period that women's reading—primarily of fiction—might negatively affect their behaviors and beliefs. Later critics, such as Pamela Gilbert in *Disease, Desire, and the Body in Victorian Women's Popular Novels*, have illustrated that sensation fiction in particular was seen as possessing the potential to materially and morally *infect* its presumably female, and thus passive, readers by way of the sensations stimulated by such reading.

Braddon reverses this critique by showing the potential danger to the professional, male reader whose specialized, supposedly objective, medical reading gives him the tools to perpetrate a crime. That Braddon attributed greater competence to her female readership than was popularly granted them is not a new idea. Flint has suggested that sensational writers such as Braddon undermined the notion of the passive female reader by encouraging these readers to actively interpret the myriad literary references included in these texts as well as the actions taken by the novel's transgressive heroines. Jennifer Phegley augments this argument in *Educating the Proper Woman Reader: Victorian Family Literary Magazines and the Cultural Health of the Nation*, maintaining that Braddon "went beyond claiming that sensation was harmless to argue that by studying sensational plots and characters women could become more, rather than less, skilled at reading critically" (135).[37] I would add to this discussion regarding Braddon's defense of the woman reader by suggesting that in *Birds of Prey*, Braddon uses a subtler tactic. Rather than focusing on the healthiness of sensation literature as reading material, Braddon *allows* the potential contamination involved in reading, but she uses the figure of Philip Sheldon to suggest that when critics locate the threat of reading in sensation fiction, they are looking in the wrong place.

In *Birds of Prey*, Braddon's defense of the woman reader arises through the depiction of a type of professional reading whose potential for morally infecting its readers is much more concrete than that assigned to women's reading of sensation fiction. Braddon highlights that *reading*, and the reading of medical literature no less, is necessary for Sheldon to bring his

[37] Phegley is one of a very few critics who engages *Birds of Prey* and *Charlotte's Inheritance* in her examination of Braddon's work. Phegley uses these two novels as evidence for Braddon's promotion of a healthy and active female reader, though her argument follows a very different trajectory than mine. She focuses on Braddon's use of ironic narration (139) and her depiction of the character Diana Paget. Diana, the daughter of a swindler, becomes friends with the soon-to-be-poisoned Charlotte Halliday. It is Diana's strength and knowledge of life's seedy underbelly that allow her to help save Charlotte's life. According to Phegley, "By juxtaposing the helpless Charlotte with the independent Diana, Braddon suggests that the 'ideal' of the inactive and dependent woman is actually a threat to society" (141).

considered plans of poisoning Tom to fruition when she entitles the second chapter "Philip Sheldon *Reads* The 'Lancet'" (my emphasis, 10)—despite the fact that the reading itself does not occur until almost the last paragraph of the chapter. Throughout this section, Sheldon considers the possibility of poisoning Tom and weighs the merits and demerits of this plan, but it is his act of reading that seals Tom's fate, for without the information gathered from *The Lancet* Sheldon would be unable to carry his plans into action.

Moreover, it is the way that Sheldon reads, a manner which draws on the biological differences supposedly separating men from women, that allows him to be contaminated. As Kate Flint has exhaustively illustrated, according to the medical literature of the period, it was women's greater sensitivity and imagination—traits supposedly biologically housed in the brain—that allowed them to be so easily influenced by what they read. This female sensibility was juxtaposed against male biological traits such as the ability to reason and carefully judge. Significantly, the narrator's descriptions of Sheldon's brain and thought processes emphasize Sheldon's association with shrewd reasoning as opposed to fancifulness. As Sheldon sits considering whether or not he should poison Tom, the narrator explains, "He was not prone to the indulgence of idle reveries or agreeable daydreams. Thought with him was labour; it was a 'thinking out' of future work to be done, and it was an operation as precise and mathematical as the actual labour that resulted therefrom. The contents of his brain were as well kept as a careful trader's ledger. He had his thoughts docketed and indexed" (14). Sheldon appears to be almost a thinking machine, and Braddon explicitly relates this mechanistic reasoning to the organization of Sheldon's brain. And it is Sheldon's practicality and reasonableness that eventually lead him to his reading of *The Lancet*, for he simply concludes before turning to that journal, "'I had better read up that business before they come,' … when he had to all appearance 'thought out' the subject of his reverie" (19). Thus, Braddon does not simply argue that men are just as suggestible or as easily influenced by their reading material as women. Rather, she cleverly sidesteps the issue of sensibility—she would, after all, have had to argue against an entire established medical tradition ostensibly based on the biological differences between men and women—and targets

the very characteristics of men that supposedly differentiated them from their overly sensitive and intuitive female counterparts, namely, their abilities to reason and carefully consider.

Braddon's alterations to this section between its initial publication in *Belgravia* and its appearance in triple-decker form emphasize the calculating rather than passionate nature of Sheldon's reading practices. Originally, when Sheldon turned to his "professional library" in the *Belgravia* version, he "took out a pile of heavy books" to study which turn out to be "bound volumes of *The Lancet*" (19), and he slowly sorts through all of these volumes. In the revised version of this section, though, Sheldon's reading of these articles in *The Lancet* becomes a purposeful and considered re-reading. When he turns to the cupboard in which he keeps his medical literature in this second version, he begins by "select[ing] a book from a row of dingy-looking volumes" and then he "opened the volume at a place in which there was a scrap of paper, evidently left there as a mark" (20). These volumes are dingy from use, and both Sheldon's selection of a specific volume and the scrap of paper within that volume suggest that his reading has not momentarily inflamed him but rather slowly affected him over time as he has carefully considered it. Braddon's revision of Philip Sheldon's reading practices underscores how reasoned reading detached from feeling can have even more disastrous results than the highly affective reading attributed to women.

Hence, though the possibility of over-identification with the overwrought heroines about whom they read was high on the list of concerns leveled at women readers, it is Sheldon's ability to *avoid identification* with those that he reads about that allows him to carry out his crimes. In *Nobody's Story: The Vanishing Acts of Women Writers in the Marketplace 1670-1820*, Catherine Gallagher argues that the fictionality of characters in the new novelistic writing of the eighteenth-century—their status as "nobodies"—was precisely the feature that made them so easy for readers to sympathize with. As Gallagher put it, "it is easier to identify with nobody's story and share nobody's sentiments than to identify with anybody else's [i.e., real people separated from you by real differences] story and share anybody else's sentiments" (172). Unfortunately, the people represented in Sheldon's medical reading are these anybody else's—

real people who, at the very least, differ from him in their roles as patients rather than medical professionals.

Furthermore, while Sheldon would hardly have sympathized with fictional victims either, the emphasis of medical writing on the affected *part* rather than the afflicted *person* assists Sheldon in distancing himself from the poisoned individuals that he reads about.[38] A quick look at the list of lectures scheduled for the inaugural year of the London-based College of Dentists demonstrates that Sheldon's clinical training would have laid the groundwork for viewing patients in this way. The talks include: "Dr Steggall on 'Descriptive anatomy' … Dr Jabez Hogg on the development of the microscope, its optics, how to make best use of it … Dr Gladstone on 'Bone enamel' and 'The metals etc, used in dentistry' … and Dr Alfred Carpenter on 'Principles of dental surgery'" (Donaldson 4-5). Only two of the topics listed above, "Descriptive anatomy" and "Principles of dental surgery," even tangentially touch on the patient involved in these procedures—and, then, only as a body to be described or operated upon.[39] As I detailed in my chapter on *Bleak House*, medical writing of the period expressed a similar emphasis on the physical. The accompanying focus in venues like *The Lancet* on aspects of anatomy rather than the personal consequences of suffering impedes identification and helps facilitate Sheldon's unfeeling response to what he reads—as well as his ability to carelessly apply this information to those around him.

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[38] Later in *Birds of Prey*, the narrator provides insight into Sheldon's inability to identify even with fictional characters because he finds most of them to be "impracticable beings, who were always talking of honour and chivalry, and always sacrificing their own interests in an utterly preposterous manner" (91)—a trait certainly not in keeping with Sheldon's coldly practical views of life. Balzac's fiction provides the one notable exception, but the figure with whom Sheldon feels a link is neither fictional hero nor fictional blackguard. Instead, Sheldon identifies with Balzac himself who, like Sheldon, "knows better" than the "dour English novelist" with his focus on "impossibly virtuous inanities" (91). Sheldon's incapacity to relate to anyone other than the *author* of a drama, sheds light on his failure to connect with any of the patients he might read about in *The Lancet*, for they are the figures who are being acted upon, not the ones who are pulling the strings.

[39] This is not to say that Sheldon's character would have attended the College of Dentists—which was founded in 1859, less than 10 years before Braddon penned *Birds of Prey*—but rather that this list of lectures illustrates a bias in Sheldon's training. Given Sheldon's comments about having gone through a regular course of medical training, he probably would have been a graduate of the Royal College of Surgeons where his dental training would have been in addition to his regular training.

Furthermore, this professional literature, unlike sensation literature, does not merely provide a fictional model of bad behavior, which, notably, usually ends up being punished by the novel's end. Instead, the information that Philip Sheldon encounters in *The Lancet* provides real-world *instructions* for criminal behavior (types of effective poisons, amounts necessary, methods for administering the poison) as well as the tools necessary to avoid the detection of these crimes. Braddon's use of *The Lancet* in this context thus operates on several levels. It serves as an implicit defense of the sensational literature that Braddon was so popular for creating, an indictment of widely-held and medically-based Victorian beliefs regarding women's susceptibility to narrative infection, and a critique of the assumptions that separated the supposedly objective discourses of the medical field and its practitioners from the sensational. Braddon illustrates the potential danger attendant upon men's typically masculine, professional reading and she does so by focusing on the questionable nature of the very medical literature that supported the popular beliefs about women and their reading.

Sensational Science

The sensational genre through which Braddon conveys the story of Philip Sheldon is key to her critique of the authority granted to the medical profession via its increasingly clinical methods and its association with scientific objectivity. Braddon aligns Sheldon with the clinical side of medicine through both his professional interests and his relations to other characters while simultaneously painting these interests and interactions as unnatural and thus sensational. Though overblown passion is often at the heart of the scandalous behavior found in the sensation novel of the 1860s, Sheldon's actions are shocking to the reader because of the coldly clinical and scientific manner in which he carries out his crimes. In the same way that Braddon granted the potentially harmful influence of *reading* in order to highlight the threats inherent in professional rather than leisure reading, so too she takes advantage of the negative connotations

associated with the *sensational* in order to sensationalize, and thus call into question, the more authoritative and distancing aspects of medical practice.

On the very first page of *Birds of Prey*, Braddon significantly describes Philip Sheldon's profession as "surgeon-dentist" (6), a designation which frequently recurs and which aligns Sheldon with medical specialization as well as the more scientific rather than treatment-based elements of the medical field. M. Jeanne Peterson in her history of British medical practice explains that medical specialization began to increase during the second half of the nineteenth century, and "specialists' scientific claims helped shake the English medical establishment loose from its devotion to 'the practical aspects of diagnosis and treatment' and prompted English medicine to engage more actively in the search for 'scientific explanations'" (*Medical* 279-80).[40] At the turn of the nineteenth century, dentistry was still often associated with rather medieval methods of tooth extraction and the sale of questionable tonics and powders for treating tooth aches. However, by the middle of the century this had all changed, and dental surgery required special licensure through a body such as the Royal College of Surgeons.[41] Braddon's careful description of Philip Sheldon as a surgeon-dentist allies him with this clinical side of medicine. Thus, when she paints him as sensational, she is not simply sensationalizing the dentist-barber of earlier centuries (an easy target, indeed), but a medical professional schooled in scientific objectivity. To be clear, this is not to say that Braddon is opposed to clinical medicine or medical specialization in and of themselves, but rather, her sensationalizing of Sheldon attacks the distancing from the patient as human and emphasis on the patient as problem-to-be-solved potentially encouraged by these scientifically-based aspects of medical practice.

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[40] Peterson is using language quoted from the autobiography of Sir Felix Simon, a throat specialist who practiced in mid-Victorian London.

[41] Though separate dental hospitals, such as The National Dental Hospital, were being formed beginning in the late 1850s, and there was a push by some dentists to differentiate themselves from other forms of medical practice, in the mid-1860s dentistry was still considered a medical specialization (grouped with other specializations like obstetrics, epidemiology, ophthalmology, dermatology, and laryngology) rather than a separate field. See Donaldson and Peterson.

From the first, Sheldon's own medical practices are more closely tied to experimentation and the *objects* of his profession than to patients. The advertisements that Sheldon circulates following the opening of his London practice make this disjunction clear. The information that Sheldon conveys to potential patients in these "neatly-printed circulars" is that "Mr. Sheldon, surgeon-dentist, of 14 Fitzgeorge-street, had invented some novel method of adjusting false teeth … and that he had, further, patented an improvement on nature in the way of coral gums" (8). These facts emphasize Sheldon's mastery of the tools of his trade and his skill at manipulating objects like plaster and coral, not his gentle touch with patients.

Following Tom Halliday's decline in health, though, these objects and a professional focus on them become overtly sensationalized by the narrator. One evening after visiting Tom, Philip Sheldon's brother, George, descends to Philip's empty office to have a talk with him. He finds Philip working on a piece of mechanical dentistry. Rather than describing Philip's work using technical terminology or as a possible means for shedding light on a medical problem, the narrator explains to the reader that Sheldon is "busied with some mysterious process in connection with a lump of plaster-of-pans, which seemed to be the model of ruined battlements in the Gothic style" (37). What should be an indicator of medical progress is instead associated with the gothic past, a time dominated by disorder, dark plots, and murder. Moreover, this predilection for "experimentalising," as Philip calls it, is connected to his ability to poison Tom, for George, who has begun to suspect his brother, replies, "You're rather fond of experiments, I think, Phil" (37). It is thus not just the model of the lower jaw that becomes an object of sensation; Philip's medical knowledge, which allows him to experiment on Tom, is sensationalized as well.

One component of medical knowledge particularly tied to professional authority is the language used to signal possession of this specialized information, and Braddon similarly sensationalizes it. When discussing Sheldon's newly patented "improvement … in the way of coral gums" (7), the narrator goes on to explain that its name "was an unpronounceable compound of Greek and Latin, calculated to awaken an awful reverence in the unprofessional

and unclassical mind" (8). The clinical, scientific side of medicine is exemplified by this type of technical terminology which confers authority to the doctor and separates doctors from laypeople. Sheldon's unabashed capitalization on the divisiveness of this terminology—along with his misuse of it—draws attention to the unquestioning acceptance of the authority increasingly granted medical professionals via markers such this one as the century progressed.

While Sheldon may show interest in scientific trials, Braddon otherwise portrays him as mechanistic and utterly detached from the feelings of others. A particularly egregious example of this lack of feeling occurs in Sheldon's interactions with Tom's wife Georgy—the woman, recall, whom he will marry following Tom's death. Before he puts his plans into action and begins poisoning Tom, it is essential that he determine how much influence he has over Georgy and thus how much control he will have over Tom's treatment and Georgy's affections following Tom's death. Hence, one evening while the Hallidays are staying with Sheldon and Tom is out enjoying himself of an evening, "Mr. Sheldon abandoned his mechanical dentistry for once and a way, and ascended to the drawing room where poor Georgy sat busy with … needlework" (26). Though Sheldon appears to be trading his professional concerns for the comforts of the domestic, we soon discover that he is merely employing his clinical gaze in a different sphere.

He begins carefully questioning Georgy about her married life and reproaching her when she expresses dissatisfaction with it, all the while gauging her reactions to his statements. Their interchange culminates in Georgy dissolving into tears. It turns out that this is precisely the outcome hoped for by her interlocutor, whose questions and proddings have merely been meant to test a hypothesis regarding his ability to control Georgy. As the narrator informs us, "Mr. Sheldon watched her tears with the cold-blooded deliberation of the scientific experimentalist. He was glad to find that he could make her cry. She was a necessary instrument in the working out of certain plans that he had made for himself, and he was anxious to discover whether she was likely to be a plastic instrument" (27). Sheldon's examination of Georgy through the eyes of "the scientific experimentalist" wholly objectifies her: she is no longer a person, but an "instrument" and her emotions are only relevant as they relate to her pliability. Just as Sheldon

experiments with the plaster-of-pans to see how well he will be able to shape it into the form of a lower jaw, his encounter with Georgy is a test intended to reveal how well he will be able to mold her. Thomas Boyle has argued that what outraged critics of sensational villainesses like Lady Audley was "the suggestion that the passionate instincts are as human as they are bestial, and that such subconscious drives … could triumph over reason" (96). I suggest instead that what is outrageous about the sensational villain Philip Sheldon has nothing to do with passion, but, rather, the fact that scientific objectivity and cool reasoning could so easily triumph over the consideration of the feelings of anyone else.[42]

"If you knew as much of doctors as I do, you wouldn't be in any hurry to trust a friend to the mercy of one": Lying Doctors and Fictionalized Afflictions

Braddon's concerns about the increased and impersonal spread of medical information and her sensationalizing of clinical medicine tie into a larger critique of the implicit trust placed in doctors. Her questioning of this trust highlights and inverts the dynamic of truthful doctor / lying patient that is repeatedly set up and reinforced through case studies in journals like *The Lancet*. Braddon upends this convention through her depiction of the deceitful Sheldon and the danger of unquestioningly accepting his veracity since Sheldon misuses the trust placed in him as a medical professional and murders his patient. While this situation is certainly extreme,

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[42] In "Sensationalizing Science: Braddon's Marketing of Science in Belgravia," Barbara Onslow addresses Braddon's regular incorporation of articles on scientific topics within her periodical. Onslow suggests that Braddon's aim was to present scientific claims as perhaps even more sensational than her own sensational literature, thereby defending her literary work against attacks of "melodramatic excess" (169). I find Onslow's claims in relation to the nonfiction, scientific pieces in Belgravia quite persuasive, but I would like to distinguish what is happening there from what is happening in Birds of Prey. Rather than illustrating scientific discourse's potential for melodramatic excess, Braddon sensationalizes scientific objectivity itself, highlighting the ease with which Sheldon can distance himself from the objects of his examination and use deceit to accomplish decidedly non-humanitarian aims.

Braddon's portrayal of Sheldon also illustrates a less deadly but perhaps more likely and thus more alarming consequence possible when doctors are provided with unchecked authority: they are able to unduly influence not only patients' physical experiences, but even the shape that patients' illnesses take. Due to the false etiology of disease encouraged by Sheldon's misnaming of Tom and Charlotte's ailments, both father and daughter feel largely responsible for the diseases from which they believe they suffer. By providing the impetus for his patients' complaints and then manipulating their diagnoses, Sheldon thus writes a certain level of guilt into the narratives of Tom and Charlotte's illnesses that would not be part of their experiences without his intervention. In a Victorian landscape in which medical expertise was often defined more by mastery of medical discourse than by efficacy of treatment or accuracy of diagnosis, this exaggerated example illustrates the impact on patients' illnesses present in any case in which ailments are misdiagnosed or a diagnosis cannot be provided at all.

The belief in patients' inherent deceitfulness and lack of cooperation found free reign in case histories appearing in prominent Victorian medical periodicals such as *The Lancet* and *The British Medical Journal.* In these case studies, the patient and the patient's family are repeatedly depicted as lying, concealing important information, or, at the very least, obstinately disagreeing with the doctor's (obviously) correct advice or request. For instance, in one typical case published in *The Lancet* in November of 1845, the surgeon, James K. Dow, relates how it was only through his examination of a patient, named "Elizabeth F," for another complaint that he discovered that she was pregnant. Though initially "neither my patient, nor her relatives around, seemed to have the remotest consciousness, or idea of the existence of this 'hidden treasure'" (474), this seeming unconsciousness is shown to be concealment when a complete lack of surprise accompanies the patient giving birth the next day. In addition, at one point in his treatment of Elizabeth F, he arrives at her home and "From an alteration in the young woman's manner, my suspicions were excited" that something had been done against his recommendations (475). As he demonstrates, his suspicions were well founded, for "*after some equivocation*, I was informed by her mother that her thirst had been quenched an hour previously

by some warm rum-and-water, she, *it was alleged*, preferring that to an infusion of toasted bread" (475, my emphasis). The language used by Dow vividly illustrates the distrust with which he accepts his patient's and his patient's family's statements as well as the well-foundedness of his belief in their lack of veracity. Elizabeth F's death at the end of this case history completes the feeling of cautionary tale for potentially dishonest patients that infuses this narrative. Though not every case study depicts the patient as this untrustworthy, the belief in patients' deceptiveness permeates case narratives of the nineteenth century.

