



All Theses and Dissertations

2009-07-07

Literary Case Histories and Medical Narratives in Nineteenth-Century Britain

Travis Wade Austin

Brigham Young University - Provo

Follow this and additional works at: <https://scholarsarchive.byu.edu/etd>



Part of the [English Language and Literature Commons](#)

BYU ScholarsArchive Citation

Austin, Travis Wade, "Literary Case Histories and Medical Narratives in Nineteenth-Century Britain" (2009). *All Theses and Dissertations*. 1797.

<https://scholarsarchive.byu.edu/etd/1797>

This Thesis is brought to you for free and open access by BYU ScholarsArchive. It has been accepted for inclusion in All Theses and Dissertations by an authorized administrator of BYU ScholarsArchive. For more information, please contact scholarsarchive@byu.edu, ellen_amatangelo@byu.edu.

LITERARY CASE STUDIES AND MEDICAL NARRATIVES
IN NINETEENTH-CENTURY BRITAIN

by

Travis Wade Austin

A thesis submitted to the faculty of

Brigham Young University

in partial fulfillment of the requirements for the degree of

Master of Arts

Department of English

Brigham Young University

July 2009

BRIGHAM YOUNG UNIVERSITY

GRADUATE COMMITTEE APPROVAL

of a thesis submitted by

Travis Wade Austin

This thesis has been read by each member of the following graduate committee and by majority vote has been found to be satisfactory.

Date

Nicholas A. Mason, Chair

Date

Matthew F. Wickman, Reader

Date

Frank Q. Christianson, Reader

Date

Daniel Muhlestein, Graduate Advisor

Date

Nicholas A. Mason, Associate Chair for
Graduate Studies

BRIGHAM YOUNG UNIVERSITY

As chair of the candidate's graduate committee, I have read the thesis of Travis Wade Austin in its final form and have found that (1) its format, citations, and bibliographical style are consistent and acceptable and fulfill university and department style requirements; (2) its illustrative materials including figures, tables, and charts are in place; and (3) the final manuscript is satisfactory to the graduate committee and is ready for submission to the university library.

Date

Nicholas Mason
Chair, Graduate Committee

Accepted for the Department

Date

Philip A. Snyder
Graduate Coordinator

Accepted for the College

Date

Joseph D. Parry
Associate Dean, College of Humanities

ABSTRACT

LITERARY CASE STUDIES AND MEDICAL NARRATIVES IN NINETEENTH-CENTURY BRITAIN

Travis Wade Austin

Department of English

Master of Arts

Literature and medicine are not usually seen as related disciplines, but scholars have already begun producing fruitful scholarship regarding historical and aesthetic interactions between them. This thesis adds to that scholarship by examining medicine and literature in nineteenth-century Britain. More specifically, Thomas De Quincey's *Confessions of an English Opium-Eater* and Robert Louis Stevenson's *Strange Case of Dr. Jekyll and Mr. Hyde* both use nineteenth-century medical case conventions to tell their stories. Furthermore, because both works deal with addiction, divided selves, and the power that physical substances can have on morality and character, these two works provide an excellent comparison coming 65 years apart. As such, they are a great point from which to begin looking more closely at how the interactions between medicine and literature evolved during the nineteenth-century in Britain.

This thesis examines the role that “scientific” discourse has played in medicine

and literature as interpretive disciplines, the rhetorical techniques and innovations surrounding the intersection of the two disciplines, and the authority that each discipline derived by implicitly borrowing ideological assumptions and textual forms from the other. *Confessions* is a wonderful example of a Romantic, autobiographical text that clearly uses the medical case study conventions; in fact, De Quincey was often cited in the years following the publication of *Confessions* as an authority on opium and its uses. By the time *Jekyll and Hyde* was published, however, a work like *Confessions* could no longer hold its own in medical debates. The professional institutions of medicine and literature had changed too much. Hence, by analyzing these two works side-by-side, I intend to illustrate different narrative approaches to similar issues at the beginning and end of the century. More importantly, I hope to use these texts in conjunction with specific medical case histories to discuss each text's reliance on interdisciplinary authority.

ACKNOWLEDGEMENTS

Writing this thesis has truly been a learning process. My sincere thanks go to the professors and faculty at Brigham Young University that worked with me and encouraged me throughout. Nicholas Mason, Frank Christianson, Matt Wickman, and Michael MacKay offered crucial guidance and feedback to make me a better writer and scholar. As my thesis chair, Dr. Mason always provided candid, useful feedback in a timely manner. If the timestamp on his emails is any indication, he often worked into the late evening giving me feedback, for which I am certainly grateful.

A big thanks also goes to my wife and to my 4-month old daughter, Rachel, who was born in the middle of this hectic process. Far from being detrimental, however, her arrival was just in time. Her smiles, sent via picture or video message by my wife, have kept me going during many long nights. Of course, the support and sacrifice of my wife, Camille, has been essential.

My late father taught me the importance of hard work, and, when he passed away unexpectedly, my mother pushed her own concerns aside and sent me back to college within the week. Both have always encouraged me in my education, and I dedicate the work I have done on this thesis to both of them.

TABLE OF CONTENTS

Introduction: Medical Science, Medical Art.....	1
Professionalization.....	3
The Theatre and the Granary in Developing Medical Science.....	6
Recent Criticism	12
Chapter 1: Pathologized Selves: De Quincey, the Opium-Eater, and Medicalized Narrative	17
De Quincey and Medical Authority.....	20
<i>Confessions</i> as a Pathological Case	23
De Quincey and the Opium-Eater.....	29
De Quincey's Divided Self.....	33
Curious Literature, Neural Romanticism.....	38
Chapter 2: Medicalized Morality: The Strange Cases of Dr. Jekyll, Mr. Hyde, and Phineas Gage.....	41
Standardized Nineteenth-Century Medical Cases and the Strange Case of Phineas Gage	44
Stevenson's Strange Case	50
Conclusion	63
Works Cited	66

INTRODUCTION: MEDICAL SCIENCE, MEDICAL ART

“Medicine is not a science.” So claimed Kathryn Montgomery Hunter after two years of studying physicians on a grant funded by the National Science Foundation. “Instead,” she maintained, “it is a rational, science-using . . . interpretive activity. . . . As an interpretive activity turned towards an endless succession of individuals, it takes the patient as its text and seeks to understand his or her malady in the light of current biological, epidemiological, and psychological knowledge” (25). While Hunter’s claim may not be completely new to the humanities, it is a claim that many of today’s medical practitioners would flatly deny. Furthermore, popular culture often perceives medicine itself (not necessarily its practitioners) as purely scientific, objective, and rational. This perception defines medicine as a search, through some perceived infallible means, for the one “right” answer to a socially defined problem of disease. But this perception is flawed.

Medical professionalization is generally agreed to have occurred, in Britain at least, during the nineteenth century, at the same time that many other disciplines were becoming professionalized. Physicians, scientists, lawyers, economists, and literary authors and critics were becoming known as professionals instead of aristocrats with extra time on their hands. In literature, for example, critics like Matthew Arnold were able to develop careers known more for their criticism than their poetry, meaning that there was significant debate about the principles of the profession itself. As part of this professionalization process, medical and literary practitioners both became more committed to a consolidated set of ideals and practices. These ideals overtly separated medicine from literature, but, as I will show in this thesis, both disciplines relied on each other in surprising ways. This interdisciplinary reliance, as well as the interpretive nature

of both disciplines and their overlapping contributions to social discourse and redefining the self, helps make them particularly appropriate for comparative studies. For example, Janis Caldwell's *Literature and Medicine in Nineteenth-Century Britain*, Alan Richardson's *British Romanticism and the Science of the Mind*, and Lawrence Rothfield's *Vital Signs* all deal extensively with the interaction between medicine and literature.

Of course, the scope of this thesis cannot detail the rise of science, medicine, or literature, nor do I intend to comprehensively critique modern or historical medicine. Instead, I intend to discuss the role that "scientific" discourse has had in medicine and literature as interpretive disciplines, the rhetorical techniques and innovations surrounding the intersection of the two disciplines, and the authority that each discipline derived by implicitly borrowing ideological assumptions and textual forms from the other. Specifically, I will examine two works of nineteenth-century literature: Thomas De Quincey's *Confessions of an English Opium-Eater* (1821) and Robert Louis Stevenson's *Strange Case of Dr. Jekyll and Mr. Hyde* (1886). These two works are uniquely well-suited to delineating the boundaries of literature and medicine, and they are also distinctly complementary to each other. *Confessions* is a wonderful example of a Romantic, autobiographical text that clearly uses the conventions of medical case studies. In fact, De Quincey was often cited in the years following the publication of *Confessions* as an authority on opium and its uses. As such, it is a great point from which to begin looking more closely at the interaction between the disciplines. By the time *Jekyll and Hyde* was published, however, a work like *Confessions* could no longer hold its own in medical debates. Medicine and literature had changed too much. Because, however, both works deal with addiction, divided selves, and the power that physical substances can have on

morality and character, these two works provide an excellent comparison coming 65 years apart. Hence, by analyzing these two works side-by-side, I intend to illustrate different narrative approaches to similar issues at the beginning and end of the century. More importantly, I hope to use these texts in conjunction with specific medical case histories to discuss each text's reliance on interdisciplinary authority.

Professionalization

As a method of professionalization, physicians and surgeons relied on the language and rhetoric of science to consolidate their ideals and focus their practices. In medicine, those ideals were dressed in the language and rhetoric of science. As Kathryn Montgomery Hunter has pointed out, however, defining medicine purely as a “science” undermines the “art” of medicine: the interpretive activity inherent within each doctor-patient interaction that results in a differential diagnosis. The scientific definition limits this interpretive activity of diagnosis to a rigid classification system: one which fails to account for the human aspects of diagnosis and treatment. Stanley Tambiah describes this problem of the pervasive “diffusion” or “spill-over” of the hard sciences into other domains by arguing that “This process of alleged scientific reasoning—alleged scientific moral reasoning and social optimization—is reluctant, even opposed, to admitting other modes of consciousness or other world orientations into any space it already occupies, for it imperialistically expands to fill all the space available” (151). Science, then, has “imperialistically expanded” to social science, political science, economics, politics, medicine, and more. But science is only one method of many for acquiring “truth” or making decisions. Scientific inquiry, like other forms of inquiry, is subject to political, institutional, individual, and cultural biases. Oftentimes, however, these biases are

ignored because of the ideology of perceived objectivity surrounding science. This objective ideal and the assumption that this ideal will help science relieve suffering, prolong happiness, and advance humanity gives scientific inquiry the authority, for example, to perform drug tests on people without knowing what side effects the drugs may have. Since the Enlightenment, science has come to rely on this objectivity as an a priori authority.

While science has expanded, literary studies have begun using other disciplines as points of entry for understanding literature. History, linguistics, philosophy, political economy, psychology, and anthropology, for example, have all played a role in shaping our understanding of literature and our readings of particular texts. Over the years, many of these debates have revolved around the question of whether or not “Literature” even exists as an essential category, and, if so, what texts should be classified as literary. Inherent within this debate is the question of whether or not a systematically applicable standard exists that gives credibility and authority to any particular set of texts. In the second half of the nineteenth century, for example, Matthew Arnold focused on “high truth” and “high seriousness” as standards of literary judgment while emphasizing the idea that, by comparing new texts with texts by authors like Shakespeare and Milton, critics would be able to understand the relative value of the new text. Arnold, then, was part of a nineteenth-century movement that worked to place literature outside of other realms of inquiry.

Literature and case studies from the nineteenth-century provide an excellent context for studying disciplinary ethos in literature and medicine because of the extent of disciplinary atomization throughout the century. Professionals in both medicine and

literature sought to separate themselves from “quacks” and “hacks” while consolidating their disciplines around a defined set of principles. Close readings of literary texts and case histories can shed light on those principles and on the nature of the ideological assumptions inherent within the application of those principles. As Margaret Kennedy noted in her study of medical case histories and literature:

During the nineteenth century, the old system of “professions” gave way to a bourgeois “professionalism” conferred both on persons and their practices. The category of the “professional” became more broadly dispersed over a range of white-collar occupations, including (besides scientific research) traditionally less-valued work like teaching and banking as well as, eventually, new incarnations of the professional, like the civil servant. Scientists in general, and physicians in particular, largely benefited from this expansion of the category of the “professional” and worked to establish their place within it, in part by inserting markers of professional standing in their texts. (11)

Throughout this professionalization period, physicians and surgeons turned increasingly to the rhetoric of science to find these validating “markers of professional standing.” At the time, these markers would variously paint medicine as objective, sympathetic, unbiased, political, applicable, and theoretical; the chameleon rhetoric of nineteenth-century science had a variety of functions, and I will assume, for the purposes of this thesis, that science in its institutional forms is a social construct rather than an existing “truth” to be discovered or an unbiased methodology of discovering nature or “reality.” In the eighteenth and nineteenth centuries, then, two aspects of the developing construct

of professionalized medical science were what Rick Rylance has called the “granary” and the “theatre.” In other words, medical publications of case histories were meant to be a part of a massive accumulation of data to be drawn upon when necessary (the granary), but these same case histories tended toward sensational narratives of the freakish, monstrous, or grotesque (the theatre). Rylance’s metaphor illustrates an important relation between literary narrative and scientific medical studies: the inevitable theatricality of medical case narratives had the potential to undermine scientific objectivity by reducing cases to entertainment. However, the temptation to tell a good story was often too difficult for case writers to resist.

