The Construction of Professional Identities in Medical Writing and Fiction, c. 1830s-1910s

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Abstract

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This thesis examines the representation of medical practitioners between the 1830s and 1910s in Britain and its Empire, drawing on the medical press and fiction. Moving away from the notion that practitioners' identities were determined chiefly by their qualification or professional appointment, it considers how they were constructed in relation to different axes of identity: age, gender, race, and the spaces of practice.

Each chapter concentrates on a different figure or professional identity. I begin by looking at the struggling young medical man, before examining metropolitan practitioners (from elite consultants to slum doctors), and the hard-working country general practitioner. I then consider how gender and professional identities intersected in the figure of the medical woman. The last chapter examines practitioners of colonial medicine in British India.

This thesis considers a range of medical journals, from well-known titles such as the *Lancet* and *British Medical Journal*, to overlooked periodicals including the *Medical Mirror, Midland Medical Miscellany,* and *Indian Medical Record.* It also examines fiction by medical authors such as Arthur Conan Doyle and W. Somerset Maugham, and lesser-known figures including Margaret Todd and Henry Martineau Greenhow. I read these texts alongside other contemporary writing (from advice guides for medical men to fiction by lay authors) to scrutinise how ideas about practice were shaped in the medical and cultural imagination.

My research demonstrates not only how medical journals fashioned networks among disparate groups of practitioners but also how they facilitated professional rivalries. I reveal the democratising tendency of print culture, highlighting how it enabled a range of medical men and women to write about practice. Ultimately, the thesis develops our understanding of medical history and literary studies by uncovering how the profession engaged with textual practices in the formation of medical identities.

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I am delighted to have been part of the AHRC-funded, cross-institutional project 'Constructing Scientific Communities' and am grateful to the whole team for their encouragement and insights over the past three years. I would also like to thank those on our 'sister' project at Oxford, 'Diseases of Modern Life', who generously offered support and suggestions along the way. These projects provided me with a sense of academic community and companionship, and inspired my work. I would also like to thank my peers at Oxford, particularly Kanta Dihal, for providing a wonderful support network during my time on the DPhil.

In researching this project, I worked with an extensive collection of nineteenth-century medical journals housed at the Royal College of Surgeons of England, and I extend the warmest thanks to their Library and Archives team, as well as staff at the Hunterian Museum. This thesis also draws on material from the Bodleian Libraries in Oxford, the Wellcome Library, and the British Library. These wonderful collections have enabled me to uncover the richness of the Victorian medical press.

I have presented portions of this research at academic conferences and I am grateful for all the feedback I received from friendly colleagues among the British Association for Victorian Studies, the Victorian Popular Fiction Association, the International Centre for Victorian Women Writers, and at the University of Exeter's Postgraduate Medical Humanities Conferences, as well as other events.

Finally, I am thankful to the Moulds family – Rosemarie, Michael, and Katherine – for their unwavering support in all my endeavours and especially to my mother for her patience, kindness, and outstanding proofreading abilities. Thank you to Azeez Siddiqui for always boosting my morale and keeping my confidence high.

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List of Abbreviations

AMA	American Medical Association
AMC	Army Medical Corps
BMA	British Medical Association
BMJ	*British Medical Journal*
EMJ	*Edinburgh Medical Journal*
Gazette	*Indian Medical Gazette*
GMC	General Medical Council
IMA	Indian Medical Association
IMS	Indian Medical Service
LSMW	London School of Medicine for Women
Mirror	*Medical Mirror*
Miscellany	*Midland Medical Miscellany*
MPC	*Medical Press and Circular*
MTG	*Medical Times and Gazette*
PMJ	*Provincial Medical Journal*
PMSA	Provincial Medical and Surgical Association
PMSJ	*Provincial Medical and Surgical Journal*
RCP	Royal College of Physicians of London
RCS	Royal College of Surgeons of England
Record	*Indian Medical Record*
SMS	Subordinate Medical Service
UCL	University College London

For the periodicals I use a mixture of acronyms and shortened titles to differentiate clearly between similar-sounding titles.

Introduction

1. Constructing professional identities

In 1876, the weekly medical journal the *Lancet* featured a leading article in which it examined 'types of professional character'. It delineated 'a few typical specimens' of the medical man, from the 'Demonstrative practitioner' whose 'principal object in life' appears to be 'the conversion of society – if possible of mankind – to the belief that he is profoundly learned in medical science', to the 'Scientific type', who is 'honoured with the confidence, and commands the respect, of his profession'. The article also outlined types in which 'the personal element is prominent', as with the 'bashfully modest practitioner' who 'frequently commits indiscretions'. The editorial presented a detailed typology of professional identities and assigned value judgements to each. Though satirical in places, it concluded that there was 'a practical service to be done by illustrating and studying' professional types. It suggested this would 'teach us how to amend the old stock, and, perhaps originate new and better varieties'.[1] The article adopted an evolutionary metaphor to suggest that writing and reading about medical identities could remould professional character. As I will demonstrate, the medical profession was remarkably self-aware about the role textual practices could play in identity formation.

This thesis investigates how medical practitioners were represented in medical writing and fiction published between the 1830s and 1910s. This was a significant period for both the professionalisation of medicine and the expansion of print culture. My aim is to interrogate the interactions between the two, asking how textual practices fashioned professional identities. This thesis represents the first full-length study of the medical profession's engagement with print and literary culture during this period. Its focus is the

[1] 'Types of Professional Character', *Lancet,* 25 November 1876, pp. 754-5.

medical press and medical fiction, two forms of writing which burgeoned in the nineteenth century. It considers how images of medical practice and professionalism were formed in both the cultural and medical imagination.

The timeframe for my thesis is shaped by my primary sources, which I will discuss shortly. It was a period of structural change within the medical profession. The movement for medical reform gathered momentum in the early decades of the nineteenth century, with considerable debate about the status of the rank-and-file and the role of general practice.[2] This agitation culminated in the 1858 Medical Act, which introduced a system of medical registration, and later the 1886 Medical Act Amendment Act, which made qualification in medicine, surgery, and midwifery mandatory for registration. Professional identities fashioned during the Victorian period underwent a significant shift with the implementation of the National Insurance Act in 1911. This inaugurated greater state involvement in healthcare and made medicine a less precarious career path. In ensuing years, the First World War would catalyse developments in medicine, thereby transforming medical men and women's working lives and practices, as well as their public and professional image.

Medical historians have documented how a tripartite division among the profession (physicians, surgeons, and apothecaries) was gradually displaced by a split between consultants and general practitioners during the nineteenth century.[3] This thesis counters the supposition that medical identities were determined by a practitioner's qualifications or professional appointment. Instead, it considers how they were constructed in relation to different axes of identity, such as a practitioner's age, gender, race, and the spaces in

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[2] See Irvine Loudon, *Medical Care and the General Practitioner, 1750-1850* (Oxford: Clarendon Press, 1986), pp. 189-207.

[3] These divisions have been described and problematised by a range of scholarship. See, for example, M. Jeanne Peterson, *The Medical Profession in Mid-Victorian London* (Berkeley: University of California Press, 1978), p. 6, 15-16. Loudon, *Medical Care*, p. 189, 268, 301.

which (s)he practised. Each chapter examines a different figure: the young practitioner; the metropolitan practitioner; the country practitioner; the medical woman; and the practitioner in colonial India. Across the thesis, I use broad terms such as 'practitioners', 'medical men', and 'medical women' to refer collectively to those engaged in different types of practice (as physicians, surgeons, or general practitioners). Representations of the 'quack' do not fall within the purview of my study, though I consider how images of alternative practice shaped ideas about regular, orthodox medicine.

At the outset of this project, I intended to focus on representations of the doctor-patient relationship. However, my engagement with the primary material taught me that this relationship was intimately bound up with other aspects of a practitioner's identity. Thus I widened my scope to think about how professional identities were conceptualised. Throughout the thesis, I interrogate how practitioners' identities were shaped around a range of factors including: their medical knowledge and practice; their interactions with professional colleagues; their relationships with patients; and their duties towards their local community and wider society. I also investigate how their professional and personal lives were depicted as interconnected.

This thesis examines the construction of both individual and collective medical identities. It considers how practitioners used their writing to participate in acts of self-definition but also to fashion ideas about their colleagues and rivals, as well as the wider profession. It explores how identities were shaped both by those 'within' and 'without' different groups. For example, it looks at how provincial practitioners depicted their metropolitan counterparts, how medical men represented female practitioners, and how British practitioners wrote about those of Indian descent. In arguing that medical writing played a key role in the formation of professional identities, I do not endorse a teleological view of professionalisation or offer a straightforward narrative of progress. Medical men

and women's textual practices did not function solely to produce affirmative images of the profession. They provided a space in which ideas about practice could be negotiated and contested.

Historical scholarship has characterised the medical profession in terms of both unity and division. It emphasises how regular practitioners were brought together by a reformist agenda, allied against heterodox practitioners or 'quacks' and – later in the century – against club or contract practice (with friendly societies), and how surgery and medicine became more unified. The profession has also been viewed in terms of internal divisions between the rank-and-file and the elite; between consultants and specialists; and between aspiring medical women and established medical men. My thesis asks how this dialectic between collegiality and conflict was shaped by print culture.

Geographically, the project focuses on England and colonial India, but has wider implications for Britain and its Empire. The construction of separate Scottish and Irish identities, as well as distinct regional and colonial identities are topics which merit studies of their own.[4] Nevertheless, my research attends to the relationship between different spaces. As historians have demonstrated, medical men and women were peripatetic during their education, training, and careers, moving across the country and between the metropole and its colonies. Further, the distribution networks of medical journals and fiction were often national and transnational. I consider how the mobility of medical practitioners and the circulation of texts exerted a significant influence on the formation of professional identities.

[4] Recent scholarship on medical identities in specific geographic contexts includes: Anna Crozier, *Practising Colonial Medicine: The Colonial Medical Service in British East Africa* (London: IB Tauris, 2007). Laura Kelly, *Irish Women in Medicine, c.1880s-1920s: Origins, Education and Careers* (Manchester: Manchester University Press, 2012).

2. Primary sources

I have selected the period from 1830s to 1910s because this was a fertile time for the development of medical and literary writing engaged with questions of medical practice and professionalism. My research uncovers how practitioners were actively involved in textual production and consumption as editors, contributors, correspondents, readers, authors, and reviewers. I focus on the medical press and fiction by medical writers as two channels for identity formation. These were ostensibly different genres, aimed at different readers: the former was primarily intended for professional audiences, while the latter was for a popular lay readership. However, as I will demonstrate, these seemingly discrete genres closely intersected. I place medical journals and fiction in the context of other contemporary writing that helped to fashion professional identities. Thus Chapter One looks at advice literature for aspiring practitioners, while later chapters examine fiction by lay authors, articles in popular periodicals, and (auto)biographies. I read across these different texts to scrutinise how images of the practitioner were shaped in both the medical and cultural imagination.

I consider how professional identities were formed in relation to ideas about knowledge production and medicine's shifting epistemological status, though clinical material is not the focus of my research. The case study format has received significant attention from literary and historical scholars in recent years.[5] Since I investigate the role of print culture in the process of identity formation, I concentrate on published material rather than unpublished case notes, correspondence, or diaries. The ways in which medical

[5] Janis McLarren Caldwell, *Literature and Medicine in Nineteenth-Century Britain: From Mary Shelley to George Eliot* (Cambridge: Cambridge University Press, 2004), pp. 143-70. Jason Tougaw, *Strange Cases: The Medical Case History and the British Novel* (New York: Routledge, 2006). Anne Stiles, *Popular Fiction and Brain Science in the Late Nineteenth Century* (Cambridge: Cambridge University Press, 2012), pp. 44-7.

practitioners constructed professional identities through private textual practices would be a fruitful area of research in itself.

The rich landscape of the professional press was demonstrated by W.R. Lefanu's bibliographic survey of medical periodicals (1938). His research on the development of the genre has been revised and extended by subsequent scholars.[6] This work has traced the antecedents of medical periodicals back to the seventeenth century.[7] It highlights that their production and circulation burgeoned from the early decades of the nineteenth century, with the launch of titles such as the *Edinburgh Medical and Surgical Journal* in 1805, the *Lancet* in 1823, and the *London Medical Gazette* in 1827. There was also the appearance (and disappearance) of short-lived journals such as *The Doctor; a Medical Penny Magazine* (1832-7). In their survey of the medical press, W.F. Bynum and Janice Wilson estimate that, during the nineteenth century, 479 medical periodicals appeared in Britain. They divide these into a range of categories: general medical titles 'aimed at the whole medical profession'; specialist periodicals (which dominated the field from the 1870s onwards); scientific journals; popular journals; and unorthodox titles.[8] This thesis develops previous work on the general medical press, focusing on how it elaborated identities across the profession.

I consider well-known titles such as the *Lancet* and the *British Medical Journal (BMJ),* which began life as the *Provincial Medical and Surgical Journal* (*PMSJ)* in 1840. I also look at other prominent journals such as the *London Medical Gazette* and its successor, the *Medical Times and Gazette* (*MTG;* 1852-1885), as well as the *Medical*

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[6] W.R. Lefanu, *British Periodicals of Medicine: A Chronological List 1640-1899,* rev. edn (Oxford: Wellcome Unit for the History of Medicine, 1984).
[7] Roy Porter, 'The Rise of Medical Journalism in Britain to 1800', in *Medical Journals and Medical Knowledge: Historical Essays,* ed. by W.F. Bynum, Stephen Lock, and Porter (London: Routledge, 1992), pp. 6-28 (pp. 8-9).
[8] W.F. Bynum and Janice C. Wilson, 'Periodical Knowledge: Medical Journals and their Editors in Nineteenth-Century Britain', in *Medical Journals and Medical Knowledge,* pp. 29-44 (p. 30, 32-3).

Press and Circular (*MPC;* 1867-1966), which was a merger between the *Dublin Medical Press* (established in 1839) and the *Medical Circular* (begun in 1852). The publication histories of these different journals, and the relationships between them, are scrutinised further in Chapter Two. I examine how these journals – originally geographically disparate in their sites of production – were increasingly metropolitan in character. In addition, this thesis looks at lesser-known titles such as the *Medical Mirror* (1864-70) and the *Midland Medical Miscellany* (1881, renamed the *Provincial Medical Journal* between 1885-95). In the final chapter, I consider two key journals published in colonial India, the *Indian Medical Gazette* (1866-1955) and the *Indian Medical Record* (1890-1903). While the former is often used by researchers working on colonial medicine, the latter has been comparatively overlooked. This thesis contributes to periodical studies by recovering journals that have hitherto been neglected.

My research draws primarily on medical journals which were printed in weekly, fortnightly, or monthly formats. As Bynum and Wilson suggest, frequent publication facilitated closer engagement with questions of medical reform. The quarterly format – which tended to focus more on clinical communications – was in decline during this period.[9] The thesis engages with a cross-section of the journals' content, including leading articles, news columns, clinical communications, transcripts from debates at professional organisations, and correspondence columns. Most of the editorial content was published anonymously, without a by-line or signature, as was conventional in the periodical press for much of the nineteenth century.[10] Leading articles appeared under the journal's title, which gave the impression they functioned as the editorial mouthpiece. In the

[9] Bynum and Wilson, pp. 37-8.
[10] The editors of the *Wellesley Index* estimated that, until 1870, around 97 per cent of articles and stories in the periodicals they examined were unsigned or pseudonymous. Signed articles gained traction after 1865. Walter E. Houghton (ed.), 'Introduction', in *The Wellesley Index to Victorian Periodicals: Volume Two* (Toronto: University of Toronto Press, 1972), pp. xiii-xxi (p. xvi).

correspondence pages, there were letters from named individuals but also many that were unsigned or pseudonymous. While highlighting the multivocal nature of the journals, I also consider the tensions between authorship and anonymity.

I recognise that the medical press was only one of the channels for identity formation and consider how journals interacted with other institutions. For instance, I look at the relationship between the *BMJ* and the British Medical Association (BMA) and the *Indian Medical Record* and the Indian Medical Association (IMA). I also examine how addresses delivered to medical societies and medical schools appeared within the journals. This enabled their ideas to be disseminated further, perhaps to audiences different from those originally envisaged. The role of medical societies in the development of professional identities and in the production of regional medical journals is outside the scope of this thesis, but has been examined by other historians.[11]

Scholars of the periodical press have become increasingly self-reflexive about their methods, considering the respective merits of working with print and digital collections, the importance of serendipity, and the role of digital humanities. During my research, I worked with physical collections at the Royal College of Surgeons of England, the Wellcome Library, and the Bodleian Library, as well as digitised runs of the *Lancet* and *BMJ*. As intimated, I have engaged with more obscure periodicals even where the print run may be incomplete and relatively little is known about the journal's editorship and production. My research is testament to the opportunities, as well as the challenges, of working with such material.

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[11] For the relationship between medical societies and professionalisation, see Jacqueline Jenkinson, 'The Role of Medical Societies in the Rise of the Scottish Medical Profession, 1730-1939', *Social History of Medicine*, 4 (1991), 253-75, and *Scottish Medical Societies, 1731-1939: Their History and Records* (Edinburgh: Edinburgh University Press, 1993). Jenkinson's survey of societies records their publishing activities. Most medical societies published their own proceedings and some also established journals; see Michael Brown, *Performing Medicine: Medical Culture and Identity in Provincial England, c. 1760-1850* (Manchester: Manchester University Press, 2011), p. 162.

The period between the 1830s and 1910s was also a crucial time for the development of medical fiction. I look at an early example of the genre, Samuel Warren's *Passages from the Diary of a Late Physician,* which appeared in *Blackwood's Edinburgh Magazine* between 1830 and 1837, attracting interest (and notoriety) among both popular and medical commentators. My focus is weighted towards the end of my period, however, when there was significant growth in fiction by medical authors. At the *fin de siècle* and into the early twentieth century, prolific writers such as Arthur Conan Doyle and W. Somerset Maugham published fiction which drew on their experiences of medical education and practice.

I position writers as 'medical' authors where I consider that their access to medical knowledge, contact with patients, and awareness of professional life helped shape their fiction. Some enjoyed relatively successful careers. Margaret Todd wrote her debut novel *Mona Maclean, Medical Student* (1892) while she was studying at the Edinburgh School of Medicine for Women and she later became assistant physician to the Edinburgh Hospital for Women and Children. Henry Martineau Greenhow was a Surgeon-Major in the Indian Medical Service and turned to writing fiction during his retirement. Some of the authors I consider – such as Warren, Maugham, and Anna Kingsford – studied medicine but did not subsequently pursue careers in practice. Others had short-lived or relatively unsuccessful careers. Arabella Kenealy gave up her medical work in London after contracting diphtheria and concentrated on writing about eugenics. Conan Doyle spent ten years working in medicine (chiefly as a general practitioner) before abandoning it for his considerably more profitable literary career instead. When he published his collection of short stories on medical life, *Round the Red Lamp,* in 1894, his practice had already drawn to a close. Another reason for categorising authors as medical writers is that the

professional press typically highlighted their medical credentials when discussing their fiction.

My thesis will consider the confluence or tension between medical and literary identities. Both Conan Doyle and Maugham, for instance, were (and continue to be) better known as popular authors than medical men. Other writers, such as Kingsford and Greenhow, have faded into relative obscurity. The writers I examine moved between their literary and medical careers in different ways, and authorship was not necessarily an activity arrogated to their medical practice. Thus, while my primary focus is on the construction of professional identities, I will consider how many of these writers were also establishing their authorial identities.

This thesis examines how medical men and women constructed their professional identities in relation (or resistance) to ideas in the public domain. I read their literary output alongside articles in the popular press and fiction by lay authors, including Charles Dickens's *Bleak House* (1853), Anthony Trollope's *Doctor Thorne* (1858), George Eliot's *Middlemarch* (1872), and Julia Frankau's *Dr Philips: A Maida Vale Idyll* (1887) among others. I consider how medical and lay authors drew on shared representational strategies and engaged with similar discussions about the role of the practitioner. Further, I reveal how popular fiction on medical themes was critically received by the professional press. One of my key findings is that medical journals incorporated literary criticism.

As indicated at the outset, the medical profession was conscious that print culture shaped ideas about what it meant to be a practitioner. Medical journals often represented themselves as important mechanisms for keeping readers informed, furthering medical knowledge, debating ideas, and developing professional networks. Medical commentators also recognised the power of fiction. In 1888, the *Lancet* featured an article entitled 'The

Doctor in Fiction', which surveyed the portrayal of medical men in popular literature. It noted that,

> the fiction of the day not only reflects, but to no inconsiderable extent moulds, current thought and opinion. It is not, then, a matter of indifference to us that our professional methods, aims and work should be honestly depicted and not maliciously caricatured, in the pages of the modern novel.[12]

This article recognised that literary writing could shape public opinions about professional life. Similarly, Herbert de Carle Woodcock's *The Doctor and the People* (1912) closed with three chapters entitled 'Doctors From a Bookshelf', in which he examined how practitioners were portrayed by authors such as Jane Austen, Dickens, and Trollope. He suggested that the representation of doctors in the past was 'of real importance' to the profession, since though 'the problems of to-day are problems of to-day', nevertheless the 'difficulties' surrounding 'character and characteristics' persist.[13] This thesis will interrogate how certain aspects of professional identity were represented as enduring, while others were revised in response to the opportunities and challenges of modernity.

Medical writing was not, of course, conceived simply as a vehicle for building professional identities or communities. I will consider how participating in textual practices was regarded as an important aspect of performing one's professional identity. In calling for contributions, medical journals often claimed that submitting clinical studies or correspondence was a professional duty or responsibility. This was partly a tactic designed to generate more content. However, engaging with literature was also seen as a way of demonstrating one's gentlemanly qualities. This was particularly important for general practitioners and surgeons, who were still divesting themselves of their old associations with trade.

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[12] 'The Doctor in Fiction', *Lancet*, 7 April 1888, pp. 685-6.
[13] Herbert de Carle Woodcock, *The Doctor and the People*, 2nd edn (Methuen: London, 1912), p. 271.

In 1898, Samuel Dodd Clippingdale – Surgeon to the Kensington Dispensary – delivered an address on '[T]he Life and Work of the General Practitioner' to the West London Medico-Chirurgical Society. It was later published verbatim in the *Lancet* and summarised in the *BMJ* and thus reached a much wider audience.[14] Clippingdale pointed towards popular fiction as evidence that the practitioner was 'growing in public estimation'. Closing the paper, he also discussed medical men's own literary endeavours, referring to earlier writers such as Oliver Goldsmith and Tobias Smollett, as well as Warren and Conan Doyle. He suggested that '[t]here must surely be something in medical practice to awaken the emotions and stimulate the intellect, for we find the highest forms of literature enriched by the contributions of members of the medical profession'.[15] Clippingdale framed medical and textual practices as mutually constitutive, suggesting the former strengthened one's literary capacities. His claim that practitioners 'enriched' literature was more than an act of self-congratulation on the part of the profession. It indicates how he perceived writing as a worthwhile activity in its own right. This thesis will interrogate both how the profession engaged with literature and, in turn, how writing shaped ideas about the profession.

3. Previous scholarship

This project builds on previous scholarship in a set of interconnected disciplines: the history of the professions; social and cultural histories of medicine; and literary and periodical studies. It also draws on fields such as the medical humanities and cultural geography. It adopts an interdisciplinary approach to analyse how professional identities were constructed and contested through medical writing and fiction.

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[14] 'Reports of Societies: West London Medico-Chirurgical Society', *BMJ*, 15 October 1898, p. 1162.
[15] S.D. Clippingdale, 'An Address on Some Considerations of the Life and Work of the General Practitioner', *Lancet*, 29 October 1898, pp. 1104-6 (p. 1104, 1106).

Historians have depicted the nineteenth century as a period in which medicine consolidated its status as a profession. Scholars working on the history of the professions typically chart this development against broader patterns of professionalisation in modern society, such as the division of labour and increased specialisation.[16] They argue that medicine's authority and influence rose with increasing public and state recognition. Penelope Corfield cites medical registration (inaugurated by the 1858 Medical Act) as the 'benchmark of professionalism', suggesting it 'clarified the definition of the medical doctor'.[17] Historians of medicine such as M. Jeanne Peterson and Ivan Waddington similarly adopt a sociological framework, plotting medicine's rising prestige against structural changes.[18] In particular, they interrogate the role of institutions such as the Royal Colleges and teaching hospitals in the production of professional identities.

My thesis develops previous work on professionalisation by positing identity formation as an uneven and continual process that was mediated through textual practices. Historians have acknowledged that the impact of structural change within the medical profession was limited. The Medical Act did not standardise entry into practice and left the profession self-regulated. Nomenclature remained confused: there was little consensus about the use of medical titles such as 'doctor' and the term 'general practitioner' only gradually gained acceptance. Throughout the period 1830 to 1910, questions such as what medical practitioners were called, what body of knowledge they represented, and what role in society they played were still in the process of negotiation. It was in this open climate that medical writing and fiction offered a means of self-fashioning. My thesis considers the democratising tendency of print culture, how it enabled a range of non-elite practitioners –

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[16] See, for example, Harold Perkin, *The Rise of Professional Society: England Since 1800,* 2nd edn (London: Routledge, 2002), pp. 23-4.
[17] Penelope J. Corfield, *Power and the Professions in Britain, 1700-1850* (Routledge: London, 1995), p. 146.
[18] Peterson, *The Medical Profession in Mid-Victorian London.* Ivan Waddington, *The Medical Profession in the Industrial Revolution* (Dublin: Gill and Macmillan, 1984).

including young medical men and aspiring medical women – to participate in the construction of professional identities.

Historians of medicine such as Irvine Loudon and Anne Digby consider the experiences of rank-and-file practitioners, exploring their mixed fortunes within the context of the medical marketplace.[19] Building on this work, my thesis considers how the economic pressures of practice were represented in medical writing and fiction and how the business side of medicine was seen to constitute a fundamental part of a practitioner's professional identity.

More recently, the medical marketplace model has been challenged by scholars who emphasise the formation of professional networks and communities. Anne Crowther and Marguerite Dupree's cohort study – which follows the career trajectories of medical students who matriculated at the Universities of Edinburgh and Glasgow in the 1860s and 1870s – considers the competitive aspects of practice but also foregrounds 'communal loyalties' and 'the group dynamics of professional life'.[20] They examine the dispersal of practitioners, revealing the transnational character of medical networks. These findings inform my own approach to the spaces of practice; I investigate how print culture facilitated the mobility of medical men and women and the formation of professional communities.

Michael Brown interrogates how 'collective identities or shared values' were formed in his research on medical cultures in York between 1760 and 1850.[21] He draws on Benedict Anderson's *Imagined Communities*, which posits that print-capitalism played a

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[19] Loudon, *Medical Care.* Anne Digby, *Making a Medical Living: Doctors and Patients in the English Market for Medicine, 1720-1911* (Cambridge: Cambridge University Press, 1994) and *The Evolution of British General Practice, 1850-1948* (Oxford: Oxford University Press, 1999).
[20]M. Anne Crowther and Marguerite W. Dupree, *Medical Lives in the Age of Surgical Revolution* (Cambridge: Cambridge University Press, 2007), p. 1, 3.
[21] Brown, *Performing Medicine*, p. 5.

fundamental role in constructing ideas of nationhood.[22] Brown suggests that medical journals and medical societies served to produce imagined professional communities, whereby practitioners conceived themselves as part of 'a spatially extensive' and 'national' group.[23] His primary focus is the *Lancet*. My thesis builds on this work, examining how a range of journals – competing against one another in the periodical marketplace – constructed different professional communities.

Historians have drawn on medical journals and fiction to investigate the experiences of medical practitioners, but their primary focus is not usually the textual or literary qualities of this material. Some scholars have begun to counteract this tendency. For example, Brown attends to the form and content of the medical press and highlights the interrelationship between geographical spaces of practice and the textual spaces of medical journals.[24] Roy Porter's *Bodies Politic* looks at the interaction between visual and textual cultures in the 'production of meanings' about doctors, patients, and disease between 1650 and 1900. He suggests that Victorian literature constructed the figure of the 'doctor-hero' which was 'quite unknown to earlier fiction'.[25] While I consider the doctor-as-hero paradigm (particularly in Chapter Three on the country practitioner), I examine heterogeneous depictions of practice. I also foreground how the medical profession responded to, and interacted with, literary representations.

My approach to medical journals has been influenced by the burgeoning field of periodical studies. Over the last fifty years, large-scale projects have uncovered the range of newspapers, magazines, and periodicals that proliferated in the nineteenth century. As

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[22] Benedict Anderson, *Imagined Communities: Reflections on the Origin and Spread of Nationalism*, rev. edn (London: Verso, 2006).
[23] Brown, *Performing Medicine*, p. 159.
[24] Brown, 'Medicine, Reform and the "End" of Charity in Early Nineteenth-Century England', *English Historical Review*, 124 (December 2009), 1353–88 (pp. 1380-1).
[25] Porter, *Bodies Politic: Disease, Death and Doctors in Britain, 1650-1900* (London: Reaktion, 2001), p. 231, 257.

part of this work, scholars have interrogated the representation of science and medicine in generalist periodicals.[26] There has also been research into how identity categories such as gender were mediated through the popular press.[27] Scholars have considered editorial strategies, reading practices, and examined the interplay between form and content, imperatives which inform my own work. In line with recent scholarship, I consider how the character and content of medical journals fluctuated, acknowledging that a title did not necessarily retain 'a uniform identity across its lifetime'.[28]

In addition to the bibliographic surveys of medical periodicals already outlined, there have been histories of individual journals.[29] There has been little sustained investigation into the role periodicals played in constructing professional identities, however. One notable exception is *Medical Journals and Medical Knowledge,* a collection of essays edited by Porter, Bynum, and Stephen Lock, which I cited previously. It considers the origins, editorship, content, and production of medical journals. Significantly, the medical press is not treated simply as evidence of professionalisation. Instead, the collection investigates how it 'serve[d] as an engine actually for *shaping* the future of medicine'.[30] It suggests that the journals fostered 'greater collective professional self-consciousness' and a 'growing sense of corporate identity amongst general practitioners'.[31] Similar ideas have been advanced by later historians such as Brown but there has been surprisingly little further scholarship dedicated to advancing our

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[26] Geoffrey Cantor and others (eds.), *Science in the Nineteenth-Century Periodical: Reading the Magazine of Nature* (Cambridge: Cambridge University Press, 2004). Geoffrey Cantor and Sally Shuttleworth (eds.), *Science Serialized: Representations of the Sciences in Nineteenth-Century Periodicals* (Cambridge: Massachusetts Institute of Technology, 2004).
[27] Hilary Fraser, Stephanie Green, and Judith Johnston, *Gender and the Victorian Periodical* (Cambridge: Cambridge University Press, 2003).
[28] Cantor and Shuttleworth, 'Introduction', in *Science Serialized,* pp. 1-15 (p. 5).
[29] Robert J. Rowlette, *The Medical Press and Circular 1839–1939: A Hundred Years in the Life of a Medical Journal* (London: [Medical Press and Circular], 1939). Peter W.J. Bartrip, *Mirror of Medicine: The BMJ, 1840-1990* (Oxford: Oxford University Press, 1990).
[30] Porter, 'Introduction', in *Medical Journals and Medical Knowledge,* pp. 1-5 (p. 3).
[31] Porter, 'The Rise of Medical Journalism', p. 9. Jean Loudon and Irvine Loudon, 'Medicine, Politics and the Medical Periodical 1800-50', in *Medical Journals and Medical Knowledge,* pp. 49-69 (p. 64).

understanding of medical journals as a genre. Building on this work, I uncover a wider range of journals and examine the interactions between them. As historians have identified, journals did not simply develop a collective identity but were also a forum for practitioners to air grievances about their colleagues. I will explore further how they mediated divisions and dissent. Moreover, I will employ a literary perspective to interrogate the form and content of the medical press and bring this material into dialogue with other contemporary writing.

Alongside research in the history of medicine, literary scholars working on the Victorian period have explored representations of illness and disease,[32] as well as the figure of the doctor. Books such as Lilian Furst's *Between Doctors and Patients,* Kristine Swenson's *Medical Women and Victorian Fiction*, and Tabitha Sparks's *The Doctor in the Victorian Novel* elucidate how practitioners were portrayed in literature. All three writers consider the textual output of several medical authors, though they largely address fiction by popular lay writers such as George Eliot, Elizabeth Gaskell, and Wilkie Collins.[33] They approach the interaction between literature and medicine in divergent ways. While Furst draws on 'literary texts as sources' of the 'changing balance of power' between doctors and patients,[34] Sparks uses the figure of the doctor to 'chart the sustainability' of the Victorian marriage-plot rather than to identify 'commonalities in the imaginative work or conceptual vocabularies of medicine and literature'.[35]

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[32] See, for instance, Athena Vrettos, *Somatic Fictions: Imagining Illness in Victorian Culture* (Stanford, CA: Stanford University Press, 1995). Jane Wood, *Passion and Pathology in Victorian Fiction* (Oxford: Oxford University Press, 1991).

[33] Lilian R. Furst, *Between Doctors and Patients: The Changing Balance of Power* (Charlottesville: University of Virginia Press, 1998). Kristine Swenson, *Medical Women and Victorian Fiction* (Columbia: University of Missouri Press, 2005). Tabitha Sparks, *The Doctor in the Victorian Novel: Family Practices* (Farnham: Ashgate, 2009).

[34] Furst, *Between Doctors and Patients,* p. 17.

[35] Sparks, *The Doctor in the Victorian Novel,* p. 2-3.

In doing so, she distinguishes herself from a separate, though parallel, line of scholarship concerned with the interrelationship between medical and literary discourse. Lawrence Rothfield's *Vital Signs*, for instance, investigates how clinical discourse shaped literary realism, looking at the ways in which novelists employ 'medical paradigm[s]' and 'medical authority'.[36] Janis McLarren Caldwell examines how doctors and writers 'negotiated between two different ways of knowing' – the personal and the clinical or scientific – in a 'double vision' she describes as 'Romantic materialism'.[37] More recently, Jason Tougaw's *Strange Cases* interrogates the 'mutual influence' of the medical case history and the novel.[38] Despite their different theoretical frameworks, these three critics share with Sparks an interest in the life-cycle of the realist genre. They adopt a diachronic reading of the relationship between literary realism and medicine in nineteenth-century Britain. Rothfield, for instance, contends that the 'emergence' and 'decline' of realism as a dominant literary mode is 'tied to the vicissitudes of clinical medicine as an ideal profession'.[39]

These approaches have influenced my thesis, which examines the overlaps or points of engagement between medical and literary genres in the Victorian period. I aim to collapse the distinction between these forms of writing and foreground the interplay between them. I examine how medical writing and fiction drew on shared rhetorical strategies and imaginative tropes. I also challenge the idea that these forms were aimed at different readerships. For instance, I consider how medical journals reviewed popular fiction by doctors and touch on how lay people contributed to the medical press through correspondence columns.

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[36] Lawrence Rothfield, *Vital Signs: Medical Realism in Nineteenth-Century Fiction* (Princeton, NJ: Princeton University Press, 1992), p. xvii.
[37] Caldwell, p. 1.
[38] Tougaw, p. 1.
[39] Rothfield, p. xiv.

Medical practitioners' close engagement with literature is significant given that their day-to-day practice was intimately connected to the human body. Literary theorist Gabriel Josipovici posits that books are 'living bod[ies]', emphasising writing and reading as physical processes. He locates a tension between the text as something which is 'produced biologically' but which is also 'a system of representation'.[40] This thesis is primarily concerned with cultural constructions and representations of the medical practitioner. In focusing on how professional identities were fashioned through print culture, it emphasises the textual quality of medical identities rather than the embodied experience of medical practice or writing. In the medical humanities, scholars such as Brian Hurwitz, Rita Charon, and Kathryn Hunter have fruitfully examined the role of narrative and storytelling in clinical practice, with particular attention to case studies and reports.[41] While the interrelationship between texts and bodies is not within the remit of this thesis, I consider representations of the physical nature of practice. For instance, I examine images of the country practitioner's toil and industry and anxieties about the male doctor's interactions with the female body.

In delineating how professional identities were elaborated in relation to different axes of identity, this thesis also engages with fields such as gender and race studies. Further, the way in which I examine identity formation through the lens of space has been informed by recent work in the fields of historical and literary geography. Charles Withers and David Livingstone's collection on the geographies of nineteenth-century science emphasises how scientific spaces are embedded in 'wider systems of meaning, authority,

[40] Gabriel Josipovici, *Writing and the Body* (Brighton: Harvester Press, 1982), p. 10.
[41] Brian Hurwitz, 'Narrative Constructs in Modern Clinical Case Reporting', *Studies in History and Philosophy of Science*, 62 (2017), 65-73. Rita Charon, *Narrative Medicine: Honoring the Stories of Illness* (New York: Oxford University Press, 2006). Kathryn Montgomery Hunter, *Doctors' Stories: The Narrative Structure of Medical Knowledge* (Princeton, NJ: Princeton University Press, 1991).

and identity'.[42] My thesis investigates how professional identities were shaped around the imagined spaces of practice, namely the metropolis, the countryside, and colonial India.

4. Structure

This thesis is divided into five chapters, each of which focuses on a different type of practitioner. As intimated, I consider how professional identities were constructed in relation to other characteristics, including a practitioner's age, gender, race, as well as the space in which (s)he lived and worked. Each chapter reads across a range of 'medical' and 'popular' texts to investigate how they interacted to shape ideas about medical practice and professionalism.

In Chapter One, I examine how the struggling young practitioner was represented through articles in the medical press and advice guides for aspiring medical men, such as Charles Bell Keetley's *The Student's Guide to the Profession* (1878), Daniel Webster Cathell's *Book on the Physician Himself* (1881), and Jukes de Styrap's *The Young Practitioner* (1890). I also consider medical fiction from the beginning and close of my period, looking at the instalment 'Early Struggles' from Samuel Warren's *Passages from the Diary of a Late Physician* (1830) and Arthur Conan Doyle's short stories 'A False Start' (1891) and 'Behind the Times' (1894), as well as his epistolary novella *The Stark Munro Letters* (1895). Reading across these genres, I consider how the early years in practice were often conceived as a period of hardship and ask how young medical men were inculcated with ideas of medical etiquette.

Chapter Two looks at competing constructions of the metropolitan practitioner, focusing on London. I examine the city's relationship with the medical publishing

[42] Charles Withers and David Livingstone (eds.), 'Thinking Geographically about Nineteenth-Century Science', in *Geographies of Nineteenth-Century Science* (Chicago: University of Chicago Press, 2011), pp. 1-19 (p. 5).

industry, considering how journals such as the *Lancet, London Medical Gazette,* and *BMJ* engaged with the capital's fraught medical politics. I then look at representations of different types of practitioners – the consultants and specialists who worked largely among the wealthy, and those in lower-status positions who primarily attended the urban poor. I examine Conan Doyle's short stories 'The Adventure of the Resident Patient' (1893), 'The Third Generation', and 'The Case of Lady Sannox' (both 1894), and W. Somerset Maugham's novella *Liza of Lambeth* (1897) and his later novel *Of Human Bondage* (1915). I also consider popular fiction including Charles Dickens's *Bleak House* (1853) and Julia Frankau's *Dr Philips: A Maida Vale Idyll* (1887). I investigate how disparate professional identities were fashioned in response to the perceived conditions of urban practice, including its anonymity and the exposure to vice and iniquity.

Chapter Three focuses on the figure of the country practitioner. It scrutinises further the relationship between medical and popular writing, investigating representations of country practice across medical journals, popular periodicals, and fiction, including Anthony Trollope's *Doctor Thorne* (1858), George Eliot's *Middlemarch* (1872), and Thomas Hardy's *The Woodlanders* (1887). I consider how the country practitioner's professional identity was shaped in relation to ideas about rural practice, including its perceived distance from centres of innovation and the challenges and opportunities of working among close-knit communities. As well as examining representations in mainstream medical journals, I consider the role played by an explicitly provincial periodical, the *Midland Medical Miscellany*, which pitched itself as particularly suited for the busy lifestyle of the country general practitioner.

In Chapter Four, I look at representations of medical women. I consider debates in the medical press about the suitability and propriety of women studying and practising medicine. I examine how journals engaged with different sides of the debate and a range of

different voices. Thus, I scrutinise arguments that appeared in favour of women's medical work, both in the mainstream medical press and lesser-known titles such as the more progressive *Medical Mirror*. The second half of this chapter concentrates on fiction produced by medical women, including Anna Kingsford's short story 'A Cast for a Fortune: The Holiday Adventures of a Lady Doctor' (1877), Margaret Todd's three-volume novel *Mona Maclean, Medical Student* (1892), and Arabella Kenealy's novel *Dr Janet of Harley Street* (1893). I ask how these texts provided an alternative means of identity formation for aspiring medical women.

Lastly, Chapter Five explores constructions of medical practitioners working in British India. It looks at journals published 'back home' in the metropole and those produced in the colony, namely the *Indian Medical Gazette* and *Indian Medical Record*. I examine how they represented those in the Indian Medical Service and those in independent practice. In addition, I consider how journals conceptualised the role played by practitioners of Indian and Anglo-Indian descent and medical women. This chapter thus opens up broader questions about the intersection between professional identities and gender, race, and ethnicity. Finally, it examines competing portraits of colonial medical men in fiction, including Conan Doyle's short stories 'The Adventure of the Speckled Band' (1892) and 'The Story of the Brown Hand' (1899), and Henry Martineau Greenhow's 'Mutiny' novel *Brenda's Experiment* (1896). I ask to what extent different types of practitioner were subsumed within overarching images of British medicine's imperialist mission.

The identity categories outlined in each chapter were elaborated in relation to one another. The image of the country doctor depended on the oppositional image of the metropolitan practitioner, while the medical woman was typically constructed as the antithesis of the hegemonic masculine professional identity. In the conclusion, I will

interrogate further the interconnections between these identities. Throughout the thesis, I consider both continuities and discontinuities in professional identities across the period, and my conclusion will look forward to how ideas about practice and professionalism were refashioned in the twentieth and twenty-first centuries.

Ultimately, this thesis contributes to our understanding of both medical history and literary studies by examining the role played by print culture in the formation of professional identities. Its purpose is to uncover the myriad ways in which the medical profession interacted and engaged with textual practices to shape ideas about what it meant to be a practitioner.

Chapter One: The Young Practitioner

> *'It seems a strange thing to me […] that the parents and guardians of young men do not warn them against entering upon a calling where competition is so very keen and remuneration for the most part so dreadfully small.*'[1]

These observations – made by a correspondent to the *Lancet* who signed himself 'One of the Crowd' – reflect anxieties about the state of the medical profession in the nineteenth century. In medical writing and fiction, the early years in practice were typically represented as a period of significant hardship, in which the young medical man struggled to make a living, attract and retain patients, and build relationships with his professional colleagues.[2]

This chapter examines how the figure of the struggling young practitioner was constructed through advice literature, medical journals, and fiction published between the 1830s and 1910s. In particular, it investigates how these disparate texts interacted to produce ideas about medical etiquette and how this code of conduct was seen to govern the young medical man's early experiences in practice.

The market for professional advice literature flourished during the nineteenth century, along with the expansion of career opportunities for middle-class men.[3] There were general guides, such as H. Byerley Thomson's *The Choice of a Profession* (1857), as well as books aimed more specifically at those wishing to pursue a medical career.[4] I will consider three popular advice guides intended for this audience: Charles Bell Keetley's *The Student's Guide to the Medical Profession* (1878), Daniel Webster Cathell's *Book on*

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[1] 'One of the Crowd', 'Correspondence: The Remuneration of Medical Men', *Lancet*, 18 July 1896, p. 213.
[2] My focus here is the representation of young medical men; cultural constructions of the medical woman will be explored in Chapter 4.
[3] This was a genre with deep historical roots. One of the earliest examples is Sir John Floyer's *Advice to a Young Physician* (c.1617).
[4] In addition to books intended for a broad medical audience, there were texts aimed at those interested in specific roles, e.g. A. Vavasour Elder, *The Ship-Surgeon's Handbook* (London: Baillière, Tindall and Cox, 1911).

The Physician Himself (1881), and Jukes de Styrap's *The Young Practitioner* (1890). All three offered practical suggestions to young men wishing to succeed in practice. Keetley and de Styrap were British medical men, while Cathell was American. My focus is the formation of professional identities in Britain, but I consider Cathell's manual because of its influence. Published in both the United States and Britain, it had reached eleven editions by 1903. Reviewing the book upon its first publication, the *BMJ* was broadly positive, noting that it contained 'numerous excellent maxims'. However, it warned that Cathell's book revealed some of the 'different sentiments' that existed between the British and American professions.[5] Similarly, the *Lancet*'s review of the book's eleventh edition suggested that it contained 'many valuable hints' but emphasised the 'differences in social customs which exist between Great Britain and the United States'.[6] These cultural differences were exploited by de Styrap, who reproduced and recast Cathell's guide for a British audience. By his own admission, *The Young Practitioner* was a derivative work, offering 'modified selections from' and 'additions to' *The Physician Himself*.[7] Its principal amendments were to revise the American phraseology and to ensure the text reflected the social context of practice in Britain.

There was also a related tradition of literature concerning medical ethics and etiquette. A landmark publication in this genre was Thomas Percival's *Medical Ethics* (1803), which combined precepts about good conduct with advice on medical jurisprudence. The book directly influenced the American Medical Association's (AMA) *Code of Ethics* (1847), which was also disseminated in Britain.[8] Prior to recasting Cathell's work, de Styrap modified the AMA precepts for British audiences in his *A Code*

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[5] 'Reviews and Notices: The Physician Himself', *BMJ*, 23 December 1882, p. 1258.
[6] 'Library Table: Book on the Physician Himself', *Lancet*, 16 May 1903, p. 1383.
[7] Jukes de Styrap, *The Young Practitioner* (London: H.K. Lewis, 1890), p. i. Further references are given after quotations in the text.
[8] *Code of Ethics of the American Medical Association* (Oxford: John Henry Parker, 1849).

of Medical Ethics (1878). This featured original introductory material, in which de Styrap represented medicine as a 'sacred' calling.[9] Across these medico-ethical codes, the basic precepts remained relatively consistent and there was considerable overlap in both content and tone. Following Percival's example, these books were moralising and didactic, emphasising the practitioner's status as a gentleman. They set out his obligations towards his fellow practitioners, his patients, and the public. These ideas also shaped *The Physician Himself* and *The Young Practitioner.* Nevertheless, medical ethics and advice guides were also modified to reflect changes in the profession over time. While Percival referred to a tripartite division of pure physicians and surgeons and apothecaries, the later works were largely angled towards family or general practice, which had gained increasing professional and cultural capital by the century's close. Cathell's references to the 'physician' reflect American nomenclature; as the *BMJ*'s reviewer identified, his book deals not with the 'class of consultants' (as physicians were known in Britain) but rather with 'the ordinary medical practitioner'.[10]

Medico-ethical codes have received scholarly attention from those working on the history of bioethics,[11] and Lilian Furst analyses *The Physician Himself* as part of her study on the power structures of doctor-patient relationships.[12] Yet there has been little engagement with how these codes of conduct shaped ideas about the medical man's entrance into practice. Of course, the precepts were not exclusively aimed at young medical men, though this was sometimes implied. Cathell conceived his guide as having a broader readership, though he acknowledged that 'youthful' practitioners 'encounter[ed]

[9] De Styrap, *A Code of Medical Ethics* (London: Churchill, 1878), p. 6.
[10] 'Reviews and Notices: The Physician Himself', p. 1258.
[11] See, for example, Robert M. Veatch, *Disrupted Dialogue: Medical Ethics and the Collapse of Physician-Humanist Communication (1770-1980)* (New York: Oxford University Press, 2004).
[12] Lilian R. Furst, *Between Doctors and Patients: The Changing Balance of Power* (Charlottesville: University Press of Virginia, 1998).

difficulties that older physicians do not'.[13] De Styrap's major innovation was to reframe Cathell's material, directly addressing it towards the young practitioner. This chapter thus draws largely on de Styrap's guide, while recognising that he did not modify materially the tenets of Cathell's earlier work.[14]

The medical press was another source of advice on how to navigate the exigencies of professional life. Journals regularly featured content relevant to the experiences of young practitioners, printing correspondence on the pressures they faced in practice and publishing addresses that had been delivered to students and graduates at medical schools. Like advice literature, these addresses usually instructed their audience on the duties and expectations of practice. They typically involved older, established professionals guiding and shaping the values of their junior colleagues. As I will discuss, advice manuals and journals variously functioned as *Bildungsroman,* foregrounding a narrative of development.

This genre also shaped representations of the young practitioner in literature. The chapter explores fiction from either end of my period. It considers 'Early Struggles', the first instalment of Samuel Warren's *Passages from the Diary of a Late Physician,* which appeared in *Blackwood's Magazine* in 1830. It also examines Conan Doyle's short stories 'A False Start' (1891) and 'Behind the Times' (1894), both of which appeared in his *Round the Red Lamp* collection. In addition, I consider his epistolary novella *The Stark Munro Letters* (1895), which comprises a series of letters written by the titular protagonist to an old friend. While Warren draws on melodrama, Conan Doyle's stories are written in a comedic vein. Nevertheless, both writers were seen to offer credible or authentic portraits

[13] Daniel Webster Cathell, *Book on the Physician Himself,* 9th edn (Philadelphia: F.A. Davis, 1890), p. 3. Further references are given after quotations in the text

[14] When quoting de Styrap, I will provide citations to comparable passages in Cathell's work.

of the early struggles in practice. Warren's young physician seeks to establish himself as a consultant since he is not 'content with the humbler sphere of a general practitioner'.[15] By contrast, Conan Doyle's stories largely focus on general practice, reflecting its rising status at the *fin de siècle*.

Medical historians have scrutinised the experiences of aspiring young practitioners. Thomas Neville Bonner's comprehensive *Becoming a Physician* focuses on medical education, tracing the disparate routes into practice.[16] Anne Digby's *Making a Medical Living* and Anne Crowther and Marguerite Dupree's *Medical Lives* both examine the early years in practice, identifying patterns in medical men's movements. They illustrate that decisions about where and how to practise were shaped by both personal and professional considerations.[17] These historians draw on medical writing as evidence of the difficulties facing young practitioners. Building on previous work, this chapter looks at a diverse range of texts and investigates the interactions between them. Using the tools of literary studies and cultural history it elucidates how the young practitioner's professional identity was constructed in both the medical and popular imagination.

This chapter considers representations of hospital and private practice, but it concentrates on the latter, which was the focus of many of my primary texts. It begins by interrogating how a medical man's early years in practice were constructed as a formative time in which he explored different career options and refined his skills. It considers how disparate texts were understood to have a didactic function. This chapter then explores representations of the young practitioner's pecuniary anxieties and how texts engaged with

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[15] Samuel Warren, 'Early Struggles', in *Passages from the Diary of a Late Physician*, 2 vols (Edinburgh: Blackwood, 1844) i, pp. 3-33 (p. 11). Further references are given after quotations in the text.
[16] Thomas Neville Bonner, *Becoming a Physician: Medical Education in Great Britain, France, Germany, and the United States, 1750-1945* (New York: Oxford University Press, 1995).
[17] M. Anne Crowther and Marguerite W. Dupree, *Medical Lives in the Age of Surgical Revolution* (Cambridge: Cambridge University Press, 2007). Anne Digby, *Making a Medical Living: Doctors and Patients in the English Market for Medicine, 1720–1911* (Cambridge: Cambridge University Press, 1994).

the remunerative side of medical practice. It subsequently examines how the young practitioner was depicted in terms of his relationships with his patients and, finally, through his interactions with colleagues. Throughout the chapter, I emphasise how ideas about medical etiquette shaped the young practitioner's professional identity.

1. Formative experiences

In Victorian medical and popular writing, a practitioner's 'early struggles' were seen to encompass roughly the first decade after he had received his qualification and/or licence to practise. Men had traditionally entered the profession from different backgrounds. Physicians had always been university-educated, while surgeons and apothecaries had usually undergone apprenticeships, sometimes starting in their mid- to late teens.[18] From the mid-nineteenth century onwards, apprenticeships were no longer the primary route into practice.[19]

The 1858 Medical Act instituted a central register for qualified practitioners and regulated entry requirements. For example, to commence practice, a man had to be 21 years old.[20] Nevertheless, there remained myriad routes available to aspiring practitioners – they could obtain a medical degree from a university or a licence from one of the UK's nineteen licensing bodies. Many held both. In *The Present State of the Medical Profession* (1860), William Dale bemoaned that this situation gave rise to 'unequal qualifications' and 'a multiplicity of titles'.[21] He set out the licensing bodies' variable requirements, which helps us to determine the likely age of the 'young' practitioner. Aspiring licentiates had to

[18]Joan Lane, 'The Role of Apprenticeship in Eighteenth-Century Medical Education in England', in *William Hunter and the Eighteenth-Century Medical World*, ed. by W.F. Bynum and Roy Porter (Cambridge: Cambridge University Press, 1985), pp. 57-104 (p. 72).
[19] Crowther and Dupree, p. 1.
[20] Crowther and Dupree show that some men studied medicine at a more 'advanced age' (which they define as over the age of 35) (p. 16).
[21] William Dale, *The Present State of the Medical Profession in Great Britain and Ireland* (London: Bennett, 1860), p. 2.

be 21 years old to enter the Royal College of Surgeons of England, but 26 years old for the Royal College of Physicians of London.[22] At the outset of Conan Doyle's *The Stark Munro Letters,* the eponymous protagonist (whose title 'Mr' indicates he is a surgeon) is 22, while Warren's narrator, a young physician, is 26 at the start of *Passages.*

The process of establishing oneself in practice was understood to take time and medical commentators warned aspiring practitioners to be realistic about their prospects. Reiterating Cathell's advice, de Styrap instructed his readers that unless they succeeded in 'establishing a fair reputation and practice in the first six or eight years, the probability is that [they] never [would]' (3).[23] The early struggles often extended well into a practitioner's mid-thirties, as historians have identified. M. Jeanne Peterson describes how, in London during the 1840s, a practitioner might expect to become an assistant surgeon at 31 and a full surgeon some ten years later.[24] This estimate is reiterated by Digby, who adds that 'the rewards came later' for those seeking 'élite status' compared to those in general practice.[25] Similarly, Roy Porter suggests that, during the 1880s, few doctors 'secured a competent living before they were approaching forty'.[26]

A medical man's formative years were often conceptualised as a period of trial-and-error in which he could explore different routes into practice.[27] In *The Stark Munro Letters,* the protagonist begins as an assistant in his father's practice but, since it is not large enough to support them both, he looks for work elsewhere. He applies to 'several steamship lines, and for at least a dozen house surgeonships', before taking up the post of

[22] Dale, p. 4, 8-9.
[23] Cathell, p. 2.
[24] M. Jeanne Peterson, *The Medical Profession in Mid-Victorian London* (Berkeley: University of California Press, 1978), p. 137.
[25]Digby, *Making a Medical Living*, p. 124.
[26] Roy Porter, *Disease, Medicine and Society in England, 1550-1860* (Basingstoke: Macmillan, 1993), p. 51.
[27] In *Medical Lives*, the chapter on 'first steps' examines the cohort's initial five years in practice. This largely entails the men exploring opportunities rather than settling into remunerative practice. Crowther and Dupree, pp. 122-51.

resident medical attendant to Lord Saltire's son, who suffers from a mental disorder.[28] Stark Munro later responds to an advertisement to assist Dr Horton in his 'large country and colliery practice' in Yorkshire (41), before entering a partnership with his old university friend James Cullingworth. At one point he receives an invitation to join a liner bound for South America as a ship's surgeon. The way in which Stark Munro flits between different opportunities is mined for its comic potential, but the range of options he considers was by no means improbable. In Keetley's *The Student's Guide*, the chapter entitled 'The Time Immediately Following Qualification' outlines a wide range of prospective openings. These include, but are not limited to, working as a resident house-surgeon or house-physician in a hospital; as an assistant medical officer to a lunatic asylum; as a public health officer; in the Indian Medical Service; or as a ship-surgeon.[29] Some positions were seen as especially transitory; Keetley advised the young practitioner against spending more than one year at sea, since the experience was prone to become 'demoralising to him from its laziness' (30). Many of the roles listed were – if not always desirable – tempting because they offered a fixed salary, though there was considerable variation across the country.

The two main options available to young men were in hospital or general practice. Crowther and Dupree found that a third of their cohort took up junior hospital appointments; they note that, while this is probably an underestimate, hospital practice was not the experience of the majority.[30] Entry-level roles included the posts of 'house'

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[28] Arthur Conan Doyle, *The Stark Munro Letters* (London: Amalgamated Press, 1907), p. 7. Further references are given after quotations in the text.
[29] Charles Bell Keetley, *The Student's Guide to the Medical Profession* (London: Macmillan, 1878), pp. 27-35. Further references to this edition are given after quotations in the text. A revised and expanded edition of the book appeared in 1885. I use the earlier version to demonstrate how advice literature developed over time. The chapter in question was not materially altered in the later edition: the advice on private practice remained the same, though it noted the improved opportunities available in the medical departments of the army and navy. Keetley, *The Student's and Junior Practitioner's Guide to the Medical Profession* (London: Baillière, Tindall and Cox, 1885), p. 42.
[30] Crowther and Dupree, p. 127.

physician or surgeon, working among inpatients on the wards or outpatients in the dispensary. Keetley estimated that a resident in a London hospital would usually get his board and lodgings, while in the country he could also earn £80-100. There was the possibility of deriving further income from students' fees or providing evidence in court (29). While direct remuneration was small, these roles were highly sought after since they enabled practitioners to raise their profile. Early hospital appointments were often preludes to private practice as a consultant; Keetley suggested that they served to 'introduce[…] a man to a locality', making it 'much easier for him to make a practice there afterwards' (29). House physicians or surgeons might also rise within the hospital to the position of assistant, while developing a private practice concurrently.[31] There was considerable fluidity between roles in this period.

Hospital work was regarded as having an instructive function. *The Student's Guide* suggested that, following graduation, it was of both 'educational' and 'commercial' value, since the public understood that it gave a practitioner 'confidence and practical knowledge'. Keetley advised his readers that '[m]edical education ought not to be considered to terminate naturally and properly at the time of qualification' (27). The idea that the newly qualified practitioner needed help to become a 'finished article' was a common refrain among medical commentators, regularly appearing in addresses to medical graduates.[32] In 1879, John G. McKendrick, Professor of the Institutes of Medicine, told a cohort at the University of Glasgow that, 'not one in ten of the medical graduates of this or of any university […] is competent at once to undertake alone the grave responsibilities of private practice'. He recommended that they spend at least two years

[31] Crowther and Dupree, p. 198.
[32] Crowther and Dupree, p. 179.

working in a hospital or as an assistant in private practice first.[33] There was some anxiety that graduates had not encountered sufficient cases. As mentioned in the introduction, it was not until 1886 that legislation required basic qualifications across medicine and surgery and some training in midwifery for entry to the Medical Register. The notion of the qualified doctor honing his skills in the hospital was often distinct from conceptions of private practice. In an address to medical graduates at the University of Edinburgh in 1876, Joseph Lister – Professor of Surgery – emphasised that the private patient 'expects you to treat him, not to study him'.[34]

General practice was the experience of most practitioners.[35] Young medical men might variously enter into assistant- or partnerships with another practitioner, buy an established practice, or set up independently. Those following the last two options found themselves thrown on their own resources. While hospital practice was relatively supported and structured, offering immediate access to patients and colleagues, private practice was regarded as more precarious and uncertain. Thus advice literature was often marketed towards young men hoping to establish themselves in family practice. On its title page, *The Young Practitioner* was framed as offering 'subsidiary aids' for those entering 'private practice'. Reviewing the book, the *BMJ* suggested it would be a valuable compendium for recent graduates, since even the aspiring medical man who leaves his hospital training 'fully armed to deal with disease in every form' may 'yet be a miserable failure in general practice'. Like the address to graduates, advice literature was predicated on the idea that the young medical man needed further instruction. The *BMJ* reviewer noted that de Styrap dealt with information on 'many points not taught in the schools, and

[33] John G. McKendrick, 'Address to the Graduates in Law and Medicine of the University of Glasgow, on 31st July, 1879', *Glasgow Medical Journal*, September 1879, pp. 161-71 (p. 164).
[34] 'Medical News', *EMJ*, September 1876, pp. 280-5 (p. 282).
[35] Crowther and Dupree found that most of their cohort entered general practice. The term 'general practitioner' remained unpopular, however, and many self-identified as surgeons or physicians, pp. 179, 28-9.

guidance in many difficulties not dealt with in textbooks'. It emphasised that 'the real difficulties' of the profession were 'not so much those which touch the brain as those which demand the whole man himself'.[36]

The *BMJ*'s reviewer identified some of the key themes of advice literature, which melded ideas about morality, masculinity, and professionalism. The expanded edition of Keetley's *The Student's Guide* (1885) included a quotation from Astley Cooper which emphasised that success and happiness in practice depended not only on knowledge and industry but 'the preservation of your moral character'.[37] The *BMJ* review indicated its approbation for de Styrap's high-minded register, noting that,

> [t]he standards which [de Styrap] sets up for our conduct towards the public and towards each other is perhaps almost too high; but though it may be beyond the attainment of all men at all times, yet it is well that the standard would be put high.[38]

This chapter will examine how medical etiquette governed ideas about one's interactions with patients and colleagues. Although the *BMJ*'s review of *The Physician Himself* was broadly positive, its response to de Styrap's version was even more adulatory. It only fleetingly acknowledged de Styrap's debt to Cathell. The *Edinburgh Medical Journal*'s (*EMJ*) review cited de Styrap's main innovation as revising the material to better suit a British context. It similarly praised the book's emphasis on gentlemanly conduct, noting that 'you can't make a gentleman by writing out rules, but you can often prevent solecism of behaviour by a wise hint to a young man'.[39] Both reviewers commended de Styrap's efforts to mould the young practitioner's professional identity. The title of his book demonstrated his conviction that young medical men needed to be actively inculcated with ideas about etiquette and a sense of duty.

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[36] 'Review: The Young Practitioner', *BMJ*, 13 September 1890, pp. 632-3.
[37] Keetley, *The Student's Guide* (1885), p. 38.
[38] 'Review: The Young Practitioner', p. 633.
[39] 'Reviews: The Young Practitioner', *EMJ*, March 1890, p. 854.

Professional advice guides were typically written from positions of authority, with writers drawing on their own experiences in practice. When *Medical Ethics* was published, Percival was 63 years old and had already enjoyed an illustrious career at the Manchester Infirmary. He referred to the book as the 'conclusion […] of [his] professional labours'.[40] When *The Young Practitioner* was published, de Styrap was 75 and had an esteemed career behind him. He retired early from clinical practice due to illness, but he remained a prominent member of the profession.[41] His earlier works – the *Code* and *The Medico-Chirurgical Tariffs* (1874) – were both well-received and indicate that his interests in the ethical and business aspects of medical practice preceded the publication of *The Physician Himself*.[42] Cathell was only 43 years old and developing a private practice as a physician in Baltimore when his book appeared. By contrast, Keetley was a relatively young practitioner when he published *The Student's Guide* at the age of thirty. However, he had already attained the post of Assistant Surgeon to the West London Hospital, thereby cementing his status.[43]

The profession tended to privilege the voices of older and more experienced men. The fact that the physician in Warren's 'Early Struggles' finds his proposed textbook on the *Diseases of the Lungs* rejected because he is 'too young […] to have seen enough of practice' indicates the way in which the medical publishing industry endorsed a link between age and authority (7). Medical addresses and advice literature were typically

[40] Thomas Percival, *Medical Ethics* (Manchester: Bickerstaff, 1803). Further references are given after quotations in the text.
[41] De Styrap studied at King's College London, before working in Ireland during the 1830s and 40s. He later set up practice in Shrewsbury, where he held positions at the Salop Infirmary and South Salop and Montgomeryshire Infirmary. He founded the Salopian Medico-Ethical Society and sat on the Shropshire Ethical Branch of the British Medical Association. In 1864 he suffered a severe illness. Veatch, p. 76.
[42] 'Review: The Medico-Chirurgical Tariffs', *BMJ*, 14 April 1888, p. 804.
[43] This position was above that of house surgeon but below the more prestigious appointment of full surgeon. In 1863, a *BMJ* article railed against the titles of assistant- physician and surgeon as 'unfitting, unjust, and inappropriate'. It suggested that these men were not so much subordinates as 'a set of extra physicians and surgeons'. 'Title of Assistant-Physician and Assistant-Surgeon', *BMJ*, 17 October 1863, pp. 427-8 (p. 427).

structured around the idea of the author or speaker as a 'mentor' and the reader or audience as 'mentee'. *Medical Ethics* epitomised this paternalistic approach. It began with a dedication to Percival's son Edward, a medical student at Edinburgh. The author described how he composed the book with another son (then deceased) in mind. He explicitly framed his work as 'a paternal legacy' (x). While this looked back to an eighteenth-century tradition of instructive literature which fathers bestowed upon their sons,[44] it also anticipated the way in which professional conduct manuals took the form of a *Bildungsroman.*

Print culture also enabled young medical men to participate in the process of identity formation. Medical journals featured letters from those at the beginning of their careers (as I will show), while writers such as Conan Doyle used fiction to represent their experiences of the early struggles in practice.[45] After graduating with a medical degree from Edinburgh in 1881, Conan Doyle spent nearly a decade working in medicine before deciding to focus on his literary career instead.[46] In 1910, he delivered an address entitled 'The Romance of Medicine' to students at the medical school of St Mary's Hospital, which was subsequently published in its *Gazette.* He acknowledged that he had 'no possible claim to be regarded as a successful medical man'. However, he suggested that since his practice had been 'very varied' and he had seen the profession from 'several points of

[44] Percival also published a book entitled *A Father's Instructions to His Children* (1776), a 'compendium of moral guidance and religious instruction'. Veatch, p. 61.
[45] Geoffrey S. Stavert, *A Study in Southsea: The Unrevealed Life of Dr Arthur Conan Doyle* (Portsmouth: Milestone, 1987), p. 5. Russell Miller, *The Adventures of Arthur Conan Doyle* (London: Random House, 2008), p. 90.
[46]Jeffrey and Valerie Meyers (eds.), *The Sir Arthur Conan Doyle Reader: From Sherlock Holmes to Spiritualism* (New York: Cooper Square Press, 2002), p. xxxiv.

view', he had valuable advice to impart.[47] While reflecting on a formative time, Conan Doyle employed a retrospective lens, which buttressed his authority.

Some commentators regarded Conan Doyle's medical fiction as serving an instructive purpose for practitioners. When the *MPC* reviewed *The Stark Munro Letters* upon its publication, it began by noting that it was 'not [its] custom to review works of fiction'. It decided to 'willingly make an exception' for two reasons: firstly, because 'the author [was] an M.D. of the University of Edinburgh' and secondly 'because [the novel] deals to a very large extent with medical subjects, and contains suggestions which cannot fail to prove of value both to practitioners and students'. The review even suggested that the novel resembled an 'Introductory Lecture'. After initially setting up a distinction between fiction and medical writing, the reviewer blurred these boundaries, arguing that medical men should read the novel precisely because of its popular appeal: 'as it is sure to be in the hands of every patient we cannot do better than advise every medical man to study it with care'.[48] This review indicated Conan Doyle's continued standing among the medical community. The fact he was later invited to give an address to St Mary's medical school is further testament to this.

When Warren's *Passages* originally appeared, it was anonymous, and many readers believed it was autobiographical, that the author was a physician sharing the details of real-life cases. Warren studied medicine at the University of Edinburgh between 1826-7, but he did not practise and later entered the law. Upon the stories' publication, a correspondent to the *Lancet* protested against *'[t]he custom of disclosing to the public the sacred secrets which are communicated to us in perfect confidence by our patients'.* He

[47] Conan Doyle, 'The Romance of Medicine', *St Mary's Hospital Gazette*, October 1910, pp. 100-6. Reprinted in *Round the Red Lamp,* ed. by Robert Darby (Kansas City: Valancourt Books, 2007), pp. 306-20 (p. 306).
[48] 'Literature: The Stark-Monro [sic] Letters', *MPC,* 16 October 1895, p. 404.

feared that the author's apparent betrayal of patient confidentiality would undermine the profession's reputation.[49] *Blackwood's* obituary for Warren in 1877 recalled the controversy surrounding *Passages*, noting that '[t]he profession was indignant at the [implied] breach of etiquette'.[50] *Passages* was regarded as sensationalist; the short-lived medical journal *The Doctor* suggested it 'wore the air of melodrama rather than the stern realities of life'.[51] Other commentators, however, considered its depiction of the early struggles in practice not only credible but even instructive. William Alexander Greenhill's *Address to a Medical Student* (1843) warned aspiring practitioners not to 'fancy that Medicine is the way to wealth and honours', noting that even when physicians did become celebrated, it was often 'only after going through some of those fearful "Early Struggles", so graphically described in the *Diary of a Late Physician*'.[52] Greenhill presented the text as a cautionary tale for ambitious young medical men. As Megan Coyer describes, recent scholars have variously read *Passages* as 'both contributing to and detracting from' the professionalisation of medicine.[53]

Lay authors' depictions of young practitioners were also considered educational. Medical commentators suggested that these characters could act as role models for aspiring medical men and help to improve the profession's public image. The *Lancet*'s article on 'The Doctor in Fiction' (1888) praised George Eliot for her representation of a 'young and high-spirited surgeon' in *Middlemarch* (1872). It described Tertius Lydgate as 'a professional portrait of which we might justly be proud'. Nevertheless, the article did not imply that fiction should offer solely affirmative portraits of medical men. It expressed amusement with *The Pickwick Papers* (1837), suggesting that, since Dickens 'delighted to

[49] 'Blackwood's Magazine, v. the Secrets of the Medical Profession', *Lancet,* 28 August 1830, pp. 878-9.
[50] 'Samuel Warren', *Blackwood's Edinburgh Magazine,* 122 (September 1877), 381-90 (p. 382).
[51] 'The Real Diary of a Physician', *The Doctor*, 3 April 1833, p. 324.
[52] William Alexander Greenhill, *Address to a Medical Student* (London: Rivingtons, Churchill, 1843), p. 15.
[53] Megan Coyer, *Literature and Medicine in the Nineteenth-Century Periodical Press:* Blackwood's Edinburgh Magazine, *1817-1858* (Edinburgh: Edinburgh University Press, 2017), p. 125.

paint […] oddities', it was unsurprising he should 'find a congenial subject in the freaks of the medical student of the day'.[54] However, a later item from the journal's Liverpool correspondent bemoaned Benjamin Allen and Bob Sawyer's prominence in the popular imagination. It was concerned that such 'little account' was taken of the author's later creation, Allan Woodcourt, 'the nobly self-denying young doctor' from *Bleak House* (1853).[55] Medical commentators cited Woodcourt as a useful paradigm for young men, one which might help temper their unrealistic expectations of fame and material reward, as I will discuss in Chapter Two.