In *Birds of Prey* and *Charlotte's Inheritance*, though, it is Philip Sheldon, the surgeon-dentist, who is unequivocally dishonest. From the first we learn that even his pleasing physical appearance results from the creation of the same sort of artful façade often associated with sensation heroines. For instance, the narrator warns us that

> The eye of the phrenologist, unaided by his fingers, must have failed to discover the secrets of Mr. Sheldon's organization; for one of the dentist's strong points was his hair, which was very luxuriant, and which he wore in artfully arranged masses that passed for curls, but which owed their undulating grace rather to a skillful manipulation than to any natural tendency. (13)

This description of Philip Sheldon's "luxuriant" mass of hair not only aligns him with sensational heroines of the day, who, according to critics like W. Fraser Rae writing in 1865, "are especially remarkable in this respect" (182), it also depicts him as untrustworthy even in the most minor details of outward appearance. Furthermore, the medical specialization that Sheldon has chosen, surgical dentistry, allows him to hone his dissimulative abilities in the realm of the physical. As the advertisements for his practice suggest, his talents lie in the fine-tuning of "*false* teeth" and the replacement of real gums with coral ones (8, my emphasis). The narrator makes clear that Sheldon's primary occupation in the evenings involves "scrap[ing] and fil[ing] and polish[ing] those fragments of bone which were to assist in the renovation of decayed beauty" (25). Sheldon's application of his faculty for altering appearances to the field of mechanical dentistry elevates his ability to create an artful façade into a science.

Moreover, the "skillful manipulation" of physical appearances perfected by Sheldon in the arrangement of his hair and choice of professions parallels the skillful manipulation of the people surrounding him which Sheldon later enacts via his medical authority. An interchange between Sheldon and his housekeeper after he has begun poisoning Tom Halliday illustrates his marshalling of professional standing and medical knowledge in the service of his devious plans. Not wanting to see anything go to waste, Sheldon's housekeeper, Mrs. Woolper, takes some of the unfinished beef tea intended for Tom Halliday. Since the beef tea is the vehicle for the poison that Sheldon is feeding his patient, Mrs. Woolper obviously gets a bit sick, and, thus, begins to suspect her employer's supposed treatment of Tom Halliday's fever. However, when she tentatively confronts him, saying the beef tea "oughtn't to have disagreed with a baby, you know, sir" (42), he shoots back, "That's a little bit of vulgar ignorance, Mrs. Woolper … if you knew as much about atmospheric influences as I do, you'd know that food which has been standing for hours in the pestilential air of a fever-patient's room isn't fit for any body to eat" (43). Not only does Sheldon use the beef tea, something often prescribed by doctors to maintain the strength and bolster the health of invalids, to undermine the health of his patient. In addition, it is his medical knowledge, or, rather, his *profession* of medical knowledge that allows him to effectively silence Mrs. Woolper.

As the novels progress, Sheldon continues to deceive both his patients and their loved ones in his role as treater of the sick. When Tom expresses his belief that he is not long for this world, for instance, Sheldon cheerfully answers, "We'll contrive to bring you round … never fear, Tom…. Why, you are looking almost your old self this morning" (46). Later, in *Charlotte's Inheritance* Sheldon relies even more blatantly on his medical standing in order to continue his poisoning of Charlotte, assuring her fiancé that there is no cause for alarm when she begins weakening with the statement, "I give you my word as a medical man" (201). This is a deliberate lie, and the form in which it is delivered implicitly calls into question the worth of a medical man's word.

This dishonesty on the part of Sheldon is juxtaposed against the general belief in his rectitude exhibited by his patients and those surrounding them. Though these patients willingly reveal all of their symptoms to their doctors and unquestioningly believe that Sheldon is only doing what is best for them, the trusting Tom Halliday dies just as surely as did the dissembling Elizabeth F under the treatment of Dr. Dow in the *Lancet* case cited above. Braddon's *Birds of Prey*, with its explicit reference to *The Lancet* and her vivid detailing of a doctor, rather than a patient, driven by deception questions the dynamic of lying patient / truthful doctor so commonly reinforced in the medical literature of the day.

This questioning also ties into Braddon's assessment of the authority increasingly granted to medical professionals as the Victorian period progressed. At mid-century, existing power structures began to shift and medical practitioners gained greater governance over their own profession. With the introduction of medical schools into the hospitals in the 1850s, choices regarding both hiring and admission were more and more in the hands of the doctors serving in these medical schools rather than the lay boards who had previously served this function. The surge toward specialization beginning in the 1860s served to further distance the lay public from knowledge of the medical world. Peterson explains this shift in terms of access to information: "Authority came to the [medical] experts as the public was increasingly closed off from knowledge of their work…. The experts gained stature not because they could always act effectively, but because only they could name, describe, and explain" (286).[43] Braddon's sensational depiction of Sheldon questions the causal link between this type of expertise and the unquestioned granting of authority, warning readers to be more wary with their acceptance of such relationships. After all, Sheldon is able to carry out his crimes in large part due to the power

[43] The 1858 Medical Act, which for the first time ostensibly unified the different branches of legitimate medical practice, is also worth mentioning here. While this Act established the General Medical Council and a single register listing all licensed practitioners, there were fissures in this unprecedented attempt at unity which led to an even greater need among medical professionals to consolidate their power by asserting their authority over their patients. For more on the 1858 Medical Act, see Peterson's *The Medical Profession in Mid-Victorian London*.

granted him by his ability to "name, describe, and explain." For instance, even though Sheldon is unable to cure, or even improve, Tom's condition, he has provided it with a label: "bilious fever" (31). This capacity to diagnose Tom's ailment subsequently allows the surgeon-dentist to explain away all of Tom's symptoms, which include "thirst," "sickness," and "an extreme disinclination for food," as "the commonest and simplest features of a very mild attack of bilious fever" (33)—a move which simultaneously solidifies his authority and shields him from any suspicion of wrong-doing.

In Charlotte's case, "neither Mr. Sheldon nor the portly and venerable physician whom he called in [to consult] could find a name for [Charlotte's disorder]" (179), yet the power to diagnose Charlotte as not having anything in particular proves equally crucial in the maintenance of medical clout. The consulting doctor that Sheldon has enlisted (and who we later discover serves as nothing more than a mouthpiece for the surgeon-dentist's views) repeatedly explains that in Charlotte's case "there were no traces of organic disease" (193). However, this refusal to name whatever it is that is troubling Charlotte ultimately serves a similar purpose to the misdiagnosis offered by Sheldon in his treatment of Tom. The doctors' declaration that there are "no traces of organic disease," rather than painting them as inept, suggests that there is nothing really wrong with Charlotte. Sheldon's hindrance of the diagnosis of Charlotte's ailment prevents her from seeking proper treatment, just as his purposefully incorrect naming of Tom's disorder maintains the practitioner's position of authority long enough for him to "treat" Tom to death.

One of the alarming consequences of this connection between expertise and authority in *Birds of Prey* and *Charlotte's Inheritance* is the shaping of patients' illnesses that the practitioner's ability to name (or misname) can exert. What unites Tom and Charlotte is the responsibility that each feels for the progression of his or her ailment. In this way, both of their narratives of illness bear the stamp of Sheldon's misuse of medical authority. Tom repeatedly blames his own supposed weakness for the course that his sickness has taken. At one point, he even assures Sheldon, "I'm not going to blame you when it's my own constitution that's in fault"

(46). His belief in this defect in his own body and the fatalistic viewpoint that results from this belief stem from his false knowledge that he is only suffering from an "ordinary" and "mild" (Philip Sheldon's words) attack of bilious fever, something which should be quite easy to overcome. Rather than doubting his doctor's assessment of "bilious fever," Tom doubts himself. The false seeds sown by Sheldon lead Tom to believe his demise inevitable, a fact which assists Sheldon in the continued poisoning of his unresisting patient.[44]

The doctors' pronouncements that there is nothing organically wrong with Charlotte place the onus of her sufferings even more squarely on her shoulders than Tom's misguided belief in his weak constitution did. In the view of Charlotte, her friends, and her family, it is not that Sheldon and the puppet-doctor that he has called in are *unable* to name the disease from which Charlotte suffers; rather, this withholding of a name leaves little possibility in their minds that Charlotte's disorder is anything but an attack of nervousness on Charlotte's part and that she is thus to blame for the progression of her complaint. Charlotte herself asserts that "My nerves are the beginning and the end of mischief; and if I could get the better of my nerves, I should be as well as ever" (179).[45] Georgy goes so far as to discount the validity of her daughter's experiences because she does not have an identifiable disease, complaining "But what is the

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[44] My arguments regarding Tom and Charlotte's experiences of their illnesses bear connections to Susan Sontag's work on disease and metaphor. In her scholarship on tuberculosis, cancer, and, later, AIDS, Sontag illustrates how the metaphors surrounding these diseases lead to fatalism by equating the diseases with death, and they undermine the patient's belief in the efficacy of medical treatments by suggesting that the diseases are expressions of character, and, thus, the patient's personality and attitude are to blame for the disease's emergence and responsible for the disease's cure. While I am not specifically taking on the metaphorical resonances of particular diseases—in large part because the misnaming of disease serves such a crucial function in these works—I am interested in the ways in which medical professionals can facilitate a feeling of responsibility in their patients and the possible resulting consequences.

[45] Both Elaine Showalter and Athena Vrettos have illustrated the Victorian gendering of nervous disorders as especially "female maladies." Sheldon's manipulation of Charlotte into believing that she is suffering from an ailment both caused by herself and for which there is no outside recourse further illustrates his mastery of Victorian medical discourses and his ability to use them to rob others of power—even over themselves.

matter with her? … People can't be ill, … without having something the matter with them, and that is what I can't make out in Charlotte's case … I dare say Lotta is not so strong as she might be; but I do not see that she can be ill, unless her illness is something definite" (181). We as readers know that Charlotte's sufferings do in fact have a definite locus in the poison which she is being fed, but without knowledge of this poisoning, her experiences, just like her diagnosis, remain (literally) ill-defined—her suffering simultaneously contributes to the delineation of who she is yet is dismissed inasmuch as it does not stem from a clear underlying cause.

The fictional nature of the diseases from which Tom and Charlotte supposedly suffer further highlights the role of Sheldon and his medical reading in the etiology of their ailments and the shaping of their illnesses. The narrative chain of contamination begins with Sheldon's careful reading of *The Lancet* and ends with his writing of disease into the bodies of both Tom and Charlotte. Their pain and distress may be quite real, but Sheldon has in effect created fictional afflictions for both of these individuals. When Valentine Hawkehurst finally discovers that Charlotte is being poisoned by Sheldon, this connection becomes clear to him, and he, the laymen, is the figure ultimately able to accurately diagnose what has plagued both Tom and then his daughter. In a moment of epiphany, Hawkehurst thinks, "Murder! The disease, which had hitherto been nameless, had found its name at last" (222). Sheldon's professional reading allows him to serve as a carrier for this disease called murder, a disease which he inevitably passes on to his victims.

Braddon uses *Birds of Prey* and *Charlotte's Inheritance* to identify the potential for a very different kind of narrative contagion than the type traditionally assigned to her own sensational writing. In the process, she sensationalizes and critiques Philip Sheldon's scientific detachment from those surrounding him, the dishonesty made possible by this extreme objectivity, and the medical publications that encouraged this kind of distancing from the patient. Ironically enough, the very publication that Braddon most overtly targets in her critiques—*The Lancet*—was founded in 1823 in order to promote reform in the medical profession. Thomas Wakley, founder of *The Lancet*, intended for the journal to shine a light on the ineptitude and

nepotism dominating the medical establishment of the 1820s. In contrast, he hoped that the creation of his periodical would encourage scientific excellence in the profession.[46] While Wakley's efforts undoubtedly contributed to change in the power structures *within* the profession, through her own periodical, Braddon illuminates the unacceptable power dynamics reinforced through journals such as Wakley's. Braddon employs her sensational fiction, a type of literature viewed as "light" in relation to its more "realistic" counterparts, to defend groups (women and patients) not taken as seriously as their more powerful counterparts (men and doctors).

Ultimately, though, it is not only the behaviors of male medical professionals that Braddon evaluates. Charlotte and Tom's unmitigated trust in those treating them, coupled with their readiness to assign fault to themselves without ever considering the possible flaws of those doling out medical advice, damns them just as surely as Philip Sheldon's actions. In her discussion of the thinking woman reader encouraged by Braddon's works, Jennifer Phegley notes that one of the lessons of Braddon's novels is to look beyond the respectable façades generated by social standing. Phegley maintains that "Braddon's motley crew of deceivers and criminals exemplifies the dangers of judging individuals solely on their outward appearances and apparent social positions. Her novels instead encourage the careful discrimination of character based on behavior rather than class status" (140). While I find Phegley's claims persuasive, I would suggest that in *Birds of Prey* and *Charlotte's Inheritance*, Braddon's admonition extends beyond the careful consideration of class. In these two novels, Braddon employs an over-the-top, sensational story to caution readers about a very real problem—namely, that the profession of medical knowledge by medical practitioners is increasingly becoming equated *by patients* with the possession of moral rectitude and an implicit authority. Thus, like *The Lancet*, Braddon's *Belgravia* also serves as an instrument for reform: her publication of these two "light" novels

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[46] For details on Wakley and reform see Roy Porter, M. Jeanne Peterson, and Sarah Wise.

within its pages calls for patients to revise their perceptions of both themselves and the doctors who minister to them.

Thinking Ill of Himself: Hypochondria and the Laboratory in *The Strange Case of Dr. Jekyll and Mr. Hyde*

Two sets of Victorian preoccupations addressed by Braddon—anxieties regarding medical knowledge and ideas about the mind and body's influence over one another—also prove central to Robert Louis Stevenson's *The Strange Case of Dr. Jekyll and Mr. Hyde*. Braddon linked these concerns by tracing the contaminating capability of medical literature. As we near the end of the century with *Jekyll and Hyde*, Stevenson sets his sights on a different venue for the production of medical data, namely, the lab. I suggest that Stevenson's gothic tale reveals the story of Dr. Henry Jekyll, a medically-trained hypochondriac, whose deep-seated and unfounded belief that there is something wrong with him prompts him to employ laboratory science to formulate a cure for his supposed condition. The result, of course, is no cure at all, but a palpable evil in the form of Edward Hyde. On a literal level, Stevenson's tale houses an indictment of medical hubris in the laboratory and the indulgence of hypochondriac fears. It is Jekyll's insistence that something within himself needs to be fixed and his access to the tools of medical science that allow him, after all, to unleash Hyde. Considering the figurative potential of Stevenson's novella lends this cautionary tale extra weight, for I propose that in the figure of Hyde, Stevenson creates not just an evil being but an allegorical representation of disease.[47] On the level of metaphor, then, the result of Jekyll's submission to his hypochondria and misuse of

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[47] Stevenson's novella has been treated as an allegory from its initial conception to the present. The work's very first outside reader, Stevenson's wife Fanny, felt immediately that the tale could be read as "a great moral allegory" (qtd. in Harman 296), and the novella has since been seen as a fable about man's dual nature, sexuality (both in terms of heterosexuality and homosexuality), and even drug addiction. For a representative sampling of such readings see Harman, Gwynn, Showalter, and Ulman.

his medical knowledge is a reversal of the usual progression from disease to illness and a perversion of the hoped-for outcomes of time spent in the lab.

This is not to say that Stevenson condemns laboratory science wholesale, but he does highlight the potential dangers of unchecked experimentation and denounce the spirit of recklessness and zeal with which Jekyll approaches his project. In the process, Stevenson offers a more complex and humanized doctor figure than the surgeon-dentist presented by Braddon. Unlike the completely villainous Philip Sheldon, Henry Jekyll is both villain and victim. *Jekyll and Hyde* thus reveals the susceptibility of doctors to harm themselves. And just as Braddon highlighted Philip Sheldon's medical knowledge as the source of his influence, Stevenson shows that the vulnerability of his doctors often stems from their roles as medical professionals.

Robert Louis Stevenson was no stranger to concerns about poor health and beliefs about the connection between the mental and the physical. From his weak constitution as a child to a host of lung problems, possibly including tuberculosis, and the threat of blindness at one point in his life, Stevenson seemed almost always to be sick. Moreover, he was constantly inundated with the hypochondriac concerns of, first, his over-protective parents, and, later, his wife Fanny.[48] In a letter to his close friend Frances Sitwell, Stevenson himself acknowledged and apologized for "the deformity of [his own] hypochondriasis" and "the sickly vanities … of a person who does not think himself well" (*Letters*, v. 1 375). Mental anguish often led to a deterioration in Stevenson's health (or, at any rate, was attributed by Stevenson to that deterioration). For instance, after confessing his loss of religious faith to his parents, the intolerable home life created by this admission led to an exacerbation of his already failing health (Harman 95-6), and

[48] During the Victorian period, "hypochondria" bore several connotations. On the one hand, it meant what we think of today—a preoccupation with one's health and a belief in the existence of various imagined diseases. On the other hand, dating from the eighteenth century, hypochondria also referred to a physical condition of the abdomen, often associated with dyspepsia, that then led to the depression, lassitude, and general mistrust of the body called up by my earlier definition of hypochondria. To be clear, in my discussion of Dr. Jekyll, Stevenson, and his family, I am invoking our more contemporary view of hypochondria rather than the earlier belief that hypochondria originates in physical disease. For more on the history of hypochondria (and its manifestations in the literature of the time), see Haley, Wood, and Frawley.

later in life when his soon-to-be-wife, Fanny, left him to see her ex-husband in the States, Stevenson credited an onset of physical sickness to the lack of correspondence from Fanny (169-70). In his representation of Dr. Henry Jekyll's concerns about his own well-being and the chilling consequences of allowing these anxieties full reign, Stevenson provides a hyperbolic admonishment regarding the potential connection between the mental and the physical.

Jekyll's concluding record is rife with indicators of his hypochondriac state, of his belief, in other words, that there is something wrong with him that needs to be remedied by medical intervention. Dr. Jekyll commences his "full statement of the case" by describing what he sees as a problem that had plagued him for most of his adult life. The doctor explains how humans are all made up of "good and ill," the components which normally contribute to "man's dual nature" (42). Unfortunately, Jekyll fears that within him these facets are no longer operating as they should; instead, they have been "severed," leading to a "perennial war among [his] members" and a "profound duplicity of life" (42). Jekyll's creation of Hyde is not the result of idle experimentation, but a deep-seated desire to fix what he sees as ailing him: "from an early date" Jekyll elaborates, "even before my scientific discoveries had begun to suggest the naked possibility of such a miracle, I had learned to dwell with pleasure, as a beloved daydream, on the thought of the separation of these elements. If each, I told myself, could but be housed in separate identities, life would be relieved of all that was unbearable" (43). Jekyll's eventual formulation of the drug that results in Hyde is thus his attempt to *cure* the "unbearable" condition from which he feels that he suffers.

During the Victorian period, Jekyll's anxiety regarding the "war among his members" and the "ill" behaviors that he continues (yet fears) to indulge could indeed have been categorized as a health concern rather than simply the product of a guilty conscience—and, thus, as subject to a medical remedy. In *The Healthy Body and Victorian Culture*, Bruce Haley draws from a range of medical texts to highlight several key fundamentals of health in the nineteenth century. The first two elements in particular help to illustrate how Henry Jekyll could have

conceived of the state in which he found himself as not only uncomfortable, but insalubrious. According to Haley, for the Victorians,

> First, health is a state of functional and structural *wholeness*….
>
> Second, since in a living organism structures are purposively functional (not just working but working usefully), the state of health is one of *telicity*. A person may be seen as whole or healthy when he acts responsibly in his environment. (20, emphasis original)

Jekyll's distress following his self-evaluation lies in his belief that he has been unable to achieve either of these ideals: he is concerned because of the more than natural division that he thinks exists within his character, and the cause of this split lies in his indulgence of ill impulses and his inability to consistently act responsibly based on his good impulses. In Jekyll's mind, in other words, he is neither whole nor telic, and he is thus not completely well. At this point, though, Jekyll's obsession is only a kind of illness—a belief that something is not quite right with his current state, rather than an identifiable physical complaint.

What transforms Jekyll's general uneasiness into a full-fledged corporeal manifestation, though, is his knowledge of the laboratory and his attempts to formulate a cure for his condition within this venue. Jekyll himself explains that while he constantly reflected on how he might repair the unhealthy split in his character, these speculations bore no fruit until "a side light began to shine upon the subject from the laboratory table" (43). Jekyll's access to the tools necessary to create the drug that he believes will be his salvation seals his fate. He has within his home the laboratory equipment needed to "prepare… [his] tincture" and he knows who to contact—"a firm of wholesale chemists"—for the "large quantity of a particular salt" necessary to complete the drug that he proposes to concoct (44). The medium of the laboratory thus allows a dejected mental state and hypochondriac tendencies on the part of Jekyll to blossom into real physical consequences.