The Theatre and the Granary in Developing Medical Science

Two case histories from the *Philosophical Transactions* of the Royal Society illustrate how the granary has performative or sensational potential. More specifically, these case histories are examples that show the professionalization process within medicine and the developing nature of “science” as manifest in a late eighteenth-century scholarly publication. *Philosophical Transactions* was the journal for the most influential group of scientists in Britain, and it was important for surgeons and physicians to be well-represented among this group. My first case can be found interwoven directly between “An Account of the Kingdom of Thibet. In a Letter from John Stewart, Esquire, F.R.S. to Sir John Pringle, Bart. P. R. S.” and “The General Mathematical Laws Which Regulate and Extend Proportion Universally; Or, a Method of Comparing Magnitudes of Any Kind Together, in All the Possible Degrees of Increase and Decrease. By James Glenie, A.M. and Lieutenant in the Royal Regiment of Artillery.” These titles give somewhat of an indication of the variety of “scientific” topics on which the fellows of the Royal Society

were publishing. Unlike the specialized academic journals of today, *Philosophical Transactions* is, in many ways, a search for anything “scientific.” Physicians and surgeons in the late eighteenth century (especially surgeons, who had only recently broken from the more trade-oriented barber-surgeons in 1745 to form the Company of Surgeons) were already making a concerted effort to remake their disciplines more explicitly in this scientific image.

The first case is a 1777 instance of a young woman, Ann Davenport, who had apparently lost the use of her limbs to some degree because of pain associated with swelling on one side of her abdomen. Dr. Fynney, the authoring surgeon, begins with some offhand observations that Ann is “a native of this town,” a “truly miserable object,” and “the most cadaverous countenance I had ever seen” (459), embellishments that seem to go hand-in-hand with Rylance’s “theatre” metaphor for medical observation. He then goes into a detailed narrative of his daily interactions with the patient, his measurements, treatments, and observations, and her eventual recovery. One of the most interesting aspects of this publication is that it ends with a certification from a local minister that the minister personally observed Fynney dress his patient’s wound “and was an eye-witness to pure foeces coming out of the wound from which he had extracted an irregular substance on the 21st of September last” (464). The minister’s short letter appears in *Philosophical Transactions* as part of the medical report. Fynney apparently felt that a new scientific logic would value the credibility of a second witness, which led him to bring the minister to Ann Davenport’s bedside while the wound was still discharging “foeces.” The minister came, during her treatment, for the sole purpose of providing a witness to Fynney’s account. It is not a stretch, therefore, to say that Fynney was

concerned all along with the emerging disciplinary standards codified in the publication process. This was a critical period for surgeons' professionalization, and Fynney was simply doing his best to make sure that his case history was well accepted in the scientific community. Fynney's publication demonstrates the increasing pressure placed on "learned surgeons" to adhere to the image of objectivity promoted by *Philosophical Transactions* as part of their professionalization.

Another case, from 1784, conveys how scientific case histories were also a collection-place for stories and details that physicians did not necessarily know how to apply: Rylance's "granary." Medical practitioners began to get the idea that the best way to advance medicine would be to develop a more objective approach and to record as many details as possible. The maxim laid out three decades later, in 1812, by French mathematician Pierre-Simon Laplace, was certainly a growing ideal in 1784. Laplace describes the omniscient scientific ideal as "an intelligence which could comprehend all the forces by which nature is animated and the respective situation of the beings who compose it . . . for [science], nothing would be uncertain and the future, as the past, would be present to its eyes" (qtd. in Taylor 1). Laplace describes the all-seeing, omniscient eye that many scientific hopefuls wanted science to become. Medicine also hoped to be a part of this movement, and one path to omniscience was fact preservation. As Thomas Beddoes wrote in 1808:

To lose a single fact may be to lose many lives. Yet ten thousand [facts] are lost for one that is preserved; and all for want of a system among our theatres of disease, combined with the establishment of a national bank of medical wealth, where each individual practitioner may deposit his gains

of knowledge, and draw out, in return, the stock, accumulated by all his brethren. (qtd. in Rylance 260)

This collection-of-facts approach to science was not new when Thomas Beddoes penned it in 1808. The 1784 case mentioned above, “An Extraordinary Case of a Dropsy of the Ovarium, with Some Remarks,” clearly abides by this same precept. The case, written by Mr. Philip Martineau, a surgeon, details a woman who had suffered for 25 years from incurable swelling. She would continually swell in her abdomen, receive a surgical draining operation, and then swell again. The case history gives numerous details about her treatment, death, post-mortem examination, and the further examination of her preserved ovarium by the acclaimed John Hunter and other surgeons.

One of Mr. Martineau’s most obvious rhetorical techniques is to bombard the reader with a load of information for which he can provide little interpretation: facts without clear narrative structure. For example, he provides the detail that “the operation of drawing off the water was generally performed on a Sunday, as the most convenient day for her neighbors to assist her” (472). The detail that operations were generally performed on a Sunday might seem medically irrelevant since the results would have been the same any other day of the week, but Martineau provided many such details that do not add significantly to the narrative and for which he offers no medical interpretation. Martineau also summarizes, using a table to organize his facts, 14 years worth of draining operations. He provides the date of each operation and the number of pints of fluid extracted. While this may not seem like an extraordinary detail from the late eighteenth-century *Philosophical Transactions*, it is another clear example of record keeping, observation, and treatment that reflects the codes normalized by *Philosophical*

Transactions. Moreover, later details about the dissection and post-mortem examination further show how Martineau's case is a "granary" of details that do not reflect a narrative design or contribute to an interpretive end. Martineau notes blocked passageways, thick membranes, and normal vessels, but he interlaces this information with other details and procedural accounts for which he does not give his reasoning or interpretation. It is as though a mere compilation data and observation notes is the basic necessity of a worthwhile case history. The case does end with two conclusions: the woman must have been absorbing water from her surroundings for the last 25 years, and we should be happy that even though there is no cure for such a disease at this time, at least the patient can live with it for a while and have some "intervals of great ease and comfort" (476). But the exorbitant amount of detail preceding these two conclusions indicates that Martineau, while writing for *Philosophical Transactions*, valued detail for its own sake.

Of course, the most obvious objection to the above interpretation is that Martineau and other surgeons who did not explicitly state their reasoning or interpretations were merely following procedures and rhetorical codes that would have been so recognizable to fellows of the society that they did not really need to be explained in the narrative. While this may be true for some aspects of the case history, it is unlikely to be true for all. For example, Martineau's menial observations that "Her appearance was truly deplorable, not to say shocking" (471), "with all she was tolerably cheerful" (471-2), and "The operation of drawing off the water was generally performed on a Sunday" (472) provide few medical facts. And while noting her "shocking" appearance and tolerable cheerfulness may make the patient's suffering and physician's intervention more heroic, that semblance of narrative structure is lost in the rest of the

case. Furthermore, Fynney's observations that his patient is "a native of this town" and a "truly miserable object" similarly add to a confusing sense of uninterpreted facts mixed with narrative tendencies, while his embellished phrase "the most cadaverous countenance I had ever seen" (459) is a clear example of unempirical embellishment.

While these comments can be seen as gestures towards the humanity of the individuals or as the emotional reactions of the observer, their publication also suggests that the writers and the readers from the Royal Society were really working simply to compile a large amount of data with the hope that something would turn out to be helpful. This archival approach to "science" shows physicians and surgeons establishing medicine as a scientific discipline through Rylance's "theatre and granary": collecting facts with little interpretation while inevitably turning towards narrative structural approaches.

This was not completely new to the late eighteenth century, and it did not stop there. In fact, the cases mentioned above are relatively commonplace examples used to illustrate my point: medicine was vying for the scientific authority that some perceived to be a powerful means to better treatment. Modern medical historians talk about the nineteenth century as one of the great centuries for change in medicine, mainly because of the surgical advances of anesthesia and antisepsis. Medical paradigms also shifted in this century, as exhibited by the advent of clinical medicine, the invention of the stethoscope, laboratory experimentation, and epidemiological discoveries which led to modifications in sanitation and hygiene. For hundreds of years, medicine had been relatively ineffective by today's standards, and some medical practitioners were becoming more aware of their therapeutic limitations. Science, then, with its promised omniscient eye, was a fitting vehicle for this shifting paradigm.

It was not until the Victorian era, however, that medicine really began to professionally detach itself more fully from the arts. Medical case histories trace this shift rather clearly, from the relatively inconsistent narratives like those quoted above to the terse, systemized descriptions of patient symptoms and signs in later periods.

Recent Criticism

Recent literary scholars have also examined this shift in the historical genre of the medical case study. A number of literary analyses, including Margaret Ann Kennedy's dissertation, *A Curious Literature: Reading the Medical Case History from the Royal Society to Freud*, and Jason Tougaw's *Strange Cases: The Medical Case History and the British Novel*, describe the often-overlooked conjunction of medicine and literature during the Romantic and Victorian periods. One of the best descriptions, however, comes from the introduction of Janis Caldwell's *Literature and Medicine in Nineteenth-Century Britain*, which elaborates on a concept Caldwell calls "'Romantic materialism': Romantic because . . . it was concerned with consciousness and self-expression, and materialist because . . . it placed a particularly high value on what natural philosophy was telling . . . about the material world" (1). Caldwell's point is that during the Romantic period, practitioners in medicine and literature were ideologically grounded in Bacon's "metaphor of God's 'two books'" (7), in which the power of God was understood to be revealed both through the book of scripture and the book of nature. Science in Britain, though developing, was not yet as antithetical to literature as later generations would describe it. And if medicine and literature were not at odds during this period to the extent that has been described in the past, then critical analysis should be able to detect, in literature, this cross-genre borrowing.

This is exactly what recent scholarship has been doing. The three books mentioned above, along with Alan Richardson's *British Romanticism and the Science of the Mind*, Neil Vickers' *Coleridge and the Doctors 1795-1806*, and others, all detect cross-pollination within literature and medicine, the visible fruit of which ripened during the Romantic period and soured by the end of the century. Many of these studies take Lawrence Rothfield's 1991 *Vital Signs* as a key text, as Rothfield explores the advent of French and British realist literature and identifies it with the rise of clinical medicine as described by Michel Foucault. This avenue of scholarship takes seriously Foucault's *The Birth of the Clinic*, in which he describes the development of clinical, objective, hands-on medicine in early nineteenth-century post-revolutionary French hospitals. Indeed, Foucault's is a seminal text both in the growing field of literature and medicine and in the field of medical history. While medical historians usually agree that Foucault lacks a certain historical rigor, there is great disagreement about the value of his methodology. Foucault's concern, however, is not so much about the history of medicine as it is about discourse and the development of structures of power within discourse. The development of clinical medicine, with its shift to objectivity over subjectivity, observable signs over describable symptoms, and the physician's "gaze" over the patient's "gaze," provides a perfect opportunity for Foucault to describe the changing nature of discourse. As the nature of discourse changed,

the question: "What is the matter with you?," with which the eighteenth-century dialogue between doctor and patient began (a dialogue possessing its own grammar and style), was replaced by that other question: "Where does it hurt?," in which we recognize the operation of the clinic and the

principle of its entire discourse. [. . .] The clinic—constantly praised for its empiricism, the modesty of its attention, and the care with which it silently lets things surface to the observing gaze without disturbing them with discourse—owes its real importance to the fact that it is a reorganization in depth, not only of medical discourse, but of the very possibility of a discourse about disease. (xviii – xix)

Foucault is using the rise of clinical medicine as an example of the way that discourse operates and changes with society's power structures. In other words, clinical science came into existence because of its own a priori set of conditions that not only made that existence possible, but also shaped the domain and structure of that existence (xv).

Foucault's book is a search for a narrative to define those a priori conditions by analyzing that discourse in conjunction with historical events.

My thesis continues along this vein of medico-literary scholarship that Rothfield, Caldwell, and others have been exploring. As mentioned above, there are several previous studies that use medical discourse to shed new light on literature. One study in particular, Margaret Kennedy's, also aims to show literature's influence on medicine. Some of these studies are concerned with medical case histories, while others focus on treatises, textbooks, notes, and hospital or other medical records. Instead of focusing on these medical records, however, the scope of my medical context will be mainly limited to medical case histories. The two works I am studying, *Confessions of an English Opium-Eater* and *Strange Case of Dr. Jekyll and Mr. Hyde*, have been underrepresented so far in this scholarly tradition. My thesis continues and extends this tradition by placing new works within a medical context, but it also deviates from this tradition by focusing

on interdisciplinary authority in scientific and literary discourse. By so doing, I hope to shed light on and add new focus to the nature of the conditions that shape that discourse.