2. Business aspects of medicine

This chapter opened by quoting a letter from 'One of the Crowd', which linked the early struggles in practice to competition and overcrowding in the profession. The dynamics of the 'medical marketplace' in this period have been analysed by scholars. Irvine Loudon, for example, suggests there was an 'over-production of practitioners' during the first half of the nineteenth century.[56] Digby contends that these pressures in general practice were not relieved until the National Insurance Act (1911) reduced financial uncertainty and made it easier to start in practice.[57] More recently, Mark Jenner and Patrick Wallis have questioned the rigour of the 'medical marketplace' approach. They argue that greater attention should be paid to analysing 'the ways in which medicine has been conceptualized and imagined through the languages of trade, market and political economy'.[58] I will consider how medical writing and fiction negotiated the commercial aspects of practice

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[54] 'The Doctor in Fiction', *Lancet*, 7 April 1888, pp. 685-6.
[55] 'Liverpool: From our Own Correspondent', *Lancet*, 15 October 1892, pp. 911-2 (p. 911).
[56] Irvine Loudon, *Medical Care and the General Practitioner, 1750-1850* (Oxford: Clarendon Press, 1986), p. 7.
[57] Digby, *The Evolution of British General Practice, 1850-1948* (Oxford: Oxford University Press, 1999), p. 18.
[58] Mark Jenner and Patrick Wallis (eds.), 'The Medical Marketplace', in *Medicine and its Market in Britain and its Colonies, c.1450-c.1850* (Basingstoke: Palgrave, 2007), pp. 1-23 (p. 17, 10).

while promoting ideals of professional respectability. As historians have suggested, the profession sought to rid itself of its associations with trade and establish its 'genteel status'.[59]

Medical writing and fiction suggested that the young practitioner's early experiences were governed by his pecuniary anxieties. In Warren's 'Early Struggles', the protagonist finds that he has gone through one year 'almost without feeling a pulse or receiving a fee' and describes himself as 'baffled in every attempt to obtain a permanent source of support from [his] profession' (5, 16). Despite practising 'the most rigid economy in [his] household expenditure', he faces increasingly straitened means (11). His debts steadily accumulate to the point that he considers himself on the brink of 'absolute starvation' (24). At the nadir of his situation, he is put in a 'sponging-house', a place of temporary confinement before one is taken to debtor's prison, though he is reprieved after his lodger covers his bail (28). The narrative emphasises the young physician's material deprivations, but also his psychological despair. At one point, he awakes each morning 'more dead than alive', fearing that he is on 'the precipice of ruin' (12). His situation is even more pressing because he has a wife (and later a baby) to support. Initially 'a lovely young creature', his wife Emily falls into 'a low, nervous, hysterical state' (29). The reader's sympathy is sustained because Emily is shown to be a modest and supportive wife, unlike *Middlemarch*'s Rosamond, who is extravagant with her husband's money.

Given *Passages* is written in a melodramatic mode, it is unsurprising that Warren represents the extremes of hardship in such vivid detail. Yet he did not necessarily overstate the pressures facing the young practitioner. Robert Woods' research on mortality and morbidity among medical practitioners from the 1860s-1911 demonstrates the

[59] Digby, *Making a Medical Living,* p. 6.

vulnerability of young doctors (whom he defines as those under the age of 35). He suggests that the medical profession had high suicide rates when compared with other occupations. Those most at risk were young practitioners, since 'prestige and position' seems to have screened more established medical men.[60]

Conan Doyle's fiction also explores the young medical man's pecuniary anxieties, though in less sensationalist language. 'A False Start' opens with its protagonist, the young Dr Horace Wilkinson, mistaking an officer from the Gas Company for a prospective patient. His desperation has reached such a pitch that he has become almost predatory in his approach to practice: '[i]n the thick, burly man in front of him, he scented a patient, and it would be his first'. After the visitor reveals the reason for his call (he has come to collect a debt) and takes his leave, Wilkinson returns to 'the terrible occupation of waiting', an activity which characterises his professional life. Keen to cultivate an image of industry and professionalism, he 'fill[s] up' the pages of his ledger, day-book, and visiting-book with 'notes of imaginary visits paid to nameless patients'.[61] Like Warren, Conan Doyle presents his readers with an apparent paradox: a doctor without any patients. He recycled this encounter between a young practitioner and a gas officer mistaken for a patient in *The Stark Munro Letters* (123-4).

Both Conan Doyle stories are broadly comic in tone, though they sympathetically represent the young practitioner's struggles. Writing to his friend about the incident, Stark Munro notes, '[y]ou'll laugh, Bertie, but it was no laughing matter to me' (123). He describes how he has 'ebbed and flowed, sometimes with a little money, sometimes without. At my best I was living hard, at my worst I was very close upon starvation' (132).

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[60] Robert Woods, 'Physician, Heal Thyself: the Health and Mortality of Victorian Doctors', *Social History of Medicine,* 9 (April 1996), 1-30 (p. 30).
[61] Conan Doyle, 'A False Start', in *Round the Red Lamp*, pp. 45-58 (p. 45, 47). Further references are given after quotations in the text.

Meanwhile, in 'A False Start', Wilkinson is plagued by 'eternal little sordid money troubles' (47). Neither character experiences the penury of Warren's narrator. Conan Doyle was perhaps sensitive to his readers' tastes; 'A False Start' first appeared in a Christmas edition of *Gentlewoman* magazine, where there was probably little appetite for graphic descriptions of hardship. The story's accompanying illustrations depict Wilkinson as simply but smartly attired, respectable if not wealthy.[62] Nevertheless, even a hint of straitened means was likely to have resonated with readers. The seasonal issue's wrapper teemed with advertisements for luxury items; against this backdrop, Wilkinson's struggles would likely have aroused sympathy.

Conan Doyle did not necessarily pander to his middle-class readers' delicacies, however. Both he and Warren carefully enumerate their characters' financial hardship. In 'Early Struggles', the young physician calculates that he has '£300 in the world, and £450 yearly to pay to an extortionating old miser' (his money-lender). He estimates that his meagre practice gives him 'about £40 per annum', and that he makes an additional £25 from contributions to magazines (12, 16). In 'A False Start', Wilkinson realises he cannot pay the Gas Company because he has only 'two half-crowns and some pennies' in his purse and 'ten gold sovereigns in the drawer' (47). The attention to detail is extraordinary. As Simon James suggests, '[t]he presence of money in a narrative almost functions as a kind of index of fidelity to real life, […] a guarantee of grimy realism'.[63] The extent of the men's poverty can be judged when one considers Loudon's estimation that, between 1820-

[62] In *Gentlewoman,* the story was accompanied by three illustrations. The final two were signed by Everard Hopkins, while the first is co-signed with H.F. Davey. Conan Doyle, 'A False Start', *Gentlewoman,* Christmas 1891, pp. 2-4.
[63] Simon James, *Unsettled Accounts: Money and Narrative in the Novels of George Gissing* (London: Anthem Press, 2003), p. 3.

1850, the average income for a country general practitioner was about £150-250, and £300-500 for a relatively successful town-based one.[64]

Periods of struggle and uncertainty characterised not only the early years of practice, but the later stages as well. In *The Stark Munro Letters*, the protagonist is partly motivated by the need to support his family, since his father, a doctor making £500 a year, is unable to do so comfortably. Stark Munro describes 'how hard a fight it is with him to keep the roof over our heads and pay for the modest little horse and trap' needed for his work (23). Nevertheless, the young practitioner was depicted as particularly vulnerable, since both his living and his reputation among patients were insecure.

Warren's narrator suggests that he has been thwarted by his 'ambition' and 'egregious vanity' in attempting to pursue fashionable metropolitan practice. He contends that the 'humbler sphere' of general practice would have enabled him to acquire a 'respectable livelihood' (11). Coyer describes how *Passages* was originally intended for the *New Monthly Magazine*, which featured attacks on the medical elite. Had it appeared in this context, it might have been read as satirising the narrator's own elitism and pretensions. However, Coyer suggests that the stories were read more sympathetically in *Blackwood's,* which instead offered an 'ideal platform' to represent the young physician as a 'professional man of feeling'.[65] In Conan Doyle's 'A False Start', Wilkinson does not attempt to practise in the fashionable metropolis but chooses the 'bustling, prosperous town' of Sutton (48). Like Warren's protagonist, he seeks to capitalise on the easy availability of patients. Although a physician by training, he seems more willing to pursue general practice, perhaps because it had achieved greater social acceptance by the *fin de siècle.* He also prepares his own medicines, reasoning that 'in such cities as Sutton there

[64] Loudon, *Medical Care,* p. 261.
[65] Coyer, p. 126.

are few patients who can afford to pay a fee to both doctor and chemist'. He acknowledges that the physician must be 'prepared to play the part of both' to 'mak[e] a living' (50). Charging for medicine was contentious given its associations with trade, as I will explore in Chapter Three.

One of the reasons why young practitioners struggled to establish themselves was the disinclination towards advertising, which was also regarded as antithetical to ideas of gentility. Such disapproval is expressed in an article entitled 'Advertising by Medical Men' which appeared in the *MPC* in 1896. It argued that:

> Medical men are not tradesman, and even if some of them should so regard themselves and feel inclined to resort to advertising for the purpose of obtaining practice, they cannot do so save at the risk of compromising the honour of their profession.[66]

Advice guides such as *The Physician Himself* explicitly warned against 'self-advertising', linking it to quackery (89). Nevertheless, Cathell recommended that doctors display a fee tariff in their consulting-room, a move that was judged to be inappropriate by some reviewers. When the *BMJ* highlighted that there were cultural differences between American and British practice, it suggested that the former permitted 'more licence in the way of advertising'.[67] It was anxious to prevent British readers from following Cathell's advice.

In the face of this prohibition on advertising, young medical men in Britain were shown to employ indirect means of self-promotion. It was common for practitioners to signify their presence in a neighbourhood through the display of a red lamp and brass nameplate. However, Keetley was sceptical that these methods would enable young men to

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[66] 'Advertising by Medical Men', *MPC*, 30 December 1896, pp. 684-5 (p. 684).
[67] 'Reviews and Notices: The Physician Himself', p. 1258.

build a practice in ‘a sober, slow place where the doctors already in possession are sound men liked by their patients’, particularly if they lacked capital to support themselves (34).

There were also more creative ways to advertise covertly. In Conan Doyle’s short story ‘Crabbe’s Practice’ (1884), the narrator helps his friend – the struggling young practitioner of the title – to stage an accident to attract public interest. The protagonist pretends to drown so that Crabbe can perform a remarkable resuscitation. As hoped, the act raises his profile among the local community and establishes him in practice. The farcical sequence of events was clearly intended to amuse Conan Doyle’s juvenile readership – the story originally appeared in the *Boys’ Own Annual* at Christmas – but it also engaged with wider debates about the difficulties facing young practitioners.[68] Conan Doyle was only too familiar with these struggles. When he arrived in Southsea, without connections, he placed a discreet item in the local newspaper announcing his change of address. Later, after intervening in a horse accident, he arranged for the incident to be reported by the local press.[69] A fictionalised account of this appears in *The Stark Munro Letters*, where the protagonist justifies his actions by explaining that, ‘it is hard enough for the young doctor to push his name into any publicity, and he must take what little chances he has’ (134).

Medical writing and fiction suggested that projecting a genteel appearance could also help a practitioner to attract patients. In Warren’s *Passages,* the narrator expresses incredulity that ‘the regularity and decorum of [his] habits and manners’ have not served as a better advertisement for his services. He wonders whether he would have been more successful had he been able to ‘exhibit a line of carriages at [his] door, […] or dash about town in an elegant equipage, or be seen at the opera and theatres’ (8). Warren parodies the

[68] Conan Doyle, ‘Crabbe’s Practice’, in *Round the Red Lamp,* pp. 207-18.
[69] Stavert, p. 19, 25.

level of ostentation needed for the consultant to satisfy wealthy patients. Later advice manuals emphasised the importance of 'making a favorable impression'.[70] Cathell and de Styrap encouraged readers to consider factors such as their attire and choice of transportation. *The Young Practitioner* counselled its readers not to 'ignore the fashions of the day' but to avoid wearing anything 'glaring or flashy' (13).[71] While social conformity was regarded as key to winning the regard of prospective patients, some show of success was also considered advisable. De Styrap remarked that, '[t]he inexperienced public' would 'infer that a practitioner who finds a carriage necessary, must have an extensive and successful practice' (16-17).[72] He also provided advice on how to present one's consulting-room in a desirable manner, noting that patients would be 'sensibly impressed and influenced' by its arrangement (4-5).[73]

When the protagonist of *The Stark Munro Letters* settles in Birchespool, he prioritises furnishing his consulting-room but then realises he has no mattress on which to sleep. He remarks that his 'mind had been so centred upon the essentials for practice, that [he] had never given a thought to [his] own private wants'. He is adamant that he 'must show a presentable front to the public' (115-6). The fact that Wilkinson in 'A False Start' rearranges his room 'a dozen times in the day' indicates that a concern for outward appearances may become obsessive. His decision to fill up his books with 'imaginary visits paid to nameless patients' shows how the young doctor might be driven to fabricate details of his practice to create a positive impression (47). Moreover, he is scuppered by appearances – his first patient, the 'gipsy' woman, protests against paying a fee on the grounds that the doctor already seems to be 'living in the lap of luxury' (51). In medical

[70] Furst, *Between Doctors and Patients*, p. 3.
[71] Cathell, p. 18.
[72] Cathell, p. 22.
[73] Cathell, pp. 5-6.

fiction, a preoccupation with external appearances is satirised, but also used to create pathos. Though there may be feelings of personal pride at stake, maintaining appearances is presented as a matter of professional pragmatism. Without a genteel reputation, the young practitioner could not hope to attract remunerative patients.

Medical historians such as Digby suggest that the 'possession of social connections' was advantageous to the development of a 'viable practice'.[74] One of the reasons why the young practitioners in Warren and Conan Doyle's fiction struggle to secure a foothold is that they are unknown. In 'Early Struggles', the protagonist regards his 'want of introductions' as a 'great misfortune'. He attempts to draw upon tentative family connections – begging help from 'a sort of fiftieth cousin' – but is mortified when his applications are met with a cool response (8). In *The Stark Munro Letters,* the protagonist attempts to establish himself in practice in Birchespool, 'without connections, without introductions' (126). Finally, in 'A False Start', Wilkinson is shocked when he is summoned by the wealthy Millbank family precisely because he is 'obscure, unknown, without influence'. He is sure '[t]here must be some mistake' (52). Which, it soon transpires, there has been.

The notion that social contacts facilitated professional success was widespread, but did not go unchallenged. De Styrap conceded that a doctor must 'put [himself] on a conversational level with the cultured classes of society' (71). However, he discouraged his readers from relying upon their 'social influence', warning that 'even your truest friends and well-wishers may well prefer that you should test your skill and gain your experience by attendance on others rather than on themselves and their families'. Moreover, he suggested that – in times of trouble – friends would rely on the doctor whom

[74] Digby, *Evolution,* p. 13.

they most trusted, rather than 'the young medical friend of whose unpractised skill they know too little' (72-3).[75]

Whether they worked in hospital or private practice, young medical men's earliest patients were likely to be drawn from the lower classes. Adapting an image from Cathell's text, de Styrap informed his readers that, '[y]our reputation will probably begin […] in the back streets and alleys, among the very poor' (37).[76] In *The Stark Munro Letters*, when the protagonist enters into an assistantship with Horton, he is allocated the working-class patients. He describes how a typical morning begins with 'Horton in a carriage and pair to see the employers; I in a dog cart to see the employed'. Many of these men are members of 'colliery clubs' who pay a fixed, year-round fee for medical attendance. Stark Munro acknowledges that club practice is held in low regard, but suggests that the income is nevertheless a 'certainty' and 'mounts up surprisingly' (43). When he later establishes his own practice, he reflects how his first patients have 'nearly all been very poor people' (132).

Instead of seeking an illustrious clientele, some medical men tailored their practice towards the poor, offering low rates. De Styrap warned that 'undercharging' depressed fees and was thus 'injurious' to the individual practitioner's interests and 'to the interests of the profession at large' (209).[77] Nevertheless, there was some sympathy towards 'sixpenny' or 'shilling' doctors. In the *Lancet*, the correspondent 'One of the Crowd' argued that,

> Young medical men are often blamed for taking miserable low fees, but what is a man to do on finding himself fully fledged, with the accompanying honour of course, and not a farthing to his pocket […]?

[75] Cathell, p. 32, pp. 85-6.
[76] Cathell, p. 50.
[77] Cathell, p. 255.

The correspondent admitted that he might have become part of the 'large army of sixpenny doctors' had he not had 'small private means' to support himself through the early struggles in practice.[78] The snobbery directed towards low-paid work is also satirised in George Bernard Shaw's preface to his play *The Doctor's Dilemma* (1906)*:*

> If you are weak-minded enough to cling desperately to your eighteenpence as denoting a certain social superiority to the sixpenny doctor, you will be miserably poor all your life; whilst the sixpenny doctor, with his low prices and quick turnover of patients, visibly makes much more than you do.[79]

Both the *Lancet* correspondent and Shaw touch on the competing pressures of professional etiquette and financial hardship, showing little sympathy for those who deride the young practitioner's expediency.

Some commentators were anxious that struggling young practitioners might be tempted not only into poorly paid but also less salubrious work. De Styrap advised his readers that the 'severest test' they would face would be when 'a liberal enticing fee is seductively offered to induce [them] to undertake questionable matters'. Though he did not expand on what these may be, he suggested declining any fee 'under circumstances which you would not *willingly* submit to investigation by the public, a medical society, or a court of justice' (204).[80] He warned readers that 'attempts to conceal the presence of contagious diseases, […] or of births resulting from clandestine marriage or immoral intercourse' may 'involve [them] in the exposures and recriminations that are apt to follow' (53).[81] Like Cathell, de Styrap repeatedly linked openness to professional honour. While medical men might encounter sensitive cases at any stage of their careers, it was perhaps young practitioners who were more vulnerable to emotional appeals or pecuniary temptation.

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[78] 'One of the Crowd', p. 213.
[79] George Bernard Shaw, 'Preface on Doctors', *The Complete Prefaces of Bernard Shaw* (London: Hamlyn, 1965), p. 224.
[80] Cathell, p. 248.
[81] Cathell, p. 270. Medical writers regularly advised caution when it came to cases of syphilis, particularly with men who might transmit the disease to their wives or children. See Alfred Fournier, *Syphilis and Marriage*, trans. by Alfred Lingard (London: David Bogue, 1881).

Medico-ethical and etiquette guides did not obscure, but actively engaged with, the financial struggles and commercial aspects of practice. Cathell and de Styrap's major contributions to the genre were to develop the precepts regarding medical charges. Building a remunerative practice was a central concern of *The Physician Himself* and *The Young Practitioner*. Both suggested in their opening pages that the doctor must 'possess a certain amount of professional tact and business sagacity' (Cathell 1, de Styrap 2). They gave practical suggestions on how to obtain appropriate remuneration. For instance, they advised readers to implement night-visit fees for calls made after bedtime and recommended instituting higher charges for contagious cases, since these might deter other patients and prove time-consuming as the practitioner would need to disinfect himself afterwards. Both books were realistic about the difficulties of obtaining fees and provided guidance on how to collect money from those who delayed or avoided paying, a problem associated with patients of all social classes. De Styrap recommended that – with 'dissatisfied patients' – medical men should 'promptly send in [their] professional account'. He warned that failure to render a bill could be taken as an admission of guilt that the practitioner had made a mistake (47).[82] This advice was pertinent to medical men throughout their careers, but de Styrap (like Cathell) emphasised that it was crucial for practitioners to implement a consistent approach to charging from the outset: 'Let the public know in the early years of your practice what your rule or system is, or it will fail you in later life' (204-5).[83]

Given the exigencies of professional etiquette, young medical men may have found it difficult to navigate the commercial side of practice. In Warren's 'Early Struggles', the narrator describes how, on two occasions, he was 'called in at an instant's warning' only to

[82] Cathell, pp. 62-3.
[83] Cathell, p. 250.

find ‘the objects of [his] visits had expired before [his] arrival’. Although offered a fee, the ‘manner’ in which this was done implied that he would be ‘cursed for a mercenary wretch if [he] accepted’ (9). De Styrap anticipated that anxieties surrounding general practice’s old associations with trade might discourage new medical men from actively pursuing remuneration. Following Cathell’s lead, he reassured his readers that,

> Business is business and should always be regarded as such. The practice of medicine is your life’s vocation; it is as honourable, as useful, and as legitimate as any other; in fact, none other earns the means of living more justly and deservedly, than does the hard-worked general medical practitioner (200).[84]

Ultimately, he sought to legitimise the business side of medicine, suggesting that – if conducted fairly – it was compatible with a respectable and gentlemanly profession. This involved guarding against competitive or predatory practices. I will now consider how vexed attitudes towards medical charges were represented as affecting doctor-patient encounters.

3. Interacting with patients

As I have suggested, young practitioners were often associated with attendance on the poor. Some commentators represented this as a demoralising experience. In an article for popular periodical the *Modern Review,* Elizabeth Blackwell – the first woman on the Medical Register in Britain – expressed anxiety that contact with ‘the coarse, degraded, and unromantic sufferings of the poor’ through hospital training would encourage aspiring practitioners to regard such patients as ‘mere subjects for medical study’.[85] Medical writing sometimes demonstrated antipathy towards lower-class patients. In Warren’s ‘Early Struggles’ the young physician describes ‘being called in to visit the inferior members of families in the neighbourhood’, namely the servants, housekeepers, and

[84] Cathell, p. 245.
[85] Elizabeth Blackwell, ‘Medicine and Morality’, *Modern Review,* 2 (October 1881), 750-8 (pp. 752-3).

porters. He claims that 'of all the trying, mortifying occurrences in the life of a young physician, such occasions as these are the most irritating', not least because they involve using the servants' entrance (9). In Conan Doyle's 'A False Start', Wilkinson feels disdain towards the 'small hard-faced [gipsy] woman' who requests his services; he fears her family does 'not look very promising' (49). Both protagonists demonstrate remarkable snobbery towards their prospective patients, though readers may have sympathised with the notion of professional men being unable to secure a 'better class' of patient.

Service towards the poor was nevertheless represented as an act of charity or a professional duty. Examining debates about dispensaries in the early nineteenth century, Michael Brown suggests that there was increasing 'scepticism' towards medical charity and that the profession increasingly positioned itself as 'perform[ing] a public service'.[86] In medical writing and fiction, however, ideas of philanthropy and service often intermingled. De Styrap advised readers that they should be 'ever willing to do [their] share of charity for the deserving poor' (221).[87] Like Cathell, he drew upon the enduring rhetoric that distinguished between the 'deserving' and 'undeserving' poor. However, he also developed his source material by specifically counselling readers to adopt a considerate manner with patients across the social spectrum: '[b]e careful to approach the sick, rich and poor alike, with noiseless step, with kindly hopeful greeting and gentle, thoughtful speech' (34). In 'A False Start', Wilkinson adopts 'his very best sympathetic manner' with the 'gipsy' woman and her baby despite his initial disdain (49). In *Gentlewoman* magazine, the story was accompanied by an illustration showing the doctor looking over the pair tenderly and conscientiously.[88] In *The Stark Munro Letters*, 'close

[86] Michael Brown, 'Medicine, Reform and the "End" of Charity in Early Nineteenth-Century England', *English Historical Review*, 124 (December 2009), 1353-88 (p. 1364, 1370).
[87] Cathell, p. 271.
[88] Conan Doyle, 'A False Start', *Gentlewoman*, pp. 2-4.

contact with the working classes' is represented as a valuable formative experience. The protagonist tells his correspondent that it has 'made [him] realise what fine people they are', though his initial impression of them as 'very homely' hints at his condescension. His cheerful fondness for 'the grip of their greasy and blackened hands' oscillates between irreverence and sentimentality, reflecting the tone of the *Idler*, where the story originally appeared (44-5).[89]

Work among the poor was also regarded as serving a practical value. Like Cathell, de Styrap represented these patients as both more readily available and 'much easier to attend than the higher classes'. He described how 'their ailments are more definite and uncomplicated, the treatment more clearly indicated, and the response of their system is generally more prompt'. By contrast, the 'wealthy and pampered' often experienced a 'concatenation of unrelated or chronic symptoms' which they described in 'indefinite or exaggerated phrases' (38-9).[90] Despite these supposed differences in care and treatment, work among the poor was seen to help develop a practitioner's skills and reputation. De Styrap conceded that there may be 'little, or no pecuniary reward', but suggested that these cases would help to 'increase your fame, and, at the same time, educate both your hand and your eye'. He added, 'no matter whether in mansion, cottage, or hovel, every patient you attend, rich or poor, will aid in enriching your experience, and forming public opinion' (36-7).[91] These lines were almost directly transposed from Cathell, though the latter's vision of a cross-class practice also encompassed bridging the racial divide and treating black and white patients.

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[89] Laurel Brake and Marysa Demoor (eds.), *Dictionary of Nineteenth-Century Journalism in Great Britain and Ireland* (Gent: Academia Press, 2009), p. 300.
[90] Cathell, p. 51.
[91] Cathell, pp. 49-50.

Both Cathell and de Styrap implicitly constructed a hierarchy of patients, however. The poor were seen as a stepping stone in one's career, while professional success was associated with work among the wealthy. In 'A False Start', Wilkinson imagines how his initial encounter with the 'gipsy' family might develop into something more prosperous: '[t]hese wandering people have great powers of recommendation [...] The hangers-on to the kitchen recommend to the kitchen, they to the drawing-room, and so it spreads' (51). It is unclear whether this free indirect discourse reflects Wilkinson's wishful thinking or Conan Doyle's own view. Although writers such as Cathell and de Styrap discussed recommendations diffusing across the social hierarchy, they were sceptical about the utility of building one's reputation among the lower classes. De Styrap warned his readers that, '[p]eople who, in their minds, associate you professionally with [their] servants, are apt to form a low opinion of your status, and of the nature and class of your practice' (37).[92] Like Cathell, he was sagacious and warned readers that 'the necessity of earning a living' should make them 'careful not to let [low- or unpaid work] crowd out your more or less remuneratory practice' (221).[93]

For young medical men seeking entry to more illustrious practice, the prospect of a 'fortuitous encounter' with a wealthy patient was a well-established 'myth', as Dorothy and Roy Porter identify.[94] In Warren's 'Early Struggles', the young physician meets an elderly gentleman with a bad cough (Sir William) in St James's Park. He offers his medical opinion but refuses the guinea offered to him since the advice has only been 'trifling'. The protagonist later reproaches himself for failing to capitalise on the exchange, considering how some medical men 'with a more plausible and insinuating address […]

[92] Cathell, p. 50.
[93] Cathell, p. 267.
[94] Dorothy and Roy Porter, *Patient's Progress: Doctors and Doctoring in Eighteenth-Century England* (Oxford: Blackwell, 1989), p. 119.

would have contrived to get into the confidence of this gentleman, and become his medical attendant'. However, the use of language such as 'insinuating' and 'contrived' points towards the way in which such behaviour might be regarded as unethical or unprofessional. Indeed, the young physician characterises his reticence as 'sensitiveness to professional etiquette' (14-15). Later, de Styrap would advise his readers

> to make *no charge* for ordinary or trifling advice incidentally given to patients […] or to persons for whom you chance to prescribe in places of public resort, where you are *not* pursuing your professional avocation (222).[95]

In 'Early Struggles', the young physician's dilemma is solved when Sir William places an advertisement in the newspaper seeking the doctor with whom he met. This circumvents the need for the doctor to advertise his services.

The protagonist later has another fortuitous encounter, when he stumbles upon a young woman injured in a carriage accident. Someone raises the cry for medical assistance, and the young physician offers his services. He places the woman in a position to alleviate her suffering and prescribes her medicine, though a surgeon is called to reduce her dislocation and dress the wound. In this instance, the physician willingly accepts a generous ten-pound cheque offered by the woman's father, an Earl. De Styrap suggested that '[t]he instinct of humanity' should 'impel' the young practitioner to 'go to all cases of sudden emergency, accidents […] without regard to the *prospect*, or otherwise, of a fee' (222).[96] However, he did not suggest it would be unethical to accept payment. In 'Early Struggles', the fact it is willingly offered by such a wealthy individual absolves the practitioner from any charge of exploitation.

In Conan Doyle's 'A False Start', Wilkinson is reprieved through an equally fortuitous incident: a case of mistaken identity. He is summoned to attend the wife of local

[95] Cathell, p. 267.
[96] Cathell, p. 269.

luminary Sir John Millbank, only to discover that the presiding doctor (Dr Mason) actually recommended another (much more eminent) doctor of the same name be called in for consultation. Mason suggested that the family receive a second opinion from Sir *Adam* Wilkinson (lecturer on pulmonary diseases at Regent's College, London and physician at St Swithin's Hospital), not Dr *Horace* Wilkinson, the local practitioner with whom he is unfamiliar.

In both 'Early Struggles' and 'A False Start', professional success is engendered by chance or Providence. Warren's young physician describes how '[f]ortune […] at last seemed tired of persecuting me; and my affairs took a favourable turn' (30). This points towards problems latent in the profession; that the young doctor who lacks connections is relatively powerless in his attempts to secure a living. Yet the narratives also illustrate how tact, discretion, and perseverance are rewarded. Warren's young physician makes a positive impression on his wealthy prospective patients through his industry and conscientiousness. His 'unremitting and anxious attentions' towards the Earl's daughter please the family and he is soon invited to attend the invalided Countess as well, in tandem with their usual physician. After 'securing the confidence of the family' he is introduced to their wider circle and 'lay[s] the foundation of a fashionable and lucrative practice' (31-2). Wilkinson impresses the Millbanks inadvertently. When he rejects Sir John's suggestion that he treat Lady Millbank without a physical examination, the client assumes that his impertinence signals his disinterestedness, that he 'care[s] nothing either for his wealth or title'. Rather than being affronted, Sir John's 'respect for his judgement increased amazingly' (55). Whereas Warren's young physician is eager to avail himself of the opportunity to attend a wealthy family, Wilkinson is less sycophantic. The stories' resolutions are perhaps determined by their genre – Warren's is an appropriate end to a

melodramatic tale of a young man forced to undergo poverty and mortification, while Conan Doyle's is fitting for a light comedy designed for Christmas reading.

As these stories indicate, success in practice entailed not simply attracting patients but retaining them in a competitive marketplace. In 1803, Percival suggested young practitioners had an advantage over their older colleagues, since they might be supposed to have 'more ardour […] in the treatment of disease' and to be 'bolder in the exhibition of new medicine' (50). In the introduction, I discussed how the *Lancet*'s article on 'Types of Professional Character' valorised the scientific medical man.[97] However, towards the century's close, medical writers also displayed wariness about the desirability of a scientific approach to practice, which is perhaps surprising given medical advances in the period. Reiterating Cathell, de Styrap implied that it might alienate the public. He cautioned readers that few patients could judge 'the amount of technical and scientific knowledge that you possess'. Instead, '[t]he majority are governed by the care and the devotion you show' (35).[98] He suggested that,

> although young practitioners have recourse to *scientific* 'extras', and modern instrumental and other aids to diagnosis, more than do the older ones, yet, in relying too much on them and too little on rational, subjective symptoms, they seemingly ignore the fact that the *art* of curing disease is more indebted to sound judgment and common-sense bedside observation and experience than to aught else [emphases added] (76-7).[99]

In this passage, the young medical man is associated with science and modernity, while the older doctor is characterised by his 'bedside manner', conceived as an 'art' form. Furst suggests that Cathell's book – de Styrap's *urtext* – 'admits only halfhearted lip service to science'.[100] However, both writers seem to assume that readers already possess scientific knowledge and that they need to cultivate a more patient-centred approach instead.

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[97] 'Types of Professional Character', *Lancet*, 25 November 1876, pp. 754-5 (p. 754).
[98] Cathell, pp. 47-8.
[99] Cathell, p. 91.
[100] Furst, *Between Doctors and Patients*, p. 98.

In popular culture, the young doctor at the vanguard of science and medicine was a common trope. Occasionally, he was associated with dilettantism. In Anthony Trollope's *The Warden* (1855) the young surgeon John Bold is 'a clever man, and would, with practice, be a clever surgeon' but rather than 'subject[ing]' himself to the 'drudgery of the profession' he instead becomes a 'reformer'. In his gently satirical tone, Trollope explains that Bold's 'passion' is 'the reform of all abuses; state abuses, church abuses, corporation abuses […] abuses in medical practice, and general abuses in the world at large'.[101] In *The Woodlanders* (1886), Thomas Hardy describes how Dr Edred Fitzpiers is 'not a practical man' and 'much preferred the ideal world to the real'. Although he practises medicine, he dismisses it as a 'very rule of thumb matter', and contemplates 'abstract philosophy' instead.[102] Depictions of the intellectual young practitioner also appeared in fiction by medical authors, such as *Perfect Womanhood: A Story of the Times* (1895), a novel by surgeon Frederick Gant. While both its narrator and protagonist are doctors, the narrative shows little interest in medical practice. Algernon Graham, the central character, finishes his hospital training 'more inclined to natural science in future than fitted for the "patient" seeing work of the profession' and he follows 'the bent of his scientific inclinations and aptitudes'.[103] Bold, Fitzpiers, and Graham all have private means and pursue their intellectual interests away from the pressures of practice. The scientific intellectual and the struggling young practitioner were not mutually exclusive representational categories, however. For instance, in *Middlemarch,* Lydgate is a forward-thinking medical man, who applies his knowledge to patient care and treatment. His use of the stethoscope marks him

[101] Anthony Trollope, *The Warden,* ed. by David Skilton (Oxford: Oxford University Press, 2008), p. 15.
[102] Thomas Hardy, *The Woodlanders* (London: Macmillan, 1993), p. 115, 118, 122.
[103] Frederick Gant, *Perfect Womanhood: A Story of the Times*, 2nd edn (London: Digby, 1895), p. 26.

out as a thoroughly modern practitioner, for – at the time the novel is set (1829) – it 'had not become a matter of course in practice'.[104]

The overly scientific young medical man was satirised in fiction. In Conan Doyle's 'A False Start', Wilkinson tries to assert his medical authority by exhibiting his copy of *Quaint's Dictionary of Medicine* and making 'as good a show as possible' of his instruments (47). His enthusiasm runs counter to contemporary advice; de Styrap warned against the display of surgical instruments, suggesting they may be regarded as 'repelling objects' (4-5).[105] Although Wilkinson is 'young and elastic', he is simply 'a very reliable plodder, and nothing more' (49, 45). When confronted with a visitor he is stumped and 'rack[s] his brains for some clue'. He feels that '[s]ome of his old professors would have diagnosed his case by now, and would have electrified the patient by describing his own symptoms before he had said a word about them' (45). Youth is once again contrasted with age, with the latter placed in the ascendant position. Conan Doyle's use of the words 'clue' and 'case' in relation to a mysterious visitor undoubtedly prompts readers to think of Sherlock Holmes, who makes expert deductions from minute observations.[106] The pattern of reasoning that Holmes deploys is reversed here; Wilkinson's attempts to offer rapid, intuitive diagnoses are met with failure. Initially, he suspects that his visitor's ruddy complexion indicates inebriation, only to find it is an effect of the heat. He diagnoses the man's cough as bronchial, only to discover it comes from chewing tobacco. It transpires that the visitor is not even a prospective patient, but an officer from the Gas Company. It is unsurprising that Wilkinson struggles to deduce any physiological symptoms, since the

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[104] George Eliot, *Middlemarch*, ed. by David Carroll (Oxford: Oxford University Press, 2008), p. 268. Further references are given after quotations in the text. For an analysis of the stethoscope in literature, see Furst, *Between Doctors and Patients*, pp. 55-85.
[105] Cathell, p. 47.
[106] When *Round the Red Lamp* was released in 1894, Conan Doyle was already well-known as the author of the Sherlock Holmes stories. *A Study in Scarlet* (1887) and *Sign of Four* (1890) had been published, and the *Adventures of Sherlock Holmes* had run in *Strand Magazine* (1891-3).

man is quite well. In mistaking him for a patient, Wilkinson has perhaps failed to read social cues as much as medical ones. Ultimately, intuitive or exceptional diagnostic skill is not needed in this encounter. Indeed, its value is called into question throughout the texts discussed here, which usually emphasise the importance of experience, or a considerate bedside manner, to patient care.

Conan Doyle's 'Behind the Times' is narrated by a practitioner who is 'young, energetic, and up-to-date'. Yet he and his friend Dr Patterson experience the archetypal difficulties in attracting patients, finding that the local community prefers the more established practitioner, Dr Winter, instead. The protagonist remarks that, '[t]he patients themselves […] followed their own inclinations, which is a reprehensible way that patients have'.[107] The aptly named Dr Winter is 'a survival of the past generation'. His approach to medicine is parodied, with the narrator describing how he has failed to assimilate the latest scientific practices:

> Vaccination was well within the teaching of his youth, though I think he has a secret preference for inoculation. Bleeding he would practise freely but for public opinion. Chloroform he regards as a dangerous innovation (4).

Conan Doyle's humour relies upon a basic familiarity with medical advances but also turns on the enduring contrast between youth and age. Though he is backward in terms of scientific theory, Winter's bedside manner is popular and effective: 'He has the healing touch – that magnetic thing which defies explanation or analysis, but which is a very evident fact none the less. His mere presence leaves the patient with more hopefulness and vitality' (5). By contrast, the narrator and his friend Patterson 'remained neglected' by patients, despite their 'modern instruments' and 'latest alkaloids'. At the end of the story, the protagonist falls ill, and finds that the 'idea' of Patterson attending him 'had suddenly

[107] Conan Doyle, 'Behind the Times', in *Round the Red Lamp*, pp. 3-7 (p. 6). Further references are given after quotations in the text.

become repugnant': 'I thought of his cold, critical attitude, of his endless questions, of his tests and tappings. I wanted something more soothing – something more genial' (6). He opts for Winter instead. The narrator's reversal of opinion is a comedic close but also conveys the story's moral: when the doctor becomes the patient, he understands the allure of a sympathetic practitioner over a scientific one. 'Behind the Times' implies that young practitioners have much to learn from the older generation.

In *The Stark Munro Letters,* Cullingworth resists strictures about the medical man's bedside manner. Though young, he has already achieved remarkable success. In part, he epitomises the scientific practitioner. He has 'a quickness of diagnosis, a scientific insight, and a daring and unconventional use of drugs'. However, he is eccentric, irascible, and thoroughly unorthodox in his methods. He offers free consultations, but charges those who wish to move to the front of the queue. Cullingworth advises Stark Munro that 'being polite' to patients is a 'fatal mistake': 'Many foolish young men fall into this habit, and are ruined in consequence'. In his own interactions with patients 'he pushed them about, slapped them on the back, shoved them against the wall' (64-5). Cullingworth's conduct drives the story's comedy and is perhaps unlikely to be taken seriously by readers. However, the events were based on Conan Doyle's own experiences of working in partnership with George Turnavine Budd.[108] In its review of the book, the *MPC* characterised Cullingworth's approach as one which 'would make the old-fashioned orthodox physicians tremble'.[109] While the review clearly did not endorse his approach, it nevertheless implied that a deferential bedside manner was outdated.

[108] Miller, p. 161.
[109] 'Literature: The Stark-Monro Letters', p. 404.

The *MPC* described Cullingworth as 'able, magnetic, unscrupulous, interesting and many-sided' and 'as distinct a creation as was Sherlock Holmes'.[110] *The Stark Munro Letters* offers no compelling alternative to this figure. The conventional Dr Horton is associated with a genial bedside manner; the narrator describes how 'he brightens up a sick room' (44). However, while he remains an important influence in the protagonist's life, his appearances are fleeting. After setting up his own practice, Stark Munro adopts a slow and steady approach. Initially, it seems the narrative will follow a trajectory from hardship to independence, and even success; this is the arc that governs both 'Early Struggles' and 'A False Start'. However, here it is firmly disrupted. By the end of the story Stark Munro has developed only a small practice and the postscript reveals that he dies in a train accident. Meanwhile, Cullingworth is discredited by other practitioners and leaves to pursue new opportunities in South America. The reader never learns how he fares with this new venture.

Conan Doyle typically advocated a sympathetic bedside manner, however. *Round the Red Lamp* (1894) depicts a range of practitioners whose methods range from the orthodox to the unusual. Yet the collection closes with an idealised image of practice presented by an older surgeon to his young colleague:

> [The doctor's] patients are his friends – or they should be. He goes from house to house, and his step and his voice are loved and welcomed in each […] It is a noble, generous, kindly profession, and you youngsters have got to see that it remains so.

Here, the older generation invites the younger to become the new custodian of medical values, though the speaker accepts that these are largely the product of experience, of a 'whole life […] seeing suffering'.[111] Conan Doyle's address to medical graduates in 1910 espoused similar ideas. He described how the 'young medical man who has all his diseases

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[110] 'Literature: The Stark-Monro Letters', p. 404.
[111] Conan Doyle, 'The Surgeon Talks', in *Round the Red Lamp,* pp. 197-204 (p. 203).

nicely tabulated, and all his remedies nicely tabulated' has missed 'the value of kindliness and humanity'. Conan Doyle suggested that this practitioner was 'really a very raw product' but that '[l]ife may turn him into a more finished article'.[112] Rather than advising further clinical training, he recommended life experience.

Comparable advice was offered by Cathell and de Styrap, who instructed their readers to 'study mankind as well as medicine'. De Styrap warned them,

> if you are not a keen observer of men and things, if you cannot read the book of human nature correctly, and unite knowledge of physic with an understanding of the thoughts, feelings, and desires of mankind […] you will be sadly deficient (1-2).[113]

He borrowed this passage from Cathell but repositioned it, using it to open his book. While both writers suggested that sympathy must become part of the medical man's repertoire, de Styrap foregrounded this as a fundamental lesson for the young practitioner. These arguments were predicated on the popular idea – identified previously – that the young medical man was an unfinished article, that he needed to learn to extend his sympathies as well as his diagnostic abilities. By suggesting that the young practitioner required further refinement, advice literature highlighted its own utility. Yet Cathell and de Styrap emphasised skills which could not be acquired through reading, only cultivated through practical experience. Furst suggests that Cathell's advice reflects the 'power structure' of nineteenth-century doctor-patient encounters, with the doctor 'cast in the subordinate role of supplicant'.[114] However, as I will show in the ensuing section, the demands of professional etiquette were sometimes represented as outranking or overriding patient preference.

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[112] Conan Doyle, 'The Romance of Medicine', pp. 308-9.
[113] Cathell, p. 38-9.
[114] Furst, *Between Doctors and Patients,* p. 5.

Medical commentators were concerned about the young practitioner's interactions with some patient groups, particularly women. De Styrap advised his readers to be 'extremely cautious […] in having married women or young females to consult you secretly' (110).[115] Such advice was commonplace. In 1885, the provincial journal the *Midland Medical Miscellany* featured an article on 'The Relation of Medical Men to their Patients'. It advised '[y]oung medical practitioners [to] bear in mind a few general truths in their dealings especially with female patients'. For instance, it recommended that '[c]onfidential relations with ladies of a household' were to be 'absolutely declined' and that 'examinations of female patients should always be made in presence of a third person'.[116] Practitioners were taught that their encounters with female patients should be conducted with propriety.

Popular fiction often depicted young practitioners as prospective romantic partners. In *Middlemarch,* Lydgate is a scientific practitioner but also 'an emotional creature'. This renders him susceptible to his female patients, for '[h]e cared not only for "cases", but for John and Elizabeth, especially Elizabeth' (136). He becomes attached to Rosamond following his attendance on her brother. In Conan Doyle's *The Stark Munro Letters,* the protagonist carries on a flirtation with one of his father's patients – Miss Andrews – while working alongside him. He admits to a certain 'recklessness' in his conduct for '[t]here was never any question of engagement', him being 'a poor devil with neither means nor prospects' (26-7). The dalliance comes to a head after a case of mistaken identity; while visiting the Andrews household to attend a servant, he intends to surprise Miss Andrews with a clinch but accidentally kisses her mother instead. Rather than reveal his flirtation with the daughter, Stark Munro allows Mrs Andrews to presume him drunk. She writes a

[115] Cathell, p. 122.
[116] 'The Relation of Medical Men to their Patients', *Midland Medical Miscellany,* 1 January 1885, p. 23.

letter of complaint to his father. The protagonist admits that it seemed ‘a shocking breach of professional honour’ but is convinced that if his father ‘knew the truth he would see that it was nothing worse than a silly ill-timed boyish joke’ (27-8). The reader feels sympathy for Stark Munro’s mortification but may admonish his foolishness. The incident plays upon the dual image of the young practitioner as romantic hero and perceived sexual threat. In Chapter Three, I will consider how practitioners in close-knit communities were seen as particularly vulnerable to scandals concerning their interactions with women.

Across different forms of writing, the young practitioner’s professional identity was shown to be fraught; any hint of indiscretion threatened to undermine his social standing. Cathell and de Styrap discussed how medical men should conduct themselves publicly, warning their readers against socialising with undesirable characters and dissipation. Cathell’s direct admonition against associating with ‘harlots’ and ‘concubines’ reflects his more forthright style and was not replicated in de Styrap’s more reticent re-working (8). However, de Styrap similarly advised his readers to ‘eschew the hotel-bar, the smoking, the billiard, and the gambling room’, adapting Cathell’s original passage to suit a British social milieu (6).[117] Sobriety was widely advocated across medico-ethical literature. De Styrap warned that, while ‘[i]nebriety may be tolerated in practitioners fully established […] it would be fatal to one commencing practice’ (63-4).[118] There is a sense that the bar for good behaviour was set higher for young practitioners.

Both Cathell and de Styrap guarded against overfamiliarity with the local community. De Styrap reiterated Cathell’s recommendation to ‘avoid, as far as may be, dining out with your patients, and attending their tea or card parties, etc’.[119] He warned

[117] Cathell, p. 7.
[118] Cathell, p. 81.
[119] Cathell, p. 83.

that 'conviviality and *abandon*' would have 'a levelling effect, and divest[…] the physician of his legitimate prestige'. However, he also acknowledged that this might seem '[un]social and seclusive' and even 'adverse to [one's] professional interests' (66). Indeed, it runs counter to images of the doctor in contemporary fiction; as I will consider in Chapter Three, practitioners were often depicted as part of the social life of a community. This advice is perhaps one of those instances in which the *BMJ* felt that 'the standards which [de Styrap] sets up for our conduct towards the public […] is perhaps almost too high'.[120] Like Cathell, he was fastidious about good behaviour. Although these strictures may not always have been followed in practice, they demonstrate that medical etiquette encompassed not only patient care but also 'social aspects of practice'. As Digby identifies, the Victorian medical man was expected to behave respectably, in order to uphold medicine's 'genteel status'.[121] Professional etiquette also foregrounded the importance of good conduct in interactions with one's colleagues.

4. Interacting with practitioners

Across different forms of writing, the young practitioner's formative experiences were represented as being moulded by his encounters with more established colleagues. In *A Code of Medical Ethics,* de Styrap warned readers that a practitioner 'should never decline to meet another, *merely* because he is his junior', hinting that some medical men were prejudiced about working with their younger counterparts.[122] This is borne out in the fiction, where inter-generational professional encounters are often fraught. They shape the narrative trajectory, providing obstacles for the protagonist to overcome, but also a sense of resolution. Throughout Warren's 'Early Struggles', the young physician is repeatedly

[120] 'Review: The Young Practitioner', p. 633.
[121] Digby, *Making a Medical Living,* p. 6.
[122] De Styrap, *Code*, p. 32.

brought into contact with other practitioners, who often treat him disdainfully. When summoned to an emergency case, he experiences his first ‘consultational visit’. He is ‘anxious to acquit [himself] creditably’ in the presence of ‘the late celebrated Dr –’. However, he is received with ‘insolent condescension’ and his medical opinion is met with a sneering rejoinder. The senior doctor directs ‘a look of supercilious commiseration’ towards the patient’s wife, implicitly discrediting the young physician in the eyes of the family. The narrator finds that his ‘future services were dispensed with’ and is incredulous that a colleague should ‘have it in his power to take […] the bread out of the mouth of an unpretending and almost spirit-broken professional brother’ (10).

This image is repeated after the protagonist’s disastrous consultation with Sir William’s physician. On this occasion, he remarks that, ‘[t]here is nothing in the world so easy, as for the eminent members of our profession to take the bread out of the mouths of their younger brethren with the best grace in the world’. Here, he seems resigned to the uneven power dynamics. In this instance, not only is the older physician already well established in the family, he is also medical attendant to a member of the Royal Family and thereby occupies the upper echelons of the professional and social hierarchy. ‘[P]olite but haughty’, he is clearly ‘much displeased’ with his patient for calling in the younger physician. The protagonist seems to be fettered from expressing his true medical opinion during the consultation. The eminent physician assures Sir William that all that is needed for his cough is ‘change of air’. ‘I could not but assent’, the young physician remarks, though he does not offer the reader an alternative course of treatment. Sir William duly follows his doctor’s advice, only to die several weeks later. Ironically, the young physician loses the prospect of ‘respectable practice’ by following the dictates of professional etiquette and acquiescing to the senior doctor’s recommendations (19). His only act of resistance is to air his grievances through his diary.

By contrast, the young practitioner in Conan Doyle's 'A False Start' zealously and enthusiastically submits to the rules. Wilkinson declines the Millbanks' offer to become the new family physician, in place of their previous attendant. As he explains to Sir John, to 'take Dr Mason's place in the middle of a case like this […] would be a most unprofessional act'. He is thoroughly convinced that, by refusing the work, he has 'upheld the best traditions of his profession'. Dr Mason is impressed; he understands how great a 'temptation' it must have been for 'so very junior a practitioner' to accept the advances of 'so very wealthy a patient' (57). Although gently ironised, Wilkinson's self-abnegating act secures his eventual success; it lays the groundwork for a friendship between the two medical men, and later a partnership. By forsaking the chance to practise on one family, Wilkinson gains access to a wider patient constituency.

For aspiring medical men attempting to navigate the intricacies of professional etiquette, medical ethics and conduct manuals offered extensive advice on how to interact with patients already under another practitioner's care. De Styrap warned readers against attempting to 'unjustly retain' patients whom they were called to attend in an emergency (42).[123] This must have been tempting for young practitioners keen to utilise any opportunity for advancement. As discussed, medical fiction presented the chance encounter as a possible entry route into remunerative practice. De Styrap also suggested that, except in an emergency, practitioners should not visit patients until their previous attendant had been dismissed. 'When […] you entertain a doubt as to whether a patient is fairly yours', de Styrap told his readers, 'do not hesitate to give your rival the benefit of the doubt' (45).[124] It is this stricture which Wilkinson so fastidiously upholds. A range of guides – including the AMA Code, de Styrap's *Code*, *The Physician Himself*, and *The*

[123] Cathell, p. 57.
[124] Cathell, p. 56.

Young Practitioner – warned that practitioners must not criticise the treatment pursued by a previous attendant. Since the practitioner was expected to be cautious about making such remarks in his predecessor's absence, it is unsurprising that Warren's protagonist feels unable to offer a differential diagnosis in the presence of an eminent colleague.

The strictures of professional etiquette were also negotiated in medical journals. In 1894, the *Lancet* featured a leading article on 'The Ethics of Consultation', which discussed patients who sought the advice of consultants 'without reference to or from' their 'ordinary medical attendant'. It declared that consultants who acquiesced and 'ignore[d] the general practitioner' contravened professional etiquette. It argued that such men needed to 'refresh their memory – not to say their morals' by reading Percival's *Medical Ethics.* The fact the editorial endorsed a guide published ninety years earlier demonstrates how ideas about etiquette endured. The article acknowledged changes in the professional landscape, arguing that since the general practitioner was better educated than before, this 'increase[d] his claim to be respected'. Further, it contended that 'cooperation' between consultants and general practitioners was in the interests of the profession and the patient.[125]

The minutiae of medical etiquette must have seemed absurd to some patients. In 'A False Start', the 'millionaire' Sir John is incredulous that Wilkinson cannot be drawn into attendance on his family (57). Cathell and de Styrap claimed that patients were liable to violate the principles of professional conduct. For instance, they might try to retain a doctor before dismissing his predecessor or even reassure the incoming doctor that the previous practitioner would never discover that he had been replaced. In such instances, it was the practitioner's responsibility to enforce professional standards. Reiterating

[125] 'The Ethics of Consultation', *Lancet,* 13 October 1894, p. 860.

Cathell's advice, de Styrap advised that such 'solicitations' should be declined, 'with an impressive assurance that you desire to retain your own respect, as earnestly as you do that of others', though he added that the refusal should be given 'courteously but firmly' (44).[126] The practitioner was expected to adhere to professional etiquette rather than accede to his patients' demands.

In the preface to his *Code*, de Styrap suggested that it was necessary to institute a set of written rules for the profession, citing as his evidence 'the applications which continually appear in the columns of the medical journals for ethical information on points of dispute'.[127] The medical press' correspondence pages enabled practitioners to debate issues that arose in the course of practice. In 1847, John Chatto wrote to the *Lancet* attacking the behaviour of another medical man, Mr Clayton. Unbeknownst to Chatto, his patient's friend had called in Clayton for a second opinion. Clayton had not realised the patient was already under another's care and resigned the case when this came to light. However, he expressed 'difference of opinion' on the mode of treatment. Chatto suggested that such conduct was 'mischievous to the patient and practitioner', since it 'destroy[ed] that confidence which is an element of cure'. His appeal to readers of the *Lancet* suggested that he anticipated support from his colleagues. Although his letter was printed without editorial comment, similar correspondence on abuses of professional etiquette appeared in subsequent issues.[128] Significantly, Chatto remarked that Clayton's behaviour would have been 'intelligible' – though not 'excusable' – had he been a 'young man, battling his way into practice'.[129] This implied that he had some sympathy for struggling young practitioners. By contrast, de Styrap did not endorse a period of leniency for medical men.

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[126] Cathell, p. 59.
[127] De Styrap, *Code,* p. 3.
[128] For example, C.F. Mackin, 'Correspondence: Breach of Professional Etiquette', *Lancet,* 26 October 1850, pp. 489-90.
[129] John Chatto, 'Correspondence: Professional Etiquette', *Lancet,* 19 June 1847, pp. 658-9.

He urged readers to uphold professional etiquette from the outset of their careers because it would be 'recognised and appreciated'. Then, should they 'ever unwillingly infringe the rule' later, 'one and all will acquit [them] of any intentional error' (42).[130]

The ability to air grievances in the medical press was an important way of regulating professional practices and developing a shared understanding of medical etiquette. However, correspondence pages also facilitated disputes. In 1854, the *Association Medical Journal* (later the *BMJ*) published an exchange between Alfred Carpenter and George Bottomley about the treatment of medical men by the Board of Guardians in Croydon. Carpenter, a general practitioner, suggested that the Board's proposed fee for treating cholera cases was an 'insult' and he lambasted Bottomley (Superintendent of the Medical Union) for siding with them.[131] Bottomley's response, published a fortnight later, denied the allegations. He suggested that Carpenter was 'a young practitioner, and a young member of the Association', implying that these factors precluded him from passing judgement on professional matters.[132] Bottomley identified himself as having 'devoted more years than Mr Carpenter is old to the improvement of the profession'.[133] He associated age with authority and used Carpenter's youth to delegitimise his argument. While the journals' correspondence pages offered an opportunity for young medical men to raise their profile, in doing so they risked exposing themselves to criticism and rebuke.

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[130] Cathell, p. 57.
[131] Alfred Carpenter, 'Editor's Letterbox: The Medical Profession of Croydon, the Poor Law Board, and the General Board of Health', *Association Medical Journal*, 1 December 1854, pp. 1084-5 (p. 1084).
[132] Carpenter was 29 years old at the time of the exchange. He later became a consulting physician, founder of Croydon General Hospital, and Chairman of the BMA Council. Nick Cambridge, 'Dr Alfred Carpenter of Croydon', *General Practitioner Memorials* (25 November 2009) <http://generalpractitionermemorials.blogspot.co.uk/2009/11/dr-alfred-carpenter-of-croydon.html> [accessed 12 May 2016].
[133] George Bottomley, 'Letterbox: The Medical Men of Croydon', *Association Medical Journal*, 15 December 1854, pp. 1131-2 (p. 1132).

The journals demonstrate that relationships between colleagues were often fractious. However, medical commentators suggested that maintaining positive intra-professional relationships was paramount for one's reputation and success. Medical etiquette was characterised as a means of suppressing competitive practices and ensuring fair play. This was seen as crucial since enmity between colleagues risked bringing the profession into disrepute. Thus de Styrap cautioned his readers to be 'extremely discreet and chary of visiting patients under the care and treatment of other practitioners, even for social purposes, as it is a frequent cause of suspicion and contention' (42).[134] Recently, Jenner and Wallis have suggested that the dominance of the medical marketplace model in historiography has obscured the fact that '[a] practitioner's success depended on […] his integration into social networks rather than conflict with every professional rival'.[135] During the Victorian period, the concept of patient ownership – the idea that a patient belonged to one practitioner – was central. Sally Wilde describes how respecting 'the proprietary interests' of one's colleagues was perceived as important both for 'making a medical living' and 'maintaining agreed ethical standards within the profession'.[136]

An important distinction between Cathell's book and de Styrap's version is that the former endorsed a certain amount of 'aggressiveness' among practitioners in the interests of 'self-preservation' (26-7). In its critique of *The Physician Himself*, the *BMJ* highlighted that in America there was 'more licence in the way of […] attracting attention, and gaining notoriety'. Nevertheless, it suggested that despite some 'blemishes', the book inculcated 'moral principles'.[137] As indicated previously, Cathell employed a consistently moralising tone and expected his readers to uphold a respectable public image. The young practitioner

[134] Cathell, p. 58.
[135] Jenner and Wallis, p. 14.
[136] Sally Wilde, 'The Elephants in the Doctor-Patient Relationship: Patients' Clinical Interactions and the Changing Surgical Landscape of the 1890s', *Health and History*, 9.1 (2007), 2-27 (pp. 20-1).
[137] 'Reviews and Notices: The Physician Himself', p. 1258.

was taught to behave like a gentleman in his interactions both with patients and colleagues. De Styrap was reiterating his advice when he told readers that 'medicine is an honourable calling; resolve that it shall be none the less so by your adoption of it' and how 'each and every individual in the profession is supposed to be a gentleman, actuated by a lofty professional spirit, and desirous to act rightly' (19, 39).[138]

The value of shared ethical standards and the concept of patient ownership are satirised in Conan Doyle's *The Stark Munro Letters.* Cullingworth gladly admits that his methods are 'unprofessional' and that he 'break[s] every law of medical etiquette'. When Stark Munro asks why he does not 'conform', Cullingworth maintains that he 'know[s] better':

> All this etiquette is a dodge for keeping the business in the hands of the older men. It's to hold the young men back, and to stop the holes by which they might slip through to the front (67).

Cullingworth contends that professional etiquette prioritises the needs of established practitioners and that his unorthodox approach better serves his own interests. Although his approach to practice is satirised, his cynicism taps into wider anxieties about the difficulties facing the young practitioner.

Medical writing did not always represent the relationship between junior practitioners and their senior colleagues as hostile or combative. Ethical codes and advice literature also promoted ideas of fraternity. De Styrap advised his readers to '[a]lways entertain and show respect for your seniors in practice' (76).[139] Inter-generational encounters paved the way for young men to receive advice, support, and opportunities. Writers extolled the benefits of younger and older practitioners meeting in consultation; Percival suggested that this would be mutually beneficial, since their co-operation

[138] Cathell, p. 31, 52.
[139] Cathell, p. 91.

represented a 'union of enterprize with caution', which might help with 'a difficult and protracted case' (51). Cathell and de Styrap also pointed to the way in which established doctors might assist younger colleagues with difficult or sensitive cases, such as 'necessary' abortions carried out to 'save' the mother's life. De Styrap warned, 'do not attempt it until after consultation with another practitioner of reputed skill and probity, and then only, in his or in the presence of another – an essential precaution for a young practitioner' (53).[140] This 'precaution' was de Styrap's insertion. He implied that if the young man's actions were later called into question, it would be helpful to have the backing of an esteemed colleague. His caution also evinces the considerable anxiety about the young practitioner's intimate contact with the female body.

In daily practice, relationships between younger and older medical men could also be more harmonious. In Conan Doyle's 'Behind the Times', for instance, the young narrator describes how when he and Patterson arrived in the district they were 'most cordially received by the old doctor, who would have been only too happy to be relieved of some of his patients' (6). It is not his actions which stifle the ambitions of the young medical men, but the unremitting loyalty of his patients. Dr Winter's *laissez-faire* approach implies that he has hitherto monopolised a wide patient constituency or that he is planning to retire. By contrast, Sir William's physician in Warren's 'Early Struggles' is territorial; as a consultant in the metropolis he is perhaps more wary of competition.

In Warren's story, although the young physician faces numerous rebuffs from colleagues, his eventual success seems dependent on the goodwill of one of them. At the story's close, he attends the Earl and Countess in conjunction with their usual doctor. The fact he manages to 'secur[e] the confidence of the family' implies that his attendance is

[140] Cathell, p. 63.

well-received not only by them but by their physician (32). Yet the ending provides little insight into how the family physician responds to the younger doctor being called in for consultation. One might expect the narrator to express pleasure or gratitude that he has been allowed to share attendance on a wealthy family, particularly given the nature of his previous encounters with older colleagues. The lack of information about the arrangement is conspicuous given the chapter ends with the narrator advocating improved intra-professional relations. He maintains that, in future, he will 'never […] turn a deaf ear to applications from the young and less successful members of [his] profession' (33). Perhaps Warren found it difficult to envisage a harmonious relationship between the younger and older physician but feared that any hint of discord would detract from the chapter's otherwise happy ending. Alternatively, Warren may have wanted to end with the image of his protagonist's personal success, untarnished by the idea that another had supported his efforts. 'Early Struggles' closes with the young physician establishing his own illustrious practice, rather than entering into a prosperous partnership.

The young practitioner as self-made man was an important trope in many medical texts. In Warren's story, working with others is conceived as a lesser alternative to independent practice. In the midst of ruin, the protagonist considers advertising for a 'small medical partnership, as a general practitioner', but realises he does not have the necessary capital (12). He later applies to be an assistant and considers accepting the '[a]bsurd' terms offered, but is rejected because he is married and thus deemed unsuitable for such a low-paid position (16). In Conan Doyle's *The Stark Munro Letters,* the protagonist has a positive experience of his assistantship with Dr Horton – whom he regards as something of a mentor – but he nevertheless sees it as a stepping stone to something more lucrative. Ironically, he leaves this situation for the ill-fated arrangement with Cullingworth, who makes a generous offer for him to lead the surgical branch of his

thriving practice. Although the partnership fails due to Cullingworth's tempestuous nature, the narrative trajectory nevertheless endorses individual practice as the ultimate goal.

Partnerships were sometimes presented as a pragmatic or even idyllic solution to the pressures of general practice. In 'A False Start', a partnership provides narrative closure, reconciling two practitioners who might otherwise be competitors. It is significant that while the wealthy patient (Sir John) attempts to pit the town's doctors against one another, they decide to work in tandem. Their joint venture subverts the potential hostilities of the medical marketplace. Furthermore, the partnership is a success; it is underpinned by 'friendship' and represents 'the largest family practice in Sutton' (57).

Advice literature discussed the desirability of partnerships. In *The Student's Guide*, Keetley proposed that they might be advantageous, since they were 'safer to buy' than an entire practice and may be popular with patients. He suggested that, if one practitioner was away, then 'patients object less to seeing a partner than an assistant'. Secondly, if a patient became 'tired' of one doctor and 'desire[d] a change', then he could be introduced to the other partner and therefore retained by the practice. Nevertheless, he was aware that partnerships carried risks. He referred to a friend who entered one with a man who turned out to be 'bankrupt in his affairs and criminal in his practice' (33). Both Cathell and de Styrap warned against entering into partnerships. De Styrap suggested that 'partners are not, as a rule, equally matched in industry, capacity for professional work, temperament, tact, and other essential qualities, indispensable to a congenial and intimate fellowship' (3).[141] These remarks anticipate the doomed partnership between the upright Stark Munro and the unorthodox Cullingworth. Unlike Keetley, de Styrap also felt that partnerships were not usually popular with the public. In a departure from Cathell, he suggested that

[141] Cathell, p. 2.

one exception was ‘a co-partnership, for a limited period, with an elderly practitioner desirous to retire’ (3).

Partnerships that matched older, more established practitioners with their junior colleagues were often seen as mutually beneficial. The younger man could receive guidance, while helping his older colleague to extend the practice. Digby suggests that some doctors approaching retirement sought partners to help alleviate ‘the personal stress and strain’ of running a practice.[142] Inter-generational assistant- or partner-ships were also perceived as less competitive and combative. In Conan Doyle’s stories, neither Dr Mason (‘A False Start’) nor Dr Horton (*The Stark Munro Letters*) is elderly, but their greater experience has a positive influence on their younger colleagues.

In 1905, an article in the *Lancet* bemoaned that there were ‘too many young medical men in England who desire[d] to start in independent practice’. It contended that they were ‘not willing to act as assistants’ and that ‘the various services have no great attraction for them’.[143] This article intimated that the preoccupation with individual success was injurious to practitioners and the profession. In the early twentieth century, the prevalence of ‘single-handed practice[s]’ began to erode, however. Digby describes how assistantships and partnerships became more common, particularly after the 1911 National Insurance Act widened the market for medicine.[144] As the structures of general practice changed, and medical careers became more secure, the experiences of the struggling young practitioner were modified.

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[142] Digby, *Evolution,* p. 16.
[143] ‘Medicine, its Practice and its Public Relations’, *Lancet,* 18 March 1905, pp. 736-9.
[144] Digby, *Evolution,* p. 16.

Conclusion

The young practitioner emerged as a remarkably stable representational category in medical writing and fiction published between the 1830s and 1910s. He was typically portrayed as a subordinate in an overcrowded profession, struggling to make his way in practice, often as a self-made man. Notions of hardship were predominant, despite competing representations of the intellectual dilettante or the young doctor of independent means. Youth was understood to confer some advantages, and was regularly associated with qualities such as modernity, energy, and industry. Yet the young practitioner was regarded as lacking the experience and insight of older practitioners. His reputation among patients and colleagues was in the process of being cultivated and his professional identity was vulnerable.

Throughout the period, the early years in practice were conceptualised as a formative journey. Even as medical education was reformed, the young practitioner was still depicted as an unfinished article, in need of further refinement. Some commentators suggested he needed to widen his clinical experience, though it was increasingly argued that he needed to develop his sympathies. Following the publication of Percival's pioneering *Medical Ethics*, conduct guides reissued similar precepts and employed the same moralistic rhetoric. Ideas about medical etiquette remained remarkably stable across the century and across Britain and the United States. Concepts of patient 'ownership' and strictures against predatory behaviour were paramount. Later in the century, Cathell and de Styrap broached the 'business' aspects of medicine with candour, but anxieties about general practice's associations with trade persisted.

Professional etiquette functioned as a hegemonic value system across a diverse range of texts. This code of conduct was represented as governing the young medical

man's business practices; his access to, and interactions with, patients; and his encounters with colleagues. It regulated both his professional and personal life. Regardless of the extent to which these strictures were followed in practice, there was a recognisable set of ideas about what constituted respectable conduct. These tenets were disseminated not only through specific medico-ethical codes, but also through advice literature, medical journals, and fiction. These texts also offered opportunities to question the exigencies of etiquette, however. Some commentators suggested that the newly qualified medical man's naiveté or desperation excused infringements. Advice manuals and correspondence in the medical press acknowledged the temptations facing young practitioners to lower their fees or inveigle themselves with prospective patients, while authors such as Warren and Conan Doyle satirised or critiqued the rigidity of ethical standards. Nevertheless, the early years in practice were largely represented as a period of assimilation and conformity. Observing medical etiquette was acknowledged as an important route to achieving professional acceptance and success, particularly for those who lacked social contacts or capital. It was conceptualised as a means of maintaining confidence among patients and legitimising medicine as a gentlemanly profession rather than a competitive trade. By addressing Cathell's advice to young medical men, de Styrap constructed the junior practitioner as a standard bearer, who had a responsibility to uphold medicine's reputation.