As the nineteenth century came to a close, previously unprecedented and grand discoveries did indeed begin to take place regularly within the laboratory. Medical historian W.F. Bynum characterizes the final decades of the nineteenth century as a "heady" time "when new

pathogenic organisms were being announced every few months. The list of infectious diseases whose causative organisms were then identified [within the laboratory] includes tuberculosis, cholera, diphtheria, plague, dysentery, gonorrhea, tetanus, and the common organisms of wound infection, staphylococcus, and streptococcus" (129). The laboratory breakthroughs that marked the end of the century were crucial in creating a new understanding of disease and its operations, but clear-cut cures for the examined disorders were not always forthcoming. As Bynum notes, a large part of Louis Pasteur's celebrity among the sea of researchers involved in the development of the germ theory of disease was the fact that unlike many of his fellow scientists, "Pasteur's was no abstract notion of microorganisms as a cause of disease, but one that was almost always attended with therapeutic or specific prophylactic implications" (128). Jekyll's desire to make such a revolutionary finding himself ultimately pushes him beyond the limits of caution in his experimentation: he explains that "the temptation of a discovery so singular and profound, at last overcame my suggestions of alarm" (44). While Jekyll's wish to establish a cure for what he sees as a potentially widespread human problem is similar to those of other late nineteenth-century researchers (and he does indisputably uncover something remarkable), his example illustrates the possible fallibility of the medical professionals responsible for mapping the great discoveries of the *fin de siècle*. Driven by personal motivations and the desire for glory, Jekyll becomes reckless. He does not, after all, even test the salt that he employs in his initial experiments, finding out only once it is too late that there must have been an "impurity" in his original stock that allowed the experiment to work (54).

Thus, rather than leading to a finding with pervasive benefits—or even a solution to Jekyll's perceived problem—the "temptation[s]" offered by the laboratory coupled with Jekyll's egotism instead open him up to a self-poisoning on par with the poisoning of others that we witnessed in Braddon's works. Philip Sheldon sat quietly in his home office and planned the poisoning of his friends and family with the help of his medical knowledge; Jekyll sits similarly quietly in his home laboratory and uses his medical expertise to experiment upon himself. In both cases, self-interest perverts what should be the altruistic aims of the medical professional.

The distinction is that the root of Jekyll's knowledge and hubris lies in the new sciences of the lab rather than the staid communications of medical professionals. What has also changed between Braddon and Stevenson is that the scientifically-inclined Jekyll's contact with the laboratory and his desire to maintain a respectable professional façade make him, rather than his patients, particularly vulnerable. While Jekyll may poison himself just as surely as Sheldon poisoned Tom and Charlotte, Jekyll does so unwittingly and with the intention of revealing a new and magnificent cure. His belief in his mastery of the experiment that he is performing coupled with a clear lack of knowledge (his ignorance regarding the salt's impurity) spell his downfall; had he been less sure of his medical expertise or more careful, Hyde might never have been released.

Stevenson's depiction of Jekyll's folly ties into widespread public uncertainty regarding the long-term benefits of laboratory science. As the critic Lilian Furst notes, though researchers were continually detecting the sources of various ailments, skepticism regarding the usefulness of these discoveries continued to reign in the general population because "therapeutics mostly lagged considerably behind diagnosis" (157). Various critics have pinpointed the lab as crucial to Jekyll's creation of Hyde in order to tie Stevenson's novella to these later-Victorian suspicions regarding the outcomes of lab science.[49] I would suggest that one of the ways Stevenson addresses these concerns within his novella is by proposing that instead of creating cures for existing diseases, the lab might be aiding in the creation of new disorders.

He makes this argument in part by creating an allegorical representation of disease in the character of Hyde. While Jekyll is initially invigorated by the release of Hyde, the doctor soon realizes that Hyde has further disordered rather than brought order back to Jekyll's life. As such,

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[49] Gordon Hirsch notes that both *Jekyll and Hyde* and *Frankenstein* "intimat[e] that scientific research beyond certain limits may be a terrible mistake" (223). Furst also comments on the role of laboratory science in Stevenson's novella, though she does not apply her historical insights regarding the dearth of cures supplied by the lab to Stevenson's work. Instead, she focuses on the negative depiction of the physical laboratory itself, concluding that *Jekyll and Hyde* provides an example of fears regarding the lab's potential for "wreaking havoc in totally unforeseeable ways" (161).

Hyde is much closer to being a new *disorder* from which Jekyll suffers than the cure after which Jekyll sought. Many critics have characterized Edward Hyde as diseased, particularly those who see him as an example of contemporary theories of degeneration.[50] These readings focus on the physical characteristics and behaviors that potentially mark Hyde as atavistic. While I agree that there are a host of markers that connect Hyde to disease, I question the assumption that these signs point to Hyde himself being diseased. I would like to suggest instead that in his depiction of a perfectly malignant corporeal manifestation that incessantly plagues Jekyll, Stevenson has created an allegorical representation of disease itself.

Seeing Hyde simply as a separate self and categorizing what is wrong with him overlooks the significance, and the horror, of what Jekyll has done in creating Hyde: where only a belief in something being wrong previously existed, a concrete and malevolent entity is now present. Even when poor health is not immediately apparent, generally speaking, we expect disease to precede illness, to be its necessary prerequisite. In *The Strange Case of Dr. Jekyll and Mr. Hyde*,

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[50] In one of the earlier comments on this aspect of the text, Donald Lawler briefly notes that the novel engages scientific thinking of the day by providing “a case study of degeneration” (252). Stephen Arata ties Hyde’s degeneration to class, suggesting that throughout the novel Hyde learns to act more like a gentleman while simultaneously degenerating, making degeneration a function of middle-class “virtue.” Guy Davidson observes that “later nineteenth-century psychiatry … constructed various forms of mental illness and social deviancy as atavisms” (31), and he focuses on the novella’s depiction of the male homosexual as a specific type of degenerate. Sara Clayson traces the ways in which Spiritualism appears in the text and the consequences that this engagement with Spiritualism can have for Darwinian theories of evolution. She suggests that Stevenson posits the atavistic Hyde as not so much a throw-back as a depiction of possible future generations.

Elaine Showalter posits another means for conceiving of Jekyll as suffering from disease. She suggests that the novel is a parable about hidden fantasies and anxiety surrounding male homosexual desire and that it is “a case study of male hysteria” resulting from the suppression of such desires (69). Hyde, a more feminized and weaker self, is thus the manifestation of Jekyll’s hysteria. While Showalter makes intriguing arguments about the allusions to homosexuality latent in the text (and she is certainly not the only critic to do this), the evidence for Stevenson’s own concerns about homosexuality here and elsewhere are speculative at best. What is certain is that Stevenson was often sick and was constantly fixated on his own health. For examples of ways in which Stevenson attempted to de-emphasize sex and sexuality in the final version of the novella, see Reid (99-100).

Stevenson engages Victorian fears regarding the link between body and mind by creating a fable in which the causal relationship between disease and illness suffers a hyperbolic reversal.

If someone is diseased, something specific is amiss within that person; he or she suffers, in other words, from a harmful alteration to his or her body. A disease, however, while negatively affecting the sick person, is complete within itself and in its function. Following this formulation through in the examination of Hyde, I contend that there is nothing wrong with Hyde—rather, he is what is wrong with Jekyll. Though the figure of Hyde conveys an aura of unhealthiness to all who encounter him, no one is able to pinpoint any signs of disease within Hyde himself. Utterson's cousin, Mr. Enfield, remarks that Hyde "gives a strong feeling of deformity, although I couldn't specify the point" (5). Utterson himself later declares that Hyde "gave an impression of deformity without any nameable malformation" (10).[51] People might feel an instant aversion towards Hyde upon meeting him, but no one is able to say with any certainty that there is something in particular wrong with him. In fact, while Jekyll is adulterated by the inclusion within himself of both good and evil, Hyde is perfect in the sense that he, unlike Jekyll, is "*pure* evil" (45, my emphasis). Sickness can have beneficial effects (such as the redistribution of power alluded to in previous chapters), but it is rarely greeted as a positive. The antipathy directed toward Hyde by all who encounter him bears resemblance to the natural human antipathy toward the evil of disease. As a representation of disease, then, Hyde quite literally puts the *mal* in malady.

Jekyll's descriptions of Hyde's appearances underscore his function as disease. For Jekyll the materialization of Hyde is marked by physical symptoms, by "a horrid nausea and the most deadly shuddering" (51). Moreover, Jekyll informs us that "The powers of Hyde seemed to have grown with the sickliness of Jekyll" (53). The inverse relationship between the waning strength

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[51] Though not with disease specifically in mind, Peter Garrett briefly and intriguingly comments on Hyde's almost contagious effect on those who come across him. Garrett observes that "Those who confront and oppose Hyde seem to turn into his doubles" becoming just as hateful and desirous of violence as him, and he describes this as a "contamination" (68).

of Jekyll and the burgeoning strength of Hyde parallels the weakening of a patient as his ailment progresses and grows within him. Once Hyde begins running rampant and appearing without being called, Jekyll's linguistic choices further emphasize Hyde's position as disease rather than diseased, for Jekyll begins referring to the drug that quells Hyde as "medicine" and he describes Hyde almost as a physical symptom that returns when the effects of the medicine dissipate. He explains, "when the virtue of the medicine wore off, I would leap almost without transition … into … a body that seemed not strong enough to contain the raging energies of life" (53).[52] Hence, Utterson is perhaps more correct than he realizes when he explains to Jekyll's butler, Poole, that "Your master, Poole, is plainly seized by one of those maladies that both torture and deform the sufferer" (30). Hyde is the destructive *physical* manifestation of Jekyll's mental concerns about his own well-being. As such, Hyde serves as both an allegorical representation of disease and an embodiment of Victorian fears about the possible origins of corporeal complaints in the mind and the laboratory.

What Jekyll intends to do through his experimentation—create a cure for something that he sees as a problematic condition—is similar to what many researchers of the period were also attempting. The distinction is that Jekyll's endeavors are intertwined with his own hypochondriac qualms. There is no ailment to be alleviated, and Jekyll's efforts accordingly result in something worse than what he had previously feared. The critique leveled by Stevenson through this "strange case" thus cuts two different ways. On the one hand, his story serves as a cautionary tale about the dangers of wallowing in, as he once put it, "the sickly vanities … of a

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[52] Jekyll's description of the drug that he concocted as "medicine" is doubly ironic, for it marks his repeated misreading of his situation. Though he only begins to call the drug a medicine at this point, he originally intended for the mixture to medically remedy the internal warring between his parts that he reads as problematic, with the result being the creation of truly malignant entity. Then, once Jekyll realizes that his current state is not preferable to his original way of being and he attempts to employ the drug—now called a medicine—to "manage" his condition, this method of treatment proves insufficient and equally unreliable.

person who does not think himself well."[53] On the other hand, since the tools of the medical experimentalist so easily lend themselves to the amplification of those personal anxieties, Stevenson's novella also lampoons the potential egotism of such researchers and the belief that the laboratory grants them a more god-like status. Ultimately, though Jekyll creates an almost inhuman creature in Hyde, his experiments underscore his own humanity—and the potential fallibility of the medical professional.

Narrative Contagion and Narrative Containment: The Dangerous Story and the Preventative Case

In her depiction of Philip Sheldon's replication of disease through his medical reading, Braddon posited a disturbing connection between the doctor's use of narrative and the spread of contagion. In the latter half of *Jekyll and Hyde*, Stevenson examines the consequences of two different types of medical narration—narratives shared *with* one's practitioner and narratives shared *by* practitioners in the form of the medical case. Dr. Hastie Lanyon's sickening mid-way through the novella after hearing Jekyll relate the story of Hyde's emergence underlines the shift in Stevenson's work to a more vulnerable and humanized medical professional. Furthermore, the implication of Lanyon's speedy decline following Jekyll's late-night tale-telling is that some narratives have the potential to create and spread infection, a possibility which reinforces Stevenson's concerns about the link between the mind and the body.

Unlike Braddon, Stevenson locates the contaminating potential of narrative not in medical writing but in more personal accounts—the confidential revelations delivered to the practicing Lanyon are what fell him, not excerpts from his medical library. As a result, the medical case serves a very different function for Stevenson than it did for Braddon. Stevenson

[53] See page 122.

sets up the case as the venue for the responsible doctor, rather than the unscrupulous one, to share information with future researchers in order to *prevent* a repetition of mistakes. In *Jekyll and Hyde*, Jekyll's concluding case narrative defuses the potential dangerousness of his tale instead of serving as a platform for future contagion, and it fulfills this function through an emphasis on analysis and explanation.

Belief in the immaterial transmission of material ailments was not unheard of in the nineteenth century. For instance, the perceived link between moral health and physical health that informed Victorian debates about topics such as masturbation implicitly invoked an etiological relationship leading from the mind to the body.[54] And in *Somatic Fictions: Imagining Illness in Victorian Culture*, Athena Vrettos details even more explicit concerns especially prominent near the end of the century regarding the mind's power over the body. Vrettos focuses on the medical disorder of neuromimesis which connected spectatorship with the involuntary mimicking of others' disease-behaviors. In this formulation, *seeing* and sympathizing with someone suffering from an ailment could lead to the contraction of a nervous disorder similar in type to the observed condition. Stevenson's depictions of allegorical and literal disease in his novella play into existing concerns about the mind's role in creating the body's afflictions, but in his consideration of Hastie Lanyon's physical deterioration he addresses these anxieties from a slightly different angle than that highlighted by Vrettos, proposing that disease could also be transmitted via narrative.

Stevenson himself repeatedly acknowledged the power of narrative to affect the body and simulate sickness. He was deeply moved by Dostoyevsky's *Crime and Punishment*, and in two separate letters to friends from November 1885 and March 1886 he described reading the novel as "having a brain fever" (*Letters*, v. 5 151) and explained that "it nearly finished me. It was like having an illness" (310). Earlier in 1883, Stevenson had advised his father against reading J.G.

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[54] For more information on the discourses surrounding masturbation in the nineteenth century and possible links between these discourses and *The Strange Case of Dr. Jekyll and Mr. Hyde*, see Moore's "Something to Hyde: The 'Strange Preference' of Henry Jekyll."

Lockhart's biography of Walter Scott, asserting, "I have just finished reading a book which I counsel you above all things *not* to read; as it has made me very ill and would make you worse" (*Selected Letters* 242).[55] For Stevenson, narrative could have material consequences—and these effects could be disease. This potential narrative etiology comes to the fore in *The Strange Case of Dr. Jekyll and Mr. Hyde* in Stevenson's descriptions of Jekyll's friend and colleague Dr. Lanyon.

At first glance, the decay of Lanyon's health might seem to conform to the type of visual contagion outlined by Vrettos. It is only after seeing Hyde transform back into Jekyll, after all, that Dr. Lanyon gets sick. And, indeed, this sight contributes to shocking Dr. Lanyon and implanting in him a "deep-seated terror of the mind" (23), a mental phenomenon which Lanyon then transforms into a physical ailment. Lanyon concretizes his mental terror by transforming it into disease, a move which echoes Jekyll's inadvertent creation of an actual physical entity as a result of his personal beliefs that something is wrong with him.

The Strange Case of Dr. Jekyll and Mr. Hyde illustrates that vision, though, is not sufficient by itself to affect this psychosomatic contagion in Lanyon; on the contrary, narrative proves a necessary component in the transmission of this infection. Seeing Hyde change into Jekyll is not the worst thing that Lanyon is exposed to that evening, for this, at least, he can record for Utterson in his letter. What he "cannot bring [his] mind to set on paper," though, is "What [Jekyll] told [him] in the next hour" following this change (41), the *story* that Jekyll tells him, in other words, explaining what he has just witnessed. As Lanyon writes to Utterson in summation, "I saw what I saw, I heard what I heard, and my soul sickened at it" (41). Many others encounter Hyde and survive (think of Enfield, Poole, or even Utterson); only Lanyon, the character exposed to the narrative of Hyde's manifestation, dies. Lanyon's refusal to put the

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[55] Though Stevenson uses the terms "illness" and "ill" here, they would not have had the connotations of a sufferer's subjective experience of disease made popular by twentieth century medical anthropologists and doctors and which I employ here and elsewhere. I take his use of these words within these contexts to refer to actual physical effects.

story that Jekyll told him into writing also suggests Lanyon's awareness of the possibly dangerous nature of this tale and the potential for its spread; Lanyon's letter is intended for an audience, and he purposely omits what Jekyll related to him.

Jekyll's admonishments right before exposing Lanyon to the story of Hyde suggest his recognition as well of the threat inherent in further discussion of his undertaking. After Lanyon has fetched Jekyll's drugs for him, Jekyll advises Lanyon to allow him to take his concoction and leave without being made to offer an explanation. He vehemently asks Lanyon, "Will you be wise? will you be guided? will you suffer me to take this glass in my hand, and go forth from your house without further parley?" (40). Unfortunately for Lanyon, his answer is no, and the mental shock that Lanyon receives from listening to this story becomes a full-fledged physical ailment characterized by a range of symptoms and finally death. Narrative has permeated and contaminated Dr. Lanyon's otherwise healthy body.

What is most distressing about Lanyon's sickening—and what most distinguishes it from the type of nervous contagion detailed by Vrettos—is its difference in form from the Hyde-disease that Jekyll has created. According to the third person narrator, Lanyon's ailment is characterized by the following symptoms: "The rosy man had grown pale; his flesh had fallen away; he was visibly balder and older"; sometimes his hands "trembl[ed]," and his voice became "unsteady" (23). Lanyon's complaint is not imitative of what he has witnessed in his friend; if anything, Jekyll appears younger and stronger when seized by Hyde, not "balder and older." Lanyon, in other words, does not take on the signs of corruption that he has just witnessed in his friend. Instead, he makes the disorder that he contracts all his own.

This difference in disease manifestation makes sense when we consider the narrative roots of Lanyon's ailment. The cultural anthropologist and historian Michel de Certeau provides a helpful model for understanding what has happened to Lanyon. In his discussion of consumers as also producers in *The Practice of Everyday Life*, de Certeau describes reading, the process of taking in narrative, as an act which involves readers making narratives their own. He explains,

> [the reader] insinuates into another person's text the ruses of pleasure and appropriation: he poaches on it, is transported into it, pluralizes himself in it like the internal rumblings of one's body…. This mutation makes the text habitable, like a rented apartment. It transforms another person's property into a space borrowed for a moment by a transient. Renters make comparable changes in an apartment they furnish with their acts and memories. (xxi)

Lanyon hears the story of Jekyll's disease, but in his reception of this story, he also makes it his own—he inhabits it just as de Certeau's readers put themselves into the texts that they read and transform those texts in the process. When Utterson visits Lanyon before his death, Lanyon tells him, "I have had a great shock … and I shall never recover. It is a question of weeks. Well, life has been pleasant; I like it; yes, sir, I used to like it. I sometimes think if we knew all we should be more glad to get away" (23). This explanation on the part of Lanyon underscores how Lanyon has made the malady with which he is afflicted his very own. His own moral uprightness cannot admit of the moral horrors contained in Jekyll's tale. Knowing what he now does, Lanyon admits that he feels it would be better to die—and that is exactly what he is doing through the creation of a disease which effectively accelerates his aging ("he was visibly … older") and diminishes his physical body ("his flesh had fallen away").

Lanyon's unique reception of this information underscores that narrative contagion for Stevenson is a two-way street. Jekyll's telling of his story provides the impetus for Lanyon's contamination, but Lanyon's personalizing of this ailment reveals that he too plays a role in the narrative contagion with which he is afflicted. While Braddon highlighted the potential influence that medical practitioners could exercise over the development of their patients' illnesses, Stevenson turns his gaze inward, returning at least some of the responsibility for illness (and subsequent disease) to the patient—and simultaneously illustrating the harm that sufferers could enact upon themselves and each other through the passing on and reception of questionable narratives of illness.

Lanyon's situation also reinforces the humanization and vulnerability of the doctor-figure that Jekyll's unintentional self-poisoning highlighted. While Jekyll's access to scientific tools and theories endangers his health, the position of the more patient-oriented Dr. Lanyon proves no

safer, for, strictly speaking, it is a patient's confidence that ultimately kills him. Right before relating the story to Lanyon that leads to his narrative contagion, Jekyll announces, "Lanyon, you remember your vows: what follows is under the seal of our profession" (40). The vows to which Jekyll refers are those of the Hippocratic Oath, which both he and Lanyon would have taken upon entering practice. While in Britain at this time there was no legal statute establishing doctor-patient confidentiality, the Hippocratic oath's strictures against revealing that which a practitioner "may see or hear, professionally or privately, that ought not to be divulged" were taken very seriously (67). The physician and Fellow of the Royal Society Alfred Swaine Taylor makes this moral prohibition quite clear for the Victorian medical man in his *A Manual of Medical Jurisprudence* from 1897. After dutifully explaining for pages that "the law concedes no special privilege of this nature [confidentiality of patients' statements] to members of the medical profession" (38), Swaine Taylor concludes that nevertheless "The safer rule for the physician is, never under any circumstance to reveal the confidence of his patient, and to preserve inviolate, every secret obtained in the course of his professional practice…. The courts will honor, rather than punish, the physician who holds his patients' secrets higher than personal considerations" (43).