My first chapter will focus on reading De Quincey's *Confessions of an English Opium-Eater* as a medical case history. I will discuss how De Quincey's text can be read as a medical case history, including information on how De Quincey gains medical authority through his use of form. Barry Milligan has recently shown how *Confessions* was originally received by the medical establishment as a credible scientific document. My argument is that the medical authority credited to De Quincey is not just accidental; *Confessions* is part of a Romantic tradition where the boundaries between medicine and literature were not as clearly defined as they would be in the Victorian period. De Quincey's use of medical case report conventions created a work that was able to function both as literature and medical case history. This dual, interdisciplinary functionality reinforces the recent critical work on the relationship between medical case reports and literary texts.

Relying on an analysis of Derrida's "Before the Law," my second chapter will show how authority was derived from beyond the literary boundaries of *Jekyll and Hyde*. This chapter will also include information on medical case studies to show that the borrowing of authority was, in fact, bilateral. While most of my case study examples will come from British medical sources, I will take an in-depth look in this chapter at one particular American case study, that of Phineas Gage, a worker who had a railroad spike driven through his head. This case study was cited extensively in British medical sources, and it deals with some of the same issues as *Jekyll and Hyde*: mind/brain interaction, the physicality of the human will, and the dual natures of mankind. Phineas Gage, therefore,

shows how literature and medicine dealt with similar social or cultural anxieties. As the boundaries separating literary and medical discourse became more established and outwardly oppositional, the rhetoric, form, and ideology of the other were forced to move underground. Thus, my exploration of *The Strange Case of Dr. Jekyll and Mr. Hyde* will look at how this occurs. By examining the unspoken medical assumptions of *Jekyll and Hyde*, the filtered narrative lens of the story, and the underlying physical fears behind the moral allegory, this chapter will build upon my earlier analysis of *Confessions of an English Opium-Eater* to show how similar aesthetic strategies remain even if they are less overt.

CHAPTER 1: PATHOLOGIZED SELVES: DE QUINCEY, THE OPIUM-EATER, AND MEDICALIZED NARRATIVE

De Quincey dabbles in emerging medical discourse throughout his 1821 *Confessions of an English Opium-Eater*. The evidence for his assertion that the “whole class of opium-eaters” is “a very numerous class indeed,” for example, anticipates and resembles the science of epidemiology, a practice not widespread until Dr. John Snow’s work with cholera in 1854. De Quincey makes his “natural inference” about the population of opium-eaters after “computing . . . the number of [opium-eaters] in one small class of English society” and reasoning that a “proportionable number” of people must consume opium. He is not satisfied, however, with his own crude statistics until he receives assurances from “Three respectable London druggists, in widely remote quarters of London” and “several cotton-manufacturers” in Manchester that “amateur opium-eaters” are abundant, especially when wages are low and they cannot “indulge in ale or spirits” (3). As epidemiology it is rudimentary to be sure, but even the attempt to catalogue the number of opium-eaters through calculation and basic research so early in his narrative signals an unusual willingness to directly engage with scientific reasoning and medical discourse.

But this is only the beginning; ultimately, De Quincey’s engagement with medical discourse goes so far that *Confessions* can actually be read *as* a medical case study. This is not to claim that *Confessions* can only be read as a medical case, but De Quincey’s aesthetics do borrow substantially from the developing genre of the nineteenth-century case study. This medical aura helped make *Confessions* successful as an autobiography and added to a literary tradition that would later include works like *Strange Case of Dr.*

Jekyll and Mr. Hyde, *The Picture of Dorian Gray*, and the Sherlock Holmes stories.

Barry Milligan has recently shown how *Confessions* was actually received by the medical establishment as a credible scientific document until after the 1856 revision. The medical authority credited to De Quincey is not just accidental; *Confessions* is part of a Romantic tradition wherein the boundaries between medicine and literature were not as defined as they became during the Victorian period. And De Quincey used medical case conventions to create a work that had the authority to function both as literature and medical case history.

Even the original published form of *Confessions* reflects this dual medico-literary functionality. *Confessions*, like many case reports and a good deal of Romantic literature, was published first in a popular periodical, the *London Magazine*. Since periodical publication implies that knowledge is transitory and evolving, it was an important venue for professionalizing physicians during the early nineteenth century. Periodicals allowed physicians to stay current with developing trends in medicine as medical information became more abundant. Mark Parker's *Literary Magazines and British Romanticism* argues that literary magazines were "the preeminent literary form of the 1820's and 1830's in Britain" (1). He also argues that magazines provided a way for the aspiring gentility and professionalizing classes to develop the language of the middle class: "the division of intellectual labor [. . . in periodicals] sets up its own internal dynamic among the competing languages of middle-class Britain – languages of aesthetics, of religious life, of economic life, or of the leisured gentleman" (15). In De Quincey's case, the languages of science and medicine can also be included.

Margaret Kennedy's argument that case reports were an essential part of the professionalizing movement for physicians is similar to that of Parker's argument about literary magazines developing the languages of the middle-class: "Just as the clinical case history came to value plain over romantic speech and the normative over the extraordinary case, clinical medicine worked hard to define norms of practice" (151). Thus, the objective values of scientific medicine were reflected in the language and aesthetics of published case histories. Historians William Bynum and Janice Wilson estimate that 479 specialist medical periodicals of some sort emerged in the nineteenth century in Britain (qtd. in Rylance 260). These periodicals reflected the growing professional aspirations of physicians as they began to standardize disciplinary ideals, but, early in 1821 when *Confessions* was published those ideals were not yet standardized. De Quincey's narrative was part of an early discourse community that had not yet drawn clear boundaries between medicine and literature in periodicals, and periodicals were one of the vehicles utilized both by doctors and literary figures as a means to profitability and respectability. Kennedy, who analyzes case histories from the eighteenth century to Freud, contends that

Because of the uniquely interdisciplinary demands upon the case history—it must produce both a fact and a story, represent both a disease and a person, display both the disinterested stance of the physician-as-scientist and the subjective response idealized in his position as a "caring physician" – this genre provisionally situates itself in both medicine and literature. But because these disciplines develop discrete, oppositional identities during the modern period, and because at the same time

medicine begins to develop its role as a “science” more than as an “art,” the case history troubles the boundary between them when it threatens to bring science and literature together in the text. (9)

Although Kennedy is talking more specifically about medical case histories than about literature, this analysis applies to *Confessions* because *Confessions* can be read as a medical case history in so many ways. The conflicts between science and art, medicine and literature, and spirituality and materialism inform De Quincey’s aesthetic, his narrative identity, and the type of self he portrays. The “curious literature” and the simultaneous fascination for and utility of bypassing traditional boundaries and invading the private self works as much in *Confessions* as in other medical case histories.

De Quincey and Medical Authority

After proving, to his apparent satisfaction, the endemic nature of English opium-eating, De Quincey then makes a claim for its addictive properties, which he simply calls “the fascinating powers of opium.” By doing so, he goes against the established norms of a medical profession that habitually prescribed opium as a sort of panacea. In a move that both recognizes and undermines medical authority on the subject of opium, De Quincey calls “medical writers” the “greatest enemies” of its fascinating powers, then goes on to cite a 1763 essay on opium, written by an apothecary, which acknowledges that “there are many properties in it, if universally known, that would habituate the use, and make it more in request with us than the Turks themselves” (4). While the origins of addiction as a medical concept are normally traced to Edward LeVinson’s 1877 text, *Die Morphiumsucht*, translated into English as *Morbid Craving for Morphia* (Zeiger 11), De Quincey’s text certainly brought attention to the difficulties of renouncing an opium habit

once begun. As Joel Black has argued, “the drug’s addictive nature had been known, but not *widely* or *compellingly* known (143, italics original). Black further elaborates: “opium was not widely thought of as an addictive substance, nor was addiction itself generally recognized as a disease. ‘Opium eating’ was regarded as a relatively harmless indulgence, one of those ‘devoted’ behaviours or acquired ‘tastes’” (145). *Confessions*, however, is widely regarded as playing a major role in the eventual recognition, by both the public and medical professionals, of the difficulties of abstaining from opium once the habit is established.

In maintaining this position, De Quincey was hinting that the established wisdom of medical professionals regarding opium was incomplete. But De Quincey does not stop at subtle hints. He later writes:

upon all that has been hitherto written on the subject of opium . . . by professors of medicine, writing *ex cathedra*,—I have but one emphatic criticism to pronounce—Lies! Lies! Lies! . . . [T]herefore, worthy doctors, as there seems to be room for further discoveries, stand aside, and allow me to come forward and lecture on this matter. (39-40)

As if that weren’t enough to make his point, De Quincey later includes a footnote about a “projected medical treatise on opium, which I will publish, provided the College of Surgeons will pay me for enlightening their benighted understandings upon this subject” (57). While some scholars have taken such quotes as evidence that De Quincey simply had a grudge against all things medical, they also indicate the extent to which De Quincey had entrenched himself in medical discourse. His diatribes against the institution of medicine, then, are more about internal discord within a system that De Quincey was

helping to develop. Barry Milligan has argued that De Quincey's self-described experiences with opium placed him in the radical camp of Brunonian medicine, which began with John Brown's *Elementa Medicinae in 1780* (a text which was later edited with an introduction by Thomas Beddoes in 1795) and challenged established medical authority. Brown's text proposed a simple medical system that derided established medicine. *Elementa Medicinae* based one's physical health on the need for equilibrium between "stimulus" and "excitability"; similar to De Quincey, Brown went against medical authority by using opium as a stimulant ("Brunonianism" 46, 51). Milligan's reading makes De Quincey a radical medical authority, thereby emphasizing his role as a marginal voice in a developing institution. Radical or not, *Confessions* changed medicine. Apparently, De Quincey's interventions in medical discourse were more than innocent speculations.

In fact, *Confessions* did play a role in shaping medical discourse. Julian North has provided evidence that physicians and surgeons used De Quincey's text as an authoritative source on medicinal opium treatments. North's review of De Quincey scholarship mentions that *Confessions* "found a place simultaneously within scientific and literary discourse" in the nineteenth century, but North does not go beyond the observation that this is an "oddity" (16). Milligan goes further, claiming that De Quincey "was a formidable rival to a medical profession whose efficacy and credibility were increasingly dependent upon opiate-based technologies" ("Morphine" 541), but Milligan's focus is on the reception of the 1856 revision and the developing controversy surrounding morphine-addicted doctors. He shows that De Quincey's work set the tone of the addiction debate throughout the nineteenth century because so many physicians took

his 1821 narrative as a point of reference. Milligan also argues that De Quincey's narrative could only gain its authority because there was no stigma associated with addiction in 1821. And while Susan Zeiger has shown that there was a literature of addiction associated with alcohol before *Confessions*, she also suggests that De Quincey's work was a groundbreaking medical treatise because it brought popular and medical attention to opium's addictive nature (Zeiger 5).

Yet despite the growing body of scholarship detailing De Quincey's medical influence, scholars have not yet dealt extensively with how De Quincey's aesthetic choices lend credibility to *Confessions* as a medical case study. Much of the rest of this chapter will be dedicated to a closer look at *Confessions* as an extended medical case report and my claim that scholars of the Romantic era would benefit from further investigation into the relationships between literary and medical forms.

Confessions as a Pathological Case

Confessions begins by invoking tropes and conventions that resemble pathological case studies. Pathological anatomy, as developed in post-revolutionary French clinics in the early nineteenth century, transformed medicine. Michel Foucault's *The Birth of the Clinic* describes this revolution as a shift from spatialized disease to localized disease. In other words, conceptions of disease shifted from a more holistic view, in which disease is simply an unbalanced part of the individual (as in the concept of the humours of disease), to a pathological view, in which disease is an entity of its own, often localized, for example, as a tumor in the brain or a lesion on the liver. This shift in medicine subjected the patient's internal and external anatomy to the "medical gaze": a supposedly objective view developed by physicians as they became more powerful in

patient-subject relationships because of the development of the clinics. The ideological shift to localized disease also made it possible to view disease as a living entity separate from the individual and, in fact, discovered only on a dead individual, or a corpse. It is with this in mind that Xavier Bichat, one of the first histologist/pathologists, said:

For twenty years, from morning to night, you have taken notes at patients' bedsides on affections of the heart, the lungs, and the gastric viscera, and all is confusion for you in the symptoms which, refusing to yield up their meaning, offer you a succession of incoherent phenomena. Open up a few corpses: you will dissipate at once the darkness that observation alone could not dissipate. (qtd. in Foucault 146)

The opening up of corpses was nothing new, but, according to Foucault, doing so in a clinical setting meant admitting the necessity of corpses for the advancement of medical knowledge. It would have been understandably difficult for practitioners to embrace the idea that they needed death in order to advance life, especially in an ideological climate that viewed disease as an imbalance of life rather than a separate entity. As Foucault explains, a historically-constructed "illusion" tells the story that digging up corpses was almost completely prohibited before the nineteenth century, but this narrative is merely a "retrospective justification: if the old beliefs had for so long such prohibitive power, it was because doctors had to feel, in the depths of their scientific appetite, the repressed need to open up corpses" (125-126). This "repressed need to open up corpses" was due to a conflict between the psychological or moral repugnance of dissection and the useful discoveries that corpses often yielded. However, medical cases justified corpse-dissection by its practical benefits; De Quincey, therefore, used similar medical case conventions to

justify his narrative. *Confessions* reveals De Quincey's self-conscious need to dissect his outer persona and display his inner workings. Instead of focusing solely on his organs and tissues, however, De Quincey focuses on his own psychology and morality as he narrates socially unacceptable answers to vital questions.