The different forms of writing discussed here can variously be considered as having an educative function, as identified at the outset. The young medical man's professional identity was largely constructed by older, more established practitioners, but the voices of their junior colleagues also emerged. Advice literature was modelled on the idea that the young man needed to be initiated into working life and his new professional identity. It contained explicit directives on how the young medical man should conduct himself in practice. While Keetley's advice was largely pragmatic, Cathell and de Styrap

adopted a moralistic tone, adopting the approach of earlier medico-ethical codes. Medical journals were a mechanism for disseminating standards among young practitioners, but also offered space for ideas about etiquette to be debated. Ensuing chapters will consider further how they built communities and facilitated disputes. Warren and Conan Doyle's fiction was written from the periphery. Neither was actively practising at the time of writing, though their texts were seen by some as carrying a sense of authority and they utilised many of the tropes common to medical discourse.

The early struggles in practice were typically represented as extending into a medical man's late twenties or early thirties, although there was no definitive endpoint to (self)identification as a young practitioner. Depictions of practice showed that medical men's financial difficulties could persist and that their expertise continued to develop. Professional etiquette was represented as governing men's actions across their careers. Nevertheless, the early years were conceptualised as a transitional phase or formative journey, from which the practitioner emerged and moved into another identity.

To some extent, the young medical man was represented in relation to the place in which he practised. In the metropolis, he might be anonymous and overlooked, struggling amidst a competitive marketplace. In the country, he might become the subject of gossip or innuendo. Yet across these different spaces the figure was distinguished by his youth and inexperience, and his struggles in practice. Thus Warren's 'Early Struggles' and Conan Doyle's 'A False Start' bear remarkable similarities despite being set in London and a small town respectively and being published at opposite ends of the century. Of course, the early years in practice might not be rooted in a fixed space; they were often characterised by the practitioner's mobility and the transitory nature of junior appointments. In *The Stark Munro Letters,* the protagonist works across a range of different roles and settings. Nevertheless, he is identified throughout as a struggling young practitioner. This category

overrides his other prospective identities. The next chapters will interrogate spatial identities further, considering how medical men were conceived in relation to ideas about metropolitan and country practice.

Chapter Two: The Metropolitan Practitioner

'Is it necessary to show that London has produced, and does produce great men?' the *Medical Times and Gazette (MTG)* asked incredulously in an article published in 1855.[1] 'The London Schools of Medicine' was a rejoinder to a series of clinical lectures by Edinburgh-based surgeon James Syme, which had recently featured in the *Lancet.* [2] The article accused Syme of disparaging the status of surgery in the capital and it intervened to defend its 'Metropolitan brethren'. The article turned on the professional rivalry between London and Edinburgh, while also engaging with the 'jealousies' that existed between 'the Practitioners of the Metropolis and those of the Provinces' within England. It suggested that, while the metropolitan practitioner was not necessarily 'better than any Provincial one', the city held 'a greater choice of men, possessing a greater diversity of faculties'. It reasoned that London granted 'readier access' to a 'wider field of practice' and 'emolument and distinction'.[3]

The *MTG*'s article contended that London had a distinctive medical identity and deployed a range of ideas about what made the city a pre-eminent site for medical practice. In particular, it depicted the concentration of practitioners and patients as vital resources for helping medical men to develop their skills and raise their status. Nevertheless, the article's defensive stance demonstrates its anxiety about the reputation of metropolitan medicine, particularly its associations with exclusivity. During the nineteenth century, the capital was variously portrayed as a place of opportunity or of fierce competition and overcrowding. Significantly, the article did not put forward a single, unitary image of the

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[1] 'The London Schools of Medicine', *MTG,* 7 July 1855, pp. 13-14 (p. 14).
[2] James Syme briefly worked as surgeon to University College Hospital in 1848 but, finding the 'conditions and surroundings uncongenial', he returned to his native Edinburgh and his position as Chair of Clinical Surgery at its University. Royal College of Surgeons of England, 'Syme, James (1799-1870)', *Plarr's Lives of the Fellows Online* (11 April 2013) <http://livesonline.rcseng.ac.uk/biogs/E003871b.htm> [accessed 10 October 2016].
[3] 'The London Schools of Medicine', p. 13.

London medical man. Instead, it suggested that the city contained a range of 'faculties' and an extensive 'field of practice'.

This chapter investigates how competing representations of the metropolitan practitioner were constructed in the professional press and popular fiction between the 1830s and 1910s. It examines depictions of both the medical elite and the rank-and-file, looking at portraits of work among wealthy clients and the urban poor. It interrogates how professional identities were fashioned in relation to ideas about the opportunities, challenges, and temptations of London practice.

Previous scholarship on metropolitan practice largely focuses on the history of public health or institutions such as teaching hospitals and the Royal Colleges. As discussed in the introduction, historians such as M. Jeanne Peterson and Ivan Waddington examine professionalisation through the lens of institutional structures.[4] In *The Medical Profession in Mid-Victorian London,* Peterson engages with the development of professional identities, discussing medical men's rising 'prestige' and 'authority', as well as their 'status and self-image'.[5] While her title implies a focus on the metropolis, her analysis conveys a broader, national picture of medical practice. In recent years, historians have also discussed the production of medical knowledge within the metropolitan context. Susan Lawrence posits that, during the eighteenth century, hospitals were 'sites for the production and legitimization of both reliable doctors and good medical knowledge'.[6] Across this scholarship, London is represented as a space riven by medical politics but also as a site of innovation and advancement.

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[4] Ivan Waddington, *The Medical Profession in the Industrial Revolution* (Dublin: Gill and Macmillan, 1984).
[5] M. Jeanne Peterson, *The Medical Profession in Mid-Victorian London* (Berkeley: University of California Press, 1978), p. 3, 286.
[6] Susan Lawrence, *Charitable Knowledge: Hospital Pupils and Practitioners in Eighteenth-Century London* (Cambridge: Cambridge University Press, 1996), p. xii.

This chapter also draws on literary scholarship which examines how the metropolis figured in the Victorian cultural imagination. Critics have long identified that images of the metropolis were constructed in dialogue with, or antithesis to, ideas about the country and the provinces.[7] This dialectic clearly shaped medical discourse, as is evident in the *MTG* article, where the metropolitan practitioner was portrayed in opposition to his provincial counterpart. Scholars have emphasised competing representations of the metropolis, an idea which is central to my argument. For instance, Judith Walkowitz demonstrates how Victorian writers engaged with ideas of London as a 'bifurcated cityscape', marked by a rift between the East and West End, archetypally areas of great poverty and great wealth. [8] Recent critics have bolstered the idea of the metropolis as a contested space. Julian Wolfreys describes how 'the city resists ontology' instead 'affirm[ing]its alterity, its multiplicities, its excesses, its heterogeneities',[9] while Nicholas Freeman emphasises London's 'bewildering multiple identities'.[10] My research considers how this imagined geography shaped the construction of professional identities.

I begin by examining how the metropolis was conceptualised in medical writing. I consider how it was typically associated with institutions such as the Royal Colleges and teaching hospitals and examine its relationship with the medical publishing industry. I then investigate representations of consultant and specialist practitioners and their interactions with wealthy patients. The following section shifts attention to portraits of medical men who worked largely among the urban poor, either in general practice or low-status hospital roles. Across the chapter, I draw on medical journals produced in the capital – including

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[7] Raymond Williams, *The Country and the City* (London: Chatto and Windus, 1973), p. 147, 149.
[8] Judith Walkowitz, *City of Dreadful Delight: Narratives of Sexual Danger in Late-Victorian London* (Chicago: University of Chicago Press, 1992), p. 20.
[9] Julian Wolfreys, *Writing London Volume 2: Materiality, Memory, Spectrality* (Basingstoke: Palgrave Macmillan, 2004), p. 4.
[10] Nicholas Freeman, *Conceiving the City: London, Literature, and Art 1870-1914* (Oxford: Oxford University Press, 2007), p. 18.

the *Lancet*, the *MTG*, and the *BMJ* – and a range of popular fiction by medical authors such as Samuel Warren, Arthur Conan Doyle, and W. Somerset Maugham, and lay writers including Charles Dickens and Julia Frankau. Ultimately, this chapter considers competing representations of metropolitan practice among rich and poor patients and investigates how different professional identities intersected in both the medical and popular imagination.

1. Defining the metropolis

In discussing metropolitan medical identities, this chapter primarily focuses on London, with reference to other urban areas. During the nineteenth century, the 'metropolis' was typically synonymous with England's capital city, which was often lauded for its abundant resources. In an address delivered to the recently opened London University in 1832, John Elliotson – Professor of the Theory and Practice of Medicine – characterised the capital as 'the first metropolis of Europe' and 'the largest and wealthiest city' in the continent.[11] London's significance was reinforced by Britain's unusually centralised structure. As the *MTG*'s 1855 editorial identified, the capital was 'the residence of the Court, the seat of law, government, commerce, and fashion'. It remarked that, with the founding of the University of London, the city became the country's 'seat of letters' as well.[12] Peterson suggests that the capital was 'the center of medical education and practice', home to the 'most important hospitals, the most prestigious medical corporations, and the more lucrative, influential, and honorific medical careers'.[13]

London's pre-eminence as a site for medical practice was by no means self-evident at the start of the century, however. Its reputation – particularly for medical education –

[11] 'University of London: Address Introductory to the Winter Medical Session', *Lancet,* 6 October 1832, pp. 33-41 (p. 33).
[12] 'The London Schools of Medicine', p. 14.
[13] Peterson, *The Medical Profession,* p. 3.

rose considerably during the period. By 1800, some of the capital's major hospitals – such as St Bartholomew's, Guy's, St Thomas's, St George's, and the London Hospital – were already 'thriving as teaching enterprises',[14] and there were private anatomy schools, including the one run by William Hunter and later Matthew Baillie on Great Windmill Street between the 1760s and early 1800s. Yet London conspicuously lacked a university at the start of the nineteenth century. London University (later University College London (UCL)) was established in 1826 and King's College London was founded in 1829.[15] They became the constituent colleges of the University of London, which received its Royal Charter in 1836. Elliotson's remarks were intended to cement London University's embryonic status and perhaps detract from Edinburgh's illustrious reputation for medical education. They were also aimed at flattering his metropolitan audience.

In medical discourse, there was a sense that London's lack of a university tradition was a source of anxiety and regret. In an address delivered to the International Medical Congress in 1881 and printed in the *MTG*, the physiologist Michael Foster remarked on the 'anomaly that the great metropolitan heart of England – London – never had a university, and, indeed, till quite recently, was without even the beginning of one'.[16] Once established, it was treated as source of considerable pride. In 1860, an article in the *Medical Circular* stated that 'what Oxford and Cambridge are to the Church, London is to Physic – its *Alma Mater,* its careful nurturing mother'. It was paraphrasing a recent address by Lord Granville, the University's chancellor and a prominent politician. The article pronounced that 'Medicine is […] on the verge of a new era'. [17] By mid-century the

[14] Thomas Neville Bonner, *Becoming a Physician: Medical Education in Great Britain, France, Germany, and the United States, 1750-1945* (New York: Oxford University Press, 1995), p. 90.
[15] Their respective hospitals opened in 1834 and 1839.
[16] Michael Foster, 'International Medical Congress: Section of Physiology', *MTG,* 27 August 1881, pp. 247-53 (p. 248).
[17] 'The Social Aspects of the Profession', *Medical Circular,* 16 May 1860, p. 334.

profession was increasingly confident that the University of London conferred prestige and emblematised medical modernity.

The city's hospitals were often associated with medical advancement and major institutions were represented as objects of national pride.[18] They were portrayed as crucial to improving practitioners' skills and expertise, while enabling poor patients to access care and treatment. In a letter to the *London Medical Gazette* in 1827, 'A Country Surgeon' reflected how patients in 'cities' or 'large towns' were 'generally near some hospital, infirmary, or dispensary' where they could access 'as good medical attendance for nothing as those above them in society can procure for money – less ceremoniously administered, it is true, but in all essential respects as good'.[19] The writer implied that medical men's bedside manner would be less refined in the hospital setting but did not present this as problematic. Hospitals were constructed as institutions for training as much as for providing healthcare and London was represented as supplying the critical mass of patients needed. In 1832, the *Lancet* suggested that medicine could not be 'properly taught, unless in the midst of a large population'.[20]

London was already established as the base for the Royal College of Physicians of London (RCP), the Royal College of Surgeons of England (as it would become known; RCS), and the Society of Apothecaries. The Colleges defined the shape of medical practice: they privileged 'pure' physic and surgery over the increasingly dominant model of general practice, and regulated the practices of those inside and outside the capital.[21]

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[18] Louise Penner, 'Dickens, Metropolitan Philanthropy and the London Hospitals', in *Victorian Medicine and Popular Culture*, ed. by Penner and Tabitha Sparks (Pittsburgh: University of Pittsburgh Press, 2016), pp. 27-40 (p. 33).
[19] 'A Country Surgeon', 'Medical Attendance on the Country Poor', *London Medical Gazette,* 22 December 1827, pp. 55-8 (p. 55).
[20] 'University of London: Address Introductory to the Winter Medical Session', p. 33.
[21] The RCP offered *intra-urbem* and *extra-urbem* licences; only those with the former could practise within a seven-mile radius of London. John Davies, *An Exposition of the Laws which Relate to the Medical Profession in England* (London: Churchill, 1844), pp. 8-9.

The Colleges were represented in varying ways – they were thought to cement the city's importance to professional life, but their activities also provoked charges of exclusivity, nepotism and corruption, as historians have documented.[22] I will shortly consider how their hegemony was contested by the medical press.

Britain's other major cities were recognised as playing an important role in professional life as well. While Edinburgh enjoyed the most prestigious reputation, Glasgow and Dublin were also eminent sites for medical education and practice. In *The Doctor and the People* (1912), Herbert de Carle Woodcock estimated that medical qualifications from their universities were 'of about equal standard' to those from London. They had their own teaching institutions, Royal Colleges, and medical periodicals, as well as their own identities. There was also increasing opportunity in industrial cities. When Woodcock discussed how the 'young doctor' might have to 'wait long years for recognition' if working in a metropolitan hospital, he noted that he was including 'such cities as Liverpool among the metropolitan'. While Woodcock recognised the importance of other urban areas, he measured them chiefly in relation to the English capital. He remarked how 'up and down the Kingdom there are smaller Londons'. He branded Edinburgh 'a minor British capital', suggested Glasgow was 'anxious to imitate London as a great medical education centre', and deemed Birmingham 'a very clever but uninspired London'.[23] Woodcock's fixation on the metropolis is significant given he was an outsider – he was educated in Leeds and Edinburgh and practised in an industrial district of Leeds.[24]

[22] Waddington, *The Medical Profession*. Irvine Loudon, *Medical Care and the General Practitioner, 1750-1850* (Oxford: Clarendon Press, 1986).
[23] Herbert de Carle Woodcock, *The Doctor and the People* (London: Methuen, 1912), p. 20, 2, 227-9.
[24] 'Obituary: H. de Carle Woodcock', *BMJ*, 7 October 1950, pp. 841-2.

With increasing urbanisation, the metropolis was seen to encompass not only central London but its suburbs as well. An 1851 article in the *London Medical Gazette* reflected on '[t]he rapid increase of the metropolitan population' during the previous decade, particularly within 'the suburban, and especially in the northern districts'. It included developing areas such as Islington within its definition of the metropolis.[25] When the Provincial Medical and Surgical Association's Metropolitan Counties Branch launched in 1853, its members were drawn from areas as diverse as Islington, Putney, Middlesex, Reading, and Surrey. The inaugural meeting emphasised that the Branch's geographic reach was intended to 'embrac[e] along with the metropolis places at convenient railway distances'.[26] Ultimately, conceptions of the metropolis were not fixed, but open to revision and reinterpretation throughout the century.

2. Print culture and the capital

London was also the centre for the publishing industry and almost 75 per cent of medical journals were printed there.[27] This included long-running stalwarts such as the *Lancet*; the *London Medical Gazette* (later the *MTG*); and the *Medical Circular* (later the *MPC*); as well as shorter-lived titles such as *The Doctor.* These journals were published in the capital and then circulated across the country. They often framed themselves as mechanisms for diffusing knowledge. For instance, in 1852, the newly formed *MTG* described how,

> [i]n our Hospital Reports, and in our Clinical Lectures, delivered by the most renowned Physicians and Surgeons of the Metropolis, we have endeavoured to place before our provincial readers the practice of those great Hospitals in whose wards they may themselves once have observed diseases and their treatment.[28]

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[25] 'Sanitary Improvements in the Suburbs of London', *London Medical Gazette,* 3 October 1851, pp. 587-8 (p. 587).
[26] 'Association Intelligence: First General Meeting of the Metropolitan Counties Branch', *Association Medical Journal*, 14 January 1853, pp. 43-6 (p. 43, 45).
[27] W.F. Bynum and Janice C. Wilson, 'Periodical Knowledge: Medical Journals and their Editors in Nineteenth-Century Britain', in *Medical Journals and Medical Knowledge: Historical Essays,* ed. by Bynum, Stephen Lock, and Roy Porter (London: Routledge, 1992), pp. 29-44 (p. 34).
[28] 'L'Envoy', *MTG*, 1852, pp. iii-iv (p. iv).

This implied that knowledge was generated in the capital and then passively received by provincial medical men. However, the passage also collapsed the distinction between metropolitan and provincial practitioners, acknowledging that many of the latter had been trained in London.

If mainstream journals privileged London then they also suggested that reading about practice outside of the capital could be instructive. The *MTG*'s earlier incarnation – the *London Medical Gazette* (which I will discuss shortly) – stated its commitment to reporting 'what is going on in the principal Hospitals, not only of London, but elsewhere'.[29] During the 1850s, the *MTG* categorised its content geographically, like many of its contemporaries. It featured a column entitled 'Provincial Correspondence', which comprised news items from areas outside of London, including major cities such as Liverpool and Edinburgh. Its clinical content was divided between columns on 'The London Practice of Midwifery and Surgery' and 'The Provincial Practice of Medicine and Surgery', which ran concurrently. The former included case studies from metropolitan hospitals such as Guy's, St Thomas's, King's College Hospital, and the Seaman's Hospital, while the latter featured studies from a range of institutions outside of the capital, from the Belfast General Hospital to the Queen's Hospital in Birmingham. On 14 July 1860, however, the *MTG* announced that it was 'abolish[ing] the distinction' between these columns, merging them into a generalised 'Reports of Hospital Practice in Medicine and Surgery'. This may have been a response to the rising status of other cities or a move to appease provincial readers. In an editorial, the journal stated that the alteration did not represent 'any material change of character' to the feature but simply a desire 'to improve and develop it'. The journal also began to 'authenticate' the feature, moving away from anonymity and printing the name of its conductor, Jonathan Hutchinson. As his by-line

[29] 'Address', *London Medical Gazette,* 8 December 1827, pp. 1-3 (p. 2).

identified, he was Assistant-Surgeon to the London Hospital and Surgeon to the Metropolitan Free Hospital. The re-branded column ostensibly effaced the distinction between London and provincial practice but also foregrounded that it was arranged by a member of the metropolitan elite.[30]

It is important to consider how different journals interacted with London's fraught medical politics. It is widely recognised that Thomas Wakley's *Lancet* (established 1823) achieved notoriety for its radicalism. It printed invectives against the medical and surgical elite, including the Royal Colleges, teaching hospitals, and prominent individuals. For example, in an 1831 editorial, the journal railed against the 'medical Colleges and Companies', branding them 'the pest-houses of the profession'. It claimed that they had never 'contributed […] to advance the interests of science' or 'to enlarge the privileges of their brethren'. The journal accused them of effectively controlling the system of hospital appointments, ensuring 'preferment' and 'favouritism' prevailed. The editorial called for an 'immediate and radical change' to the system.[31] During the 1840s, there was considerable agitation to introduce a rival College of General Practitioners, though the plan was never realised. Irvine Loudon charts Wakley's changing stance towards the proposed College, demonstrating how medical periodicals became more interested in lobbying for medical registration.[32] Historians have emphasised that Wakley's incendiary style was a drastic departure from previous medical journalism. Some scholars attribute this to the editor's personal temperament, while more recently Michael Brown situates the journal's 'stylistic radicalism' within its 'immediate political context'.[33]

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[30] 'Reports of Hospital Practice', *MTG,* 14 July 1860, p. 35.
[31][Editorial], *Lancet,* 22 January 1831, pp. 564-8.
[32] Loudon, *Medical Care,* pp. 294-5.
[33] Michael Brown, '"Bats, Rats and Barristers": *The Lancet,* Libel and the Radical Stylistics of Early Nineteenth-Century English Medicine', *Social History,* 39 (May 2014), 182-209 (p. 185).

The *Lancet*'s inflammatory approach tempered over the decades, but it continued to critique the established corporations and defend the rank-and-file. In 1862, an editorial called for better representation of provincial practitioners among the upper echelons of the RCS. It welcomed the fact that the College had restyled its suffix to 'of England' rather than 'of London' (a move made in 1843) and called for corresponding changes to the institution's governance. The article declared it a 'disgrace to the College' that members of its governing body had been 'selected entirely from London surgeons' and added that '[n]o greater names are connected with our profession than those of many men who practise far away from the metropolis'.[34] While the *Lancet* engaged extensively with London's medical politics, it also championed the interests of provincial practitioners, who it suggested had been traditionally excluded and disempowered.

The *London Medical Gazette* was founded in 1827 by several metropolitan luminaries – including surgeons Benjamin Brodie and John Abernethy – in direct opposition to the *Lancet.* Its opening 'Address' directly attacked Wakley's journal, including his practice of publishing medical lectures without permission. The rivalry between these two journals has been detailed by scholars of the periodical press.[35] In 1852, the *Gazette* amalgamated with the *Medical Times* (1839-52) and over its three decades in publication, the combined journal – the *MTG* – remained a leading competitor to the *Lancet*. The aforementioned article on 'The London Schools of Medicine' was partly a critique of Wakley's decision to publish Syme's lectures. The article accused Syme of effacing London's illustrious surgical history embodied in 'men of talent' such as

[34] 'The Forthcoming Election at the College of Surgeons', *Lancet,* 31 May 1862, p. 579.
[35] For a summary of this conflict see Laurel Brake and Marysa Demoor (eds.), *Dictionary of Nineteenth-Century Journalism in Great Britain and Ireland* (Gent: Academia Press, 2009), pp. 375-6.

Abernethy and Astley Cooper.[36] Its passionate defence of these practitioners is unsurprising given the journal was enmeshed with the London elite.

For a conservative publication such as the *Gazette,* London was the bastion of intellectual and cultural capital. In 1834, it featured correspondence from a provincial medical man who suggested that 'the metropolitan practitioner' was 'exposed to the influence' of 'the highest orders of intellect and attainment, not only in his own profession, but in every walk of life'. He argued that 'constant association' with the 'admirable, and refined' would 'dispose [a mind] to the fullest and severest cultivation of its powers'. He suggested that opportunities for intellectual exchange elevated the metropolitan practitioner's 'capabilities' above those of 'his provincial brethren in general'.[37] The city was constructed as a stimulating environment and metropolitan practice as a convivial and gentlemanly pursuit. These images recall the culture of 'medico-gentility' Brown identifies as a feature of the late eighteenth-century profession. He demonstrates how practitioners used 'forms of sociability' to fashion themselves as gentlemen.[38]

Editorial and publishing activities were of course not restricted to London. Edinburgh was the 'second center of the British book trade', though it remained small in comparison to London.[39] The *Edinburgh Medical and Surgical Journal* (the *Edinburgh Medical Journal* from 1855-1954) was a significant presence in the journal marketplace. There were also journals published in the provinces, such as those linked to individual medical societies and hospitals. A journal's site of management and production was not necessarily static and its regional identity might change over time. For instance, the *MPC*

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[36] 'The London Schools of Medicine', pp. 13-14.
[37] 'On Provincial Education: The Bristol Memorial Considered', *London Medical Gazette,* 5 July 1834, pp. 480-1 (p. 480).
[38] Brown, *Performing Medicine: Medical Culture and Identity in Provincial England, c. 1760-1850* (Manchester: Manchester University Press, 2011), p. 9.
[39] Aileen Fyfe, *Steam-Powered Knowledge: William Chambers and the Business of Publishing, 1820-60* (Chicago: University of Chicago Press, 2012), p. 41.

originated in Ireland as the *Dublin Medical Press* (founded in 1839). During its early decades of publication, it was a leading voice in the agitation for medico-political reform in Ireland.[40] In 1866, it purchased, and combined with, the London-based *Medical Circular* (established in 1852), forming the *MPC*. From 1868, the combined journal was published in London, though Archibald Jacob – a prominent ophthalmologist in Dublin – remained as editor from 1860 until his death in 1901. The journal's especial interest in Irish medicine was initially sustained but diminished over time.[41]

A periodical's site of publication could be highly politicised. This is evident from the early history of the journal that became known as the *BMJ*. Launched in 1840 as the *Provincial Medical and Surgical Journal (PMSJ)*, it was originally an independent commercial speculation, though primarily aimed at members of the Provincial Medical and Surgical Association (PMSA). This link was strengthened in 1844, when the PMSA assumed proprietorship of the journal and moved publishing operations to Worcester, where it was based. In 1853, however, the journal relocated back to London. These early decades were a tumultuous period for the journal – involving changes to production, editorship and format – as identified by Peter Bartrip. His comprehensive history of the journal characterises the period between 1840 and the mid-1860s as 'a struggle for survival', since the Association was divided about the existence and direction of the journal. He contends that the debates during this period reveal 'a kind of civil war between London expansionists and provincial conservatives'.[42] Building on his research, I will scrutinise the rhetoric used in these debates to evince competing ideas about metropolitan practice. Further, I will consider how the debates were mediated through the medical press.

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[40] Robert J. Rowlette, *The Medical Press and Circular 1839-1939: A Hundred Years in the Life of a Medical Journal* (London: [Medical Press and Circular], 1939), pp. 12-38.
[41] Rowlette, p. 84.
[42] Peter W.J. Bartrip, *Mirror of Medicine: The BMJ, 1840-1990* (Oxford: Oxford University Press, 1990), p. 35, 28.

When Charles Cowan, a Reading-based practitioner, proposed moving editorial operations back to London in 1852, he anticipated the resistance with which he would be met. He attempted to reassure the Association's members that moving the publication would 'not alter its feature of provinciality', while arguing that 'its continuance at Worcester would only be perpetuating provincial weakness and provincial defects'. His comments indicate the fraught status of the term 'provincial', for he presented it as a feature worth preserving but also as an obstacle to improvement. In the next chapter, I will consider further the changing meanings attached to provincialism. Cowan claimed that 'a London Editor' would 'possess advantages from his position' and this would enable the *PMSJ* to become 'the *best* medical periodical in the kingdom'. He portrayed relocation as a question of 'effect[ing] improvement in periodical literature' and elevating the Association itself, transforming it into a national institution. Cowan maintained that rather than 'exclud[ing] from their ranks their metropolitan brethren', the Association should 'blend all in one body, united for the furtherance and protection of their mutual interest'.[43] Ultimately, he suggested that both the journal and the Association should be refashioned into something more inclusive and expansive.

The *PMSJ*'s incumbent editors – surgeon John Walsh and physician William Ranking – were infuriated by the proposed move, which threatened their positions. In a series of passionate leading articles, they argued for the importance of the journal retaining its provincial identity. They maintained that it 'would lose its distinctive character if conducted by a metropolitan Editor' and suggested that it could 'never […] be made to compete' with 'commercial' publications such as the *Lancet* or *Medical Times.* Instead of 'its being reduced to a third or fourth-rate London periodical', they suggested it needed to keep its 'own proper vocation'. They praised their contributors, whom they described as

[43] 'Twentieth Anniversary Meeting', *PMSJ,* 4 August 1852, pp. 385-409 (pp. 394-5).

'anxious to make known the results of their labours' despite being 'engaged in the toils of country practice'. This was despite the fact they may not always be 'able to compete in elegance of diction with their London compeers'.[44] The use of the term 'elegance' implied there was something superficial or vain about the metropolitan practitioner's knowledge. By contrast, Walsh and Ranking characterised provincial practitioners as hard-working and industrious, images I shall interrogate further in the following chapter.

Ultimately, Cowan's proposal for the future of the journal was adopted and it moved from fortnightly publication in Worcester to weekly in London. Editorship passed to John Rose Cormack, a Putney-based general practitioner and founder of the *London Journal of Medicine,* which effectively combined with the *PMSJ* to create the *Association Medical Journal* from 1853. In his inaugural leading article, Cormack echoed Cowan's sentiments, praising the 'literary and scientific centre in London, where editorial resources are more abundant, more varied, and more easily available, than in any other city in the world'. His assertion of the capital's international reputation recalls rhetoric put forward to celebrate London University. Ultimately, Cormack suggested that the capital's resources would enhance the Association's reputation and activities.[45] Despite his confident rhetoric there was further in-fighting about the direction of the journal and Cormack resigned in 1855.

Discussions about the future of the journal and the Association were interlinked. In 1854, members debated renaming the organisation the British Medical Association (BMA). In a letter to the *Lancet,* the Croydon-based surgeon George Bottomley expressed fears that 'the greatest harmony and good feeling' which had 'always prevailed' at their meetings would be threatened by the participation of metropolitan practitioners. He

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[44] 'Dr Cowan's Alteration in the Management of the "Journal"', *PMSJ,* 9 June 1852, pp. 297-8.
[45] John Rose Cormack, [Editorial], *Association Medical Journal,* 7 January 1853, pp. 1-3 (p. 1).

described his hope that 'no seeds of discord sown in the metropolis will take root and flourish amongst us'. Bottomley represented practice in the city as fractured by competition and resentment and suggested that the provinces should be screened from its poisonous influence. He was anxious that this spirit of dissension could affect the tone of the journal, suggesting that it might report 'the personal squabbles of individuals of whom we know nothing' or 'the party intrigues of cliques of which we desire to know less'.[46] The letter's insertion in the *Lancet* is interesting given Wakley's notoriety for personal rivalries, though Bottomley's references to 'intrigues' and 'cliques' suggest he held a similar disdain for the corporations.

Despite some resistance, in 1857 the Association became the BMA and the journal was also renamed. In the opening issue of that year, the *BMJ* expressed its 'hope' that 'a more comprehensive name' would lead to a 'Journal more comprehensive'.[47] In ensuing years, there was a shift in content and tone; the editorship of Ernest Hart (1867-9, 1870-98) – a London-based ophthalmic and aural surgeon – has been credited with transforming the journal from a 'somewhat parochial publication' to 'a thriving, intellectual weekly covering both national and international issues'.[48] Scholars of the medical press emphasise its increasingly metropolitan orientation.[49]

These debates among the Association from the 1840s to 1860s reveal fundamental disagreements within the profession about London's status. Some members characterised the city as a space of ambition, opportunity, and resources, while others associated it with rivalries and resentments. Commentators were divided over whether medical practice in

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[46] George Bottomley, 'The Position of the Provincial Medical and Surgical Association', *Lancet,* 15 July 1854, p. 39.
[47] 'The British Medical Journal', *BMJ,* 3 January 1857, p. 9.
[48] Brake and Demoor, pp. 78-9.
[49] Peterson, 'Medicine', in *Victorian Periodicals and Victorian Society,* ed. by J. Don Vann and Rosemary Van Arsdel (Toronto: University of Toronto Press, 1994), pp. 22-44 (p. 33).

the capital and the provinces were complementary pursuits or fundamentally different vocations. Nevertheless, the direction of the journal and Association indicate the increasing pre-eminence of the city in the medical imagination. London was no longer simply the preserve of institutions representing the medical elite but also the site of reformist journals which provided alternative means of identity formation.

3. Consultants and specialists in the medical press

When medical commentators discussed the disparities between the metropolis and the provinces, they referred not only to medical politics but also the nature of day-to-day practice, specifically the prevalence of consultant and specialist medicine. These were represented as largely urban phenomena because they required access to a sufficient number of prospective, remunerative patients. In his letter to the *Lancet*, Bottomley insisted that there was a 'very decided difference […] between the provincial and metropolitan practitioner'. He characterised the former as 'a one-faculty practitioner', who acted in the capacity of physician, surgeon, and accoucheur. By contrast, Bottomley suggested that metropolitan practice was 'divided into three grades – physician, surgeon, and apothecary'. He added that, '[t]he metropolitan practitioner divides his responsibility with some consulting brother', while suggesting this was not possible in the provinces since 'a pure surgeon is a very scarce person'. Instead, the provincial practitioner must take 'the weighty responsibility of the whole upon himself'.[50]

Similar ideas were put forward in a leading article in the *Provincial Medical Journal (PMJ)*, published in 1887. It enthusiastically reprinted excerpts from a recent piece in the *New York Medical Record* which it felt would resonate with English readers, including the assertion that:

[50] Bottomley, 'The Position of the PMSA', p. 39.

> All other things being equal, the only difference between the metropolitan and rural practitioner is in the surroundings. The former is in a position to have plenty of help, and very many, if need be, to think for him; the latter is generally alone in an emergency and has to do his own thinking […] the metropolitan practitioner can, if he chooses, fasten the different tendrils of his web to the door-posts of all the experts and specialists in his neighbourhood. Counsel in the city is the rule, in the country it is the exception.[51]

This passage represented metropolitan and country practice through the lens of space, emphasising their divergent 'surroundings'. It portrayed the rural practitioner as comparatively isolated, while suggesting the metropolitan practitioner could easily access help. This support network was symbolised by the image of the spider's web. There is something sinister in the metropolitan medical man's perceived dependency on others, which is encapsulated in the remark that he may have others 'to think for him'. The notion of medical practitioners working within a broader network of colleagues was also represented as advantageous to the profession, however. At the launch of the Metropolitan Counties Branch of the PMSA in 1853, Cowan described how, '[f]rom the fact of the numbers congregated in a limited space, there are opportunities of benefiting the profession at large in a higher degree than any other branch of the Association possesses'.[52] The metropolis was presented as a space that facilitated communication and exchange. These images of collegiality were an important counterweight to prevailing ideas of competition and in-fighting.

The allegiances of Bottomley and the *PMJ* were clear, however. They suggested that consultant or specialist practitioners lacked the self-sufficiency and wide-ranging skillset of provincial general practitioners. These articles erased the struggles of the metropolitan general practitioner, implying that his ability to access support and advice

[51] [Editorial], *Provincial Medical Journal*, 1 February 1887, pp. 72-3 (p. 72).
[52] 'Association Intelligence: First General Meeting', p. 45.

lightened his professional load. Chapter Three will consider further the *PMJ*'s representation of provincial practice.

Between Bottomley's letter and the *PMJ* article there is a shift in language: when the former speaks of 'consultants' he refers to pure physicians and surgeons, while the *PMJ* discusses 'specialists'. Their use of terminology reflects the changing shape of medical practice over the course of the nineteenth century. At the start of this period, there was considerable prestige attached to pure physic and surgery, though their pre-eminence began to wane as general practice accrued increasing esteem. The Medical Act Amendment Act (1886) effectively signalled the 'legal and symbolic integration of medicine and surgery'.[53] Nevertheless, consultant practice continued to be regarded as fashionable and potentially lucrative. In the early decades of the nineteenth century, medical specialties existed only in embryo, but they flourished during the second half of the century. Disciplines such as dermatology, obstetrics and gynaecology, and neurology became a recognisable part of the medical landscape, with their own hospitals and periodical literature.[54] Both consultant and specialist practitioners typically combined an eminent hospital post with fashionable private practice.

Medical writing sometimes represented these groups in overlapping ways, blurring the distinctions between them. In 1885, the *Lancet* claimed that '[t]he consulting surgeon or physician of the past is gradually merging into the specialist'.[55] However, the two roles should not necessarily be conflated. As historians have identified, many specialist hospitals were founded by 'upwardly-mobile' and entrepreneurial medical men who found themselves 'excluded from elite positions' in general hospitals (those held by 'pure'

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[53] Peterson, *The Medical Profession,* p. 3.
[54] For an overview of specialist periodicals see Peterson, 'Medicine', pp. 27-8, 33. Bynum and Wilson, p. 33. For details on the growth of specialist hospitals see Keir Waddington, *Charity and the London Hospitals, 1850-1898* (Woodbridge: Boydell Press, 2000), p. 9.
[55] 'Patient, Family Doctor, and Consultant', *Lancet,* 18 April 1885, pp. 714-5 (p. 715).

physicians and surgeons with connections).[56] In turn, consultants and general practitioners often felt threatened by the rise of specialist hospitals, which were popular with the public and thus attracted interesting cases and remunerative patients.[57] I will employ the term 'consultant' when referring to a 'pure' physician or surgeon, and 'specialist' where the practitioner has a specific field of expertise.

Consultant and specialist practice were both represented as important for advancing medical science and the status of the profession. As early as 1834, a correspondent to the *London Medical Gazette* reasoned that, as '[t]he medical art is so complex, and embraces so wide a field', there was 'a necessity, if full justice is to be done to the subject, for a *division of labour*'. The writer suggested that this would give 'stimulus to think', since generalists usually found their 'time and mental labours' largely 'engrossed' elsewhere, in preparing drugs or practising midwifery.[58] The correspondent drew upon the contrast between the pure surgeon of the metropolis and the provincial general practitioner, though his rhetoric anticipated arguments that would later be deployed in favour of further specialisation and sub-division. Significantly, the correspondent identified himself as a provincial practitioner. While this may have been an alias adopted by a metropolitan medical man, it nevertheless indicates that the *London Medical Gazette* was keen to engage with provincial perspectives, albeit those which supported the direction of metropolitan medicine. This correspondence is something of an exception, since provincial practitioners often expressed scepticism about the growth of specialist medicine.

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[56] Lindsay Granshaw, '"Fame and Fortune By Means of Bricks and Mortar": The Medical Profession and Specialist Hospitals in Britain, 1800-1948', in *The Hospital in History*, ed. by Granshaw and Roy Porter (London: Routledge, 1989), pp. 199-220 (p. 200, 215). See also Waddington, *Charity and the London Hospitals*, p. 11.

[57] Granshaw, p. 206. Anne Digby, *Making a Medical Living: Doctors and Patients in the English Market for Medicine, 1720-1911* (Cambridge: Cambridge University Press, 1994), p. 33.

[58] 'On Provincial Education', p. 480.

In the capital, developments were variously greeted with resentment, trepidation or pride. Lindsay Granshaw highlights that the *BMJ* campaigned against the rise of specialist hospitals during the 1860s, representing them as exploitative and unnecessary.[59] In 1864, a piece in the *Lancet* reasoned that specialties could 'serve purposes of progress and education' within 'the bosom of the hospitals and the centres of instruction'. However, it warned that if they were '[l]eft to themselves', they would 'grow rank and overrun the place'.[60] The image of decayed weeds implied that specialist medicine might become unwieldly and even debased if not properly controlled. The inference was that specialties should be pursued in the interest of medical knowledge rather than material gain. In 1881, a correspondent to the *Lancet* contended that, 'honestly practised, [specialties] are of service to the profession and the public', though he felt that many so-called specialists were simply acting as consultants.[61] In 1895, another correspondent to the journal – who self-identified as a 'Specialist' – claimed that, '[t]o argue against specialism now is to argue against civilisation'. Responding to accusations that specialists were guilty of over-charging, he suggested general practitioners were similarly culpable.[62] Specialist medicine was heavily scrutinised by the medical press: it seemed to epitomise the scientific zeal and modernity of the metropolis, but nevertheless needed to be kept in check.

In 1905, the *Lancet* published a series entitled 'Medicine, its Practice and its Public Relations'. One instalment reflected on the changing status of consultant, specialist, and general practice. In laudatory terms, it suggested '[t]he consulting physician and the consulting surgeon represent the fine flower of success in the medical profession'. It also engaged with some of the struggles encountered by consultants, warning that '[s]uccess is

[59] Granshaw, pp. 206-8.
[60] 'Medical Annotations: Specialties', *Lancet,* 12 March 1864, p. 304.
[61] 'Correspondence: Specialism in Medicine', *Lancet,* 12 November 1881, p. 885.
[62] 'A Specialist', 'Correspondence: Specialism in Medicine', *Lancet,* 24 August 1895, p. 483.

only won by incessant hard work, self-denial, and courage'. This emphasis on nobler characteristics counteracted earlier images of nepotism. The article warned that increased competition was pushing many consultants into specialist practice, however, and that the growth of specialist hospitals had led to a shift in patient expectations. It suggested that 'the public believe implicitly that the medical man ought to be a specialist'.[63] Once again, the ubiquity of specialist medicine was represented as a threat undermining both consultant and general practice.

4. Consultants and specialists in fiction

Anxieties surrounding consultant and specialist practitioners also manifested in popular fiction, where these figures were variously associated with scientific advancement, patient exploitation, and personal greed. This section will examine Conan Doyle's short stories 'The Adventure of the Resident Patient' (first published in *The Strand* in 1893 and later in *The Memoirs of Sherlock Holmes*), 'The Third Generation' and 'The Case of Lady Sannox' (both published in *Round the Red Lamp* in 1894), all of which portray consultants or specialists engaged in private practice in the metropolis. Conan Doyle had attempted a specialist career himself. After studying ophthalmology in Vienna in 1890, he began a practice in Devonshire Place, not far from Harley Street, though he failed to attract patients.[64] His fictional representations of illustrious medical men emphasise their brilliance and striving for success, but also engage with the more ambivalent or shadowy aspects of consultant and specialist practice. I will analyse his stories in the context of contemporary debates in the medical press and other popular fiction.

[63] 'Medicine, its Practice and its Public Relations', *Lancet,* 18 March 1905, pp. 736-9 (p. 737).
[64] Douglas Kerr, *Conan Doyle: Writing, Profession, and Practice* (Oxford: Oxford University Press, 2013), p. 80.

'The Resident Patient' begins with the young Dr Percy Trevelyan visiting Sherlock Holmes to seek his advice on a 'very singular train of events'. Trevelyan is introduced as an aspiring specialist, the author of a monograph on 'obscure nervous lesions'. He has had a 'promising' start at London University and 'excite[d] considerable interest' through his research at King's College Hospital, all of which suggested a 'distinguished career' lay before him. However, Trevelyan was unable to gain a foothold in the profession due to his want of 'capital'. He bemoans the fact that 'a specialist who aims high is compelled to start in one of a dozen streets in the Cavendish Square quarter, all of which entail enormous rents and furnishing expenses'.[65] It is well-known that certain areas of London – particularly around Harley Street – were associated (and continue to be associated) with lucrative practice.[66] These fashionable sites of medicine were a common trope in literature. In Robert Louis Stevenson's *Strange Case of Dr Jekyll and Mr Hyde* (1886), Cavendish Square is described as the 'citadel of medicine' and is home to the respectable Dr Lanyon. Significantly, though, it is only a stone's throw from Soho, where Hyde carries out his disreputable activities.[67] The sites of specialist and consultant practice were designed to appeal to the tastes of wealthy and illustrious patients. Trevelyan also discusses the 'preliminary outlay' associated with specialist practice, the fact that the young doctor must be 'prepared to keep himself for some years, and to hire a presentable carriage and horse' (163). This passage revisits many of the tropes surrounding the young practitioner, particularly the need to display oneself in order to attract and retain patients. Trevelyan's fortunes change when a man named Blessington approaches him with a 'strange proposal'.

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[65] Arthur Conan Doyle, 'The Resident Patient', in *The Memoirs of Sherlock Holmes* (London: Penguin, 1950), pp. 158-78 (pp. 162-3). Further references are given after quotations in the text.
[66] M. Anne Crowther and Marguerite W. Dupree, *Medical Lives in the Age of Surgical Revolution* (Cambridge: Cambridge University Press, 2007), p. 186.
[67] Robert Louis Stevenson, *Strange Case of Dr Jekyll and Mr Hyde and Other Tales,* ed. by Roger Luckhurst (Oxford: Oxford University Press, 2008), p. 11.

He offers the young doctor money to set up a practice on the condition that he becomes its 'resident patient' (164-5).

Trevelyan narrates a second mysterious event, a visit from a man apparently suffering from a cataleptic attack. As this falls within Trevelyan's specialty, his interest is unsurprisingly piqued. He describes how, '[m]y first feeling […] was one of pity and horror. My second, I fear, was rather one of professional satisfaction'. After examining the man, Trevelyan decides that the case is 'an admirable opportunity' for 'testing [the] virtues' of a particular treatment and he abandons the patient to retrieve a drug from his laboratory (167). After some delay in locating it he returns to the consulting-room to find the patient has disappeared. Trevelyan's response to the case implies that he prioritises his scientific interests over patient care. However, the reader is not invited to dwell on his shortcomings, for it soon emerges that Trevelyan has been duped by not one but two men feigning illness, both the cataleptic man and the 'resident patient'.

Explaining his arrangement with Blessington, Trevelyan comments that, '[h]is heart was weak, it appears, and he needed constant medical supervision' (165). It is unclear whether it 'appears' weak from the doctor's own examination or from Blessington's own assurances. Regardless, Blessington was motivated neither by philanthropic concern for medical men nor his own health – instead he wished to conceal his whereabouts. Holmes reveals that he is really a man named Sutton, a member of the Worthingdon Bank Gang, who turned informer on his criminal confreres. When they were released from prison sometime later, he sought to avoid retribution by going into hiding. The man with catalepsy is revealed to be another member of the gang, who hoped to gain access to the house by posing as a patient in order to have his revenge on Blessington/Sutton. His illness is – according to Holmes – '[a] fraudulent imitation […] though I should hardly dare to hint as much to our specialist. It is a very easy complaint to

imitate. I have done it myself' (171). The plot shows the ease with which the aspiring specialist is fooled, implicitly calling into question his medical expertise. Yet the narrative also emphasises the vulnerability of the young man struggling to set himself up in specialist practice.

The story inverts ideas about the power dynamic of the specialist-patient encounter. Rather than an unscrupulous doctor exploiting a vulnerable patient, Conan Doyle portrays a naïve medical man who becomes victimised by a criminal gang. If specialist medicine was viewed by some as illustrious, entailing a wealthy and prestigious clientele, here it is depicted as bringing the medical man into contact with the criminal class. The plot twist is predicated on the anonymity of metropolitan practice, where patients and practitioners are unknown to one another. Peterson posits that 'the greater fluidity of the population' in London 'tend[ed] to undermine the social basis of practice',[68] and this anxiety underpins Conan Doyle's detective story.

The boundaries between fashionable and disreputable practice, and between lucrative and immoral patients, were also blurred in representations of venereology. This is the subject of 'A Man About Town' (1830), an instalment in Warren's *Passages from the Diary of a Late Physician* series, which I discussed in Chapter One. The narrator (now an established medical man) describes treating a patient implicitly afflicted with syphilis. The Hon St John Henry Effingstone is 'an abandoned profligate' and 'irreclaimable reprobate', his lifestyle explicitly linked to his painful decline.[69] He becomes 'an exile from society', hiding out in an 'obscure and distant part of town' (174, 168). The story's shift in setting – from West to East End – emblematises the disreputable nature of the case. The doctor

[68] Peterson, *The Medical Profession*, p. 98.
[69] Samuel Warren, 'A Man About Town', in *Passages from the Diary of a Late Physician*, 2 vols (Edinburgh: Blackwood, 1844) i, pp. 151-86. Further references are given after quotations in the text.

struggles with his own aversion; he finds the sick-chamber 'revolting' and is 'haunted' by the 'piteous spectacle' of his patient (175). Ultimately, Effingstone cannot be cured nor guided towards redemption. Despite his lack of success, the narrator fashions himself as a source of medico-moral authority by investing the story with a sense of purpose. He presents it as a cautionary tale warning other young men about the dangers of vice.

Venereology had an ambiguous status. Historian Anne Hanley describes how it was 'not elevated to the level of specialism', with venereal diseases largely the province of generalist medicine and related disciplines such as dermatology and ophthalmology.[70] Nevertheless, as she explores, there were practitioners who made it the focus of their work. Contemporary attitudes towards the subject can be detected in John Russell Reynolds's 'An Address on Specialism in Medicine' which was delivered to UCL's Medical Society in 1881. As consulting physician to the College's hospital, Reynolds spoke from a position of authority, and his address was reprinted in the *MTG, Lancet*, and *BMJ*. He approached his discussion of venereology circuitously, noting that there were 'many surgeons in large cities who never, except by caprice, accident, mistake, or good nature, find a lady in their consulting-rooms'. Employing euphemistic language, he suggested that such medical men found their practice 'somewhat closely confined to a particular class of maladies that most frequently arise from irregular modes of life'. Reynolds accepted that there were medical men who chose this area of work and acted 'with good to their patients, credit to their profession, and honour to themselves'. However, he also called into question the medical and moral legitimacy of some self-styled venereologists. He described how they,

> prey upon the sense of shame, and extort money for needless operations and worthless drugs, holding in terror over their victims the knowledge of facts that have been confided to them, and using that knowledge, which is power, to benefit, not their patients, but themselves.

[70] Anne Hanley, *Medicine, Knowledge and Venereal Disease in England, 1886-1916* (London: Palgrave, 2017), pp. 7-10.

In sensationalist language, he described how '[t]he consulting-room – as sacred as the confessional – is degraded to the lowest depths of degradation when it is used, or abused, as the engine of terror and extortion'.[71] Reynolds suggested that unscrupulous medical men might exploit their patients' trust. There is something not only predatory but criminal about the way in which they are seen to 'prey upon' and 'extort' from those seeking their help.

In Conan Doyle's 'The Third Generation', the eminent Dr Horace Selby seems to embody the venereologist of 'credit' and 'honour' that Reynolds describes. Hanley posits that he resembles Jonathan Hutchinson, whom I previously discussed in conjunction with his work for the *MTG*.[72] Hutchinson was Britain's foremost authority on venereal diseases and he also specialised in ophthalmology and dermatology. Selby has 'a European reputation' and is the author of five books on his specialty, the nature of which is heavily implied if not explicitly identified. His 'bulk and dignity' are 'reassuring' to patients.[73] Further, his syphilitic patient – Sir Francis Norton – cannot be charged with 'irregular modes of life' like Warren's Effingstone or the figures in Reynolds's address. As the story's title suggests, Sir Francis has inherited the disease from his debauched grandfather, and Selby imagines how the older man's 'deeds' are 'living and rotting the blood in the veins of an innocent man' (35). In this scenario, both doctor and patient are exculpated from dishonourable conduct.

Conan Doyle eschews the lurid descriptions of syphilis that characterise Warren's story but his representation of venereology is nevertheless ambivalent. Selby's practice is depicted as a shadowy place. Based in Scudamore Lane, near Monument, the narrator

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[71] J. Russell Reynolds, 'An Address on Specialism in Medicine', *MTG*, 22 October 1881, pp. 483-6 (p. 484).
[72] Hanley, p. 7.
[73] Conan Doyle, 'The Third Generation', in *Round the Red Lamp and Other Medical Writings*, ed. by Robert Darby (Kansas City, Missouri: Valancourt, 2007), pp. 30-9 (p. 33-4). Further references are given after quotations in the text.

remarks that it was ‘a singular street for so big a man’. Though his eminence outstrips the need for him to inhabit the more salubrious environs of specialist medicine, the clandestine nature of his consulting-room carries its own appeal: ‘In his particular branch […] patients do not always regard seclusion to be a disadvantage’ (30). Furthermore, while Warren’s physician assiduously attends Effingstone, Selby remains personally detached. The consultation with Sir Francis interrupts his dinner party and the doctor confesses to feeling ‘a conflict of duties’ between his responsibilities as a host and as a medical adviser (32). While he is capable of showing ‘human sympathy’, his intellectual curiosity threatens to undermine his sensitivity. At one point, he ‘had so forgotten the patient in his symptom that he had assumed an almost congratulatory air towards its possessor’ (34). Selby bluntly informs Sir Francis that he must cancel his engagement and the patient feels stifled by the limited options available to him. Although he thanks the doctor for his ‘sympathy and advice’, Selby learns from the next day’s newspaper that Sir Francis was killed under a horse dray after leaving the consulting-room, the implication being that he has committed suicide. The fact that Selby feels ‘sick and faint’ may indicate his pity for the man’s plight but also suggests that he feels culpable for not having provided greater emotional and practical support (38-9). While Selby avoids the unwholesome atmosphere Warren’s physician encounters, he is nevertheless contaminated by his interaction with a syphilitic patient.

In ‘The Resident Patient’ and ‘The Third Generation’, the doctor-characters are embroiled in plots involving criminality, venereal disease, and suicide, elements which are mined for their melodramatic and sensational appeal. While the medical men themselves are largely represented ambivalently or even sympathetically (Trevelyan is, of course, the victim of a criminal plot), the stories nevertheless create a shady atmosphere around the metropolis’ consulting-rooms, which become shrouded in secrecy and deception. Conan

Doyle engages with wider discursive practices which associated London with vice and immorality.

Medical writing and fiction depicted men at all stages of their career as vulnerable to the temptations of city living. In 1836, an article in *The Doctor* considered how 'the great body of medical students' were 'at the most critical period of their lives, left entirely without control, and exposed to all the seducing temptations of the Metropolis'.[74] In Stevenson's *Dr Jekyll and Mr Hyde,* Henry Jekyll's friends suspect he may be being blackmailed because he was 'wild when he was young' and may have 'some old sin' or 'concealed disgrace' lurking in his past. In fact, Jekyll's immorality has a more insidious effect. When he reflects on his 'progress and position in the world', he finds himself 'committed to a profound duplicity of life', and it is this conviction which prompts the experiments with separating his two selves.[75] It is pertinent that Stevenson selects a medical practitioner to represent man's duality. While Jekyll's chemical expertise is undoubtedly central to the plot, his role as a metropolitan medical man also seems to embody the tensions between duty and instinct. The fact that his alter-ego loses his professional title ('Mr' Hyde) may suggest that it is his medical work which anchors him to respectable society, although it is his days as a medical student which seem to have introduced him to vice.[76]

Charges against the morality of metropolitan medical men cast aspersions on both their personal and professional conduct. In an inflammatory article for the *Modern Review* on 'The Medical Profession and its Morality' in 1881, social reformer Frances Power Cobbe represented the 'ordinary English country practitioner' as eminently respectable,

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[74] 'On the Education of Young Men Intended for the Hospital Profession', *The Doctor,* 23 November 1836, p. 60.
[75] Stevenson, p. 17, 52.
[76] 'Mr' was a professional title for surgeons, but Jekyll goes by 'Dr'.

while describing the 'grave charges and suspicions (chiefly attaching to the fashionable physicians and surgeons of the great cities and health resorts)'. She conflated the metropolis with other fashionable and lucrative sites of practice.[77] Cobbe accepted that both the 'skilful London physician' and 'poor country practitioner' may be guided by more humane motives. Nevertheless, she perpetuated the traditional distinction between town and country, and between consultants and general practitioners.[78]

In his macabre short story 'The Case of Lady Sannox', Conan Doyle represents a medical man succumbing to both personal and professional temptations. Douglas Stone is depicted as a 'celebrated' and 'daring' surgeon.[79] The narrator describes how '[h]is vices were as magnificent as his virtues' and how his large income is 'far beneath the luxury of his living' (98). His lascivious tastes are encapsulated in his 'notorious' affair with the married Lady Sannox, which – as his colleagues warn him – threatens to ruin his 'professional credit' (99-100).

One night Stone receives a mysterious call from a man in Turkish dress, who claims that his wife has been fatally injured by a poisoned dagger and urgently requires an operation. Despite entertaining reservations, Stone is ultimately tempted by the 'extraordinarily high' fee offered and the 'interesting case' (101-2). As with Selby and Trevelyan, his initial response is governed by his scientific zeal rather than his interest in patient care. When presented with the patient, who is veiled and appears to be heavily drugged, the narrator describes how '[t]his was no longer a woman to him. It was a case' (105). Stone is persuaded by the Turk to excise the woman's injured lips in order to save

[77] There were popular spa towns and seaside resorts across Britain – such as Bath, Bristol, and Scarborough – which attracted affluent patients. Digby, *Making a Medical Living,* p. 209.
[78] [Frances Power Cobbe], 'The Medical Profession and its Morality', *Modern Review,* 2 (April 1881), 296-328 (p. 308, 303).
[79] Conan Doyle, 'The Case of Lady Sannox', in *Round the Red Lamp,* pp. 98-107 (p. 98, 100). Further references are given after quotations in the text.

her life. After he performs the operation, the case is revealed to be a macabre hoax. The cuckolded Lord Sannox (dressed as the Turk) tricked Stone into disfiguring the disguised Lady Sannox, to punish her for her sexual indiscretions.

Stone is the victim of Lord Sannox's elaborate machinations, yet the character invites little sympathy. Even before disfiguring Lady Sannox, there is something ambivalent about his surgical practices. The narrator emphasises his boldness: 'Again and again his knife cut away death, but grazed the very springs of life in doing it' (98). On the day of Lady Sannox's operation, he has already performed an operation against the advice of six colleagues. Although the results are 'brilliant beyond all expectation' (100), his daring is almost hubristic. It is this audacity which Lord Sannox manipulates for his 'surgical revenge plot' (as Tabitha Sparks terms it).[80] The way in which the fashionable surgeon becomes embroiled in shadowy practices is represented through the story's imagined geography, as Stone is led by the Turk to 'a mean-looking house in a narrow and sordid street' (104). Although Stone allows himself to be persuaded that surgical intervention is necessary, his willingness to perform a disfiguring operation for financial gain and intellectual satisfaction seems grotesque.

The story's lurid climax has been read in the context of Victorian fears about surgical interference. Elaine Showalter persuasively argues that the operation functions as a 'displaced clitoridectomy'.[81] In the 1860s, Isaac Baker Brown – a metropolitan specialist in gynaecology and obstetrics – pioneered clitoridectomies as a treatment for a range of nervous disorders linked to female sexual transgression. Though initially praised as a skilful surgeon, he was expelled from the Obstetrical Society in 1867 and his procedure

[80] Tabitha Sparks, *The Doctor in the Victorian Novel: Family Practices* (Farnham: Ashgate, 2009), p. 139.
[81] Elaine Showalter, *Sexual Anarchy: Gender and Culture at the Fin de Siècle* (London: Virago, 1992), p. 136. More recently, Robert Darby has argued that Conan Doyle's story engages with *fin-de-siècle* fears about male circumcision. *Round the Red Lamp,* pp. 108-14.

was discredited by the 1880s and 1890s. In Conan Doyle's story, Stone ultimately loses his lover and his illustrious career, for the events precipitate a loss of sanity, as his 'great brain' becomes reduced to 'a cap full of porridge' (98).

In its review of *Round the Red Lamp*, the *Lancet* initially suggested that the collection could not be considered 'a success' given the author's literary standing. It feared Conan Doyle had 'gone into medical detail to an extent that should unfit the stories for popularity'. However, it singled out for praise 'The Case of Lady Sannox', which it likened to the work of Thomas Hardy and judged 'likely to give the reader a real thrill'. The review prioritised the story's sensational effects and appeared unconcerned by its ambivalent portrait of a medical man and depiction of surgical violence.[82]

The relationship between a medical man's personal vices and professional activities is also a major theme in Julia Frankau's *Dr Phillips: A Maida Vale Idyll* (1887). Published under the pseudonym Frank Danby, the novel has attracted scholarly attention largely due to its virulent anti-Semitism.[83] The eponymous protagonist is a charismatic and successful general practitioner. However, the narrator suggests he has 'degenerated' from a promising medical man 'into the pet of Maida Vale drawing-rooms', largely catering for his own Jewish social circle.[84] Although married and seemingly respectable, Phillips secretly keeps a gentile mistress – Mary Cameron – the mother of his illegitimate daughter. His identities as doctor and adulterer are interconnected. The narrator parodies his appeal to women, noting '[y]ou could see at a glance he was essentially the lady's doctor' (16).

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[82] 'Christmas Books', *Lancet,* 15 December 1894, pp. 1443-4 (p. 1443).
[83] Nadia Valman suggests that the novel exploits stereotypes about the 'perverse sexuality of the Jewish male'. *The Jewess in Nineteenth-Century British Literary Culture* (Cambridge: Cambridge University Press, 2007), p. 196. Recently, the novel has also attracted interest from scholars working on literature and medicine. Sparks argues that syphilis functions as a 'symbolic disease' in the novel, entwined with its anti-Semitism. 'Illness as Metaphor: Reading Popular Fiction against Medical History', in *Victorian Medicine and Popular Culture*, pp. 137-46 (p. 143).
[84] [Julia Frankau], *Dr Phillips: A Maida Vale Idyll* (London: Vizetelly, 1887), p. 28. Further references are given after quotations in the text.

Further, Phillips uses his professional duties to exculpate his affair. He develops a 'convenient fiction' that the success of his practice depended on his being 'on friendly, not to say affectionate, terms with many women' (27). He introduces his mistress to his wife and friends as a widowed patient.

Phillips's possessive attitude towards women reaches its nadir when he schemes to murder his invalid wife Clothilde so that he may marry Mary. He seizes his chance after Clothilde undergoes an ovariotomy. This was a controversial gynaecological procedure, which remained fashionable after clitoridectomies had been discredited.[85] The operation is graphically described by the narrator, who emphasises how '[t]he unconscious woman lay at the mercy of these [medical] men' (270). While Clothilde recovers, Phillips secretly injects her with additional morphine, precipitating an overdose. He allows his colleague who performed the operation to believe himself responsible for her death. Phillips's method is inextricably interlinked with his medical knowledge. He describes it as 'a delicate little operation' and takes 'deep-seated pride in his professional skill' (284, 293). While Douglas Stone is ruined by his violent operation on Lady Sannox, Phillips becomes enraptured with, and emboldened by, his act. Mary is horrified by his actions and Phillips discovers she has already chosen another lover. Though despondent, Phillips escapes detection and pursues medicine with increasing zeal.

Ultimately, he flourishes as a consulting surgeon, becoming 'a prominent light in the medical world'. His rise to the upper echelons of the profession is presented as chilling – his new practice is built on the money inherited from his wife's death and the support of the colleague he has duped. The narrator emphasises that his success is facilitated by his 'Machiavellian talents' (339). Phillips also becomes invasive in his methods. The narrator

[85] Showalter, p. 131.

describes how he 'champion[s]' the current 'rage for surgical interference' by 'unsex[ing] woman and maim[ing] men'. His practice is characterised by 'manual dexterity and moral recklessness' (340-1). Like Conan Doyle, Frankau portrays the violence of the surgical encounter, engaging with fears about controversial practices such as clitoridectomies, ovariotomies, and male circumcision.[86] Further, she blurs the boundaries between Phillips's murderous and surgical practices. The author's critique of medical men seems even more incisive given rumours that Phillips was based on Hart, the then-editor of the *BMJ*, whose wife had died in mysterious circumstances more than twenty years earlier.[87]

In popular fiction, consultants and specialists were often portrayed as technically brilliant but morally ambivalent and even villainous figures. They were depicted as participating in and even profiting from the vices of the capital. However, there also emerged competing representations of practitioners who prospered while eschewing the temptations of city life. In his biography of Thomas Wakley (1897), Samuel Squire Sprigge described how 'the country-bred lad' found 'no attraction' in 'the grave licentiousness rife among the medical students'.[88] Renouncing the temptations of the metropolis is also a theme in the memoir of the eminent surgeon Sir James Paget, published in 1901. The editor (Paget's son) insisted that the surgeon and his wife 'saw nothing of the fashionable side of London life' at the outset of his career. In his own words, James Paget emphasised how his success was not attributable to 'self-advertisement', 'extortion', or 'greediness'.[89] He was constructed as a professional and moral exemplar, who accrued a lucrative practice without being corrupted by fashionable London life. However, the defensive posturing found in these texts indicates that the

[86]Valman, p. 199.
[87] Stephen Lock, 'Introduction', in *Dr Phillips: A Maida Vale Idyll* (London: Keynes Press/ BMA, 1989), pp. v-xii (pp. vi-xi).
[88] S. Squire Sprigge, *The Life and Times of Thomas Wakley* (London: Longmans, Green, 1897), p. 21.
[89] James Paget, *Memoirs and Letters of Sir James Paget*, ed. by Stephen Paget, 2nd edn (London: Longmans, Green, 1901), p. 182, 186.

association between metropolitan practice and vice was potent in the popular and medical imagination.

5. Practice among the poor

In his address on '[T]he Life and Work of the General Practitioner', delivered to the West London Medico-Chirurgical Society in 1898, Samuel Dodd Clippingdale (Surgeon to the Kensington Dispensary) posited that there was a divide between those who catered for the rich and those who attended the poor in the metropolis. He suggested that,

> We who live among cultured people, […] who receive remunerative fees, and are shown hospitality by our patients, are, I fear, but ill-acquainted with the struggles of our equally deserving brethren who practise exclusively among the poor. I am not certain whether we do not look upon them with something like contempt and complain of the small fees which they unfortunately are obliged to accept.[90]

As discussed in the previous chapter, charging low fees was represented as a breach of professional etiquette, hence the 'contempt' these medical men attracted.

Bemoaning this disconnect, Clippingdale highlighted the commonalities that existed between the medical elite and the rank-and-file. He insisted that 'the poor man's medical attendant is generally one of vast experience and often a man of culture'.[91] One section of his address considered the question 'What duty do we have to our brother practitioners in the poorer parts of London?'. In it, he proposed 'an interchange of practices':

> The West-end practitioner would be glad to realise the hardships of his less fortunate brother in the East. The East-end man would find relief by a stay in the West. An outcry would be raised by our wealthy patients, but they would have to follow us into the East and bring their wealth with them.[92]

[90] S.D. Clippingdale, 'An Address on Some Considerations of the Life and Work of the General Practitioner', *Lancet*, 29 October 1898, pp. 1104-6 (p. 1105).
[91] Clippingdale, p. 1105.
[92] Clippingdale, p. 1105.

By contrasting the work of the 'West-end practitioner' and the 'East-end man' through the lens of space, Clippingdale deployed conventional images of a bifurcated city. He propounded a fantasy of co-operation, even suggesting (somewhat wryly perhaps) that professional interests should override patient preference. For some, the suggestion that West-End practitioners would be 'glad to realise the hardships' of their lower-status colleagues would have seemed disingenuous. Many commentators alleged that it was the 'successful and eminent practitioners at the head of consulting practice' who were responsible for 'depreciat[ing], the remuneration of practitioners in general' and thereby suppressing their status.[93]

In the metropolis, the poor were served in myriad, often overlapping ways: through hospital wards, out-patient dispensaries, workhouse infirmaries, and by poorly paid Poor Law medical officers and general practitioners. Some practitioners engaged in club or contract practice. As intimated in the previous chapter, this entailed a group of patients (organised through working men's clubs or friendly societies) paying one doctor or a panel of doctors a regular salary in return for services when they were required. This work was held in low regard due to its association with undercharging.[94] In this section, I will focus on the representation of medical men who primarily attended the poor, including those who worked as general practitioners or in low-status hospital and dispensary positions. These roles were characterised in terms of their drudgery and intimate contact with poverty.

The atmosphere of destitution surrounding poor patients was sometimes imagined as having a potentially degrading or destabilising impact on a medical man's professional identity. In a letter to the *Lancet* in 1876, Dr Garrett described how two young

[93] 'Medical Fees', *BMJ*, 10 August 1872, pp. 169-70 (p. 170).
[94] Peterson, *The Medical Profession,* pp. 114-5.

acquaintances – working towards their exams at the RCS – had decided to 'open a self-supporting dispensary' in Rotherhithe, which he characterised as a 'growing and populous, but poor locality'. He suggested that they chose this site 'chiefly from the practical experience they might expect to get in their profession – certainly not for emolument or dignity'. [95] Self-supporting dispensaries had a mixed reputation: Michael Brown describes how they were intended to encourage 'responsibility' among working-class patients while providing a fair income to practitioners but that many in the profession disliked such ventures, given that remuneration remained low.[96] For Garrett, dispensary practice in a 'poor locality' gave one experience, but did not confer status or reputation. Practitioners working in degraded circumstances were often imagined on the same footing as their impoverished patients; Clippingdale suggested that they were looked upon with 'contempt'. A 1905 article in the *Lancet* delineating different walks of medical life described how 'some must live the life of the poor with the poor', though it treated this situation with equanimity.[97]

It was not necessarily seen as important for hospitals and dispensaries to be built around the needs of the poor. In 1885, the *Lancet* published an article which acknowledged concerns that practitioners and hospitals were often removed from their patients. It defended the situation by arguing that it was 'a matter of importance that the hospitals should be reasonably near that quarter of the town where [practitioners'] residences are to be found'. It suggested that this enabled patients to 'receive the best attention that science and experience can ensure', an 'advantage' which 'must be reckoned against the

[95] Dr Garrett, 'Notes, Short Comments, and Answers to Correspondents: "The Double Prop of the Unqualified Practice"', *Lancet,* 5 February 1876, p. 230.
[96] Brown, 'Medicine, Reform and the "End" of Charity in Early Nineteenth-Century England', *English Historical Review*, 124 (December 2009), 1353-88, (p. 1364, 1370).
[97] 'Medicine, its Practice and its Public Relations', p. 737.

disadvantage of remoteness from some of the poorer and more populous districts'.[98] The article appeared in a supplement specifically designed to promote the Hospital Sunday Fund, a philanthropic cause. It illustrates how practitioners' convenience was prioritised over that of their patients, for it implied that practitioners should live and work in a 'respectable' environment to maintain their self-respect and dignity.