Dr. Lanyon has clearly taken this injunction to heart, for he squarely denies himself the relief that might be provided by relating the tale that Jekyll has told him to a friend. For instance, when Utterson inquires as to the cause of Jekyll's decline, Lanyon shuts down the conversation before it can begin, stating "Some day, Utterson, after I am dead you may perhaps come to learn the right and wrong of this. I cannot tell you" (23). Significantly, Lanyon does not maintain that he would rather not tell Utterson; instead, he "*cannot* tell" him (my emphasis). Lanyon's position as medical professional *prevents* him from revealing that which he knows. Even the letter that he eventually pens for Utterson is written with the caveat that it may only be read following "the death or disappearance of Dr. Henry Jekyll" (24), the patient in question. The story that Jekyll reveals to Lanyon "under the seal of [their] profession" pollutes Lanyon's mind and body, and the need to maintain confidence ultimately leaves Lanyon with few options for ethically

transmitting this contaminating information, and, thus, possibly purging himself of the contagion which Jekyll's story has fostered within him.

The one permissible form in which Lanyon could have conveyed at least some of the information that he had gleaned from Jekyll would, of course, have been a medical case history; though Lanyon never pursues this course, Jekyll closes the novel with his own "Full Statement of the Case" (42). A host of critics have noted the resonance between the "case" in the novella's title and the medical case study, but none have fully considered the function that Jekyll's documentation of his attempts to cure himself and their results in his final statement might serve.[56] As Lauren Berlant notes in her introduction to *Critical Inquiry*'s recent special issues on the case, "The case-study method always assumes the sociality of knowledge, the circulation of discourse as its condition, and the clarifying obligation of analytic narrative" (668). Of importance here is not just the concept of the "case," but the notion of "study"—of learning, in other words. Yes, the case narrative disseminates, but its purpose is first to elucidate and then to spread information in the service of halting further contagion. The difference, then, between Jekyll's statement of the case and Jekyll's late-night confession to Lanyon rests in the final clause of Berlant's statement: when one is providing a study of a particular case, one is attempting to analyze the conditions of that case in an effort to solve or shed light on the problem

[56] Robert Mighall observes at the outset of his article that the novella is like a medical case, but he suggests that it is "a fictional case-study in what was known at the time as 'morbid psychology'" (145), and the remainder of his article focuses on how specific passages from the novella line up with contemporary psychiatric, criminological, and sexological writings. Stephen Heath also briefly notes that it is important that the novella is a case since it is about the representation of sexuality, something ordered by doctors in the nineteenth century (102). Julia Reid mentions that "The narrative's presentation as a 'Case' indicates its affiliation with modern legal and medical discourses as well as detective fiction" (94). Stephen Lawler pithily alludes to the novella as "a case study of degeneration" (252), while Elaine Showalter describes it as "a case study of male hysteria" (69).

Jason Tougaw's treatment of *Dr. Jekyll and Mr. Hyde* in his *Strange Cases: The Medical Case History and the British Novel* promises a fuller examination of the novella in terms of the case form. However, outside a brief mention that this work (along with three others) is an example of the kind of "case that documents a scientific experiment" (140-41), Tougaw does not really examine *Jekyll and Hyde*'s relationship to the case form, instead focusing on its connection to Victorian debates regarding altered states induced by chloroform, ether, and mesmerism.

at hand, not simply amaze and perhaps horrify your friends with the discoveries that you have made.[57]

The result of closing the novella with Jekyll's explanatory record is that Stevenson, unlike Braddon, promotes medical writing in the form of the case study as one of the few narrative means available for thwarting, rather than spreading, contagion. Stevenson's depiction of these two susceptible doctors may express skepticism regarding the god-like status and unquestioned authority of the medical professional, just as Braddon's portrayal of Philip Sheldon did, but Stevenson's questioning of medical knowledge does not ultimately follow the same trajectory as Braddon's. Stevenson was wary of the expertise of doctors, stemming from the multiple and sometimes conflicting diagnoses that he constantly received, yet he maintained a respect for scientific and medical writing. He was an avid reader of Charles Darwin and Herbert Spencer (Harman 44), and his wife Fanny held a subscription to the *Lancet* while Stevenson was writing *Jekyll and Hyde* (Harman 300). In *The Strange Case of Dr. Jekyll and Mr. Hyde*, the case thus becomes a vehicle for passing on knowledge and preventing the exacerbation of illness and the spread of disease, rather than the contaminating narrative portrayed by Braddon. It is only by writing about his self-experiments in this *analytical* form that Jekyll can keep future generations from repeating his mistakes.

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[57] Though we never hear the version of Jekyll's tale that he relates to Lanyon, its impassioned, rather than analytical, nature is underscored by the few descriptions of its telling that we do receive from Lanyon. Jekyll enters upon his midnight telling to Lanyon not in the spirit of sober explication but as a heated challenge to a rival: "you who have so long been bound to the most narrow and material views, you who have denied the virtue of transcendental medicine, you who have derided your superiors—behold!" (40). The relation that follows proves an emotional roller-coaster ride, for after this initial rush of pride, Lanyon explains that Jekyll tells his story amidst "tears of penitence" (41).

The analytical requirements of the case study also emphasizes why this type of narrative is never an option available to Lanyon. Since the practitioner admits that he will go to his grave still somewhat "incredulous" about the discoveries which Jekyll has revealed to him in the realm of transcendental medicine" (41), Lanyon would be hard-pressed to craft a properly explanatory narrative about Jekyll's case. Moreover, Lanyon's distaste for Jekyll's line of inquiry (which he refers to when conversing with Utterson as "unscientific balderdash" [7]) coupled with his own moral qualms about the continuation of any research in this vein accounts for his hesitancy to record the details to which he is privy in this form.

Indeed, Jekyll's statement conforms in many important ways to a nineteenth-century medical case history. Though he is also the sufferer, Jekyll narrates his statement in his role as doctor. He begins with dates as any scientific case study would: "I was born in the year 18--" (42). And he provides the patient's (in this instance, his) history, including general facts such as his family's "large fortune" and that he was "endowed besides with excellent parts" at birth, before moving on to background more specifically related to the development of his supposed ailment, such as, his "desire to carry [his] head high, and wear a more than commonly grave countenance before the public" (42). Following this patient history, he proceeds to document the experimentation and drug use involved in his proposed cure, and he records the physical symptoms experienced by himself during Hyde's manifestations, such as "racking pangs … a grinding in the bones, deadly nausea" (44). Significantly, Jekyll's statement does not simply describe, though; he also offers hypotheses about the properties of his condition, speculating, for instance, on Hyde as a physical being and issues such as why he is smaller in stature and younger (44-5).

The similarity between Jekyll's case narrative and the medical case study would not have been lost on Stevenson's contemporaries. For example, in Oscar Wilde's 1889 essay "The Decay of Lying," Wilde employed the character of Vivian to note the similarity between Stevenson's novella and medical writing of the period. Vivian, horrified at the attention to detail and accuracy to life of contemporary literature, exclaims at one point, "Even Mr. Robert Louis Stevenson, that delightful master of delicate and fanciful prose, is tainted with the modern vice…. the transformation of Dr. Jekyll reads dangerously like an experiment out of the *Lancet*" (167). Though Stevenson's text is undoubtedly fanciful at times, what Wilde's Vivian pinpoints with his comparison is the rigorousness and wealth of explanatory details that characterize Jekyll's account.

In addition to the surface indicators of the case narrative form, Jekyll repeatedly offers explications for future readers of how he might have better proceeded in his investigations and what actions might have been detrimental to his health. He does not simply pass along

information, in other words, he also attempts to analyze what he has learned and offer these analyses to prospective readers. From the start, Jekyll acknowledges the fact that investigators will continue to attempt what he has already performed. He explains at the outset of his statement, “Others will follow; others will outstrip me on the same line” (43). What will lead to an outstripping rather than simply repetition, though, is Jekyll’s detailing of his own case and the mistakes that he has made. For instance, Hyde’s original manifestation might have been quite different, and Jekyll provides information to future researchers explaining this aspect of his experience: “Had I approached my discovery in a more noble spirit, had I risked the experiment while under the empire of generous or pious aspirations, all must have been otherwise” (45). He also offers a host of warnings about factors that could serve as catalysts for more violent “outbreaks” of Hyde. For example, frequently taking the drug that liberates Hyde leads to Hyde gaining strength (48). At the same time, continual suppression of Hyde by means of this same drug results in increasingly more malevolent actions upon Hyde’s release. This is of course what leads to the murder of Sir Danvers Carew; according to Jekyll this outcome results because “My devil had long been caged, and he came out roaring” (49).

Besides outlining the circumstances that led to the initial creation of Hyde and his gradual strengthening, Jekyll also cautions against that which cemented the shift in his condition from chronic to terminal. Significantly, Jekyll’s discovery regarding this final change further illustrates the mind’s role in creating and sustaining Hyde, for the doctor’s revelation exposes the impact of his thoughts on the return of his symptoms. One day, after indulging his lower impulses “as an ordinary secret sinner” (that is, not in the form of Hyde), Jekyll sits in the park “licking the chops of memory…. reflect[ing that he] was like [his] neighbors; and then [he] smiled, comparing [his] active goodwill with the lazy cruelty of their neglect” (51). Unfortunately for Jekyll, this seemingly innocuous mental activity triggers physical effects, and “this brief condescension to [his] evil finally destroyed the balance of [his] soul” (51). As he relates, “at the very moment of that vainglorious thought, a qualm came over me, a horrid nausea and the most deadly shuddering” (51). This is the beginning of the end for Jekyll, for it is at this

point that his drug loses any efficacy that it once held as a medicine and Jekyll truly loses control over when and where Hyde appears. This detailed account, along with Jekyll's previous explanations regarding why Hyde manifested as he did and how Hyde gained strength as Jekyll weakened, is crucial in order to facilitate the outstripping by future researchers predicted by Jekyll at the beginning of his case study rather than a repetition of his own mistakes. Thus, in his last act of narrating his case, Jekyll finally plays the role of responsible doctor and provides the analyses necessary to prevent the unleashing of another Hyde.

Whereas Braddon presented medical literature as a vehicle for the immoral doctor to spread contagion, then, Stevenson illustrates that in the hands of the conscientious doctor (even if one who finds himself belatedly so), the medical case can also serve as a means to prevent the spread and facilitate the understanding of human suffering. And this preventative, rather than contaminating, function of Jekyll's final act of narration ultimately helps to account for the novella's abrupt ending following Jekyll's statement of his case. After the extended narrative frame that precedes Lanyon's letter and Jekyll's record, many readers are surprised by the lack of a similar frame following Jekyll's remarks. I would suggest, though, that Jekyll's statement of his case serves to *encase* and that the seemingly abrupt ending thus serves as Stevenson's final indication that the case study, at last, has contained the narrative contagion and the transformations of illness into disease that have punctuated the rest of his novella.

One might suggest of course that the narrative is not picked up again because Utterson, the original recipient of Jekyll's case narrative, has been struck down by the very narrative contagion which felled Lanyon before him. However, we must remember that the beginning of the novella, while often focalized through Utterson's perspective, is conveyed via an outside, third-person narrator. Thus, Utterson is not even really necessary for narrative continuation, for the same third-person narrator who began *The Strange Case of Dr. Jekyll and Mr. Hyde* could just as easily return and explain that Utterson has been contaminated. In my earlier chapter on *Bleak House*, I considered the ways in which the medical case drew on one root sense of the word "case," namely, as something which "befalls" an individual, and, thus, as a falling away

from the normative. Stevenson's decision to conclude his tale with Jekyll's statement of his case suggests that Stevenson envisions the case form as calling on yet another connotation of the word case: "A thing fitted to contain or enclose something else" (*Oxford English Dictionary*).[58] Ultimately, in *The Strange Case of Dr. Jekyll and Mr. Hyde*, Jekyll's analytical case study contains by preventing further manifestations of figures like Hyde and the type of personalized narrative contagion that felled Lanyon.

The Moral and the Medical: Shifting Narratives

Arising concomitant with the nineteenth-century's increasing secularization was a focus on the sciences as a means for explaining the workings of the natural world. Between the Victorian public's growing interest in health and the increase in medical specialization, the medical sciences played a central role in fulfilling this explanatory function. While this shift was essentially knowledge based (that is, science rather than religion was being called upon to provide information about how things worked), *moral authority* was also passed on to those members of the scientific world most involved with helping their fellow humans—namely, doctors. Nevertheless, near the middle of the century when Braddon was writing, the medical professional's ability to name disease coupled with what was often an inability to cure led to skepticism as to whether doctors had earned the right to the moral authority with which they had been granted. Braddon implicates the medical writing of the period in helping to solidify practitioners' influence by providing them with access to technical information not always available to or understood by the general public, while simultaneously (and rather circularly)

[58] In my thinking through of this concept, I am grateful to Susan Wolfson whose forthcoming Longman edition of *The Strange Case of Dr. Jekyll and Mr. Hyde* includes a helpful listing of meanings of the word "case" derived from the *Oxford English Dictionary*.

assuming that these practitioners already held the moral authority necessary to responsibly handle these materials.

As the century progressed, methods of medical investigation centering on the lab became more prominent. One writer reporting in *The Lancet* on the International Medical Congress of 1881 voiced an opinion gaining currency with many in the medical field. The reviewer asserts that "[The Congress] has demonstrated to the world the progress that medicine has recently made, that it is advancing because it has become more scientific, and that the only great advances yet in store for it must result from the successful application of the same methods" (qtd. in Bynum 144). The promise of extraordinary breakthroughs provided a powerful endorsement of the lab's methodology; at the same time, with a few notable exceptions such as Louis Pasteur's vaccines, the applicability of these discoveries to the treatment of patients' complaints was not always clear. In the same volume of *The Lancet* in which this review appeared, we still find over one hundred reports regarding clinical cases. *The Strange Case of Dr. Jekyll and Mr. Hyde* (penned by a man, remember, whose spouse held a subscription to *The Lancet*) picks up on this dual focus and promotes the more established method of gathering data. The novella presents the medical case narrative and its clinical underpinnings as a necessary counterpoint to unchecked experimentation. The morally responsible doctor was ethically sound now, according to Stevenson, *because* of his careful use of tools such as the analytical case study and his passing on through this medium of detailed information that could assist future researchers in his field.

The movement between Braddon's and Stevenson's texts provides a useful bridge from the earlier novels of Dickens and Collins, in which the patient took center stage, and the later works of Conan Doyle and Stoker to which we will turn next—and in which the case narrative is now ascendant. Earlier in the century, the concerns that Braddon highlights regarding unscrupulous medical professionals all return to the sufferer, for Braddon illustrates the ways in which patients' determinations of their own narratives of illness could be manipulated by unprincipled practitioners. Stevenson, a perpetual patient himself, is of course also concerned with sufferers, but he draws attention to the ways in which patients can do themselves harm as

well. Hence, in conjunction with displaying the shift from devaluing clinical detachment and scientific objectivity in the medical practitioner to valuing careful and responsible case-reporting, Braddon and Stevenson's accounts examined together also foreground the accompanying movement in popular Victorian fiction away from the patient's narrative as organizing principle and toward the doctor's case narrative as central.

CHAPTER FOUR
"YOUR CASEBOOK WAS EVER MORE FULL THAN THE REST": MEDICAL REPORTING AS ANTIDOTE IN *DRACULA* AND THE SHERLOCK HOLMES TALES

At the close of a century in which clinical medicine predominated, the medical case study finally takes literary center stage in Bram Stoker's masterwork of fantasy, *Dracula*, and Sir Arthur Conan Doyle's famous Sherlock Holmes stories. As my last chapter began to suggest, though, this movement toward the use of the case as model occurs only as the clinic begins to lose its foothold as the primary producer of knowledge in medicine. In his work on literary realism and clinical medicine, Rothfield notes that "a new epistemological hierarchy takes shape during the latter part of the century, so that clinical medicine, once queen of the human sciences, becomes subordinated as a form of knowledge to the more exact sciences of bacteriology, chemistry, and microscopic anatomy" (141). Public feeling about this new voice in medicine demonstrates that the science of the lab was far from being viewed by ordinary citizens as the solution to their ills, however. On the contrary, as Lilian Furst points out and as I noted in my previous chapter on *The Strange Case of Dr. Jekyll and Mr. Hyde*, "Despite this increase in the number and scope of laboratories [as the century progressed], public response was mixed, tending toward skepticism" (157).[59] I would suggest that this shift in attention from the clinic to the lab *coupled* with the public's reaction to it was greatly significant for the application of the case model to literary works. Now that the clinic was no longer the monolith against which the sick individual must battle to make his or her voice heard, texts like *Dracula* and the Holmes tales could safely acknowledge the benefits that might accrue from following a case method.

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[59] Many doctors, in addition to their patients, shared this suspicion. As medical historian W.F. Bynum notes, "At times, it would have seemed to rank-and-file practitioners that possible benefits lay only in the future, for the translation of chemical, physiological, or bacteriological knowledge from the laboratory to the bedside or consulting room was not straightforward" (118). Thus, even with the growth in these new practices, not all medical professionals simply transferred allegiance to the laboratory from their usual clinical practices.

My previous chapter on *Birds of Prey* and *Charlotte's Inheritance* and *The Strange Case of Dr. Jekyll and Mr. Hyde* hinted at the literary results of this shift in paradigms, but their achievement comes in the form of Stoker's novel and Conan Doyle's detective stories. Earlier in the century, when the clinic still reigned, Mary Elizabeth Braddon cautioned through her works against doctors' unchecked access to potentially dangerous facts located in clinical writing. Closer to the century's close, however, Robert Louis Stevenson's allegorical tale warned against the dangers of the new laboratory science while alluding to the necessity of documenting cases for future medical researchers. Though Dr. Jekyll may not have succeeded in healing himself or fully elaborating the how's and why's of his situation, Stevenson nevertheless suggested that the type of case documentation employed by Jekyll near the end of his work could serve as both a means toward preventing future contamination and a defense against individual doctor's fallibilities. In this chapter, I propose that the ideals posited but never fully realized by Dr. Jekyll's statement of his case come to fruition in Conan Doyle's Holmes stories and Stoker's *Dracula*. Both works employ the medical case as a model and organizing principle, simultaneously illustrating the merits of sharing medical knowledge via this format and positing a host of reasons which necessitate this type of reporting.

Together, the Holmes stories and *Dracula* highlight the benefits of not only case documentation but the amassing of such cases—as well as the limitations on medical professionals that make such an accumulation necessary. One of the merits of case accretion can be an increased ability to cure or diagnose—the compilation of Lucy and Renfield's cases, after all, facilitates Drs. Seward and Van Helsing's proper understanding of Mina's infection and the group's capacity to eventually eradicate Dracula's contagious influence. At the same time, the emphasis in these works on the advantages of compiling as much information on a specific medical phenomenon as possible does not serve to simplistically reinforce medical authority. On the contrary, Holmes's facility at resolving mysteries based on their similarity to previous cases that he has encountered coupled with his occasional failures in judgment demonstrate that one function of the case is to serve as a bulwark against the fallibility of individual investigators and

what they may have missed. The mistakes made by Seward and Van Helsing certainly reinforce this point, but Stoker's novel goes even further in suggesting that failure in the treatment of a patient can have positive results in the production of medical knowledge. Thus, according to these two works, the value of the medical case lies not in its role as unquestioned instance of authoritative accounting, but as a tool to protect against future errors and as a means to learn from those that have already been made.

The centrality of case narration to the structure of *Dracula* becomes even more evident because of the lack of fully articulated illness narratives within *Dracula*—even though the novel includes a series of patients. At the same time, this dearth continues to complicate a critical assessment of *Dracula* as unproblematically adopting the case method as dependable. I contend that explicit patient accounts are absent within this novel because they now fall into the category of the *nonnarratable*, theorist D.A. Miller's term for textual elements that would necessarily lead to a story's resolution and the consequent end of narration. Since, within the logic of *Dracula*, the end of narration is synonymous with cure and the elimination of disease, Stoker's decision to exclude complete descriptions of illness underscores the potential healing benefits of fully explicit patient stories. His invocation of the multivocal medical casebook—a journal kept by medical students which included their and their superiors' opinions as well as a careful documentation of the patient's perspective—rather than the published case study further emphasizes Stoker's support of more than one voice in the process of treatment. Nevertheless, the limitations on full patient accounting introduced by contemporary manuals for keeping casebooks—such as a patient's age or mental state—coupled with the glaring lack of illness narratives within the novel highlights the impossibility of sufferer narratives ever being completely explicit. The unachievability of fully developed patient accounts thus points out further grounds for the existence of case reporting: this type of medical documentation is sometimes all that those trying to heal have to go on.