Thus, even from the beginning of *Confessions*, De Quincey is similarly repulsed by the grossness of openly exposing himself, but, like medical clinicians, he is also attracted by the discoveries that his exposed narrative body is bound to yield. In the opening paragraph of *Confessions*, De Quincey links personal character with corpses and objectifies moral or psychological weakness as a separate, diseased entity: "Nothing, indeed," says De Quincey, "is more revolting to English feelings, than the spectacle of a human being obtruding on our notice his moral ulcers or scars, and tearing away that 'decent drapery,' which time, or indulgence to human frailty, may have drawn over them" (1). De Quincey's imagery renders his moral self and inner psychology in corporeal terms. In so doing, he is already borrowing tropes from pathological case studies.

Indeed, the materialization and objectification of his own inner morality that De Quincey takes from medical case studies is essential to the narrative. De Quincey, for instructive purposes, feels it necessary to continue the "public exposure of [his] own errors and infirmities," and he further assures us that he has "for many months hesitated about the propriety of allowing this, or any part of my narrative to come before the public eye, until after my death" (1). He knows his exposure would be more appropriate if he were already a corpse. Still, although his confessions expose a part of himself that is considered revolting to the public eye, he is going to separate himself from those

confessions by objectively presenting the “disease” as a living entity separate from his own identity. In this way, medical sensibilities become, in De Quincey’s narrative, an important context for understanding and explaining his own identity. He is able to compartmentalize and objectify a part of his identity as an observable disease rather than an imbalance in the moral humours of his own self.

This contradictory fascination in and repulsion from the inner details of a person’s private life also helped make *Confessions* successful. Similarly to the medical institutions that needed corpses they could not get, the reading public wanted to understand the private workings of an “excessively disgusting” and socially unmentionable psychology. De Quincey’s contemporaries seemed to be concerned about the propriety of De Quincey’s narrative, but those concerns apparently did not keep them from reading it. One critic, William Maginn, publicly observed the grotesquerie of De Quincey’s confessional narrative by writing that De Quincey’s text should have been hidden out of sight because “there is something excessively disgusting in being obliged to look into any man’s private life” (qtd in North 10). Of course, as North notes, Maginn is self-contradictory: his main interest lies in those details of private life that he had touted as “excessively disgusting.” While Maginn’s reaction to *Confessions* does seem contradictory, North clarifies this reaction by explaining one *Monthly Review* critic’s review of *Confessions* as follows: “he explained the attraction of the book as its unusual degree of sensational self-revelation. Confessional autobiography, he argued, holds a double allure: it not only gives an insight into an individual mind, it also implies ‘self-accusation’” (8). This two-fold attraction of confessional autobiography resembles Rylance’s “theatre and granary” explanation for the development of case studies: that is,

the dual attraction of compiling facts from which to draw useful information and writing narratives that entertain or become theatrical. Therefore, as with scientific cases, *Confessions* provided important information that offered a storehouse of “insight into an individual mind” while appealing to readers’ fascination for grotesque or theatrical “self-accusation.” According to North, De Quincey’s contemporaries generally seemed to assume that “all literature could and should bear a close relationship to real life.... These critics are not merely passing judgment on the book as a book, they are offering a moral verdict on the autobiographer as a spiritual case history” (North 9,10). To write an autobiography that seemed to combat moral repugnance and provide an instructive, acceptable “spiritual case history,” De Quincey turned to medical case history aesthetics. In other words, although De Quincey protested against the self-accusatory interpretation of his autobiography, he was only able to do so under the guise of the *Confessions*’ instructiveness. This guise of practical application, also found in medical case studies, helped make De Quincey’s confessional autobiography more palatable to the reading public.

This paradoxical fascination for and repulsion from De Quincey’s objectified psychology could have presented commercial difficulties for *Confessions* had De Quincey been unable to successfully create a work that could function both as literature and case history. The social taboos surrounding *Confessions* were part of the allure of the book, and De Quincey himself hints at this by alluding to Rousseau in his title. But because De Quincey’s medicalization of *Confessions* objectifies his immorality as a morally-neutral disease, the medicalization provides justification for reading the “excessively disgusting” text: corpses are disgusting, but they must be opened to

understand truths about the body that can be discovered no other way. De Quincey's self-defense against a moral verdict occurs within the first few pages of the text. Despite invoking a Rousseauian tradition by calling his works *Confessions*, De Quincey also makes a self-conscious effort to separate his "self-accusation" from "a confession of guilt" on the grounds that "Infirmity and misery do not, of necessity, imply guilt" (2). It is clear in De Quincey's justification that he is able to separate the guilt from the confession by a metaphorical dissection of his own objectified self. Thus, De Quincey justifies his own confessions in terms of a narrative of muted or secretive progress that resembles the scientific justification for opening up corpses.

By presenting his own moral dissection as a pathological case study in this way, De Quincey imbues his autobiographical narrative with medically-authoritative language. He becomes a more reliable source both as medical expert and autobiographer. This was important because the public fascination for De Quincey's grotesque morality needed public justification, and De Quincey's own authority was necessary in establishing the text's reliability. Most criticism about *Confessions* was concerned with two general matters: *Confessions*' imaginative power and its fact-value. The early critics, as mentioned earlier, were especially interested in the "self-accusation" and "authenticity" of De Quincey's text: "The *Confessions* tell of marvels but, in order for this to be a good autobiography, they must be genuine marvels... The assumption was that it was the factual basis of the genre that gave it its value" (North 8, 9). This autobiography, then, mingles Romantic story-telling with practical purpose. Again, as with so many scientific narratives during this period, we see fact creation and data collection blended with an underlying fascination with the grotesque and a need to invoke curiosity and fancy: in

other words, Rylance's "theatre" and "granary." De Quincey's authoritative medical text made possible the critical move of turning a literary text into a case history or anatomy of the moral self. By separating the disease of his localized confessions from the literary persona of the narrative, De Quincey created an objectified self that struck a nerve among his contemporaries. If, as Caldwell suggests, the tension between co-existing scientific and spiritual ideologies during the Romantic period created key meaning in Romantic selfhood, De Quincey's text exemplifies this tension by presenting a case history as a work of literary art.

De Quincey and the Opium-Eater

De Quincey's pathologized self has tangible consequences in the narrative. The objectified persona is simply called "the opium-eater" throughout *Confessions*, as in the following: "as some people . . . will persist in asking what became of the opium-eater, and in what state he now is, I answer for him" (78). De Quincey was so successful at creating this persona, that, as an anonymous author, he often signed his future texts as "the Opium-eater." But although De Quincey refers to himself both as third-person and first-person narrator, the above quote also sheds light on how he used this divided self to lend credibility to his narrative persona. "The opium-eater" is the persona that is unable to remit the opium habit and unable to respond to critics, while "I," as a now-recovered narrator, can answer for him. In the same paragraph, De Quincey reverts solely to first-person: "I saw that I must die if I continued the opium: I determined, therefore, if that should be required, to die in throwing it off" (78). Again, it is the "I" narrator, courageous and willful, who is revealing the secrets of the dead and dissected opium-eater. De Quincey thus gains sympathy through medical case aesthetics as a courageous, moral

individual defined in opposition to the objectified “other,” or his immoral but pathologized psychology.

Some may argue, however, that De Quincey delves too deeply into his own subjective experiences to be viewed as an objective and reliable medical narrator. While he does indeed spend more time with these experiences than other case histories because his purpose is not overtly to advance medical science, dwelling on subjective or curious experiences in nineteenth-century case studies is not without precedent. Furthermore, the fact that the patient is the physician in De Quincey’s case of self-experimentation renders the subjective treatment all the more forgivable. The practice of self-experimentation was a medically acceptable form at that time. Although Barry Milligan has shown that self-experimentation with narcotics became less acceptable in the second half of the nineteenth century, evidently because of the newly emerging stigma of addiction (“Morphine” 546), it would have been perfectly acceptable in 1821.

For example, *Medico-Chirurgical Transactions*, a medical periodical that lasted for many years as one of the pillars of the professionalizing and objective physician-class, printed “History of a Case of Remitting Ophthalmia and its Successful Treatment by Opium” in 1812. This case narrative, written by physician James Curry, relates the history of ophthalmia throughout Curry’s life and his self-treatment by opium. While the assumed intent is to show a diagnosis, treatment, and cure, Curry uses a great deal of the narrative to relate details that are objectively unnecessary. He begins the narrative with, “In the early period of my life, my eyes were remarkably strong; and the power of my vision very complete, both to distant and minute objects” (348). He goes on in the narrative to weave late-night reading, an “eight-month residence in Bengal,” the

“westerly wind” (349) off the Cape of Good Hope on the way home, the chief mate of the ship’s ague, the Thames being “so completely frozen as to have booths erected upon it (350), and many other details seemingly irrelevant into the case itself. The extent of this extraneous information does not equal that found in De Quincey’s narrative, but similarly to De Quincey’s justification for extra details, Curry eventually writes that “This detail may to some appear tedious and uninteresting, but I thought it might be satisfactory to the Society, as it certainly would be to me, to have a complete history of the rise and progress of a complaint, which subsequently displayed itself in so distinct a shape, and with such severity of symptoms as I shall now describe” (354). The “tedious” and “uninteresting” aspects of the details show that, although Curry was self-conscious about the details he included, medical conventions allowed him to justify those details by their potential practicality, even if he himself could provide no definite correlation between the “tedious” events and the classification or treatment of his illness.

De Quincey too uses the severity of subsequent symptoms as the rationale for self-consciously including potentially unrelated information. These extra details allow De Quincey, like Dr. Curry, to give the “complete history” of a complaint which displayed itself in “so distinct a shape.” In other words, De Quincey’s case is so far out of the ordinary that even small details for which he can provide little interpretation can be justified in the narrative by their usefulness rather than their entertainment value. The detailed incident in which a Malay shows up at De Quincey’s cottage and bolts an inordinate amount of opium, for example, is related because, “trifling as it was, the reader will soon meet it again in my dreams, which it influenced more fearfully than could be imagined” (55). Case reports of self-experimentations, then, are allowed to digress from

objective treatment if authors can justify this subjective treatment by making the narration useful to a medical understanding of the case.

And De Quincey repeatedly conveys the message that his text is meant to advance others' understanding. From the very first paragraph, the tale is meant to be "not merely an interesting record, but, in a considerable degree, useful and instructive" (1). Again, this dual nature of the narrative reflects precisely Margaret Kennedy's "curious literature" and Rylance's "theatre and granary." In both cases, medical case reports, intended to be objective and straightforward, seemingly cannot resist the urge to tell a good story. Because of this, we get cases with names like "Dr. Barnes' Account of the Knife-Eater's last Illness," "Attempt at Suicide by Swallowing a Key," and "Dr. Pickell's Case of a Woman who Discharges Insects from the Stomach" (Rylance 263). These case reports intrinsically justify their telling of a curious story by an objective tone and an appeal to medical knowledge. Like case reports, literature also seemingly cannot resist the urge to merge occasionally with scientific usefulness. While the "useful" nature of *Confessions* can also be seen as moral rather than just scientific instruction, this association with religion serves only to strengthen the argument that the boundaries were blurred for De Quincey, the editors of the *London Magazine*, and at least some members of the reading public. De Quincey's declaration that he is the "only member—the alpha and omega" of the "true church on the subject of opium" (42) has a rhetorically religious appeal, but placing religion in a non-religious context is also somewhat disrespectful or sacrilegious. Similarly, De Quincey's assertion to doctors that their knowledge is deficient both undermines and affirms medical authority: "therefore, worthy doctors, as there seems to be room for further discoveries, stand aside, and allow me to come

forward and lecture on this matter” (40). This bold declaration is part of a narrative that juxtaposes multiple and confused dimensions of experience, and the dual possibilities of reading this statement as a taunt and a plea for authority suggest that De Quincey was both repelled by and attracted to medical authority, in the same way he was repelled by and drawn to religion, the orient, sensual pleasure, and opium itself. Bacon’s books of *Nature and Scripture*, as defined by Caldwell, were clearly intertwined.

De Quincey’s opium-induced dreams further suggest this hermeneutical attraction and repulsion towards objective medicine and his subjective experience. De Quincey clearly privileges his early life and subjective experience, but does so for medical purposes. He justifies his subjective treatment of the case not only on the grounds that it makes “the confessions themselves more interesting” and allows for more sympathy, but also on the grounds that this background is necessary to understanding the dreams themselves (3). In other words, the dual nature of the medical case narrative is inherent throughout. De Quincey tells us that he is not the main subject of his story, that “not the opium-eater, but the opium, is the true hero of the tale, the legitimate centre on which the interest revolves” (78). Thus, even though he goes against case narrative convention by privileging the subject or patient, he states that he does so in order to shed further light on the drug itself. Yet this continued use of medical case conventions to create authority and inhabit the intersecting Romantic-era space between science and religion or medicine and literature has ramifications that go beyond scientific discourse.