Hospital practice tended to be represented as more dignified. Even though the junior roles were often poorly remunerated, it was regarded as more genteel to provide care charitably than in return for low fees. However, there was a widespread perception that the system was exploited by patients. In 1866, the *Medical Mirror* commented that, in London,

> the hospital system has been, and is hourly, terribly abused. Others besides the poor and needy, use the hospitals, and thus the pockets of the hardworking, and ill-paid general practitioners, are systematically picked.[99]

It was argued that patients able to afford medical attendance were claiming charitable care, thereby depriving general practitioners of legitimate paid work. In 1889, the *BMJ* ran an exchange of correspondence on the abuse of outpatient departments which showed that the problem was not restricted to London.[100] However, it was perhaps most keenly felt in the capital given the range of hospitals available to the public and the size of the patient population.[101] In *Of Human Bondage* (1915) Maugham represents a London hospital at the *fin de siècle.* He portrays patients attempting to cheat the system by adopting 'shabby clothes' to pretend they are destitute. However, the narrator describes how the assistant

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[98] 'The Claims of the Medical Charities', *Special Supplement on the Hospital Sunday Fund, Lancet,* 9 June 1888, p. 1164.
[99] 'Occasional Notes: Village Hospitals', *Medical Mirror,* November 1866, pp. 703-4 (p. 704).
[100] 'Hospital and Dispensary Management: Alleged Abuse of Outpatient Departments', *BMJ,* 3 August 1889, pp. 286-8.
[101] The introduction of paid wards in some hospitals was seen to aggravate the problem, creating further competition for remunerative patients. Peterson, *The Medical Profession,* p. 229. By 1893, five of the eleven teaching hospitals accepted paying patients. Henry Burdett, *Hospitals and Asylums of the World,* 4 vols. (London: Churchill, 1893), iii, p. 846.

physician 'had a keen eye to prevent what he regarded as fraud'.[102] He serves a disciplinary as well as medical function, acting as a gatekeeper to care and treatment. By contrast, some general practitioners suggested that consultants corroborated in abuse of the system, since they were more interested in the medical and surgical character of the cases rather than checking patients' socio-economic status.[103]

Representations of metropolitan practice often emphasised medical men's interactions with their environment. When the *Medical Circular* launched in 1852, its opening address imagined two different (though closely related) 'types' of readers. It portrayed those engaged in metropolitan and country practice, contrasting their duties chiefly through the lens of space. Both were depicted as hardworking, but their experiences were shaped by the distinctive settings in which they worked. The address described how,

> The *weariness of heart* incidental to London practice embitters yet more the ordinary anxieties attendant on our professional pursuits. After a man has spent his day in running through *dingy streets and filthy alleys*, reverberating incessantly with the hum of the human bee-hive; after visiting the sick in the *abodes of suffering and wretchedness*, and breathing, as it were, an *atmosphere of misfortune and pain*, he is not in a condition to explore the new facts or doctrines that may be broached in the various lengthy communications that appear in our periodical literature [emphases added].[104]

The article's images of grimy metropolitan practice are in stark contrast to the portraits of fashionable physicians in their sanitised and luxurious Harley Street consulting-rooms. It portrays the medical man amidst labyrinthine 'dingy streets' and 'filthy alleys' and claustrophobic 'abodes of suffering and wretchedness'. These images anticipate the mode of urban Gothic, which infiltrated contemporary fiction and social investigation writing. Robert Mighall defines the sub-genre as one in which 'terrors derive from situations

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[102] W. Somerset Maugham, *Of Human Bondage* (London: Vintage, 2000), p. 456. Further references are given after quotations in the text.
[103] Peterson, *The Medical Profession*, p. 229.
[104] 'Address to the Reader', *Medical Circular*, 14 January 1852, pp. 1-2 (p. 2).

peculiar to, and firmly located within, the urban experience'. He identifies 'the exchange between the sanitary and the sensational' as characteristic of the mode.[105] This interplay figures in the *Medical Circular*'s address, which portrayed the metropolitan practitioner as beleaguered by noise, dirt, overcrowding, and poverty. It suggested his anxieties were more acute than those of the provincial practitioner because the tumultuous environment in which he worked engendered a 'weariness of heart'. The journal sought to appeal to these readers, marketing its condensed format as better suited to their circumstances than extant periodical literature.

6. Slum practice in fiction

Contemporary fiction also scrutinised the relationship between medical men and the urban environment, exploring their encounters with the slums. Published anonymously, *Dives and Lazarus: The Adventures of an Obscure Medical Man in a Low Neighbourhood* (1858) was presented as an autobiographical account of London practice. It was instead a work of fiction by William Gilbert. Though he had studied medicine at Guy's Hospital and worked as an assistant surgeon in the navy, he abandoned his medical career. The book's narrator is the 'obscure medical man' of the title, who returns to England following a peripatetic career across the Empire. After his long absence he is almost a stranger to the city, but gradually becomes acquainted with it, particularly the condition of poverty. The book comprises a series of vignettes, which narrate his interactions with medical colleagues and patients he encounters in general practice and a hospital setting. The narrator represents the depredations and degradations of the London poor, with lingering descriptions of 'squalid poverty'.[106] As with much social reform writing of the period, the

[105] Robert Mighall, *A Geography of Victorian Gothic Fiction: Mapping History's Nightmares* (Oxford: Oxford University Press, 1999), p. 30, 68-9.
[106] William Gilbert, *Dives and Lazarus: The Adventures of an Obscure Medical Man in a Low Neighbourhood* (London: Judd and Glass, 1858), p. 126.

book deploys sensationalist imagery and a moralising tone. The narrator is preoccupied with questions of respectability and associates cleanliness with virtue. Through discussions with colleagues, however, he also comes to appreciate how environmental conditions precipitate vice, including criminality and prostitution. Ultimately, the text implies that medical men have a moral and social responsibility to investigate and critique social conditions. The book is an explicit invective against the operation and effects of the New Poor Law (1834). Its purpose is set out in the opening chapter, when the narrator expresses his 'vain hope of converting' the reader to his 'way of thinking'.[107] In medical and popular writing, the metropolitan practitioner functioned as a social observer, using his intimate access to the poor to communicate social problems to middle-class audiences.

For many medical commentators, the most faithful and potent representations of urban poverty were produced by Dickens. In *The Doctor and the People*, Woodcock notes:

> It has lately been decided that the medical attention received by the poor is far from sufficient. Not that this is a new discovery: it was made years ago by Charles Dickens, and the medical profession agreed with him.[108]

By crediting Dickens with this 'discovery', Woodcock emphasised his influence on medical thinking. The author held an enduring appeal among the profession. *Bleak House* (1853) proved especially popular due to its affirmative portrait of a medical practitioner.

Dickens characterises Allan Woodcourt as a young medical man with a sense of vocation. He is portrayed as having a 'strong interest in all that [medicine] can do' and as being prepared for 'considerable endurance and disappointment' in his career.[109] Having 'very little influence in London', he works largely among the slums. Esther Summerson describes his tireless efforts, how 'he was, night and day, at the service of numbers of poor

[107] Gilbert, p. 9.
[108] Woodcock, p. 50.
[109] Charles Dickens, *Bleak House*, ed. by Stephen Gill (Oxford: Oxford University Press, 2008), p. 246. Further references are given after quotations in the text.

people, and did wonders of gentleness and skill for them, [though] he gained very little by it in money' (255). Woodcourt combines both compassion and expertise in his attendance, which he repeatedly provides gratuitously. When he interacts with Jenny, the brick-maker's wife who has been injured at her husband's hands, he speaks without 'condescension'. He criticises her husband's cruelty but remains 'busy and composed', preoccupied with his professional duty rather than pressing an unwanted intervention, which puts her at ease (658).

It is Woodcourt's work among the poor which establishes his good character. However, with 'no fortune or private means' to support him, he leaves the capital midway through the narrative (255). He becomes a ship's surgeon, and ultimately distinguishes himself during a shipwreck in the East-Indian seas, where he performs 'generous and gallant deeds' (525). Sylvia Pamboukian suggests that Dickens draws a parallel between 'the urban slums and foreign countries', depicting both as 'objects for Woodcourt's charity'.[110] However, Woodcourt's departure from the city and removal to an exoticised setting are also instrumental in allowing him to display his heroism. They give him a romantic appeal which Dickens perhaps considered lacking in work among the slums.

After Woodcourt's return and marriage to Esther, the couple relocate to Yorkshire, where he becomes 'a medical attendant for the poor', a role which once again represents 'a great amount of work and a small amount of pay' (851). Patrick Parrinder argues that the narrative offers an 'escape' from the city, though one which remains 'subdued'. He contends that Summerson and Woodcourt's 'oasis of domestic privacy' is problematic because it offers 'no prospect of public recognition' and 'the rising young metropolitan

[110] Sylvia A. Pamboukian, *Doctoring the Novel: Medicine and Quackery from Shelley to Doyle* (Ohio: Ohio University Press, 2012), p. 68.

doctor will surely find his gifts wasted in such an isolated spot'.[111] Yet Dickens's portrait of provincial medical life and domestic contentment strongly appealed to medical readers.

Woodcourt was repeatedly cited as a role model for young practitioners. In 1867, the *Lancet* printed a leading article entitled 'The Methods and Aims of Medical Education', which offered 'some words of counsel' to students. It warned that '[f]ame, wealth, influence, and public honour' were rare rewards in the profession, but suggested that 'duty, manfully accepted and fairly done, brings true and enduring happiness in its train'. The writer claimed that these lessons were exemplified in 'the few and simple words that one of the greatest of living novelists has put into the mouth of the doctor's wife'. The article quoted the following passage from *Bleak House,* which is narrated by Esther towards the novel's end:

> We are not rich in the bank, but we have always prospered, and we have quite enough. I never walk out with my husband but I hear the people bless him. I never go into a house of any degree but I hear his praises, or see them in grateful eyes. 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 […] Is not this to be rich? (913)[112]

This is an idealised vision of the doctor-patient relationship, where the patient's regard is a valuable return for the practitioner's labour, outstripping even material gain. The article evoked Woodcourt as a moral and professional paradigm, one designed to inculcate realistic but noble goals in young readers.

The same passage from *Bleak House* was also quoted in an address delivered by ophthalmic surgeon Robert Brundenell Carter at the opening session of the St George's Hospital medical school in 1873, which was subsequently printed in the *BMJ* and *MTG*. Carter introduced the novel when he came to 'define the sources of […] happiness' in

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[111] Patrick Parrinder, *Nation and Novel: The English Novel from its Origins to the Present Day* (Oxford: Oxford University Press, 2006), p. 227.
[112] 'The Methods and Aims of Medical Education', *Lancet,* 14 September 1867, pp. 315-8.

professional life and he told his audience 'it is given to each one of us, if we will, to realise the picture for ourselves'.[113] It is significant that a successful London specialist such as Carter selected Woodcourt, an ordinary general practitioner, as his exemplar. The passage he cited from the novel refers to Woodcourt's work in Yorkshire, though since it was taken out of context, its application becomes much broader. In the *BMJ,* Carter's address featured under 'Abstracts of Introductory Addresses Delivered at the Metropolitan and Provincial Schools'.[114] The title implied a distinction between these sites, yet the addresses would have attracted a mixed readership in the journal. Woodcourt's appeal perhaps stemmed from his multiple medical identities: as slum practitioner, imperial adventurer, and medical attendant in the provinces. He moves between different types of practice and replicates his exemplary qualities across each setting.

Dickens's representation of Woodcourt's medical practice fuses elements of social realism and sentimental romance. At the century's close, Maugham engaged with the contemporary genre of naturalism to depict encounters between metropolitan medical men and the urban poor. His first novella *Liza of Lambeth* (1897) was written during his time as a medical student and obstetric clerk training at St Thomas's Hospital in Lambeth. Maugham qualified as a doctor but subsequently gave up medicine to focus on his literary career. When *Of Human Bondage* was published in 1915, his literary credentials were firmly established. However, the original manuscript was written shortly after his time at St Thomas's and the novel is set at the *fin de siècle.* In both books, Maugham self-consciously drew on his experiences of hospital work.

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[113] 'Abstracts of the Introductory Addresses Delivered at the Opening of the Medical Schools: St George's Hospital', *MTG,* 11 October 1873, pp. 406-7 (p. 406).
[114] 'Abstracts of Introductory Addresses Delivered at the Metropolitan and Provincial Schools', *BMJ,* 11 October 1873, pp. 443-4.

Liza of Lambeth follows the eponymous protagonist, a young factory worker, as she embarks on an affair with her married neighbour, Jim Blakeston. After their affair is exposed, Liza is attacked by Jim's wife and the narrative closes with Liza's miscarriage and death. In the novel, slum life is characterised by poverty, illness, alcoholism and domestic violence and the medical practitioner is a familiar (if not altogether welcome) figure. When Liza tells her mother, Mrs Kemp, she should go to the hospital about her recurrent pains, the older woman refuses, complaining that it would entail 'a dozen young chaps messin' you abaht, and lookin' at yer; and then they tells yer to leave off beer and spirits'.[115] Her invective rehearses a common anxiety held by patients (particularly women) that hospital care exposed them to the scrutiny of medical students. However, the doctor's injunction to avoid liquor appears reasonable to the reader, given Mrs Kemp is an alcoholic, whose pains are frequently symptomatic of her hangover. Nevertheless, her comment highlights how the urban poor anticipate being subjected to moral judgement in the medical encounter.

Another woman, Mrs Stanley, complains of the doctor's response when she seeks help for injuries inflicted by her husband. Initially, he agrees that the incident is 'disgraceful', expressing concern for her circumstances. However, he subsequently interrupts her account of domestic violence to enquire whether she had been drinking. He thereby shifts culpability for the attack from husband to wife, implying her drunkenness might have had a part to play in the altercation. She responds:

> I 'ave my glass of beer, and I like it. I couldn't do withaht it, wot with the work I 'ave, I must 'ave somethin' ter keep me tergether. But as for drinkin' 'eavily! Well, I can say this, there ain't a soberer woman than myself in all London (58-9).

[115] Maugham, *Liza of Lambeth* (London: Vintage, 2000), p. 19. Further references are given after quotations in the text.

For Mrs Stanley, the doctor's misplaced concern breaks down the relationship, since she feels that he does not understand her drinking habits nor her living conditions. This is a clear contrast to the scene in *Bleak House* whereby Woodcourt establishes a rapport with Jenny. Ultimately, Maugham implies there is a divide between the doctor who serves the metropolitan poor, and the patients with whom he comes into contact.

The novella's final scene presents the reader with another doctor-patient encounter. After her public confrontation with Mrs Blakeston, Liza spends the night drinking and suffers pains and a fever. Her mother fetches a neighbour, Mrs Hodges, who recognises that Liza is miscarrying and sends for a doctor. Maugham thus stages an encounter between an unofficial (female) practitioner and an official (male) doctor. Mrs Hodges claims that she has acted in the capacity of a nurse for twenty years, and the narrator describes her 'bustling forwards authoritatively in her position of mid-wife and sick-nurse' (131). Although this might suggest she is something of a nuisance in the sickroom, she clearly invites trust from the local community. One of her neighbours comments that he would 'back Mrs 'Odges against forty doctors' (133). It is unclear whether this is a product of their faith in Mrs Hodges or lack of confidence in the medical profession. The doctor who arrives on the scene accurately predicts Liza's decline, and his attentions are neither unwanted nor negligent. His inability to alleviate her sickness indicates not so much his inefficacy but the difficulty of interceding in debased conditions.

The major difference between Mrs Hodges and the doctor is not their medical authority, but the extent to which they are fleshed out as characters. Mrs Hodges is enmeshed in slum life, as suggested by her Cockney dialect. She is portrayed as intuitive and pragmatic, suggesting that Mrs Kemp have a drink to 'calm [her] nerves' and enquiring whether she has her daughter's life insured (133). She is not a character of great sympathy. She thoughtlessly comments, 'this mikes the second death I've 'ad in the last

ten days', before adding that the woman who died 'was only a prostitute, so it didn't so much matter. It ain't like another woman, is it?' (134). Her remark seems callous, particularly given that Liza's behaviour has been judged as sexually transgressive. Nevertheless, Mrs Hodges is a part of community life. While she is individualised, the doctor has no name, and while she is garrulous, he is given few words. His interactions with Liza, her mother, and her friends are decidedly limited. He remains faceless and removed; the reader learns nothing of his background, status, or personal characteristics. The fact he is visiting a poor patient in her home suggests his standing is relatively low; yet he remains an outsider in the Lambeth slums.

Liza of Lambeth depicts relatively few medical encounters but it was shaped by Maugham's experiences of hospital practice. In a later preface to the novella, the author identified his work at St Thomas's – particularly his training as an obstetric clerk – as providing the 'material' for the book: 'I exercised little invention. I put down what I had seen and heard as plainly as possible' (vii). At the time of writing he was 'working all day' as an obstetric clerk. He explains that medical students were given the role for a three-week period, during which time they had to be 'on hand day and night' to attend confinements, visiting patients in their own homes (vi). Maugham describes a typical call in detail. He would be summoned in the middle of the night by the hospital porter to find the woman's husband or son waiting to take him to the patient's bedside. He describes how, '[t]he messenger led you through the dark and silent streets of Lambeth, up stinking alleys and into sinister courts' (vii). His evocative depiction of these claustrophobic spaces recalls the mode of urban Gothic and reflects his naturalistic style.[116]

[116] Maugham discusses his literary influences in the preface. He describes how, before writing fiction, he tried producing plays of 'a harrowing nature and unflinching realism' in the vein of Henrik Ibsen (v). *Liza of Lambeth* also has clear affinities with the work of contemporary naturalists such as Gustave Flaubert, Guy de Maupassant, and Émile Zola.

Maugham describes entering places ‘where the police hesitated to penetrate, but where your black bag protected you from harm’ (vii). He suggests that the doctor’s professional role gave him licence to explore areas that might otherwise escape or repel attention. The implication is that the doctor was in a unique position to observe and, in Maugham’s case, record. Unlike a sanitary investigator, however, his graphic depiction of slum life is not mediated by any moralising social commentary. Scenes of violence and alcoholism are detailed unflinchingly – even luridly – but they are also offered without much embellishment or authorial intervention. The use of dialogue seems to offer unmediated access to the urban poor, but Maugham’s heavy use of Cockney dialect and the lack of interiority accorded to the characters also imply condescension. It seems paradoxical that Maugham suggests his work intimately acquainted him with slum life but that the practitioners he represents are remarkably distanced from their patient communities.

In his later novel, *Of Human Bondage*, Maugham offers a less pessimistic representation of the metropolitan medical man’s interactions with his patients. The novel traces the experiences of its self-conscious and introspective protagonist, Philip Carey, who eventually decides to follow in his deceased father’s footsteps and train as a doctor at St Luke’s Hospital in London. While much of the narrative concerns Philip’s tortured and masochistic romantic life, it also details his medical education and hospital training, which involves work among inpatients and outpatients, both medical and surgical cases. Philip trains alongside the medical elite, such as the assistant physician Dr Tyrell who, although only 35 years old, is already ‘a successful man, with a large consulting practice and a knighthood in prospect’ (454). Yet the narrative focuses on low-status drudgery, drawing on Maugham’s own experiences. When Philip takes on the role of obstetric clerk, he

tackles 63 cases during his three-week appointment – the exact same number that Maugham handled.[117]

During his studies, Philip yearns to be 'brought in contact with men and women as well as with text-books' (366). The once aimless young man seems to find a sense of vocation in his interactions with patients, which are vividly portrayed. He describes hospital work as teeming with life, as being 'manifold and various' and 'tumultuous and passionate' (462). He becomes 'a favourite with the patients' and one who 'inspired confidence in the people among whom he was thrown' (553, 644). He aims to 'preserve the distance between the hospital patient and the staff' that was deemed appropriate, and admits at one point to feeling no 'deep sympathy' for their condition (485, 483). Nevertheless, he establishes connections with some of the patients. When Philip visits one couple shortly after the wife's confinement – as is hospital convention – he is invited to join them for dinner, an arrangement which brings 'pleasure' to both parties (649). He also establishes a close and long-lasting friendship with a hospital inpatient (Thorpe Athelny) and his family. He later marries Athelny's daughter, Sally.

Philip's familiarity with his patients marks him out as distinct from his colleagues and runs counter to images of London practice as anonymous. Lilian Furst suggests that Philip's sympathy towards his patients derives from his 'artistic sensibility' and his experiences of disability (he has a club-foot, of which he is painfully embarrassed).[118] However, Maugham also suggests that Philip's experiences of penury – he suspends his studies after a failed speculation leaves him penniless – bring him closer to his patient constituency (644). *Of Human Bondage* does not offer a romanticised portrait of medical

[117] He relates this fact in the preface to *Liza of Lambeth* (p. vii).
[118] Lilian R. Furst, *Between Doctors and Patients: The Changing Balance of Power* (Charlottesville: University Press of Virginia, 1998), p. 144.

work among the poor and it engages with graphic descriptions of poverty, referencing drunkenness and domestic violence. In an image almost identical to that used in the preface to *Liza of Lambeth,* Philip describes how '[t]he black bag was a passport through wretched alleys and down foul-smelling courts into which a policeman was not ready to venture by himself' (649). Maugham suggests that hospital work brought the practitioner into contact with the seamier side of metropolitan life. In contrast to his earlier novella, *Of Human Bondage* also implies that the doctor adjusts to these surroundings during his work.

Despite the satisfaction he derives from his training in the metropolis and from his subsequent post as an assistant physician, Philip does not settle in the city. For much of the narrative he fantasises about work abroad, as a ship's surgeon or as a private practitioner in Europe or the East. With the characteristic zeal of the aspiring young practitioner, he tells a friend that he 'want[s] to see the world', noting that '[t]he only way a poor man can do that is by going in for the medical' (356). However, he ultimately chooses to stay in England. He initially makes the decision when he believes his unmarried lover, Sally, has fallen pregnant. Although she reveals it was a 'false alarm', Philip has become enraptured by the idea of simple domesticity (698). He proposes to Sally and accepts a generous offer to enter into a partnership with an older practitioner in Dorsetshire. While metropolitan practice is characterised by its richness and vitality, it seems to be antithetical to the novel's more conventionally happy ending.

Both *Liza of Lambeth* and *Of Human Bondage* attracted the attention of the professional press, though it is perhaps surprising that the former received a warmer critical reception. While some literary critics pronounced *Liza of Lambeth* a 'sordid story',[119] the *Lancet*'s review was largely positive, judging it to be 'powerful if somewhat

[119] 'New Novels: Liza of Lambeth', *Academy,* 11 September 1897, pp. 65-6 (p. 66).

sombre'. The review opened by noting that the author was 'a medical man'. Such statements were commonplace in reviews of fiction in the medical press, as though it was considered necessary to justify their inclusion in a professional publication. The review largely focused on Maugham's representation of the urban poor, which it deemed 'wonderfully graphic', while conceding it was 'not a pleasant one'. It added,

> we [do not] mean to contend that all the poor are like his characters. But that there are such among the lower classes no one who has ever done any work among them will deny for a moment.[120]

The reviewer's denial that the narrative is representative of lower-class life suggests he was hesitant to associate the urban poor with the degradations Maugham presents. Arguably, this obscures the fact that the characters are depicted as victims of their surroundings. Nevertheless, the *Lancet* review credited Maugham with 'the gift of observation' which it felt was integral to the profession and indicated that his characterisation would resonate with those who had 'work[ed] among' the poor. The review effectively suggested that medical men's insights rendered them unique writers and readers of fiction. It indicated its approval for Maugham's style when it suggested he avoided 'the somewhat Dickens-like pathos' of contemporary slum fiction. However, it also expressed ambivalence about the naturalist mode when it concluded that 'should Mr Maugham write another book – and we hope he will – he might choose a somewhat less sordid subject'.[121]

The seedier aspects of Maugham's writing were emphasised by the *BMJ*, in its pejorative review of *Of Human Bondage,* which appeared under the title 'The Seamy Side'. By this time, Maugham had acquired literary fame and the reviewer described him as a 'well-known playwright'. Yet he also referred to Maugham by the title 'Doctor',

[120] 'Library Table: Liza of Lambeth', *Lancet,* 16 October 1897, p. 989.
[121] 'Library Table: Liza of Lambeth', p. 989.

foregrounding his medical credentials. The article's main objection – as its title suggests – was the unhealthy or sordid atmosphere of the novel. It described Philip as 'unwholesome' and claimed that many of the characters left one with 'a slight feeling of nausea'. Although it remarked that, 'whether [Philip] is a valuable acquisition to the medical profession is a matter for the reader to decide', its own opprobrium was clear.[122] The review seems particularly moralising and sententious when compared to the *Lancet*'s response to *Liza of Lambeth.*[123]

The medical press' enthusiastic endorsement of Woodcourt could be contrasted with its disquiet over the characterisation of Philip Carey. The former is a romantic and honourable character, who exemplifies a sense of vocation. By contrast, the latter is presented as aimless for much of the novel and his relationships with women are often depicted as sordid. It is only towards the narrative's close that Philip discovers a sense of direction amid his hospital training and practice. These characters offer conflicting representations of the urban practitioner, though both suggest that work among the poor can showcase a man's nobler qualities. Across different forms of writing, the medical man's encounters with filth and depravity enable him to demonstrate his sense of duty, his humanity, and his wider value to society, thus elevating him above the indignities of his work.

Conclusion

Medical writing and fiction produced heterogeneous images of the metropolitan practitioner. Some commentators represented his life as one of comparative luxury, while others emphasised his struggles and industry. Consultant and specialist practitioners were

[122] 'Reviews: The Seamy Side', *BMJ*, 18 September 1915, pp. 436-7 (p. 437).
[123] As the *Lancet* did not publish a review of *Liza of Lambeth*, their responses cannot be compared directly.

typically portrayed as ambitious and eminent men, who attracted fame and fortune through their encounters with wealthy clients. Yet writers expressed uncertainty as to whether these practitioners were motivated by the advancement of science or their own personal interests. Medical men who worked primarily among the poor were variously represented as downtrodden figures labouring amid degrading conditions in return for small pay, or heroic individuals nobly bringing medical care to long-suffering and impenetrable parts of the city. In fiction, writers deployed sensational and Gothic modes to represent the vices of consultant and specialist practitioners, and engaged with the genres of social realism and naturalism to depict the challenges of attendance on the poor.

To some extent, the metropolitan profession was represented as bifurcated, with a split between the elite (the West-End practitioner) and the underdog (the East-End man). The medical press and fiction were powerful tools for exposing and critiquing some of these inequalities in the profession. Journals variously celebrated the elite but also sought to democratise knowledge and bring together traditionally divided groups within an imagined community. In the medical press and fiction, low-status medical men were portrayed as educated and cultured professionals who performed a necessary and even benevolent public duty. Across the writing discussed here, the conditions of city life bridged the gulf between different medical men. Eminent consultants, ordinary practitioners, and medical students were all depicted coming into contact with the seamy side of London and being exposed to its challenges and temptations.

Representations of the metropolitan practitioner – from the elite consultant to the low-status medical man – reveal a preoccupation with his personal character and conduct amid the temptations and degradations of the cityscape. In Chapter One, I discussed how advice guides typically constructed medicine as a gentlemanly profession and emphasised the need for young practitioners to behave with propriety. The metropolis was represented

as a crowded and competitive space which threatened to erode a medical man's gentility or respectability. During the first half of the century, the *Lancet* attacked the Royal Colleges and teaching hospitals, constructing the city as a place riven by nepotism and in-fighting. The medical press valorised the hospital system as a place of knowledge production but also engaged with its disreputable side, discussing its abuse by ambitious practitioners and patients feigning poverty. There also emerged anxieties that elite consultants and specialists might exploit their patients for financial gain or that low-status practitioners might undercharge their patients and bring the profession into disrepute. Concerns about the moral character of medical men were expressed in the medical press and exploited for sensational effect in contemporary fiction. Authors portrayed the elite as ostensibly genteel but as concealing lascivious personal vices. Those who worked exclusively among the urban poor were depicted working in an unwholesome atmosphere. Images of exploitation in Harley Street consulting-rooms produced an atmosphere of depravity that recalled tropes surrounding slum life. The ideal practitioner was expected to rise above the iniquities of city life, asserting his moral character in his personal conduct and humanity in his interactions with patients. This trope emerges across the medical press, life-writing, and popular fiction.

Metropolitan medical identities were fashioned in relation to ideas about the city's diverse patient population. Some authors portrayed practitioners who established familiarity with their patients. Frankau's Dr Phillips acts as a family doctor among his immediate social circle, though they know little of his true nature. Meanwhile, Dickens's Allan Woodcourt and Maugham's Philip Carey establish a rapport with their impoverished patients. However, there was frequently an emphasis on unfamiliarity and estrangement. In Conan Doyle's fiction, Percy Trevelyan discovers his supposed patients belong to a criminal gang, while Douglas Stone is unable to penetrate the disguises employed by Lord

Sannox. *Liza of Lambeth* presents faceless doctors, distanced from their patient communities. In these stories, interactions with unknown patients are represented as characteristic of London practice. This emphasis on anonymity and impersonality is antithetical to representations of doctor-patient relationships in the countryside which were often constructed around what Raymond Williams terms 'knowable communities', as I will explore in the next chapter.[124]

If the patient population was represented as fluid, then so was the profession and medical identities were shaped in relation to the perceived mutability of urban practice. In 1912, Woodcock remarked that '[e]veryone in medicine is sooner or later in London',[125] and the mobility of the metropolitan practitioner figured as a recurrent trope in medical writing and fiction. Gilbert's 'obscure medical man' returns to London after decades working in spaces across the Empire, but feels a sense of estrangement, shocked by the poverty he encounters. Young medical men like Woodcourt and Carey perceive metropolitan practice as just one stage in their careers but are nevertheless moulded by their experiences of city life. Thus while a metropolitan medical identity might be adopted or discarded upon entering or leaving the city, it was not necessarily a transitory identity. The range of texts discussed here imply that the experiences of urban practice – particularly its iniquities and poverty – had an enduring impact on one's personal and professional character.

[124] Williams, pp. 165-81.
[125] Woodcock, p. 227.

Chapter Three: The Country Practitioner

In 1901, general practitioner Harry Roberts delivered an address to the West Penwith Medical Society in Cornwall on 'The Status of the Country Doctor'. He concluded that:

> the position of the country doctor is better to-day than it ever has been, and […] if we play the game skilfully and fairly […] we may still further improve our status, our influence, and consequently our power of materially modifying the structure of provincial life.[1]

Roberts portrayed a typical country doctor who was nevertheless capable of wielding 'exceptional power' in his community.[2] His address was an act of self-definition, enabling him to mould his own professional identity, and a direct appeal to the Society's members. Through its publication in the *Lancet,* it also reached a much wider professional audience.

A similar image of the country practitioner was constructed in Frances Power Cobbe's 'The Medical Profession and its Morality' (1881). As outlined in Chapter Two, the article was a scathing attack on what Cobbe conceived as medical immorality and she used the figure of the country practitioner as a foil to 'the fashionable physicians and surgeons of the great cities and health resorts', whom she associated with misconduct. She suggested that, '[t]he ordinary English country practitioner, with his small pay, his rough work in all weathers, and his general kindliness and honesty, is one of the most respectable and valuable members of the community'.[3] Although Cobbe and Roberts were writing for different purposes and audiences, they deployed remarkably similar ideas about the country practitioner. They presented him as amiable, industrious, and steadfast. He was not a peripheral figure, but enjoyed stature and prestige.

This chapter examines how the country practitioner was represented in medical and popular writing between the 1830s and 1910s. It focuses primarily on the professional

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[1] Harry Roberts, 'The Status of the Country Doctor', *Lancet,* 16 March 1901, pp. 806-8 (p. 808).
[2] Roberts, p. 807.
[3] [Frances Power Cobbe], 'The Medical Profession and its Morality', *Modern Review,* 2 (April 1881), 296-328 (p. 306).

press, considering mainstream journals such as the *Lancet,* the *BMJ,* and *Medical Circular,* as well as lesser-known titles such as the *Medical Mirror* (a London-based journal which ran from 1864-70), and the explicitly provincial *Midland Medical Miscellany* (established 1881), a Leicester-based publication which rebranded itself as the *Provincial Medical Journal* in 1885, a title it retained until it folded in 1895. This chapter considers how medical journals functioned as a textual space through which the country practitioner's identity was fashioned and his professional networks were constructed.

Depictions of the country practitioner also proliferated in fiction. In its editorial preface to Roberts's address, the *Lancet* noted that '"[t]he country doctor" is a favourite subject of novelists and other writers'.[4] Although it did not name specific texts, a comprehensive (though by no means exhaustive) list of such characters in Victorian fiction would encompass Edward Hope in Harriet Martineau's *Deerbrook* (1839); the eponymous practitioners in Elizabeth Gaskell's *Mr Harrison's Confessions* (1851) and Anthony Trollope's *Doctor Thorne* (1858); Mr Gibson in Gaskell's *Wives and Daughters* (1866); Tertius Lydgate in George Eliot's *Middlemarch* (1872); and Edred Fitzpiers in Thomas Hardy's *The Woodlanders* (1887).[5] Not all of these texts replicate the romantic depictions of country practice found in Cobbe's and Roberts's writing. While Hope, Harrison, Thorne, and Gibson function chiefly as heroic figures in their respective novels, Lydgate oscillates between heroism and failure, and Fitzpiers is an inveterate adulterer.

In considering how the country practitioner was portrayed in realist fiction, I build on recent scholarship by Lilian Furst and Tabitha Sparks.[6] My approach scrutinises further

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[4] 'The Status of the Country Doctor', *Lancet*, 16 March 1901, pp. 797-8 (p. 797).
[5] The country doctor also featured prominently in fiction outside of Britain, appearing in novels as varied as Honoré de Balzac's *Le Médecin de Campagne* (1833), Gustave Flaubert's *Madame Bovary* (1856), and Sarah Orne Jewitt's *A Country Doctor* (1884).
[6] Lilian R. Furst, *Between Doctors and Patients: The Changing Balance of Power* (Charlottesville: University of Virginia Press, 1998). Tabitha Sparks, *The Doctor in the Victorian Novel: Family Practices* (Farnham: Ashgate, 2009).

the interplay between literature and medical discourse, foregrounding how the profession engaged with realism's representational strategies. Medical commentators were keenly aware of fictional portraits of the country practitioner. In 1896, Assistant Physician William Alfred Willis delivered an address on 'Medicine in Literature' to the Westminster Hospital Medical School, in which he surveyed representations of the doctor in fiction spanning the previous two centuries. He referred to Martineau's selection of 'a medical man for her hero' in *Deerbrook,* 'the charming Dr Thorne', and Gaskell's representation of 'an excellent type' of practitioner in *Wives and Daughters,* among others.[7] The professional press also engaged with less affirmative representations of the country doctor. In a short piece about the way in which medical men function as exemplars for other professionals, the *BMJ* noted that '[t]he doctors' in *Middlemarch* and *The Woodlanders* are 'not characters which do much credit to their profession'.[8]

This chapter investigates how the country practitioner's professional identity was conceptualised through the lens of space. As such, it is informed by scholarship on rural healthcare and the spatial dimensions of general practice in the nineteenth century.[9] Michael Brown's recent cultural history of provincial medical cultures between the mid-eighteenth and mid-nineteenth centuries has also influenced my work.[10] While he concentrates on a specific regional case study (York), my chapter considers how professional identities were fashioned in relation to the imagined geography of the British countryside.

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[7] W.A. Willis, 'An Introductory Address on Medicine in Literature', *Lancet,* 10 October 1896, pp. 996-1000 (p. 999).
[8] 'The Medical Profession as an Example', *BMJ,* 27 July 1901, p. 226.
[9] See, for example, Anne Digby, *The Evolution of British General Practice, 1850-1948* (Oxford: Oxford University Press, 1999), p. 3.
[10] Michael Brown, *Performing Medicine: Medical Culture and Identity in Provincial England, c. 1760-1850* (Manchester: Manchester University Press, 2011).

In analysing how the country practitioner was constructed in opposition to the metropolitan practitioner, I draw on Raymond Williams's conception of the dialectical relationship between the country and the city. He argues that depictions of the countryside in realist writing both privileged (and problematised) the idea of 'knowable communities'.[11] Building on this tenet, I explore how the country practitioner was portrayed in relation to his local community, as a familiar figure but one who occupied a liminal social position. My approach is also informed by literary scholarship on the 'provincial' and 'regional' as categories of Victorian fiction. Critics have explored shifting conceptions of provincialism and considered how rural spaces were represented in relation to the metropolis and the nation,[12] as well as global networks.[13] This attention to the interactions between different spaces shapes my own arguments about the construction of professional communities.

Country and provincial practitioners were represented in overlapping ways and the terms were sometimes used interchangeably, as in Roberts's address. Both were variously portrayed as backward and parochial or (conversely) noble and hard-working. Robin Gilmour and Ian Duncan suggest that provincialism acquired increasingly pejorative connotations (from around the 1860s onwards), which undermined its imaginative appeal.[14] I revisit this claim and consider how 'provincial' and 'country' identities intersected. However, my primary focus is on the 'country practitioner' because this figure endured in the cultural imagination, as I will demonstrate.

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[11] Raymond Williams, *The Country and the City* (London: Chatto and Windus, 1973), pp. 165-81.
[12] Robin Gilmour, 'Regional and Provincial in Victorian Literature', in *The Literature of Region and Nation*, ed. by R.P. Draper (Basingstoke: Macmillan, 1989), pp. 51-60. Ian Duncan, 'The Provincial or Regional Novel', in *A Companion to the Victorian Novel* (Malden, MA: Blackwell, 2002), pp. 318-35.
[13] John Plotz, 'The Semi-Detached Provincial Novel', *Victorian Studies*, 53 (Spring 2011), 405-16. Josephine McDonagh, 'Rethinking Provincialism in Mid-Nineteenth Century Fiction: *Our Village* to *Villette*', *Victorian Studies*, 55 (Spring 2013), 399-424.
[14] Gilmour, p. 52. Duncan, p. 326, 332.

This chapter begins by examining how writers defined the parameters of country practice. I consider how the country practitioner was mapped onto an imagined geography and examine the ways in which the temporal and spatial dimensions of his work were foregrounded. In the following section, I interrogate how the country practitioner's medical knowledge and practices were represented in relation to his perceived isolation from the metropolis. I then examine how the country practitioner was depicted in relation to professional networks, considering representations of both collegiality and conflict. Lastly, in the closing section of this chapter, I concentrate on how the country practitioner was depicted in terms of his interactions with individual patients and his local community.

1. Defining and imagining country practice

During this period, medical provision in Britain was concentrated in urban areas. Although the increasing supply of practitioners from the early nineteenth century onwards provided more medical coverage in the provinces, disparities continued, as Anne Digby identifies. By 1901, one in four of the population resided in rural areas, but only one in seven medical practitioners was based there.[15]

The profession recognised this uneven distribution of medical men. In 1888 the *BMJ* ran an article on 'The Waste and Supply of Medical Practitioners', which highlighted that urban and southern areas enjoyed a higher concentration of practitioners, while rural and northern districts had a 'deficient supply'. The article concluded by remarking that these figures were 'commended to the careful perusal of all who are wishing to settle and practise with success'.[16] It implied that those entering the profession should consider establishing themselves or relocating outside of the metropolis. Journals could help

[15] Digby, *Making a Medical Living: Doctors and Patients in the English Market for Medicine, 1720–1911* (Cambridge: Cambridge University Press, 1994), p. 20.
[16] 'The Waste and Supply of Medical Practitioners', *BMJ*, 15 December 1888, pp. 1346-7.

regulate where their readers practised, since they were able to encourage and even facilitate movement. They featured vacancies for apprentices, assistantships, and partnerships, as well as practices for sale.[17] The oversupply of medical men was represented as creating a competitive atmosphere; thus the profession had an obvious investment in practitioners taking positions in less populous areas. This may explain why the journals so often represented the country doctor as an attractive figure.

Despite the relative scarcity of the country practitioner, he was a familiar figure in medical and popular writing. This ubiquity can be illustrated through a simple keyword search of two of the major medical journals which have been digitised: the *Lancet* and the *BMJ* (as well as its forerunners).[18] As seen in Fig. 1, between their respective launch dates and 1910, these journals used 'country' as an epithet considerably more often than 'provincial', while 'metropolitan' was scarcely used. This disparity could be interpreted as a sign that metropolitan practice was treated as the dominant type or norm, and that the suffix 'country' was used to designate one different or other. However, I will show that it denoted a distinctive and affirmative professional identity.

Terms used	*Lancet* (1823-1910)	*BMJ* and forerunners (1840-1910)
Country practitioner	731	429
Country surgeon	292	159
Country doctor	154	277
Provincial practitioner	50	70
Provincial surgeon	142	138
Provincial doctor	3	11
Metropolitan practitioner	18	9
Metropolitan surgeon	13	23
Metropolitan doctor	1	0

Fig. 1. Frequency of epithets used in the *Lancet* and *BMJ*

[17] Digby uses the *BMJ Advertiser* in her analysis of medical men's career opportunities. It remains a scarce resource since most libraries removed this part of the journal before binding the issues for the year. *Making a Medical Living*, p. 128, 141-7.

[18] By selecting the timeframe 1840-1910 the JSTOR library scans the *BMJ* and its predecessors: the *PMSJ* and the *London Journal of Medicine* which combined to form the *Association Medical Journal.* The journal's publication history is outlined in Chapter Two.

The structural opposition between town and country informed much of the discourse about the 'country practitioner', but one must be cautious about privileging a binary division. Both the *BMJ* article and Digby's research attest that the situation was decidedly more complex, with discrepancies between North and South as well.[19] Further, commentators acknowledged the marked differences between rural spaces. In *The Medical Profession* (1879), Walter Rivington – Surgeon to the London Hospital – reflected on the desirability of different locations, drawing a contrast between '[d]ecaying towns, out-of-the-way places, country districts with a poor and scattered population' and '[v]illages in more civilised parts of the country'. He suggested the former attracted few practitioners, while the latter were likely to have 'a large proportion of medical men to the population'.[20]

In medical writing and fiction, country practice was associated with a range of different locales and regions. As Rivington suggested, it denoted medical work in rural villages and small towns, but also in more remote and outlying areas. For instance, the phrase 'country doctor' appeared in a *Lancet* news item entitled 'Difficulties of Medical Men in the Highlands' (1888). It quoted a letter sent to the *Scottish Leader* about a practitioner unable to visit a patient 'fourteen miles distant' due to the state of the roads.[21] An editorial on 'Country Practice and Sudden Cold' printed by the journal some twenty years later referred to notes received from a correspondent living and working in 'a bleak district rather to the west of Norfolk'. His concerns – which related to the challenges of providing medical care during cold weather – were presented as having wider relevance, particularly for those medical men 'living in a sparsely populated neighbourhood' or 'an out-of-the-way district'. The article included an anecdote about the difficulty of securing a doctor in a village in the North of England and cited Scotland and Ireland as those regions

[19] Digby, *Making a Medical Living*, p. 21.
[20] Walter Rivington, *The Medical Profession* (Dublin: Fannin, 1879), p. 4.
[21] 'Difficulties of Medical Men in the Highlands', *Lancet*, 24 March 1888, p. 589.

most likely to have people living many miles from a medical man.[22] Country practice also encompassed more prosperous work in busier towns. In *Mr Harrison's Confessions,* the eponymous protagonist joins Mr Morgan at his 'capital country practice' in Duncombe, which 'calls itself a town', but is more of a 'village' in the former's estimation.[23] Meanwhile, Lydgate – also a 'country doctor' – works in the 'provincial town' of Middlemarch which, far from being underrepresented by medical men, boasts several practitioners.[24]

Country practice was a malleable concept, which blurred separate regional and local identities. Duncan argues that '[t]he region […] is a place in itself, the source of its own terms of meaning and identity, while the province is a typical setting defined by its difference from London'.[25] Country practice does not fit either of these polarised definitions. In the writing discussed here, it denotes a generic (rather than fixed) space but one which nevertheless carries its own 'meaning and identity'. It was an imaginative category as much as a geographic one. Cobbe, for example, contrasted the country practitioner with those medical men working in 'great cities and health resorts'.[26] For her, country practice was the antithesis not simply of metropolitan medicine but all fashionable sites of practice. In its preface to Roberts's address, the *Lancet* suggested that his references to the 'country doctor' were meant to denote not 'only those who live in small villages, but virtually all general practitioners, as distinguished from the "separate class of physicians"'.[27] In his analysis of mid-Victorian realist fiction, Duncan posits that the 'provincial' (often represented as a rural setting) functioned as 'the dominant topos for

[22] 'Country Practice and Sudden Cold', *Lancet*, 16 January 1909, pp. 178-9.
[23] Elizabeth Gaskell, 'Mr Harrison's Confessions', in *The Cranford Chronicles* (London: Vintage, 2007), pp. 1-86 (pp. 4-5). Further references are given after quotations in the text.
[24] George Eliot, *Middlemarch*, ed. by David Carroll (Oxford: Oxford University Press, 2008), p. 133, 116. Further references are given after quotations in the text.
[25] Duncan, p. 323.
[26] Cobbe, p. 306.
[27] 'The Status of the Country Doctor', p. 797.

representing national identity'.[28] Drawing on this idea, I argue that the country practitioner became the template or synecdoche for a broader professional identity. The metropolitan practitioner (particularly the consultant) was not the dominant or presumed type, but was instead defined by his alterity.

The archetypal country practice was characterised by its distance from a large city and the vast area it covered. This space required a general practitioner or family doctor who could serve the whole neighbourhood, moving between different social classes. General practice and country practice were often represented as synonymous, as indicated in the previous chapter. In 1845, a correspondent to the *PMSJ* (later the *BMJ)* asserted that '[e]very man […] in rural districts, must be termed a general practitioner in the proper sense of the term'.[29] The image of the heroic generalist tending to the community's needs was mobilised across different forms of writing. In 1881, William Pratt (surgeon to the Montgomeryshire Infirmary) shared 'Cases in Country Practice' with the *Lancet*. He suggested that metropolitan practitioners could not understand 'the anxieties and responsibilities of their provincial brethren, who oftentimes, unaided and uncounselled, must grapple with the most formidable accidents and the most unmanageable diseases'.[30] The tropes of the benevolent country practitioner and the exploitative specialist were also satirised, as in the poem 'The Country Doctor', which first appeared in the *St Bartholomew's Hospital Journal* in 1899 and was reproduced by the *BMJ* in 1904.[31] It parodied Rudyard Kipling's 'Soldier an' Sailor Too', which celebrated the Royal Marines. The reworked version valorised the figure of the country doctor – characterised as 'surgeon an' midwife too' – contrasting him with 'them specialist thieves' who 'watch yer

[28] Duncan, p. 323.
[29] 'A General Practitioner', 'Correspondence: Remuneration of the General Practitioner', *PMSJ*, 12 February 1845, p. 106.
[30] William Pratt, 'Cases in Country Practice', *Lancet,* 17 September 1881, pp. 498-9 (p. 498).
[31] E.G.B.A., 'The Country Doctor', *St Bartholomew's Hospital Journal,* August 1899, p. 174.

die with a winkin' eye for a 'undred pound or so'. The *BMJ* printed the poem at the request of a reader, noting it had attracted 'much interest', presumably for its acerbic commentary on medical rivalries.[32]

Medical historians have examined how general practice became the norm in the countryside. It was usually associated with medical men licensed by the Royal College of Surgeons, the Society of Apothecaries, or both (hence surgeon-apothecaries). However, those who were qualified as physicians also assumed generalist responsibilities in rural and provincial areas to 'supplement slender incomes'.[33] In fiction, country practitioners are drawn from a variety of backgrounds. In *Middlemarch* – set during 1829-32 – the town is served by a number of practitioners, including the resident physicians – Dr Sprague and Dr Minchin – and, at the lower end of the socio-professional scale, the surgeons Mr Wrench, Mr Toller, and finally Mr Gambit who is 'a little lower in status', being 'especially esteemed as an accoucheur' (418). Lydgate is not easily incorporated into this hierarchy, since he is determined to 'resist the irrational severance between medical and surgical knowledge' (136). While his attitude anticipates later medical reform he also resembles other country practitioners in contemporary fiction, who undertake diverse duties among a cross-section of the local community.

2. Temporal and spatial dimensions

In the medical press and fiction, the country doctor was embedded in an imagined landscape. Writers constructed a rich topography, defined by its difficult terrain. They borrowed from realism, which typically defines its setting through the particulars of time

[32] E.G.B.A, 'Literary Notes: The Country Doctor', *BMJ*, 5 March 1904, p. 558.
[33] Furst, *Between Doctors and Patients*, p. 66.

and place.[34] However, they also drew on melodramatic and Gothic imagery to counter suppositions that the country was an idyllic space in which to work. The inaugural issue of the *Medical Circular* featured an opening address in which it imagined a diverse readership, as explored in the previous chapter. While the archetypal metropolitan practitioner was pictured in 'dingy streets and filthy alleys', the rural practitioner was depicted journeying over 'bleak moorland and rugged hill-sides'. These Gothicised landscapes foregrounded the dangers of both urban and country practice. The writer also emphasised the heroism associated with labour and industry, representing the country practitioner 'anxiously brooding over the untoward occurrences of some important case'.[35] The article's sympathetic rhetoric may have been informed by the experiences of the journal's founder and proprietor, James Yearsley. Before establishing himself as an aural surgeon in London in 1837, he had worked as a general practitioner in a market town in Herefordshire. However, the journal was edited by London-based general practitioner George Ross.[36] These men's different experiences may have shaped the opening address, with its dual appeal to urban and country practitioners.

An emphasis on the topographical dimensions of practice also figured in 'The Country Doctor and his Work' (1870), an article printed in the *Medical Mirror*. Employing similarly melodramatic language, it described the rural practitioner travelling:

> Down hill, over dale, through treacherous gaps to the house of suffering, and home again to find, perhaps, a journey equivalent in danger and distance to be undertaken in another direction forthwith, and all this exposure to the inclemency of the night, and risk to life, for a few shillings.[37]

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[34] Furst, *All is True: The Claims and Strategies of Realist Fiction* (Durham: Duke University Press, 1995), p. 24. George Levine, *How to Read the Victorian Novel* (Malden, MA: Blackwell, 2008), p. 154.
[35] 'Address to the Reader', *Medical Circular,* 14 January 1852, pp. 1-2 (p. 2).
[36] Robert J. Rowlette, *The Medical Press and Circular 1839–1939: A Hundred Years in the Life of a Medical Journal* (London: [Medical Press and Circular], 1939), p. 66, 83.
[37] 'The Country Doctor and his Work', *Medical Mirror,* 1 November 1870, p. 195.

The rhythm of the prose reflects the country doctor's journey over an undulating and forbidding landscape. His work is represented as perpetual, for his return home does not provide refuge but rather marks the beginning of a new (and equally dangerous) excursion.

This preoccupation with the temporal and spatial aspects of the doctor's work, and the recurrent tropes of long journeys through difficult terrain and a busy schedule marked by night calls, also appeared in writing for popular audiences. In 1863, the magazine *Leisure Hour* featured an article entitled 'The Country Doctor', in which an anonymous medical man recalled his experiences as an apprentice to a country general practitioner.[38] He claimed that, '[t]own and city practitioners little know of the expanse of ground a country doctor must daily cover', rehearsing common ideas about the differences between urban and rural practice. The writer recalled his governor's night calls, picturing him 'riding on a lonely moor, winds howling, rain pattering, lightning flashing, and thunder-rattling'.[39] The sequence of present participle verbs invests the memory with a sense of immediacy and urgency. In *Reminiscences of a Country Doctor, 1840-1914* (1914), Scottish general practitioner David Pride provided a collection of autobiographical sketches. In 'The Night Journey to Fanny's Hut', Pride recalled a treacherous trip to attend a boy residing on a bleak moor. The narrative opened on 'a very dark and stormy winter night',[40] drawing on common literary tropes to delineate the challenges of country practice.

The disruptive or perilous night-call also appeared in fiction. In *Wives and Daughters*, Mr Gibson's inability to fall in with his new wife's domestic routine due to the demanding and unpredictable nature of his work becomes almost a structuring device and

[38] *Leisure Hour* (1852-1905) was a penny paper published by the Religious Tract Society though it was not 'overtly religious' in tone. Laurel Brake and Marysa Demoor (eds.), *Dictionary of Nineteenth-Century Journalism in Great Britain and Ireland* (Gent: Academia Press, 2009), p. 356.
[39] 'The Country Doctor', *Leisure Hour*, 7 February 1863, pp. 87-91 (p. 88).
[40] David Pride, *Reminiscences of a Country Doctor, 1840-1914* (Paisley: Alexander Gardner, 1914), p. 45.

he is conspicuously absent at many of the key moments in the novel, disappearing from the highly anticipated Charity Ball, and returning home late on the day his stepdaughter Cynthia receives a proposal from Roger Hamley. The trope appears so familiar (even to lay writers) that it is ironised. In *Doctor Thorne,* when the protagonist is summoned to a patient's bedside, his niece Mary remarks 'it always happens at night'.[41] The night-call was used to denote the practitioner's industry.

Competing portraits of the country practitioner also circulated, however, some of which depicted him enjoying a leisurely and even idle lifestyle. In 1881, the illustrated weekly the *Graphic* printed an article which sought to combat common misconceptions about 'the life of the country doctor'. It opened by suggesting that many people were envious of his career, for '[h]e appears to make plenty of money and to make it easily'. They presume 'the greater part of his work consists in riding or driving about the country, spending a few minutes by his patients' bedside' before visiting some 'well-to-do personage' for 'pleasant chat or social intercourse'.[42] A *BMJ* article entitled 'How to be Happy though a Doctor' (1902) described how some men among the profession idealised 'the life of a country doctor' as the most 'enjoyable position in the whole range of medical practice'. They imagined him enjoying 'a first-rate position', 'hold[ing] his own in entertaining and in general social life'. By contrast, they perceived metropolitan practice as '[o]ne continuous rush and hurry from morning till night'. For these men, the '[b]roken meals' and 'interrupted sleep' sometimes associated with country practice typified the London practitioner's schedule. Nevertheless, the tone of this passage was satirical; the writer gently mocked the medical man who dreamt of a profitable country practice that would enable him to 'educate his children fashionably' and 'take a sufficient holiday every

[41] Anthony Trollope, *Doctor Thorne* (London: Penguin, 2012), p. 313.
[42] 'The Country Practitioner', *Graphic,* 2 July 1881, p. 11.

year in Scotland'.[43] Significantly, both the *Graphic* and *BMJ* articles sought to dismantle stereotypes about country practice. Medical and popular writing tended to focus on the country doctor as a hard-working figure, diligent in his duties, and the idle or self-serving practitioner served as a foil to illuminate these nobler qualities. Thus in *Middlemarch,* Lydgate's sympathetic and innovative approach to medicine is offset against the recalcitrance of his rivals.

The motif of the difficult journey remained resilient across the period, even as debates about the medical man's mode of transport changed. In 1851, a practitioner in the Lake District wrote to the *Lancet* to argue that 'the ever-toiling practitioner of a country district' should be included in the list of those exempt from 'the horse-tax'.[44] The tax was levied on those who owned a horse, including for trade purposes, and was not repealed until 1874. By the late 1890s, the debate had shifted. Both the *Lancet* and *BMJ* regularly featured articles and correspondence discussing the advisability and utility of the motor car. From an early stage, it was recognised as having a potentially transformative effect on the country practitioner's work. In 1898, the *BMJ* noted there had been 'numerous advocates' for using a car in country practice,[45] and by 1903, the *Lancet* suggested it 'may be a real blessing to rural communities'.[46] However, reservations were also expressed in the pages of the medical press, as commentators grappled with the financial implications of driving and maintaining a car, the challenges presented by difficult weather and hilly terrains,[47] the problems posed by breakdowns in more remote areas,[48] and the risk of

[43] 'How to be Happy though a Doctor', *BMJ,* 31 May 1902, pp. 1371-3 (p. 1371).
[44] 'Volucris', 'The Country Medical Practitioners and the Horse-Tax', *Lancet,* 15 March 1851, p. 310.
[45] 'Motor Cars for Medical Men', *Lancet,* 16 September 1899, pp. 732-3 (p. 732).
[46] 'The Motor-Car Bill', *Lancet,* 8 August 1903, pp. 415-6.
[47] 'Motor Cars', *BMJ,* 3 December 1898, pp. 1719-20.
[48] 'Motor Cars for Medical Men', p. 733.

accident and injury (to both self and others).[49] A piece in the *BMJ* added that overused vehicles would be unlikely to 'lend dignity' to professional visits.[50]

In 1909, an article in the *Lancet* contended that 'there [was] no more important factor in the successful working of a country practice than good roads'. Though the writer suggested that the medical man's work may be 'facilitated' by the use of a car, he emphasised that 'frost and snow interfere with the smooth working of a country practice in an out-of-the-way district in more ways than by increasing the medical man's labour in travelling', chiefly by preventing patients from sending for him.[51] Significantly, even as the spatial and temporal dimensions of the country practitioner's work were in the process of being radically altered by new technologies, old tropes persisted: he remained defined by the challenges he faced in accessing his patients. The dialectic between continuity and change has been recognised as a defining feature of provincial fiction. Duncan posits that representations of (semi-)rural spaces variously offer an 'inquiry into the process and effects of historical change' or 'make it a site that escapes change'.[52] In medical writing and fiction, portraits of country practice were often nostalgic but they also engaged with the demands of modernity.

3. Medical knowledge and practice

The imagined spaces of country practice were variously represented as either strengthening or enervating the medical man's knowledge and practice. In 1861, the conservative weekly the *Saturday Review* published an article in which it suggested that '[t]he country doctor is apt to be unskilful' since he 'enjoy[s] an almost absolute monopoly, and ha[s] little to fear

[49] 'The Insurance of Motor Cars', *BMJ,* 22 October 1903, p. 1106. 'Notes, Short Comments, and Answers to Correspondents: "The Man it Was that Died"', *Lancet,* 6 September 1902, p. 719.
[50] Edward Phillips, 'Motor Cars for Medical Men', *BMJ,* 27 September 1901, pp. 981-2 (p. 982).
[51] 'Country Practice and Sudden Cold', p. 178.
[52] Duncan, p. 324.

from failure'. This argument turned on the scarcity of country practitioners, implying they each held sway over a 'rigidly preserved' terrain. In Chapter One, I explored how professional etiquette was seen to govern the actions of practitioners and their patients. The *Saturday Review* article suggested that '[m]edical etiquette' exercised a 'powerful tyranny' over country patients, making it difficult for them to dismiss one doctor and engage another in his place. Essentially, the article implied that the doctor-patient relationship was predicated on the complacency of the country practitioner and the lack of options available to his patient. The writer suggested that the country doctor 'claims the sole right to purge, blister, and destroy', gesturing towards outdated and harmful medical practices.[53] Similar fears were expressed in an article in the *Graphic,* which contended that, '[i]n some parts of England, the doctors are so far behind the day, that you might almost as safely be taken ill in Italy'.[54] It represented the backward country doctor as undermining national pride in modern medicine.

Unsurprisingly, the medical press was provoked by these allegations. The *BMJ* printed a piece attacking the 'ignorant thoughtlessness' and 'bad taste' of the *Graphic*'s contributor. It suggested that, while there were 'degrees of intelligence and degrees of skill' in the profession, these could not 'be estimated by place of residence'. However, it implicitly concurred with some of the prejudices about country practice, conceding that 'a patient in a city has his choice, whilst in a village he may choose to have none'.[55] The *Lancet,* meanwhile, featured a leading article refuting the accusations made in the *Saturday Review*. The explicit purpose of this editorial was to 'vindicate the high title which our professional brethren possess to the confidence of the public'. While it accepted there were 'more restricted opportunities' for country doctors, it highlighted the fact that

[53] 'Country Doctors', *Saturday Review*, 7 September 1861, pp. 240-1.
[54] [Untitled], *Graphic,* 5 February 1870, p. 218.
[55] 'Country Doctors', *BMJ,* 12 February 1870, pp. 160-1 (p. 161).

they had undergone the same 'earnest study' and 'verification by competitive examination'.[56] It suggested that the country practitioner was limited, but not wholly defined, by the space he inhabited.

The suggestion that medical men's qualifications were uniform was rather deceptive, however. As outlined in Chapter One, there were diverse routes into medical practice and different licensing bodies with variable requirements, even after the 1858 Medical Act.[57] Representations of the country doctor did not necessarily imply that he had received less rigorous training than his metropolitan counterparts. A common trope in literary depictions of the country practitioner is his arrival in a village or small town after pursuing his medical education in a major city. For instance, Gaskell's Mr Harrison comes to Duncombe from Guy's Hospital in London. Meanwhile, Lydgate has studied at the fashionable centres of medicine, though his cosmopolitanism distinguishes him from his fellow country practitioners. The town's physicians sneer at the fact he has not been 'to either of the English universities' but instead has 'a libellous pretension to experience in Edinburgh and Paris'. The narrator clearly satirises their perspective, noting that medical degrees from Oxford and Cambridge were (at this time) characterised by an 'absence of anatomical and bedside study', while Edinburgh had 'abundant' opportunities for 'observation' (171). Indeed, both Edinburgh and Paris were leading centres for medical education in this period. Contemporary writing also idealised less prestigious routes into practice. In the *Leisure Hour*'s article on 'The Country Doctor', for instance, the writer fondly recalled his experiences as an apprentice to a country general practitioner.[58]

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[56] 'Country Doctors and the "Saturday Review"', *Lancet*, 28 September 1861, pp. 297-8.
[57] Thomas Neville Bonner, *Becoming a Physician: Medical Education in Great Britain, France, Germany, and the United States, 1750-1945* (New York: Oxford University Press, 1995), pp. 193-6.
[58] 'The Country Doctor', *Leisure Hour*, pp. 86-7.

Medical and lay writers recognised that what distinguished the country practitioner from his urban counterparts was his alienation from hospital practice. As demonstrated in Chapter Two, hospitals were typically portrayed as vital sites for medical education and practice, which bestowed clinical experience and social status. There were of course hospitals outside of the metropolis; by 1800, over thirty provincial voluntary general hospitals had been established and by mid-century they had been erected in most major towns.[59] However, Steven Cherry suggests that the average 'rural or small town general practitioner' was 'rarely allowed to practise' in these hospitals.[60]

Despite its sensationalising rhetoric about the shortcomings of the country practitioner, the *Saturday Review* article offered a more measured conclusion when it asked, '[m]ight it not be possible to establish hospitals on a small scale in the smaller market towns, and so to diffuse more widely the advantages which they confer both on doctors and patients?'.[61] The article gestured towards the emerging cottage hospital movement, widely thought to originate with surgeon Albert Napper, who converted a cottage into a hospital in Cranleigh, Surrey in 1859.[62] The ensuing movement entailed houses being adapted into small, rural hospitals or existing dispensaries being altered to include inpatient facilities. Cottage hospitals were modelled on provincial general hospitals but on a smaller scale and were staffed by general practitioners. They did not usually accept infectious patients and thus differed in kind from fever hospitals.[63] The movement

[59] Steven Cherry, 'Change and Continuity in the Cottage Hospitals c. 1859-1948: The Experience in East Anglia', *Medical History*, 36 (July 1992), 271-89 (p. 272).
[60] Cherry, p. 273.
[61] 'Country Doctors', *Saturday Review*, p. 241.
[62] Earlier antecedents to the cottage hospital have been identified, but Napper's initiative was the beginning of a concerted movement. See Cherry, p. 272.
[63] Henry Burdett, *Cottage Hospitals: General, Fever and Convalescent*, 3rd edn (London: Scientific Press, 1896), p. 11.

quickly gathered momentum: by 1875, there were 148 cottage hospitals and a further 146 were developed over the next two decades.[64]

The scheme was actively promoted by both metropolitan and provincial medical journals; positive reports appeared in the *BMJ*; the *Medical Circular* and its later incarnation, the *MPC*; and almost twenty years later in the *Midland Medical Miscellany*.[65] The *Medical Mirror* was a particularly enthusiastic adherent of the scheme, running reports by Napper (including practical advice on how to establish a cottage hospital) and positive reviews of his published work. In one article, Napper emphasised that these hospitals not only played a crucial role in 'the alleviation of the sufferings of the poor' but also in raising the profile and prestige of the country practitioner. Recognising that a hospital appointment was 'always considered a sufficient guarantee of high professional attainments' among affluent private patients, he suggested that 'in the absence of any such means of affording proof of his ability, the country surgeon is too frequently regarded with distrust'.[66]

The movement was also endorsed in books aimed at medical and generalist audiences. One of the best-known advocates was Henry Burdett, the founder and editor of the journal *The Hospital* (1886-1920), who had a career in hospital administration and finance. He compiled a guide entitled *Cottage Hospitals: General, Fever and Convalescent,* which was first published in 1877. In the preface to the third edition (1896), Burdett emphasised that his aim was to 'promote the success of cottage hospitals everywhere'. He highlights their 'value and importance to all who reside in rural districts'

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[64] Cherry, p. 273.
[65] 'Cottage Hospitals', *BMJ,* 3 March 1860, p. 171. 'Village Hospitals in Great Britain', *MPC,* 9 May 1866, pp. 488-9. E.J. Waring, 'On the Establishment of a Cottage Hospital', *Midland Medical Miscellany,* 1 October 1883, pp. 292-4.
[66] Albert Napper, 'On the Advantages Desirable to the Medical Profession and to the Public from the Establishment of Village Hospitals', *Medical Mirror,* January 1864, pp. 20-4 (p. 22).

and the fact they have 'enabled the country practitioner to become an accomplished and skilful surgeon, to keep himself well abreast of the new features of medical practice'.[67] As in the medical press, cottage hospitals were characterised as a boon to both patients and practitioners. Other books on the subject were explicitly aimed at popular readers, such as Horace Swete's *Handy Book of Cottage Hospitals* (1870), which outlined the history and principles of the movement and described existing hospitals. The title page advertised the author's credentials as former Surgeon to the Wrington Village Hospital.[68]

Thus far, scholarship on cottage hospitals has largely concentrated on regional case studies, examining the hospitals' facilities and interactions with their local communities.[69] While historians consider the way in which the hospitals were advantageous to general practitioners, it is important to emphasise that the broader movement influenced national conceptions of the country practitioner. The hospitals were represented as improving his skillset, status, and interactions with patients. In 1992, general practitioner Dr Meyrick Emrys-Roberts published a comprehensive history of the movement. His passionate campaign to retain GP-led hospitals indicates how these sites of practice continued to be intimately bound up with a doctor's professional identity and self-respect.[70]

Another way in which medical men in the country kept up-to-date with clinical practices was through the professional press. As indicated in the previous chapter, metropolitan journals often framed themselves as an invaluable resource for isolated practitioners. This was a strategy to cement or expand their readership in outlying areas. In

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[67] Burdett, *Cottage Hospitals,* p. v.
[68] Horace Swete, *Handy Book of Cottage Hospitals* (London: Hamilton, Adams, 1870).
[69] As well as Cherry, see also Julia Neville, 'Cottage Hospitals and Communities in Rural East Devon, 1919-39', in *Healthcare in Ireland and Britain from 1850: Voluntary, Regional and Comparative Perspectives*, ed. by Donnacha Seán Lucey and Virginia Crossman (London: Institute of Historical Research, 2014), pp. 117-38.
[70] Meyrick Emrys-Roberts, *The Cottage Hospitals 1859-1990: Arrival, Survival and Revival* (Motcombe: Tern, 1991).

1837, *The Doctor* commenced a series of articles entitled 'The Village Practitioner'. The preface to this feature noted that,

> [i]n remote districts, far removed from medical advice, our publication is in many instances the only guide which is to be readily found, by which the true nature of disease is ascertained, and appropriate medicines are pointed out.[71]

The series encompassed articles on complaints as diverse as fever, inflammation of the bowels, smallpox, and rheumatism, indicating the range of cases with which the country doctor was thought to come into contact. However, the wording of the preface suggests that the series may have been intended for lay people who were unable to access a practitioner but who felt responsible for the healthcare of others. From 1836 the journal specifically pitched itself as 'Adapted for the Use of Clergymen, Heads of Families, Nurses'. The fact that it was edited by George Shipman, a general practitioner based in Ludgate Hill (City of London), reinforces the sense that the series was predicated on a diffusionist model whereby knowledge was passed from the metropolis to the countryside and possibly from the medical man to the layperson.

In its rejoinder to the *Saturday Review*'s invective against country practice, the *Lancet* editorial emphasised the role of an 'active and independent medical press' in keeping the country practitioner informed of 'all that is new in science'. However, it also credited rural medical men with playing an active role in shaping its content: 'Our columns testify, also, how large a share he brings to the common stock of original information'.[72] The clinical contributions that opened the journal came from a variety of practitioners, including physicians and surgeons at London and provincial hospitals, as well as those in general practice in the metropolis, provinces, and countryside. By placing these observations alongside one another, the journal created the impression that they were all

[71] 'The Village Practitioner', *The Doctor*, 8 March 1837, p. 180.
[72] 'Country Doctors and the "Saturday Review"', p. 298.

valuable reading for the medical community. However, the opening pages were typically dominated by contributions from the metropolitan elite.