The Sherlock Holmes stories are more straightforward in their endorsement of the case method, for instead of touching on the potential, though perhaps unrealizable, benefits of patient

narration, Conan Doyle's tales meditate on what can be gained from emotional distance between practitioner and sufferer. They do so by taking as their model a type of case study which necessarily de-emphasizes the sufferer's perspective—the case narrative which concludes with autopsy rather than cure. Narrative theorist Peter Brooks observes "that plot is the internal logic of the discourse of mortality" (22). Plot progression, in other words, is always inevitably moving us toward an ending, an ending wherein meaning can finally be conferred on a completed whole. Nowhere is this clearer than in the Holmes stories which begin with Watson's description of the case's background and sequence of events and which end with the explanatory Holmesian summation. In their correspondence to the case narrative which starts with the patient's history and concludes with the doctor's examination of that now-deceased patient's body, these stories underline that death is necessary not only for closure but for full *disclosure*. The Holmes tales, in other words, illustrate that the autopsy, the most distancing practice of clinical medicine and often the only method available for determining a patient's cause of suffering, is sometimes necessary to advance medical knowledge and explain the often unlinked experiences of the sufferer.

Although *Dracula* and the Sherlock Holmes stories draw attention to opposite ends of the medical reporting spectrum—Stoker's novel focuses on initial medical case notes while the Holmes stories engage a particular type of published case history concluding in post-mortem exam—their incorporations of the medical case as organizing principle ultimately fulfill similar functions. On the level of theme, in both *Dracula* and the Holmes tales, the medical record serves as an antidote to absent patient voices. In *Dracula* detailed case notes fill the gap left by the shortage of fully-realized narratives of illness while helping to reveal the impossibility of such patient accounts. The Sherlock Holmes stories then figuratively illustrate the necessity of the most objectifying form of case-recording once the patient's voice is gone for good. Furthermore, on the level of structure, both works are simultaneously preoccupied with a movement toward narrative closure and the case's relationship to this closure.

I propose that it is only as clinical medicine becomes less predominant, and, thus, less threatening, that marginalized literatures such as the fantastic and detective fiction can truly embrace it. In *Vital Signs*, Rothfield highlights the historical shift described above to help explain what he sees as a movement away from the clinical model in genres coming after realism such as naturalism and detective fiction. Rothfield is certainly right about the importance of this historical change and its impact on literary development. However, he tends to misconstrue the trajectory of this development, for the medical case—the primary narrative manifestation of clinical medicine—informs the structure of later non-realistic works within the nineteenth century even more overtly than it earlier did. These more popular genres—the other voice in literature, as it were—are finally able to take on the case method and highlight its merits precisely because clinical medicine is no longer the only voice in medicine. Stoker and Conan Doyle's acknowledgement of the limitations that necessitate and sometimes plague case reporting signals this newly approachable nature of the medical case. Thus, just as the earlier literature that I examined offered another perspective to counteract clinical medicine's exclusive claims to knowledge, so too now the clinical case narrative offers an alternate method for garnering knowledge than that provided by the new, and often distrusted, laboratory sciences.

The History of the Case in Holmes and *Dracula*

Until this point, I have focused on the narrative form of the case study as it was co-opted by patients to elucidate their illnesses and as a tool employed by authors to highlight either fears regarding the dispersal of medical information or the case's potential to help prevent the spread of disease. Conan Doyle's Sherlock Holmes tales and Stoker's *Dracula* illustrate a shift in organizing principles evident in the late nineteenth century. Conan Doyle's stories and Stoker's novel still depict victims of suffering, but in these two works the doctor-figure and the medical perspective from which he records come to the fore. Hence, rather than drawing on an aspect of

the case or overtly criticizing this type of accounting, both Conan Doyle and Stoker adopt the logic of the case study to provide the narrative scaffolding which underlies the structures of their fictional accounts.

Arthur Conan Doyle, author of the Sherlock Holmes stories, was a general practitioner for several years before he began to pen these famous tales, and his medical experiences undoubtedly influenced aspects of his writing. Conan Doyle's choice to pursue a literary rather than medical career has led some to conclude that he was uninterested in his initial calling and a middling doctor at best, but his qualifications in his first field of practice were in fact quite sound. He received his Bachelor of Medicine and Master of Surgery degrees in 1881 (Stashower 44), followed by an M.D. degree in 1885 (70). As Alvin Rodin and Jack Key remind us in their *Medical Casebook of Doctor Arthur Conan Doyle*, "in Britain, unlike America, [the M.D.] was and still is a graduate degree awarded only after several years of practice and the writing of an acceptable thesis" (87). In addition to this thesis, Conan Doyle's medical writings include several letters to *The British Medical Journal* and *The Lancet* regarding suggested treatments and causes of diseases such as neuralgia, leukemia, and gout (Rodin 81-7).[60] Conan Doyle was not only familiar with the medical literature of his day; he was an active and astute participant in this discourse.

The possible medical antecedents for the character of Sherlock Holmes are well-documented. Conan Doyle himself repeatedly acknowledged his debt in creating Sherlock to Dr. Joseph Bell, his former mentor at the medical school of Edinburgh University. As a medical student, Conan Doyle worked closely with Dr. Bell for several years as his clerk (Stashower 27-9). In his autobiography, Conan Doyle explained his motivations for drawing on Bell in his depiction of his now-famous detective: "I thought of my old teacher Joe Bell…. If he were a detective, he would surely reduce this fascinating but unorganized business to something nearer

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[60] Rodin and Keys, a practicing M.D. and a professor of Biomedical Communications, describe the letter in which Conan Doyle diagnosed a case of gout as "a display of clinical acumen at its best—in part intuitive and in part based on a broad knowledge of disease" (86-7).

to an exact science" (qtd. in Wallace 28). Indeed the science of close observation practiced by Bell seems quite similar to Holmes's. In one interview, Conan Doyle described Bell's methods: "Dr. Bell would sit in his receiving room … and diagnose people as they came in, before they even opened their mouths. He would tell them their symptoms, and even give them details of their past life" (qtd. in Wallace 8). This proficiency at drawing conclusions from a close scrutiny of details certainly parallels Holmes's modus operandi as he applies it near the beginning of almost every case that he takes. For instance, in "A Case of Identity," Holmes correctly diagnoses the type of problem that Mary Sutherland will be bringing to him based on the nature of her hesitating movements before entering his abode. Holmes simply and tellingly explains in response to Watson's queries regarding his certitude, "I have seen those symptoms before" (148). While a convincing case can be made for Bell's influence in the creation of Holmes, further medical prototypes have also been suggested, ranging from other professors at Edinburgh University to the famed American doctor and writer Oliver Wendell Holmes (often identified as the source of Sherlock's last name). Some have even asserted that Conan Doyle himself ought to be considered the original of his detective. [61] Whoever the ultimate source may be, the fact remains that Conan Doyle's medical education and knowledge of the field greatly impacted his most famous creation.

Moreover, within the stories themselves, their narrator is clearly identified as a practicing medical man. Dr. John Watson's very first words as narrator of *A Study In Scarlet*—the inaugural Holmes tale—in fact read, "In the year 1878 I took my degree of Doctor of Medicine of the University of London, and preceded to Netley to go through the course prescribed for surgeons in the army" (11). Our introduction to the narrator of all of Holmes's cases thus begins

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[61] Accardo suggests that Sir William Arbuthnot Lane, a senior surgeon at Guys Hospital and the Hospital for Sick Children, Great Ormand Street may have inspired Conan Doyle, and he, more elaborately than other critics, illustrates potential connections between Oliver Wendell Holmes and Sherlock (24, 30-2). He also notes similarities in character between Conan Doyle and his detective (24). Rodin and Key put forward Dr. John Syme of Edinburgh as another contender, and they fully endorse the possibility that Holmes's roots lie in Conan Doyle himself, citing as one piece of evidence the author's own son's contention to that effect (200-01).

with a statement of his medical credentials, which, like his creator's, include an advanced degree not held by most medical practitioners of his day. We also learn on the same page that Stamford, the young man who later introduces Watson and Holmes, "had been a dresser under [Watson] at St. Barts" (11). As Helen Simpson astutely observes in her study of Watson's medical practice, Watson's having had someone under him to dress wounds indicates that "he held, for an unknown period, the post of house-physician or surgeon at St. Bartholomew's Hospital," and "the hospital posts were, and still are, sought only by ambitious men, awarded only to men of marked competence" (37, 38). In other words, while Watson may not be able to match some of Holmes's observational skills, Conan Doyle nevertheless presents this relater of the Holmes tales as a well-informed and vetted member of the medical profession.

The detection of disease is generally not the overt focus of the Holmes cases presented by Watson,[62] but these narratives are striking in their similarity to the medical case study. Throughout the stories, Conan Doyle depicts his narrator as a practitioner who continues to keep abreast of the latest in medical discourse even as he assists Holmes. In "The Adventure of the Resident Patient," for instance, Watson queries the doctor who comes to see Holmes, "Are you not the author of a monograph upon obscure nervous lesions?" (389); and near the beginning of "The Adventure of the Stockbroker's Clerk," Watson is in the midst of "reading the *British Medical Journal*" when Holmes pops in for a visit (331). Katherine Montgomery, who teaches a seminar at Northwestern University Medical School which pairs the Holmes stories with discussions of diagnosis, neatly sums up the most obvious similarities between the way that Watson narrates Holmes's assignments and the narration of medical cases. She observes that the tales "begin … with the sufferer's account of the evil for which he or she seeks help…. A physical examination follows—house calls! Signs are investigated, tests sometimes performed. In the process Holmes pieces together the likeliest narrative explanation of the puzzling event, an

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[62] Rodin and Keys do nevertheless catalogue the appearance of well over fifty different diseases throughout the Holmes canon.

explanation that will make sense of even the unlikeliest signs" (300). I will later augment this rather straightforward assessment of the breakdown of the Holmes's stories in relation to the medical case—arguing that they match even more clearly with the prevalent case narrative during the period that concluded not with cure but with post-mortem exam—but the connection between the histories provided by Watson and the medical case history are unmistakable.

While it is difficult to make as transparent a case for the mathematician and theater manager Bram Stoker's medical knowledge or his use of the medical model in forming *Dracula*, a number of factors nevertheless suggest the accuracy of this model when describing the novel. Stoker was himself not a doctor, but he came into close contact with a number of medical professionals. One such connection was the physician William Stoker (identified by various biographers as either Stoker's uncle or grandfather). As a child Bram Stoker endured an unidentified and on-going infirmity, and some critics suggest that he may "have suffered surgically induced trauma by bloodletting" (Murray 25). This experience coupled with its relevance to his later writings has led one of Stoker's biographers to speculate that "The future author of *Dracula* may have read Dr. William Stoker's prolific medical writings on the linked issues of blood and contagion in his youth" (26). Certainly, "[William Stoker's] clinical descriptions of the horrible deaths and the post-mortem dissection of the bodies of his patients" resonate with Bram's later fictional creations (26).

More direct influences came in the form of Stoker's siblings. Stoker's younger brother George, who lived with Stoker and his wife in the late 1870s, was a successfully practicing doctor, and at one point he served as physician to the Lyceum Theatre where Stoker served as manager (Willis 304). His brother-in-law through his younger sister Margaret was also a well-respected surgeon, and he was probably introduced to Margaret by Stoker's older brother Thornley who was an even more renowned practitioner (Murray 76). Bram's eldest brother, Sir Thornley Stoker, graduated from the Royal College of Surgeons in Dublin and later received an M.D. degree from Queen's College, Galway (174). He also served as President of the Royal College of Surgeons from 1894 to 1896, resulting in his being knighted, and he was later

President of the Royal Academy of Medicine in Ireland (Murray 175). As various critics have noted, the Irish doctor who looks after Seward's asylum for him whilst he is in the throes of battling Dracula holds the same qualifications as Thornley—"M.D., M.R.C.S.. L.K.Q.C.P.I." (Stoker 166). Moreover, Stoker is known to have directly consulted Thornley during the creation of the novel. Still extant, for instance, in Stoker's notes on *Dracula*'s composition, are letters and diagrams from Thornley providing information on the effects of head injuries to be used by Bram in his depiction of Renfield (Murray 174).

In addition to these medical influences, the presence of Dracula in England rather obviously parallels the presence of a contagious disease. The similarities, for example, between Stoker's descriptions of Dracula and his mother Charlotte's descriptions of the spread of cholera through her Irish village in 1832 (written to Bram Stoker in a letter of 1875) are overwhelming. Charlotte's account begins with the explanation that "the cholera['s] … bitter strange kiss, and man's want of experience of knowledge of its nature, or how best to resist its attacks, added, if anything could, to its horrors" (qtd. in Ludlum 25). The image of the "bitter strange kiss" and the lack of knowledge regarding how to treat the contagion call up both Dracula's method of passing along his vampiric infection and Dr. Seward's initial unfamiliarity with Lucy's affliction. Various critics have also linked Dracula's victims to fears about the spread of specific diseases such as syphilis or malaria throughout England.[63]

Though I am less concerned with illustrating Dracula's convergences with a specific disease—particularly since I will later suggest that the Crew of Light's examination of Dracula

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[63] Since Elaine Showalter's early assertion that *Dracula* serves as an example of male fears of contaminating female sexuality and intense misogyny related to syphilis, it has become commonplace to connect Dracula to some type of venereal disease. Michael Kline, for instance, also draws out the similarities between vampirism and syphilis, and in a different vein, Tabitha Sparks sees the novel as a backlash against the repeal of the Contagious Diseases Acts in 1886. Other takes on Dracula's relationship to disease include Joseph Bierman's argument that the novel represents fears stemming from Stoker's own invalidism as a child and Ross Forman's connection of the figure of Dracula to malarial infection. Though he does not focus on specific ailments, Martin Willis intriguingly describes the ways in which Dracula showcases the conflicting theories of disease at play in late Victorian Britain (specifically, miasmatist, contagionist, and germ-based theories) and the social implications of these various beliefs.

parallels medical examinations of lesser-known disease-types—it is nevertheless significant that Dracula's contamination is treated within the novel as disease. For instance, once Lucy Westenra begins to suffer under Dracula's influence, she physically weakens and doctors are called in to treat her. Dr Van Helsing maintains from the start that what afflicts Lucy must be treated as a disease, "for not to be all well is a disease" (125). Later, Van Helsing talks with Dr. Seward about "diagnos[ing] the case" (144) and of a "cure" for Dracula (254). Even after Mina Harker has been bitten and Dracula as the source of contagion has become clear, Dr. Van Helsing explains that "He have infect you" (340), and Jonathan Harker caustically refers to "that devil's illness" affecting Mina (377). Thus, while religion and superstition certainly come into play within the novel, throughout *Dracula* the doctors and their associates continually treat Dracula as a source of infection rather than simply evil incarnate.

In conjunction with the group's focus on Dracula's contagiousness, the figure of the doctor and the medical method of precisely recording details of individual cases become central to driving this novel forward and curing the disease transmitted by Dracula. In the midst of their treatment of Lucy, Dr. Van Helsing and Dr. Seward confer, and Van Helsing makes clear the importance of taking thorough case notes in the solution of the mystery of this disease. He explains to Dr. Seward,

> You were always a careful student, and your casebook was ever more full than the rest…. knowledge is stronger than memory, and we should not trust the weaker…. this case of our dear miss is one that may be…of [great] interest to us and others…. Take then good note of it. Nothing is too small. I counsel you, put down in record even your doubts and surmises. (129-30)

Dr. Van Helsing's advice is telling in terms of the structure of the larger novel since his description of the method and reasoning behind good case note-taking is quite similar to the method and motivations behind many of the characters' journal-keeping—the very journal-keeping, that is, which makes up the body of the novel. From the first, the novel's prefatory note presages Van Helsing's admonition to record rather than relying on memory, for it states, "There

is throughout no statement of past things wherein memory may err, for all the records chosen are exactly contemporary" (6).

Then, throughout the novel itself, characters' explanations for their writing and the type of information that they include illustrate the casebook note-taking aesthetic outlined by Van Helsing. For instance, Jonathan Harker comments on the multitude of "details" and "facts" that populate his journal (32), and he remarks at one point that "There was a certain method in the Count's inquiries, so I shall try to put them down in sequence" because "the knowledge may somehow or some time be useful to me" (37). Similarly, in describing her journal to Lucy, Mina explains, "I don't mean one of those two-pages-to-the-week-with-Sunday-squeezed-in-a-corner diaries…. I shall try to do what I see lady journalists do: interviewing and writing descriptions and trying to remember conversations" (62). Her detailed descriptions of Whitby and her conversations with others—which she tries to record "*verbatim*" (194)—testify to her adherence to the principles that she sets out for herself. Moreover, Mina, like Seward and Harker, also makes a point to "record even … doubts and surmises" as Van Helsing advises above. As an example, in the entry where she describes Lucy being fed upon by Dracula, she notes everything that she observes, even though she is not certain about what she is witnessing: "it seemed to me as though something dark stood behind the seat where the white figure shone, and bent over it. What it was, whether man or beast, I could not tell" (101). Mina's journal-keeping acknowledges the value of noting even details which may, at the moment, seem irrelevant or unaccounted for.

In addition, the organization of the entries within the novel also parallels the organization of most nineteenth-century case records, which usually consist of a series of dated entries that follow the progress of the patient and his or her disease from day to day. The narration of Dracula is similarly serial, each entry beginning with a date and following a progression from "3 May" (7) to "6 November" (395). Hence, the ordering of the accounts and the detailed, contemporary note-taking of the various narrators, with potential future usefulness of these notes in mind, comes quite close to following the recommendations for taking medical case notes that Dr. Van Helsing lays out for Dr. Seward.

Much, of course, has been noted about the significance of recording to the novel at large; indeed, the function and method of reporting in *Dracula* has sparked an increased critical interest in recent years. Many studies, such as Friedrich Kittler's and Jennifer Wicke's, focus on the up-to-date means of reproducing language in the text.[64] Other critics, David Schmid and Vicki Hill included, explore the function of writing for individual characters on a more personal level.[65] Neither of these approaches, however, accounts for the novel's emphasis on the accumulation of detailed reports focused on a specific—and, I would add, medicalized—phenomenon. And while Allison Case does observe the importance of scientifically "collecting, collating and interpreting information" to the group's success, her object is to demonstrate that this method allows them to reduce Dracula "to a predictable, and, hence, defeatable 'criminal type'" (223), not to an agent of infection.

Unlike previous critics, Erik Butler does consider the relationship between writing and contagion within the novel, but he argues that documenting facilitates contamination, not that the doctors and other characters employ it as a tool to combat the future spread of disease. Moreover, despite the fact that Butler illustrates contiguity (yes, many characters are "exposed" to writing before Dracula attacks them), his argument for causation (that is, that the writing performed or transcribed by these characters actually opens them up to infection) is less convincing. Thus, though many investigations of the novel's unique structure and the purpose of writing within *Dracula* exist, I would suggest that the rapid physical degeneration of the Count's victims

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[64] Kittler emphasizes typewriting within the novel, for instance, as a new information technology responsible, among other things, for women's shifting societal roles. According to Wicke, all of the mass-media forms which make up *Dracula*, including journalistic pieces and references to advertising as well as the use of stenography, the phonograph, and the typewriter, perform similarly consumptive functions to those enacted by the vampire or they cause us to become vamped ourselves, consuming as the vampire does.

[65] Schmid argues that writing serves as a refuge for characters when they are unable to perform more manly actions. Hill also notes the therapeutic function of writing for Harker in particular, and she points out the professional capacity of the writing performed by Harker and Seward.

coupled with the type of information included in the text by the various narrators suggests another model for the reporting function in this text—namely, the medical case narrative.

Keeping Up "Good Habits" and Making "Blunders": Clinical Accumulation and Professional Failure

As suggested, Conan Doyle's Sherlock Holmes stories and Stoker's *Dracula* share both structural and thematic similarities with the case history. The logic of the case method rests on the theory that compiling and communicating information on a variety of cases will prove beneficial as information on particular diseases accumulates. Thus, in contrast to earlier novels like *Bleak House* and *The Moonstone* which co-opted aspects of the case to demonstrate the necessity of recognizing individual patient narratives, both Conan Doyle and Stoker's works illustrate the merits of accumulating data from a series of similar cases all focused on a specific phenomenon. Rather than simply adding a veneer of authority to the practitioners of the case as one might expect, however, the use of the case method in these works serves to humanize those who record these details. Thus, perhaps surprisingly, the emphasis on taking careful case notes is presented not only as a means toward cure or proper diagnosis, and, thus, medical authority, but as a defense against the fallibility of individual doctors. While the Holmes stories present an accumulation of information as protection against potential lapses, *Dracula* goes so far as to demonstrate that, sometimes, failure even serves as a tool from which doctors learn and medical knowledge is advanced.