De Quincey’s Divided Self

This medicalization of De Quincey’s autobiographical, literary text creates a divided, compartmentalized self that Alina Clej has argued “plays an important and

mostly unacknowledged role in the development of modern and modernist forms of subjectivity (v). Although Clej is more concerned with the effect of De Quincey's written experience about opium addiction on the development of the modern self, her argument that "through his confessional writings De Quincey is in many ways responsible for defining the modern self" (vii) deals necessarily with the alienation that intoxication both reproduces and cures. According to Clej, intoxication symbolizes and constitutes "the imperative to produce while in a state of alienation. . . . one of the central paradigms of modernity" (ix). The alienation represented by De Quincey is also a result of the objectified self he portrays as his autobiography becomes medicalized. His confessional self is distanced from his narrative self through the text's pathologization. In this way, then, medical narratives and ideologies influence more than just formalities: they become part of De Quincey's identity.

Several passages help illustrate this divided self. When De Quincey finds himself being scrutinized by a Jewish lender, he makes the observation, "It was strange to me to find my own self, *materialiter* considered . . . accused, or at least suspected, of counterfeiting my own self, *formaliter* considered" (25, italics original). De Quincey's narrative thus draws attention to the difference between a formal identity and a physical identity and to the possibility of counterfeiting the self. Later, De Quincey observes that "So thick a curtain of manners is drawn over the features and expression of men's natures, that to the ordinary observer, the two extremities, and the infinite field of varieties which lie between them, are all confounded" (28). In yet another passage, De Quincey remarks, in reference to his lawyer acquaintance, that "the inner economy of such a man's daily life would present a most strange picture" (19). In other words, De

Quincey's observations in these and other passages work to develop the idea that one person can compartmentalize and present conflicting selves that are housed in the same body. This "modern self"—conflicted and alienated but productive—reflects and is altered by De Quincey's medicalization in *Confessions*.

Furthermore, these conflicting identities, shaped by medical case aesthetics, change the shape of the narrative and even the extent of his sympathy as De Quincey slides back and forth between observer and participant. At one moment he is simply "I," but in another he becomes "the opium eater." He can easily apostrophize directly to his old companion Ann, "yet no! let me not class thee, Oh noble minded Ann—, with that order of women," and then turn around and passionlessly explain, "By such questions as my interest about her prompted, I had gradually drawn forth her simple history. Hers was a case of ordinary occurrence" (21). By the same medicalization, he removes himself from his relationship with the young orphan child by objectively describing her: "Apart from her situation, she was not what would be called an interesting child: she was neither pretty, nor quick in understanding, nor remarkably pleasing in manners." He even feels it necessary to justify his affection for the poor girl by stating, "I loved the child because she was my partner in wretchedness" (20). Clearly, *Confessions* portrays a divided identity that is often confused and at odds with itself. In a text that both represents and distances the plight of the lower class, it is partly because De Quincey keeps returning to medical case conventions that this divided, sympathy-shifting self becomes so integral to *Confessions*. This objectification or alienation is part of what Clej refers to as the modern self; as such, the modern self has inherited, through De Quincey, a medico-literary genealogy that merits further exploration.

The presence of these dual identities in the same “self” or body can be further explained in the context of the nineteenth-century materialist-vitalist debate, a medical debate in which *Confessions* is steeped. Alan Richardson, in *British Romanticism and the Science of the Mind*, chronicles this debate about the mind’s materiality. Although Richardson does not write about De Quincey, it is clear that materialists considered mind-altering physical substances an important part of the argument that the mind was physically housed in the brain. *Confessions* is, therefore, as a medical case study and popular work of literature, remarkably entrenched in this early nineteenth-century debate. The brain, according to Richardson, was not “definitively established as the organ of thought” until after it had been “challenged on religious and other grounds well into the 1820’s” (1). Yet De Quincey does not shy away from writing about the brain as a seat for both thought and emotion. For example, when he starts using less opium, he states that, “Instantaneously, and as if by magic, the cloud of profoundest melancholy which rested upon my brain . . . drew off in one day” (55). De Quincey chose not to say heart or mind; instead, the melancholy rested upon his brain. Later, De Quincey asserts that, “though possibly it will appear ludicrous to a medical man,” he feared that his haunting dreams about lakes and “silvery expanses of water” were a sign “that some dropsical state or tendency of the brain might thus be making itself . . . objective, and the sentient organ *project* itself as its own object” (72, italics original). In other words, De Quincey’s idea is that a dropsical, swollen, edematous brain might forcefully manifest itself as a self-aware organ over his dreams. This explanation, however, gives the material brain a power over mind and thought that further objectifies the immoral or guilty half of De Quincey’s divided self, which can be explained away by opium’s material influence. But it is not the

case that De Quincey's text simply came down on an extreme side of the materialist-vitalist debate and granted the brain full power over mind and will. By complicating the brain as an organ of thought with a will of its own, De Quincey creates a sort of doppelganger inside himself that can be blamed for De Quincey's own gross, guilty, or immoral behavior. Ultimately, because De Quincey's "I" self is able to overcome the other being, or the "opium-eater," he vindicates a human will that lies outside the brain. But the strength he grants his material self also simultaneously locates his temptation in that objectified self inside his own physical body. Because nineteenth-century medicine had not yet grappled with addiction psychology, male hysteria, the fear of a materialist soul, or other complicated issues, De Quincey's medicalized autobiography thus adds a new perspective to medical texts themselves: a perspective that directly affected both medical ideology and literary representation.

Opium, therefore, as a physical substance, alters De Quincey's moral center, and perhaps even his soul. De Quincey's escape from this state of bondage further medicalizes his self-narrative. Rick Rylance has argued that formulaic medical case reports usually ended with a "double D—death or discharge from care" (272). While other forms of narrative are more open to considering the effects and consequences of treatment, the case history either ends with the patient escaping illness or ultimately succumbing to its overwhelming power. As I have explained previously, De Quincey initially mentions fear about publishing his narrative before his death, since it opens up his moral body for a kind of narrative dissection. He feels like he should not report the case because he knows that the patient, De Quincey himself, has not yet been discharged. In order to comply with this convention, then, De Quincey ends the narrative by

supposedly overcoming forever his addiction to opium. De Quincey's later works show that he certainly had not given opium up for good, and that the "moral of the narrative"—"that the issue of my case is at least a proof that opium, after a seventeen years' use, and an eight years' abuse of its powers, may still be renounced" (79)—is artificial. The moral was constructed to fit the form of the narrative. By ultimately conforming to the narrative convention, De Quincey appeases his readership and constructs a narrative voice that changes literary and religious tropes to fit the conventions necessary for a seemingly-objective, medicalized, and professionally-distanced narrator. In this way, medical case aesthetics—the overtly objective tone, the "medical gaze," the repressed fascination for the grotesque and for localized disease found only in a corpse, the autobiographical division between narrator and patient, etc.—work throughout the narrative to modify and be modified by both literature and medicine.

Curious Literature, Neural Romanticism

The aspects of medical case report aesthetics that are entrenched within De Quincey's narrative are evidence of a greater trend in Romantic-era literature and medicine that aligns clinical and Romantic discourse in ways that have traditionally been unexplored in literary criticism. De Quincey may have not aspired to be a physician or treat patients, but he certainly used aesthetic forms that were essential to medical rhetoric, thereby setting himself up as a medical and literary authoritative professional. *Confessions*, then, is an important example to add to current scholarship on Romantic-era discourse about the co-existence of dual scientific and literary ideologies. Richardson's "neural Romanticism," like Caldwell's "Romantic materialism," explains this phenomenon. As Richardson details the relationship between literature and the emerging

neuroscience of the nineteenth century, he remarks that, “Although literary romanticism has most often been associated with idealistic and transcendental conceptions of mind, the many points of contact between scientific and literary representations of the embodied psyche helps remind us of an antidualistic, materialist register within Romantic writing that has, until recently, been badly ignored” (36). Despite Richardson’s extensive exploration, however, he leaves De Quincey out. Thus, while critics have been finding these points of contact with Keats, Coleridge, Austen, Edgeworth, Mary Shelley, Emily and Charlotte Bronte, Thomas Carlyle, and more, *Confessions* deserves more exploration as a critical text in this tradition. These points of contact are part of what Caldwell calls, “if not formally or self-consciously a movement, at least a striking cultural formation—certainly more substantial than a fleeting transitional phase between literary or historical periods” (1-2). Understanding this cultural formation will lead to a better understanding of Romantic literature and narrative and literary developments. Obviously, this does not entirely discredit the imaginative, individualistic, and nationalistic categorizations of Romantic ideology. Rather, these interactions between literature and medicine supplement criticism by giving traditional and avant-garde Romantic-era medical discourse a place at the critical table. And De Quincey should not be excluded from these studies, because he holds a key position at the point of contact between literature and medicine.

While it is true that there are several passages in *Confessions* that seem to show outright hostility towards the medical profession—De Quincey occasionally portrays physicians as unknowledgeable, naïve, and inexperienced—De Quincey’s external hostility towards the medical profession in *Confessions* is less important to the text than

his internal compliance with medical forms. Indeed, his arguments against the understanding of the medical profession show that he was entrenched within a community of opium-related medical discourse. He was hostile towards medicine, but he was still engaging in a conversation with medicine, in the same way that physicians, scientists, and literary critics still disagree within their own specialties today. De Quincey calls the druggist who first gave him opium “dull and stupid, just as any mortal druggist might be expected to look on a Sunday,” but then also says that the druggist ever after seemed to him to be “celestial” and “an immortal druggist, sent down to earth on a special mission to myself” (38). This contrasting view between the way the druggist actually looked and what the druggist became in later visions can be compared to the way De Quincey seems to depict the entire medical establishment. He rants against medicine, but uses medical case conventions as a narrative form to construct reliability through an objective, scientific, and authoritative distance. That reliability coincides with the same fascinating appeal of the discoveries found inside corpses, which De Quincey adorns with the literary art of a Romantic author, thereby changing the representation of his own selfhood. Thus, although he writes disenchantedly about medicine’s knowledge of opium, medicine’s views, philosophies, and formats continue to haunt and support him throughout *Confessions*, thereby creating a lasting effect on both medicine and literature.

CHAPTER 2: MEDICALIZED MORALITY: THE STRANGE CASES OF DR.
JEKYLL, MR. HYDE, AND PHINEAS GAGE

In the previous chapter, I showed how Thomas De Quincey's *Confessions of an English Opium-Eater* functioned as both a literary text and an authoritative medical case study. De Quincey's 1821 text became, despite De Quincey's lack of professional medical qualifications, a foundational text for physicians' understandings of opium addiction. But as the nineteenth century progressed and literature and medicine evolved into more distinct disciplines, accounts like De Quincey's were no longer medically viable. Indeed, by the time of De Quincey's 1856 revision, *Confessions* itself was aggressively attacked by a medical profession that felt threatened by De Quincey's mixture of medical presumptions and autobiographical, literary elements (Milligan 545). In other words, *Confessions*, and literature in general, could no longer overtly challenge medical knowledge on its own terms as De Quincey had done in 1821. That does not mean literary and medical texts were no longer in a dialogue with each other, but the dialogue became less overt. This chapter will show how disciplinary changes in the course of the nineteenth century affected epistemological and aesthetic components of this medico-literary dialogue; more specifically, this chapter will address these issues by exploring late nineteenth-century medical case studies and Robert Louis Stevenson's own contribution to the medical case genre: *Strange Case of Dr. Jekyll and Mr. Hyde*.

The disciplinary changes that led to medicine's perceived estrangement from literature were typical of general disciplinary changes of the time. Derrida's essay "Before the Law" illustrates the nature of these changes. In an analysis of Freud's *Totem and Taboo*, Derrida shows that Freud's account of "mankind's earliest festival" (Derrida

198) narrates the basis of morality from an event that never happened, the “first murder of the father.” Derrida comments that “The structure of this event is such that one is compelled neither to believe nor disbelieve it. Like the question of belief, that of the reality of its historical referent is, if not annulled, at least irremediably fissured. . . . [T]his quasi-event bears the mark of fictive narrativity. . . . It is the origin of literature at the same time as the origin of law” (199). Freud’s account here is based on an event which, according to Derrida, is important not because of its historical accuracy, but because it establishes “the law.” Narrative, then, fictional or nonfictional, uses literary tropes and conventions to establish inaccessible “laws”; these enable the narrative to function or contribute within the unacknowledged boundaries of a genre, society, or culture. Derrida’s logic accurately characterizes the nineteenth-century relationship between medicine and literature. Thus, as disciplines divided and became consolidated around specific ideals during the nineteenth century, they began to establish their own “laws” through literary conventions. Yet, as with Freud’s “quasi-event,” even the principles of historical or fact-seeking disciplines bore “the mark of fictive narrativity.” In constructing disciplinary “laws,” then, nineteenth-century professionals could not avoid a reliance on literary forms, but they also could not acknowledge that reliance because conceding the constructed literary nature of scientific, historical, or moral truths would threaten the laws and ideals on which those truths were based.