Fiction represented young, heroic country practitioners keenly engaging with the medical press. In Gaskell's novella, Harrison publishes the difficult case of John Brouncker's wrist injury (the source of his quarrel with Mr Morgan) in the *Lancet* (49), while in *Deerbrook* Hope recalls that he has 'a case to report for a medical journal' even while he is ostracised by his own local community.[73] Authors also portrayed country practitioners who resisted the influence of medical journals. In *Middlemarch,* Sprague announces that he 'disapprove[s] of Wakley' (the *Lancet's* infamous founding editor), whom he considers 'an ill-intentioned fellow' ready to 'sacrifice the respectability of the profession […] for the sake of getting some notoriety for himself' (147). Sprague's distaste for Thomas Wakley's reforming zeal is satirised, used to signify his recalcitrance. The *Lancet* (at this point edited by Wakley's son, James) found the passage so amusing it printed it at length in its positive review of the novel.[74] In Conan Doyle's 'Behind the Times' (1894) – discussed in Chapter One – the old-fashioned country practitioner Winter reads a weekly medical paper only out of a sense of 'duty', so that 'he has a general idea as to the advance of modern science', which he nevertheless judges to be 'a huge and rather ludicrous experiment'.[75] Once again, resistance to the medical press is used to indicate backwardness, though Winter is shown to be a genial practitioner.

In responding to the accusations made in the *Graphic* and the *Saturday Review,* both the *BMJ* and *Lancet* editorials proposed that country practice provided myriad opportunities for carrying out personal research. The *BMJ* piece suggested that '[i]n some

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[73] Harriet Martineau, *Deerbrook*, ed. by Valerie Sanders (London: Penguin, 2004), p. 243. Further references are given after quotations in the text.
[74] 'Reviews and Notices of Books: Middlemarch', *Lancet,* 23 November 1872, pp. 745-6.
[75] Arthur Conan Doyle, 'Behind the Times', in *Round the Red Lamp and Other Medical Writings,* ed. by Robert Darby (Kansas City: Valancourt, 2007), pp. 3-7 (p. 4).

respects, country surgeons have advantages over city residents. They are thrown more completely on their own resources'. In an apparent nod towards Edward Jenner's work on vaccination, it noted that, 'the most beneficent of medical discoveries was born in the brain of a village surgeon'.[76] In a similar vein, the *Lancet* article suggested that 'the first, the dearest, the most cheering recognition of a new discovery or an improvement in medicine is sure to proceed from country doctors'. It described how,

> In London the mass of men are often too busy or too distracted by cares – their practice is rendered by the tendency to specialism too limited – to permit of that quick and accurate appreciation of new views and facts which distinguish the more contemplative position and universal experience of the country surgeon.[77]

This passage draws on familiar tropes about metropolitan and provincial practice, valorising the generalist over the specialist. Nevertheless, it is striking that a London-based journal like the *Lancet* implied that the 'mass of [medical] men' in the city were 'too distracted' to make clinical observations. In contrast to writing which foregrounded the physical toils experienced by the country practitioner, here he is endowed with a 'contemplative position'. This emphasis on the intellectual and philosophical aspects of his work counteracted the notion that general practice was akin to trade. While accepting that the country doctor did not face the same 'stimulus of rivalry' as his urban counterparts, the article suggested that he was driven by 'the far more lasting and certain appetite for knowledge'.[78] In these editorials, the periphery was reconceptualised as a productive space for advancing medicine away from the pressures, or even taint, of the metropolitan hospital.

The romanticised image of the scientifically minded country practitioner at the vanguard of modern medicine appealed to writers of fiction. The ideals propounded in the

[76] 'Country Doctors', *BMJ*, p. 161.
[77] 'Country Doctors and the "Saturday Review"', p. 297.
[78] 'Country Doctors and the "Saturday Review"', pp. 297-8.

Lancet article anticipate Lydgate's motivations for settling in Middlemarch. The narrator describes how he wished to 'keep away from the range of London intrigues, jealousies and social truckling' to pursue his own research and 'win celebrity, however slowly, as Jenner had done, by the independent value of his work'. Ultimately, Lydgate seeks '[t]o do good small work for Middlemarch, and great work for the world' (136, 139). This is the fantasy of the country doctor who, rather than being parochial, is progressive and broad-minded. As a modernising practitioner, however, Lydgate also believes in the value of the hospital system and thus he hopes that the Fever Hospital might become 'the nucleus of a medical school' (116).[79] The ideal of the country practitioner who had the time and space to pursue individual research and remain at the forefront of medical practice was called into question by some commentators, however. The following sections will consider how the country doctor was represented as struggling against professional conflicts and public prejudices.

4. Professional networks and conflicts

The image of the country practitioner enjoying a 'contemplative position' was resisted by some journals as unrealistic. When the *Medical Circular* launched in 1852, it claimed that it had identified 'an opening for establishment of a new Medical Journal that should be *cheaper, more liberal, more comprehensive,* and more adapted to the limited opportunities for reading enjoyed by the busy medical practitioner'. It pictured the country doctor arriving home, worrying about a case 'in whose issue his own character and a patient's life may be at stake'. In these circumstances, the journal argued, the country doctor was 'not in a disposition to devote the half-hour that he may snatch from toil and care to the perusal of

[79] Lydgate's interest in the Fever Hospital is one of the ways in which Eliot characterises him as ahead of his time. These hospitals afforded doctors the opportunity of studying fevers, about which little was hitherto understood. In 1849, research at the London Fever Hospital enabled William Jenner to discern that typhus and typhoid fever were separate diseases. See Leonard G. Wilson, 'Fevers', in *Companion Encyclopedia of the History of Medicine,* ed. by W.F. Bynum and Roy Porter (Abingdon, Oxfordshire: Routledge, 1993), pp. 382-411 (pp. 402-3).

a voluminous paper on any matter'.[80] The editorial drew on common images of the country practitioner's busy working life to suggest that extant periodical literature was ill-suited to his needs. This was a promotional strategy, enabling the *Medical Circular* to claim it was filling a gap in the market.

Almost thirty years later the *Midland Medical Miscellany* (hereafter *Miscellany*) appeared with a similar mission statement. While noting that its 'careful selection of information' would not 'be uninteresting to those in what are commonly considered to be the higher ranks of the profession', it insisted that it was specifically designed to be of 'especial value to the hardworking and leisureless General Practitioner'.[81] In a subsequent issue, it reprinted comments made by Thomas Michael Dolan, a Halifax-based doctor, who had characterised the *Lancet* and *BMJ* as essentially 'London publication[s]'. He had suggested that:

> the literary activities of the provincial general practitioners were increasing each year – the London Practitioner alone could produce enough material to fill the *Lancet* and *Medical Journal* – therefore, if they desired not to be beaten out of the field, they must look for a new vehicle for the conveyance of their thoughts.[82]

Dolan implied that the *BMJ* privileged metropolitan practitioners, thereby alienating its traditional provincial readership. This was the fear expressed by some members of the BMA when the journal dropped its original title, the *PMSJ,* as discussed in the preceding chapter. The *Miscellany* suggested that it did not lay claim to be 'at present in a position adequately to represent the General Medical Practitioners of the Country', but emphasised that it was 'compiled in [their] interests'.[83] The journal's rhetoric subsumed country and provincial practitioners into a collective identity and thus here I will discuss these figures in tandem.

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[80] 'Address to the Reader', p. 1.
[81] 'Introduction', *Midland Medical Miscellany,* January 1881, pp. 1-2 (p. 1).
[82] 'A Journal for the General Practitioner', *Midland Medical Miscellany,* April 1882, p. 55.
[83] 'A Journal for the General Practitioner', p. 55.

The *Miscellany's* editor, Kenneth W. Millican, framed himself as a representative for provincial practitioners, but he himself enjoyed a peripatetic and cosmopolitan career. He did have a general practice in the village of Kineton, Warwickshire, but his work also took him to London, Mexico, and California. He ended up working for the mainstream press he had once covertly attacked, taking up positions at the *New York Medical Journal* and the *Journal of the American Medical Association*, before becoming assistant editor to the *Lancet.* Indeed, his obituary in the *BMJ* did not even mention his editorship of the *Miscellany.*[84] Dolan took over as editor of the *Miscellany* between 1885 and 1895. He was also a 'frequent contributor' to both the *BMJ* and *Lancet*, as noted in his obituary.[85]

Under Dolan's editorship, the periodical assumed the title the *Provincial Medical Journal.* This was presumably a marketing tactic designed to increase the journal's appeal outside the Midlands; by this time, it was also published in London, Edinburgh, and Dublin. By framing itself as a journal for provincial practitioners, it also positioned itself in the space once occupied by the *PMSJ*, perhaps in a bid to claim the *BMJ*'s disaffected readers. Literary critics have discussed the diminishing popularity of the 'provincial' as a template for national identity, with Gilmour referring to the 'widespread problematics of the provincial in late Victorian culture'.[86] However, Dolan's use of the term as late as the 1880s and 1890s indicates a desire to reclaim provincialism and reassert it as a broader, national identity. The journal addressed itself to all those who practised outside of the metropolis and printed articles specifically discussing the challenges of country practice, as I will examine in the next section.

[84] 'Obituary: Kenneth William Millican', *BMJ*, 11 December 1915, p. 878.
[85] 'Obituary: Thomas Michael Dolan', *BMJ*, 2 November 1907, p. 1283.
[86] Gilmour, p. 52.

In their mission statements, the *Medical Circular* and *Miscellany* both suggested that there was an opening in the market for a new type of medical journal. They implied that many general practitioners – particularly those in the country or the provinces – felt underrepresented by mainstream (metropolitan) medical journals, perhaps finding their price, format, or content unappealing. Both titles accused their major rivals of failing to present images of country and provincial practice that were commensurate with their readers' lived experiences. These new journals self-consciously positioned themselves as offering more authentic representations of general practice.

The opening address was an important tool in a journal's project of community-building, for it fashioned a like-minded group of readers from a disparate body of practitioners. Though these medical men might not encounter one another physically, they were brought together through their shared readership of the journal. Critics re-evaluating the category 'provincial' emphasise how such spaces were conceptualised as part of broader networks. John Plotz argues that 'provincial worlds' contained 'linkages to a greater world beyond', while Josephine McDonagh suggests they were 'experienced as nodes in a complex web of communication, diffuse and separate, yet joined together in mutually beneficial relations'.[87] Medical journals portrayed themselves as a medium through which 'diffuse and separate' practitioners could be 'joined together'. This tactic was particularly pertinent to the country practitioner's professional identity, for the imagined community was represented as an important way for him to overcome the disadvantages of his sequestered position.

Some journals constructed an imagined community which encompassed those working in different spaces; the *Medical Circular* presented archetypal metropolitan and

[87] Plotz, p. 410. McDonagh, p. 404.

country practitioners, united through their shared readership of the journal. Major journals such as the *Lancet* and *BMJ* positioned content by or about country and metropolitan medical men alongside each other, implying that it all served an overarching professional interest. Benedict Anderson describes how the newspaper form juxtaposes articles which, though they may be unrelated, nevertheless assume an imagined 'linkage' through their inclusion in a specific dated edition and their 'consumption' by readers at roughly the same time.[88] This image is apposite to the medical press' format and its project of community building. Nevertheless, some journals alleged that the country practitioner's needs were marginalised by mainstream periodicals and capitalised on these tensions to create alternative communities. The *Miscellany*'s address played upon the rivalry between the metropolis and the provinces, the consultant and the general practitioner. It created a professional identity which was defined by its readers' sense of difference from London medical men. Across the medical press, the country practitioner was imagined as part of different professional networks, which might either assimilate or repudiate his metropolitan counterparts.

One source of the resentment towards metropolitan practitioners was the fear that consultants might extend their services to patients outside the city. While the London elite had long made special trips when invited for consultation, the 'geographical range of practices' was also 'widen[ing] for everyday […] consultancy' due to the development of the railways.[89] In 1874, the *Lancet* printed a piece on 'London and Country Doctors' in which it noted the 'increasing custom' of 'metropolitan and hospital physicians and surgeons laying themselves out systematically for country patients in their immediate neighbourhood'. It felt this posed an 'injury' to country general practitioners, 'both in

[88] Benedict Anderson, *Imagined Communities: Reflections on the Origin and Spread of Nationalism*, rev. edn (London: Verso, 2006), pp. 33-5.
[89] Digby, *Making a Medical Living,* p. 187.

pocket and reputation'.[90] Commentators suggested that the problem affected relations between medical men in other parts of Britain as well. The *Dublin Medical Press* warned its readers that, though '[i]t may perhaps answer for a young man to boast of his consultations with metropolitan meteors […] men of standing are not served by assisting at such displays'.[91] The writer suggested that there was something degrading in a reputable practitioner genuflecting to the metropolitan elite. The generalist's ability to fulfil all functions was portrayed as a source of pride and honour.

The medical press both foregrounded and contained these professional tensions. The *MTG*'s article on 'The London Schools of Medicine' – discussed in the previous chapter – sympathised with the 'jealousies' of the provincial practitioner. It suggested that the 'Consulting Physician has, in respect to diagnosis, great advantages over those who have had charge of the case beforehand' since he 'sees it at a later period, when time has developed more prominent symptoms; and has the benefit […] of knowing, at least, what plan of treatment has failed'. The article sought to reconcile these two groups of men, reasoning that there were 'diversities in the position and duties of the Metropolitan and Provincial Practitioner, which […] intensely demand the greatest conceivable mutual esteem and good feeling'.[92] The mobility of metropolitan practitioners was variously represented as a threat or as providing an invaluable support system for provincial colleagues and their patients. One reason that consultations might be more cooperative was that they could draw on pre-existing relationships or networks. Country practitioners sometimes referred cases to metropolitan colleagues who were formerly their teachers or fellow students during their medical education and training.

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[90] 'Medical Annotations: London and Country Doctors', *Lancet*, 16 May 1874, p. 703.
[91] Quoted in: 'Medical News, Facts, Notices, and Remarks: Country Practice of Dublin Doctors', *Lancet*, 20 June 1846, p. 693.
[92] 'The London Schools of Medicine', *MTG*, 7 July 1855, pp. 13-14 (p. 14).

Popular fiction represented both competition and cooperation between urban and country doctors. In *Wives and Daughters,* Gaskell suggests these different medical men play complementary roles, while tacitly endorsing the country practitioner as more capable. Mr Gibson's skill surpasses not only that of the local university-educated physician Dr Nicholls (who is called in to attend Osborne Hamley), but also that of metropolitan practitioners in the instance of treating Lady Cumnor:

> [Mr Gibson's] opinion had been proved to be right, in opposition to that of one or two great names in London. The consequence was that he was frequently consulted and referred to during the progress of her recovery.[93]

Here the fashionable physician does not encroach on the country doctor's practice; instead, the latter's professional reach extends outwards. Mr Gibson finds himself not only having 'much to do in the immediate circle of his Hollingford practice' but also having 'to write thoughtful letters to his medical brethren in London' (532). In showing how his medical advice is sought by his metropolitan colleagues, Gaskell subverts the idea that the country doctor is backward.

This fantasy of the country doctor's diagnostic superiority is predicated on the idea that the practitioner who is more familiar with the patient (the family doctor) will provide more effective treatment, as Furst identifies.[94] This idea was also perpetuated in the medical press. In an article on 'Patient, Family Doctor, and Consultant' (1885), the *Lancet* emphasised the importance of knowing the patient's family and personal history. It suggested this was 'a factor in diagnosis which often enables a family practitioner to arrive at a right conclusion, when the highest talent and learning might be at fault'.[95]

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[93] Elizabeth Gaskell, *Wives and Daughters,* ed. by Angus Easson (Oxford: Oxford University Press, 1987), p. 532. Further references are given after quotations in the text.
[94] Furst, *Between Doctors and Patients,* p. 45.
[95] 'Patient, Family Doctor, and Consultant', *Lancet,* 18 April 1885, pp. 714-5 (p. 715).

Medical journals were not solely concerned with defending country practitioners, however. They also tackled what they considered to be unfair attacks on those working in the metropolis. In 1861, the *Lancet* featured a letter from a practitioner named R.N. Day, who responded to the *Saturday Review*'s vituperative attack on country doctors. He suggested that 'London medical men' were culpable of 'disparag[ing]' country practitioners and contended that, '[t]he malicious article in the *Review* is doubtless penned by an accomplished London physician'.[96] While the *Lancet* chose to print Day's letter, it carefully inserted an editorial note afterwards. It suggested that the correspondent was 'as unjust to the London doctors, as the *Saturday Review* is to the country doctors'. It adopted a conciliatory role, contending that it was unlikely the *Saturday Review*'s article was written by a metropolitan physician and suggesting that it was probably produced by 'one of our homeopathic friends' instead.[97] This comment deflected the allegation and reframed the dispute. It downplayed tensions between town and country doctors, shifting culpability to a common adversary: the unorthodox practitioner.

Medical writing and fiction also represented professional disputes between country practitioners. Although these men were sometimes depicted as relatively isolated, they were also portrayed competing for medical work among close-knit communities with small patient constituencies. In fiction, narratives are structured around the way in which patients (both rich and poor) oscillate between rival practitioners. In *Doctor Thorne,* the protagonist's long-term patient and friend – Sir Roger Scatcherd – temporarily defects to Dr Fillgrave, displeased with Thorne's straightforward attitude towards treating his alcoholism. However, when Fillgrave arrives at his house, Sir Roger changes his mind and asks for him to be dismissed. This is portrayed as a breach of professional etiquette, one

[96] R.N. Day, 'Correspondence: London and Country Doctors', *BMJ,* 14 September 1861, p. 291.
[97] 'Correspondence: London and Country Doctors', *BMJ,* 14 September 1861, p. 292.

which is heightened when Scatcherd's wife offers to remunerate Fillgrave for services which have never been delivered. The scene is mined for its comic potential; as Timothy Ziegenhagen suggests, it reveals the hypocrisy of Fillgrave, who is himself shown to be 'grasping for money'.[98]

In *Deerbrook,* the malicious Mrs Rowland introduces a new surgeon, Mr Walcot, into the neighbourhood as a rival to Hope, to whom she has taken great dislike. Walcot initially manages to poach many of Hope's patients, capitalising on the fact his status has fallen as the result of pernicious rumours about him. However, Martineau represents Walcot as a naïve young man, almost wholly manipulated by Mrs Rowland. Further, the novel closes with an idealised image of a partnership between the pair, one which adequately reflects their respective experiences (594). Meanwhile, in *Middlemarch,* Lydgate repeatedly 'challeng[es] the diagnosis of his rivals': he discerns that Nancy Nash is suffering not from a tumour (as Dr Minchin believes), but cramp, and immediately intuits that Fred Vincy is ill from typhoid fever.[99] Lydgate is only summoned by the Vincys because their usual practitioner (Wrench) is unavailable, and – as he anticipates – his engagement and new diagnosis is likely to provoke his rival. The narrator portrays '[c]ountry practitioners' as 'an irritable species, susceptible on the point of honour' (246).

In *Doctor Thorne* and *Middlemarch* – set in the 1850s and 1830s respectively – Thorne and Lydgate's attitudes towards dispensing drugs bring them into conflict with other practitioners in the community. Whereas Thorne is treated with disdain because of his willingness to dispense and charge for drugs, Lydgate is scorned because of his refusal to do so. In Trollope's novel, Thorne departs from the precedent set by other local doctors

[98] Timothy Ziegenhagen, 'Trollope's Professional Gentleman: Medical Training and Medical Practice in *Doctor Thorne* and *The Warden', Studies in the Novel*, 38 (Summer 2006), 154-71 (p. 161).
[99] Asa Briggs, 'Middlemarch and the Doctors', in *The Collected Essays of Asa Briggs, Volume Two: Images, Problems, Standpoints, Forecasts* (Urbana: University of Illinois Press, 1988), pp. 49-67 (p. 62).

(such as his major rival, Fillgrave), which is to maintain 'the principle of *giving* advice and of selling no medicine', thus preserving 'a distinct barrier between the physician and the apothecary' (35). He is derided as a 'pseudo-doctor' and 'half-apothecary' (533). The narrator sympathises with the protagonist's approach, however, suggesting it would be more widespread if country practitioners 'consulted their own dignity a little less and the comforts of their customers somewhat more' (32). It is interesting that Trollope endorses this position, as charging for medicine became increasingly criticised over the course of the century. In *Middlemarch*, Lydgate's decision is regarded as 'offensive both to the physicians whose exclusive distinction seemed infringed on, and to the surgeon-apothecaries with whom he ranged himself'. He declines to dispense drugs because he believes charging for medicine is liable to make doctors 'almost as mischievous as quacks', since '[t]o get their own bread they must overdose the king's lieges'. However, his views are distorted by both his rivals and the public; rumours begin circulating that he 'went about saying physic was of no use' (417-8). Both Trollope and Eliot (who read the *Lancet* as part of her research for *Middlemarch*) recognised that medical charges were a subject of considerable controversy.[100] Indeed, Thorne and Fillgrave take their dispute to the medical press, where it divides opinion.

In medical journals, commentators discussed how charging for drugs might encourage overmedication and lower the status of the profession. These objections were articulated by a correspondent to the *PMSJ* in 1845. He suggested that '*ten* times the quantity of medicine [is] administered that there should be', and argued that, consequently, 'science is retarded, professional status lowered, and what should be a high and noble calling in itself, is converted into a low and grovelling trade'.[101] In 1869, a country doctor

[100] Briggs, p. 51.
[101] 'Remuneration of the General Practitioner', *PMSJ*, 12 February 1845, p. 106.

wrote to the *MTG* to complain that the widespread practice in 'country districts' of making 'the amount of medicine supplied […] the basis of remuneration' had a pernicious influence on prescribing habits. He suggested this was 'demoralising, unprofessional, and inexcusable!'[102] While charging for drugs was a feature of both urban and rural areas, it was conceived as particularly commonplace in the countryside.

The *MTG* preceded the above letter with an editorial commentary, which adopted a less vociferous stance. It characterised the correspondent as coming from 'one of those benighted rustic regions' where doctors still charge for medicine, noting that this practice was 'universal' some thirty years before. It acknowledged that the system was 'in many respects a very bad one', reasoning that 'where it can be done, as in the higher class of practice in large towns, Medical men should be remunerated for their skill and time only'. However, it recognised that this was difficult to implement among poorer patients who 'cannot possibly pay separately and adequately for visits and medicine'.[103] This editorial intervention served an ameliorative role, acknowledging the correspondent's concerns without discrediting those practitioners who relied on payment for drugs. It arbitrated between two warring professional impulses – the desire to uphold one's professional dignity and the concern with one's duty towards poorer patients.

Essentially, while the practice of charging for drugs was regarded as backward and akin to trade, it was not altogether reviled when employed by country general practitioners, since they were deemed to have fewer options if they wished to retain patients and maintain an adequate income. In both the medical press and fiction one detects a 'double attitude toward money', the sense that it is necessary but also somehow tainted or

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[102] 'A Constant Reader and Subscriber', 'Correspondence: Medical Charges', *MTG*, 4 December 1869, pp. 667-8.
[103] [Untitled], *MTG*, 4 December 1869, pp. 661-2.

tainting.[104] Thus Roberts's address on 'The Status of the Country Doctor' warned general practitioners that 'haggling over money' would 'degrade' the profession.[105] This unease was a point of overlap between the medical and literary professions – Lawrence Rothfield describes how both had to navigate their relationship with the marketplace and the extent to which their 'labour' could be seen as 'transcending the cash nexus'.[106]

Much like metropolitan practice then, country practice was represented in terms of rivalries and resentments. In its 1888 article on 'The Doctor in Fiction', the *Lancet* expressed concern that 'professional jealousy and professional differences' were topics which 'unfavourably impress[ed]' upon novelists, thereby jeopardising public perceptions of medical men. However, the article recognised that professional conflict was not the invention of fiction, commenting that 'serious difference of opinion, even amongst the ablest and wisest of our profession, is often inevitable in dealing with the difficult and sometimes inscrutable process of disease'.[107] As suggested in previous chapters, the dialectic between collegiality and competition shaped professional identities and medical journals both produced communities and generated conflicts.

5. Interacting with patients and the community

In medical and popular writing, the country practitioner's identity was formed in relation to his interactions with professional colleagues and patients. In his address on 'Medicine in Literature', Willis suggested that novelists offered a 'realistic portraiture' by 'depict[ing] the medical man as an integral part of society' and showing how 'his character reacts upon his life both professional and social'.[108] These key themes shaped representations of the

[104] Levine traces this attitude in realist fiction, p. 150.
[105] Roberts, pp. 807-8.
[106] Lawrence Rothfield, *Vital Signs: Medical Realism in Nineteenth-Century Fiction* (Princeton, NJ: Princeton University Press, 1992), p. 188.
[107] 'The Doctor in Fiction', *Lancet*, 7 April 1888, pp. 685-6 (p. 686).
[108] Willis, p. 998.

country doctor, which typically emphasised the intersection between the practitioner's professional and personal identities. This section will consider how medical journals and fiction depicted the country practitioner's encounters with individual patients and his position among a 'knowable community'.

The country practitioner was often portrayed as being on familiar terms with his patient constituency. In its article 'The Country Doctor and his Work', the *Medical Mirror* suggested that the practitioner's industriousness invited such esteem: 'There should be no better friend to the public than the man who, at all times, in all seasons, is ready to risk his own life trying to save theirs'. The article modelled the doctor as an unsung hero, who unlike 'the soldier', received no 'acknowledgement […] for risks to limb and life'. It verged on hagiography when it described how the country doctor must 'work with the calm resignation and placid countenance of an angel'.[109] This image recast the ordinary depredations of practice as extraordinary labour. Medical commentators sometimes acknowledged that there was a gulf between the ideal and the reality. In 1883, the *Lancet* featured an article entitled 'The Dislike of Doctors' which interrogated why some people were disinclined towards medical attendance. It contended that '[t]he medical adviser is, or ought to be, the best known and the most sincerely trusted of all the friends of his patient'.[110] Although the writer did not refer specifically to country practitioners, he invoked the image of the family doctor. Contemporary fiction also contained romanticised or even sentimental images of the country doctor's relationship with his patients. As I have shown, his access to patient histories was portrayed as facilitating his superior diagnostic ability.

[109] 'The Country Doctor and His Work', p. 195.
[110] 'Annotations: "The Dislike of Doctors"', *Lancet,* 24 March 1883, p. 508.

Medical and popular writing also engaged with more problematic aspects of doctor-patient interactions. In its opening address, the *Midland Medical Miscellany* asserted that, among its chief interests were 'Ethics and Etiquette, the relations of members of the profession with the public'.[111] Rather than adopting a romanticised perspective of the doctor-patient relationship, the journal discussed the challenges of practice. In 1882, it published a lengthy article entitled 'The Question of Patients', which focused on the difficulties encountered in 'diagnostic interrogation'. The article demonstrated remarkable snobbery towards 'the badly educated classes', dwelling on the 'sheer inability […] of persons who have led unintelligent lives, to grasp the meaning and importance of questions that are put to them'.[112] This recalls images of the metropolitan practitioner's alienation from patients in slum neighbourhoods and runs counter to the idea that the country doctor moved seamlessly between different social classes.[113] In his analysis of Eliot's fiction, Williams contends that the 'problem of the knowable community' is 'a problem of language', highlighting the author's struggles to represent authentically the lived experiences of lower-class characters.[114] This tenet could be applied to interactions between the country practitioner and his poorest patients. While the *Miscellany* article clearly did not aim for sympathetic engagement, it conceptualised language as a fundamental barrier to understanding.

Two months later the *Miscellany* published a feature on 'A Practitioner's Grievances', many of which related specifically to country practice. Reflecting on 'the Doctor's time', the article complained that 'in country districts, especially, it is almost impossible to induce patients to send their messages to the doctor in decent time'. It

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[111] 'Introduction', *Midland Medical Miscellany,* pp. 1-2.
[112] 'The Question of Patients', *Midland Medical Miscellany*, February 1882, pp. 21-4 (p. 22).
[113] The perceived gulf between the practitioner and his poor patients recalls the situation in W. Somerset Maugham's *Liza of Lambeth,* discussed in the preceding chapter.
[114] Williams, p. 171.

described the practitioner arriving home after a long day, 'weary and hungry', only to 'find a message awaiting him' to return to a village he had journeyed through earlier that day. His frustration was compounded by the fact he 'finds that the patient has been ill for a week, and that to-morrow morning would have done just as well'.[115] A similar passage appeared in the *Medical Circular* fifteen years earlier:

> Another tantalizing occurrence in the daily work of a medical man, one which happens more frequently in country than in town practice, is to be summoned late in the day to see a patient who resides at a distance, and who, though ill, it may be, for days, only sends then because it suits his convenience.

The writer lambasted the fact that 'the convenience of the doctor is never for a moment considered by such people', who expect him to 'answer the call immediately' even though their case is not serious in nature.[116] While the country doctor's night calls and long journeys were widely used to signify industriousness and heroism, here they were depicted as an inconvenience and source of frustration. The *Circular* and the *Miscellany* played a cathartic function, allowing practitioners to share their grievances.

Similar complaints appeared in writing for popular audiences. The *Leisure Hour's* article 'The Country Doctor' discussed farmers' 'fixed notion' that the medical man should be summoned at the end of the working day, a belief which it characterised as 'dangerous on behalf of the patient' and 'unfair […] on behalf of the doctor'. The article avoided direct attacks on the public however, instead reflecting on wider social conditions that had undermined the doctor-patient relationship. It suggested that the 1834 Poor Law had 'destroyed much of the kindly intercourse that prevailed between doctor and pauper patients', by engaging practitioners in poorly paid (and thus degrading) work.[117] The consequences of this law were represented as affecting general practice across different

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[115] 'A Practitioner's Grievances', *Midland Medical Miscellany,* April 1882, pp. 51-2 (p. 51).
[116] 'Medical Men and their Patients', *Medical Circular,* 23 May 1866, pp. 548-9 (p. 548).
[117] 'The Country Doctor', *Leisure Hour,* pp. 90-1.

spaces. In the previous chapter, I discussed how William Gilbert's *Dives and Lazarus* (1858) highlighted its insidious effects upon metropolitan practice.

The medical man's interactions with female patients were also problematised, as I identified in Chapter One. Fears about male attendance on women were not restricted to country practice, but doctors in small towns and villages were presented as being particularly vulnerable to rumour and innuendo. In 1883, *Punch* magazine published a poem entitled 'The Doctor's Dream' in which the speaker – a village practitioner – indulges in half-conscious reminiscences about his life and career. One of the challenges he recalls is having '[t]o face and brave the gossip and stuff that travels about through a country town;/ To be thrown in the way of hysterical girls, and live all terrible scandal down'.[118] The poem was reprinted in the *Miscellany,* which judged it 'worthy of preservation in medical literature' and likely to 'strike a chord in every medical man's heart'.[119]

The *Miscellany*'s later incarnation, the *PMJ,* featured an article on 'Doctors and Lady Patients' (1887) which warned of the dangers surrounding long visits to women, as I discussed in Chapter One. It highlighted the country doctor's susceptibility, noting that '[i]n London possibly they might escape, for a time, from the eye of Mrs Grundy […] In provincial towns medical men who are too attentive, very soon fall under her ken and then – Nemesis!'[120] This piece drew a contrast between the (relative) anonymity afforded to metropolitan practitioners and the scrutiny to which provincial practitioners were subjected. Social historian Hera Cook argues that '[c]ommunity pressure' traditionally regulated men and women's sexual behaviour, but that this declined during the nineteenth

[118] 'The Doctor's Dream', *Punch*¸ 20 January 1883, p. 35.
[119] 'The Doctor's Dream', *Midland Medical Miscellany,* February 1883, pp. 63-4 (p. 63).
[120] 'Annotations: Doctors and Lady Patients', *Provincial Medical Journal,* 1 January 1887, p. 35.

century with increasing urbanisation.[121] Interestingly, in medical writing across the period, community surveillance was represented as proscribing and policing the practitioner's (professional) conduct towards women.

The theme of the country doctor dogged by sexual scandal also featured in popular fiction, which explored how practitioners might become implicated in local love affairs, real or imagined. In Gaskell's *Mr Harrison's Confessions*, the eponymous young doctor learns – much to his dismay – that his name has become attached to several women in Duncombe, earning him a reputation as a 'gay Lothario' (77). His mentor, Mr Morgan, berates him, before discovering that he too is pursued by an unexpected admirer. By the close of Gaskell's gentle comedy, the men's (personal and professional) reputations are restored and they are united with their chosen women. A darker instance of the doctor's relations with women appears in Hardy's *The Woodlanders*, where Fitzpiers's profession is shown to afford him opportunities for infidelity and a ready alibi. When his fiancée spies his lover, Suke Damson, leaving his rooms early one morning, he convinces her she was simply an anonymous patient.[122] Intimacy between medical men and the young women of their acquaintance was not always problematised in fiction, however, and country practitioners often functioned as eligible bachelors.[123]

In medical writing and fiction, the country doctor's personal and professional conduct were scrutinised. Country life was characterised by gossip, superstition, and petty jealousies, which were represented as jeopardising the country doctor's progressive practices and scientific zeal. In *Deerbrook*, even the naïve Walcot – at this stage the

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[121] Hera Cook, *The Long Sexual Revolution: English Women, Sex, and Contraception, 1800-1975* (Oxford: Oxford University Press, 2004), p. 64.
[122] Thomas Hardy, *The Woodlanders* (London: Macmillan, 1993), p. 161. Further references are given after quotations in the text.
[123] Sparks discusses the doctor's changing relationship to the marriage plot in *The Doctor in the Victorian Novel*.

village's preferred practitioner – complains that 'his skill and knowledge could have no fair play among a set of people so ignorant'. In the grip of fever, the community 'put more faith in charms than in medicines or care' (542). The novel also hints at contemporary prejudices when Hope notes that Mrs Rowland is spreading rumours that he 'rob[s] the church-yard, and vaccinate[s] children to get patients' (309). Both *Deerbrook* and *Middlemarch* contain allusions to body-snatching, with the young medical men erroneously accused of practising dissection. Similar fears are satirised in *The Woodlanders* when Grammer Oliver regrets her 'post-mortem compact' with Fitzpiers regarding the use of her brain (122). While such prejudices had clear antecedents in the Burke and Hare scandal and the 1832 Anatomy Act, in these instances the rumours are ill-informed and signal the communities' narrow-mindedness. In *Mr Harrison's Confessions*, the young doctor becomes the target of gossip about his medical practices when rumours circulate that one of his patients (who is convalescing elsewhere) has died under his treatment. In these novels, practitioners struggle against the narrowness of their communities. Rather than the 'backward' country doctor of popular prejudice, the reader encounters intelligent and able young men constrained and limited by the 'backward' nature of country life.

Both fiction and the medical press emphasised the dangers facing the practitioner who became too embroiled in the pettiness of provincial or country affairs. In *Middlemarch,* Lydgate becomes entangled in local conspiracies through his involvement with the Fever Hospital and its financier and director, the Evangelical banker Nicholas Bulstrode. Ironically, this connection brings him into contact with the very 'intrigues' he wished to avoid (136). Initially he is caught up in machinations surrounding the vote for the hospital's new chaplain. Later, he falls from favour after the town learns that he has accepted a loan from Bulstrode and assumes that he is complicit in the death of Raffles.

Although both Dorothea Brooke and Mr Farebrother recognise that he is the victim of rumour, he is effectively driven from the town. In *Deerbrook,* Mr Grey advises Hope that he is 'quite absolved from interfering in politics' because '[n]obody expects it from a medical man' (215). However, Hope follows his principles, openly voting against the candidate put forward by the local aristocrat Sir William Hunter, who is effectively Hope's patron, since he oversees his appointment at the alms-house. Hope's political persuasions arouse hostility and he is faced with mounting accusations about his medical practices. He loses many of his patients and later sees his home and consulting-room attacked by a mob. He is forced to divest himself of his horse and several of his servants, clear markers of his falling social status. Sparks suggests that the character's 'willingness to jeopardize his career' shows that he has a 'higher purpose' than 'professional success'.[124]

Medical readers might have been more critical of such conduct, however. Professional advice literature – such as Daniel Webster Cathell's *The Physician Himself* (1881) and Jukes de Styrap's *The Young Practitioner* (1890) – actively discouraged readers from becoming too deeply involved with politics.[125] Similar advice was propounded in the *BMJ*'s article 'How to be Happy though a Doctor', which suggested that the country practitioner's 'lines will be cast in pleasant places' on the condition that 'he steers clear of politics and does not trouble himself too much with local affairs'.[126]

Significantly, by the close of *Deerbrook* and *Middlemarch,* both Hope and Lydgate recover their fortunes. Through his valiant efforts during the local fever epidemic, Hope regains the town's good graces and restores his personal and professional status. Lydgate's financial security comes at a cost, however: he must forsake his professional aspirations

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[124] Sparks, *The Doctor in the Victorian Novel,* p. 34.
[125]Daniel Webster Cathell, *Book on the Physician Himself,* 9th edn (Philadelphia: F.A. Davis, 1890), p. 21. Jukes de Styrap, *The Young Practitioner* (London: H.K. Lewis, 1890), p. 15.
[126] 'How to be Happy though a Doctor', p. 1371.

for his wife's social ambitions. He leaves Middlemarch and, although he gains an 'excellent practice', writes a treatise on Gout, and 'alternat[es], according to the season, between London and a Continental bathing-place', he nevertheless 'regard[s] himself as a failure' (781). His move from the countryside to the fashionable centres of medicine marks economic prosperity, but signals a radical departure from his original ambitions. Medical commentators suggested Lydgate's defeat was chiefly due to external factors. The *Lancet*'s review of *Middlemarch* emphasised how Lydgate was 'dragged into the vortex of petty country-town politics',[127] while Willis's address on 'Medicine in Literature' blamed the 'narrow, selfish mind' of his wife, Rosamund.[128] These readers did not question (as both contemporary and recent critics have) Lydgate's foolishness in selecting a partner whose ambitions were incompatible with his own.[129] Nevertheless, they recognised how a character might be constrained by his environment, a theme which characterises Eliot's realism.[130]

The country practitioner was portrayed as a familiar figure in the community but also as one who was vulnerable because of his dependency on the good opinion of others. Medical and popular writing interrogated this fraught social position. In 'How to be Happy though a Doctor', the writer recalled how, 'in the country districts […] doctors used to be classed with tradesmen and shopkeepers and had to be kept in their proper place'. As evidence, he quoted *Middlemarch*'s Lady Chettam, who claims that she 'like[s] a medical man more on a footing with the servants' (84). He suggested that these prejudices had become 'old-fashioned views' by the start of the twentieth century, that the medical man's standing had 'vastly improved' and that he was now 'recognized as a cultured gentleman'.

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[127] 'Reviews and Notices of Books: Middlemarch', p. 746.
[128] Willis, p. 999.
[129] See, for example, [A.V. Dicey], 'Middlemarch', *Nation*, 23 January 1873, pp. 60-2; 30 January 1873, pp. 76-7.
[130] Levine, p. 142.

However, the end of the article suggested that there was a 'feeling which unhappily lingers on in the country districts, that a doctor, however capable and well-educated he may be, is inferior socially' to the churchman or landowner.[131] Medical writing and fiction emphasised how the limited social opportunities afforded by country life – and the relative paucity of other professional men – could marginalise the medical man. This is thrown into sharp relief in fiction when the doctor considers his marital prospects. In *Wives and Daughters,* for instance, Gibson wonders who would make a suitable wife since,

> Among his country patients there were two classes pretty distinctly marked: farmers, whose children were unrefined and uneducated; squires, whose daughters would, indeed, think the world was coming to a pretty pass, if they were to marry a country surgeon (104).

Ultimately, he marries a vicar's widow, though the match proves to be ill-suited due to his wife's temperament. Realist fiction – from Gaskell's *Mr Harrison's Confessions* to Trollope's *The Warden* – suggests that the most appropriate romantic union for the country doctor is with a clergyman's daughter.

In popular and medical discourse, practitioners and vicars were often represented as occupying similar positions in local society. Both had a liminal social status, as educated men in supposedly backward communities. Their work typically brought them into contact with different social classes and they exercised a certain authority in local affairs. In some remote and outlying parishes, clergymen had traditionally played a role in delivering medical advice or care. Thus, Thomas John Graham's *Modern Domestic Medicine* (1827) and the journal *The Doctor* were pitched as suitable compendiums for clergymen.[132] Friendships between the two figures function as common motifs in *Mr Harrison's Confessions* and *Middlemarch.*

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[131] 'How to be Happy though a Doctor', pp. 1372-3.
[132] Thomas John Graham, *Modern Domestic Medicine* (London: Simpkin and Marshall, 1827).

The analogy between religious and medical men was not always welcomed, however. In a piece entitled 'Medical Men as Confessors', the *Lancet* insisted that, 'the two functions, that of spiritual and that of medical adviser' were not 'comparable'.[133] The emphasis on confession here is significant; Sally Shuttleworth demonstrates that both medical and lay commentators resisted what they saw as a 'false analogy' between the physician and the priest, due to anti-Catholic sentiments.[134] Some practitioners were anxious that the analogy might prejudice public attitudes towards medical attendance. In 'The Dislike of Doctors', the *Lancet* remarked that public distaste 'may arise from the recognition that "doctors" stand very much in the same relation to the body and mind as the minister of religion occupies towards the conscience'.[135] If patients regarded the medical interview as analogous to religious confession, then they might be reluctant to discuss their illness or disclose their history. Shuttleworth suggests this anxiety left some psychiatrists reluctant to draw on patient testimonies.[136]

The practitioner's intimacy with his patients was also seen as important to his role in the community, however. In Martineau's *Deerbrook,* Hope acknowledges that he is the 'depository of so much domestic and personal confidence' (95), an image that recalls the idea of confession. Critics suggest that the character elides the function of doctor and priest: Roy Porter characterises Hope's valiant efforts during the fever epidemic as a 'personification of Christian charity – the doctor as the new pastor',[137] while Sparks emphasises Hope's 'missionary dedication' and 'saintly commitment' to his community, despite the persecution he has faced.[138] Although the analogy between religious ministry

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[133] 'Medical Men as Confessors', *Lancet,* 27 November 1886, p. 1046.
[134] Sally Shuttleworth, 'Spiritual Pathology: Priests, Physicians, and *The Way of All Flesh*', *Victorian Studies,* 54 (Summer 2012), 625-53 (p. 639).
[135] 'Annotations: "The Dislike of Doctors"', p. 508.
[136] Shuttleworth, p. 627.
[137] Roy Porter, *Bodies Politic: Diseases, Death and Doctors in Britain, 1650-1900* (London: Reaktion, 2001), p. 258.
[138] Sparks, *The Doctor in the Victorian Novel,* p. 27, 34.

and medical attendance carried unwanted connotations, it also provided an opportunity to foreground the doctor's duty and integrity, combating anxieties about his scientific and materialist impulses. Rather than the priest prying into one's innermost secrets, the doctor was usually likened to a benevolent clergyman. Both acted as intermediaries in the community, providing guidance to those in need.

Some commentators represented the country practitioner enjoying a more elevated position in local society. As early as 1863 the anonymous medical writer in the *Leisure Hour* claimed that 'the village doctor falls into the position of a minor country gentleman'.[139] Roberts's address on 'The Status of the Country Doctor' contended that 'the village doctor has nowadays often much of the influence formerly wielded by the parson, and this displacement is growing'.[140] I opened this chapter by quoting his suggestion that practitioners' rising social status would enable them to become 'the true directors of provincial social life'. This was linked to the doctor's liminality (his ability to move between the classes) and his visibility (his ability to influence those within his community): Roberts contended that, given his 'intimate and peculiar relations with people of every class', the doctor was uniquely placed to 'overthrow' the tyrannies of country life, its 'narrow and ignorant' character, and its 'snobbery and bourgeoisdom'.[141] 'How to be Happy' explicitly commended the fact that doctors had become 'an important integral and indispensable factor in the social life of the country'.[142] The country practitioner was represented as enjoying local autonomy and as having a civilising or improving function. His ability to reform the backward rural community resembles images of the urban doctor

[139] 'The Country Doctor', *Leisure Hour,* p. 88.
[140] Roberts, p. 806.
[141] Roberts, p. 807.
[142] 'How to be Happy though a Doctor', pp. 1372-3.

improving life among the slums or the colonial practitioner civilising the native patient population.

In popular fiction, the country practitioner's integration into respectable (even illustrious) society is often facilitated by his remarkable personal qualities. Doctor-characters are frequently endowed with traits that mark them out as dignified, exceptional, or genteel. In *Wives and Daughters*, the narrator suggests that Gibson could 'lunch with a duke any day that he chose'. This relates to the fact he is 'perfectly presentable': '[h]is accent was Scotch, not provincial' and his 'leanness goes a great way to gentility' (36-7). Convinced of his prestigious ancestry, rumours circulate that he is 'the illegitimate son of a Scotch duke, by a Frenchwoman' (28). Fiction regularly depicted country doctors as both ordinary men (who worked hard to make a living) but also as extraordinary figures. Gibson is described as 'far above the average' morally and professionally (28), and in *Deerbrook,* Hope is 'no ordinary case of the village apothecary' (38). Lydgate has an aristocratic lineage and there is 'a general impression that [he] was something rather more uncommon than any general practitioner in Middlemarch' (133). His exceptionality is heightened by the fact that Eliot presents his research interests and medical practices as innovative, bordering on anachronistic, though she also imbues him with 'spots of commonness' (141).[143]

In fiction, country practitioners are portrayed as sources of local authority who mediate between divided social classes and factions, as well as individual families. While Hope tends to the community that ostracised him in *Deerbrook,* Trollope's Thorne moves (and adjudicates) between the newly moneyed Scatcherds and the illustrious Gresham family, and Gibson attempts to arbitrate between Hamley and his sons in *Wives and*

[143] Furst, *Between Doctors and Patients,* pp. 77-8.

Daughters. Fictional country doctors intervene not only in the community's medical complaints, but also in personal rivalries and disputes. Furst describes how the trope of the doctor as 'confidential friend' figures in both *Doctor Thorne* and *Wives and Daughters*.[144] However, the characters' efforts at remedying these situations meet with varying levels of success; few have the influence to effect fully Roberts's ambitious vision in which the doctor becomes an agent of social change.

The country practitioner's role in local affairs was also scrutinised in 'An Address on the Position of the Country Doctor in 1879 and To-morrow' which John Lynn Thomas delivered to the Medical Society of the Vale of Teifi in 1914 and which was subsequently printed in the *BMJ*. Thomas had grown up in the Welsh market town of Llandysul and was invited to address the local Society by its President, under whom he had served his medical apprenticeship. At the time of its delivery, Thomas was a prominent hospital surgeon in Cardiff. According to the *Dictionary of Welsh Biography* he was 'the first purely consulting surgeon in Wales'.[145] His authority to speak on the position of the country doctor derived from his past experiences but he addressed his audience as 'we', constructing a professional community. By invoking a familiar set of tropes about the anxieties and aspirations of the country practitioner, Thomas mobilised a shared or collective identity.

Recalling his days as an apprentice, he described his 'admiration for the mutual relation that existed between the doctor and his patients'.[146] He expressed concern that 'the attitude of the general public towards the general body of the profession' was not 'what it used to be'. This anxiety, and the implied nostalgia, was commonplace. In 1885, an article

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[144] Furst, *Between Doctors and Patients,* p. 37.
[145] Arthur Rocyn Jones, 'Sir John Lynn-Thomas', *Dictionary of Welsh Biography* (National Library of Wales, 2009) <http://yba.llgc.org.uk/en/s-LYNN-JOH-1861.html> [accessed 21 August 2015].
[146] J. Lynn Thomas, 'An Address on the Position of the Country Doctor in 1879 and To-Morrow', *BMJ,* 25 July 1914, pp. 170-1 (p. 170).

in the *Lancet* suggested that '[d]uring the last quarter of a century the relations subsisting between families and their ordinary medical attendants have been growing less and less intimate', partly because patients felt able to consult different practitioners without informing their family attendant.[147] While the *Lancet* deflected blame onto the patient, Thomas was more introspective about the state of medicine. He felt there was increasingly 'too much dogma in the profession' and that doctors faced accusations of 'all sorts of wickedness' (chiefly surrounding the practice of vivisection). Thomas argued that medical men should take the public 'much more into [their] confidence' to help end the 'peculiar attitude towards us'.[148] His proposed model for the doctor-patient relationship departed from both the cynicism of the *Miscellany* and the ideal of 'confidential friendship' which was predicated on the doctor's authority.[149] Thomas offered a rallying cry, which valorised the role of the country practitioner:

> We want to restore the profession to the proud position it was in years ago, and it will be done if it is left in the hands of family doctors who understand the inward history of progress of our science and art.[150]

Thomas's address – as its title implied – was structured both around a historical moment (1879) and the future ('tomorrow'). It emphasised both continuity and change, suggesting that the lessons of the past were apposite to the present, while exploring the future direction of medical practice and the profession. It simultaneously expressed nostalgia and a desire for progress and improvement.

Conclusion

In medical and popular writing, the country practitioner's professional identity was fashioned through a common set of tropes. He was typically portrayed as intimately

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[147] 'Patient, Family Doctor, and Consultant', p. 714.
[148] Thomas, p. 170.
[149] Furst, *Between Doctors and Patients*, p. 45.
[150] Thomas, p. 171.

connected with the space in which he worked, an imagined geography of rural or semi-rural Britain. This periphery risked consigning him to professional obscurity and outmoded methods. However, it was often re-conceptualised as a productive space away from the pressures and conflicts of metropolitan practice. The country practitioner was depicted as a familiar figure in his community, who had a close relationship with his patients and wielded local authority. However, he was also characterised as under close scrutiny, his professional and personal reputation vulnerable to the vagaries of public opinion. Medical and popular writing negotiated the country practitioner's relationship to the space in which he worked, including his efforts to bring modern medicine to a provincial or rural backwater.

The country practitioner was not always represented in uniform or consistent ways. Many journals and authors implied that his struggles against the limitations of country practice and his attendance on a whole community made him a heroic figure. However, others resisted this hagiographic impulse and emphasised the frustrations of his practice. Journals contended for readers and subscribers in a crowded periodical market and competed to offer more appealing or authentic images of country practice. Nonetheless, despite these different representational strategies, there emerged a relatively coherent portrait of the figure. This is striking when one considers the divergent representations of metropolitan medical men that appeared – ranging from the exploitative specialist to the struggling slum practitioner – as outlined in the previous chapter. The country practitioner was depicted largely positively across both literary and medical genres. Although there lingered some prejudice that he might be backward or idle, the dominant image was of a hard-working and industrious medical man, who functioned as a useful member of both his professional and local community. The potency and ubiquity of this figure rivalled and

even superseded the hegemony of metropolitan practice in the medical and cultural imagination.

A dialectic between tradition and progress or between nostalgia and modernity informed images of the country practitioner. Some depictions were romantic or even sentimental, drawing upon a fantasy of rural spaces as knowable communities. The idea that the country practitioner remained a stable or fixed type arguably provided reassurance in a changing world, where both social and medical structures were shifting. However, constructions of the country practitioner were not simplistic or naïve. Both medical and popular writers engaged with the challenges of his work and adapted images of country practice to reflect the expectations and demands of modernity. In the medical press, the country practitioner was represented as contributing to the stock of medical knowledge through innovative research, refining his skills in the cottage hospital, and making use of new technologies such as the motor car.

Scholarship on the interplay between literary and medical discourse during the nineteenth century tends towards a diachronic reading. It posits that, in literature, a commitment to the realist mode was supplanted by an interest in more experimental techniques while, in medicine, the importance of general practice was superseded by increasingly scientific, institutionalised approaches.[151] Against this grain, I suggest that the figure of the country general practitioner – fashioned largely through the conventions of realism (as well as melodrama and the Gothic) in both the medical press and fiction – was remarkably resilient throughout the nineteenth and well into the twentieth century.

Lay and medical writing constructed a professional identity for the country practitioner that was stable enough to ensure its longevity, but mutable enough to respond

[151] Rothfield, p. xiv.

to the implications of modernity. This dynamic can still be traced in portraits of country practice into the mid-twentieth century. For his book, *A Fortunate Man: The Story of a Country Doctor* (1967), writer John Berger followed real-life general practitioner, John Sassall, who worked in a deprived rural community in the Forest of Dean. The book was a collaboration between Berger and photographer Jean Mohr, whose images provide an intimate insight into the rural landscape, the community, and the doctor's interactions with his patients. Sassall is represented as an 'overworked' general practitioner who acts as 'a sort of mobile one-man hospital' in his 'obscure country practice'.[152] Berger meditates on the doctor's role in his local society. Sassall is a central figure who is seen as 'belonging' and who functions as the '"consciousness" of the district' (101, 144) Yet his speculative position marks him out as different from the community, which is chiefly characterised (in Berger's somewhat condescending tone) by its 'cultural deprivation' and 'backwardness' (100, 144). While the book reflects changing social mores and medical practices (not least the advent of the National Health Service), it draws on major themes which characterised nineteenth-century representations of country practice. Towards the book's close, Sassall is quoted as reflecting, 'how much of me is the last of the old traditional country doctor and how much of me is a doctor of the future. Can you be both?' (147). The image of the country practitioner's duality – his self-conscious positioning between tradition and progress – endured in the cultural and medical imagination.

[152] John Berger, *A Fortunate Man: The Story of a Country Doctor* (New York: Vintage, 1967), pp. 54-5. Further references are given after quotations in the text.

Chapter Four: The Medical Woman

> *'The medical-women question is perennial. It knows no limits; we encounter it at every turn – at the universities and at the examining boards, at medical schools and in hospitals, in periodical literature and in works of fiction.'*

This editorial in the *Lancet* appeared in response to Charles Reade's novel *A Woman Hater* (1877). It accused the author of being so forthright in his campaign for medical women that he 'denie[d] to others the liberty to entertain any conscientious scruples'.[1] Reade's novel-with-a-purpose offered a sympathetic portrait of a woman doctor, Rhoda Gale. She was modelled on Sophia Jex-Blake, who, several years before, had fought to gain access to a medical education at the University of Edinburgh. As the *Lancet*'s editorial identified, debates about the role of women in medicine were mediated through different forms of writing, including popular fiction and the periodical press. Indeed, the *Lancet*'s readers would have been well-aware of the ubiquity of the 'medical-women question' given that it regularly featured in the journal itself.

This chapter investigates how medical women's professional identities were constructed through medical journals and fiction between the 1860s and 1900s. Although women had long practised as healers and midwives, during this period they made inroads into the established, 'orthodox' profession. In 1865, there were two female practitioners on the Medical Register, Elizabeth Blackwell and Elizabeth Garrett (later Garrett Anderson). Both took advantage of loopholes in the system, which were subsequently closed to prevent other women following suit.[2] The profession began treating the woman-doctor question with real immediacy and urgency in 1869, amid Jex-Blake's campaign in Edinburgh. If successful, she and her peers would have become the first women to take

[1] 'Medical Women', *Lancet,* 3 November 1877, p. 659.
[2] Blackwell registered under a special (short-lived) clause in the Medical Act (1858) which permitted those who had a foreign medical degree and were already practising to register. Garrett studied privately and threatened legal action against the Society of Apothecaries if they refused to examine her. The Society later stipulated that only those who had studied at recognised medical schools were eligible.

medical degrees from a British university. Although they were ultimately barred from graduating, they paved the way for reform and in 1876, the Enabling Act officially sanctioned (though did not compel) medical schools to examine women. A year later the King and Queen's College of Physicians of Ireland became the first licensing body to open its examinations to women. Other institutions followed its example, and by 1892 there were 135 female practitioners on the Register.[3]

The *Lancet*'s phrase 'medical-women question' yoked the issue of women in medicine to broader debates about women's access to higher education and work (the so-called 'woman question'), while emphasising its distinctiveness. It entailed discussions about the suitability and propriety of women studying and practising medicine, and debates about their membership of medical societies and professional bodies. The different obstacles and prejudices that women encountered in their pursuit of medicine have been well-documented. While I consider arguments for and against the movement, I focus on how these debates were mediated through different textual practices.

The first half of this chapter concentrates on the medical press, exploring how it worked to frame and re-frame the tenets of the medical-woman question. I look at long-running titles such as the *Lancet*, *BMJ*, and *MPC*, as well as the shorter-lived *Medical Mirror*. Within these journals, I examine coverage of the medical-woman movement across different forms of content. I begin by looking at the role played by leading articles and news items (where an editorial voice was either implicit or explicit), before considering how journals circulated and dissected transcripts from debates at professional bodies. I then examine how correspondence columns facilitated exchanges on the topic. The second half of this chapter investigates how aspiring medical women interacted with

[3] 'Extraordinary General Meeting', *BMJ*, 30 July 1892, pp. 262-4 (p. 262).

print culture, considering how fiction provided an alternative means of identity formation. I look at three texts by medical women: Anna Kingsford's 'A Cast for a Fortune: The Holiday Adventures of a Lady Doctor' (1877), Margaret Todd's *Mona Maclean, Medical Student* (1892), and Arabella Kenealy's *Dr Janet of Harley Street* (1893). Ultimately, this chapter explores how different forms of writing – the journals and the fiction – interacted to shape ideas about women in medicine.

Scholarship on nineteenth-century medical women has burgeoned in recent decades. Moving away from biographical studies of pioneering figures, historians have increasingly concentrated on the wider movement. They have considered women's mixed experiences during their medical education and careers,[4] and their interactions with medical and surgical practices, as well as patients.[5] Major themes emerging from this body of work include the segregation between medical men and women within Britain and the extraordinary mobility of female practitioners in their pursuit of a medical education and career. This chapter principally focuses on the movement within Britain, though it reflects on developments in Europe and North America. In the following chapter, I will examine debates about the role of medical women in British India.

Historians have considered how medical and popular periodicals responded to the movement. Laura Kelly argues that their hostility illustrates anxieties about femininity and the continued investment in women's roles as wives and mothers.[6] Examining the *Lancet*'s treatment of the issue between the 1860s and 1880s, Claire Brock contends that medical

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[4] Thomas Neville Bonner, *To the Ends of the Earth: Women's Search for Education in Medicine* (Cambridge, MA: Harvard University Press, 1992). Anne Digby, *The Evolution of British General Practice, 1850-1948* (Oxford: Oxford University Press, 1999), pp. 154-86. M. Anne Crowther and Marguerite W. Dupree, *Medical Lives in the Age of Surgical Revolution* (Cambridge: Cambridge University Press, 2007), pp. 152-75. Laura Kelly, *Irish Women in Medicine, c.1880s-1920s: Origins, Education and Careers* (Manchester: Manchester University Press, 2012).
[5] Crowther and Dupree, pp. 167-9. Claire Brock, *British Women Surgeons and their Patients, 1860-1918* (Cambridge: Cambridge University Press, 2017).
[6] Kelly, pp. 30-1.

men were preoccupied by the medical-woman question but that they were neither 'coherent [n]or unified in [their] objections'. She suggests that these inconsistencies reveal the profession's anxieties regarding its own status.[7] At the crux of the debates were competing definitions of womanhood, medicine, and professionalism. Building on this previous research, I scrutinise how medical journals mediated the debates, analysing the role played by editors, readers, and different forms of content in constructing ideas about women in medicine. I also highlight the multivalency of the medical press, the way in which it enabled a range of individuals – men and women, professionals and lay people, supporters and detractors – to participate in the debates.

Literary scholars have examined representations of the medical woman in Victorian fiction. In an unpublished thesis, Rachel Carr looks at portraits of the 'Girton Girl' and 'Lady Doctor' in women's writing,[8] while a monograph by Kristine Swenson analyses depictions of female nurses and doctors in popular fiction.[9] Both critics engage primarily with the representation of gender and sexual politics, considering how these themes interact with debates about medical education and practice. This chapter reorients attention to how medical women's fiction constructed professional identities. It also brings the fiction more fully into dialogue with the medical press to consider how debates moved across different forms of writing.

This chapter scrutinises the relationship between gender and medical identities. Terms such as 'medical woman', 'lady doctor', 'female surgeon' and variants thereof demonstrate how these figures were defined by their gender. Brock and Anne Digby trace

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[7] Brock, 'The Lancet and the Campaign Against Women Doctors, 1860-1880', in (*Re)Creating Science in Nineteenth-Century Britain*, ed. by Amanda Mordavsky Caleb (Newcastle: Cambridge Scholars, 2007), pp. 130-45.
[8] Rachel Carr, 'The "Girton Girl" and the "Lady Doctor": Women, Higher Education and Medicine in Popular Victorian Fiction by Women' (unpublished doctoral thesis: King's College London, 1998).
[9] Kristine Swenson, *Medical Women and Victorian Fiction* (Columbia: University of Missouri Press, 2005).

the ‘linguistic trajectory’ of these terms, though they differ in their conclusions as to which ones grew and declined in popularity.[10] I contend that these descriptors were used throughout the period, often in overlapping ways, and did not necessarily carry fixed meanings. Thus ‘lady doctor’ might be used ironically, to suggest that being a gentlewoman was incompatible with practising medicine. However, the term was also used as a marker of respect. Similarly, the phrases ‘medical woman’ and ‘woman doctor’ could suggest professional esteem but were also used by those opposed to the movement. These interrelated terms primarily functioned to indicate alterity, foregrounding women’s difference from the hegemonic masculine professional identity. This chapter will chiefly use the term ‘medical women’ because it is the most expansive, encompassing female medical students, as well as women physicians, surgeons, and general practitioners. These different groups were largely subsumed within an overarching professional identity. The way in which unqualified and qualified women were grouped together was sometimes used as a tactic to derogate medical women’s professional status and authority. However, it was also a strategy to establish a shared identity among those who faced common experiences of prejudice.

1. Leading articles and news columns

In the professional press, coverage of the medical-woman movement emerged during the late 1850s and 1860s, when journals began tracking developments in Europe and America in their news columns. These items often appeared without editorial commentary and the impression conveyed was the perceived novelty of the proceedings, the sense that they were early ‘experiments’ in women’s medical education. In 1868, the *Lancet* recorded that the new director of Zurich’s medical school had granted official registration to ‘Miss

[10] Brock, ‘The Lancet and the Campaign’, p. 141, 144. Digby, *Evolution,* p. 183.

Laura'. It noted that her female predecessor Nadidja Suslava was awarded a medical degree but attended lectures only as a 'guest'. The fact it designated the new director 'more gallant' than his predecessor suggests some sympathy for the women's endeavours.[11]

Medical journals also featured more extensive commentaries on the medical-woman movement at this time. The *BMJ* indulged in titillating remarks about 'lady doctors',[12] but also contained explicitly hostile coverage. In an editorial satirically entitled 'Room for the Ladies!' (1859), it remarked that,

> The practice of medicine by women would for the present have been regarded by us merely as a curious American 'institution', were it not for the fact that Dr Elizabeth Blackwell has lately again honoured this metropolis with her presence.[13]

There was considerable scrutiny of the movement in the United States, where the greatest strides in women's medical education were initially made.[14] The *BMJ* editorial derided the 'idea of a female practitioner' as 'lamentably ridiculous', suggesting that British women were unlikely to follow Blackwell's example and thereby 'diminish the esteem and affection with which they have ever been regarded'.[15] Nevertheless, the way in which the article conceptualised Blackwell's visit to London as an incursion or threat indicates its anxiety.

Debates about women in medicine gathered pace after 1869, as controversies at the University of Edinburgh encouraged commentators to (re)focus their attention on

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[11] 'Medical News: Lady Doctors', *Lancet*, 5 December 1868, p. 750. Initially, Suslava was allowed only to audit lectures, but in 1867 the university granted her retroactive matriculation and she graduated that year. The *Lancet*'s reference to a 'Miss Laura, said to be the daughter of a New York barrister' seems to be a confused allusion to Susan Dimock (the cousin of a New York attorney) who began studying at Zurich in autumn 1868. She was not the first woman to matriculate since Suslava, but the first American to do so. See Bonner, *To the Ends of the Earth*, pp. 34-7, 41-4.

[12] See, for example, 'Medical News: Lady Doctors on Horseback', *BMJ*, 14 November 1863, p. 539. 'A New Profession for Ladies' and 'Lady-Doctors in Russia', *BMJ*, 18 May 1872, p. 532.

[13] 'Room for the Ladies!', *BMJ*, 9 April 1859, pp. 292-4 (p. 293).

[14] America's 'relaxed system' both facilitated and undermined the medical-woman movement. It provided opportunities in sectarian schools and women's colleges, but these were often regarded as inferior. Bonner, *To the Ends of the Earth*, p. 30.

[15] 'Room for the Ladies!', pp. 293-4.

developments closer to home. There was continued discussion about women's mental and physical capacity for medical study and work, and increasing concern about the prospect of co-educational medical classes. These were adopted by some of the European schools but staunchly resisted in Britain.[16] In 1870, a leading article in the *BMJ* described medicine as 'one of the least desirable fields in which female intelligence and activity could occupy itself'. It made co-education the focus of its vehemence, branding it

> a measure which would imply either the emasculation of their courses of instruction, or a violation of the reserve and a forgetfulness of the delicacy – nay, even of the decency, which has always hitherto pervaded, and, it must be hoped, always will pervade the relations of the two sexes.[17]

The article suggested that since medical education was inherently masculine, female students could not be accommodated with propriety. Detractors of coeducation frequently figured mixed classes as intimate or even sexual encounters. A month previously, the *BMJ*'s Parisian correspondent had reported on 'demoralising spectacles' in the city, where the medical education of women was more advanced. He described seeing 'a young woman dissecting the thigh of a male subject while several male students were dissecting other parts of the same body' and 'another young woman, with unblushing front, taking notes along with young men, her fellow-students of a lecture […] exclusively devoted to the mons Veneris, clitoris, and hymen'.[18] He suggested the female students were desensitised to these lurid scenes.

In time, the co-education question was effectively forestalled (or deferred) by the growth of separate schools. The opening of institutions such as the London School of Medicine for Women (LSMW) in 1874, the Edinburgh School of Medicine for Women in 1886, and Queen Margaret College in Glasgow (1889) enabled women to undertake

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[16] Bonner, *To the Ends of the Earth,* p. 124.
[17] 'Lady-Doctors', *BMJ,* 30 April 1870, p. 444.
[18] 'Special Correspondence, Paris: Women-Doctors: Parisian Socialists and Edinburgh Professors', *BMJ,* 28 May 1870, pp. 559-60 (p. 560).

medical study in single-sex environments. While co-educational advances also took place, these did not always entail mixed classes.[19]

Throughout the spring of 1870, the *BMJ* printed articles openly hostile towards the movement. One particularly histrionic editorial branded the 'lady-doctor' a 'traitress to her sex'. It insisted that a civilised society should see women dependent on men, rather than following their own 'eccentric longing[s] for the will-o'-the-wisp pleasures of independence'.[20] A month later, another editorial suggested that the movement was a sign of 'retrograde civilisation'. It listed seven reasons why female practitioners were unnecessary or undesirable, including the fact that the medical profession was 'already well supplied as to numbers'.[21] Those opposed to women doctors often suggested they would aggravate the state of overcrowding.[22]

This cluster of articles antagonistic towards the movement appeared under the editorship of Jonathan Hutchinson. As mentioned in Chapter Two, he was an eminent surgeon (specialising in venereology) and he conducted the *BMJ* between late 1869 and the summer of 1870. This was during the short-lived absence of Ernest Hart, who edited the journal between 1867 and 1869 and from the second volume of 1870 until his death in 1898. Peter Bartrip's history of the *BMJ* describes how Hutchinson staunchly opposed the medical women, whereas attitudes tempered under Hart, who was a friend of Garrett Anderson.[23] Despite the shift in opinions, readers may have considered these early editorials as evidence of the *BMJ's* definitive stance on the medical-woman question.

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[19] Digby, *Evolution*, pp. 156-8.
[20] 'Lady Surgeons', *BMJ*, 2 April 1870, pp. 338-9.
[21] 'The Admission of Ladies to the Profession', *BMJ*, 7 May 1870, pp. 474-5.
[22] In 1869, Andrew Wood – who sat on the University of Edinburgh's General Council – warned that 'the competition in the medical profession had arrived at such a pitch that many medical men were actually starving for want of employment'. 'Scotland: Admission of Ladies to Medical Classes', *MPC*, 24 November 1869, pp. 419–21 (p. 420).
[23] Peter W.J. Bartrip, *Mirror of Medicine: The BMJ, 1840-1990* (Oxford: Oxford University Press, 1990), pp. 172-3.

A journal's response to the issue of women in medicine undoubtedly fluctuated with changes in editorship. The *Medical Mirror,* for instance, became increasingly interested in women's rights along with the arrival of a new editor. The journal was originally conducted by metropolitan physician William Abbotts Smith. In July 1866, editorship passed to his colleague Alexander Thorburn Macgowan, who had served as Staff-Surgeon in the 52nd Oxfordshire Light Infantry. Under Macgowan's auspices, the *Mirror* commented on the American experiment. It expressed concern that in Boston, Massachusetts, where 'the rights of women have been for some time fully recognised', the birth rate was steadily diminishing. It cautioned that, 'while cultivating their minds', women should not 'neglect a department of usefulness for which Nature has peculiarly fitted them', a reference to childrearing.[24] Three years later, Macgowan retired and sold the copyright of the journal.[25]

The *Mirror*'s next editor – who oversaw production between September 1869 and December 1870 – remained anonymous and has not been identified. He implicitly adopted a more liberal agenda, broadly sympathetic towards medical women. An editorial on 'Female Physicians' suggested that only 'experience' could 'decisively answer' questions concerning women's suitability for medicine and whether they would 'obtain a fair share of practice'. However, it maintained that 'women have a perfect right to every facility for the study of medicine now enjoyed by men'. Moreover, the editorial positioned the *Mirror* in direct opposition to its contemporaries, portraying itself as more progressive than its rivals in the journal market. It derided the *BMJ* for its 'medieval notions concerning women' and the *MTG* for its 'pseudo-scientific dogmas' about women's 'physical and mental capacity'.[26] In a later piece, the *Mirror* castigated Thomas Laycock – Professor of

[24] 'The Rights of Women', *Medical Mirror,* August 1866, p. 506.
[25] [Untitled], *Medical Mirror,* 1 September 1869, p. 113.
[26] 'Notes and Comments: Female Physicians', *Medical Mirror,* 1 December 1869, p. 173.