As early as the eighteenth century, doctors like Francis Clifton, who promoted a prototype of the case history in the form of keeping tabular data on individual patients in hospital, stressed the diagnostic power of well-kept records. He asserted, "If this plan be followed, the consequence will be, that Diseases will be better known, and easier cur'd, even supposing the *Materia Medica* shou'd stand as it does" (qtd. in Epstein 42). Julia Epstein, in her

brief history of the case method, glosses the import of Clifton's injunction: "In other words, the accumulation of data generated by observation could enhance clinical proficiency and advance medicine even if all else in physic remained static. To record is to know" (Epstein 42). Though the clinical case history of the nineteenth century (with its added emphasis on diagnosis and the explanation of disease causation) had come a long way from Clifton's merely descriptive tables of patient data, the development of the clinical case study nevertheless illustrated the still-present impulse to compile information on particular disease-types as a means toward medical knowledge. Indeed, late into the nineteenth century, this motivation for keeping careful case notes prevailed. For instance, "In 1887, W.H. Allchin argued that without detailed records, every case would become an exception instead of an opportunity to accumulate knowledge about causation and pathology" (Epstein 48). By recording and sharing cases, in other words, diseases could be transformed from unusual to knowable. Furthermore, the boom in periodical publishing witnessed in both specialized and lay journals during the nineteenth century made the collecting and dispersal of information on cases of disease an even more practical and practicable idea than it had been in previous centuries.

Like their medical antecedents, the case-based plots of the Holmes stories and *Dracula* are structured by the impulse to gather and share information. Via Holmes's methods as a detective and Watson's continued recording of Holmes's cases, these stories continually emphasize the value of accumulating and objectively recording knowledge about a variety of phenomenon for later use. The similarity between previous cases and new ones, coupled with Holmes's familiarity with these similarities, repeatedly aids the detective in reaching his seemingly-miraculous conclusions. *Dracula*, in turn, relates the beneficial nature of compiling information even more specifically to a medical setting in its treatment of Mina. In Stoker's novel, the accumulation of data in the cases that precede Mina's infection by the vampire allows the group of investigators to move forward in handling Dracula's latest victim. In contradistinction to Braddon's *Birds of Prey* and more concretely than Stevenson's *Strange Case*, then, Sherlock Holmes and *Dracula* model the *merits* of sharing medical information.

Readers often remember the unusual aspects of Holmes's cases and Holmes certainly values the unique, but the detective habitually draws on similarities between current and previous cases in order to resolve them. One of his primary tools in the service of this method is described by Watson in the first Holmes short story: "For many years he had adopted a system of docketing all paragraphs concerning men and things, so that it was difficult to name a subject or a person on which he could not at once furnish information" ("Scandal" 121-22). Sherlock's detailed compilation of this information bespeaks his reliance on previously recorded case histories in order to solve the mysteries presented by his clients. Indeed, before he has even begun investigating the disappearance of Hosmer Angel in "A Case of Identity," Holmes's accumulation of data allows him to assert that the mystery "is rather a trite one. You will find parallel cases, if you consult my index, in Andover in '77, and there was something of the sort at the Hague last year" (153).

Moreover, we repeatedly learn of Holmes's appreciation for collection in the form of his own additions to the stores of knowledge available to future researchers. For instance, in *The Sign of Four* and "The Boscombe Valley Mystery," Sherlock mentions one of the many monographs that he has penned, this one cataloging "the ashes of 140 different varieties of pipe, cigar, and cigarette tobacco" ("Boscombe" 171). The purpose of this publication—emblematic of Holmes's other writerly contributions as well—is to delineate types of ash through lists of characteristics so that readers will be able to identify ashes that they have found. This monograph thus operates in much the same way that previously recorded cases of disease do, aiding doctors in matching symptoms to diseases and subsequently providing diagnoses of patients' ailments.

Holmes's reliance on type and similarity parallels the shifts that occurred in the medical case history from the eighteenth to the nineteenth centuries. In her study of the medical case during these two periods, Kennedy observes the differences between a typical eighteenth-century practitioner's medical notes and those of a doctor who presages the more clinical, nineteenth-century mode:

> Whereas Cheyne [the representative eighteenth-century doctor] specifically set out to chronicle the uncommon presentations of disease, Morgagni … declares that 'observations of the common diseases are far more profitable than those of the unusual ones'…. In sum, the 'singular' becomes itself a rarity as the individual case of an unusual illness is replaced by the typical case of a common illness. (128-29)

Holmes's interest certainly kindles at the prospect of something new—perhaps *because* it is so rare—but he nevertheless maintains that most of the crimes he investigates are commonplace based, in large part, on the store of knowledge that he has accrued regarding previous cases. He even explains to Watson at one point, "As a rule, when I have heard some slight indication of the course of events I am able to guide myself by the thousands of other similar cases which occur to my memory" ("Red-Headed" 133). Nine times out of ten, then, the availability of earlier case-information to Holmes, rather than an innate ability to solve mysteries, is what allows him to produce his seemingly miraculous diagnoses of the problems at hand.

This dictum proves true even in the case of "The Red-Headed League," an instance which Holmes initially describes as "most refreshingly unusual" (138). While Jabez Wilson's tale of being paid to copy from the *Encyclopedia Britannica* for a span of two months based solely on the qualification of his red hair certainly seems strange, in the end it is Holmes's accumulated knowledge that reveals the presence of a villain and makes the mysterious explicable. Holmes's use of the descriptor "refreshingly" to describe this odd occurrence suggests from the start that even the most unusual tales do not usually seem so to Holmes because of the stores of information he has accrued. He illustrates this principle in his initial interchange with Wilson when he asserts that his client has spent time in China. In response to Wilson's amazement, Holmes explains, "The fish which you have tattooed immediately above your right wrist could only have been done in China. I have made a small study of tattoo marks, and have even contributed to the literature of the subject" (133). Even Holmes practice of describing aspects of his clients' lives to them before they have revealed them hinges on details about specific phenomenon that he has drawn together.

This small detail notwithstanding, near the beginning of the case, Holmes is "forced to admit that the facts are, to the best of my belief, unique" (133). In the telling of Jabez Wilson's

tale one point in particular nevertheless stands out for Holmes: the presence in Wilson's household of a surprisingly assertive and obliging assistant willing to work for half wages. Holmes's further inquiries into the assistant's physical description lead to his recognition of the man as John Clay, a criminal who he has "had one or two little turns" with in the past (142). With this revelation, which results from knowledge of past cases in which Clay has been involved, the mystery unfolds for Holmes and he is soon able to explain Clay's involvement and the motivation underlying the existence of the Red-Headed League. The unusual, in the end, is revealed as just one more instance of Clay's flair for the dramatic and Holmes's ability to diagnose based on similarities in type.

Though Holmes usefully draws on his collected knowledge to amaze Watson and the readers of his tales with his ability to explain the seemingly inexplicable, Holmes does not succeed in every case that he takes. The authoritative tone taken in the published case history of the nineteenth century often elides the potential fallibility of medical practitioners, just as Watson's catalogues of Holmes's successes and his assertions regarding Holmes's powers relegate the detective's shortcomings to the background. Nevertheless, as Holmes himself repeatedly notes (and as a savvy reader can observe in cases where he does not fully accomplish his goals such as " A Scandal in Bohemia" or "The Five Orange Pips"), Holmes does fail. After committing a mistake in judgment in "The Adventure of Silver Blaze," Holmes even reminds Watson that this "blunder … is, I am afraid, a more common occurrence than anyone would think who only knew me through your memoirs" (291). Indeed, given his failures, Holmes's compulsive recording of facts and his distribution of information about which he is certain appear in a different light: as a bulwark against a perfectly human failing from which even learned men such as himself suffer, namely, gaps in knowledge or judgment and faulty hypotheses based on these gaps.

The difference between Conan Doyle's stories and Stoker's novel is that the tales stop at this acknowledgement of fallibility in places where one expects authority and highlighting of fallibility as a motivation for the accumulation of knowledge. In contrast, Stoker's novel, while

also drawing attention to medical mistakes as a reason for sharing information, goes one step further and points out that sometimes failure is in fact necessary in the advancement of medical knowledge. The sad reality presented in Stoker's novel is that others need to suffer in order for the group to understand Mina's ailment and rid her of it. A buildup of cases is, ultimately, beneficial just as is it was in the Holmes stories, but Stoker's novel demonstrates that this accretion necessarily requires that others go through similar pain and distress in order for data to be collected.

In Stoker's *Dracula*, the necessity of an accumulation of information in figuring out how to eradicate Dracula's contagious influence drives the novel's movement toward a resolution. Before becoming infected by Dracula's bite, Mina highlights the importance of recording and distributing Dr. Seward's diaries to all of those involved in hunting Dracula. She explains that this dissemination is necessary "because in the struggle we have before us to rid the earth of this terrible monster we must have all the knowledge and all the help which we can get" (237). Implicit in this statement are the beliefs that knowledge results from putting together different pieces of information and that this compilation will be a key tool in their attempts to destroy Dracula. Moreover, the group's methods for combating Dracula illustrate that the rest of the characters share the beliefs laid out by Mina; they see their ability to begin affecting a "cure" (254) for this particular scourge as made possible by all of the documents that they have collected. Here is Seward, in fact, immediately before their first official meeting: "And so now, up to this very hour, all the records we have are complete and in order…. so when we meet in the study we shall all be informed as to facts, and can arrange our plan of battle with this terrible and mysterious enemy" (251). Acquaintance with all of these records about Dracula fuels the group's capacity to aggressively attack the infectious agent in their midst. The novel's very makeup, then, composed as it is of the host of accounts focused on Dracula's actions and powers, embraces the principle so simply stated by Mina and so clearly reflected in the logic underlying the case history.

The entire novel might be described as an elaborate case study of Dracula as carrier of disease, but within its pages there are also specific cases of individuals who suffer from Dracula's contaminating influence: namely, Renfield, Lucy, and then Mina. Having Lucy and Renfield's cases on record serves as a prerequisite for understanding how Dracula operates, identifying the dangers to Mina once Dracula has infected her, and figuring out how to handle her case once she has been exposed to this contagion. By including these previous cases, the novel demonstrates that the more shared information you are able to accumulate about a disease, the better your chances are of curing that disease.

The impact that their lack of direct knowledge about Dracula has on Lucy's affliction brings this point home. During their treatment of Lucy, Drs. Seward and Van Helsing do not know when or where Lucy's ailment first took hold of her, and while Van Helsing clearly bears suspicions regarding the vampiric nature of her contagion, he and Seward are wholly unacquainted with Dracula's particular presence. As the group accumulates information regarding the vampire following Lucy's death, the import of this earlier dearth of knowledge causes Seward to lament (in reference to letters that connect Carfax, and thus Renfield, to Dracula), "Oh, if we had only had them earlier we might have saved poor Lucy!" (240). Fortunately, by the time that Mina is infected, Seward has made careful studies of both Renfield and Lucy, and the group is beginning to consider the significance of these two cases in conjunction with one another. As Julia Epstein explains, in terms of understanding disease, cases must often function together, for "Nosology [the classification of disease] relies on the accumulation of particular case histories that determine, in aggregate, a 'natural history of disease'" (29). In order to classify Dracula and correctly assess the type of threat that he poses, the group has to wait until they have accumulated a series of case histories that deal directly with his influence.

While the minutiae included in Seward's records illustrate that he has kept up the "good habit" of taking careful case notes recommended by Van Helsing (129), the group's later use of these notes demonstrates that even so the case is not always useful in and of itself to the initial

recorder of case details. Rather, cases are helpful because of their circulation to fellow researchers who may, in conjunction with additional information available to them, be able to take the initial writer's doubts and surmises to another level. A piling up of information, rather than simply discrete bits of data, is what leads to an understanding of a particular ailment and the ability to alleviate suffering. For example, when taking his original notes on Renfield's case, Seward observes on several occasions that different times of the day lead to specific behaviors in Renfield: "Three nights has the same thing happened – violent all day, then quiet from moonrise to sunrise. I wish I could get some clue to the cause. It would almost seem as if there was some influence which came and went" (118). In a later instance of similar behavior, Seward postulates that perhaps "there is a malign influence of the sun at periods which affects certain natures" (127). Though he is partially correct, without additional data, Seward nevertheless misses a key component in this malign influence (the presence of Dracula) and he is at a loss when it comes to defining what makes Renfield particularly susceptible, falling back on the vague idea of "certain natures."

However, after reading about the progression of Lucy's condition in conjunction with Dr. Seward's notes on Renfield, Jonathan Harker is easily able to make sense of these changes in Renfield's mood and to advise that Seward ought to follow up with his patient as soon as possible, for "hitherto he has been a sort of index to the coming and going of the Count" (240). The centrality of the *accumulation* of knowledge in allowing Jonathan to make this claim becomes clear when Seward initially responds, "I hardly see this yet, but when I get at the dates I suppose I shall" (240). Jonathan's suggestion by itself does not lead to a revelation for Seward, making sense of his numerous speculations regarding Renfield; instead, Seward must withhold judgment until he is able to compare the now-chronologically organized accounts provided by the various observers.

The added presence of Lucy's case further allows the doctors to determine the significance of Mina's symptoms following her infection and to decide how to monitor her as a patient. For instance, Van Helsing is obviously familiar with much vampire lore previous to his

encounters with Lucy and Mina, but there are clear moments in which his general knowledge is usefully supplemented by the presence of Lucy's specific case. One example occurs shortly before Lucy dies. Dr. Seward observes, "Towards dusk she fell into a doze. Here a very odd thing occurred. Whilst still asleep she took the paper [which documented Dracula's final attack on her] from her breast and tore it in two…. Van Helsing seemed surprised" (163-4). Two points are striking here. First, Lucy's behavior illustrates the control that Dracula can assert over the actions of those contaminated by him even before they fully transform into vampires themselves—an important bit of information indeed when the group is trying to determine what role Mina should play following her encounter with Dracula. Second, Van Helsing's surprise at Lucy's behavior demonstrates the novelty of this information to him. Thus, even the member of the group most learned in the field of "obscure diseases" (122) must rely on the details gleaned from new individual cases in order to fully form the "natural history of disease" necessary to combat that disease.

As such, the insight provided by the example above, as well as specific knowledge of the progression of Lucy's symptoms, prove integral in Seward and Van Helsing's decisions regarding how to handle their new patient. When consulting with Seward, Van Helsing stresses the importance of keeping Lucy's case in mind as they treat Mina:

> Madam Mina is changing…. *With the sad experience of Miss Lucy, we must this time be warned before things go too far*…. I can see the characteristics of the vampire coming in her face. It is now but very, very slight…. Her teeth are some sharper, and at times her eyes are more hard. But these are not all, there is to her the silence now often; *as so it was with Miss Lucy*. She did not speak, even when she wrote that which she wished to be known later. Now my fear is this. If it be that she can, by our hypnotic trance, tell what the Count see and hear, is it not more true that he who have hypnotize her first, and who have drink of her very blood and make her drink of his, should, if he will, compel her mind to disclose to him that which she know. (344, emphasis added)

The physical changes in Mina paralleling Lucy's transformation coupled with the knowledge of Dracula's influence over his victims garnered from Lucy's case lead to one of Dr. Van Helsing's most crucial surmises: that Dracula could influence Mina's actions now that she has been bitten by him, thus jeopardizing their plans to eliminate the source of Mina's infection and affect her

cure. The doctors' conclusion (also reached by Mina herself) that she must be excluded from some of their planning *following* her contamination by Dracula is well-founded based on the evidence that they have now acquired.

Seward and Van Helsing's initial decision to exclude Mina from the group's confidence (before she has ever even been bitten) and the result of this decision illustrate, however, one of the prime reasons that the recording and sharing of medical cases is necessary in the first place—because doctors are fallible. Previous to their resolution, Mina has shown minimal signs of breaking down under the stress of doubting her husband's sanity, then learning that he was almost killed by a vampire, and finally losing her best friend (in contrast to Lord Godalming's uncontrollable crying jag in her arms and her husband's bout with brain fever). The doctors nevertheless consult and determine that Mina should no longer participate in either gathering information regarding Dracula or discussing its import. Right after Mina has compiled all of the records to-date and right before she is attacked by Dracula, Van Helsing explains to Seward, "after tonight she must not have to do with this so terrible affair…. Even if she be not harmed, her heart may fail her in so much and so many horrors; and hereafter she may suffer – both in waking, from her nerves, and in sleep, from her dreams" (250). Indeed, Mina does, after this night, begin suffering from terrors in the night and nervousness during the day; however, these symptoms result not from the horrors to which she has been exposed through her participation in the group's decision-making, but rather, from the night-time attacks by Dracula facilitated by her exclusion from the group. Even with Van Helsing's "open mind" (a characteristic that he encourages in others repeatedly throughout the novel) and his belief that Mina is no typical woman with her unique "man's brain" (250), Van Helsing still falls back on medical conventions of the day, mistakenly assuming—against the evidence to the contrary—that the woman in their midst is far more susceptible to hysterical attacks than her male counterparts.

It seems surprising that none of the others notice the changes in Mina, but in addition to the men's preconceived notions regarding women and nervousness reinforced by the misguided medical opinions of Seward and Van Helsing, this lack of awareness also stems from Mina's

belief that the group is already unduly concerned with her well-being. Mina's recognition that the others are focused on how her supposedly fragile psyche is holding up prevents her from sharing her strange "dreams" and seeming nervousness with the others. She notes, at one point, "Jonathan would be miserable if he knew that I had been crying. He and the others were out until dinner-time, and they all came in tired. I did what I could to brighten them up" (276). Van Helsing and Seward's decision inhibits Mina from sharing her experiences with them and plants the idea in her mind that she has been over-taxed by her involvement so far, resulting in the doctors and the rest of the men being just as much in the dark regarding the full progression of Dracula's influence as Mina is. Medical fallibility is not checked in this instance precisely because the doctors' erroneous opinions encourage a lapse in what serves as the primary guard against the triumph of individual unreliability—the accumulation and sharing of information.

Ultimately, the doctors are stronger and more able to counteract Dracula's contagion when they admit that they do not always have the answers and are willing to share "even their doubts and surmises" with each other (130). Despite the fact that Van Helsing crucially misjudges Mina, he remains a central figure in the group's ability to understand and eradicate Dracula. But he is only introduced to the novel because of Seward's initial willingness to admit the failure of his own expertise and because of his belief that additional opinions will aid him in understanding and combating Lucy's ailment. As he explains to Lord Godalming when he cannot identify the source of Lucy's decline, "I am in doubt, and so have done the best thing I know of; I have written to my old friend and master, Professor Van Helsing" (122). Seward's admission of failure in treating Lucy leads to the introduction of the only character able to convince the group of Dracula's pathogenic existence.

Though these examples underscore the fallibility that plagues even the most learned of doctors, and, thus, one of the prime reasons for accumulating and distributing cases histories to a host of researchers who do not, hopefully, all share the same biases and gaps in knowledge, they also illustrate a further point: that failure itself can serve a useful function in the advancement of medical knowledge. Sometimes the way in which doctors fail can reveal more about a disease,

its progression, and the proper course of treatment than will an initially effective treatment which a practitioner does not fully understand or which he may have simply happened upon. Telling, in terms of the potential benefits of failure and, more importantly, the *documenting* of failure is Van Helsing's advice to Seward regarding the importance of recording careful case-notes. In addition to explicitly stating that the reason for keeping up this "good habit" lies in the potential future usefulness of "this case of our dear miss … to us and others" and recommending that "Nothing is too small" for inclusion (130), Van Helsing makes an unexpected admission about the value to be gleaned from "Tak[ing] … good note" of the progression of Lucy's symptoms and treatment. He concludes his manifesto on the case with the surprising pronouncement: "We learn from failure, not from success!" (130).

Although Van Helsing certainly hopes to help cure Lucy with Seward's assistance, his advice to Seward in this final sentence suggests that saving Lucy, the sufferer at hand, may not be the only practical purpose of Seward's case notes. Rather, even carefully describing how they failed in this instance could be helpful—presumably because the record of this case will help them (and possibly "others") the next time they must deal with this situation. And, indeed, without having seen Lucy's case to the end, Van Helsing and Seward's knowledge of the infection's progression would be incomplete. Their earlier inability to quell the disease that has overtaken Lucy allows them to monitor the import behind the series of changes that they witness in Mina after she has been bitten in a way that they could not had they "cured" Lucy early on in her infection.

The accumulation of cases charting Dracula's victims (a process present but elided in the Holmes stories) ultimately transforms the singular into the understandable. The dramatization of the process of case compilation present in *Dracula* highlights the price of this knowledge in a way that the Holmes stories do not always do: the previous suffering of others and doctors' failures in treating these individuals facilitate the adoption of the appropriate means for addressing new cases. The paradox of the case brought home by these works is thus that the case

history's detailed documentation of suffering is both an intended and necessary means to quell pain in the future.