In this chapter, I will first show how medical cases during the Victorian era derived their unacknowledged scientific authority—their “law”—through these suppressed literary conventions. More specifically, medicine’s reliance on scientific or objective ideals and boundaries for medical professionalization and progress suppressed

literary conventions and made case histories narratively ill-equipped to deal with the subtleties of social discourse: the objective language and scientific focus on signs rather than symptoms repressed the recognition of literary forms even though those forms were integral to medical cases. Victorian literature picked up the threads of medical narrative discourse; by using medical case conventions in obviously fictional stories, literature began dealing with social, psychological, and moral issues that these ill-equipped, hyper-objectified medical case studies could no longer adequately address. Thus, although a De Quinceyan medico-literary case study could no longer function professionally in both disciplines at once, literature like *Jekyll and Hyde* continued to use medical case conventions to discuss medico-social issues.

Hence, while medicine and literature became overtly separated through disciplinary professionalization throughout the nineteenth century, medicine still relied heavily on literary aesthetics to create meaning and scientific facts. This chapter will also show that literature, somewhat ironically, appropriated medical case conventions to create its own “laws.” In Stevenson’s case, *Jekyll and Hyde* was written as a moral allegory, but the moral laws of the text depend on natural or scientific codes that are assumed, but unacknowledged, in the allegory: medical case aesthetics. Consequently, the quasi-scientific authority of *Jekyll and Hyde*’s narrative affected the moral, psychological, and social “truths” of the allegory. At the same time, medicine’s search for “fact” through repressed literary conventions and its consequent failure to address Victorian medical anxieties created a void in Victorian discourse; literature, including Stevenson’s *Jekyll and Hyde*, filled that void by embedding medical case conventions within recognizably fictional accounts. But by filling that void, literature itself took on a

quasi-scientific or natural authority, and the social, moral, and psychological “truths” of some literature became more reliant on natural or scientific principles than on traditional values.

Standardized Nineteenth-Century Medical Cases and the Strange Case of Phineas Gage

Changes in nineteenth-century medicine provided the impetus for this appropriation of medical aesthetics into literature. Medicine changed immensely from 1821 to the publication of *Jekyll and Hyde* in 1886. Medical professionalization and scientification during the nineteenth century led to advances in anesthesia, antisepsis, germ theory, hygiene, laboratory research, and more. Indeed, by the end of the century, the advent of anesthetics and antisepsis meant that patients were living through surgical operations that had previously been all but impossible; medicine was reaping benefits from the scientific method and experimentation. At the same time, however, the increasing scientific stigma associated with seemingly non-objective language or perspectives meant that these professional changes also limited medicine’s ability to deal with certain psychological and social complexities of individual disease. This is partly because the standardization necessary in making nineteenth-century case histories more overtly objective and scientific led medical case-history writers to remove “storytelling” elements from their narratives. Whereas medicine and literature were more visibly intertwined during the Romantic era, Victorian case studies became less autobiographical, less obviously theatrical, and more reliant on physicians’ “objective” assessments. As medicine became more overtly scientific, case history writers became even more focused on objective, clinical signs than on individual patient stories.

Jonathan Gillis has comprehensively studied and described “the normative principles of practice” for clinical encounters after 1850 in the United Kingdom and United States. His study illustrates the changes that the medical case genre underwent in the course of the nineteenth century. He explains that “the structure of the clinical assessment became more defined around the 1860s with a general medical distinction between physical ‘objective signs,’ as elicited and detected by the doctor, and ‘subjective symptoms’ narrated by the patient” (493). Thus, while physicians began more overtly constructing their own narratives of patient illness, patients’ voices themselves became increasingly silent: this silencing of the patient worked against autobiographical narratives like De Quincey’s. Gillis relates several examples of typical physician attitudes: for example, an 1873 guide by physician Samuel Fenwick explained that “Most persons [patients] ramble in describing their symptoms, and many insist on giving their own or other persons’ opinions as to the nature of their disease, instead of confining themselves to the narration of the facts” (qtd. in Gillis 494). In another example, the physician Thomas Laycock counseled students in 1856 to let patients speak because “Nothing gratifies patients so much as attentive listening. . . . While the patient is speaking, you need not be idle. You can now study more minutely and carefully the various external characteristics” (qtd. in Gillis 495). In both accounts, students are reminded that facts are more important than patient narratives and that only a physician’s professional assessment can recreate the facts. Students were told to let the patients speak because patients would demand to speak, not because of the diagnostic information that patients might offer. Physicians were also thus reminded to actively construct a “true” account of the illness by using their medical diagnostic skills instead of relying on the

patient's own narrative explanation. This illustrates how empirical, objective knowledge took priority over testimonial knowledge in late nineteenth-century medical case studies: physicians could include or remove, at their own discretion, any part of the patient's account; this physician interpretation was then used to establish medical laws or principles. However, since there can be no "true" account of a patient's illness—it is a multifaceted historical event rather than a scientific "fact"—medical laws were thereby necessarily established from the accounts constructed by the physicians, and these medical laws were then assumed to be the result of professional objectivity, or "fact."

A prime example of this is Dr. John Harlow's 1868 presentation to the Massachusetts Medical Society on the rather well-known case of Phineas Gage. Gage was a railroad foreman, and in 1848 an accidental explosion sent an iron bar through his face, behind his eye, and out the top of his head (Macmillan 12). After initially being knocked to the ground, Gage walked himself to the nearest physician, received treatment, and recovered. While initial reports indicated that Gage suffered no mental impairment from the injury, later reports told otherwise.

Harlow presented his findings to the Massachusetts Medical Society in 1868, twenty years after the original accident and after Gage's death. Although there were several case history publications of Gage's accident, I emphasize Harlow's 1868 representation for two reasons: firstly, Malcolm Macmillan's comprehensive study of Gage cites this account as the most reliable available, and secondly because the 1868 case history is more representative of late nineteenth-century medical case history aesthetics generally. One of the most remarkable sections of this case report concerns Gage's post-accident behavior:

His (meaning Gage's) contractors, who regarded him as the most efficient and capable foreman in their employ previous to his injury, considered the change in his mind so marked that they could not give him his place again. The equilibrium or balance, so to speak, between his intellectual faculties and animal propensities, seems to have been destroyed. He is fitful, irreverent, indulging at times in the grossest profanity (which was not previously his custom)... A child in his intellectual capacity and manifestations, he has the animal passions of a strong man. Previous to his injury, though untrained in the schools, he possessed a well-balanced mind, and was looked upon by those who knew him as a shrewd, smart business man, very energetic and persistent in executing all his plans of operation. In this regard his mind was radically changed, so decidedly that his friends and acquaintances said he was 'no longer Gage.' (qtd. in Macmillan 414-415)

Though Harlow's account is considered a "reliable" case study, it clearly uses testimonial, hearsay, and other narrative elements, instead of reproducible experimentation, to report Gage's post-accident behavior and life. Gage's contractors, friends, and acquaintances are cited as sources, but no account of their actual words is given. And some of Harlow's assertions do not even cite specific individuals. His claim, for instance, that Gage "was looked upon *by those who knew him* as a shrewd, smart business man" is completely devoid of scientific analysis. Furthermore, Harlow clearly sets up a literary contrast between two different Gages to achieve an effect: he was "the *most* efficient foreman," "indulg[ed]... in the *grossest* profanity," and was an intellectual

“*child*” with “*animal* passions.” In this instance, then, the scientific interpretation of the case relies on summarized rumor, hyperbole, and metaphor. None of the symptoms or personality effects described can be considered “scientific evidence.” Gage was said to have been reduced to a man controlled by lower brain functions, but no one, including Dr. Harlow and other medical professionals close to Gage, could corroborate that “fact.” It is ironic that, in a story about a traumatic event affecting Gage, Gage’s voice is only heard through the observations of physicians, a post-mortem examination of his skull, and the surviving tamping iron. But that was a medical case convention of the late nineteenth century: the physicians actively constructed narrative accounts about the subjective illness of the patient, but the narrativity of this approach was suppressed by medical professionals whose scientific aura could have been damaged by acknowledging the non-objective literary elements of medical cases.

Besides illustrating the literary nature of medical case conventions during the latter part of the nineteenth century, Dr. Harlow’s 1868 report also helps illustrate some of the medical case conventions that kept the moral, psychological, and social implications of patient illness from being an obvious part of late nineteenth-century medical case aesthetics. More specifically, Harlow’s account shows how physicians focused on autopsy reports (case history patients were usually either dead or discharged from care), how social taboos were violated in the name of useful scientific instruction, and how the patient’s own voice could only be heard marginally or indirectly; the physician-constructed scientific context mediated between reader and patient to provide a pre-packaged interpretation. This scientific context of patient illness usually consisted of physical observations, measurements, diagrams, and charts or graphs. But while Harlow

did focus a great deal of his report on intricate measurements, diagrams, and physical proof that the bar passed through Gage's head, he also made the following observation:

It is regretted that an autopsy could not have been had. . . . In consideration of this important omission, the mother and friends, waiving the claims of personal and private affection... at my request have cheerfully placed this skull (which I now show you) in my hands, for the benefit of science.

I desire, here, to express gratefully my obligations, and those of the Profession, . . . for their kind cooperation in executing my plans for obtaining the head and tamping iron, and for their fidelity in personally superintending the opening of the grave and forwarding what we so much desired to see. (qtd. in Macmillan 415-417)

An autopsy could have confirmed details about the extent of the damage to Gage's brain, and was therefore an "important omission" (Gage was far away from Harlow and other interested physicians at the time of his death). Despite this omission, however, Harlow apparently cooperated with Gage's mother and friends to open the grave and retrieve the skull "for the benefit of science." Thus, scientists were left with two physical artifacts—an exhumed skull and a railroad spike—as the only physical evidence from which they could construct the entire medical case history. This reconstruction is given by Harlow through diagrams, careful measurements, and a detailed explanation of the examination of the exhumed skull and the inferred route through which the iron passed (Macmillan 418). Although Gage could conceivably have been observed more closely by physicians during his lifetime, there was no way to get at the scientific objective of the case until

they could observe the skull itself: Gage had to be dead for the mystery to be solved. The autopsy, the scientific observations, the “benefit of science,” and the scientific context, as interpreted by the physician, were more important than Gage’s own voice for understanding Gage’s illness.

Stevenson’s Strange Case

Physicians in the latter half of the nineteenth century were much more active than their early nineteenth-century counterparts in constructing patient narratives based on objective or measurable descriptions, and this hyper-objectivity deemphasized narrative or interpretive elements of the case history. The same nineteenth-century conventions seen in the Gage case are present in *Jekyll and Hyde*, and the remainder of this chapter will provide a reading of *Jekyll and Hyde* as a medical case study to help illustrate, in detail, the interaction between literary texts and medical laws. Although several scholars have explored this interdisciplinary space in the Victorian era, none have shown how Stevenson’s unacknowledged medical case conventions established and affected his moral allegory. More broadly, no scholars have written specifically about how case study conventions inform literary representations of late Victorian morality and psychology.

This does not mean, however, that the similarities between *Jekyll and Hyde* and medical case studies have gone unnoticed by scholars and commentators. As early as 1889, Oscar Wilde observed in “The Decay of Lying” that “the transformation of Dr. Jekyll reads dangerously like an experiment out of the *Lancet*” (qtd. in Stiles 879). More recently, Jason Tougaw has suggested that *Jekyll and Hyde* and several other “sensational” texts are “modeled on a type of case history . . . that documents a scientific experiment” (140). And Anne Stiles has dubbed *Jekyll and Hyde* a parody of medical

case studies that critiqued the developing institution of medicine; she states, “Not only does Robert Louis Stevenson’s *Strange Case of Dr. Jekyll and Mr. Hyde* resemble contemporary medical case studies in its form and structure, but its core idea may also have originated from medical literature.” By this “core idea,” Stiles is referring to the possibility that the “double brain” in *Jekyll and Hyde* may have originated from several specific Victorian psychiatric case studies (879).

My discussion diverges from these because of my focus on the fictionality of the case studies and the quasi-scientific presentation of *Jekyll and Hyde*. Since, as with Phineas Gage, the interpretive and social nature of individual disease was not recognized in most case studies from the latter half of the nineteenth century, the quest for scientific “facts” in case studies led scientists to stop focusing on the social, psychological, moral, and cultural implications of their findings. But when Victorian literary narratives like *Jekyll and Hyde* encroached upon this abandoned medical discursive territory by embedding medical case conventions into obviously fictional stories, the moral and psychosocial implications of the narratives also came into play. *Jekyll and Hyde* thus indicates how medical conventions found their way, unacknowledged, into moral, social, and literary discourse as the nineteenth century progressed: medical cases relied on literary forms to establish scientific “laws,” but literature, too, sometimes relied on similarly appropriated medical conventions. Thus, while I have shown that, as Lyotard says, “Scientific knowledge... could not help resorting . . . to narrative knowledge” (27), *Jekyll and Hyde* shows how literary narrative sometimes resorts to medical knowledge.