Medicine at Edinburgh and author of a *Treatise on the Nervous Diseases of Women* (1840) – for asking how to 'ascertain when a Magdalene came to their classes'. The *Mirror* retorted that the 'sexual aberration[s] of young men have never been held to disqualifying [sic] them from attending medical lectures', before suggesting that 'the average morality of the young women who may study medicine will be incomparably superior'.[27] This rejoinder counteracted images of female medical students as indelicate or impure.

Significantly, the *Mirror*'s interjections were part of a broader sympathy for women's rights. In another piece, it scathingly suggested that a *BMJ* journalist read 'J.S. Mill's judicious, enlightened, and enlightening work on the "The Subjection of Women"', and it stridently opposed the 'degrading and demoralizing influence' of the Contagious Diseases Acts.[28] Since the journal ceased publication in 1870, we cannot know whether this positive coverage of the (medical) woman question would have been sustained. Conversely, the *Mirror*'s bold stance might have rendered it unpopular with readers and therefore contributed to its demise.

Journals which remained under more continuous editorship also revised their opinions. After Thomas Wakley's death in 1862, the *Lancet* was edited by his son James until 1886 and it remained in the family's hands until 1909. During this time, the journal demonstrated 'fluctuations and inconsistencies' in its editorial opinion, as Brock has identified.[29] In March 1870, the journal reluctantly conceded that the diseases of women and children would be 'the most appropriate field' for female practitioners.[30] This was the

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[27] 'Notes and Comments: Professor Laycock's Objection to the Medical Education of Women', *Medical Mirror,* 1 May 1870, p. 83.
[28] 'Notes and Comments: Syphilography for Ladies', *Medical Mirror,* 1 November 1869, p. 154. 'Prostitution: The Contagious Diseases Acts', *Medical Mirror,* 1 November 1869, pp. 155-7 (p. 157). Medical women were not necessarily sympathetic to the repeal movement, however; Garrett Anderson supported the Acts.
[29] Brock, 'The *Lancet* and the Campaign', p. 142.
[30] 'Notes, Short Comments, and Answers to Correspondents: Lady Doctors', *Lancet,* 12 March 1870, p. 400.

specialty that aspiring medical women usually claimed as their especial province, arguing that female patients might be reluctant to receive male attendance due to their modesty or delicacy. However, the journal effectively backtracked two months later, when it featured a leading article suggesting that there would be no appetite for female practitioners among female patients. This argument was commonly deployed by the movement's detractors, though the *Lancet* was particularly vituperative, claiming that 'women hate one another, often at first sight, with a rancour of which men can form only a faint conception'.[31] It supplied no evidence to support its extraordinarily misogynistic assertion.

In a later editorial, the *Lancet* denied that its opposition to women entering the profession stemmed from pettiness or self-protectionism. In 1875, in the midst of legislative change that would result in the Enabling Act, it claimed that it was not afraid of competition 'in the form of girl-graduates'. Its infantilisation of the prospective medical women indicates both its contempt for them and its defensiveness. Given the *Lancet*'s reputation for radicalism under James's father, Thomas, it is unsurprising that it disclaimed it was seeking to exclude women and thereby monopolise the medical marketplace. Ultimately, the article deferred taking a position on the specific issue of women's entry to the Medical Register by re-framing it as a much wider question with far-reaching ramifications. It portentously warned that women in medicine would 'mark a new era in social and political history'.[32]

In all the journals, editorial opinions demonstrated indecision and inconsistency. In 1870, the *MPC* – under the editorship of Archibald Jacob – published a pair of leading articles which equivocated over the medical-woman question. The first editorial suggested that women should be allowed to pursue a medical education in the spirit of 'enlightened

[31] 'The Medical Education of Women', *Lancet*, 7 May 1870, pp. 672-3.
[32] 'Admission of Women to the Medical Profession', *Lancet*, 7 August 1875, p. 213.

toleration'. The journal presented its approach as just and chivalrous, characterising it as the 'more generous ground and a manlier position'.[33] This attitude accorded with broader ideas about medical etiquette, which typically emphasised the importance of tolerance.[34] Yet the *MPC'*s second editorial, published a week later, contended that women were unlikely to succeed in practice. It valorised medicine as an occupation which demanded 'the highest qualities of scientific intellect' and 'the vigour, […] the knowledge of the world, the downright nerve, that have always distinguished the masculine temperament and character'. The writer claimed that there were 'an abundance of cases' in which the physician cured purely through 'being able to "put his foot down"; in one word, by being a – man'. Although he conceded there might be some instances in which female patients would prefer a woman doctor, he insisted that 'when grave cases arise' they would 'place much greater confidence in the skill and general power of men than in that of their own sex'.[35] This editorial conceptualised masculinity as an integral part of a doctor's professional identity. Its forthright tone arguably served to overwrite the first article, rendering its gesture towards fair play purely tokenistic.

Medical journals often used leading articles and, to a lesser extent, news items to make explicit interventions into contemporary debates. They also engaged with subjects more circuitously, however. It was common practice for journals to reprint stories from both the domestic and international press, including medical and popular publications. The *Edinburgh Medical Journal* (*EMJ)* rarely intervened explicitly in debates close to home.[36] However, in 1872 it featured a dispiriting account from a woman doctor which had

[33] 'Lady Doctors', *MPC,* 16 February 1870, pp. 127-8 (p. 128).
[34] Daniel Webster Cathell suggested that '[t]oleration of a difference of opinion is a lofty virtue'. *Book on The Physician Himself,* 9th edn (Philadelphia: F.A. Davis, 1890), p. 73.
[35] 'Lady Doctors', *MPC,* 23 February 1870, pp. 146–7 (p. 147).
[36] In its review of Jex-Blake's polemical *Medical Woman* later that year, the journal said it would 'forbear comments' regarding the situation in Edinburgh. 'Reviews', *EMJ,* September 1872, pp. 262-6 (p. 264).

originally appeared in the New York *Evening Mail*. She explained that, though she was initially 'successful' in 'restoring [her] patients and building up a large practice', she 'could not compete with young men in the medical profession because of inability to bear over-work, and exposure to bad weather'. She argued that while most men were 'always well enough to visit a patient […] this is not true of women until they are nearly fifty years old'. The writer implied that medical practice was incompatible with female physiology, at least until after the menopause. The *EMJ* did not comment on the excerpt, besides remarking that its tone of 'forlorn hope' was preferable to that of the *Lancet.*[37] While disassociating itself from the belligerence of a rival journal, it arguably used the excerpt to express its own reservations towards the movement. At this stage, the first tranche of female students in Edinburgh were battling for access to clinical instruction. As scholars have shown, the women had garnered increasing public support after they were mobbed by male medical students during the infamous 'Surgeons' Hall Riot' in 1870.[38]

The medical press tended to moderate its stance towards the medical-woman question in the following decades, particularly as more women moved into practice. In 1884, an editorial in the *Lancet* discussed the role of female practitioners in India. It suggested that,

> Nothing that has ever been urged in these columns against the pretensions of women to engage in the study and practice of medicine can be held to apply to the case of those countries in which women are as a sex secluded or so far kept apart that [medical] men may not minister to their needs.[39]

The journal framed the issue of women practising in the colony as an essentially different question. As I will discuss in the following chapter, it was widely held that Indian women were unable to receive male medical attendance due to practices of veiling and segregation

[37] 'Medical News', *EMJ*, May 1872, pp. 1051-6 (pp. 1053-4).
[38] Swenson, pp. 88-9.
[39] 'Women Doctors for Women', *Lancet*, 29 March 1884, p. 580.

and that female practitioners were thus responding to an unmet need. Significantly, however, the *Lancet*'s editorial also acknowledged the utility of medical women at home. It suggested that,

> the perils which beset male practitioners in their professional relations with the opposite sex are too many and too great to leave any room for deep or lasting regret if the women of Western Europe were henceforth to be attended by practitioners of their own sex.[40]

After proposing that the role of medical women in the East and West were essentially different questions, the editorial collapsed the distinction between these spaces, suggesting that female attendance on women might be preferable across both. This was an extraordinary concession. The editorial hinted at anxieties surrounding male attendance on women, which I have examined in previous chapters.

It should not be presumed that the journals became uniformly more tolerant, however. Certain aspects of the medical-woman question continued to vex some, while others were apparently untroubled. In 1883, the Government made its first appointment of a medical woman, recruiting Edith Shove to work as physician to the Post Office's female staff.[41] The *Lancet* strongly opposed the move. When it first heard rumours that a woman was to be appointed, it urged Henry Fawcett (the then-Postmaster General, and brother-in-law to Garrett Anderson) to 'think twice' about the decision. 'We do not question the right of a lady to practise medicine,' it claimed, 'however we may question the fitness of her doing so'.[42] This veiled allusion to impropriety can perhaps be better understood in the light of comments made in a later issue, which questioned whether a 'gynaecological aspect' would become part of the role.[43] Throughout the period there were concerns about medical women circulating sexual and reproductive knowledge. During debates about the

[40] 'Women Doctors for Women', p. 580.
[41] The Post Office was becoming a 'large-scale employer of women'. Crowther and Dupree, p. 161.
[42] 'A Lady Doctor for the Post-Office', *Lancet,* 20 January 1883, p. 112.
[43] 'The Appointment of Miss Shove, M.B., to the Post Office', *Lancet,* 17 March 1883, p. 468.

admission of women to Edinburgh, Reverend Doctor Phin insisted that 'there was great risk of practitioners of the female sex appearing who would enter upon very improper practices',[44] while his colleague Professor Laycock openly aired his disdain for Blackwell lecturing on family planning methods to women.[45] Significantly, the *Lancet*'s news reports also suggested Shove's appointment might be against the wishes of the Post Office's female employees. Fearing the decision would be made 'without reference to their feelings',[46] it later doubted 'the appointment will be agreeable' to them, thereby subverting female practitioners' appeals to patient choice.[47] On the same day, the *BMJ* reported on the appointment without comment.[48] This indicates the journal's increasingly progressive stance towards women doctors under Hart's editorship.

The *BMJ*'s equanimity is also evident in its attitude towards a potentially more contentious issue: female practitioners taking up public appointments relating to a mixed-sex patient group. In 1892, the *BMJ* reported on the case of a woman doctor who was denied the position of assistant medical officer to the Lambeth Infirmary allegedly because she was female. The piece suggested that '[t]he question of the suitability of women for the profession' had hitherto been 'befogged' by the idea that there was sufficient work available for them among women and children. It emphasised that 'we shall soon see how far medical women propose to undertake the *full duties* of their profession, irrespective of the sex of their patients'. However, confronting this idea, the journal simply intimated that 'the last ten years have made a great difference in the way in which this question is regarded, both by the profession and by the public'.[49] While implying that the prospect of

[44] 'Scotland: Admission of Ladies', p. 420.
[45] 'Notes and Comments: Professor Laycock's Objection', p. 83.
[46] 'A Lady Doctor for the Post-Office', p. 112.
[47] 'The Appointment of Miss Shove', p. 468.
[48] [Untitled], *BMJ,* 17 March 1883, p. 523.
[49] 'Medical Women as Workhouse Doctors', *BMJ,* 17 February 1894, p. 371.

women's attendance on men was a new facet of the medical-woman question, it suggested that controversy might be forestalled by increasing sympathy towards the movement.

Comparing the *BMJ*'s coverage of women doctors in 1859 and 1892 demonstrates not only a shift in attitudes, but also how images of nursing were variously deployed to undermine or buttress the medical-woman's cause. In 1859, the *BMJ* drew a firm distinction between the nurse and the medical woman. It characterised 'the mission of lady-doctors of medicine' as one of 'arrogance and self-glorification', in contrast to 'the mercy and benevolence' that drove Florence Nightingale.[50] However, in 1892, the journal suggested that the 'spread of nursing as an occupation for educated women' had de-stigmatised the medical-woman question, by showing that 'a scientific interest makes all things pure' and that 'women can retain their tenderness and true womanliness' even when 'steeped in the knowledge of all that is most vile'.[51]

Editorial content was a crucial way in which the tenets of the medical-woman question were negotiated and revised. Some commentators suggested that each new development in the movement posed essentially new problems, while others referred to an overarching medical-woman question with far-reaching ramifications. Both strategies ensured that the question of women's participation in medicine remained contentious. However, commentators also engaged with ideas of tolerance and fair play to cede (limited) territory to aspiring medical women or drew on evidence of women's successes in nursing and medicine to suggest that they had a role to play in professional life. Many of the journals oscillated between these different positions within individual articles and across time. The sense of indecision and inconsistency was reinforced by the fact that the journals typically contained many voices commenting on the issue.

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[50] 'Room for the Ladies!', pp. 293-4.
[51] 'Medical Women as Workhouse Doctors', p. 371.

2. Transcripts of debates

One regular feature of the medical press that was inherently multivocal was the transcripts of debates that took place among medical societies and professional bodies. The *Lancet* and *BMJ* published these seemingly verbatim, in the form of reported (apparently unexpurgated) speech, attributed to named persons. While there was a sense that the content had been mediated by a secretary or reporter (the third-person was substituted for personal pronouns) these features offered access to a range of perspectives. Throughout the period, organisations debated various aspects of the medical-woman question and the transcripts illustrate the multiplicity and diversity of opinions that were aired, both between different organisations and within them.

In 1875, the General Medical Council (GMC) was tasked by the Government to produce a report on the prospect of medical women's registration, ahead of legislation that resulted in the Enabling Act. The GMC debated the issue in depth, with members touching on familiar issues such as the propriety of co-education, women's physical and mental capability for practice, and whether there was sufficient appetite for their services. In a lengthy speech, Edinburgh-based surgeon Andrew Wood argued that 'women are not adapted to the medical profession and the medical profession is not adapted to women'. His statement crystallised a common theme, the supposed (in)compatibility of medicine and femininity. Despite vocal opposition, the GMC finally agreed that its report should state that it was 'not prepared to say that women ought to be excluded from the profession'.[52] This equivocal phrasing was intended neither to encourage nor discourage women.

[52] 'The General Council of Medical Education and Registration: Session 1875', *Lancet*, 10 July 1875, pp. 55-63.

During the 1890s, the British Medical Association (BMA), the Royal College of Physicians of London (RCP), and the Royal College of Surgeons of England (RCS) all debated whether to admit women. At an Extraordinary General Meeting (EGM) in 1892, the BMA voted in favour of female membership. Resistance among some members triggered a second EGM, but this ratified the earlier decision.[53] In 1895 both Royal Colleges voted against admitting women to the Conjoint diploma, a decision that was not reversed until 1908. These debates are significant because they demonstrate the range of arguments put forward against medical women at a relatively late stage in the movement, once a considerable number had already qualified, registered, and set up in practice.

Some medical men claimed that they remained unconvinced by women's fitness for medical practice and professional membership. At the BMA, Dr Samuel Haughton from the University of Dublin claimed that the presence of women would 'diminish [the Association's] opportunities of discussing questions in that thorough and complete manner that science required'.[54] His anxiety about exchanging ideas in a mixed-sex environment recalled earlier fears about co-education. At the RCP debate, London-based physician Dr Charles John Hare suggested that women 'had no capacity for creating knowledge or advancing it'.[55] He constructed professional membership as an honour which demanded innovation and originality. Other members moved away from the question of membership and used the debates as an opportunity to revisit wider questions about women's fitness for medicine. For instance, during the RCP discussion, Sir Joseph Fayrer discussed the role of female practitioners in India. He claimed that 'too much had been made' of the idea native women preferred the attendance of their own sex and claimed that 'there was no difficulty

[53] 'British Medical Association: Admission of Women', *BMJ,* 27 August 1892, pp. 481-2.
[54] 'British Medical Association', p. 481.
[55] 'Royal College of Physicians of London: Debate on the Petition for Admission of Women to the Examinations and Diplomas', *Lancet,* 2 November 1895, pp. 1125-7 (p. 125).

in the way of medical men entering the most jealously guarded harem'.[56] He spoke from a position of authority; following an illustrious medical career in India he was President of the India Office's Medical Board between 1874 and 1895.

By contrast, other commentators asserted that the medical-woman question had been answered and that women doctors had already proven themselves. During the BMA's EGM, Surrey-based general practitioner John Henry Galton contended that '[t]he question against the general admission of women to the profession no longer existed' and 'all that remained was that they should be admitted freely'.[57] These ideas were echoed in the BMA's subsequent debate, when surgeon Frederick James Gant asked how the Association could 'in justice exclude any body of legally-qualified practitioners from entrance into the Association?'. Gant was connected with the Royal Free Hospital and taught students from the LSMW.[58] In his speech, he conceded that he had initially been unsympathetic to the cause but that he felt the women had acquitted themselves admirably. He argued that there could be 'no doubt' as to their 'professional, social, and moral character'.[59] In the RCP debate, Sir William Broadbent suggested that, '[m]ost of the remarks made […] had been addressed to the question of the admission of women to the medical profession, but the question *is* decided'.[60] As Physician-in-Ordinary to the Prince of Wales, Sir William commanded considerable authority.

Exceptionally and rather ironically, a medical woman was able to participate in the BMA debate. In 1874, the Association had accepted Garrett Anderson as a member through an 'oversight' before it officially vetoed the admission of women four years

[56] 'Royal College of Physicians', p. 1125.
[57] 'Extraordinary General Meeting', p. 262.
[58] He was also the author of *Perfect Womanhood,* which I briefly discussed in Chapter One.
[59] 'British Medical Association', p. 481.
[60] 'Royal College of Physicians', p. 1126.

later.[61] When the issue resurfaced in 1892, Garrett Anderson utilised her unique platform to argue for the rights of her female colleagues. She insisted that women's exclusion was an impediment to progress, as it prevented them from cultivating 'any feeling of solidarity with other members of the profession', while also hampering them from extending their medical knowledge.[62] At the second EGM, Nelson Hardy (a Dulwich-based surgeon) praised Garrett Anderson, describing how she had conferred 'honour' on the BMA and the profession.[63] Both effectively suggested that women's involvement in the Association was in the profession's best interests.

Within these debates, professional membership was constructed as an integral part of one's medical identity. While some medical men, as we have seen, represented membership as a privilege of which the women were ill-suited or unworthy, others suggested that women were entitled to it by dint of their achievements and claimed that excluding them undermined professional collegiality and collaboration.

By publishing debate transcripts, the medical press enabled those who were not present at the meetings to keep themselves informed. Yet the journals were not simply vehicles for disseminating this material. Coverage of the debates spilled over into other sections, including editorials. Reflecting on the Royal College debates, the *Lancet* noted that it was pleased the petitions were being discussed, since this indicated 'that the women are to have fair play'.[64] Following the debates, the *MPC* criticised arguments put forward against the women, which it claimed were based on 'sordid commercial ground'. It implied that it was discreditable for the profession to exclude women through fear of competition and rivalry. Both journals suggested that the medical-woman question should be broached

[61] Described in footnote in 'The Constitution of the BMA', *Supplement to the BMJ*, 14 March 1953, pp. 67-9 (p. 67).
[62] 'Extraordinary General Meeting', p. 263.
[63] 'British Medical Association', pp. 481-2.
[64] 'Women and the Royal College of Physicians of London', *Lancet*, 2 November 1895, p. 1115.

with fairness and toleration. Nevertheless, the *MPC* also (re)opened questions about women's participation in medicine by querying whether they were 'physically and mentally unfit for the work of [the] profession'.[65]

In the correspondence pages, there was extensive discussion about the outcome of the debates. The *BMJ* received numerous letters disputing the legitimacy of the BMA's vote, which led to the second EGM.[66] Meanwhile, some correspondents revisited specific claims put forward during the debates. After printing Sir Joseph's comments on the role of medical women in India, the *Lancet* received correspondence both welcoming and challenging his contention, which it published between November 1895 and February 1896.[67] This exchange shifted attention away from the original question of women's professional membership and revisited debates about the desirability of women in colonial practice.

Tracking the coverage of these debates demonstrates the considerable interplay between the journals' heterogeneous content; their editorials, transcripts, and correspondence pages. Conversations about debates that had taken place among professional organisations traversed separate sections of the journal and spread across different issues. Thus, even after votes had been cast, the debates were extended and reenergised within the pages of the medical press.

3. Correspondence

Previous chapters have demonstrated how the journals' correspondence pages were often sites for lively debate. This dynamic is thrown into sharp relief when studying coverage of

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[65] 'Notes on Current Topics: Admission of Women to the Profession', *MPC*, 20 November 1895, pp. 532-3.
[66] See, for example, 'Correspondence: The Admission of Women to the Association', *BMJ,* 13 August 1892, pp. 383-4.
[67] G.D. McReddie,'Correspondence: Women and the Profession in India', *Lancet,* 18 January 1896, p. 197. B.L. Dhingra, 'Correspondence: Women and the Profession in India', *Lancet,* 15 February 1896, p. 450.

the medical-woman question, for it attracted letters from a range of individuals expressing a broad spectrum of opinions. While these were primarily written by medical men, I will also scrutinise women's engagement with the correspondence pages. I will interrogate how gender was deployed in service of their arguments and how it was foregrounded within the space of the correspondence columns.

At times, journals printed letters which accorded with their current editorial position. In the same issue in which the *Lancet* published its leading article suggesting there was no appetite for female practitioners since '[w]omen hate one another',[68] it featured correspondence ostensibly from a laywoman, who asserted her opposition to the medical-woman movement. The correspondent claimed to be self-conscious about her participation in a traditionally male textual space, suggesting she had 'misgiving as to a lady correspondent being admissible in [the journal's] pages'. However, she also emphasised her status as a respectable woman, implying it lent authority to her argument. In signing her letter, she adopted the feminine and maternal pseudonym 'Mater' and she claimed to speak for 'the wives and mothers of England'. She strenuously denied that there was any appetite among women for female practitioners, claiming that '[m]orally, women are not fitted to be doctors, because they cannot (even the best of them) hold their tongues'.[69] Medical women's moral character was frequently attacked by the movement's detractors and 'Mater' represented them as incapable of upholding patient confidentiality. The authenticity of the letter is questionable; 'Mater' may have been the pen-name of an ordinary woman who wished to express her distaste for the notion of female practitioners or of a disgruntled medical man seeking to discredit the campaign. Regardless, the *Lancet*

[68]'The Medical Education of Women', p. 673.
[69]'Mater', 'Correspondence: A Lady on Lady Doctors', *Lancet*, 7 May 1870, p. 680.

may have included the letter in this issue precisely because it supported its contention that medical women were unnecessary or undesirable.

The journal also engaged with correspondents whose views were antithetical to its own. Two weeks later, the *Lancet* inserted a list of petitions organised by Sarah Kingsley (wife of the novelist Henry Kingsley, and a staunch supporter of the medical-woman cause) in *favour* of female medical education.[70] Correspondence columns functioned as a space in which medical women and their supporters could share information and express their views. At an early stage in the movement, the *MTG* enabled Garrett to advertise scholarships available to women.[71]

Journals often engaged directly with correspondence, acknowledging that it played a vital role in generating and shaping debates. In 1869, the *MPC* printed letters on the medical-woman question for several weeks before wading in and expressing its own edict through two leading articles. It noted that it had already

> freely thrown open [its] columns to the advocates on both sides of the question […] conceiving that, wherever the truth of the subject may lie, discussion, open and unfettered, is the one and only manner of reaching it.[72]

The journal featured letters from a range of individuals, including medical men for and against the movement and some interventions from laywomen. Why did it print such an extensive range of correspondence before intervening? Perhaps – as it claimed – it wished to cultivate a sense of openness, or to gauge readers' responses to the issue before formulating its own. The *MPC* privileged its readers' voices, giving them the opportunity to set out their opinions first. Further, the journal did not use its leading articles to close down the debate and continued to print letters on the subject for several months.

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[70] S.M.K. Kingsley, 'Notes, Short Comments, and Answers to Correspondents', *Lancet,* 21 May 1870, p. 757.
[71] Elizabeth Garrett, 'Notes, Queries, and Replies: Medical Scholarships for Women', *MTG,* 4 September 1869, p. 298.
[72] 'Lady Doctors', *MPC,* 16 February 1870, p. 127.

Among the run of correspondence were two letters from a woman named Eliza Arnold. She initially wrote in to dismiss remarks made by a previous male correspondent, suggesting that 'the gentleman has very little knowledge of the wants and wishes of so large a class as the unmarried women of this country now constitutes'.[73] Arnold argued both for women's access to work and later the importance of patient preference. Her second letter declared, 'as to women's complaints, there can be no doubt that a refined lady would, in many cases, rather consult a woman, were she equally capable'.[74] Like 'Mater', she implied that her gender conferred authority. She spoke for the class of unmarried women but similarly emphasised her respectability by referring to the preferences of the 'refined lady'.

The journal also featured a letter entitled 'A Lady on Lady Doctors' ostensibly from the widow of a Welsh country doctor who queried whether she would be able to follow in her husband's footsteps. The questions she posed were largely about how she could reconcile her gender with practice. She asked whether, as a 'lady doctor', she could 'undertake general family practice' or whether she 'must limit [her] practice to the ladies and female servants'. She asked what attire she could wear for horseriding on professional calls and wondered whether she had 'reached the time of life when all feeling of womanly bashfulness may be laid aside'.[75] The way in which she forged a link between a woman's age and her professional identity recalls the views expressed by the American medical woman in the *EMJ*'s excerpt; she too suggested that it was more practicable for older women to practise medicine.[76]

[73] Eliza Arnold, 'Correspondence: Women Physicians', *MPC*, 29 December 1869, p. 525.
[74] Arnold, 'Correspondence: Lady Doctors', *MPC*, 2 March 1870, p. 176.
[75] 'Correspondence: A Lady on Lady Doctors', *MPC*, 9 March 1870, p. 199.
[76] 'Medical News', *EMJ*, May 1872, pp. 1053-4.

Among the medical men sympathetic to the movement was a correspondent who identified himself as a physician. He began by suggesting that medicine was 'really not a science at all'. He claimed that, when medical knowledge was applied to the sick body, 'our scientific grasp becomes tentative and uncertain'.[77] Medical humanities scholars continue to characterise medicine as an interpretive activity. Using similar rhetoric, Kathryn Hunter suggests that it is 'not a science', and that, when applied to the patient, there is 'uncertainty inherent' in the activity.[78] The *MPC*'s correspondent implied that men possessed 'a large development of the logical faculty and strong powers of abstract and mathematical reasoning', but he claimed that the practice of medicine relied upon a different set of skills. He suggested that it required 'powers of keen and accurate observation', 'intuitive and almost instinctive sagacity', and 'practical tact', noting that 'women have quite as large a share of these endowments as men, and display them quite as fully whenever […] necessity call them forth'. This argument disputed the *MPC*'s earlier editorials, which constructed medicine as a masculine profession. The correspondent also challenged stereotypes about women, suggesting they could withstand 'irregular meals and hours, night watching, lack of sleep'.[79] As shown in the previous chapter, ideas about general practice were fashioned through these tropes. Ultimately, the correspondent revised ideas of womanhood and medicine to suggest they may be compatible.

The correspondence pages were also a contested space, where medical women and their detractors engaged in direct and often bitter debate. To interrogate the dynamics of these interactions, I will briefly study two separate exchanges in the medical press, which centred on the controversial topic of women's midwifery work. Midwifery had

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[77] 'Correspondence: Female Physicians', *MPC*, 11 May 1870, pp. 382-4 (p. 383).
[78] Kathryn Montgomery Hunter, *Doctors' Stories: The Narrative Structure of Medical Knowledge* (Princeton, NJ: Princeton University Press, 1991), p. 25, 28.
[79] 'Correspondence: Female Physicians', p. 383.

traditionally been the preserve of women until the rise of the 'man-midwife' during the eighteenth century.[80] It was variously represented as women's natural province or as encroaching upon the terrain of ordinary medical men for, as noted in a review of a women's health textbook, 'midwifery and the diseases of women form the chief portion of a general practitioner's business'.[81] Acting as an accoucheur brought in fees and could cement a medical man's status as the family doctor, but the bulk of the work was conceptualised as low-status drudgery.

In 1870, the *Lancet* featured a letter from Henry Bennet, who had been Physician-Accoucheur to the Royal Free Hospital. He contended that women were 'sexually, constitutionally, and mentally unfitted for the hard and incessant toil […] of general medical and surgical practice'. However, he suggested that there were 'few medical men […] who would not gladly, thankfully, hand over to a body of well-educated and friendly midwives their half-guinea or guinea midwifery cases'.[82] Bennet alleged that femininity could not be reconciled with the demands of a full medical practice and implied that aspiring medical women were better suited to work as trained midwives, thereby derogating their professional identity. Jex-Blake, in a rare but impassioned letter to the medical press, rebuffed his proposal and characterised it as 'the genuine view of a true trades-unionist'.[83] She deployed this term to accuse the profession of exclusivity and protectionism in its attempts to stop women entering the medical marketplace.

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[80] Adrian Wilson, *The Making of Man-Midwifery: Childbirth in England, 1660-1770* (Cambridge, MA: Harvard University Press, 1995).
[81] 'Reviews and Notices of Books: Graily Hewitt on The Diseases of Women', *Medical Mirror*, 1 January 1868, p. 26.
[82] Henry Bennet, 'Correspondence: Women as Practitioners of Midwifery', *Lancet*, 18 June 1870, pp. 887-8 (p. 887).
[83] Sophia Jex-Blake, 'Correspondence: Women as Practitioners of Midwifery', *Lancet*, 9 July 1870, pp. 63-4 (p. 63).

When women did take up midwifery cases among poor patients, this also aroused hostility. In 1895, the *Lancet* printed a heated exchange on the subject of midwifery fees. In his initial letter, surgeon Albert Morton welcomed the RCP's recent decision to continue excluding women. He alleged that 'modern medical women are doing more to degrade and lower the standard of the profession than any body of medical men have ever done', by attending midwifery cases for low fees.[84] As shown in previous chapters, undercharging was associated with trade and portrayed as an affront to medicine's genteel status. Significantly, while some suggested women might refine the image of the profession, Morton claimed they were dishonouring medical etiquette. His accusations were refuted by Marion Ritchie, who identified herself as Honorary Secretary of Clapham Maternity Hospital and St John's Maternity, Battersea. She contended that no medical woman had accepted 'less than a guinea as her minimum fee for a midwifery case', and suggested that Morton was confused by the fact that certain maternity hospitals training women students required outpatients to pay towards the hospital funds on registering their name for attendance. She insisted that this was not equivalent to a doctor's fee.[85]

Editors selected, arranged, and potentially even modified the letters that appeared on the printed page. They often encouraged back-and-forth letter-writing between correspondents. These exchanges made for stimulating reading and were an important strategy to retain subscribers' interest in a competitive periodical market. However, journals also intervened to regulate and control these debates. The *Lancet* featured correspondence from Ritchie and her detractors about midwifery fees across several issues. After printing a second letter from Ritchie, it intervened with the comment: 'This

[84] Albert Morton, 'Correspondence: The Admission of Women to the Royal Colleges of Physicians of London and Surgeons of England', *Lancet,* 16 November 1895, p. 1255.
[85] Marion Ritchie, 'Correspondence: The Admission of Women', *Lancet,* 15 December 1895, pp. 1537-8.

correspondence must now cease'.[86] The journal allowed Ritchie to engage in debate but also controlled her participation. This does not necessarily indicate suppression of the female voice, however, for the admonition was seemingly also directed towards her critics. Moreover, it was a standard line used to curtail ongoing debates between practitioners that might otherwise become too tedious or confrontational.[87]

In Chapter One I suggested that the correspondence columns had a democratising tendency, enabling the rank-and-file to participate in discussion. Analysing coverage of the medical-woman debates reveals an even more complex picture, with a wide range of individuals – male and female, professionals and laypeople – offering their views. If deemed authentic, then the contributions of women such as 'Mater' and Arnold offer a rare glimpse of patients' perspectives. Scholarship on the periodical press has recognised that correspondence columns are useful for complicating the image of 'implied reader' put forward by the journals, but that they cannot necessarily be considered 'representative' of the general readership.[88] In the professional press, it seems likely that some correspondents on the medical-woman question were regular readers and subscribers, while others were energised by this single issue. It can be difficult to determine their interest, for some names are hard to trace while others wrote under pseudonyms, perhaps designed to conceal the writer's gender or any vested interests. Questions concerning authorship cannot always be resolved but it is apparent that the correspondence columns functioned as a richly multivalent space. They enabled a range of voices to engage with, and renegotiate the terms of, the medical-woman question.

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[86] Ritchie, 'Correspondence: The Admission of Women', *Lancet*, 28 December 1895, p. 1668.
[87] See also 'Correspondence: The Title of "Doctor"', *Lancet*, 11 May 1895, pp. 1215-6 (p. 1216).
[88] Lynne Warren, '"Women in Conference": Reading the Correspondence Columns in *Woman* 1890-1910', in *Nineteenth-Century Media and the Construction of Identities*, ed. by Laurel Brake, Bill Bell, and David Finkelstein (Basingstoke: Palgrave, 2000), pp. 122-34.

4. Women's voices

In the medical press, women's voices did not appear solely in the correspondence pages or, more rarely, the debate transcripts. Towards the end of the century, journals also included clinical contributions from women. For instance, the *British Gynaecological Journal* printed studies from Mary Scharlieb and Mary Dixon in the 1890s, several years before women were admitted to its Society in 1901.[89] The next chapter will consider how medical women contributed to professional periodicals in British India. The way in which they were able to publish their clinical reports and observations (alongside those of their male counterparts) suggests that they were valued not simply for their interactions with female patients but for their contributions to medical knowledge as well. As historians have emphasised, women's engagement with the medical press was infrequent.[90] Nevertheless, the inclusion of their voices in the medical journals is significant given the opposition they faced in their attempts to enter other professional enclaves.

In order to examine more rigorously how medical women constructed their own professional identities in this period, it is necessary to adopt a multi-source approach. Vanessa Heggie draws on (auto)biographies, journal cuttings, and archival material from medical institutions to explore how the first tranche of medical women portrayed themselves. She detects 'a quite distinctive professional voice, an unapologetic self-identity as intelligent and ambitious'.[91] Undoubtedly women doctors' private papers and their records from working in female-led institutions gave them space to express themselves without fear of criticism or rebuke. While there are examples of women's

[89] Mary Scharlieb, 'Notes of Three Cases of Hysterectomy', *British Gynaecological Journal*, May 1896, pp. 100-1. Mary Dixon Jones, 'The Fourth Hitherto Undescribed Disease of the Ovary, Colloid Degeneration', *British Gynaecological Journal*, November 1899, pp. 398-411.
[90] Kelly, p. 127.
[91] Vanessa Heggie, 'Women Doctors and Lady Nurses: Class, Education, and the Professional Victorian Woman', *Bulletin of the History of Medicine*, 89 (Summer 2015), 267-92 (p. 270).

assertiveness in the medical press, these were sporadic, and their voices were frequently mediated and undermined.

Print culture nevertheless offered aspiring medical women myriad opportunities to advance their cause and they engaged with a range of textual practices to fashion their identities. Digby suggests that they preferred contributing to popular periodicals (rather than medical journals), perhaps convinced they would find a more sympathetic audience there.[92] They found an obvious ally in the feminist press, particularly the short-lived *English Woman's Journal* (1858-64) which actively promoted women's education and access to work. It featured polemical writing by Blackwell, and supporters including the suffragist Emily Davies, a friend of Garrett Anderson. Early medical women such as Blackwell, Garrett Anderson, and Jex-Blake also contributed to unpartisan (though largely liberal) periodicals such as the *Fortnightly Review* (1865-1954), *Macmillan's Magazine* (1859-1907), and later the *Modern Review* (1880-4). They sometimes engaged in debate in the conservative press, particularly the *Times.* The *Lancet* suggested that the movement's 'appeals to periodical literature […] usually aroused a feeling of resentment'.[93] However the journal was arguably anxious about the medical-woman question moving outside of its editorial control and garnering popular support.

Aspiring medical women used their prose for polemical purposes. In 1869, during her struggles to secure a place at Edinburgh, Jex-Blake wrote an essay entitled 'Medicine as a Profession for Women' which was published as part of a series of essays edited by campaigner Josephine Butler. Jex-Blake later revised and expanded the essay for her full-length book *Medical Woman: A Thesis and a History* (1886).[94] It traced the woman

[92] Digby, *Making a Medical Living: Doctors and Patients in the English Market for Medicine, 1720-1911* (Cambridge: Cambridge University Press, 1994), p. 292.
[93] 'Medical Women', p. 659.
[94] Jex-Blake, 'Medicine as a Profession for Women', in *Woman's Work and Woman's Culture: A Series of Essays,* ed. by Josephine Butler (London: Macmillan, 1869), pp. 78–120. Jex-Blake, *Medical Woman: A*

doctor's historical antecedents and made passionate arguments for her value to society. Between the publication of the original and revised version of the essay, the medical-woman movement and Jex-Blake's own career advanced considerably, yet her key messages remained consistent. She challenged the male monopoly of medical practice, suggesting it would be more 'natural' for women to be attended by members of their own sex, and fashioned ideas about patient preference (7). One of the page headers in her book affirms that *'Patients should have their Choice'* (51). Mary Wilson Carpenter suggests that, as specialties such as gynaecology and obstetrics emerged, the 'female patient' became a distinct sub-group, promoting the emergence of women doctors. She contends that it 'was logical that such patients might desire a practitioner of their own sex' and that 'the medical profession had to acknowledge that women physicians might be the natural choice for women patients'.[95] However, the idea that women doctors were a 'logical' or 'natural' choice was actively constructed as part of the medical-woman campaign and was heavily contested by the medical press, as I have demonstrated.

The second section of this chapter considers fiction by (aspiring) medical women. By dividing the chapter, I do not mean to suggest men and women's textual practices were discrete, for there was considerable overlap. As demonstrated, medical journals offered a space in which both could participate in debate. The interplay between different voices within print culture is also evident in Charles Bell Keetley's *The Student's Guide to the Medical Profession* (1878). In Chapter One, I discussed how this book initiated aspiring practitioners into the challenges of medical life. The majority of the advice was written by Keetley himself, though the final section – 'A Special Chapter for Ladies who Propose to

Thesis and a History, 2nd edn (Edinburgh: Oliphant, Anderson, & Ferrier, 1886). Further references from this edition are given after quotations in the text.

[95] Mary Wilson Carpenter, *Health, Medicine, and Society in Victorian England* (California: Praeger, 2010), pp. 150-1.

Study Medicine' – was provided by Garrett Anderson. By designating it a 'special chapter', the book asserted the medical woman's alterity and the chapter functioned almost as an appendage to the main text. Nevertheless, it participated in the book's wider project of practical instruction. Garrett Anderson opened her chapter by explaining that Keetley had invited her to contribute so that the guide would be 'of use to women as well as men'. She was optimistic about medical women's prospects, but closed by warning that they continued to face 'prejudiced disapproval'.[96] The way in which aspiring medical women navigated these challenges and opportunities was represented through their fiction.

5. Medical women's fiction

In opening this chapter, I quoted an editorial in the *Lancet*, which emphasised the medical woman's ubiquity in contemporary fiction. In Britain and America, between the late 1870s and 1890s, there emerged a distinct sub-genre concerned with this figure. In 1893, the popular periodical the *Nineteenth Century* featured an article on 'Medical Women in Fiction' by Jex-Blake. It reviewed a selection of novels in terms of their approach to what she labelled 'a great social question'. In her view, portraits of medical women did not need to be 'drawn by friendly hands' but 'should be in some sense taken from life'.[97] *Blackwood's Edinburgh Magazine* also printed an article on 'The Medical Woman in Fiction' (1898), written by journalist Hilda Gregg. She also considered a range of novels in relation to the real-life medical-woman movement, declaring that, 'even to the most reactionary mind, the medical woman is neither a fad nor a fancy, but an established

[96] Garrett Anderson, 'A Special Chapter for Ladies who Propose to Study Medicine', in *The Student's Guide to the Medical Profession*, ed. by Charles Bell Keetley (London: Macmillan, 1878), pp. 42-8 (p. 42, 48).
[97] Jex-Blake, 'Medical Women in Fiction', *Nineteenth Century*, 33 (February 1893), 261–72 (pp. 261-2).

fact'.[98] Recent scholarship broadly follows this tradition, providing a critical survey of medical-woman fiction by both popular and medical authors.[99]

This section focuses on three works of fiction written by medical women. The short story 'A Cast for a Fortune: The Holiday Adventures of a Lady Doctor' was published anonymously in *Temple Bar* magazine in 1877. It is narrated by the protagonist, Dr Mary Thornton, who becomes entangled in a murder plot while on holiday. She takes on the mantle of amateur detective, intervening to save a wealthy widow, who is being targeted by her brother-in-law, Dr George Pomeroy. The story was written by Anna Kingsford, a medical student in Paris. She later graduated, and used her medical credentials to lend authority to her vegetarian and anti-vivisection campaigns.

I also examine the three-volume novel *Mona Maclean, Medical Student* (1892), which was published under the pseudonym Graham Travers, but written by Margaret Todd, a student at the Edinburgh School of Medicine for Women. She would later become assistant physician to the Edinburgh Hospital and Dispensary for Women and Children and publish several further novels. *Mona Maclean* follows its eponymous heroine – a student at the LSMW – after she fails her Intermediate Examinations and takes an extended break from her studies. She stays with her cousin, a shopkeeper in rural Scotland, who asks her to conceal her identity as a medical student. The novel is a female *Bildungsroman* written in the realist mode, which depicts its heroine undergoing a series of medical and romantic adventures, before she successfully graduates from medicine and establishes a practice with her new husband.

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[98] Hilda Gregg, 'The Medical Woman in Fiction', *Blackwood's Edinburgh Magazine,* 164 (July 1898), 94-109 (p. 95).
[99] Carr, 'The "Girton Girl" and the "Lady Doctor"'; Swenson, *Medical Women and Victorian Fiction.*

Finally, I look at *Dr Janet of Harley Street* (1893), which was written by Arabella Kenealy, a graduate of the LSMW, who worked among the metropolitan poor. The novel depicts a young woman, Phyllis Eve, who runs away from her husband, the Marquis de Richeville, on her wedding day after realising his dissipation. She finds refuge with Dr Janet Doyle, a successful medical woman who makes Phyllis her protégé. Medical study and practice form a significant backdrop to the novel, though it is principally concerned with Phyllis' efforts to escape her undesirable marriage and find love with Janet's cousin, Paul Liveing. The novel's sensationalist plotline encompasses bigamy, a faked death, and suicide. A year after the novel's publication, Kenealy contracted diphtheria and gave up practice. She focused on her writing, which dealt largely with eugenics.[100]

Thus far, scholars have considered Todd and Kenealy's novels in the context of contemporary New Woman writing. Swenson positions *Mona Maclean* and *Dr Janet* as 'New Woman Doctor Novel[s]',[101] while Carr suggests that they are distinguishable from this genre by their principal interest in women's medical education and practice.[102] As outlined in my introduction, while previous critics primarily consider the sexual politics of Todd and Kenealy's novels, I will interrogate further how they construct medical women's professional identities. I examine their portrayal of the medical woman's relationships with medical men and her interactions with female patients. I also consider Kingsford's short story, which has been overlooked by extant scholarship.

Aspiring medical women's writing offered an opportunity to highlight female experiences and subjectivity. This was an important corrective to portraits of the medical woman produced by men in the press and popular fiction. Although Reade's *A Woman*

[100] Swenson, p. 150.
[101] Swenson, p. 123.
[102] Carr, p. 21.

Hater offered a sympathetic portrait of a woman doctor, Rhoda Gale is introduced as a victim. The novel's protagonist (Harrington Vizard) discovers her starving on the streets of London and effectively rescues her by giving her a medical practice.[103] She also remains marginalised by the narrative's romantic plotline.[104] Later stories by male authors represented medical women as objects of titillation and attraction. Wilkie Collins's 'Fie! Fie! Or, the Fair Physician!' (1882) depicts a beautiful woman doctor who becomes besotted with one of her male patients,[105] while Conan Doyle's 'The Doctors of Hoyland' (1894) portrays a medical man who falls in love with his female rival.[106] Although these stories differ widely in their sympathies they all construct the figure of the medical woman through the male gaze.

I will begin by considering to what extent my primary texts were positioned as interventions into the medical-woman debates. Kingsford's 'A Cast for a Fortune' appeared at a critical time in the movement, a year after the Enabling Act was passed and the same year that a licensing body first admitted women. Yet the story disclaims any polemical interest. In the opening passages, the narrator asserts that her 'purpose' is not to 'deliver a homily upon the higher education of women'. Nevertheless, her support for women's access to medical education is tacitly conveyed. She explains that she took her medical degree at 'a continental university' (Zurich) precisely because it was 'denied' to her by her 'own country'. She also foregrounds her noble motives for pursuing a medical education, highlighting her 'love of knowledge'.[107] Kingsford's story appeared in *Temple Bar* a month after its serialisation of Annie Edwardes' *A Blue-Stocking* had ceased. While

[103] Charles Reade, *A Woman Hater* (London: Chatto and Windus, 1926).
[104] For an analysis of the novel see Swenson, pp. 93-103.
[105] Wilkie Collins, 'Fie! Fie! Or, the Fair Physician', *Pictorial World Christmas Supplement*, December 1882 <http://www.web40571.clarahost.co.uk/wilkie/etext/fie.htm> [accessed 30 November 2014].
[106] Arthur Conan Doyle, 'The Doctors of Hoyland', in *Round the Red Lamp and Other Medical Writings*, ed. by Robert Darby (Kansas City: Valancourt, 2007), pp. 185–96.
[107] Anna Bonus Kingsford, 'A Cast for a Fortune: The Holiday Adventures of a Lady Doctor', *Temple Bar*, 51 (December 1877), 469–92 (p. 469). Further references are given after quotations in the text.

Edwardes portrays her intellectual young woman (Clementina Hardcastle) as an eccentric, Kingsford eschews caricature in her depiction of Mary.

When the story begins, Mary is taking a holiday in Germany to recuperate from the exhaustion of her medical degree. She explains that '[t]he fatigue and excitement' of her examinations have 'impaired [her] health and wearied [her] brain' (469). While Kingsford engages with anxieties about the demanding nature of medical study, her heroine is not represented as constitutionally unsuited for the work. Instead, Mary is healthy, energetic, and self-sufficient. When she realises that a fellow English tourist, the invalided Ada, is being poisoned, she acts swiftly and decisively to save her. Furthermore, she is portrayed as confident in her professional identity. She uses her recently acquired title 'Dr' with 'natural and irrepressible gratification', a feeling which she anticipates 'the sympathetic reader will surely condone'. Furthermore, her medical authority is recognised and validated by other characters. Ada requests her attendance after learning of her credentials and the police later rely upon her evidence to detain the doctor-poisoner Pomeroy, acknowledging her position as 'a qualified physician' (489). This is perhaps a fantasy of the medical woman's social acceptance, enacted outside Britain in a continental setting.

Mona Maclean also presents a heroine who overcomes the trials of medical study to become a self-assured and competent medical woman. At the start of the narrative, she fails her examinations. Her peers suggest her difficulties stem from the fact she is 'too good a student' and that she has 'a spirit of genuine scientific research'.[108] She does not lack intelligence but struggles to apply her knowledge. As I will discuss, the novel depicts Mona undergoing a period of self-development in order to attain success. Ultimately, she not only graduates but takes the Gold Medal in physiology.

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[108] Margaret Georgina Todd, *Mona Maclean, Medical Student*, 3 vols (Edinburgh: Blackwood, 1892), iii, pp. 90-1. Further references are given after quotations in the text.

Todd's novel directly engages with debates about the suitability or propriety of women studying and practising medicine. One of the major obstacles to the heroine's ambitions is her aristocratic uncle, Sir Douglas Munro. Mona is an orphan and her uncle represents the main source of patriarchal authority in the novel. She identifies him as a 'decided enemy of the "movement"' and 'don[s] her armour wearily' before wading into a debate with him. He deploys some of the conventional arguments against medical women that we encountered in the medical press. For example, he suggests that, by pursuing a medical education and career, 'a woman loses everything that makes womanhood fair and attractive' (i.37). The bitterness of earlier disputes seems to have dissipated, however. Sir Douglas presents little concerted opposition and even expresses sympathy with the movement. As with Kingsford's story, there is a tacit assumption that the reader already approves of the cause.

Gregg suggested that *Mona Maclean* came at 'the close of a transition period' when 'the noise of the struggle ha[d] died down, and the dust of conflict ha[d] cleared away'.[109] Nevertheless, Jex-Blake maintained that it was important 'to those who care about the progress of any movement' how it was presented in fiction since this could 'influence' the public's 'judgment or action'. Her approbation for *Mona Maclean* stemmed partly from its ability to present a persuasive image of the medical woman. Although Jex-Blake affected ignorance regarding the book's authorship – claiming not to know whether it was written by a man or a woman – this was disingenuous.[110] She was Todd's mentor and companion and had a role in negotiating *Mona Maclean*'s publication.[111] As I will

[109] Gregg, 'The Medical Woman', pp. 108-9.
[110] Jex-Blake, 'Medical Women in Fiction', p. 261, 269.
[111] Swenson, p. 131.

show, Todd also deploys many of the arguments for medical women popularised in Jex-Blake's earlier work.

Kenealy's *Dr Janet* also features exchanges between characters sympathetic and antagonistic towards the medical-woman movement. The question here is not whether women *can* practise medicine. Janet is a confident and successful doctor. In addition to her Harley Street practice, she is senior physician to the Minerva Hospital for Women, dean of its medical school, and a lecturer to several colleges. Instead the novel asks what *type* of woman is suited to medicine. Janet is an androgynous figure, with 'large, broad hands' and 'masculine features'. She describes her own 'neuter-nature' as incapable of 'romantic' sentiment.[112] Swenson suggests that this description renders the character 'harmless'; for although Janet may be read as a 'protolesbian New Woman', her 'neuter' status expunges any fears of 'sexually deviant behavior'.[113] Janet also believes women's habit of 'apeing' men is a great 'folly' and hopes that Phyllis will emerge from her studies 'womanly of heart and mind' (145). Yet Phyllis's delicacy ultimately precludes her participation in medical life. Despite her hard work and intellectual curiosity, she becomes overwrought and appears before her examiners in a state of 'nervous tension' (177). While Janet's neuter-nature enables her to thrive as a medical woman, Phyllis dwindles from the pressure. She is revived only by her romantic attachment to Paul, which makes her 'radiant' (218).

The story unfolds as a battle between Janet and Paul for Phyllis's future, and their arguments centre around her competing identities as a young woman and a medical student. Paul is convinced that these identities are irreconcilable, arguing that '[a] woman

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[112] Arabella Kenealy, *Dr Janet of Harley Street* (New York: Appleton, 1894), p. 124, 127. Further references are given after quotations in the text.
[113] Swenson, p. 158.

like that is made for love and home and children' rather than 'skeletons and pharmacopeias' (143). When Janet later acknowledges defeat, she describes how 'Cupid has forestalled Aesculapius'. Persuaded as to the incompatibility of femininity and medicine, she decides that '[t]he next girl' she chooses for a partnership 'shall be a plain, certain-aged, spectacled neuter' (264). She suggests that an older, androgynous woman – almost a direct replication of herself – would not be distracted from medical work by a romantic entanglement.

All three stories engage with the interrelationship between the medical woman's gender and professional identity. *Mona Maclean* offers the most confident assertion that femininity and medicine can be reconciled. Countering suppositions that medical women might become masculine or desexualised, Todd repeatedly emphasises Mona's femininity. Casting a critical eye over his niece, Sir Douglas finds 'not a trace that is not perfectly womanly' (i.38). Mr Cookson, an acquaintance in Scotland, is similarly puzzled, failing to see how 'an attractive, well-to-do young lady like Miss Maclean' could belong to the 'ranks' of medical women (iii.148). Todd's protagonist revises preconceptions of the medical woman by seamlessly combining her feminine charms and medical accomplishments. Yet Todd does not present only one 'type' of female practitioner; she depicts a range of medical women from the brusque Dr Alice Bateson to the light-hearted medical student Lucy Reynolds. Whereas Kenealy conceptualises only the 'neuter'-woman excelling in medicine, Todd posits that different types of women are capable of the work.

Medical women's writing also participated in debates about women in medicine through representing the necessity or desirability of female practitioners for female patients. For example, *Mona Maclean* engages with anxieties about the impropriety of male attendance on women. Even Sir Douglas concedes that there is a 'terrible necessity' for female doctors. He is scandalised by the current model of care, protesting 'it makes me

mad to think how a woman can allow herself to be pulled about by a *man'* (i.36-7). Later in the novel, Mona's friend Doris Colquhoun ventriloquises the fears of vulnerable young women when she reports that:

> A young girl in my Bible-class went into the Infirmary a few weeks ago […] and you should have heard what she told me! Of course I know it was only routine treatment. It would have been the same in any hospital; but that does not make it any better (i.140).

The evasive nature of the anecdote indicates Doris's modesty but also invites the reader to speculate what aspect of the 'routine' treatment her friend found so unsettling.

The young woman's insistence that she 'would rather die' than consult a medical man again might be interpreted as the impetuous outburst of a hysterical girl (i.140). Yet Mona later meets an older, working-class woman who is similarly reticent about her health. Referring to her illness, she tells Mona she has 'niver been able tae bring mysel' tae speak o't'. Mona discovers that the case is now so advanced it may be 'beyond the possibility of surgical interference' (iii.65-6). Todd effectively suggests that both chaste young girls and their worldlier counterparts might be reluctant to receive male attendance. This strategy recalls Jex-Blake's 'Medicine as a Profession for Women', which argued that 'the unwillingness of very many girls on the verge of womanhood to consult a medical man' occasioned 'an enormous amount of preventable suffering', and also claimed that many 'ladies have habitually gone through one confinement after another without proper attendance, because the idea of employing a man was so repugnant to them' (46, 42). Both writers imply that male monopoly of the profession jeopardises women's health.

Todd and Jex-Blake associate the male doctor-female patient encounter with feelings of repulsion and aversion. However, while they suggest women might *feel* discomfited, neither impugns medical men of improper conduct. Indeed, Mona actively defends her male counterparts. She reassures Doris that 'some of the young men of whom

you speak so scornfully are truly scientific, and many of them have infinite kindness of heart' (i.141). Mona also encourages the older woman to visit a doctor, 'a good man' whose medical knowledge is superior to her own (iii.66). In both instances, Mona reassures female patients that medical men unite scientific knowledge and sympathetic understanding. This is another image she perhaps borrowed from her mentor, for Jex-Blake acknowledged 'the honour and delicacy of feeling habitually shown by the gentlemen of the medical profession' (7-8).

'A Cast for a Fortune' departs from the ameliorative approach taken by Jex-Blake and Todd, depicting a medical man who is an outright villain. The story draws upon the trope of the vulnerable female patient whose body is manipulated by an unscrupulous male doctor. Dr Pomeroy's designs on Ada are pecuniary, for he plans to murder his sister-in-law 'for the sake of coin' (475). Nevertheless, the story also hints at sexual impropriety – he has already proposed to his sister-in-law (though their union would have been prohibited under the 1835 Marriage Act) and he is later revealed to have made false promises of marriage to Ada's maid (his accomplice), and an unwitting woman named Nelly, the mother of his illegitimate children. Mary must intervene to shield Ada from Pomeroy's machinations.

In *Dr Janet*, a female doctor also guards a vulnerable woman against a male threat. Here it is not a medical man who is guilty of improper conduct, though readers may be discomfited by the way in which Liveing harbours a passionate attraction towards his medical student, the teenaged Phyllis. Nevertheless, his self-restraint distinguishes him from the dissolute Marquis, who reveals his lascivious nature hours before his wedding to Phyllis. As she escapes from him before their union is consummated, Janet implicitly functions as the protector of her virginity.

The medical woman was repeatedly positioned as the most suitable confidant for female patients. Jex-Blake argued that 'a woman's most natural adviser is one of her own sex' (49) and this tenet is represented across the fiction. In both Kingsford and Kenealy's stories, the natural or instinctive bond between two women overrides familial or marital ties between man and woman. Ada and Phyllis implicitly trust Mary and Janet, even though they are strangers. Further, Mary is depicted as uniquely placed to help Ada because of her position as both a woman and a physician. Pomeroy has prohibited his victim from consulting any other doctor, but she is confident that Mary can assist her undetected since '[l]adies are so rarely physicians' (473). Ada requests that Mary visit her in the guise of 'an old friend or school-fellow' instead. Although the narrator is wary of a request which points to a case of an 'unpleasant and delicate nature', she is moved by 'more worthy feelings' and also curiosity about 'so interesting a patient' (470-1). She develops a strong sense of responsibility towards Ada, later referring to herself as 'the best friend' she has (480).

Affective relationships between women are also central to Todd's novel, both in terms of Mona's close friendships and her interactions with patients. Swenson argues that *Mona Maclean* is 'a novel of education', whereby the heroine must learn to supplement her scientific abilities by extending her human sympathies. She suggests that Mona does not pass her examinations until she has found a sense of purpose and vocation.[114] The 'epoch' or 'turning-point' in Mona's personal and professional journey is the night in Barntoun Wood where she helps deliver Maggie's illegitimate baby (iii.29). The events demand much of her, for she must ensure the physical health of Maggie and her premature baby, as well as the girl's moral and mental health. She demonstrates both her medical training and compassion. The narrator relates, 'I know not whether the woman or the

[114] Swenson, p. 133.

doctor in her rejoiced more truly when she saw that all immediate danger was past' (iii.22). The suggestion is that these challenging circumstances call upon her capabilities as a woman and as a doctor.

The protagonist feels 'responsible in a greater or a less degree for every girl with whom she came into contact' (ii.104). When Matilda Cookson confides that she has been having secret assignations with her drawing-master, Mona warns the girl that her conduct is not respectable. Mona is represented as tactful and discreet: although she does not agree to conceal Matilda's secret, neither does she expose the truth, and she protects Maggie's confidentiality. As identified previously, the medical press contained accusations about the moral character of aspiring medical women. The way in which Mona shields the girls' 'improper' conduct recalls fears that female practitioners might collude with their patients, perhaps discussing birth control. Yet Mona carefully navigates the 'sexual improprieties' of others, eschewing 'ignorance' while retaining her 'innocence', as Charles Ferrall and Anna Jackson note.[115] This effectively downplays anxieties about the medical woman's access to, and dissemination of, sexual knowledge. Furthermore, Mona is presented as a steadying and moralising influence over other young women. Maggie wonders 'if she could only be with Miss Maclean always, how easy it would be to be good' (iii.29). Mona later rehabilitates the young woman, finding her employment with her friends, the Colquhoun family. This recalls the close of 'A Cast for a Fortune', where Mary and Ada offer Pomeroy's abandoned mistress employment. In both stories, domestic service is presented as offering redemption for the working-class 'fallen' woman. Such characters fulfil Jex-Blake's vision for medical women to play a reformative role through their 'contact with their sinning and suffering sisters' (44). In Todd's novel, Matilda – whose

[115] Charles Ferrall and Anna Jackson, *Juvenile Literature and British Society: The Age of Adolescence* (New York: Routledge, 2010), pp. 73-4.

flirtation never progresses to sexual impropriety – is rehabilitated through her friendship with Mona. The girl abandons her entanglement and renounces her 'vapid little life' (ii.104). Although the reader may not take her ambitions to study medicine seriously, she has clearly been directed towards self-improvement.

Kenealy's novel indirectly engages with images of the fallen woman. Although the narrative endorses Janet's protection of Phyllis, her actions are shown to run counter to prevailing legal and social mores. By keeping husband and wife apart, she disregards the marriage laws. When the Marquis re-enters the narrative to reclaim Phyllis, he describes Janet's conduct as criminal and suggests it has facilitated an illicit romance between Phyllis and Paul. He also vilifies his wife's chosen lifestyle. In one scene, Phyllis is pictured returning home in the early hours of the morning after attending a poor patient, for her 'professional duties' at the hospital require 'some amount of night-work' (242). The Marquis encounters her by chance and accuses her of 'wandering about the streets' in 'a disreputable fashion' (245). He draws an implicit link between medical work and prostitution, casting Phyllis in the role of fallen woman. This recalls some of the diatribes in the medical press against women's moral character. However, the Marquis's accusations are clearly portrayed as unjust and hypocritical, given his state of intoxication and profligate nature.

Across all three stories, medical women typically act as sources of medical expertise and moral authority, though their use of power is sometimes ambivalent. In 'A Cast for a Fortune', Mary declines to tell Ada why she is suffering, asking the patient to trust her implicitly. Further, Mary later exploits her access to medical paraphernalia, using chloroform to subdue Ada's maid Clara whom she suspects of being George's accomplice. Nevertheless, Mary's actions are validated when her suspicions are proved correct and Ada's life is saved.

In *Dr Janet*, Kenealy uses the titular medical woman as a mouthpiece for her eugenic philosophy. As Angelique Richardson has shown, eugenic discourse and New Woman writing often closely intersected.[116] Janet vehemently warns of the dangers of degeneration, depicting working-class sexuality as a threat to the national health. While working among the poor in the hospital, she asks the parents of 'sickly or evilly-disposed children' if they are 'not ashamed to have brought such "human rubbish" into existence'. The narrative presents these startling invectives as blunt and eccentric but not callous. It then emphasises her compassion, describing how she provides dinners for these same children, whose plight 'hurt her big heart' (195-6).

In the narrative's sensational and murky denouement, Janet draws upon eugenic ideas to persuade the Marquis that he must commit suicide to release his wife. Following her separation from Paul and the loss of her child, Phyllis contracts puerperal fever, and loses her sanity. Janet tells the Marquis to 'atone' for his sins through an act of 'sacrifice', suggesting it would be a 'release to [his] soul to free it from the blindness and disease of [his] faculties' (318, 320). In a lurid scene, the Marquis – in a state of feverish hallucination – recalls her words and kills himself. In the final passages of the novel, Janet learns of his act and reflects that, though she is 'a wicked woman', she 'thank[s] God that he did it' (340). Reviewing the novel, Gregg suggested that Kenealy's method of dispatching the Marquis was 'highly ingenious'. She added '[i]n Miss Kenealy's opinion, it is also highly moral in character, but this is a matter on which a very different view may be held'.[117] As Gregg intimates, Janet is implicitly absolved by the novel's moral schema; she has prevented the Marquis from asserting his ownership of Phyllis, paving the way for her return to health and reunion with Paul. Though Janet conceptualises her own 'neuter-

[116] Angelique Richardson, *Love and Eugenics in the Late Nineteenth-Century: Rational Reproduction and the New Woman* (Oxford: Oxford University Press, 2003).
[117] Gregg, 'The Medical Woman', p. 108.

nature' as degenerative she is also portrayed as upholding the purity of the national stock.[118]

Each of these stories presents a formidable medical woman who exerts considerable medico-moral authority. To what extent do these characters challenge male (professional) hegemony? As I have shown in this chapter, hostility towards medical women often stemmed from fears of competition. The ending to *Mona Maclean* indicates Todd's essentially ameliorative approach to sexual politics and the medical-woman debate. The novel is effectively structured around the archetypal marriage plot. Mona rejects several suitors before making an idealised match with a young medical man, Ralph Dudley. Their union is also the foundation for a medical partnership, however. Swenson suggests there is something 'radical – if overly sanguine' in the character finding both 'personal happiness and professional fulfilment',[119] while Tabitha Sparks argues that the narrative's reconciliation of a woman's marriage and medical career is 'unique' in comparison to other medical-woman novels.[120] Significantly, the ending also downplays fears that female practitioners will undermine the medical man's position.

Earlier, *Mona Maclean* toys with the idea that medical women will pose a source of competition. The heroine notes that 'the supply of medical women will exceed the demand in the next ten years' (iii.97). Nevertheless, in the novel, medical men are not necessarily concerned about competition. Dudley tells Sir Douglas that 'there is a part of our work which ought to be in the hands of women' and that he is willing to 'gladly hand it over to them' (ii.192). This is enacted in the denouement, where Dudley's passes the female patient over to Mona. Sparks suggests that this is a subtly subversive ending, which

[118] See Carr, pp. 127-8.
[119] Swenson, p. 129.
[120] Tabitha Sparks, *The Doctor in the Victorian Novel: Family Practices* (Farnham: Ashgate, 2009), p. 152.

assigns Dudley a 'capitulatory rather than managerial' role.[121] Yet the couple's shared practice forestalls the problem posed by women's participation in the medical marketplace. Mona becomes Dudley's partner (both in marriage and practice) rather than his rival.[122] The idea that there was a separate sphere of work for medical women was commonly deployed. Jex-Blake suggested that they could 'find full and remunerative employment', 'without withdrawing a single patient from her present medical attendant' (47). Finally, Mona's medical work is also conceived as philanthropic rather than competitive. She and her husband eschew lucrative practice; though Sir Douglas 'begged them to settle in Harley Street', they are 'too enthusiastic to forego the early days of night-work and practice among the poor' (284).

By contrast, Kenealy's Dr Janet has 'a large and varied practice' in Harley Street. It becomes a 'fashion' to consult her, though she does not actively pursue lucrative practice. Far from being obsequious towards patients, her approach is informed by her 'social ethics' which are 'inherently radical'. In her cross-class practice, her patients must wait their allotted time regardless of their social standing. Thus '[t]he name of a royal personage seeking her advice, stood upon the list beside *and after* that of a humble tradesman's wife' [emphasis added] (96). Further, despite her popularity, she limits the size of her practice to ensure it remains manageable. The way in which she avoids competitive behaviour arguably renders her less threatening. Like Todd, Kenealy also portrays a marriage between a medical man and woman. Phyllis 'persist[s] in taking her degree before [her] wedding', though this is perhaps as much to appease her mentor as to satisfy herself (266). There is no suggestion that she will practise medicine after her marriage. Although she is pictured preparing to 'join' Paul on his morning rounds, the

[121] Sparks, *The Doctor in the Victorian Novel*, p. 156.
[122] It was not uncommon for husbands and wives to work together in general practice in this period. Digby, *Evolution*, p. 169.

narrator suggests only that she will ‘drive with him’, not that she will assist him in his duties (282). The implication is that she will accompany him in her role as doctor’s wife rather than in her own professional capacity.

In differing ways, both Todd and Kenealy disclaim the idea that medical women pose a direct threat to their male counterparts. By contrast, Kingsford depicts a courageous female practitioner usurping a corrupt male doctor. Pomeroy’s villainy is wholly enmeshed in his status as a medical man. Mary recognises that the assault on Ada is clearly ‘conducted by a person possessing medical knowledge and professional means of obtaining the poison’ and brands his act ‘deliberate scientific murder’ (474-5). The character’s abuse of power recalls the actions of real-life doctor-poisoners from the preceding decades, namely William Palmer and Edward William Pritchard. It also anticipates later fictional medical villains such as Frankau’s Dr Phillips (whom I discussed in Chapter Two) and Conan Doyle’s Dr Roylott from ‘The Adventure of the Speckled Band’ (whom I will examine in Chapter Five). To evade trial and punishment, Pomeroy later commits suicide with the emblematic tool of his profession: a lancet.

Kingsford downplays some of the subversive implications of her narrative, however. There is no suggestion that Pomeroy is meant to figure as a synecdoche for the wider body of medical men. His ‘absolute and unconditional refusal’ to allow Ada to see ‘any other physician than himself’ exemplifies how he acts alone (473). Mary also expresses incredulity that the would-be murderer is a ‘member of [her] own honoured profession’ (475). The narrative suggests that, by denouncing Pomeroy, she will restore medicine’s reputation. Thus Mary functions not so much as an anomaly or outsider but as the guardian of medico-morality and professional ethics. Further, while the male practitioner is excluded from the story’s close, this does not facilitate the woman-doctor’s professional advancement. The closing scene shows Mary establishing a domestic idyll

with Ada rather than a thriving medical practice. The ending is more dissident for its disruption to the heteronormative marriage plot, for the image of two women cohabiting shows that the man's conventional role within the home has been displaced.

The fiction discussed here represents a diverse range of medical women. What unites these characters is their journey to find a sense of purpose and vocation. Mary and Mona undergo trials that test their ability in order to grow from medical students or graduates to capable physicians. Like Janet, they are unapologetic and confident in their professional identities. In Kenealy's novel, Janet and Phyllis must learn that their different natures mean they are suited to different roles – one as a doctor, the other as the wife of a medical man. Surprisingly, perhaps, these stories are not principally concerned with representing women overcoming prejudice; rather they explore individual journeys of self-development. Yet the focus on medico-moral authority also served to counteract charges against medical women's personal character and professional expertise which circulated in the medical press.

6. Critical reception in the medical press

Given the stories' assertive portraits of medical women, it may not seem as though they would have appealed to the professional community. In her 1898 review of *Mona Maclean,* Gregg suggested that it was regarded as 'the hysterical work of a sentimental female' and that it was 'the pet aversion in literature of the male medical student'.[123] Swenson draws on this remark to suggest that the novel was unfavourably received by the profession. By contrast, I have found that it was met with a largely positive response in the medical press. Since 'A Cast for a Fortune' and *Dr Janet* were overlooked, it is not possible to compare the stories' critical receptions. The *BMJ* reported that Kenealy was to

[123]Gregg, 'The Medical Woman', p. 108.

bring out a book 'intended to portray female life from within' and later listed that it had received a copy from the publishers, as did the *Lancet*.[124] However, neither journal published a review. While one can only speculate why Kenealy's novel was ignored, I will consider why *Mona Maclean* might have been particularly well-received.