"Why Did I Hesitate to Write the Word?": The Absent Illness Narrative in *Dracula*

Though *Dracula* may call attention to the need for patient suffering, unlike *Bleak House* and *The Moonstone*, one of the defining features of *Dracula* is its lack of developed illness narratives. To borrow a term from D.A. Miller, I contend that within the novel, explicit sufferer narratives remain not only unnarrated, they have in fact become *nonnarratable*. In *Narrative and Its Discontents*, Miller defines the *narratable* as "the instances of disequilibrium, suspense, and general insufficiency from which a given narrative appears to arise. The term is meant to cover the various incitements to narrative, as well as the dynamic ensuing from such incitements to narrative" (ix). Gaps and tensions in textual content, in other words—such as those created by the lack of shared illness experiences within *Dracula*—make narratives go. As a more specific example, Miller explains regarding Austen novels that "The narrative of happiness is inevitably frustrated by the fact that only insufficiencies, defaults, deferrals, can be 'told.' Even when a narrative 'prepares for' happiness, it remains in this state of lack, which can only be liquidated along with the narrative itself" (3). Thus, while gaps and tensions give rise to narrative, the filling of these gaps or the resolution of these tensions necessarily result in an end to narrative.

As such, then, "the *nonnarratable* elements of a text are precisely those that … serve to supply the specified narrative lack, or to answer the specified narrative question…. What defines the nonnarratable element is its incapacity to generate a story" (5, emphasis added). I am not proposing that perfectly explicit illness narratives are nonnarratable in the same sense, for instance, that the happiness of the married couples at the end of Jane Austen novels remains nonnarratable—illness is not a state of perfect contentment, after all, which characters spend an

entire novel seeking. I am suggesting, though, that the absent and undeveloped illness narratives of the sufferers in *Dracula* fall into the category of the nonnarratable in that their presence would cut off the larger narrative of *Dracula* before it had a chance to progress. At every turn, completely uninhibited articulations regarding Dracula's contaminating influence from the mouths of Lucy, Renfield, and then Mina would have aided the vampire hunters' attacks on Dracula and thus drawn this narrative to a speedier close.[66]

Narrative resolution would be, within *Dracula*, synonymous with eradication of disease and cure. Hence, whereas nonnarratable items such as complete patient accounts would be detrimental to narrative progression, they would be inversely valuable for the realization of cure. By excluding fully articulated patient narratives which would move us toward an alleviation of disease, Stoker backhandedly acknowledges the potential benefits for medical science of a multivoicedness which incorporates the patient's voice as well as those treating him or her.

Stoker's use of the casebook (the notes on individual patients kept by medical students in conjunction with the practicing physicians whom they attended) endorses multivocality in case-recording while conceding its limits—and, thus, bridges the apparent gap between his recognition that fully articulated illness narratives would have been a significant boon in the movement toward cure and the fact of their absence within this novel. Student manuals for keeping casebooks both encouraged a recognition of the patient's perspective and acknowledged the impossibility at times of being able to fully establish this perspective. This casebook model provides a useful parallel for understanding a novel which simultaneously endorses the merits of developed illness narratives and fails to include them.

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[66] To be clear, just as Miller does, I too am making a distinction here between the nonnarratable and the unnarrated. As Miller notes in reference to nonnarratable elements, "It is not the case that such elements cannot be designated by the text's language, or that they literally cannot be mentioned. The nonnarratable is not the unspeakable" (5). Indeed, during the Victorian period in particular, the number of memoirs related to personal sickness and the amount of discussion afforded to such topics in correspondence suggest that there was nothing taboo about introducing your illness experiences to others. Frank illness narratives are thus not missing due to their unspeakable nature—which is what prevents the narration of issues such as Jonathan and Mina Harker's sexual relationship—but because of the narrative function that they would serve if present.

From the first, Stoker depicts the relationship between Van Helsing and Seward as stemming from Seward's days as a medical student under Van Helsing's tutelage; Seward describes him as not only an old friend, but as his former "master" (122). And when Van Helsing advises Dr. Seward to take thorough case notes, he directs Seward back to this initial medical training, reminding him that "You were always a careful student, and your casebook was ever more full than the rest" (129). As a result, the case-model brought to the fore here is not the published case history of previous chapters, but the medical case notes kept in hospital by medical students. Guidebooks for learning to keep casebooks encouraged the incorporation of students' and practicing physicians' opinions as well as sufferers' voices within these written records, but, at the same time, they tempered this guidance by pointing out the obstacles preventing full patient disclosure.[67]

Unlike the case study appearing in venues such as *The Lancet* or *The British Medical Journal* which usually bore the byline of a single doctor, the casebook's very existence acknowledged the multivocality of medical knowledge. M. Jeanne Peterson notes that "In his last year of medical studies a student was required to serve at least three months as a clinical clerk to a hospital physician or a dresser to a surgeon" (84). It was in this role that students were formally introduced to the art of case-note taking, and there were many manuals directed at the medical student learning to take case notes for the first time "on commencing his duties as clinical clerk" (Warner v). Though the clerk took dictation from the attending physician, he was also meant to take his own notes on individual patients. One guidebook from the period, John Southey Warter's *Observation in Medicine, or The Art of Case-Taking*, instructs, for instance: "A clerk will find it advantageous to perform auscultation, &c. of a patient by himself, without any aid from the physician. This note of investigation should be separately kept, and compared with the results of the examination made by the physician himself" (ix-x). Thus, one function of a

[67] The structure of the larger novel further suggests the casebook, rather than the published case study, as the model that Stoker is employing, for the host of narrators who contribute to *Dracula* parallel the multiple voices making up the case notes of the medical clerk.

clerkship was clerical—following practicing doctors on rounds and noting their observations—but students also saw patients themselves and were encouraged to *compare* their own observations with their mentors', "even if your opinion differs from that of the physician" (x), rather than simply parroting back their superiors' thoughts on a case.

While the casebook was kept by medical personnel rather than by sufferers, a careful recording of the patient's perspective also forms a significant portion of the case documentation recommended by the student manuals. For instance, Francis Warner begins his "Instructions for Case-Taking" in *The Student's Guide to Clinical Medicine and Case-Taking* with a guide for gathering patient information on "Family History," "Personal History," and "History of Present Illness," and he even admonishes clerks to "State what the patient complains of, as far as possible using his own words" (xi). Phrases from patients' descriptions of their ailments did sometimes find their way into published case histories, but they were greatly pared down and these later accounts were generally dominated by the doctor's experience of disease-treatment rather than the sufferer's subjective experience of illness. By invoking the medical casebook, rather than simply the published case study, the novel thus endorses the existence of multiple voices—including the patient's—in the creation of medical knowledge.

However, the instructions conveyed in books like Southey Warter's and Warner's simultaneously illustrate the difficulties that could inhibit retrieval of completely explicit patient narratives. Both works bring in special subsections, for instance, addressing situations in which sufferers might not be able to speak for themselves. Warner's manual highlights children's narratives as problematic, first suggesting in the general guidelines for case-taking that one must note the descriptions offered by a child's caretakers rather than using the child's own words and then separately including "Additional Instructions for Children's Cases" (xi, xiv). Southey Warter incorporates the "Method of Taking a Case When the Patient is in a Fit" which focuses exclusively on what to observe in the sufferer, rather than what to ask the sufferer, since someone in a fit obviously cannot be questioned in the same way that other patients might be (5). Southey Warter even goes so far as to warn medical students about the impact of deception or

nervousness on patients' responses, and he cautions new clerks to "attend to the face as well as to the oral expressions of a patient … and always keep an eye open for imposture or hysteria" when asking questions or performing physical exams (1). Thus, even as Stoker's use of the casebook-model explicitly draws attention to the value of patients' contributions to their histories of disease, this model nevertheless accentuates the gaps in self-knowledge, lapses in facility of expression, and potential for unreliability that make the possibility of fully developed illness narratives suspect.

Within Stoker's novel, these issues become paramount because having been infected by Dracula, Lucy, Renfield, and Mina all lose their capacity to speak freely about the contagion that is attacking them. The infection from which they suffer robs these three victims of the ability to fully transform their diseases into illnesses through narration.[68] This is a feature common to actual complaints in which patients are unable to articulate that which ails them due to factors such as intense pain, impediments to speech-centers in the brain, or lack of consciousness. Thus, even as the powerlessness to fully describe or explain aspects of the affliction from which they suffer falls under the category of the supernatural for Lucy, Renfield and Mina, this inability serves as an exaggerated example of a very real possibility. The very fantasticness of the ailments in *Dracula* makes them, in turn, ripe for the explanatory rubric of the case study, a narrative model which functions by making the seemingly incoherent coherent.

From the first, one symptom of Mina's infection by Dracula is her incapacity to talk about Dracula and make surmises about her and the group's situation as unreservedly as she once

[68] Other critics have briefly commented on the silencing of Dracula's victims, though within very different contexts. In her feminist reading, Kaley Kramer notes in passing that Lucy and Mina's "silence as vampires is not so different from their silence as proper women" and she argues that the trade-off is the power that Mina gains within the Crew of Light following Dracula's bite (75). While I find Kramer's connection of these two types of silence intriguing, I would suggest that Mina's contributions to defeating Dracula actually increase as her voice begins to return, not as a result of this loss of voice. Christine Ferguson provides a very different take on this lack of voice within a larger argument about Dracula's defeat due to his conformity to standard English. She suggests that "The novel pits linguistic incoherence and variation against the vampiric attempt to purify and eradicate language. In *Dracula* the vampire's agenda is first to standardize and then to silence the language of his victims" (236).

did. Having observed Mina's behavior after she has shared Dracula's blood, Dr. Seward suspects this phenomenon and notes it in his journal. He explains: "I fear that in some mysterious way poor Mrs. Harker's tongue is tied. I *know* that she forms conclusions of her own [regarding Dracula], and from all that has been I can guess how brilliant and how true they must be; but she will not, or cannot, give them utterance…. I suppose it is some of that horrid poison which has got into her veins beginning to work" (343). Mina is literally prevented here from participating in her own cure, for the very contagion from which she suffers blocks her from sharing her subjective experiences and beliefs regarding that which is attacking her. Mina herself demonstrates this inability to speak as freely as she would like about Dracula later in her journal as she records the group's plans for defeating the vampire. In explaining Jonathan's mixed feelings regarding whether to stay with her or leave with the group which will probably vanquish Dracula, Mina writes, "the boat service would, most likely, be the one which would destroy the… the…the…Vampire. (Why did I hesitate to write the word?)" (377, ellipses original). The fact that Mina finds it difficult even to speak about the recognized source of her infection underscores the impossibility of her candidly discussing her experience of her illness.

The prevention of the full transformation of disease into illness via patient narration has far-reaching consequences, for this inhibition of articulation both delays a cure and aids the spread of Dracula's contaminating influence. Immediately preceding Mina's infection by Dracula, Renfield requests that he be discharged from Dr. Seward's lunatic asylum. Although his prime reason for this request turns out to be his desire to avoid exposing Mina and the others to Dracula's influence, Renfield is utterly unable to explain this to the doctors examining him. When queried by Van Helsing, "Can you not tell frankly your real reason for wishing to be free tonight?" (261), Renfield responds, "Dr. Van Helsing, I have nothing to say…. If I were free to speak I should not hesitate a moment; but I am not my own master in this matter" (262). Dracula's disease literally silences its sufferers, and Renfield's powerlessness to put his concerns about his affliction into words not only leads to his death, it opens up the entire house to the contagious influence already affecting him.

This obstruction of perfectly frank and clear illness narratives has repercussions for the spread of Dracula's contamination within the novel *and* for the continuation of the larger novelistic narrative itself since these illnesses prove not only unnarrated within the novel's content but *nonnarratable* in terms of the novel's progression. Ironically enough, by prohibiting their presence, *Dracula* ends up demonstrating the positive role that developed illness narratives could play in achieving resolution or cure. For instance, had Renfield been able to speak openly about his experiences, the group could have prevented Dracula from entering Seward's asylum and Dracula's contagion would thus not have spread to Mina. Given foreknowledge of Dracula's specific plans, the group could even have prepared for Dracula's attempted entry and assault, perhaps putting an end to him and his contaminating influence before it ever spread beyond Lucy and Renfield.

The moments when slippage occurs and bits of patient narrative emerge prove the rule, for these episodes illustrate the possibility of or movement toward closure. Van Helsing is briefly made privy to Lucy's painful experiences once her death is imminent. This window into her thoughts occurs via the letter that she attempts to destroy following Dracula's last attack on her. Having finally gained access to some of Lucy's reflections, albeit in the face of her attempts to erase these musings, Dr. Seward observes "a look of grim satisfaction in [Van Helsing's] face, as of one who has had a doubt solved" (160). The change in Van Helsing's manner indicates that if Lucy had been able to articulate her experiences previous to this moment, Van Helsing's suspicions would have been confirmed sooner. The results of a more rapid substantiation of Van Helsing's theories would likely have been Lucy's salvation and a more coordinated strike launched against Dracula earlier—both of which events would have significantly whittled down the plot of this lengthy novel.

Mina's briefly renewed ability to narrate following Dracula's escape from England and his withdrawal of some of his influence over her further demonstrates the foreclosing potential of uninhibited patient narratives. With the "horrid poison" in her blood somewhat less active, Mina is finally able to voice one of the "brilliant" "conclusions" that Seward believes she has been

making all along. In this state of remission, as it were, Mina successfully surmises Dracula's likely escape route back to his home and essentially plots the course that eventually leads to his destruction. This feat on Mina's part suggests that an ability to share earlier conclusions unarrived at by her male counterparts might very well have led even more quickly to Dracula's annihilation. By positioning developed accounts of patients' experiences in this way, *Dracula* grants the potential usefulness of multiple voices, including the patient's, in the processes of eliminating disease and restoring health. At the same time, while the very latency of most illness narratives within the text ends up underscoring their importance, it also demonstrates another reason for the case's necessity: namely, the many obstacles blocking a full expression of a sufferer's subjective experience of disease. Just as possible medical fallibility highlighted the need for an accumulation of cases on a given affliction, so too does the patient's potential inability to clearly convey his or her end of this experience emphasize the fact that in many instances the medical case is all that doctors do have to go on in facilitating recovery and cure.

What has changed, then, between the illness narratives represented in texts like *Bleak House* and *The Moonstone* and those decidedly not represented in *Dracula* is not the illness narrative itself—the patient's experiential story of his or her encounter with disease—so much as the goals involved in depicting or not depicting these accounts. The perhaps incomplete but nevertheless evocative illnesses included within *Bleak House* and *The Moonstone* create a recognition of patients' experiences as distinctly valuable in establishing the self-revisionary nature of encounters with disease. Since these narratives are present in order to call our attention to the tensions and disequilibriums involved in any illness, they are ideally narratable in Miller's sense of the term and they thus serve as narrative motors (to employ Peter Brooks' terminology again) which build up the text as they push it forward. In neither of these novels, though, is cure the ultimate goal—Esther Summerson wins her battle against smallpox hundreds of pages before the novel's close and Ezra Jennings acknowledges his ailment as incurable from the start.

In *Dracula*, however, the forward momentum of the novel is always directed at eliminating Dracula's contagious influence and healing those who suffer from his infection.

Stoker thus considers the illness narrative in terms of its potential contribution to this end. The fact that cure, or somatic resolution, is the novel's goal becomes clear when we turn to its conclusion. Following Dracula's demise, Stoker takes pains to detail the purging of all physical indicators of disease from Mina's now-healthy body. For instance, in place of the exhaustion that plagued Mina in the final days of her infection, she is lively: she "flew," she tells us, to the dying Quincey Morris's side (401). Most obviously, the red disfiguration that marked her brow as a sign of Dracula's contagious presence disappears—now, "the snow is not more stainless than her forehead" (401). A further definitive signal of her return to physical wellbeing is revealed in Jonathan Harker's closing note. Much earlier in the novel, one of Van Helsing's motivations for excluding Mina from the pursuit of Dracula rests in the fact that "she is young woman and not so long married; there may be other things to think of some time, if not now" (250). The "other things" at which Van Helsing so coyly hints are clearly the future children that Mina is expected to bear. It is thus fitting that Mina's return to health is marked on the final page of the novel by a concrete example of her reproductive soundness, for we learn from Jonathan that he and Mina have a son (402). The uncertainty that plagues many readers at the end of *Dracula* about the possibility of the vampire's lingering influence parallels the types of questions regarding the lasting psychological consequences of disease that might accompany our reading of a particularly troubling case study. In both Stoker's fantastic novel and the medical case, closure arises, though, through a limited focus on a specifically somatic facet of human experience.

Dracula may call attention to the potential gains resulting from acknowledgement of the patient's voice, but the praise here is tempered by the recognition that a completely frank and explicit narrative of illness is just as much of an ideal as the completely authoritative and infallible doctor. This shift in treatment of the patient's story is accompanied by a concomitant shift in narrative motivation. In *Dracula*, we have reached a point where illness and its narratives have become the ideal after which we seek, perhaps, but not something which can exist within the narrative.

Cataloguing Parts: Death and Distance as Explanatory in Sherlock Holmes

There is one moment in which many diseases unfortunately culminate when patients certainly cannot be relied upon to divulge their experiences, and that moment is death. I contend that Conan Doyle's Sherlock Holmes stories meditate on what can be gained from this outcome in their correspondence to a particular kind of medical writing prevalent during the Victorian period: the case narrative which provides closure via post-mortem exam rather than patient cure. The presence of death is not as obvious in the Holmes stories as it is in *Dracula*; people sometimes die, but actual client death is not a defining characteristic of the stories as a whole. However, by casting the analytical Sherlock as the doctor who performs the autopsy following a patient's demise in contrast to Watson's role as the recorder of patient histories, the stories' narrative movement toward Holmesian summation parallels nineteenth-century case studies which culminate in death. In this capacity, instead of highlighting the human pain at the core of medical advance or the gains to be had from patient narratives as *Dracula* does, the Holmes stories focus on the explanatory function of death and the benefits to be reaped from emotional *distance* between doctor and patient.

This emphasis in the Holmes stories on the importance of the autopsy highlights the fact that in many case studies, one must wait until a patient has died to know what was wrong with him or her. Peter Brooks and Walter Benjamin have both commented on the necessity of death for the creation of final meaning within literary narratives, and I would suggest that the same holds true for these medical cases. Brooks, drawing on Benjamin, notes that "what we seek in narrative fiction is that knowledge of death which is denied to us in our own lives: the death that writes *finis* to the life and therefore confers on it its meaning" (22). Within the type of medical narratives mentioned above, the patient's demise serves a similar function. Without this death and the subsequent autopsy, the how and why underlying the patient's experiences (those events recorded in the first section of the case report) would remain a mystery. Death and the distance

involved in documenting it are also necessary here—both for making meaning of the patient's experience and for creating further medical knowledge.

What has thus shifted between the earlier novels that I examined and the Sherlock Holmes stories is that the medical case's examination of death is now rewriting textual meaning instead of illness. In my chapter on *The Moonstone*, I drew on medical anthropologist Byron Good in order to emphasize the "subjunctive" rather than "indicative" nature of illness—its revisability rather than factuality, in other words. I suggested that illness itself is retrospectively constructed and that it is thus able to retrospectively construct meaning within literary narratives. Death, though, and the certainty provided by the autopsy allow for a different kind of meaning-making in the Holmes tales. Meaning is being created here not so much by a rethinking of the terms of the previous narrative, not by giving it new life as it were, but through authoritative *explanation* of what has come before. It is the indicative nature of the autopsy that allows it to produce certainty and consequently create meaning once we have reached the end of a life or the end of a narrative.[69]

Through their depiction of Sherlock in the role of post-mortem examiner, the Holmes stories illustrate that even objectification can serve a useful function. In *Dracula*, the fact is that others had to suffer and die—meaning that medical intervention had to fail—in order for Mina to live. While Holmes, too, has his failures, the one capacity in which he always succeeds is his ability to explain what has transpired. Thus, unlike *Bleak House* and *The Moonstone*—which strove to focus attention on patient interiority—and *Dracula*—which depicts two medical professionals so invested in their patients' well-being that they sometimes overlook crucial details—the Holmes stories illustrate the merits of distancing oneself from the case being handled. Furthermore, with the Holmes paradigm in mind, the reasons underlying the

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[69] To be clear, while death is certainly a necessary component in this meaning-making capacity, I am suggesting that the autopsy and what it reveals are the actual producers of meaning. Just as for Brooks the presence of a reader outside the text is necessary to create meaning once a literary narrative has reached a close, so too the outside medical examiner who documents the body is necessary to provide meaning-making explanations once a life has ended.

disappointment and incompleteness of Jekyll's experimentation in *The Strange Case of Dr. Jekyll and Mr. Hyde* become clearer. In his role as both patient and physician, Jekyll can document his failure for future generations of researchers, but he leaves behind no one capable of physically documenting his human remains and what they, rather than simply his speculations, might reveal. In the Holmes tales, however, there is always a distanced professional present at the story's conclusion to elucidate not just what has happened but how it happened and why—and that professional is Sherlock Holmes.