This medical knowledge and its effect on Stevenson’s literary “truths” can be better understood by examining the medical case conventions that underlie *Jekyll and*

Hyde. While some of these medical case conventions were discussed in chapter one, Victorian medical case writers often amplified the objectivity of these medical conventions, thereby marginalizing more completely the patients' narratives. Obviously, the full title of the novella, *Strange Case of Dr. Jekyll and Mr. Hyde*, invites readers to view the text as a medical case. But while the title's ambivalence leaves room for interpretation (it could also be a legal case, for example), other aspects of the novella are more pointed. For example, as with the case of Phineas Gage or the pathological cases discussed in the previous chapter, the case of *Jekyll and Hyde* probes human nature and reveals disturbing "truths" about human psychology and physiology; however, the shocking or disturbing findings are justified by the lessons they teach or knowledge they construe. Furthermore, as with Gage, the facts behind and lessons from Jekyll's case are only revealed after Jekyll is dead. Thus, Dr. Jekyll's "Full Statement of the Case" and Dr. Lanyon's narrative ultimately establish the moral truths of the allegory, similarly to the ways in which the exhumed skull and tamping iron Gage left behind establish scientific principles only after Gage has passed away. Additionally, while Jekyll's voice is never really heard in the body of the text, and is ultimately only heard after being contextualized by Utterson's third-person narrative, Hyde's story is never heard in the narrative. Instead, like a medically-diagnosable illnesses, Hyde is characterized through the verifiable sensory assessments of multiple individuals. Therefore, while Stevenson's allegorical moral depends upon Hyde's characterization as pure evil, that evil is only established by scientific conventions. As these examples help illustrate, although Stevenson's novella established moral rather than scientific "facts," medical case conventions underwrite the moral allegory itself.

As physicians constructed patient narratives and collected them for scientific interpretation, they often violated moral or cultural standards to obtain and report useful information. Accordingly, while it may have been unsettling for Phineas Gage's family to exhume his skull and allow it to be displayed next to the iron bar, they "cheerfully" did so, according to Dr. Harlow, "for the benefit of science." Of course, this principle is also reflected in corpse-dissection, as mentioned in the previous chapter, and in other theatrical preoccupations in medical cases with grotesqueness or monstrosity. Even so, medical scientists in the late nineteenth century, counteracting the protests of anti-vivisectionists and other moral opposition, became even more rigidly devoted to objective rhetorical appeals. "The benefit of science," therefore, could easily justify sensational narratives couched in scientific terminology and medical ideology, as long as those narratives were used to establish scientific principles.

Jekyll and Hyde operates on a similar "usefulness" principle. Its usefulness consists of its promise of moral advancement; Stevenson wrote the narrative with the expressed intention of making it a moral allegory. Couched in this moral allegory, then, the grotesque, gothic-style narrative became a public phenomenon in part because of its clear moral purposes. As Graham Balfour (Stevenson's nephew) suggests, "Its success was probably due rather to the moral instincts of the public than to any conscious perception of the merits of its art. It was read by those who never read fiction, it was quoted in pulpits, and made the subject of leading articles in religious newspapers" (Balfour 79). In other words, despite the somewhat disturbing nature of the narrative's violence, monstrosity, and psychological insight, it was safe because it could be read as a source of moral instruction.

Hence, like a medical case writer, Stevenson attempts to establish, describe, or archive a “law” or universal principle. The following account of the Rev. Dr. Nicholson from *The Leamington Spa Courier* in 1888 may give some idea of Stevenson’s success in creating that moral law:

The preacher selected as his text the last verse of the 7th chapter of St. Paul’s Epistle to the Romans. . . . He said he took it for granted that his hearers were acquainted with the case of Dr. Jekyll and Mr. Hyde, and he would not, therefore, proceed to a minute account of the incidents of it. It had taken a firm hold of the public mind. . . . About two years ago, it fell into his hands, and he took to reading it; and before he had got beyond the first half of the book, he was reminded of the 7th chapter of Romans—not that the author referred to it—and he concluded the book with the opinion that it was one of the most moral sermons ever preached, or, at all events, ever written. (“The Rev. Dr. Nicholson” 103)

Dr. Nicholson’s sermon illustrates the power of the moral allegory: the novella had “taken a firm hold of the public mind” and “was one of the most moral sermons ever preached.” Indeed, the report here makes *Jekyll and Hyde* almost biblical. It therefore makes sense that the allegorical nature of Stevenson’s novella or his attempt to construct a “law” helped place *Jekyll and Hyde* above other sensational works in the public mind. The moral lessons of the tale justified its sensationalism. Thus, even though the murder of Sir Danvers Carew and the violent final scene wherein Utterson finds Hyde’s body “sorely contorted and still twitching” (39) both portray graphic imagery that would have

offended Victorian morality, the public continued reading the novel in part because its grotesqueness had a clear moral justification.

Of course, many of these disturbing conventions come from the novella's Gothic undertones; it has clear ties to Mary Shelley's *Frankenstein*, for example, with its dark theme, monstrous character, and reliance on narrative fragments. I do not argue that the novella is based on medical instead of Gothic conventions, but that, as Anne Stiles also argues, this juxtaposition of the Gothic with medical case conventions only makes *Jekyll and Hyde* a more compelling critique of medical conventions and a more effective contributor to Victorian medico-social discourse (881). Furthermore, as with medical cases that hinted at disturbing psychological "facts" and embedded curious, theatrical, or grotesque narratives within scientific boundaries, Stevenson's conventionally Gothic novella rationalizes the socially disturbing nature of its Gothic undertones by its moral usefulness. That moral aesthetic would have been especially popular amongst the Victorians. Hence, the Gothic nature of *Jekyll and Hyde* does not limit the significance of its medical case conventions. Rather, the medical case conventions, like the rhetorical "benefit of science" that medical scientists were so fond of, justify Stevenson's Gothic novella by promising to improve Victorian morality.

Moreover, other formal elements of the tale clearly portray medical case aesthetics. As part of her argument that medical conventions add to the Gothic elements of the novella, Stiles also notes that "The typical case study commences with an ostensibly objective third-person narrative," which is followed by anecdotes, data, and illustrations (889). This, of course, is a late nineteenth-century development that would have helped increase the apparent objectivity of the case studies while limiting patient

subjectivity, meaning that this standardized format helped increase the authority of physicians' "medical gaze." Unlike Romantic-era case studies, which occasionally used other literary conventions like autobiography, Victorian case studies closely followed this standardized format. Stiles further shows that this structure is similar to that of *Jekyll and Hyde*: the "data" at the end of the typical case study is similar to the two narratives—Dr. Jekyll's and Dr. Lanyon's—that complete the novella (889). Furthermore, as mentioned previously, Rick Rylance has shown that typical case studies ended with a "double d: death or discharge from care" (272). This narrative convention was essential because, as with the case of Phineas Gage, the patient needed to be dead in order for physicians to fully reconstruct the medical narrative and derive or interpret medical truths. Without the physical evidence of an autopsy, it was difficult to reach any decisive conclusions.

In line with late nineteenth-century medical case aesthetics, *Jekyll and Hyde* follows these narrative conventions. Utterson's third-person account, followed by Jekyll's and Lanyon's disclosures, corresponds with both Stiles' and Rylance's descriptions of medical cases. Dr. Jekyll's "double d," as spelled out in his own will and Dr. Lanyon's narrative, are "death or disappearance" (30) instead of "death or discharge." The term "disappearance" initially bewilders Utterson, but disappearance is merely another way of saying that the patient is discharged as incurable. And it is only after this death or disappearance that Jekyll's case is considered complete; only then can the sealed envelopes—the symbolic unopened corpses—finally be opened. Like the conclusive data or autopsy report at the end of a medical case history, this symbolic moral autopsy reveals certain moral lessons or truths by probing Jekyll's previously-hidden behavior.

Moreover, read as a medical case, Utterson's last-minute violent intervention to save Jekyll parallels a last-resort surgical intervention, thereby setting the stage for Dr. Jekyll's and Dr. Lanyon's narratives as symbolic autopsy reports. The setting of the final scene portrays a palimpsest of a relatively short period of medical history: Jekyll's laboratory has been set up in an old surgical operating theatre. This operating theatre, where physicians, students, and interested spectators would once have gathered to observe dissections and operations, is the site where Mr. Utterson finally determines that violent, aggressive intervention is necessary if he is to ever uncover the truth about Jekyll's abnormal behavior. Utterson and his assistant, the butler Poole, use their own crude surgical instruments, an axe and a kitchen poker, to force their way into Jekyll's personal room. Their forced entry into Jekyll's laboratory at the scene of an old operating theatre and the "screech of animal terror" (38) from the patient makes this scene reminiscent of an old surgical operation. The patient dies in the operation, however, leaving behind the sealed envelope from which his "full statement of the case" is taken. This envelope contains the truth about Henry Jekyll that is only revealed, without further interpretation or a continuance of Utterson's narrative, as an appendage to the text.

Eventually, however, the contents of both Dr. Lanyon's and Dr. Jekyll's sealed envelopes are revealed. They stand alone at the end of the case as conclusive evidence for Jekyll's behavior, but their moral application goes beyond the characters of *Jekyll and Hyde*. Like a medical case from which general medical laws are derived from specific instances, Jekyll's case—his dual psychology, moral downfall, and loss of control—is applied to humankind by the text's allegorical nature. Furthermore, the truths revealed in Lanyon's narrative also go beyond the specific case of Henry Jekyll; Dr. Lanyon's

narrative can be read as a commentary on late nineteenth-century medicine's inability to cope with difficult questions and Victorian anxieties. Most importantly, however, both of these narratives reveal truths that resemble medical knowledge and medical case aesthetics.

Examining Lanyon's and Jekyll's sealed envelopes provides answers or truths that have been hidden throughout the rest of the case. For example, Dr. Lanyon's death is explained as the disease of a "soul sickened" by the "moral turpitude that [Jekyll and Hyde] unveiled to [him]" (47). Lanyon's narrative suggests professional medicine's inability to exist in a medico-literary space; in this way, one of the final truths or principles that *Jekyll and Hyde* teaches is that medical case histories are unfit as vehicles for discussing the moral, social, and psychological implications of medical experiments and discoveries. In other words, although Jekyll's experiments are supposedly founded on scientific principles and the promise of medicine, no one in the story is prepared to deal with those discoveries. And Lanyon's professional vows as a medical doctor—the Hippocratic Oath or "seal of our profession"—are what keep him from revealing the truth about Dr. Jekyll and Mr. Hyde until after Jekyll's death. Hence, Lanyon's sealed envelope exposes the limitations of Victorian professional objectivity. Ironically, the same late nineteenth-century medical case innovations that caused these medical limitations provide the narrative structure through which *Jekyll and Hyde* exposes them.

Jekyll's "Full Statement of the Case" stands without commentary as the final chapter, contextualized, however, by the initial third-person narrative and Lanyon's narrative. Like Victorian medical patients' narratives, Jekyll's voice is silenced throughout the text. Unlike De Quincey's autobiographical text, then, Jekyll, in

accordance with late nineteenth-century medical conventions, is unable to speak for himself until the moral autopsy reveals the “truth.” Even then, his attempts to justify his downfall are overshadowed by the moral lessons of the tale. In other words, as with the post-mortem examination of Phineas Gage’s skull and tamping iron, only artifacts remain, from which the reader can then construct a moral determination or judgment about the case as a whole. Jekyll, by his own estimation, as reported in his confession, has already been dead for some time: “this is my true hour of death,” writes Jekyll, “and what is to follow concerns another than myself. Here then, as I lay down the pen and proceed to seal up my confession, I bring the life of that unhappy Henry Jekyll to an end” (62).

Accordingly, Jekyll’s confession, like the demystifying power of an autopsy report, reveals his hidden experiments, sins, and struggles. His confession details and rationalizes his moral downfall, but, because Jekyll is the patient, the context in which his confession is placed limits Jekyll’s power. For example, he states that the pleasures he sought were “undignified; I would scarce use a harsher term” (53), that “the worst of my faults was a certain impatient gaiety of disposition” (47), and that “Many a man would have even blazoned such irregularities as I was guilty of; but...I regarded and hid them with almost a morbid sense of shame” (48). He sets himself on a moral high ground, and even through the end of the narrative demonizes Hyde as something separate from himself: “In the hands of Edward Hyde, [my pleasures] soon began to turn towards the monstrous” (53). He postulates that man is “a mere polity of multifarious, incongruous and independent denizens” (48) and asserts that he is not Hyde with a hesitating, “He, I say—I cannot say, I” (59). In this way, Dr. Jekyll attempts to distance himself from the

repulsive Hyde. While such justification may gain some sympathy from readers, Jekyll's confession is hedged by Victorian medical case aesthetics, Lanyon's narrative, and the story as a whole. In this way, readers are left to decide whether or not they will accept Jekyll's narrative of the case, or whether they will come to their own moral conclusions. Jekyll's voice is one of many, and it is made frail because the medical gaze—the discrediting of patients' subjective narratives—has been turned on Jekyll himself. Furthermore, if the moral allegory is to effectively teach readers to avoid sin, they must not give credence to the disturbing revelations about the nature of human psychology that Dr. Jekyll's narrative reveals because his moral interpretations are unreliable. As with a post-mortem examination of a diseased patient, the inferred law of the case takes precedence over the patient's own narrative. Consequently, in this instance, the moral interpretation of the case depends upon late nineteenth-century medical case aesthetics and the power of the medical gaze in the form of Jekyll's contextualized confession.