Upon its publication, Todd's novel came to the attention of several leading medical journals. The *Lancet* deemed it 'a capital book' and a 'well-written, and effectively-told tale',[125] while the *EMJ* designated it 'eminently readable'. It prefaced its review by stating that it rarely had the 'opportunity of exercising [its] wits' on a novel.[126] As noted previously, the medical press's literary reviewers often suggested that critiquing fiction was a novel activity for them. The *MPC* was less enthusiastic in its response, suggesting that the plot was rather 'feeble,' but it nevertheless conceded that the book held a certain 'charm'.[127]

None of these reviewers was troubled by the characterisation of Mona. The *Lancet* writer barely commented on the fact that the protagonist was an aspiring female practitioner, though his description of the book as 'healthy' was perhaps intended to reassure readers that it was not morbid or hysterical, traits conventionally associated with the medical-woman movement and New Woman fiction.[128] Several years later, a correspondent to the *Lancet* would scathingly suggest that, since 'the new woman is, *par excellence*, a morbid product', it was 'quite intelligible that she should wish to study morbid anatomy'.[129] In 1900, the *Lancet* reviewed the fifteenth edition of *Mona Maclean*,

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[124] 'Literary Intelligence', *BMJ*, 8 April 1893, p. 764. 'Books, ETC, Received', *BMJ*, 29 April 1893, p. 940. 'Books Etc. Received', *Lancet*, 22 April 1893, pp. 965-6 (p. 965).
[125] 'Reviews and Notices of Books: Other Seasonable Productions', *Lancet*, 17 December 1892, p. 1394.
[126] 'Review: Mona Maclean', *EMJ*, December 1892, pp. 569-70 (p. 570).
[127] 'Literature: Mona Maclean, Medical Student', *MPC*, 19 April 1893, p. 424.
[128] 'Reviews and Notices of Books: Other Seasonable Productions', p. 1394.
[129] Claude A. P. Truman, 'Correspondence: The Admission of Women to the Royal Colleges of Physicians of London and Surgeons of England', *Lancet*, 23 November 1895, pp. 1321-2.

describing it as a 'wholesome story'.[130] The *EMJ* reviewer briefly acknowledged Mona's status as a New Woman when he flippantly suggested that 'the heroine is the latest fine flower of civilisation and progress'. Yet he claimed to have enjoyed the novel 'without turning a hair,' implying that he did not consider it particularly subversive.[131]

By contrast, the *MPC* opened its review by noting that the book 'champion[s]' the medical-woman 'cause'. However, it added that readers who expected to encounter 'some developments of feminine characteristics which should place the question of fitness or unfitness of women for the profession on some tangible basis, will be disappointed'. This implied that it did not deem the book particularly successful as a polemic. Nonetheless, the reviewer commended the characterisation of Mona, describing her as 'bright', 'intelligent', and an 'interesting personage'. It even suggested that she 'commands [the reader's] every sympathy'.[132]

Mona was received as a lively if undemanding heroine. The *MPC* noted that her 'clever repartee' was the 'charm' of the book,[133] while the *EMJ* also described the heroine as 'charming'.[134] This parallels the response in the popular press. In the *Academy,* William Wallace recommended *Mona Maclean* as 'one of the freshest and brightest novels of the time',[135] while the *Speaker* praised the protagonist as a 'natural lady' and the book as 'good and artistic work'.[136] The *Athenaeum*'s critic expounded more on the novel's 'obvious blemishes'; like others, he recognised it as an authorial debut. He bemoaned that it was 'a novel with a purpose' but suggested that it showed 'decided promise' and was 'in

[130] 'Library Table: Mona Maclean', *Lancet,* 9 June 1900, p. 1663.
[131] 'Review: Mona Maclean', p. 570.
[132] 'Literature: Mona Maclean', p. 424.
[133] 'Literature: Mona Maclean', p. 424.
[134] 'Review: Mona Maclean', p. 570.
[135] William Wallace, 'New Novels', *Academy,* 3 December 1892, pp. 504-5 (p. 504).
[136] 'Fiction', *Speaker,* 12 November 1892, pp. 598-9 (p. 599).

parts exceedingly enjoyable'.[137] Across these reviews there is perhaps a hint of condescension, which could be attributed to the fact that *Mona Maclean* was widely identified as the work of a female author. The *Lancet*, *MPC*, and *Academy* all suggested it was written by a woman, while the *Athenaeum* asked whether it should refer to the author as '(he)or she?'.[138] For Jex-Blake – who concealed Todd's identity – the novel's 'charm and freshness' did not detract from, but rather augmented, its realism and favourable impression upon the reader.[139]

Initially, it seems as though *Mona Maclean* was aimed at young female readers. Gregg suggested that she would 'present a copy to any girl […] who was entering on the study of medicine', to show her that the 'ideal medical career' entailed husband and wife working alongside one another.[140] More recently, literary critics Ferrall and Jackson include the novel in their survey of juvenile and adolescent literature for girls.[141] In the Victorian medical press, however, *Mona Maclean*'s imagined readership was much broader. The *Lancet*, *EMJ*, and (to a lesser extent) *MPC* effectively endorsed it to their readers, the majority of whom would have been medical men. None of the journals stated that the book would make a suitable gift for a wife or daughter, though the fact the *Lancet* and *EMJ* reviewed it around Christmas might have suggested this to some readers. Significantly, the *Lancet*'s 1892 review did not appear in its column 'New Books for Young People' but under the ensuing column 'Other Seasonable Productions'. Moreover, in 1900, the journal praised the publishers for bringing out a 'cheap edition' of *Mona Maclean*, thus putting the story 'within the reach of everyone'.[142]

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[137] 'Novels of the Week', *Athenaeum*, 3 December 1892, pp. 773-5 (p. 774).
[138] 'Novels of the Week', p. 774.
[139] Jex-Blake, 'Medical Women in Fiction', p. 271.
[140] Gregg, 'The Medical Woman', p. 109.
[141] Ferrall and Jackson, pp. 72-6.
[142] 'Library Table: Mona Maclean', p. 1663.

Crucial to the journals' approbation of *Mona Maclean* was its representation of medical life. The *Lancet* reviewer judged the novel to be 'just *sufficiently medical* to give it special interest to medical readers, but not of so professional a character as to diminish its *interest for the public*' [emphases added].[143] Similarly, Jex-Blake contended that *Mona Maclean* would resonate with medical readers, since they would recognise it as written 'by a brother, or sister, of the healing art, and one who loves his or her profession'. However, she also praised the way in which 'the medical element in [the novel] is kept strictly subordinate to the development of the story and the play of the characters'.[144] The *EMJ* reviewer noted that the author handles 'the delicate topics involved in the dissecting-room episodes' with 'a light hand'.[145] This is pertinent, given anxieties expressed in the medical press that women might be coarsened by medical instruction. The *MPC* review seemed amused by the way in which Todd combined her feminine characters and medical subject matter. It quoted the character Lucy Reynolds, who suggests that 'the art of dressing one's hair is at least as important as the art of dissecting' (i.1), playfully endorsing this as a 'common-sense opinion'.[146] Todd's spirited treatment of women's medical studies differs from Kenealy's more morbid approach. When dissecting a body, the overwrought Phyllis cannot overcome her 'sense that the dead heart and eyes and limbs were human things' (131-2). Not all reviewers agreed that Todd handled her medical material skilfully. The *Athenaeum* piece suggested that the author was 'a little too anxious to advertise his familiarity with the pharmacopoeia and the dissecting-room'. However, rather than finding this material distasteful, the reviewer simply noted that the author's preoccupation made the dialogue 'terribly sloppy' at times.[147]

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[143]'Reviews and Notices of Books: Other Seasonable Productions', p. 1394.
[144] Jex-Blake, 'Medical Women in Fiction', p. 278, 266.
[145] 'Review: Mona Maclean', p. 570.
[146] 'Literature: Mona Maclean', p. 424.
[147] 'Novels of the Week', p. 774.

Todd's novel contained potentially subversive elements, yet it clearly appealed to the profession's sensibilities and self-image. Despite some reservations, it was seen as a novel which bridged the literary tastes of medical and popular readers and represented medical life in a way which satisfied both. By portraying a lively and genteel young woman who finds medical work rewarding, Todd not only allayed fears about the New Woman and medical-woman movements but – significantly – represented medical study and practice as wholesome and respectable. The novel's critical reception shows the profession's unexpectedly affirmative engagement with medical women's writing.

Mona Maclean gained traction among the profession. Following its publication, medical journals continued to associate Todd with its authorship. In 1894, the *BMJ* reported that three women – including the 'authoress of *Mona Maclean'* – had passed the Conjoint examinations in Scotland.[148] In 1895, the same journal summarised Todd's response to controversial correspondence from Kenealy about whether doctors should intervene to prevent miscarriage in the case of syphilitic children. It referred to Todd as '[t]he Author of *Mona Maclean*'.[149] On these occasions, the *BMJ* provided neither Todd's pseudonym nor her given name, identifying her simply as the author of *Mona Maclean.* This implies the journal expected its readers to be familiar with the novel, even though it had never reviewed it.[150] The fact that Todd was acknowledged in this way even when she was discussed in terms of her subsequent medical work indicates how the boundaries between her authorial and medical identities were blurred. Rather than undermining her clinical credentials, this shorthand appears to have been a mark of professional esteem.

[148] 'Medical News', *BMJ*, 11 August 1894, p. 346.
[149] 'Correspondence: A Question of Conscience', *BMJ*, 5 October 1895, pp. 870-1.
[150] The *BMJ* did, however, feature a summary of Jex-Blake's 'Medical Women in Fiction', including her endorsement of *Mona Maclean*. 'Literary Intelligence', *BMJ*, 11 February 1893, p. 306.

In following years, Todd used her authority to refashion images of medical women. In 1908, the *Lancet* printed a glowing obituary of Edith Pechey-Phipson, one of the first tranche of students at Edinburgh. It quoted extensively from a 'sympathetic letter' it had received from Todd.[151] She may also have had a role in constructing Jex-Blake's obituary in 1912, which described the deceased's 'valiant championship of the rights of women in medicine'.[152] Certainly Todd was responsible for a hagiographic biography of Jex-Blake which appeared six years later, and which the *Lancet* described as 'admirable' and 'as absorbing as a good novel' in its review.[153] The deaths of the early pioneers in the opening decades of the twentieth century inspired increasingly affirmative representations of the medical woman in the professional press.

Conclusion

Medical men and women have been regarded as occupying largely separate professional spheres during the nineteenth century. This chapter has examined how these gender divisions shaped (and were shaped by) textual practices. The medical press was a predominantly masculine textual space, in which the editors, contributors, correspondents, and readers were typically male. Journals frequently printed pieces outwardly hostile towards the medical-woman movement. In this climate, it is unsurprising that aspiring women doctors engaged with other forms of writing, both to find new (more sympathetic) audiences and alternative means of identity formation.[154] Nevertheless, this chapter has argued that there was considerable overlap between their textual practices. Further, the

[151] 'Obituary: Mary Edith Pechey-Phipson', *Lancet,* 25 April 1908, p. 1250.
[152] 'Obituary: Sophia Jex-Blake', *Lancet,* 13 January 1912, p. 130.
[153] Todd, *The Life of Sophia Jex-Blake* (London: Macmillan, 1918). 'Reviews and Notices of Books: The Life of Sophia Jex-Blake', *Lancet,* 10 August 1918, p. 174.
[154] Medical publishing remained heavily gendered into the twentieth century. The Medical Women's Federation (established in 1917) launched its own publications, thus creating its own community.

interplay between the journals and the fiction was crucial to renegotiating the medical woman's professional identity.

The medical-woman movement generated such extensive coverage in the medical press because it opened up debates about what constituted professional identity. It was represented as a 'question' or set of questions comprising women's access to medical education, patients, professional appointments, and professional membership. Women's participation in medicine was often framed as a problem to be solved or forestalled. However, it also stimulated debate about what qualities were needed to practise medicine. Supposedly oppositional categories of 'woman' and 'medicine' were interrogated and redefined. Significantly, the democratising tendency of print culture meant that a range of individuals, including women, could engage in discussion and it is pertinent that an apparently broad spectrum of people were energised by the medical-woman question. While the professional press facilitated competing representations of medical women it nevertheless tended to homogenise the group. In part, this was a strategy to impose control on a complex issue which developed unevenly across the period.

Literature by medical women facilitated the construction of more complex personal and professional identities. It engaged with themes prevalent in the medical press, such as the compatibility of femininity and medicine, and enabled women to respond to accusations about their moral character and professional authority. However, the fiction did not present itself as pure polemic, as a rejoinder to the movement's critics. Instead, it refocused attention on women's individuality and autonomy. Within these narratives, medical women were not subordinates but invested with agency and authority. These stories provided richer portraits of medical women and enabled the authors to mould their own identities. Fiction was ideally suited to exploring affective relationships between women, thereby codifying female patients' preference for women doctors as natural or

instinctive. The enthusiastic response to *Mona Maclean* and Todd at the *fin de siècle* indicates the professional press was becoming more receptive to new cultural constructions of the medical woman.

In the medical and cultural imagination, perceptions of the medical woman shifted across time. The figure was initially treated as an anomaly, then a problematic category, before being incorporated (to some extent) as part of the professional community. While print culture facilitated heterogeneous representations of the medical woman, she continued to be defined primarily by her gender. Identification as a 'medical woman' foregrounded her enduring alterity in a predominantly masculine profession. By contrast, the other identity categories I have examined in this thesis were conceived as more fluid. Medical men transitioned out of the early struggles in practice and could identify as metropolitan or country practitioners according to their place of practice. Medical women were primarily identified by their gender, though they were also conceptualised in relation to other identity categories. As I have intimated, a woman's age influenced her perceived suitability for medical practice. My final chapter will explore imperial medical identities, considering how ideas about women's gender, race, and ethnicity intersected in the colonial context.

Chapter Five: The Colonial Practitioner in British India

In December 1894, the First Indian Medical Congress gathered in Calcutta, the then-capital of British India. It was presided over by Surgeon-Colonel Robert Harvey, a senior official in the Indian Medical Service (IMS). In his opening address – reprinted in medical journals in both India and Britain – Harvey described how,

> by bringing together from all parts of the country all sorts and conditions of medical men and women, European and Indian, official and non-official […] [the Congress] tends to establish a solidarity of interests and aims which is devoutly to be wished for, and to strengthen the influence of the profession by concentrating it in one broad current.[1]

Harvey's address fashioned a collective professional identity which incorporated a diverse range of individuals. The practitioners of Western medicine in India were depicted playing complementary roles, regardless of their gender or race, and whether they were in official or private employment. The fact that 'solidarity' was 'devoutly to be wished for', however, indicates that this imagined community was an aspiration. The Congress was conceived not as a natural outcrop of professional collegiality, but rather as a means of engendering it.

This chapter examines the representation of colonial practitioners in British India in medical journals and medical fiction. Through the activities of the East India Company, Britain had gained control of almost two-thirds of the Indian subcontinent by 1850. Its reach extended across the present-day nation states of India, Pakistan, and Bangladesh, though its rule was most visible in the Presidency towns of Bengal, Bombay, and Madras. The remaining third of the continent encompassed the 'princely states', which were notionally independent and headed by indigenous rulers, though subject to subsidiary alliances with the British.[2] This chapter concentrates on the formation of medical identities

[1] Robert Harvey, 'The Medical Profession and its Work in India, Past, Present and Future', *IMR,* 1 January 1895, pp. 1-7 (p.1).
[2] This chapter uses nineteenth-century place names to avoid confusion when citing primary sources.

in the period after the 1857 Indian 'Mutiny' or Rebellion, when governing power was transferred from the Company to the British Crown. While I focus on medicine under British rule, the professional press also discussed developments in the princely states, as I will demonstrate.

This was a period of High Imperialism, in which colonial medicine – as David Arnold argues – became 'one of the most confident expressions of British political and cultural hegemony'.[3] It was undergoing its own process of professionalisation. As in Britain, this was characterised by the inauguration and expansion of medical schools and hospitals, professional societies, and medical journals. However, there was considerable anxiety about the colonial profession's public image and the need to reform the medical services. Mark Harrison has discussed the low status accorded to IMS employment, emphasising that a preoccupation with 'gentility' characterised the profession in Britain and India.[4] In both spaces, there were parallel debates about how to strengthen medical education and the system of professional appointments; how to improve public health; the status and prestige of medical men; and the necessity for, or desirability of, medical women.

A substantial body of scholarship on colonial medicine in India has developed in recent decades. Historians have examined the imperial administration's public health measures and its encounters with indigenous communities. They have explored the production of medical knowledge, demonstrating how ideas and practices were (re)fashioned in the colonial context.[5] Scholars have pointed towards what Biswamoy Pati and Harrison characterise as 'a gap between the reality and the rhetoric of medical

[3] David Arnold, *Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth-Century India* (California: University of California Press, 1993), pp. 11-12.
[4] Mark Harrison, *Public Health in British India: Anglo-Indian Preventive Medicine, 1859-1914* (Cambridge: Cambridge University Press, 1994).
[5] Arnold, *Colonizing the Body*, p. 9.

progress in India'.[6] The Indian Government framed its healthcare provision as benevolent but used coercive approaches which engendered apathy and resistance from indigenous peoples. It devolved responsibility for health to local authorities (which lacked the necessary funding and expertise) and neglected outlying areas. This chapter focuses on medical discourse rather than policymaking, but the gulf between *rhetoric* and *reality* emerges in the medical press, which considered the obstacles faced by, and the limitations of, Western medicine in India.

This chapter builds on research into how professional identities were conceptualised in imperial spaces. In *Medicine and Colonial Identity,* Bridie Andrews and Mary Sutphen propose that medicine was an 'aspect of cultural positioning' through which 'colonists and colonized alike defined both themselves and the colonial other'.[7] I develop the idea that medical and colonial identities were interconnected, focusing on the formation of professional identities. The experiences of patients (European and Indian) fall outside the scope of this thesis, and the journals provide limited opportunities to engage with subaltern voices. Developing Harrison's work, I will scrutinise how anxieties about the status of work in India were mediated through the medical press. In his recent thesis, Kieran Fitzpatrick follows the careers of Irish surgeons in the IMS between 1850 and 1920. He foregrounds the development of networks between Ireland and India, discussing how professionalisation was a 'transnational' project.[8] My chapter scrutinises how journals facilitated the construction of imagined communities within India and between the colony and the metropole.

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[6] Biswamoy Pati and Mark Harrison, 'Introduction', in *Health, Medicine and Empire: Perspectives on Colonial India* (London: Sangam, 2001), pp. 1-36 (p. 3).
[7] Bridie Andrews and Mary P. Sutphen (eds.), 'Introduction', in *Medicine and Colonial Identity* (London: Routledge, 2003), pp. 1-13 (p. 6).
[8] Kieran Fitzpatrick, *Tense Networks: Exploring Medical Professionalization, Career Making and Practice in an Age of Global Empire, Through the Lives and Careers of Irish Surgeons in the Indian Medical Service, c. 1850-1920* (unpublished doctoral thesis: University of Oxford, 2016), p. iii.

I focus on British India as a specific site of medical practice. In *Practising Colonial Medicine,* Anna Crozier examines the role of the Colonial Medical Service in British East Africa, tracing the development of 'a distinct colonial medical identity'. She suggests that her conclusions 'provide a cultural-historical template with which to view the colonial experience in general'.[9] While professional identities conceptualised in different colonial contexts undoubtedly intersected, we must be cautious about representing them as synonymous or interchangeable. As Gayatri Chakravorty Spivak cautions, 'the Indian case cannot be taken as representative of all countries, nations, cultures [….] that may be invoked as the Other of Europe'.[10] The British Empire encompassed a diverse range of territories, from aggressively colonised areas of East Africa to more independent dominions such as Canada and New Zealand.

This chapter advances our understanding of periodical culture in British India, which developed during the nineteenth century. In 1941, the *BMJ* featured a piece celebrating the seventy-fifth anniversary of the *Indian Medical Gazette* (1866-1955; hereafter *Gazette*), at this point the country's longest-running medical journal. It reflected that, '[d]uring the past century dozens of medical journals have sprung up […] and had their brief day, usually petering out after a few years'. It highlighted several titles which had secured a firmer foothold, including the *Gazette* and the *Indian Medical Record* (1890-1903; hereafter *Record*).[11] I will concentrate on these two prolific titles, both intended for general medical audiences. Thus far, historians have drawn upon the *Gazette* and (to a much lesser extent) the *Record* as evidence of imperial medical policy or opinion.[12]

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[9] Anna Crozier, *Practising Colonial Medicine: The Colonial Medical Service in British East Africa* (London: IB Tauris, 2007), p. 2.
[10] Gayatri Chakravorty Spivak, 'Can the Subaltern Speak?', in *Discourse and Postcolonial Theory,* ed. by P. Williams and L. Chrisman (Cambridge: Harvester Wheatsheaf, 1993), pp. 66-111 (p. 76).
[11] 'Seventy-Fifth Anniversary of the *Indian Medical Gazette', BMJ,* 3 May 1941, p. 679.
[12] In the main text I refer to the journals as the *Gazette* and the *Record* to distinguish more easily between them. In the footnotes I use acronyms (*IMG* and *IMR*) to provide a simple but comprehensive reference.

However, little attention has been paid to the interactions between these publications and their relationship to the British medical press.

Both the *Gazette* and the *Record* were produced in Calcutta (Bengal), which was the capital of British India until 1911. From the late eighteenth century, it was the centre of the British Indian publishing industry, 'a rival to London as the centre of literary production', stimulating a 'vibrant newspaper industry'.[13] Both journals offered similar content in comparable formats: they included original communications and notes from hospital practice, as well as editorials, news items, and correspondence columns. They recalled the style and layout of popular British medical journals such as the *Lancet, BMJ,* and *MPC.* The *BMJ* attributed the *Gazette*'s success to its longest-running editor Kenneth McLeod (1871-92) and one of his successors, Walter Buchanan (1899-1918), both of whom held senior appointments in the IMS. By contrast, the *Record* was the brainchild of one individual, its founder and editor James R. Wallace, an independent medical practitioner.[14] When the *Record* launched in 1890, its opening editorial shrewdly observed the exigencies of the journal market. Noting that many medical periodicals 'have come into existence, have served a useful purpose, and become extinct', it identified the *Gazette* as one title which had 'braved the storm', before stating that it intended to fulfil a different purpose.[15] This chapter will examine how these titles were conceived as rivals in the journal market but also how they attracted overlapping readerships. I begin by looking at how the journals represented 'official' and 'independent' practice, before considering their

[13] Deana Heath, *Purifying Empire: Obscenity and the Politics of Moral Regulation in Britain, India and Australia* (Cambridge: Cambridge University Press, 2010), p. 157.
[14] As the enterprise of one man, the *IMR* was relatively short-lived, and ceased publication with Wallace's death, though it was periodically revived thereafter. It remains an important source due to its insights into independent practice. 'Seventy-Fifth Anniversary', p. 679.
[15] 'Ourselves', *IMR,* 1 January 1890, pp. 1-2 (p.1).

depiction of native and Anglo-Indian practitioners, and finally medical women. I will examine how race and gender intersected in the formation of professional identities.

The closing section of this chapter shifts its focus to popular fiction by medical writers, examining how the colonial practitioner was represented to the British reading public. I look at Henry Martineau Greenhow's 'Mutiny' novel *Brenda's Experiment* (1896) and Conan Doyle's short stories, 'The Adventure of the Speckled Band' (which first appeared in *Strand Magazine* in 1892 and later as part of *The Adventures of Sherlock Holmes*) and 'The Story of the Brown Hand' (published by *Strand Magazine* in May 1899). These stories variously portrayed the colonial medical man as a benevolent, ambivalent, or even villainous figure. While Conan Doyle's stories have received attention from postcolonial critics, *Brenda's Experiment* has been overlooked. I analyse how this fiction interacts with, and departs from, ideas about colonial practice disseminated in the medical press.

The primary texts for this chapter are drawn from the period between the 1860s and 1910s, but my attention is oriented towards the final decade of the century when the *Record* and the fiction identified above were published. In comparison to the broad historical scope of Chapters 1-3, my focus here is narrower, concentrating on professional identities elaborated after the consolidation of Crown rule. Ultimately, the chapter investigates how print culture shaped the aspirations and anxieties surrounding colonial medicine in India and considers how professional etiquette was (re)constructed in this context. I investigate the extent to which a homogenous professional identity was projected among those working within the Western medical tradition. This chapter examines how ideas about practice in British India were shaped in the medical and cultural imagination in both the colony and the metropole.

1. Official and independent practice

Britain's medical role in India was inaugurated and expanded by the Company and later the Crown. During the mid-eighteenth century, medical services – 'predominantly military in orientation' – were established in the key Presidencies, with responsibility for administering European hospitals.[16] The Indian Medical Service (IMS) provided attendance to the Indian Army and accepted both British and Indian recruits. Meanwhile the Army Medical Corps (AMC) catered for British troops and recruited only those of 'unmixed European blood'.[17] Historians suggest that the medical services in India were often seen as 'a last resort' due to their relatively low status,[18] though the IMS provided a reliable source of employment and offered 'more freedom of action' than the AMC.[19] The latter was typically regarded as less prestigious.[20] In the medical press, there was anxiety about the unpopularity of the medical services. In 1876, an editorial in the *Lancet* acknowledged that they were held in low esteem by the profession and sought to reassure readers that the IMS presented 'openings for enterprise' and 'opportunities for distinction'.[21] As identified in Chapter Three, journals could shape readers' career paths, influencing decisions about where and how to practise. Some medical men may have regarded colonial service as an opportunity to escape the perceived pressures of overcrowding among the British profession.

The IMS was increasingly involved in providing civilian medical services in civil stations, dispensaries, jails, and the police force. In 1912, IMS officials Major B.G. Seton

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[16] Harrison, *Public Health,* p. 7.
[17] 'Medical Administration in India', *BMJ,* 25 February 1882, pp. 275-6 (p. 276).
[18] Harrison, *Public Health,* p. 46.
[19] M. Anne Crowther and Marguerite W. Dupree, *Medical Lives in the Age of Surgical Revolution* (Cambridge: Cambridge University Press, 2007), p. 298.
[20] It was, however, reorganised into the Royal Army Medical Corps in 1898. W.F. Bynum, 'The Rise of Science in Medicine, 1857-1913', in *The Western Medical Tradition: 1800-2000,* eds. Bynum and others (Cambridge: Cambridge University Press, 2006), pp. 110- 240 (p. 232).
[21] 'Competitive Examination for the Public Services', *Lancet,* 8 April 1876, p. 544.

and Major J. Gould produced a handbook on *The Indian Medical Service.* Published in Calcutta, Simla, and London, it was aimed at officers who sought to understand better their conditions of service. The guide opened by affirming that the IMS was 'primarily a military service' before adding that, during peacetime, men were extensively employed in 'civil medical duties' as well.[22] The medical services largely privileged the needs of Europeans and the military,[23] though commentators were preoccupied by the low take-up of Western medicine among indigenous peoples, attributing it to their supposedly superstitious and backward natures. There was a general sense that the profession needed to overcome these obstacles to assert its legitimacy and authority. In addition to medical men in 'official' positions there was also a growing body of private practitioners – of British and Indian descent, and of mixed racial heritage – who attended both elite native and European patients.

It is worth considering how the medical profession in British India was conceived. Although medical registration was not introduced until 1912, practitioners fashioned the idea of a regular profession, comprising those qualified within Western medicine.[24] At the Indian Medical Association's first Annual General Meeting in 1895, Wallace (the Association's Secretary, as well as editor of the *Record*) suggested that it was intended for 'every section of our profession recognised as "qualified"'.[25] The reason for the delays in introducing medical registration was the complex landscape of medical pluralism and equivocation about the role of indigenous practices.[26] Systems such as *Ayurveda* and *Yunani* were often presented as the antithesis of Western medicine.[27] In an address to the

[22] B.G. Seton and J. Gould, *The Indian Medical Service* (London: W. Thacker, 1912), pp. 1-2.
[23] Pati and Harrison, p. 3.
[24] It was instituted first in Bengal before being extended to other Presidencies in 1914.
[25] 'The First Annual General Meeting of the Indian Medical Association', *IMR*, 16 January 1895, pp. 52-4 (p. 52).
[26] Pati and Harrison, p. 11.
[27] *Ayurveda*, thought to have originated in Buddhist monasteries in India, became absorbed into the Hindu tradition. *Yunani* was a Graeco-Arabic system of medicine, brought into India with Islam during the

1894 Congress, Ernest Hart, the *BMJ*'s long-running Editor, distinguished between these practices and '[r]ational medicine introduced and developed by the English'.[28] The former were widely represented as backward while Western medicine was lauded as scientific and modern. As Edward Said has posited, 'European culture gained in strength and identity by setting itself off against the Orient'.[29] Indigenous practices were used as a foil to buttress Western medicine's own self-image. However, there were growing fears about the popularity of *Ayurveda* and *Yunani*, and commentators were wary of causing offence. In the printed edition of Hart's address, a lengthy footnote recorded that he wished 'not [to] be understood as condemning Hindu medicine […] as mere barbarism and superstition' and conceded that European practitioners may 'have something to learn from Hindu medicine'.[30] As historians have shown, there was greater regard for local sensitivities after the 1857 Rebellion, with a shift towards 'accept[ing] India's "enduring" difference'.[31]

In the British cultural imagination, the practitioners of Western medicine – both official and unofficial – were often characterised as an extension of the national medical profession. For instance, in its coverage of the Congress, a *Lancet* editorial described the 'pioneers of sanitation in India' as 'remarkable examples of our national energy'. Yet it also conceived these practitioners as a separate group with a distinctive role to play. It noted that 'a congress of medical men whose life work has been largely done in the East should result in the dissemination of knowledge well-nigh invaluable [….] to their Western brethren'.[32] As Arnold contends, Western medicine in India was 'not simply an extension

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medieval period. Maneesha Lal, '"The Ignorance of Women is the House of Illness": Gender, Nationalism, and Health Reform in Colonial North India', in *Medicine and Colonial Identity*, pp. 14-40 (p. 14).

[28] Ernest Hart, *The Medical Profession in India: Its Profession and its Work* (Calcutta: Thacker and Spink, 1894), p. 5.

[29] Edward Said, *Orientalism* (London: Penguin, 2003), p. 3.

[30] Hart, p. 11.

[31] Samiksha Sehrawat, *Colonial Medical Care in North India: Gender, State, and Society, c. 1830-1920* (Delhi: Oxford University Press, 2013), p. xxxii.

[32] 'The Indian Medical Congress', *Lancet*, 19 January 1895, p. 162.

or transference of Western science to a colonial outpost' but 'a colonial science'.[33] Medical work in India was represented as an opportunity for practitioners to generate new knowledge and fashion new identities. These ideas counteracted more negative stereotypes about the low status of the medical services.

Throughout the period, British medical journals regularly covered practice in India. Both the *Lancet* and *BMJ* featured semi-regular columns on the subject.[34] These often focused on the medical services. Between March and September 1877, the *BMJ* printed a column entitled 'The Medical Profession in India: From Our Own Correspondent' which followed 'the experiences of a medical officer in India' as he accompanied British troops on their journey to Allahbad.[35] It is not clear whether this figure was real or fictitious; the column functioned less as a news report and rather as a descriptive piece of writing, often reminiscent of a travelogue. One week, the correspondent noted that '[e]verything is strange to a man visiting India for the first time', before adding that 'all the new sights and the clearly balmy atmosphere give a feeling of buoyancy to the spirits that is very enjoyable'.[36] India was not portrayed simply as a place of sickness and disease and the writer acknowledged improvements to sanitary arrangements and medical treatment.[37] The column's rhetoric both familiarised and defamiliarised India: it conveyed the vastness and richness of the place, while providing reassurance that the imperial regime was operating effectively.

The image of India as an unfamiliar space was also deployed in the colonial medical press. The *Gazette*'s opening issue in 1866 featured an article entitled

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[33] Arnold, *Colonizing the Body*, p. 9.
[34] During the 1880s the *Lancet* carried an occasional news column entitled 'India (From a Correspondent)', and between 1898 and 1934 it featured another called 'Notes from India'.
[35] 'The Medical Profession in India: From our own Correspondent', *BMJ*, 3 March 1877, pp. 278-9 (p. 278).
[36] 'The Medical Profession in India', *BMJ*, 9 June 1877, p. 729.
[37] 'The Medical Profession in India', *BMJ*, 15 September 1877, pp. 396-7.

'Professional Co-operation' which explored the challenges facing the young medical officer upon his arrival in India. It described how he 'may be sent at once to do battle with disease as it occurs among men whose constitutions, customs, diet, and prejudices are new and foreign to him'. Further, he must 'surmount these difficulties through the medium of a strange language'. Like the *BMJ* column, this article represented colonial medical service as a quest or adventure. Its depiction of the tropical space as hostile and its use of militaristic language ('battle') also anticipated the rhetoric of late Victorian imperial romance. The article suggested that the medical officer's difficult situation was compounded by his professional isolation, the fact he might be 'alone in a station far removed from the assistance, advice, and sympathy of other medical men'.[38] While the editorial did not explicitly propose the medical press as a means for developing professional networks, this may have occurred to its readers.

The figure in this article was implicitly an IMS or AMC officer who had been trained in England before coming out to India. The fact he was presented as a representative type – an 'everyman' – implies that the journal imagined a readership largely comprised of British men in official employment. The article also set out the *Gazette'*s commitment to promoting sympathy between medical men and to encouraging the exchange of clinical and sanitary information so that '[t]he *service we owe to Government and India* may thereby also be amplified and rendered more useful while, as a consequence, our influence in the country will be more readily acknowledged and respected' [emphases added].[39] While the *Gazette* did not explicitly identify itself as an IMS publication, it was regarded as 'official' in character. In 1874, the *BMJ* printed a

[38] 'Professional Co-operation', *IMG*, 1 January 1866, pp. 6-7 (p. 6).
[39] 'Professional Co-operation', p. 6.

positive review of the journal which remarked that its editors were IMS officials and that its contributors 'belong[ed] chiefly, although far from exclusively, to the Indian service'.[40]

When the *Record* launched nearly twenty-five years later in 1890 its opening address suggested there was a gap in the market for a new medical journal since, '[w]hether rightly or wrongly, [the *Gazette*] is viewed by the large and ever-increasing body of *independent physicians* as an officially subsidised organ, almost exclusively devoted to the *sectarian interests* of the *official classes*' [emphases added]. While crediting the *Gazette* as an 'able expositor of medical truths', the *Record* claimed that the 'conception of its official character' had played a role in 'hedging and handicapping its popular acceptance and its extended influence for the good of the profession and the public'.[41] Whereas the *Gazette* imagined itself augmenting the status of the IMS, Wallace suggested that its narrow focus had curtailed its impact. Significantly, the *Record* questioned the *Gazette*'s ability to represent the whole profession. From its inception, Wallace fashioned his journal as an alternative to the *Gazette*, aimed at 'independent' or 'private' practitioners, 'the general body of practising physicians'.[42] The suggestion that a group of practitioners had been underrepresented by the extant professional press resembles the marketing tactics of British journals such as the *Medical Circular* and *Midland Medical Miscellany*, which I discussed in Chapter Three. The journal's commitment to representing the rank-and-file also recalls the ideology underpinning the British Medical Association (BMA) and its periodical.

The journal's rhetoric also reflected the professional landscape of British India, however. Rather than turning on the structural opposition between the metropolis and the

[40] 'Review: The Indian Medical Gazette', *BMJ*, 20 June 1874, pp. 808-9 (p. 808).
[41] 'Ourselves', p. 1.
[42] 'Ourselves', p. 1.

provinces, or elite consultants and general practitioners, it distinguished between those in Government or Army employment and those who practised independently. Terms such as 'non-official' or 'independent' were commonly used in medical discourse in India. Harvey's address, cited at the beginning of this chapter, also referred to 'official' and 'non-official' practitioners. The distinction between these two groups does not neatly map onto the British context. It resembles the split between elite medical men with hospital appointments and the rank-and-file. Many IMS officials also supplemented their salaries with private work among wealthier Indians and Europeans.[43] However, IMS practice carried a distinct cultural and professional hegemony because it was part of the imperial apparatus. Wallace also referred to the 'local' profession to differentiate the Anglo-Indian medical community from those practitioners who came over from the metropole. The tensions between these two groups will be discussed in the following section.

Wallace called for greater recognition for independent practitioners. From 1892, he published *The Medical Register and Directory of the Indian Empire.* According to a review in the *Lancet,* this was 'intended to clear the way for systematic regulation of medical practice in India'. By providing a list of regular practitioners, it was a means of affording 'the scattered members of the profession in that empire […] definite knowledge of one another's existence'.[44] Wallace conceived print culture as a means of developing professional networks. He also agitated for the establishment of an Indian Medical Association (IMA) along similar lines to the BMA. In 1893, the *Record* featured a letter which urged its inception on the grounds that the journal was already 'the acknowledged mouth-piece of the local medical profession'.[45] It is unsurprising that Wallace printed a letter which flattered his journal's self-image and validated its claims to represent wider

[43] Bynum, 'The Rise of Science in Medicine', p. 232.
[44] 'Reviews and Notices of Books: Our Library Table', *Lancet,* 19 March 1892, p. 64.
[45]'Britannicus', 'Correspondence: The Indian Medical Association', *IMR*, 16 December 1893, p. 407.

professional interests. When the IMA was subsequently established in 1895, Wallace became its Secretary and the *Record* was framed as its official organ.

Commentators suggested that independent practice had been traditionally overlooked. At the IMA's first AGM, Wallace emphasised that 'there [was] heaps of room in India, without reference to the IMS', with myriad opportunities for 'lucrative practice'.[46] In 1912, a *BMJ* article remarked that 'there are numbers of clever, prosperous, and contented independent doctors, European and native, a few of whom are making incomes which will compare favourably with successful colleagues in Europe'.[47] It highlighted the role played by medical men of different racial identities, subsuming them within its collective identity of independent practice. The article conveyed a sense of optimism but also implied that only a minority of practitioners reached the status of their counterparts in Europe.

It was frequently alleged that the IMS's monopoly on civil appointments restricted opportunities for independent practitioners. The relationship between the IMS's military and civil arms was contested during the second half of the century. In 1882, an article in the *BMJ* called for 'a complete separation' of the two, while in 1896, the *Record* noted that although the Service was 'essentially a military establishment, it is in reality a quasi-civil one'.[48] Some commentators suggested that the IMS's civilian responsibilities could be transferred to independent practitioners, though others (including the *BMJ*) resisted such proposals.[49] In 1895, the *Record* featured a letter from B.B. Chatterjee, who complained that the IMS's reputation was so dominant that it was difficult for unofficial practitioners to persuade the public of their legitimacy. Chatterjee argued that the imperial

[46] 'The First Annual General Meeting', p. 53.
[47] 'Independent Medical Practice in India and the Indian Medical Service', *BMJ*, 24 February 1912, pp. 437-8 (p. 437).
[48] 'Indian Medical Service Reform', *IMR*, 16 June 1896, p. 422.
[49] 'Independent Medical Practice', pp. 437-8.

administration failed to recognise the role played by independent practitioners, refusing to accept their signatures on medical certificates, for example.[50] Although these men conceived themselves as part of the orthodox profession, the prominence of the IMS and the absence of registration meant that it was difficult for them to establish their medical authority and professional legitimacy among the public.

Wallace's *Record* was characterised by its campaigning zeal, which recalls the approach adopted by Thomas Wakley in the *Lancet.* Over time, Wallace's attacks on the *Gazette* became increasingly incendiary in tone and assumed political and commercial dimensions. In an 1893 article entitled 'A Bid for Popularity', Wallace claimed that the *Gazette* was in receipt of the 'misapplied support of a subsidising Government' and called for 'honest and manly competition' between the journals.[51] Between 1891 and 1899, the *Record* repeated these accusations sporadically. Wallace claimed that he had made enquiries to the Government and Provincial Government to determine the level of support the *Gazette* received, but that he was met with evasions and equivocations.[52] He presented his attempts to expose the *Gazette*'s Government subsidy as a professional and public duty. To some extent, the *Record*'s hostility towards the *Gazette* stemmed from anxiety about, and envy towards, the high status enjoyed by IMS practitioners compared to independent medical men. However, its concerns reveal wider fears about the position of the medical press in India.

In one article, Wallace suggested that the Government's 'unjust partiality' towards the *Gazette* manifested in 'crooked policies which tend to the perpetuation of monopolies that crush out every effort at honest, independent enterprise'. He implied that the

[50] B.B. Chatterjee, 'Correspondence: Government Ignores the Certificates of Private Practitioners', *IMR,* 1 May 1895, p. 350.
[51] 'A Bid for Popularity', *IMR,* 16 October 1893, p. 261.
[52] 'Government Support to Indian Medical Journals', *IMR,* 1 November 1893, pp. 284-7 (p. 287).

Government had once believed that state support was the only means of sustaining medical journalism in India. However, with numerous titles now 'competing in the field', Wallace suggested that, 'the time has come for the withdrawal of such paternal anxiety and wet-nursing'. He implied that the profession was being infantilised. He insisted that he was not asking for similar support for the *Record* since, through his own '*private* proprietary', he had 'placed within the reach of the local profession, a cheap and thoroughly approved fortnightly medical journal, serving all and more than the purposes of [the *Gazette*]'. Wallace championed a free market, suggesting that a progressive profession should be able to support its own active, independent, and commercially viable medical press. Wallace also accused the *Gazette* of vested interests, describing how its 'policy could not harmonise with any scheme that would place the local profession on a plane of equality with officialdom'.[53]

The relationship between medicine and the imperial administration was tacitly acknowledged or even explicitly celebrated in the British and colonial medical press. While fashioning itself as an organ for independent practitioners, the *Record* also praised the work of the IMS. It described how, historically, its officers 'paved the way for that successful political intercourse with the dominant rulers of the past'. The article claimed that 'India herself will never fail in her gratitude and praise for the blessings which have come to her from England through the direct agency of the officers of this grand old service'.[54] Wallace's journal drew on common imperialist ideologies. Similar rhetoric appeared in the *Lancet* in 1896, in an item entitled 'The Political Power and Uses of the Medical Services in India'. It claimed that 'the medical profession has been instrumental in rendering immense services to the State in India'. The article suggested that, while a

[53] 'Government Support', p. 284.
[54] 'The Indian Medical Service', *IMR*, 1 February 1890, pp. 11-12 (p. 12).

purely military invasion would have aroused 'enmity and opposition', the medical profession had 'gained the confidence and earned the gratitude of the people, and in that way advanced the policy of the Government of India and paved the road to peace and amity'.[55] These articles suggested that medicine had played a fundamental role in legitimising imperialism. They constructed indigenous peoples as grateful recipients of colonial medicine, though elsewhere the medical press complained of their recalcitrance, as I will demonstrate.

The medical press was not wholly enmeshed with the colonial administration, however. In 1874, the *BMJ* praised the *Gazette* for its 'tone of manly independence, combined with perfect courtesy' when it came to commenting on the Indian Government, with whom its views did not always correspond.[56] In 1871, for instance, the *Gazette* lamented that the Government had 'thrown cold water' on efforts to introduce vaccination and thereby 'advance the causes of science and humanity'.[57] Both the *Gazette* and *Record* participated in wider debates about the need for IMS reform. The latter expressed concern that the 'civil capacity and functions' would be 'underrated' in discussions. Although cautious about the *Gazette*'s fixation with rank, it 'cordially endorse[d]' its rival's hope that 'the interests of those who joined the service' would be 'as far as is consistent with the public good, respected'.[58] The journals did not wholly deviate in either their sentiments or interests. They were both aggrieved by certain aspects of the state-backed system, particularly practitioners' status and remuneration.

In their inaugural issues, both the *Gazette* and the *Record* deployed similar imperialist rhetoric to describe the functions of the medical press. The *Gazette*'s first

[55] 'The Political Power and Uses of the Medical Services in India,' *Lancet*, 17 October 1896, p. 1102.
[56] 'Review: The Indian Medical Gazette', p. 808.
[57] 'Vaccination in Bengal', *IMG*, 1 March 1871, pp. 54-5.
[58] 'The Indian Medical Service', pp. 11-12.

editorial characterised the journal's aim as 'the ennobling, by every possible means, of the Medical Profession in India' and announced its commitment to rendering 'good [to] suffering humanity'.[59] Almost thirty years later, the *Record* described how 'the cause of suffering humanity' would be 'bettered and ameliorated' by the medical press.[60] These references to 'suffering humanity' drew on common tropes, portraying the Indian population as backward and debased, in need of the enlightening and civilising influence of Western medicine. It is unsurprising that both journals participated in this entrenched narrative, which bestowed status on colonial practitioners.

As well as espousing similar rhetoric, the journals shared overlapping readerships, attracting subscriptions and contributions from both IMS officers and independent practitioners. Bound volumes of the *Gazette* and *Record* often open with a list of contributors, which includes their titles. From this, it is possible to deduce that the *Gazette* featured articles by a substantial body of IMS officials and men from the Subordinate Medical Service (SMS; a group I shall consider in the ensuing section), but that it also included clinical material from those without an official title. Similarly, the *Record*'s list of contributors comprised a range of practitioners, including those in the IMS, AMC, and SMS, as well as independent medical men. This suggests that, while *official* and *independent* practitioners were recognised as separate groups, their medical and professional interests often interweaved. They were united through their shared readership of these journals.

Both the *Gazette* and the *Record* suggested there was a need for greater collegiality in British India and framed themselves as helping to facilitate professional networks. As mentioned previously, the *Gazette*'s first issue included an article on 'Professional Co-

[59] [Editorial], *IMG*, 1 January 1866, p. 1.
[60] 'Ourselves', p. 2.

operation'. This discussed how to overcome the 'difficulties and discouragements to professional zeal and advancement' thought to characterise colonial medicine.[61] Meanwhile, the *Record* presented itself as a response to 'the pressing need for closer communion' among professional colleagues. It claimed that 'the cause of scientific medicine suffer[ed] in India by the absence of mutual cooperation'. The *Record* aimed to 'establish a feeling of brotherhood, such as has been never known to exist in India'. It urged the profession to follow the example of Britain, where '[a]n *esprit de corps* […] sends a throb of kindred sympathy for every member'.[62] In part, the motivation for establishing these journals seems to have been a desire to emulate or replicate qualities of the British medical profession, including its perceived collegiality and energy.

For the colonial medical press, ensuring high-quality clinical content was a particular concern. Anne Crowther and Marguerite Dupree suggest that, from the outset, the *Gazette* 'tried to prove that the IMS could contribute significantly to medical knowledge'.[63] The *BMJ*'s review of the journal adjudged it chiefly in terms of its clinical content. It reassured its readers that the *Gazette* would 'bear a favourable comparison with contemporary journals, not only in England, but in Europe'. While it was positive about the *Gazette,* it judged it with reference to the Western medical press, which it constructed as the paradigm. Noting that 'our brethren in the East work hard to keep themselves abreast of the progress of medical science in Europe', it added that 'the Indian medical service does not leave fallow the vast field of enquiry they are sent to cultivate'.[64] Its agricultural metaphor suggested that the profession was actively involved in the production

[61] 'Professional Co-operation', p. 6.
[62] 'Ourselves', pp. 1-2.
[63] Crowther and Dupree, p. 304.
[64] 'Review: The Indian Medical Gazette', pp. 808-9.

of medical knowledge. However, it also implied that the services were subordinate to a higher authority who determined the 'vast field of enquiry' they were to explore.

The Indian journals expressed anxiety about their ability to match the example set by their European counterparts. In 1897, the *Record* complained that '[e]very medical journal in India is weak and uninteresting in its clinical section'. It instructed its readers to 'record their work' in order to 'fulfil a most emphatic and necessary duty to members of their calling, and to the cause of suffering humanity'.[65] Elsewhere, the journal complained that practitioners were publishing medical and sanitary reports in the 'lay press', a symptom of 'official discourtesy' it deemed 'common experience in India'. It argued that '[t]he force of the professional example in the home-land ought to conduce to a better state of things in India'.[66] The *Record* instructed its readers to replicate the professional etiquette and industry of the metropole, suggesting this would elevate the position of the colonial profession. In doing so, it overlooked the fact that British journals were similarly anxious about medical reports appearing in the popular press, which they also conceptualised as an affront to medical ethics.[67]

In their inaugural issues, both the *Gazette* and the *Record* highlighted the patchy history of periodical publishing in India, the way in which previous titles had floundered in the market. There was considerable anxiety that a torpid or stagnant medical press was an indictment of the lack of professional zeal in British India. The *Record* represented the press as a remedy for this, commenting that 'when viewing the advancement of medical literature in other countries', it became apparent that India was particularly in need of 'the useful educating influence of medical journalism'.[68] Yet Wallace also perceived medical

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[65] 'Clinical Reports in India', *IMR*, 16 October 1897, p. 292.
[66] 'Medical Writers in India and the Daily Press', *IMR*, 26 July 1899, pp. 100-1.
[67] See, for example, 'Annotations: Medical Essays for Lay Readers', *Lancet,* 5 October 1878, p. 487. 'Medical Details in Lay Papers', *Lancet,* 28 November 1891, pp. 1231-2.
[68] 'Ourselves', pp. 1-2.

men's apathy as a major obstacle to the maintenance and augmentation of an active medical press. While both official and independent practitioners were sometimes accused of a lack of drive, this trait was more strongly associated with native practitioners.

2. Native and Anglo-Indian practitioners

Men of Indian descent were involved in the medical services from an early stage. The East India Company initially employed them as compounders, dressers, and apothecaries and from the 1760s they were organised into a Subordinate Medical Service (SMS) in each Presidency. Originally the SMS worked among military personnel but it also moved into civilian practice from the 1830s. From 1835, these men were trained exclusively in European medical science. Military and civil assistant surgeons and hospital assistants were expected to pursue a two-year course of instruction followed by an apprenticeship.[69] The medical press often valorised the way in which the Company and the Government had produced a class of natives educated in, and practising, Western medicine. In 1890, the *Record* remarked that, '[t]he turbulent, suspicious, caste-ridden Hindu or Mahommedan is now the able and willing colleague […] of the western surgeon whose predecessors taught him the science and art of western medicine'.[70] This image of the unruly native civilised by Western science is striking for its unabashed imperialist rhetoric, particularly given that men of Indian descent were likely to have encountered the article.

The implied reader of the journals was typically British or, in the case of the *Record*, Anglo-Indian (as I will demonstrate shortly). This is evident in the *Gazette*'s article 'Professional Co-operation', which described the young medical man arriving from Britain to encounter *foreign* and *strange* surroundings. However, both journals also

[69] Harrison, *Public Health*, pp. 6-8.
[70] 'The Indian Medical Service', pp. 11-12.

imagined, and even actively encouraged, a mixed readership. In 1876, the *Gazette* published a lengthy leading article which reflected on its first decade of existence. It claimed that one of its original intentions was to cement 'a bond of union by means of which medical men working in India of *whatever service or creed or race*, in whatever place or capacity employed, should be brought together for mutual edification and improvement' [emphases added].[71] Significantly, this wording implied that both British and native readers would be enriched in tandem and united through their shared readership of the journal.

The *Record*'s opening issue contained a direct 'appeal' to 'European and native brethren alike' for 'co-operation and support'.[72] The journal established different subscription rates to ensure its accessibility for those in the SMS. Its second issue announced a standard annual subscription fee of 12 rupees and a six-rupee fee for medical missionaries, assistant surgeons, and army apothecaries. In 1895, the fee for army medical officers, civil and non-official surgeons and physicians was 18 rupees, medical missionaries and assistant surgeons (both civil and military) paid half this price, and hospital assistants just six rupees.[73] Nevertheless, it seems that the *Record* struggled to induce the SMS to subscribe. In 1900, in an editorial celebrating its tenth anniversary, the journal warned that its current subscription list could not cover the cost of publication. It highlighted the number of Military Assistant Surgeons falling off the list and accused these practitioners of distributing the journal among themselves. The *Record* suggested that this was neither 'fair' nor 'patriotic', and it appealed to readers who had been 'remiss in their duty' to turn over 'a new leaf'. While promoting co-operation, the journal suggested that

[71] '1875', *IMG*, 1 January 1876, pp. 12-23 (p. 19).
[72] 'Ourselves', p. 2.
[73] 'Business Notices', *IMR*, 1 January 1895, p. li.

readers had an individual 'duty' to take a paid subscription to support the journal.[74] This strategy exploited native readers' anxieties, suggesting they had erred in their patriotic duty and neglected professional etiquette.

Both the *Gazette* and *Record* claimed to represent native practitioners working within colonial medicine. Arguably, they sought to attract these readers to inculcate Western medical knowledge and values. In 1866, the *Gazette* published an article entitled 'Professional Etiquette Disregarded in India'. It opened by endorsing a petition presented by the Sub-Assistant Surgeons of Bengal to the Lieutenant Governor, which outlined 'grievances' and asked for 'redress'. It commended the petition as 'well written, temperate and explicit' and branded it a 'reasonable and just complaint'. However, while supporting the surgeons' campaign, the article also emphasised the importance of compliance. It urged native practitioners (in both official and private practice) to reassess their conduct to ensure 'due observance of those ethical rules which stringently regulate all professional intercourse and practice'. The article expressed concern about native men who practised medicine 'as though it were the meanest of trades', chiefly by poaching one another's patients. While insisting that '[t]he Science of Medicine is as […] skilfully practised here as in Europe', the article concluded by remonstrating with native medical men, insisting that they must be 'prepared to adopt with the theories of European Medicine the practice of European ethics'.[75] The article suggested that the lack of status accorded to the men was partly a problem of their own making and claimed that adherence to Western medical ethics would improve their position. In constructing the European profession as a moral exemplar, it elided the fact that infringements of medical etiquette on home soil were perennially discussed in the British medical press as well.

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[74] 'Comments and News: The "Indian Medical Record" is Ten Years Old', *IMR*, 3 January 1900, p. 18.
[75] 'Professional Etiquette Disregarded in India', *IMG*, 1 March 1866, pp. 68-9.

Elsewhere, journals demonstrated greater appreciation of racial and cultural difference. In an 1871 article entitled 'Our Sub-Assistant Surgeons', the *Gazette* suggested that the Government needed to provide incentives to retain its educated native workforce. It was concerned that the Indian medical man's progress has been stymied by Western prejudice, remarking that it would be 'weary waiting for him' to be relieved of his 'present disabilities for advancement' if one delayed until 'nature changes the native's skin'. In a reflective aside, the article commented that '[w]e should do well to remember how little knowledge we have of the circumstances surrounding a native which mould and influence his character', adding that his habits may seem 'strange' for 'no other reason than that they differ from our own'.[76] While acknowledging that ideas of 'strangeness' may be socially constructed, the article retreated to familiar tropes of Indians as unknowable or impenetrable. It conceptualised native medical men as playing an important role as intermediaries. It claimed that 'sanitary science' would only have 'practical effect on the natives of India' through 'the endeavours of educated native medical men'. The article claimed that British practitioners were brought over at an 'enormous expense' and yet might be unable to 'grasp[…] this subject with reference to the natives'. The writer imagined a barrier between Eastern and British attitudes towards sanitation which only a native trained in Western medicine could overcome.[77] The journals oscillated between celebrating the contributions of native medical men and endorsing British values as the gateway to status and prestige.

Indian practitioners' voices also featured in the medical press. From the journals' lists of contributors, it is possible to conclude that native medical men played an active role in supplying clinical material. Reflecting on its first decade of publication, the *Gazette*

[76] 'Our Sub-Assistant Surgeons', *IMG,* 1 April 1871, pp. 75-6.
[77] 'Our Sub-Assistant Surgeons', p. 76.

remarked that it received contributions from native practitioners – working as Assistant Surgeons, Apothecaries, Hospitals Assistants, and private doctors – with 'pleasure'. It designated their communications evidence of 'laudable ambition', expressing its hope that printing such material would dispel prejudices that these men were 'incapable of original research' or that, once qualified for remunerative practice, they were content with a 'life of stagnation and inertness'.[78]A lack of industry was one of the chief allegations made against native medical men.

The *Gazette* positioned itself as the champion and supporter of these practitioners, while adopting a paternalistic approach. It commended itself on 'develop[ing] the literary industry' of these practitioners and suggested that their contributions were 'evidence' of 'the soundness of the education which they receive'. This reduced native medical men to passive recipients of the enlightening influence of the journal and Western medicine more generally. Although the *Gazette* welcomed the way in which it could help to challenge negative stereotypes, it also issued an 'appeal' to its 'native brethren in the profession', urging them to 'quicken their will and effort' so that they could 'entirely obliterate the stain' against their name.[79] The word 'stain' is remarkably loaded, carrying connotations of immorality. Here, the journal reconceived native practitioners as agents, suggesting they were responsible for reshaping their own professional identities.

Articles which called for native practitioners to reform their manners and improve their image were chiefly aimed at those in low-status SMS positions or in independent practice. Other men of Indian descent pursued more lucrative opportunities. Those able to travel to London could undertake the competitive examinations for IMS entrance (which were introduced in 1855) and thus try for the 'superior' medical service. In 1905 only 5 per

[78] '1875', p. 20.
[79] '1875', p. 20.

cent of the IMS were of Indian origin, though the proportion grew in the early twentieth century under the Government's policy of 'Indianisation'.[80] Some native men also developed more prestigious private practices. The transactions of medical societies – reproduced at length in the medical journals – demonstrate that elite Indian doctors enjoyed a prolific role in professional life. The *Gazette* printed discussions among the Calcutta Medical Society, which had been established by McLeod, while the *Record* included the proceedings of the IMA. The interrelationship between periodicals and medical societies seems particularly pronounced in British India. Both organisations included men of Indian descent among their ranks and the IMA was presided over by Dr Lal Madhub Mukerji. He was a Fellow of Calcutta University and the President and Teacher of Ophthalmology at its Medical School. The prominence of these men's voices in the proceedings is significant when one considers how the experiences of Indian practitioners were usually mediated and controlled by the colonial medical press. Elite practitioners – who qualified with Westernised medical degrees or were members of the superior medical service – were more easily accommodated into the broader professional identity projected by the journals.

The medical press was an important platform for advocating reforms that would improve the opportunities available for rank-and-file native medical men as well. Both the civil and military arms of the IMS were perceived to be understaffed, a situation which had become particularly apparent during the famine and bubonic plague outbreaks of the mid-1890s. In 1901, the *Record* printed an editorial which suggested that 'in no branch of the public service in India' – for which 'long and laborious study and practical training' were required – were 'the children of the soil […] worse treated than in the medical'. It alleged that the IMS failed to attract the best practitioners from the metropole and that it contained

[80] Harrison, *Public Health*, pp. 31-2.

'a good proportion of men who are distinctly below the average'. While these accusations corresponded with Wallace's critique of official practice, the article also suggested that – in some large towns – European civilians summoned the Indian Assistant Surgeon 'in preference' to the IMS or RAMC man who was officially in charge of the station or district. The article reversed conventional professional hierarchies, by highlighting the utility of Indian medical men in subordinate positions over their British counterparts in the 'superior' service. It suggested opening up Civil Surgeoncy appointments, which had hitherto accepted only a limited number of native men.[81] The class of Assistant Surgeons was conceived as under-appreciated and overlooked by the IMS.

A vocal critic of the IMS's organisation was Sarat K. Mullick, whose views appeared in both the British and Indian medical press. Educated in Calcutta and Edinburgh and with a practice in London, Mullick was part of a cosmopolitan Indian elite. Nevertheless, he agitated for native practitioners with fewer opportunities. In one letter (printed in the *Lancet* and the *Record*) he suggested that the Government did 'their best to exclude' native men by holding IMS examinations exclusively in London. He described how those Indians who did travel to the metropole 'risk the perils of the deep, leave their hearth and home, and everything that is near and dear to them, to spend a number of years in an inhospitable climate'.[82] Mullick shrewdly reversed the trope of British men leaving their domestic comforts to work in a hostile tropical environment to highlight the considerable barriers to IMS entry facing Indian men.

The examinations were also seen to exclude Anglo-Indian and Eurasian men. These terms were sometimes used in overlapping ways, but 'Anglo-Indian' typically

[81] 'Comments and News: Indians and the IMS', *IMR,* 12 June 1901, pp. 638-9.
[82] Sarat K. Mullick, 'Correspondence: The Indian Medical Profession', *Lancet,* 13 April 1901, pp. 1105-6 (p. 1106).

denoted people of British descent born and raised in India or British expatriates who had lived and worked in India for a sustained period, while 'Eurasian' referred to those of mixed racial heritage. In 1900, the *Record* featured an article entitled 'The Anglo-Indian Problem', in which Wallace indicted the inaccessibility of the higher rungs of the medical profession and the Civil Service as 'the progeny of official prejudice'. He suggested that Anglo-Indian and Eurasian men were disadvantaged since many were unable to travel to qualify for the IMS. He called for service examinations to be held in India as well as London. He agitated for reform on the grounds of fair play, arguing that the Anglo-Indian had been 'exclude[d] from rising to a sphere which, by every sense of right and justice, by due regard to ability and merit, he is legitimately and morally entitled to rise'.[83] The journal demonstrated its characteristic campaigning zeal, attacking policies which maintained a dichotomy between those in official and unofficial practice. Many of its readers might have been private practitioners not necessarily through choice but because of the barriers to IMS entry.

The *Record*'s article was framed as a riposte to statements made by Charles W. McMinn – a senior Indian Civil Service official, latterly Commissioner of Patna – in *The Englishman* (a daily paper in Calcutta). McMinn had criticised the conduct of Anglo-Indian and Eurasian men, alleging that 'the Indian-born boy will not work'. He also claimed that the expatriate community had to 'go home' for decent medical services. In response, Wallace accused McMinn of 'wantonly ridiculing and condemning a race about whom he knows little or nothing, and for whom he cares less'. The *Record* refashioned the image of Anglo-Indian and Eurasian men, insisting that 'the administrative machinery' of

[83] James R. Wallace, 'Correspondence: The Anglo-Indian Problem', *IMR*, 13 June 1900, pp. 585-6 (p. 585).

the Indian Government depended upon 'the descendants of Britishers and Europeans' and that poverty among this class was chiefly due to 'want of work' rather than idleness.[84]

Calls for IMS reform were met with considerable opposition. When Mullick put forward a resolution on the subject to the BMA, Surgeon-General Harvey (at this point Director-General of the IMS) published a formal rejoinder in the *BMJ*. He argued that:

> The statement that Indians are practically disqualified […] is disproved by the fact that there are some forty-six natives at present in the Service, to say nothing of a considerable number of Eurasians who are also in a sense natives of India.

While Wallace conceptualised Anglo-Indians as a separate 'race', Harvey collapsed the distinction between Indians and Eurasians, suggesting that the latter were 'in a sense natives'. This illustrates how professional identities were filtered through, and interacted with, complex ideas about racial and ethnic identities. Harvey further maintained that, while the IMS was 'open to all natives who choose to compete' it 'would be most undesirable to open it to men who have never left India, and are *ignorant of Western manners and modes of thought'*.[85] He suggested that the medical service was shaped by Western values and implied that admitting men who had not visited Britain might jeopardise its gentlemanly status.

In the journals, ideas of enduring racial difference were pervasive. While the *Record* repeatedly defended the contributions of native medical men, it questioned the extent of their participation. In 1896, the journal featured an article entitled 'European Interests in the Medical Reform Question in India', which argued that European patients must have access to European medical attendance. It described how British troops had long been 'officered and doctored entirely by men of their own race' for 'socio-political reasons' and suggested non-military personnel should be entitled to similar treatment:

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[84] Wallace, 'Correspondence', p. 585.
[85] Harvey, 'The Indian Medical Service', *BMJ,* 14 September 1901, pp. 720-2 (p. 721).

'European officials naturally expect medical attendance from members of their own race'. This preference was represented as natural, given that 'indigenous races are honey-combed with every conceivable form of caste and race prejudice'. It suggested that the native practitioner's professionalism was stymied by his ethnic and racial background and that this rendered his attendance upon European patients impracticable and undesirable. While characterising the medical profession in India as 'cosmopolitan', the article maintained that there was nevertheless 'a distinction of interests that are called into existence by racial peculiarities'.[86]

Colonial journals presented themselves as instruments through which native practitioners could receive and disseminate ideas but closely controlled their professional identity. On one hand, the journals stripped away prejudices about native medical men and tried to further their interests, sharing their clinical contributions and advocating for them to have more opportunities. Yet the journals simultaneously reinforced stereotypes about these practitioners, tacitly calling into question their industriousness and the extent to which their racial prejudices might influence their professional responsibilities. Although the native medical man's professional identity was refashioned – particularly towards the century's close – he was represented in terms of his alterity and primarily judged by his ability to observe and emulate Western values. The problem faced by the medical press was how to advance native practitioners (which many agreed was economically and culturally necessary) while maintaining the importance of the British medical man. In the 1890s there were some concerns that Indian practitioners were being prioritised over their European counterparts. In 1893, a piece in the *Record* referred to 'the breathless craze that now exists for doing everything for natives'. It cited anecdotal evidence that a native

[86] 'European Interests in the Medical Reform Question in India', *IMR*, 16 January 1896, pp. 44-5.

female medical student's needs may have been privileged over those of a European woman.[87] The next section considers how gender and racial identities intersected in the representation of medical women and their patients.

3. Medical women in India

The medical-woman movement in Europe and the United States – discussed in the previous chapter – paved the way for female practitioners in India. The first woman missionary doctor, an American named Clara Swain, arrived in 1869, and was followed by medical women from Britain.[88] Developments also gathered pace within India. In 1875, the Madras Medical College admitted Mary Scharlieb, a British woman who had come out to India with her husband. She was soon joined by three Anglo-Indian women. In 1883, a male Parsi philanthropist (Pestonji Cama) founded a hospital for women and children in Bombay which employed British physician Edith Pechey as medical superintendent. The first Indian woman to take a medical degree was Anandibai Joshi. She studied in America, graduating from the Women's Medical College in Pennsylvania in 1886.[89]

What began as a series of ad hoc developments was effectively absorbed into the imperial apparatus. In 1882, Frances Hoggan – a British-based female doctor – produced an article calling for a publicly funded women's medical service to help the 'suffering subjects' of India.[90] It was published across different platforms, appearing in the British liberal monthly the *Contemporary Review* in August; in *The Indian Magazine* (the periodical of Britain's National Indian Association) in October;[91] and then as a standalone

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[87] 'Female Medical Practitioners Under the Dufferin Fund', *IMR*, 16 August 1893, p. 116.
[88] Margaret I. Balfour and Ruth Young, *The Work of Medical Women in India* (London: Oxford University Press, 1929), pp. 15-16.
[89] Balfour and Young, pp. 25-6, 23.
[90] Frances Hoggan, *Medical Women for India* (Bristol: J.W. Arrowsmith, 1882), p. 1.
[91] Open University, 'National Indian Association', *Making Britain: Discover How South Asians Shaped the Nation, 1870-1950* <http://www.open.ac.uk/researchprojects/makingbritain/content/national-indian-association> [accessed 4 January 2015].

pamphlet issued by J.W. Arrowsmith. Hoggan's proposal was echoed by Scharlieb and missionary Elizabeth Bielby (who later trained as a doctor) during interviews with Queen Victoria. Following their intercession, Victoria instructed Lady Dufferin (the wife of the viceroy of India) to inaugurate a scheme for medical women.

The National Association for Supplying Female Medical Aid to the Women of India (or the Dufferin Fund, as it was more commonly known) was nominally established in 1885. In contrast to Hoggan's original proposal, it was a private enterprise funded by subscriptions. It supported European women doctors who wished to work in India and provided scholarships to train Indian women in Western medicine. By 1888, it employed eleven women, six of whom were residents of India.[92] The Fund's primary function was to provide medical care to native women who observed *purdah* (the practice of veiling or being physically segregated from men) or *zenana* (the space in a household where women lived separate from men). These customs were variously practised by both Hindus and Muslims, though often observed more closely by high-caste or wealthy women, since those who worked found it difficult to avoid the public sphere.[93] *Purdah* and *zenana* were seen as having curtailed the reach of Western medicine by barring native women from receiving male medical attendance. The Dufferin Fund sought to address this through a network of single-sex hospitals and dispensaries. These were regarded as mechanisms for 'lifting [native women] out of their confined seclusion', which was routinely associated with ill-health and disease.[94] After the inception of the Dufferin Fund, ideas about *zenana* medical care gained traction in the metropole. In 1891 the *Westminster Review* asserted that '[n]o man, especially a European can, with propriety, see a native lady, even to

[92] Balfour and Young, p. 37.
[93] Sehrawat, p. xxxv.
[94] Narin Hassan, *Diagnosing Empire: Women, Medical Knowledge and Colonial Mobility* (Farnham: Ashgate, 2011), p. 78, 67.

prescribe for her in sickness'.[95] However, as examined in the previous chapter, such claims were disputed by prominent commentators on colonial medicine, such as Sir Joseph Fayrer.