During the nineteenth century a surprising number of case narratives published within both *The Lancet* and *The British Medical Journal* end with the patient's death rather than the patient's cure. Within a random sample of case studies taken from these two journals between the years 1845 and 1895, in fact, the number of records that end with death ranges between one third and almost one half of the documented episodes. In these studies, the narration of the history of the case is usually followed by a description of the patient's autopsy. Without this post-mortem examination, the patient's specific ailment, the cause of death in other words, would often remain unknown. Thus, the autopsy helps to provide closure and tie together all of the various patient symptoms and observations that the doctor has described up until this point.

The narrative differences between these two components of the nineteenth-century case study are many. One distinction lies in the type of language employed. Take for example "A Case of Tumour of the Brain, Simulating Apoplexy" presented by Alfred Martin in *The British Medical Journal* of January 9, 1875. In his description of his patient's history, Martin explains that "On the evening of June 14th, [M.L.] complained of not feeling well, and… of pain in her head. She appeared slightly excited and when accused of having taken the other patient's beer at dinner, became noisy and abusive…. She was reported next morning as having been sleepless during the night, and occasionally noisy, quarreling with another patient in the same dormitory" (42-3). This history portion of the case study does not begin to approach the more technical, distanced tone adopted in the reporting of the post-mortem examination. Here, much more clinical descriptions dominate the narration, such as, "The right auriculo-ventricular opening was

1 ¾ inches in diameter" and "The right lung … was adherent at the apex to the costal pleura, and was congested inferiorly and posteriorly" (43). The factuality and resulting certainty of the autopsy statements contrasts with the more speculative and inclusive descriptions included within the history.

In addition to the type of language used, there is also a shift in the story-like quality of the narration. The initial portion of this case study charts a sequence of events and their progression. The autopsy portion, on the other hand, does not document a series of events so much as catalogue the condition of M.L.'s various organs. However, regardless of the less literary qualities of the autopsy portion of this report, this section does still serve a crucial narrative function: the resolution of the mystery regarding M.L.'s behavior and death. Dissecting M.L. leads to the revelation that "In the right cerebral hemisphere, and forming the roof and part of the outer wall of the right lateral ventricle, was a fibrous tumour" (43). In his final remarks, Martin himself notes the necessity of the autopsy in diagnosing this patient's ailment and tying together all of the loose threads present in this instance, for he observes that "it would have been too bold in this case to predicate the existence of a cerebral tumour without other data [aside from M.L.'s symptoms] on which to found a diagnosis" (43). Here, as in so many other case narratives ending in death, this "other data" is provided through the means of the autopsy.

As Margaret Kennedy notes in reference to the Victorian case, the genre as a whole strove to present an objective stance—and nothing was more emblematic of this critical distance than the autopsy. According to Kennedy, in the nineteenth century, "The autopsy offer[ed] an objectifying ideal of medical certainty in which eighteenth-century methods of diagnosis could be augmented and verified simply by opening a body so that all questions might be answered" (121). The post-mortem exam transforms a subjective entity such as M.L., in other words, into an inanimate object of investigation consisting of "cerebral hemisphere[s]" and "lateral ventricle[s]." While there is something horrifying about this transformation for the individual, the result is often a heightened ability to explain and to understand the mysteries of the disease from which the individual suffered.

Throughout Conan Doyle's tales, Holmes continually maintains a critical distance from the subjects of his cases that corresponds to the objective positioning enacted by the pathologist. For instance, he is much more interested in the mysteries presented to him than in the people involved. In "The Copper Beeches," Watson laments, "As to Miss Violet Hunter, my friend Holmes, rather to my disappointment, manifested no further interest in her once she had ceased to be the centre of one of his problems" (287). Even when Holmes does occasionally feel for the people who he is helping, this feeling rarely prompts him to become personally involved in their dilemmas. Once Holmes has uncovered the treachery of Mary Sutherland's step-father in "A Case of Identity," he is briefly impassioned enough to threateningly move toward his horse-whip. However, after the man flees, Holmes only laughs instead of following him, and he avers that he will not even bother informing Miss Sutherland of her stepfather's cruel actions since she would not believe him if he did. Indeed, this ability to distance himself often aids Holmes in solving the mysteries presented to him. In "The Adventure of the Naval Treaty" Holmes immediately suspects his client's soon-to-be brother-in-law of stealing a sensitive treaty in his client's charge, but this conclusion never occurs to the client since he is too close to the criminal himself.

This objectifying perspective on the part of Holmes is particularly striking because of its juxtaposition against the more caring manner of Watson, the other doctor-figure within the tales.[70] There are a number of textual hints that align Watson with the doctor who records the patient's background and treatment and Holmes with the performer of the autopsy. Throughout the Holmes stories, Watson refers to his position as a general practitioner and his interactions

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[70] The distinctions between these two medical figures are in fact what lead me to diverge from Katherine Montgomery's straightforward reading of the tales in their correspondence to the case study. I agree with Montgomery's claim that the Holmes stories generally parallel the medical case in their documentation of histories of suffering, physical examinations, and explanations which link together the various reported signs. I would like to take these connections between Holmes's adventures and medical case studies a step further, though, by distinguishing between the functions of Watson and his narrative recording of the events leading up to and surrounding these mysteries and Holmes and his narrative dissection of the problems with which he is confronted.

with patients. For instance, in "A Case of Identity" (1891), Watson mentions that "A case of great gravity was engaging my own attention at the time, and the whole next day I was busy at the bedside of the sufferer" (154). Despite the fact that Watson often seems ready to leave his practice to the attendance of a colleague when Holmes needs him, when his practice is busy, ministering to the needs of individual patients takes precedence for him. In addition, throughout the tales Watson not only monitors Holmes's health, in one instance warning him against embarking on a new case when his "nerves are all in shreds" ("Reigate Squire" 365), but he provides treatment for suspects and clients alike. In one striking example, Watson describes how "with the aid of ammonia and brandy, I had the satisfaction of seeing [an almost asphyxiated client] open his eyes, and of knowing that my hand had drawn him back from the dark valley in which all paths meet" ("Greek Interpreter" 409). In his reference to saving a patient from death, Watson decidedly depicts himself here as a treater of the ailing rather than a documenter of the deceased.

Holmes, on the other hand, is characterized as preserving a more strictly scientific mindset and by a familiarity with both anatomy and pathology. In "A Study in Scarlet," the first of the Holmes stories, the young medical man introducing Holmes to Watson explains that "Holmes is a little too scientific for my tastes" (12). We also discover in this story that one of the "branches of science" in which Holmes specializes is anatomy (12), a fact driven home by such experiments as "beating the subjects in the dissecting-room with a stick….to verify how far bruises may be produced after death" (12). In a later tale, Holmes demonstrates familiarity with medical dissection when confronted with two severed ears packed in salt within a cardboard box. He explains to the police inspector who suspects medical students of perpetrating the crime:

> The presumption is strongly against it. Bodies in the dissecting rooms are injected with preservative fluid. These ears bear no signs of this. They are fresh, too. They have been cut off with a blunt instrument, which would hardly happen if a student had done it. Again, carbolic or rectified spirits would be the preservatives which would suggest themselves to a medical mind, certainly not rough salt. ("Cardboard Box" 311)

In this single brief analysis, Holmes illustrates knowledge of decomposition, the medical preservatives used on dead bodies, and the tools employed to probe these bodies. His acquaintance with morbid pathology also comes up in "The Sign of Four" where he demonstrates knowledge of the progression of rigor mortis following Benjamin Sholto's death (81).

Moreover, the narrative dissimilarities between Watson's initial narration of his and Holmes's adventures and Holmes's inevitable, concluding summation of his deductive maneuvers correspond to the narrative distinctions outlined above between the history portion of the medical case and the post-mortem exam. Within the Sherlock Holmes stories, the Holmesian summing up that completes each of these tales serves the same purpose as the autopsy, while Watson fulfills the role of the doctor who initiates the narration of the case study by describing the patient's history as well as his interactions with the patient. In the Holmes tales, Watson conveys what he sees and hears in a linear fashion as the story unfolds. On many occasions this means that Watson's narration of the mystery concludes with the description of the culprit being discovered or captured. This follow-through to the end of the story in Watson's reports is analogous to knowing the outcome in the medical case described above (i.e., that the patient dies), yet still being in the dark as to how or why this death has transpired. Thus, the very thing that remains missing from Watson's narration of what happened is the explanation of how Holmes was able to nab the criminal and, often, why the culprit even committed the crime. These explanations are supplied by Holmes's final remarks. Hence, the Holmesian summation, like the autopsy, provides the how and why and fills in the blanks left by Watson's recounting of the superficial events of the case.

An example from one of the Holmes stories demonstrating the contrast between Watson's more personal "history" of the case and Holmes's concluding catalogue of his deductive maneuvers underscores the stories' inclusion and movement between the two facets of this particular type of medical case. In "The Adventure of the Speckled Band," Watson introduces us to the sufferer at hand. After being awakened by Holmes, Watson remarks, "I rapidly threw on my clothes, and was ready in a few minutes to accompany my friend down to the sitting-room. A

lady dressed in black and heavily veiled, who had been sitting in the window, rose as we entered." He later continues, "She raised her veil as she spoke, and we could see … her face all drawn and grey, with restless, frightened eyes, like those of a hunted animal. Her features and figure were those of a woman of thirty, but her hair was shot through with premature grey, and her expression was weary and haggard" (214-15). Watson's narration follows the pattern of a story being told (complete with evocative phrases like the simile "eyes, like those of a hunted animal" and the charting of a series of events). In addition, the information he chooses to highlight parallels the type of information included in the history portion of a medical case study, including how and when he became involved in the case and his initial physical description of the ailing person upon first encountering her.

Holmes's concluding remarks, on the other hand, much like the autopsy, do not tell a story so much as fill in all the gaps left by Watson's recounting of the events of the case. Watson admits as much near the end of "The Speckled Band" when he explains that what "I had yet to learn of the case was told me by Sherlock Holmes as we travelled back next day" (228). At this point, Watson has already revealed to the reader that the culprit in the case is the step-father of the young woman who came to see Holmes and Watson, but how Holmes knew the step-father to be the culprit and that he was employing a poisonous snake to kill his stepdaughters is unclear. Holmes explains these salient points in his closing remarks by carefully cataloging what he saw in both the remaining stepdaughter's and the stepfather's rooms. For instance, in the young lady's room, "The discovery that this [a bell-rope hanging above the bed] was a dummy, and that the bed was clamped to the floor, instantly gave rise to the suspicion that the rope was there as a bridge for something passing through the hole, and coming to the bed" (229). Then, in the stepfather's room, "An inspection of his chair showed me that he had been in the habit of standing on it" (229). It is the close observation of both of these physical signs, coupled with the inspection of other tangible details such as whistles and bowls of milk, that leads Holmes to the discovery of how the villainous father executed his crimes.

Within this story in particular, Holmes's function as medical examiner, as a professional called in to offer explanations after it is already too late for at least one sufferer, becomes particularly evident, for the stepdaughter originally seeks Holmes in order to determine how her sister passed away. She announces from the first that "it is of her death that I wish to speak to you" (217) since "the coroner… was unable to find any satisfactory cause of death" when he investigated (218). When queried mid-way through his investigation about what killed the young woman, Holmes's reply tellingly echoes the sentiment of the doctor who observed the necessity of a full post-mortem exam in determining what ailed the deceased. Holmes explains, "I should prefer to have clearer proofs before I speak…. I think there was probably some *more tangible* cause [of her death than fright]" (224, my emphasis), a tangible cause that can only be uncovered by Holmes's careful dissection of the facts.

Holmes himself hints at the distinction between the more colorful language and story-like quality of Watson's narration in comparison to the more distanced and bare-bones account that Holmes himself would have included near the beginning of "The Adventure of the Copper Beeches." Holmes comments to Watson, "you have erred, perhaps, in attempting to put colour and *life* into each of your statements, instead of confining yourself to the task of placing upon record that severe reasoning from cause to effect which is really the only notable feature about the thing…. You have degraded what should have been a course of lectures into a series of tales" (272, my emphasis).[71] Holmes's disparaging tone notwithstanding, his comment does aptly draw attention to many of the differences between his summation and the rest of Watson's narration that I have been discussing. His statement also highlights Holmes's emphasis on cold reasoning rather than "colour and life" and that his reasoning follows from cause to effect. This movement from cause to effect is precisely what happens in the autopsy (there is a tumor, which cause must

[71] Bonnie Plummer also draws attention to this moment of differentiation in the Holmes tales, but not in the context of medical narrative. Plummer highlights Holmes's comments to illustrate the meta-textual nature of Conan Doyle's detective stories, suggesting that this statement points out the gap between the reality being represented and the fact that someone is representing it.

have led to the effect of strange behavior and death) as opposed to the history which describes the effects (the symptoms) in order to, hopefully, discover the cause.

As I illustrated earlier, Holmes is able to pronounce the certainties that he does via the knowledge he has accumulated from previous cases. That the remaining sister in "The Speckled Band" is saved from an identical fate by Holmes's intervention underscores not only the benefits of accumulating case details but the potential future usefulness of information gleaned through sufferers' deaths and the use of distancing tactics. On the level of the individual, the ability to revise illness is crucial. What the Holmes stories demonstrate, though, is that on the level of medical knowledge, the end of this ability for self-revision often equals the beginning of the capacity to uncover at least some certainties regarding disease which might then help future sufferers. The most extreme form of distancing possible between doctor and patient characterizes the means by which this knowledge is divulged, for the doctor confirms, denies, or augments a patient's experiences through a complete objectification of that patient's body once patient comment has become no longer possible.

In both *Bleak House* and *The Moonstone*, the aim of acknowledging illness narratives was to help alleviate the afflicted individual's mental and physical pain by drawing attention to less obvious consequences of that suffering and recognizing its depth and complexity. And, indeed, even *Dracula*, with its emphasis on failure's role in the accumulation of knowledge, calls attention to the presence of individual distress at the root of medical advance. The Holmes tales, however, focus on the aftermath of illness, the moment when patient articulation becomes impossible, in order to demonstrate the explanatory potential of a distanced interaction between medical examiner and the now necessarily objectified body. Just as *Dracula*'s exclusion of fully developed illness narratives illustrated a shift in the principles determining illness's presence or exclusion within a text, so too do the Holmes tales help to illuminate a change. Conan Doyle's stories, indirectly at times, emphasize the medical case's role not so much in curing the individual but in understanding disease more broadly, an effect which, over time, could lead to the more effective treatment or prevention of disease.

The Case Comes Into Its Own

In their insistence on the merits of the medical case's use and distribution, both Stoker's *Dracula* and Conan Doyle's Sherlock Holmes stories avoid idealizing the medical profession and its perspective. Nevertheless, *Dracula* and the Holmes tales do reflect on the positive role that doctors and their use of the case can play in the process of disease control and detection. The benefits of a reliance on the case study are present within these two works, in other words, but not sugarcoated. Indeed, both the novel and the tales emphasize the necessity of this type of medical documentation, but this necessity is made clear through a recognition of the potential fallibility of doctors and patients alike. These two works thus serve a humanizing function in addition to their role in endorsing the primary form of clinical narration employed during the period.

While Holmes's coldness and detachment may not seem indicative of the same type of humanization afforded by his and Drs. Seward and Van Helsing's failures, these stories also remind us that our desire for the kind of resolution that Holmes supplies is only human. The accomplishment of the explanation that concludes these stories requires some emotional distance on the part of the investigator, but we, as readers, nevertheless crave that explanation and admire Holmes's ability to achieve it. Though previous chapters may have illustrated the foreclosing potential of an exclusive reliance on the medical perspective, and this chapter does not provide the opposite picture of completely reliable medical professionals, Stoker and Conan Doyle's works nonetheless underscore the potential gains of employing a clinical case model.

The Sherlock Holmes tales provide a harder sell than *Dracula* for embracing the merits of the case model since they end in allegorical death rather than cure, but through them Conan Doyle is offering a method other than the new and unproven lab sciences for making the causes (and, thus, potential cures) of disease more manifest. In his argument that clinical medicine no longer structures fiction following realism, Lawrence Rothfield specifically identifies the figure of Sherlock Holmes as aligned with "the more exact, basic, or specialized sciences [that displace

clinical medicine] in the last quarter of the nineteenth century" (142). In support of this position, he maintains that "In the detective story, although truth about the self is still at stake, the object of knowledge is no longer the pathologically embodied person of realism, but what one might call the individuated body" (134), "a corpus of isolated, discrete elements" (135). I concur with Rothfield's analysis of Holmes's focus on the "discrete elements" that make up a person. However, what Rothfield misses is that Holmes's practice of individuation also has a clinical correlate in the medical case study concluding in post-mortem exam, a type of documentation which merely epitomizes the often-objectifying ideals of the medical case history more generally.[72] Learning what we can from the inevitable end of suffering need not be a callous approach so much as a practical one, though. Since death not only helps to create certainty but is, after all, certain, this most objectifying of case models simply makes use of the data at hand along with methods of documentation that have been tested over time.

In the end, while they may be supporting a form of knowledge production no longer at the fore, Conan Doyle's tales and Stoker's novel are decidedly more modern than their predecessors. At mid-century, *Bleak House* promoted the recognition of both patient and medical perspectives, with the prime model for this union being the marriage of the sufferer Esther Summerson and the surgeon Alan Woodcourt. Dickens's novel thus emphasized the potential complementarity of these two discourses when recognized in conjunction. Stoker's novel also

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[72] Rothfield associates what he sees as Sherlock's allegiance to post-clinical, scientific models of gathering information with the entire Holmes corpus (and detective fiction more generally). There are several later pieces of criticism which attempt to connect the figure of Holmes to bacteriology as well; the difference is that these examinations focus on the later, twentieth-century Holmes stories, those dating after Conan Doyle's time serving in the Boer War in 1900 when his exposure to wide-scale contagion in British soldiers may have impacted some of his views regarding the efficacy of bacteriology. See, in this respect, especially Laura Otis's work and, to a certain extent, Susan Cannon Harris's. I, however, have been focusing my attention on Conan Doyle's specifically Victorian detective stories. The Conan Doyle of this period may have been receptive to ideas stemming from the new sciences—he was the first British doctor to travel to Berlin in 1890 to investigate Koch's claims regarding his cure of tuberculosis following his discovery of the tubercle bacillus (Rodin 105-07)—but he was also suspicious of bacteriology's claims of achievement in fields in which clinical medicine had thus far been unable to make headway—following his trip to Berlin, he was the first observer of Koch's supposed cures to correctly and repeatedly express written skepticism about the *curative* properties of Koch's discoveries (Rodin 107-09).

acknowledges the potential gains of a multivoicedness in the description of disease, but his conclusions are much less romantic than Dickens's. For Stoker, a union of multiple medical perspectives and the patient's voice into a fully explicit narrative of disease progression would certainly facilitate cure, but the possibility of achieving such an ideal is remote. Perhaps now, at the end of the century, the notion of polygamy that continues to surface in *Dracula* would make a better model for the connection between narratives of illness and the medical case model found in *Dracula*. This type of marriage may sound good—as Lucy's oft-quoted lament regarding her inability to marry three men at once indicates—but this wedding of multiple participants can never be fully realized, and the only attempt—the transfusion of all of her suitors' plus Van Helsing's blood into Lucy—fails to save the victim at hand. Thus, in the face of the inefficacy of this model, the medical perspective must accumulate what data it can in order to provide, via case recording, what are sometimes the only means for saving potential sufferers in the future.

In earlier works, such as *Bleak House*, *The Moonstone*, *Birds of Prey*, and *Charlotte's Inheritance*, illness and the limitations imposed upon its sufferers by medical documentation provided the narrative momentum. As the narratives of *Dracula* and the Holmes tales build toward the realization of the goals implicit in case recording—cure and the eradication of disease, on the one hand, explanation perhaps contributing to that same end, on the other—we can see that the logic of the medical case has now become the logic of narration itself. Although the case undoubtedly surfaced in previous chapters, the *concept* of the case—including its connotations and its more abstract principles—was paramount. In this final chapter on *Dracula* and the Holmes stories, the representation of the case—versus illness—has not only become central, it has also become specific.

Between these two works we can see the two ends of a case-reporting spectrum. On the one pole, Stoker's novel traces the impact and efficacy of medical professionals' initial case notes, expressing both skepticism about the possibility of fully capturing patients' experiences and hope that medically recording these individual cases of suffering will eventually result in the ability to cure. Conan Doyle's short stories illustrate the other pole, the ultimate end-point in

case representation: the polished and published case study which concludes with the contributions to explanation that can only be achieved through examination of a body no longer able to speak for itself. Although these two types of case recording start from opposite points, both *Dracula* and the Holmes tales reflect on the case's unique ability to narrate that which cannot be otherwise represented. And in its emphasis on making comprehensible that which defies mastery through other means lies the case's essential fit with literary narrative.

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