For objectivity's sake, nineteenth-century medical case studies relied on and emphasized verifiable physical evidence. While this was true at the beginning of the century, it became even more fundamental to medical science by the time Stevenson wrote *Jekyll and Hyde*. This physical evidence laid an objective foundation in case studies from which scientific truths could ultimately be established. For example, while physicians could interpret Phineas Gage's case in a number of ways, researchers could always return to the physical tamping iron and skull, complete with its holes from the passage of the iron bar, to settle certain disputes. In other cases, physicians often had second or third opinions from experts who could verify that they discerned, with their

own physical senses, the tumor, lesion, laceration, or other physical ailment. Those objective descriptions laid the base for the medical knowledge derived from the cases.

Jekyll and Hyde uses similar sensory descriptions to establish one of the vital details of the allegory: Hyde's evil nature. This is important because if Hyde's moral state could not be objectively determined, there would be more room for moral interpretation. Evil, however, is not usually considered as being detectable through the five senses, so Stevenson's allegory makes a point of characterizing the loathing people felt towards Hyde as universal. Indeed, many of the descriptions locate the sense of Hyde's deformity in some physical expression. For example, even before Utterson knows that Hyde is the transmogrification of Jekyll, he calls him "the cancer of some concealed disgrace" from Jekyll's youth (18), thus objectifying Hyde as an illness to be observed and classified.

As with the "truth" established from Victorian scientific case studies, then, Hyde is detected as evil by the consensus of individuals who have actually sensed that evil. Mr. Enfield remarks that he "had taken a loathing to . . . [Hyde] at first sight" and that he could also see "the Sawbones turn sick and white with the desire to kill him" (9) whenever the surgeon looked at Hyde. Enfield later explains, "I never saw a man I so disliked, and yet I scarce know why. He must be deformed somewhere; he gives a strong feeling of deformity, although I couldn't specify the point" (11). This "feeling of deformity" is shared by others: Utterson describes "an impression of deformity without any nameable malformation" (17), and the police reports concur "On only one point . . . and that was the haunting sense of unexpressed deformity with which the fugitive impressed his beholders" (24). These descriptions are attempts to describe, using the five

senses, a sensory perception that can not clearly be defined in such terms. Instead, the narrative resorts to constructing Hyde's evilness from a combination of extrasensory perception and attempted physical descriptions which are not unlike the sensory perceptions, empirically observed by a consensus of scientists, on which nineteenth-century medical narratives began so consciously to rely.

In this way, Stevenson creates the medical case history of a moral decline and establishes it on quasi-scientific principles from the Victorian era. The descriptions of this extrasensory perception that occurs around Hyde become more physical later in the text. For example, the butler Poole describes it as something felt "in your marrow kind of cold and thin" (37). But it is the physician, Dr. Lanyon, who seems to have the keenest insight into the physical symptoms of the "odd, subjective disturbance caused by [Hyde's] neighborhood." Lanyon explains that it "bore some resemblance to incipient rigor, and was accompanied by a marked sinking of the pulse. . . . [T]he cause [lies] much deeper in the nature of man, and [turns] on some nobler hinge than the principle of hatred" (44-5). Lanyon, Poole, Utterson, Enfield, the "Sawbones," and the people from the police report all express, in their own way, similar feelings after physically observing Hyde. As with scientific reasoning, it is thereby established by specific observations that there must be some greater, general principle or law at work. Hence, Stevenson's moral allegory relies on the quasi-scientific authority of late nineteenth-century medical case aesthetics; part of the power of the novella lies precisely in establishing Hyde as a being that is a sort of objective, empirical, or natural "evil."

As I have shown, the medical case aesthetics of *Jekyll and Hyde* are similar to those of the case of Phineas Gage. However, as with Freud's account of the "first murder

of the father,” there is no way to accurately reconstruct the event of Gage’s accident and illness in its entirety. The event is inaccessible, and, to the extent that it is inaccessible, it is also an interpretive construction that relies on narrative conventions rather than scientific evidence to determine medical laws or principles. Yet this interpretative nature of “scientific” details in case studies was not recognized in scientific circles during the late nineteenth century. Thus, although literary works, like *Jekyll and Hyde*, were categorized as sensational, impossible, or unscientific, Dr. Harlow’s and others’ accounts of Gage, as well as other medical case studies, could be equally imaginative. Case reports, by nature, work to establish laws based on events that cannot be accessed. Literature, on the other hand, works to establish or undermine laws based on events that are in some ways more accessible because of their fictionality.

Conclusion

Jekyll and Hyde represents a case study with a medicalized foundation for morality. This is the same medical foundation for literary authority that is at work in De Quincey’s *Confessions*. When De Quincey follows medical case history conventions by discharging himself from care and declaring himself emancipated, he assumes a position of moral authority and regains credibility. In De Quincey’s case, he is both the metaphorical patient and physician, but it is his authority as a physician and his reliance on medical case conventions that establishes him as a “cured” man. Although later relapses show that this “cure” was not exactly final, it was a necessary convention in a narrative that may have otherwise been received as too degenerate, immoral, or inappropriate. As I have explained, De Quincey relied on the “usefulness” of the

narrative as his justification for writing, just as Stevenson's allegory relied on its own moral instructiveness.

Yet even though *Confessions* and *Jekyll and Hyde* both deal with addiction, divided selves, and the science of morality, the narratives are presented in ways that, on the surface at least, widely differ. One reason for this is the change that medicine underwent during the nineteenth century: professionalization, a reliance on the "scientific method," a cult of objectivity, and less reliance on the patient's own narratives. As Barry Milligan explains with respect to medicine's changed Victorian attitude towards De Quincey: "Medical writers kept to the recently entrenched battle lines between subjective poets who breath 'spontaneous wisdom' and objective scientists who 'murder to dissect' (in Wordsworth's famous terms) and began to take a stand against De Quincey on this ground of his subjectivity" (545). Thus, the boundaries between medicine and literature became more defined. And any attempts that medicine made to become more overtly literary were merely

the medical profession's attempts to reconcile irreconcilable demands. . . .

A doomed attempt to retain the authority of the objective doctor while assimilating its threatening antithesis, the authority of the subjective patient, all the while striving to maintain the division between the two without which orthodox medical authority would have neither definition nor province. (Milligan 549)

In other words, medicine's professionalization and standardization meant that medical cases could no longer reconcile the objective and the subjective if they were to retain their authority. While *Confessions* could take on medical case aesthetics and seriously

enter a discussion on the medical topic of opium use, later developments in medicine eclipsed that possibility during the Victorian era.

Consequently, unlike De Quincey, Stevenson did not use his moral allegory to set himself up as a medical expert, neither did he write a tale from a subjective, autobiographical viewpoint. Stevenson does not claim to be writing a “true” account of illness, but rather a moral allegory. Still, the presence of medical case aesthetics illustrates literature’s movement into a discursive space that had previously been occupied by texts that were more overtly on the borders between literature and medicine. When the ramifications of professionalization deprived society of overt medico-literary hybridity, literature filled that discursive space with a less obvious medical aesthetic. And while, as in the case of Phineas Gage, medical case histories also continued to rely on literary conventions to tell and interpret patient stories, the literary elements of case histories also became more suppressed. By the end of the nineteenth century, then, both medicine and literature had responded to professionalization and boundaries within their disciplines by appropriating, and relying on, the aesthetic of the other. Consequently, medical and literary texts developed an unacknowledged authority that helped construct and alter their accepted disciplinary “truths” or “laws.”

WORKS CITED

- Balfour, Graham. "Summary of Composition and Early Reception." *Strange Case of Dr. Jekyll and Mr. Hyde*. Ed. Katherine Linehan. Norton Critical Edition. New York: Norton, 2003. 77-79.
- Black, Joel. "National Bad Habits: Thomas De Quincey's Geography of Addiction." *Thomas De Quincey: New Theoretical and Critical Directions*. Ed. Robert Morrison and Daniel S. Roberts. New York: Routledge, 2008. 143-164.
- Caldwell, Janis. *Literature and Medicine in Nineteenth-Century Britain*. Cambridge: Cambridge UP, 2004.
- Clej, Alina. *A Genealogy of the Modern Self: Thomas De Quincey and the Intoxication of Writing*. Stanford: Stanford UP, 1995.
- Cosslett, Tess. *The "Scientific Movement" and Victorian Literature*. Sussex: The Harvester Press, 1982.
- Curry, James. "History of a Case of Remitting Ophthalmia and its Successful Treatment by Opium." *Medico-Chirurgical Transactions* 3 (1812): 348-371.
- De Quincey, Thomas. *Confessions of an English Opium-Eater*. Oxford: Oxford UP, 1985.
- Derrida, Jacques. *Acts of Literature*. Ed. Derek Attridge. New York: Routledge, 1992.
- Foucault, Michel. *The Birth of the Clinic: An Archaeology of Medical Perception*. Trans. A.M. Sheridan Smith. New York: Vintage Books, 1994.
- Fynney, Fielding Best, Thomas Percival, and J. Rogers. "The Case of Ann Davenport. By Mr. Fielding Best Fynney, Surgeon at Leek, in Staffordshire; Communicated to

Thomas Percival, M. D. F. R. S. and by Him to Sir John Pringle, Bar. P. R. S.”

Philosophical Transactions of the Royal Society of London 67 (1777): 458-464.

Gillis, Jonathan. “The History of the Patient Since 1850.” *Bulletin of the History of*

Medicine 80 (2006): 490-512.

Hunter, Kathryn Montgomery. *Doctor’s Stories*. Princeton: Princeton UP, 1991.

Kennedy, Margaret Ann. *A Curious Literature: Reading the Medical Case History from*

the Royal Society to Freud. Diss. Brown University, 2000.

Liotard, Jean Francois. *The Postmodern Condition*. Trans. Geoff Bennington and Brian

Massumi. Minneapolis: U of Minnesota P, 1984.

Macmillan, Malcolm. *An Odd Kind of Fame: Stories of Phineas Gage*. Cambridge:

Massachusetts Institute of Technology Press, 2000.

Martineau, Philip Meadow, and John Hunter. “An Extraordinary Case of a Dropsy of the

Ovarium, with Some Remarks. By Mr. Philip Meadows Martineau, Surgeon to

the Norfolk and Norwich Hospital; Communicated by John Hunter, Esq. F. R. S.”

Philosophical Transactions of the Royal Society of London 74 (1784): 471-476.

Milligan, Barry. “Brunonianism, Radicalism, and the Pleasures of Opium.” *Thomas De*

Quincey: New Theoretical and Critical Directions. Ed. Robert Morrison and

Daniel Sanjiv Roberts. New York: Routledge, 2008.

---. “Morphine-Addicted Doctors, the English Opium-Eater, and Embattled Medical

Authority.” *Victorian Literature and Culture* 33 (2005): 541-553.

North, Julian. *De Quincey Reviewed: Thomas De Quincey’s Critical Reception, 1821—*

1994. Columbia, SC: Camden House, 1997.

- Parker, Mark. *Literary Magazines and British Romanticism*. Cambridge: Cambridge UP, 2000.
- Richardson, Alan. *British Romanticism and the Science of the Mind*. Cambridge: Cambridge UP, 2001.
- Rothfield, Lawrence. *Vital Signs*. Princeton: Princeton UP, 1992.
- Rousseau, G.S. "Literature and Medicine: The State of the Field." *Isis* 72.3 (1981): 406-424.
- Rylance, Rick. "The Theatre and the Granary: Observations on Nineteenth-Century Medical Narratives." *Literature and Medicine* 25.2 (2006): 255-276.
- Smith, Andrew. "The Whitechapel Murders and the Medical Gaze." *Jack the Ripper: Media, Culture, History*. Ed. Alexandra Warwick and Martin Willis. Manchester: Manchester UP, 2007.
- Stevenson, Robert Louis. *Strange Case of Dr. Jekyll and Mr. Hyde*. Ed. Katherine Linehan. New York: Norton, 2003.
- Stiles, Anne. "Robert Louis Stevenson's *Jekyll and Hyde* and the Double Brain." *Studies in English Literature* 46.4 (2006): 879-900.
- Tambiah, Stanley. *Magic, Science, Religion, and the Scope of Rationality*. Cambridge: Cambridge UP, 1990.
- Taylor, Jonathan. *Science and Omniscience in Nineteenth-Century Literature*. Brighton: Sussex Academic Press, 2007.
- "The Rev. Dr. Nicholson on 'Dr. Jekyll and Mr. Hyde.'" *Strange Case of Dr. Jekyll and Mr. Hyde*. Ed. Katherine Linehan. Norton Critical Edition. New York: Norton, 2003. 102-104.

Tougaw, Jason Daniel. *Strange Cases: The Medical Case History and the British Novel*.

New York: Routledge, 2006.

Vickers, Neil. *Coleridge and the Doctors 1795-1806*. Oxford: Clarendon Press, 2004.

Waller, John. "Lessons from the History of Medicine." *Journal of Investigative Surgery*

21.2 (2008): 53-36.

Zeiger, Susan. *Inventing the Addict: Drugs, Race, and Sexuality in Nineteenth-Century*

British and American Literature. Amherst: U of Massachusetts P, 2008.