As in Britain, resistance to the medical-woman movement in India was most prevalent at its outset. One of the most scathing critiques in the professional press was an editorial in the *Gazette.* 'Women Doctors for India' (1882) claimed that arguments put forward by supporters were 'one-sided and strained'. The article suggested that these advocates had 'taken for granted' that middle- and upper-class native women were reluctant to call in medical men. While conceding that there might be a 'great deal of physical suffering in zenanas', the article also maintained that 'the picture of excessive obstetric and uterine suffering has been overdrawn'. It drew on stereotypes about the constitution of indigenous peoples, portraying Indian women as stronger and sturdier than their British counterparts. It cited as evidence the apparently 'notorious' fact that 'native women, high and low, get over their confinements more speedily and with less suffering'. However, when the article confronted the idea of women practising as doctors, it queried whether 'native ladies, as society is now constituted' had 'sufficient physical and moral stamina for the position'.[96] Paradoxically, it conceptualised native women as robust enough to recover swiftly from childbirth but insufficiently strong to undertake medical work. Competing representations of native women's physiology were widespread in medical and popular discourse.[97] The *Gazette* article also questioned whether even native medical women would be admitted to the *zenanas*, reinforcing the notion that these were impenetrable spaces.

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[95] C.N. Barham, 'Child Marriage in India', *Westminster Review*, 135 (January 1891), 113-23 (pp. 122-3).
[96] 'Women Doctors for India', *IMG*, 1 July 1882, pp. 184-5 (p. 184).
[97] This is particularly striking in debates about child marriage and the age of consent. See, for example, 'Child-Wives', *IMG*, September 1890, pp. 272-3 (p. 272).

The arguments put forward in this article often accord or overlap with those made by medical women's detractors in Britain. There are similar doubts about whether women are suited (either physically or morally) to work as physicians or surgeons, and comparable suggestions that the nursing profession (augmented or in its current form) would be a more appropriate vocation.[98] Commentators often undermined the medical-woman movement's fundamental claim that female patients would *prefer* female medical attendance. A major distinction is that – in the Indian context – debates about the appetite for women doctors intersected with anxieties about the barrier posed by the *zenana* and concerns about insufficient demand for Western medicine more generally.

Responding to Hoggan's claims that existing hospitals and dispensaries were under-used by female patients, the article suggested that 'our system of medicine has as yet become by no means universal among or universally sought by, natives of India'. It argued that, 'in religious and social matters, so in medical, women are more conservative and timid than men', and were thus unlikely to accept female medical attendance. The editorial criticised the medical-woman movement for making assumptions about the preferences of native women, but substituted its own. Across the medical press, male commentators assumed the authority to speak for female patients.[99] The article suggested that, even where medical women had found demand for their services, this had not proven remunerative, since the patients had been unwilling (or unable) to pay. The *Gazette* conceded that, while it 'seems pretty certain' that medical women would find 'abundant practice among women and children of the lower order', it had not been 'proved' that demand existed among the middle- and upper-classes.[100] The question of which *type* of

[98] 'Women Doctors for India', p. 185.
[99] Patient voices are relatively absent across the medical press but this is especially problematic in the colonial context given the erasure of native women's experiences from history. Spivak, p. 102.
[100] 'Women Doctors for India', pp. 184-5.

native women would use female practitioners remained contentious at the century's end, as I will examine. Effectively, the *Gazette* suggested that demand among poor women did not render medical women either necessary or desirable. These ideas were enmeshed in wider prejudices about the lower classes of India and reflected concerns that medical care should be largely self-supporting.[101]

The *Gazette* was not alone in its opposition to the medical-woman movement in India. In 1884, it reported that female medical students at the Grant Medical College in Bombay had faced verbal and even physical assaults from their male counterparts. The incident recalled prejudice faced by medical women in Edinburgh, particularly the infamous Surgeons' Hall Riot (1870). The *Gazette* reprinted an excerpt from the *Englishman* (a Calcutta-based periodical), which discussed how objections to women's medical education (particularly the prospect of mixed classes) led to the seven female students (four Parsees and three Europeans) being 'hissed in public by the male students' and even 'pelted with small stones'. In response to this episode, the *Gazette* overcame its earlier objections and instead invoked the idea of fair play so common in British coverage of the medical-woman movement. 'Whatever opinions medical students hold on the subject of female medical education', it concluded, 'they ought […] to behave themselves like gentlemen'.[102] The article implied that the male students' conduct brought the profession into disrepute.

Given the level of scrutiny faced by early medical women, some commentators suggested (as in Britain) that they needed to police their own conduct. In 1886, Lady Dufferin addressed a cohort of female students (both British and Indian) at the Madras Medical College. Commending them on their choice of an 'honourable and useful career',

[101] Sehrawat, p. xxxviii.
[102] 'Current Medical Topics', *IMG*, February 1884, pp. 53-4 (p. 54).

she nevertheless warned them about the 'peculiar temptations' they faced, presumably a coded reference to the prospect of their encountering young men in professional life. She advised them that 'good conduct and a spotless reputation [were] the first and most necessary qualifications you can possess'. The *Gazette* printed Lady Dufferin's guidance at length, praising its 'high moral tone' and 'large-hearted sympathy', and 'recommend[ing] its ethics to those outside the college'.[103] While it is unclear whether this was directed at female readers or medical men as well, Lady Dufferin's emphasis on exemplary conduct and reputation reflected wider preoccupations with medico-morality and etiquette among the colonial (and, indeed, British) profession.

Despite early caution and criticism, the Dufferin Fund came to command considerable respect. Chapter Four discussed how the British medical press gradually acknowledged the merits of the scheme, and this spirit of optimism was shared (and even surpassed) by the Calcutta-based journals. In 1886, the *Gazette* carried two reports, which appeared within several pages of one another, on the achievements of the early pioneers. One item described the destinations of women graduates from the Madras Medical College, noting they had been 'very successful' and were 'drawing fair incomes'. It concluded that, 'as the demand for lady doctors is sure to increase, a promising career is opening up to many young women in this country'.[104] A second article detailed developments in the medical-woman movement across India. It described how Mrs Van Ingen's work at the Countess of Dufferin's Dispensary for Women in Calcutta had 'gained the confidence of the public', with patients 'sure that they will receive careful attention without any risk of their privacy being invaded by men'. Meanwhile, in the Princely State of Ulwar, Miss Smith had 'won the confidence of the Maharajah and her people'. 'The

[103] 'Lady Dufferin's Scheme at Madras', *IMG*, July 1886, pp. 212-3.
[104] 'Current Medical Topics: Female Medical Students in Madras', *IMG,* August 1886, p. 246.

success of this movement is already ensured', the article declared, 'if eagerness to claim the benefits to be derived therefrom can be taken as a criterion'.[105] In these two articles, the *Gazette* spoke of the movement with considerable zeal and marshalled convincing evidence as to its achievements. The indices for success were the medical women's material prospects, their appeal to native female patients, and the regard in which they were held by the Indian elite. The *Gazette*'s earlier fears about the lack of appetite for female attendance had disappeared and it was confident of rising demand. Once again, however, it was the voice of the male colonisers that determined the scheme's popularity with native women.

From the mid-1880s through to the century's close, the journals featured regular updates on the medical-woman movement, tracking developments in female medical education and clinical activity at women's hospitals and dispensaries. The coverage appeared intended both to satisfy curiosity about medical women and promote confidence in their work. These pieces usually either implicitly or explicitly endorsed the movement, assuring readers that the women were working diligently, following a noble vocation, and that patients were profiting by their intervention. Unlike their male counterparts, they were not usually characterised as apathetic. They were also typically discussed in tandem, whether they worked in the Dufferin Fund or as missionaries; the distinctions between official and unofficial practice did not appear to translate to this context. Further, preoccupation with racial difference tended to surround their patient communities rather than the medical women themselves, as I will show.

Medical women were portrayed as well-respected and even aspirational figures. The *Record* carried a regular feature entitled 'Our Picture Gallery', which offered full-page

[105] 'Countess of Dufferin's Fund', *IMG,* August 1886, p. 248.

illustrated profiles of notable personalities in the profession. In May 1895, the column granted considerable visibility to an Anglo-Indian woman by sharing a biographical sketch of Florence Dissent, who was born in Calcutta and had been educated in London, Edinburgh, and Brussels. The article recorded her personal and professional achievements and used her as an example of the opportunities available to women. 'The zenanas will remain closed to men physicians for another century', it asserted, noting that 'all this while women physicians have to themselves an unexplored field of service that is unsurpassed in its possibilities for doing good'.[106] The writer mobilised familiar ideas of imperial duty and adventure, representing the *zenana* as unchartered terrain which offered unique opportunities for medical women.

One of the major reasons that the colonial medical-woman movement was accorded such respect was that the work it performed was widely perceived as necessary and benevolent. In 1890, the *Record* reprinted an item – originally from the *Lancet* – about female medical missionary work. It applauded efforts to 'alleviate the bodily sufferings of the helpless native women of India, who are not allowed to be attended by men'. In archetypal fashion, the Western female was depicted in the role of saviour, with the native woman cast as victim. The piece also imagined medical missionary women as having a wider impact, describing how 'the old barriers of prejudice, religion, and caste' were 'gradually broken down before [their] steady, persistent, and devoted work'.[107] Medical women were simultaneously conceived as a response to the exigencies of caste prejudice and a means of dispelling these beliefs. In 1899, the *Record* published an article on the Dufferin Fund which emphasised that its work was of 'great importance to the advance of medical science in India'. It was envisaged as 'the means of spreading the light and

[106] 'Our Picture Gallery: Miss Florence Dissent', *IMR*, 1 May 1895, p. 334.
[107] 'Medical Extracts: Zenana Medical Work in India', *IMR*, 1 March 1890, p. 37.

civilisation of the West into the darkest and most remote corners of the land'.[108] In articles such as these, medical women were imagined not only providing relief to individual patients but as playing a wider role in reforming indigenous communities. They were subsumed into a broader professional identity which was predicated on imperialist ideas about medicine's civilising role.

Women actively participated in colonial medical networks through their engagement with the professional press. In its plea for clinical content in 1897, the *Record* announced that it was 'prepared to receive a report from every man or woman who cares to write one', implying women were already on its subscription list.[109] Both journals featured clinical communications from medical women; their case notes appeared next to those of their male counterparts and they were credited alongside men in the list of contributors.[110] Outside of the medical press, some became prominent commentators on medical and social issues; Edith Pechey and Dr Rukhmabai, a high-caste Hindu woman who graduated from the London School of Medicine for Women and later worked as Medical Officer of Surat, voiced concerted criticism about child-marriage and the *purdah* system.[111] In the pages of the medical press, however, coverage of the medical-woman movement was largely contained by, and mediated through, a male editorial voice. A possible exception is a piece of correspondence which appeared in the *Record* in 1901. Signed only by 'Reporter', its intimate knowledge of the Dufferin scheme implies that the writer may have worked within it. The letter complained about the low salaries granted to medical women and insisted that the Dufferin Fund should be reorganised along the lines of the IMS in order to

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[108] 'The Viceroy and the Dufferin Fund', *IMR,* 15 March 1899, pp. 335-6 (p. 336).
[109] 'Clinical Reports in India', p. 292.
[110] Florence Dissent, 'Mirror of Medicine: Two Cases of Large Uterine Polypus', *IMG,* December 1891, p. 334. Miss K Bonnar, 'A Mirror of Practice: Ovarian Tumour in a Girl Thirteen Years Old', *IMR,* 30 January 1901, pp. 110-1.
[111] Kumari Jayawardena, *The White Woman's Other Burden: Western Women and South Asia During British Rule* (London: Routledge, 1995), p. 87.

boost its reputation and attract 'good, experienced, and capable women'.[112] The correspondent expressed concern that the relatively low status accorded to the women's work meant that the Fund failed to attract the best candidates. As I have shown, however, there were parallel fears about IMS recruitment.

The medical press' growing recognition of, and respect towards, the medical-woman movement did not preclude serious engagement with some of its limitations and failures. At the *fin de siècle*, with the movement's perceived benefits cemented by the medical press, there was increasing debate about how to augment its influence.[113] There were calls to establish country dispensaries and cottage hospitals to reach patients in the *mofussil*, those regions outside the three Presidency capitals.[114] These proposals recalled debates about rural healthcare in Britain (as discussed in Chapter Three). There were periodic and contradictory fears that the movement was either not attracting poor,[115] or middle- and upper-class patients. In 1893, the *Record* discussed the Calcutta Zenana Hospital's 'unpopularity' among higher-class *purdah*-women. The Hospital Secretary suggested that it 'would stand a better chance of attracting' these patients 'if a Brahmin lady doctor were appointed on the staff'. The *Record* refuted this idea, commenting incredulously that 'surely Brahmin ladies don't object to being attended to by one of their own sex, no matter what her color [sic] or creed!'.[116] While the *Record* considered it a fundamental right for European patients to have access to European doctors, it ridiculed the idea that native Brahmin women might prefer to receive medical attendance from their own caste. Although the Dufferin Fund was ostensibly conceived in response to

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[112] 'Reporter', 'Correspondence: Dufferin Victoria Hospital for Indian Women', *IMR*, 19 June 1901, p. 673.
[113] These concerns eventually led to the movement's expansion and reorganisation. In 1914 a Women's Medical Service was established under the auspices of the Dufferin Fund, with improved conditions of service. Balfour and Young, pp. 51-2.
[114] 'The Viceroy and the Dufferin Fund', p. 336.
[115] 'Female Medical Aid for Women', *IMR*, 1 April 1893, p. 226.
[116] 'Unpopularity of the Calcutta Zenana Hospital', *IMR*, 1 September 1893, p. 158.

indigenous beliefs, medical commentators were not necessarily interested in grappling with the intricacies of patient preference.

In an article entitled 'The Dufferin Hospital for Indian Women in Calcutta, How to Reach the Purda Woman' (1901), the *Record* purported to engage with the issue of patient choice. It called into question some of the principles behind the Dufferin system. It claimed that experience had shown that *purdah*-women were resistant to hospitals and dispensaries because they did not wish to leave their homes due to the 'agonising fear of exposure to public view'. The article proposed extending the Dufferin scheme's influence through 'a system of house visitation', noting that European women were already able to receive female medical attendance in their own homes. The article offered an ostensibly patient-centred solution, designed to counteract women's anxieties. It claimed that '[o]nly those who are *intimately acquainted* with the sensitive feelings of our Indian fellow-subjects' [emphases added] could 'estimate the insuperable difficulty' of drawing women out to public hospitals, implying it had a special understanding of these patients' preferences.[117] However, the writer cited no evidence that '*purda-nashins*' had requested a system of home visitation. While some women would undoubtedly have preferred this, the writer made his own generalisations. Further, he implied that poor women would continue using the hospitals and dispensaries, regardless of their preferences.

The article's attitude towards native women oscillated between an outward show of courtesy and explicit criticism of their beliefs. It characterised 'purda-women' as 'a class that has much in it to command not only our warmest sympathy, but our admiration and respect'. Yet it dismissed their way of life, describing '[h]ow centuries of custom and centuries of prejudice have established the *purda-nashin* system and it will take centuries

[117] 'The Dufferin Hospital for Indian Women in Calcutta, How to Reach the Purda Woman', *IMR,* 19 June 1901, pp. 663-4 (p. 664).

to uproot and destroy it'. In the *Record*'s opinion, only 'the general education of Indian women and their emancipation from the thraldom of social inequality' could effect this change.[118] The article purported to offer a sympathetic response to the preferences of the *purda-nashins*, but also condemned their lifestyle and called for its reformation. Despite some acknowledgement of the distinctions between high- and low-caste (or rich and poor) patients, medical writing repeatedly deployed reductive portraits of native women. As Samiksha Sehrawat argues, commentators effaced the different ways in which women observed *purdah* or *zenana* to construct essentialised images of Indian womanhood which accorded with imperialist ideologies.[119]

In 1901, the *Record* published correspondence about the alleged lack of success at the Dufferin Victoria Hospital in Calcutta. The aforementioned letter – signed by 'Reporter' – took a markedly different approach to patient care. It complained that medical women had been 'hampered' by 'unnecessary rules and regulations'. It alleged that there would be greater numbers of patients, 'if the lady doctor were permitted to give her services to *all* women, and not so much fuss and ado made about the so-called *purda-nashin*'. The writer accepted that 'caste and religious prejudices' should be respected, but insisted that women's hospitals should not exclude 'the many poor Europeans, Eurasians, Jew, Native Christian, and low caste Hindoo and Mahomedan women'. The correspondent highlighted the diversity of the medical women's prospective patient constituency. (S)he insisted that women's hospitals 'should give free admission to women, irrespective of caste, creed, or nationality', since many 'would prefer death to exposure and being handled by a male doctor'.[120] The writer both reinforced and collapsed racial difference, categorising female patients according to race or religion while suggesting that their

[118] 'The Dufferin Hospital', p. 664.
[119] Sehrawat, p. xxxv.
[120] 'Reporter', p. 673.

interests were nevertheless aligned. The correspondent re-oriented attention away from the specific needs of the *zenana* patient, claiming that there was a wider demand for female medical attendance. This tactic recalled aspects of Hoggan's original proposal for the medical-woman scheme. While emphasising the needs of women who observed *purdah* and *zenana*, she refashioned native women's 'so-called prejudices' as a 'natural modest shrinking from doctors of the male sex'.[121] Undermining ideas of racial difference, she drew upon conceptions of the doctor-patient relationship familiar to British readers, namely the idea that propriety or modesty were sufficient to explain women's disinclination towards male medical attendance.

Generally, however, discussions of the Indian medical-woman movement in the colonial medical press deployed essentialising images of the 'suffering' native woman. A movement ostensibly devised as a response to the native woman's lifestyle was largely preoccupied with remedying her situation. This rhetoric legitimised the medical woman's professional identity by positioning her in the role of saviour. It suggested that she had a distinctive role to play, with her own separate sphere of work, set apart from that of medical men. Despite some initial resistance to the movement, medical women in India were not conceived as a competition or a threat as they were in Britain. This is because there was widespread recognition of unmet patient need in India. The rise of the medical woman was perceived as a way to extend imperial medicine's role in enlightening hard-to-reach patient communities. These ideas about the colonial medical woman also circulated in Britain and played an important role in tempering hostilities towards the wider movement.

[121] Hoggan, p. 2.

4. The colonial practitioner in fiction

This chapter has examined how imperial professional identities were constructed by the medical press in India and Britain. This closing section investigates representations of the colonial practitioner in popular fiction for British readers. It considers how these fictional portraits interacted with ideas found in the journals, but also highlights how authors produced competing representations of colonial practice which infiltrated the cultural imagination. I begin by looking at *Brenda's Experiment* (1896), a novel by Henry Martineau Greenhow, before considering two short stories by Conan Doyle, 'The Adventure of the Speckled Band' (1892) and 'The Story of the Brown Hand' (1899).

Greenhow was intimately acquainted with medical service in India. He was an IMS official who served during the Indian Rebellion. At the infamous Siege of Lucknow, he aided several wounded soldiers from the relieving force, for which he was promoted and awarded the Mutiny Medal with two Clasps. Greenhow became a Surgeon Major in 1873, before he retired three years later. As his obituary in the *BMJ* attests, he then published several novels of Anglo-Indian life, including *Brenda's Experiment.*[122] Set against the backdrop of the 1857 'Mutiny', the novel follows a young British woman, Brenda Mogadore, who marries a Muslim man named Ameer Ali. The novel frames interracial marriage as an 'experiment' trialled by Brenda and her bohemian parents and it proves to be an ill-fated match. While medical practice does not feature heavily in the narrative, it depicts two colonial medical men: the retired Dr Barton, a family friend of the Mogadores who has returned to London after a career in India, and Assistant Surgeon Bolton, who helps the British military in its defence of the Residency. Further, the novel's title page

[122] 'Obituary: Henry Martineau Greenhow', *BMJ,* 14 December 1912, p. 1694.

identified the author as 'Surgeon-Major Greenhow', thus establishing it as the work of an official medical man.

In depicting the events of 1857, Greenhow drew on his own experiences while engaging with a wider literary tradition. In an article for *Blackwood's* in 1897, Hilda Gregg suggested that there was a 'flood of Mutiny literature' during the 1890s. 'Of all the great events of this century, as they are reflected in fiction, the Indian Mutiny has taken the firmest hold on the popular imagination', she wrote.[123] Gregg provided a catalogue of 'Mutiny literature' from the 1860s to 1890s, though *Brenda's Experiment* did not feature. Indeed, it has received scant critical attention, and appears only as a bibliographic listing in Gautam Chakravarty's comprehensive *The Indian Mutiny and the British Imagination*.[124] Upon its publication, however, the novel was reviewed by several British-based periodicals. *Hearth and Home* noted that, while the narrative was 'readable and entertaining', Greenhow had made 'the Oriental' (Ali) 'such a brute that no woman could have been happy with him, whatever his race, rank, or religion'.[125] Similarly, the *Speaker* deemed the book 'readable and interesting', but found the depiction of Ali inherently problematic, complaining that 'we should like, once in a while, to meet in fiction with a Mahomedan who was not a villain'.[126] As reviewers identified, Greenhow's treatment of race is crude and unpalatable.

The narrative deploys common Orientalist tropes, particularly in its representation of Muslim men as cruel and untrustworthy. Ali initially presents himself as a liberal-minded convert to Christianity to win the trust of Brenda and her parents. After settling his

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[123] [Hilda Gregg], 'The Indian Mutiny in Fiction', *Blackwood's Edinburgh Magazine,* 161 (February 1897), 218-31, (p. 224, 218).
[124] Gautam Chakravarty, *The Indian Mutiny and the British Imagination* (Cambridge: Cambridge University Press, 2005), p. 221.
[125] 'Books and Authors by Paper Knife', *Hearth and Home,* 9 April 1896, p. 836.
[126] 'Fiction', *Speaker,* 14 March 1896, pp. 324-5 (p. 325).

new wife in a 'native house' in Rownpore, however, he reveals his true nature.[127] He introduces a second wife to the home and promises Brenda as a gift to his cousin, the Nawab (the figurehead of the 'Mutiny'). Many of the Sepoys in the Rownpore Rangers – barring the loyal and even courageous Seikhs – prove treacherous, with the ringleaders murdering their British officers in gruesome and unprovoked attacks. For instance, Dillawur Khan targets Captain Wright when he is unarmed, slitting his throat and then carrying his head on a stick as a 'hideous trophy' (149).

Greenhow establishes a contrast between East and West through his depiction of Muslim and Christian characters' divergent responses to the injuries they sustain in battle. After his capture, the Nawab complains loudly of his wounds, though Assistant Surgeon Bolton finds nothing 'beyond some bruises'. He instructs the Nawab to look to Captain Leslie; though his shoulder is 'torn open' he 'utters no complaint' and is 'quite cheerful' (226). In this passage, the Nawab represents enfeebled, unhealthy Islam, while Captain Leslie functions as the epitome of muscular Christianity. Bolton is convinced that Leslie will recover, remarking that his 'health and strength' ought to carry him through (230). While Leslie prospers (and goes on to marry the newly widowed Brenda), the Nawab is convicted, banished, and eventually commits suicide. Bolton plays a minor but important role in the narrative. His confrontation and arrest of the Nawab effectively purges the diseased body politic, restoring order to the colonial outpost. It seems pertinent that Greenhow conferred this responsibility on a surgeon rather than any of the military characters. He implies that bravery is shown by all those acting in the service of Empire and that victory need not demand violence so much as ingenuity and courage.

[127] Henry Martineau Greenhow, *Brenda's Experiment* (London: Jarrold, 1896), p. 86. Further references are given after quotations in the text.

Structurally, Dr Barton also occupies a small but significant role in the text. The novel opens with a conversation between him and Brenda's father, Professor Mogadore, who is instructing Ali in Law. Barton warns Mogadore against his implicit trust of Ali and Indian people in general, speaking from the experience of one whose 'life indeed has practically been given to India' (he spent twenty-five years working there) (7). Barton voices similar prejudices to those found in the medical press, including the idea that, intellectually, Indians have 'a want of originality, or striking out new lines of inquiry' (9). Barton's rigid belief in 'racial distinctions' oscillates between biological and social determinism. He tells his friend, 'never forget the differences that exist between the Eastern races and ours – the differences of moral nature which it must take generations to overcome, if indeed such a change is possible under any circumstances' (13).

It is Barton who first detects that Ali's professed conversion to Christianity may be a sham and that he has designs on Brenda. The narrator portrays him as a shrewd observer, noting that 'Barton saw it all' (26). He both *diagnoses* the situation (predicting the impending nuptials) and makes a remarkably accurate *prognosis*, immediately doubting that the outcome will bring happiness to Brenda and her family. While Mogadore hopes that the interracial marriage will show that 'the narrow limits of race are falsely drawn by the narrow prejudices of mankind', Barton remains convinced that the 'mixture of certain races should be avoided' (41, 30). Although he discourages the match he treats Brenda kindly, writing to her cousin, who is also based in India, with instructions to welcome Brenda and Ali so as to secure them a place in European society.

Barton acts in the capacity of both doctor and family friend, and his advice derives its authority from his experiences in India as a medical practitioner and as a man of the world. Advice on prospective marital unions was certainly considered within the scope of a practitioner's professional role. In 1895, the *Record* featured an article entitled 'The

Physician as a Moralist', which suggested that the 'model man of our noble calling' would 'endeavour […] to minimise those ill-advised and regrettable unions which give promise of unhappiness'.[128] At the end of the novel, Barton intercedes once more in nuptial arrangements, this time endorsing Brenda's marriage to the heroic Captain Leslie. By now the reader recognises that Barton's opinion is sagacious and astute.

In the novel's denouement, then, Greenhow's medical characters – one a heroic young man, the other a sage advisor – both bring about and confirm Britain's ultimate prosperity. Using the 'Mutiny' as an emblem of national pride was by no means unusual – Henry Merriman's contemporaneous novel *Flotsam* (1892), for instance, described the events of 1857 as 'a corner-stone of our race'.[129] Greenhow represents professional and national identities as firmly interlinked in a way which recalls the imperialising ideology found in the medical press.

Conan Doyle, unlike Greenhow, did not practise in India. His comparatively scant experience of colonial medicine involved working as a medical officer on a steamer travelling between Liverpool and West Africa before he settled as a general practitioner in Portsmouth. His interest in the colony perhaps owed more to his literary ambitions, as his praise for Rudyard Kipling's fiction and his later engagement with imperial romance suggest.[130] In contrast to Greenhow's noble medical men, Conan Doyle presents much more ambivalent doctor-figures in 'The Adventure of the Speckled Band' and 'The Story of the Brown Hand'. Both stories depict medical men who retire to Britain after careers in India. While Dr Grimesby Roylott returns a convicted criminal, Sir Dominick Holden is a celebrated but broken man. Across the fiction examined here, practice in India is presented

[128] 'The Physician as a Moralist', *IMR*, 1 August 1895, pp. 96-7 (p. 96).
[129] Henry Seton Merriman, *Flotsam, The Study of a Life* (London: Smith, Elder, 1909), p. 144.
[130] Lisa Fluet, '"Distinct Vocations" and the Anglo-Indian in Sherlock Holmes' England', *Victorian Review*, 24 (Winter 1998), 130-62 (p. 136). John A. McClure, *Late Imperial Romance* (London: Verso, 1994), p. 11.

as a transformative experience. However, while Greenhow suggests imperial service reinforces national identity, in Conan Doyle's stories, men are physically and psychologically impaired by their work in India.

'The Adventure of the Speckled Band' is a Sherlock Holmes mystery, in which the detective thwarts Roylott's attempts to murder his stepdaughter, Helen Stoner. When Helen first appeals to Holmes for help, she offers a detailed description of her stepfather's antecedents. Though Roylott comes from an aristocratic lineage, previous heirs were of a 'dissolute and wasteful disposition' and he therefore sought an income. After studying medicine he travelled to Calcutta where he 'established a large practice' purely through 'his professional skill and force of character'. Despite this initial success, Roylott became enraged over a series of robberies at his home and 'beat his native butler to death'. After a spell in prison, Roylott returns to his family seat at Stoke Moran (on the Western border of Surrey) and becomes a recluse, who nevertheless engages in 'ferocious quarrels' and 'disgraceful brawls' with the local people.[131] He is the antithesis to Greenhow's valiant medical men.

Rather than upholding British values, Roylott is warped by Eastern influences, which he transports back to the metropole. His appearance and conduct indicate his Orientalised nature: his face is 'burned yellow with the sun' and he has 'huge brown hands' (176-7). He smokes 'strong Indian cigars' and befriends other social and ethnic outsiders, the 'wandering gypsies'. He also collects Indian animals, allowing a cheetah and baboon to 'wander freely over his grounds'. Roylott's unpredictable and irascible temperament is portrayed as both a hereditary disposition and a product of his time in India. Helen tells Holmes, '[v]iolence of temper approaching to mania has been hereditary

[131] Arthur Conan Doyle, 'The Speckled Band', in *The Adventures of Sherlock Holmes* (London: Penguin, 1981), pp. 165-90 (pp. 168-9). Further references are given after quotations in the text.

in the men of the family, and in my stepfather's case it had, I believe, been intensified by his long residence in the tropics' (169). Roylott's violent temper is revealed not only in his backstory but also in his treatment of Helen. As is evident from *Brenda's Experiment,* cruelty towards women was a trait stereotypically ascribed to Indian (particularly Muslim) men.

The image of a man corrupted by the experiences of life in India is rendered explicit when Holmes brands Roylott's choice of murder weapon – an adder with untraceable venom – 'just such a one as would occur to a clever and ruthless man who had an Eastern training' (189). Roylott's criminality is also associated with his medical knowledge. Holmes remarks, 'when a doctor does go wrong he is the first of criminals' (185). In previous chapters I have traced the figure of the doctor-poisoner in popular fiction, suggesting these figures recalled real-life medical murderers such as William Palmer and Edward William Pritchard.

Literary scholar Lisa Fluet argues that Roylott's 'original professional role in India' becomes 'an almost total inverse of itself in Britain'. The doctor suffers the 'debilitating effects of the colonial sphere' and thus tarnishes Britain's 'conceptions of its own physical superiority and professional medical prowess'.[132] However, this analysis is complicated by Roylott's status as an independent rather than official medical man. Fluet identifies that he is a general practitioner rather than an IMS official, but conflates the two when she describes this 'entrepreneurial g.p. [sic]' as a 'medical representative of the British colonial system'.[133] At the start of this chapter, I considered how the medical press incorporated both official and independent practitioners into broader ideas of medicine's imperial mission. However, I also emphasised anxieties about the unofficial practitioner's

[132] Fluet, p. 154, 151, 153.
[133] Fluet, p. 146, 141.

marginalisation. The disconnect between official and independent practice seems pertinent to Conan Doyle's story; Roylott is not portrayed as an agent of Empire and he operates outside of professional networks. His experience of colonial medicine is distinct from Dr Watson, for instance, who served as an Army doctor in Afghanistan.

By contrast, Sir Dominick Holden – in 'The Story of the Brown Hand' – is 'the most distinguished Indian surgeon of his day', wholly enmeshed in imperial and professional life. He begins by working for the British Army, before 'settling down into civil practice in Bombay', and visiting many parts of India in the role of consultant. His name is 'remembered in connection' with the Oriental Hospital, of which he is the founder and supporter.[134] He is an imperial official and a philanthropist. Nevertheless, there remain curious similarities between Sir Dominick and Dr Roylott. Both re-locate to the British countryside after their time in the tropics and while Sir Dominick does not return criminalised, he comes back a mysteriously 'broken man' (499). He similarly incorporates aspects of Indian life into a British rural and domestic space, having 'curious pungent delicacies' served to him by 'a stealthy, quick-eyed Oriental waiter' (501). Further, just as Helen perceives her stepfather to be marred by his experiences in the East, so the narrator of 'The Brown Hand' suggests that 'the breakdown of [Sir Dominick's] nervous system might be due to his forty years in India' (503). This remark carries even greater authority given that the narrator (Sir Dominick's nephew, Hardacre) is a British medical man.

During the narrative, it emerges that Sir Dominick is being haunted by the ghost of a former patient whom he treated during his time in India, some ten years before the events of the story take place. The patient was an Afghan hillman, 'from some mountain tribe'. Sir Dominick deduced that he was suffering from a cancerous swelling on one of the

[134] Conan Doyle, 'The Story of the Brown Hand', *Strand Magazine*, 17 (May 1899), 499-508 (p. 499). Further references are given after quotations in the text.

metacarpal joints and persuaded him that amputating his hand was necessary. After the operation, the hillman asked Sir Dominick his fee. Registering the man's poverty, Sir Dominick replied that he instead wished to take the man's hand to add to his 'pathological collection'. The patient replied that, in his religion, it was 'an all-important matter that the body should be reunited after death' (505). Sir Dominick implicitly asserted his superior, 'rational' Western medical knowledge, claiming he had better methods for preserving the hand, and the hillman relented. After the patient dies some time later, his ghost returns to Sir Dominick in search of his lost hand. Unbeknown to him, Sir Dominick's pathological collection has been destroyed in a fire.

Hardacre – who is not only a doctor but also a member of the Psychical Research Society – seeks to exorcise the ghost and free his uncle. Consulting a book about occultism, he realises that 'a reasonable compromise' must be 'effected' (506). Accordingly, Hardacre searches for a substitute brown hand with help from his friend, a house-surgeon at Shadwell Seamen's Hospital. After first displeasing the ghost by mistakenly offering a left hand rather than a right one, Hardacre finally locates an appendage that satisfies the phantom. Postcolonial criticism focuses on the apparent interchangeability of brown hands in the story. A recent monograph by Aviva Briefel investigates how the portrayal of 'racialized hands' in Victorian writing reveals the patterns of 'domination and resistance that mark imperial relationships'.[135] Analysing Conan Doyle's story, Briefel argues that the narrative implies 'one brown hand is as good as another' not only to the Western medical men, but also to the Afghan patient. She emphasises that the construction of a 'generic brown hand' seems to 'overwrite […] their

[135] Aviva Briefel, *The Racial Hand in the Victorian Imagination* (Cambridge: Cambridge University Press, 2015), pp. 1-2.

distinctive characteristics'; the patient is not only appeased by the severed hand of a Lascar, but one which was injured in a wholly different manner.[136]

Preoccupation with the substitution plotline threatens to obscure some of the more ambiguous aspects of the narrative, however. Conan Doyle is ambivalent, even critical, about Sir Dominick's behaviour towards the Afghan hillman. The fact that the doctor suggests 'in jest' that a man who is 'almost a beggar' pay for his operation by the gift of his hand seems troubling, given that healthcare for the poor (in both British and colonial contexts) was often provided charitably (505). Although Sir Dominick claims he did not originally intend to keep the hand, he exploits the hillman's credulity to bolster his pathological collection. He thus oversteps his professional authority and disrupts medical etiquette. As well as disregarding his patient's request, he is flippant about his religious beliefs. When the Afghan patient reminds him he will return for the hand after he is dead, the surgeon 'laugh[s] at the remark' and, when the appendage later burns in the fire, he gives the matter 'no particular thought' (505). The story serves as a cautionary tale in which Sir Dominick is punished for his lack of sensitivity or respect for Eastern beliefs. It is only by honouring the patient's original request that Sir Dominick can finally be granted respite. In his final appearance, shortly after he accepts the substitute hand, the Afghan performs 'the low Eastern salaam which is their solemn leave-taking' (508). With a hand restored to him, he offers a courteous farewell. The plotline hinges on Sir Dominick's need to make reparations.

Much of the narrative suspense derives from the frisson of an Oriental phantom invading the British countryside. Yet the story does not necessarily posit a binary distinction between East and West. Briefel argues that 'the British characters' superstitious

[136] Briefel, p. 36, 38.

fixation on the severed hand threatens to undermine their Western rationality'. However, the occult power exerted by the brown hand would not necessarily have seemed superstitious to Conan Doyle who, like Hardacre, combined a medical education with psychical interests. Furthermore, Sir Dominick and Hardacre's suspicions are fully vindicated by the narrative. Nevertheless, I agree with Briefel that the story 'erodes barriers in racial and personal identity'.[137] It ostensibly closes with the restitution of order and the ascendancy of British values. The Oriental ghost is banished, leaving Sir Dominick and his wife to enjoy 'a very happy old age' on their Wiltshire estate, installing the worthy Hardacre as their heir. However, during Sir Dominick's final years, he turns to Hardacre for 'advice in everything which concerned that English life of which he knew so little' (508). After his retirement from medical practice in India, the celebrated surgeon needs to be instructed in British socio-cultural norms. Sir Dominick may have functioned as a tool of Empire, but he nevertheless becomes estranged from British values in the process. This reflects anxieties about the alterity of British men long domiciled in India. As Fluet identifies, the colonial doctor who returns to the metropole occupies a 'liminal position',[138] and Sir Dominick's national identity is compromised. Significantly, 'The Brown Hand' ends with the death of the colonial surgeon, and it is the 'hard-working country doctor' who becomes 'the head of an important Wiltshire family'. The ending turns on a fantasy of social mobility and Hardacre recognises that he has 'reason to bless' the memory of the Afghan patient (508). His inheritance – which reinforces middle-class British values of property and domesticity – is facilitated by the Eastern spirit.

To some extent, all three stories discussed here mobilise the idea of the Orient as a threatening space, with medical men variously repudiating or succumbing to its influences.

[137] Briefel, p. 40.
[138] Fluet, p. 131.

The practitioners' national identities are reinforced or compromised through their work in India. In their representations of colonialism, 'The Story of the Brown Hand' is assuredly the most complex, for it seems to both endorse British values while critiquing exploitative aspects of Empire. Literary critics have discussed whether Wilkie Collins's *The Moonstone* (1868) functions as an anti-imperialist novel and 'The Brown Hand' has a similarly vexed status.[139] In both texts, Eastern characters are Orientalised and made 'Other' but also treated as wronged parties who seek retribution rather than vengeance. Greenhow's novel and Conan Doyle's stories offer competing representations of the colonial practitioner, but they similarly suggest that imperial practice was a definitive aspect of one's identity. They thus demonstrate the mobility of medical identities, how identification as an imperial practitioner might follow one back to the metropole.

Conclusion

The colonial practitioner's identity remained heavily contested at the *fin de siècle* and print culture both facilitated and stymied the process of professionalisation. In the British cultural imagination, India was a space of imperial adventure and self-discovery where a medical practitioner's professional and personal character might be cemented or destabilised. While Greenhow's medical men function as emblems of patriotism and national zeal, Conan Doyle's practitioners find their identities compromised in the Indian context. These depictions of colonial practitioners as heroes or villains may seem crude representations intended for a domestic readership. However, analysing them alongside the journals enables us to understand how imperial medicine's ambitions and anxieties about unprofessionalism infiltrated both the cultural and medical imagination.

[139] For an overview of postcolonial criticism of *The Moonstone* see Lyn Pykett, *Authors in Context: Wilkie Collins* (Oxford: Oxford University Press, 2005), p. 224.

As in Britain, the profession in India was riven by fractures and the medical press both mediated and facilitated these conflicts. The hegemony of official, IMS employment generated discontent among independent practitioners, who considered themselves marginalised. The *Record*'s attacks on the *Gazette* reproduced these conflicts within the periodical marketplace. There was considerable discussion about the role Indian, Anglo-Indian, and Eurasian practitioners should play within imperial medicine. These groups were sometimes accused of apathy or prejudice and of jeopardising the profession's reputation. However, journals also agitated for their rights and provided a platform for their views to be heard. In differing ways, these figures were identified in terms of their racial alterity but were expected to replicate Western professional values. In the last chapter, I identified how the medical press was a predominantly male textual space. This chapter has revealed how journals in India reproduced racial and gender hierarchies within the colonial profession. Their editors, contributors, and readers were largely white men.

The collegiality imagined in Harvey's opening address at the First Indian Medical Congress was optimistic but unity was seen as imperative in order for the profession to assert its authority and legitimacy. While promoting rivalries, the medical press also constructed imagined communities and sought to engender greater professional co-operation. The profession's diversity was paradoxically conceived as both a problem (a threat to gentility) but also a solution to extending the reach of Western medicine. Commentators recognised that practitioners of Indian descent might pave the way for medicine to be accepted by indigenous communities. Meanwhile, medical women in India received earlier acceptance and even approbation than their British counterparts because of the way in which they actively reinforced ideas about imperial medicine's vocation.

The medical press constructed shared ideas of professional duty. Practitioners were conceived as working towards a common aim, providing relief to 'suffering humanity' and

exerting a civilising influence. This idea was ubiquitous, variously deployed in representations of the IMS and the SMS, independent practice, and the medical-woman movement. While many male practitioners chiefly attended European patients or those within the military, the profession was represented as bringing rational and scientific medicine to a backward population and struggling against a hostile tropical environment. Previous chapters have shown how medical writing and fiction represented the struggles of metropolitan and country practice. India was also connoted as a place of adversity, which was compounded by its strangeness. The British and Indian medical press engaged with the obstacles of colonial practice, while deploying aspirational images to bolster the profession's status. Popular fiction represented the colonial space as a testing ground in which medical men might reveal their heroism or immorality.

This chapter has discussed the considerable anxieties about medical etiquette and respectability in British India. Fiction exploited prejudices about colonial practitioners and Orientalised tropes of indigenous peoples for sensational effect. The colonial medical press charged a range of practitioners with a lack of professional zeal and co-operation. The journals conceived themselves as an antidote to this apathy, a way to energise and engage readers with both the clinical and ethical aspects of medicine. They instructed medical men and women to police their conduct and to ensure they upheld professional ideals to improve their reputation. For the Indian journals, replicating the success of the medical press in Britain and Europe was imperative to legitimise colonial practice as progressive. However, periodical culture was at an earlier stage of development and there was anxiety about its durability and the quality of its content.

Professional identities in colonial India were interconnected with ideas about the British medical community, with the latter typically constructed as a moral and professional exemplar. This rhetoric involved effacing the problems afflicting practice in

the metropole. As we have seen, anxieties about conduct and behaviour were also prevalent in the British medical press. However, these fears were more acute in India, where the profession was nascent and insecure. It had to assert its equality with British medicine and its superiority to indigenous practices while tackling the perceived lack of appetite among patient communities. While reproducing Western values, the colonial medical press constructed distinct professional identities rooted in the specific conditions of practice in India. These identities reflected imperial medical networks such as the IMS and the Dufferin Fund and closely interacted with other axes of identity such as gender, race, and ethnicity. The medical press recognised the diversity of the profession in India. It attempted to navigate these differences while calling for greater collaboration to elevate the status of colonial practice.

Conclusion

'[Professions] live by *persuasion and propaganda*, by claiming that their particular service is indispensable to the client or employer and to society and the state [emphases added].'[1]

In his history of the professions, Harold Perkin contends that occupations cement their status by articulating their utility and value in the public sphere. This thesis has argued that the medical profession's engagement with print culture was crucial to its process of identity formation. However, while medical journals and fiction could function as 'persuasion and propaganda' they were not purely conceived as vehicles for self-promotion. Medical men and women interacted with writing in diverse ways to produce heterogenous images of the profession.

Each chapter of this thesis has delineated a different professional identity while drawing out overarching ideas about the relationship between identity formation and print culture. This conclusion will expand upon some of the key themes that have emerged: the interconnections between different professional identities; the negotiation of shared professional values; and the production of communities and rivalries. It also reflects on the intersection between medical and literary culture, interrogating how and why the profession engaged with textual practices in this period. The thesis closes with an epilogue, looking forward to how medical identities were revised in the twentieth and twenty-first centuries.

1. The interplay between professional identities

Narratives of professionalisation typically focus on an occupation's corpus of knowledge. This thesis has reoriented attention to how professional identities interacted with other axes of identity, such as age, gender, race, and the spaces of practice. Crucially, certain

[1] Harold Perkin, *The Rise of Professional Society: England Since 1800*, 2nd edn (London: Routledge, 2002), p. 6.

'personal' characteristics were represented as overwriting other prospective 'professional' differences. A young medical man was typically defined by his age and his junior status regardless of where he practised, though his early struggles were also conceptualised as a transitional stage. A medical woman was primarily identified by her gender, whether she was a medical student or a successful practitioner. In British India, 'native' (and to some extent, Eurasian and Anglo-Indian) practitioners working within colonial medicine were defined by their perceived racial difference. In varying ways, these groups were represented in terms of their alterity and subordination to the dominant professional identity which was unsurprisingly codified as white, male, and middle-aged.

This thesis has proposed a typology of professional identities while emphasising the significant interplay between different categories. Some professional identities were articulated through structural oppositions: the country practitioner was imagined as the antithesis to his metropolitan counterpart, while colonial practice was defined against practice in the homeland. If identities determined by personal characteristics remained relatively fixed, then identities fashioned in relation to space were more mutable. They were shaped around a specific context and were therefore fluid as practitioners moved between different places of practice. Medical education, training, and careers were represented as peripatetic and medical writing facilitated this mobility. This does not mean that spatial identities were conceived as transient or expendable. The experiences of metropolitan, country, and colonial practice were represented as having enduring effects on a practitioner's personal and professional identity. Memories of rural practice were often depicted through a sentimental or nostalgic lens. The depredations of urban practice and colonial work in India were variously represented as developing one's resilience or enervating one's medical knowledge and even corrupting one's character.

Practitioners could be associated with multiple professional identities. Medical men were represented in relation to both their current place of practice but also the site of their education and training. Thus urban consultants might fondly recall their days as an apprentice to a rural general practitioner, while country practitioners might also define themselves by their metropolitan alma mater. This thesis has considered the depiction of practitioners whose careers spanned different places, whose identities were a patchwork of different experiences and influences. They might engage with metropolitan, provincial, rural, and colonial identities throughout their working lives, transporting elements of one and assuming aspects of another. While women's professional identities were articulated in terms of their gender difference, this had more affirmative connotations in British India, where it was conceived as intrinsic to their work among indigenous female patients. In this space, the medical woman was co-opted into broader ideas about imperial medicine's civilising mission. The cultural constructions of the medical woman illustrate the complex interplay between gender, professional, and colonial identities. They also show how individual identities could be subsumed within overarching ideas about professional duty.

2. Medical etiquette and morality

The plurality of identities that emerged, and the tensions between them, did not preclude the construction of collective professional values. This was crucial for consolidating medicine's status in a period when practitioners were often accused of self-interest and competitive practices. Throughout this thesis, I have examined how medical etiquette functioned as an important rhetorical strategy for regulating professional behaviour. Chapter One demonstrated how medical men were inculcated with ideas of professional obligation from the outset of their careers, while Chapter Five revealed how Indian medical journals reproduced ideals of etiquette in the colonial context. Upholding the

standards of gentility was widely represented as a professional duty. However, medical writing and fiction did not simply produce professional values, they also provided a space in which they could be contested. In journals, correspondents quarrelled over personal and professional slights, while medical fiction satirised the exigencies of this code of conduct. Nevertheless, the preoccupation with etiquette across different forms of writing demonstrates its hegemony.

Professional etiquette has its antecedents in earlier value systems. Michael Brown describes how, in the late eighteenth century, a culture of 'medico-gentility' privileged qualities such as 'politeness, sociability and civic engagement'. He explores how these values were transmuted during the early nineteenth century into ideals of 'collective responsibility', 'public duty', and vocational competence.[2] Ideas of personal conduct and public duty remained cornerstones of medical etiquette across the nineteenth century. Significantly, medical writers often emphasised the enduring nature of professional values. In the 1890s, the *Lancet* praised Thomas Percival's *Medical Ethics* (1803) as the byword in professional etiquette.[3] Referring to a durable set of values was a way for the profession to buttress its self-image. It highlighted that medicine enjoyed a long history as a liberal profession and that the tradition of manners was sustained even as medical practice became more scientific. Furthermore, a shared value system was important because, following the 1858 Medical Act, the profession in Britain was self-regulated. In colonial India, there was agitation for a similar system of medical registration. The profession thus needed to demonstrate that it was responsible and respectable, able to police its own conduct.

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[2] Michael Brown, *Performing Medicine: Medical Culture and Identity in Provincial England, c. 1760-1850* (Manchester: Manchester University Press, 2011), p. 9, 222.
[3] 'The Ethics of Consultation', *Lancet*, 13 October 1894, p. 860.

During the Victorian period, professional values were increasingly underpinned by notions of respectability and morality. Some historians suggest that respectability's cultural authority peaked at mid-century but remained influential.[4] It exerted considerable influence on the profession through to the century's close. Anne Crowther and Marguerite Dupree discuss the 'moralisation' of the medical profession, which they associate with the generation of students who matriculated in the 1860s and 1870s.[5] When Frances Power Cobbe's article in the *Modern Review* (1881) attacked the profession on the grounds of morality it sought to directly undermine increased efforts to promote a reputable image. Into the twentieth century, the profession remained anxious that negative public opinion could inhibit its status.

Significantly, practitioners' personal and professional lives were represented as interconnected and they were expected to conduct themselves with propriety across different areas of their life. This was conceived as crucial for practitioners in a precarious social position, since, as historians have argued, performing respectability was a way for middle-class men to 'join the social elite'.[6] As shown, practitioners' encounters with women were portrayed as a particular source of anxiety, especially for those in close-knit communities who were vulnerable to rumour. The anonymity of metropolitan or colonial practice afforded more freedom but was represented as posing greater risks to a medical man's morality. Fiction depicted villainous practitioners who not only shunned respectability but who exploited their medical knowledge for nefarious purposes. The image of the medical man steeped in scandal or depravity was sensational because it exposed the anxieties that underlay the respectable ideal.

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[4] Mike J. Huggins, 'More Sinful Pleasures? Leisure, Respectability and the Male Middle Classes in Victorian England', *Journal of Social History,* 33 (Spring 2000), 585-600 (p. 586).
[5] M. Anne Crowther and Marguerite W. Dupree, *Medical Lives in the Age of Surgical Revolution* (Cambridge: Cambridge University Press, 2007), p. 369.
[6] Huggins, p. 587.

The doctor-patient relationship was conceived as an important component of medico-morality, and was often depicted as sacrosanct and inviolable. Medical and literary writers stressed the value of the family doctor against the rise of specialist and hospital-based medicine. They also emphasised the importance of obligation towards one's patients. Providing gratuitous care for the (deserving) poor was conceptualised as a philanthropic act or increasingly as a public service, crucial to one's status as a professional and a gentleman. The profession fashioned itself as a source of moral authority with an important role to play in local affairs and public life. Medical men and (from the 1860s onwards) medical women argued that they could civilise 'backward' communities. This idea was applied to different spaces including the metropolitan slums, rural backwaters, and indigenous communities in colonial India. Those opposed to aspiring medical women sometimes attacked their moral character to delegitimise their campaign. However, women used their prose writing and fiction to suggest that male medical attendance was anathema to female modesty and to portray themselves as better suited to safeguard female patients' physical and moral health.

Crucially, medical writing and fiction also explored practitioners' grievances and frustrations with patients. The way in which patients shifted their allegiance between different practitioners was conceptualised as an affront to medical etiquette. Ire was also directed towards patients who abused the hospital system, and those who reneged on bills or requested attendance at inconvenient times. Criticism was directed across all levels of society. For example, wealthy and middle-class patients were accused of avoiding payment and of disloyalty towards their family attendants. However, attitudes towards patients were also shaped by prejudices relating to class, gender, and (especially in the colonial context) race and religion. In medical discourse, the individual needs of women, the poor, and indigenous peoples were often undermined. Furthermore, the system of medical etiquette

emphasised obligations towards one's colleagues, which were sometimes seen to outrank individual patient preferences.

3. Professional communities and professional conflicts

This thesis has interrogated how a dialectic between professional collegiality and conflict was mediated through textual practices. I have demonstrated how the medical press functioned to produce imagined communities. Journals forged networks between readers who were at different stages of their careers and who were geographically dispersed. The diverse content of the medical press – from leading articles to correspondence columns, and from clinical communications to printed addresses – typically engaged with a range of issues, encompassing consultant and general practice, and work in metropolitan, provincial, rural, and colonial spaces. The multivalency of the form enabled different practitioners to shape discussions and debates. The journals constructed the idea that medical practice was a joint or collective enterprise, with common interests and shared values. They suggested that different practitioners played complementary roles within the profession. The journals' heterogeneous content had a strategic function, ensuring their appeal to readers in a competitive periodical market.

The medical press also fuelled conflicts within the profession, as I have shown. It often featured leading articles hostile in tone or printed belligerent letters. These might contain charges of nepotism against the elite, accusations that individuals had breached medical etiquette, or sustained attacks on the capabilities and character of medical women. Some journals framed open and unfettered discussion as an important component in developing a liberal and democratic profession. The ideology of self-regulation was replicated within the journals. Practitioners were expected to behave relatively cordially and where they transgressed, editorial interventions contained arguments and mediated

hostilities. However, journals arguably used ideas of toleration and fair play as a veneer. This allowed them to print sensationalist material – which would sustain the interest of readers and subscribers – while disclaiming any infringement of medical etiquette.

Hostilities between practitioners were not only reflected in, but reproduced by, the rivalries between different journals. The conservative *London Medical Gazette* was established in opposition to the radical *Lancet*, and thereby replicated the conflict between the elite and the rank-and-file. The *Midland Medical Miscellany* framed itself as a riposte to the dominance of the London periodical press and capitalised on the provincial medical man's perceived resentment towards his metropolitan counterparts. Finally, the *Indian Medical Record* pitched itself as an organ for the independent practitioner, in opposition to the 'official' *Indian Medical Gazette*, which was affiliated with the Indian Medical Service. During debates about the medical-woman movement, the *Medical Mirror* positioned itself as a progressive voice challenging the backward views of its contemporaries. The passionate debates about the direction of the *Provincial Medical and Surgical Journal* (later the *BMJ)* show how the production, publication, and consumption of a journal could be deeply politicised.

Medical journals constructed professional identities but they also produced rivalries and formed separate communities of readers. These conflicting impulses were shaped by the competitive aspect of the periodical market, in which journals vied for authority in debates and to retain readers and subscribers. Moreover, individual journals were not coherent and unified in their identity. In Chapter Four, I examined how inconsistencies could be attributed to changes in editorship and production, the multivocality of the genre, and shifting social mores. We must be cautious about treating a single article or journal as a barometer of medical opinion for this elides the heterogeneity of the professional press,

its editors, and its readers. Thus I have scrutinised not only the relationships between different journals but the internal dynamics of individual titles.

4. Interactions with print culture

During this period, there was considerable cross-fertilisation between medical and literary writing. This discursive interchange went beyond a broad exchange of tropes. Medical practitioners were avid writers, readers, and critics of popular fiction. In the medical press, leading articles and addresses urged the profession to keep pace with the portrayal of doctors in literature and presented fictional medical men such as Allan Woodcourt as exemplars to young practitioners. Medical journals' literary reviews engaged not only with representations of medicine but also with the aesthetic qualities of fiction. The profession framed itself as an active participant in literary culture.

This close engagement with literature developed from an older medical culture in which physicians presented themselves as learned scholars versed in the classics and 'polite and ornamental knowledge'.[7] However, the textual practices I have discussed were not restricted to the medical elite but enabled a range of practitioners to take part. To some extent, this participation was regulated, with editors and publishers acting as gateways to print and circulation. As discussed, medical publishing endorsed a link between age and authority, and leading journals often privileged metropolitan practitioners' clinical communications. They were also largely masculine in orientation. However, journals and fiction also enabled those in precarious or unstable positions to engage in acts of self-definition. The professional press featured correspondence and contributions from young medical men, isolated rural practitioners, and aspiring medical women, groups which were otherwise disadvantaged in terms of their access to professional networks. Further, medical

[7] Brown, *Performing Medicine,* p. 49.

students such as W. Somerset Maugham and Margaret Todd, and struggling practitioners such as Arthur Conan Doyle, published fiction which drew on their experiences of medicine and which attracted attention from critics in the popular and professional press. The democratising tendency of medical writing and fiction served to counteract the system of patronage and nepotism that governed more established professional networks and provided alternative means of identity formation.

The profession's interaction with literary culture reached its acme during the 1890s. In this decade a range of medical men and women – including Conan Doyle, Maugham, Todd, Arabella Kenealy, and Henry Martineau Greenhow – produced fiction on medical themes, using their literary endeavours to supplement or supplant their medical education and practice. One reason for this surge in medical authorship was that the expansion of print culture had opened up opportunities for new writers. Further, I suggest that publishers and readers would have been more receptive to fiction by medical authors. Across the century, print culture had bolstered the profession's credibility: the medical press developed its status, and popular novels such as *Bleak House* and *Middlemarch* made the doctor a familiar figure in the public imagination. By the 1890s the profession had accrued cultural authority and this paved the way for medical students and practitioners to pursue literary careers. While not all medical authors received critical recognition, it was possible for men and women to combine, or shift between, medical and literary practice.

This thesis has demonstrated medical fiction's diverse approaches to genre, plot, and characterisation. Todd's fresh and buoyant medical student Mona Maclean is the antithesis of Maugham's morbidly self-conscious Philip Carey. Conan Doyle's fiction represents a spectrum of practitioners, from the sympathetic young medical man Stark Munro, to the scientific specialist Dr Horace Selby, and the violent colonial doctor Grimesby Roylott. The author engaged with a range of popular perceptions and prejudices

about the medical practitioner. Medical fiction was not primarily aimed at producing propaganda for, or panegyrics about, the profession. Instead, the authors' portraits of medical practice owed much to their desire to establish their literary credentials, whether it be through the modes of realism, naturalism, sensation, or satire. To portray the richness and variety of medical life – its challenges and opportunities, its pleasures and disappointments, its light and shade – was a way to engage the sympathies or imagination of professional and popular readers. Some medical writers were reflective about their literary endeavours. In a preface to the *Round the Red Lamp* collection, Conan Doyle argued that '[o]ne cannot write of medical life and be merry over it' and that it was 'the province of fiction to treat painful things as well as cheerful ones'.[8] In *The Partial View,* a collection of autobiographical reflections, Maugham conceded that while '[t]he medical profession did not interest [him]', he 'did not know a better training for a writer than to spend some years in the medical profession'.[9] He regarded his experiences in medicine as material for his writing rather than the means to a career in practice. These writers blurred their authorial and medical identities.

My research has revealed that medical journals were often eager to 'claim' medical authors as part of the profession, even where they were ambivalent or critical about their literary output. At the *fin de siècle,* Todd, Maugham, and Conan Doyle were all represented as 'medical' writers despite the diversity of their work. Conan Doyle and Maugham were identified in terms of their medical credentials even after they had stopped practising, while Todd continued to be associated with her debut novel even when she subsequently commented on clinical issues. The reviews of their fiction indicate that there was a fine line between appealing to, and alienating, a mixed readership. Commentators

[8] Arthur Conan Doyle, 'The Preface', in *Round the Red Lamp,* ed. by Robert Darby (Kansas City: Valancourt, 2007), p. 2.
[9] W. Somerset Maugham, *The Partial View* (London: Heinemann, 1954), p. 36, 38.

differed over the extent to which medical subject matter should be represented for general readers. The profession's critical reception of fiction was influenced by its values of morality and respectability. This can be detected in the general approbation of *Mona Maclean* as healthy and in the *BMJ*'s critique of Maugham's *Of Human Bondage* as sordid.

Journals constructed these ideas of medical authorship to bolster the profession's image. In the introduction to this thesis, I quoted an address delivered by Samuel Dodd Clippingdale in 1898. He argued that, '[t]here must surely be something in medical practice to awaken the emotions and stimulate the intellect, for we find the highest forms of literature enriched by the contributions of members of the medical profession'.[10] He represented medical and literary practices as interrelated, suggesting that both were forms of emotional and intellectual engagement. This idea was powerful because it counteracted medicine's old associations with trade and physical drudgery, refashioning it as an art and a cerebral activity. For Clippingdale, the profession's active participation in literary production was a means for it to demonstrate its cultural capital. While he referred to the 'highest forms of literature', he highlighted authors such as Warren and Conan Doyle whose fiction had a broad popular appeal.

This thesis argues that the medical profession's engagement with print and literary culture helped construct its identity as a liberal, educated occupation, one which was not removed from, but in touch with, the interests of the reading public. Although the profession's textual practices did not function purely as 'persuasion and propaganda' – interacting with the frustrations and disappointments of practice, as well as the seamier

[10] S.D. Clippingdale, 'An Address on Some Considerations of the Life and Work of the General Practitioner', *Lancet*, 29 October 1898, pp. 1104-6 (p. 1106).

side of medical life – they nevertheless helped to cement its cultural authority and thereby its status in public life.

Epilogue

During the twentieth and twenty-first centuries, professional identities were reshaped by changes in medical practice and healthcare delivery. As care and treatment shifted from the patient's home to the consulting-room and hospital, medical authority was augmented. Revolutions in medical knowledge and technology (from the discovery of antibiotics to the advent of keyhole surgery) fostered greater public confidence in medical interventions. Legislative changes such as the National Insurance Act (1911) and the National Health Service Act (1946; effective from 1948) paved the way for medicine to become a considerably less precarious career path.[11] Medicine is no longer characterised by an oversupply of doctors but increasing patient demand. Thus the image of the young medical man struggling to find and retain patients has become wholly unfamiliar. Instead of practitioners having to depart Britain to find opportunities in the Empire, the NHS has attracted (and depended on) foreign workers, including those from former colonies.

Despite changes in the conditions of practice and status of medicine, many tropes common in nineteenth-century medical and literary writing persist. A nostalgic fantasy of family practice is still lauded as an ideal, functioning as the antithesis to images of depersonalised hospital practice. In the nineteenth century, medical etiquette sought to regulate a practitioner's interactions with his patients and colleagues. There has been a renewed focus on the interpersonal aspects of medicine in recent decades and communication skills are now embedded in medical education and clinical training. Across

[11] It was not welcomed by all practitioners, since some regarded it as an infringement on 'medical independence'. Crowther and Dupree, p. 337.

the nineteenth, twentieth, and twenty-first centuries, there have been debates about how technological innovations – the stethoscope, the motor car, the Internet – might threaten or enhance the quality of doctor-patient interactions.

Some of the professional identities formulated in the nineteenth century continue to resonate and have adapted to reflect the exigencies of current practice. While financial hardship no longer typifies the early years of practice, the struggling young practitioner has clear parallels in present-day images of the overworked and underpaid junior doctor. Dissatisfaction with quality of life has reawakened interest in work abroad, and *BMJ Careers* has printed features on re-location explicitly aimed at junior doctors, which recall nineteenth-century articles.[12] The image of the overburdened country general practitioner also has its twenty-first-century counterpart. As home visits are increasingly rare, the long and treacherous journey to access patients is no longer a common trope. Nevertheless, rising patient demand has ensured working hours remain long. In 2015, the Royal College of General Practitioners released a discussion paper warning that family doctors were experiencing 'fatigue' due to a 'persistent and excessive workload'.[13]

Women no longer occupy a peripheral role in the profession, making up more than 45 per cent of the Medical Register.[14] Nevertheless, gender imbalance persists at senior levels and female practitioners continue to face prejudice, particularly from those who consider a medical career to be incompatible with motherhood. In 2014, the *Daily Mail*

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[12] See, for example, Tessa Glyn, 'Finding a job in Australia as a junior doctor', *BMJ Careers* (24 June 2014) <http://careers.bmj.com/careers/advice/Finding_a_job_in_Australia_as_a_junior_doctor> [accessed 13 March 2017]. Margaret Million Samin, Thofique Adamjee, and Jason Cheng, 'Finding a job in Singapore as a junior doctor', *BMJ Careers* (7 April 2015) <http://careers.bmj.com/careers/advice/Finding_a_job_in_Singapore_as_a_junior_doctor> [accessed 13 March 2017].

[13] Royal College of General Practitioners, *Patient Safety Implications of General Practice Workload* (July 2015), p. 2 <http://www.rcgp.org.uk/policy/rcgp-policy-areas/fatigue-in-general-practice.aspx> [accessed 13 March 2017].

[14] General Medical Council, 'List of Registered Medical Practitioners - Statistics' (updated 12 July 2017) <http://www.gmc-uk.org/doctors/register/search_stats.asp> [accessed 10 September 2017].

featured an article by consultant surgeon J. Meirion Thomas which claimed that the prevalence of women doctors was 'hurting the NHS'. He argued that women's tendency to work part-time, and to choose general practice over specialties, posed problems for healthcare delivery.[15] He implied that their work patterns were influenced by their family lives. Unsurprisingly, the article elicited a backlash from many practitioners and professional bodies such as the Royal College of Surgeons of England (under the direction of its first female President). The increased representation of minority groups has begun to reshape professional identities. There is also much greater ethnic and racial diversity; for instance, almost a quarter of registered practitioners are from Asian and Asian British backgrounds.[16] Changes in the demographic profile of the profession are challenging the default image of the medical practitioner as a white male.

Textual practices remain crucial to the construction of professional identities. In 2013, the General Medical Council revised its guidance on *Good Medical Practice.* It was reviewed in consultation with a range of stakeholders, including doctors and healthcare professionals, regulatory bodies, Royal Colleges, and patient groups.[17] The discussions were structured around a fundamental question: 'What Makes a Good Doctor?'. Responding to this, Sir Peter Rubin (Chair of the GMC) suggested that, '[t]hrough all the changes driven by research and public expectations, some of the art and science of medicine has endured down the ages and defines medicine as a profession'.[18] His comment implies that fundamental aspects of medicine's identity – that dialectic between 'art' and

[15]J. Meirion Thomas, 'Why Having So Many Women Doctors is Hurting the NHS', *Daily Mail* (2 January 2014) <http://www.dailymail.co.uk/debate/article-2532461/Why-having-women-doctors-hurting-NHS-A-provovcative-powerful-argument-leading-surgeon.html> [accessed 3 March 2017].
[16] General Medical Council, 'List of Registered Medical Practitioners'.
[17]General Medical Council, *The Development of Good Medical Practice 2013* (22 April 2013) <http://www.gmc-uk.org/FINAL_Development_of_GMP_22_April_2013_updated.pdf_51825302.pdf> [accessed 15 November 2016].
[18]General Medical Council, 'What Makes a Good Doctor?' <http://www.gmc-uk.org/guidance/10058.asp> [accessed 15 November 2016].

'science' – have endured despite broad clinical and cultural changes. From the nineteenth to twenty-first centuries, the 'art' of medicine has been variously used to denote its status as an interpretive activity or the way in which it engages the emotions and the imagination. The GMC's exercise exemplifies how textual forms, both print and digital, mediate definitions of the 'good doctor'.

The explosion of print culture in the Victorian period has been paralleled by the rise of digital culture in recent decades and the Internet has augmented the democratising tendency of nineteenth-century textual practices. New formats for exchanging ideas have emerged, including blogs, forums, and social media. While there were occasional instances of lay voices in medical journals previously, the Internet has facilitated patient empowerment and the profession has sought new opportunities for collaboration. In 2014, the *BMJ* launched a 'patient partnership' strategy, which it characterised as an 'ethical imperative'. The journal co-produces content with patients and has committed to advancing debates on embedding patient partnership in all aspects of medicine, from service delivery to education.[19] New media have altered the grounds on which conversations between the public and the profession take place.

I have argued that, between the 1830s and 1910s, the medical profession engaged closely with popular writing and there was a keen awareness of how textual practices and cultural forms mediated professional identities. The relationship between medical journals and fiction has its present-day parallels. As in the Victorian period, the *Lancet* continues to run features on literature about medical subjects or by medical authors.[20] In 2014, it

[19] British Medical Journal, 'Partnering with Patients' <http://www.bmj.com/campaign/patient-partnership> [accessed 12 March 2017].
[20] See, for example, Sandra Hempel, 'The Art of Medicine: Doctors in Fiction: The Medical Profession through Author's Eyes', *Lancet,* 20 August 2016, pp. 753-4.

Tweeted 'Was there a novel that inspired you to become a doctor?'.[21] The question was designed to stimulate debate – the journal coined the hashtag #MedicalReads to unify the conversation – and it elicited responses from followers who identified as medical practitioners. They cited a range of characters, books, and authors that had inspired them, including Dr Watson in Conan Doyle's Sherlock Holmes series, Maugham's *Of Human Bondage*, and George Eliot's *Middlemarch* (as well as more recent texts).[22] The debate centred on how literature shaped one's professional identity.

This thesis has opened up new perspectives on the relationship between literature and medicine. The rise of the medical humanities has sparked some scepticism in public discourse, with some questioning the value of literary scholarship to medical education and practice.[23] While resistance has eroded in recent years, it remains crucial to show how medical professionals have long engaged with different forms of writing. Between the 1830s and 1910s, they recognised that textual practices had the power to form and transform the meanings attached to medical practice in both the professional and popular imagination. Their writing enabled them to construct identities, build networks, and air grievances and concerns. While in the Victorian period the medical profession availed itself of the opportunities facilitated by the rise of print culture, in the digital age many practitioners utilise opportunities enabled by the Internet. Across these different historical and cultural contexts, textual practices have remained central to negotiating what it means to be a medical practitioner.

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[21] The Lancet, 'Was there a novel that inspired you to become a doctor? #MedicalReads' [Twitter post] (@TheLancet, 6 April 2014).

[22] Jason K. Lee, '@TheLancet Dr Watson in Sherlock, by sir Arthur Conan Doyle' [Twitter post] (@lee_jasonk, 6 April 2014). Jane Currie, '@TheLancet Of human bondage by Somerset Maugham. I think it put the idea in my head when I was floundering in the wrong degree' [Twitter post] (@janecurrie, 6 April 2014). Rachel Napper, '@TheLancet Middle March by George Elliot' [sic] [Twitter post] (@rachel_napper, 6 April 2014).

[23] Belinda Jack, 'The Rise of the Medical Humanities', *Times Higher Education* (22 January 2015) <https://www.timeshighereducation.com/features/the-rise-of-the-medical-humanities/2018007.article> [accessed 17 November 2016].

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