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About

Gender forum is an online, peer reviewed academic journal dedicated to the discussion of gender issues. As an electronic journal, *gender forum* offers a free-of-charge platform for the discussion of gender-related topics in the fields of literary and cultural production, media and the arts as well as politics, the natural sciences, medicine, the law, religion and philosophy. Inaugurated by Prof. Dr. Beate Neumeier in 2002, the quarterly issues of the journal have focused on a multitude of questions from different theoretical perspectives of feminist criticism, queer theory, and masculinity studies. *gender forum* also includes reviews and occasionally interviews, fictional pieces and poetry with a gender studies angle.

Opinions expressed in articles published in *gender forum* are those of individual authors and not necessarily endorsed by the editors of *gender forum*.

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Target articles should conform to current MLA Style (8th edition) and should be between 5,000 and 8,000 words in length. Please make sure to number your paragraphs and include a bio-blurb and an abstract of roughly 300 words. Files should be sent as email attachments in Word format. Please send your manuscripts to gender-forum@uni-koeln.de.

We always welcome reviews on recent releases in Gender Studies! Submitted reviews should conform to current MLA Style (8th edition), have numbered paragraphs, and should be between 750 and 1,000 words in length. Please note that the reviewed releases ought to be no older than 24 months. In most cases, we are able to secure a review copy for contributors.

Article Publishing

The journal aims to provide rapid publication of research through a continuous publication model. All submissions are subject to peer review. Articles should not be under review by any other journal when submitted to *Gender forum*.

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Editorial

By guest editor Carmen Birkle, Philipps University, Marburg, Germany

1 This special issue of *gender forum* focuses on the intersections between medicine, literature, and gender. The interest in the interface of literature and medicine from the specific point of view of gender is triggered by the intriguing similarities between the medical and literary disciplines (cf. Brieger 402-06). The doctor, like the literary scholar, is faced with a text, a narrative voiced by the patient either through language or bodily symptoms. In order to understand this narrative, the doctor, like the scholar, needs to listen closely, to examine the constituents of the narrative carefully, to consider the subjectivity of the narrative, to read between the lines, and to interpret ambiguities coded in metaphorical language (cf. Brody; Davis).

We constantly tell stories, listen to them, and watch them. Our human experiences, including those we tell to our doctors, are the stuff of narrative. Narrative, then, is the way we make sense of the world. As the clinical narrative tells us much about the patient's illness, so the way we tell our history of medical ideas and practices indicates a great deal about how we perceive ourselves as an occupational group, as a profession, as healers. (Brieger 406)

The relationship between reader and text – on both levels – is embedded in the gender matrix of a given context. Furthermore, Susan Sontag's analysis of the ways in which illnesses are used as metaphors to express social, political, moral, or cultural crises offers fruitful ground for discussion.

2 When I sent out this call for papers for a special issue of the journal *gender forum* with the specific focus on the interfaces of literature, gender, and medicine earlier this year, I never expected so much interest. Within a few days, I received far more than 30 proposals as well as e-mails stating people's interest in the topic and asking whether I would let them know when the issue would be available online. The proposals covered a wide variety of questions addressing the overarching theme. Soon I realized that the possible contributions mostly fell into the three categories of historical accounts of women (doctors) in medicine (with an emphasis on the nineteenth century) (cf. Abram; Furst, "From Speculation to Science"; Morantz-Sanchez; More), literary representations of women – both doctors and patients – in medicine and doctor-patient relationships (cf. Bassuk; Bauer; Blackie; Browner; Burns; Furst, "Halfway Up the Hill"; Masteller; Swenson), and personal narratives of illness (cf. Hawkins). Because of the large number of interesting and well written proposals, the general editors of

the journal agreed on accepting two separate issues with one focus on history and literature and one on personal narratives.

3 This first issue consists of six original articles covering a variety of approaches, however, concentrating on the nineteenth and early twentieth centuries, and transcending national borders from the United States via England to France, Switzerland, and Germany. Two historical case studies of women in medicine in nineteenth-century U.S. America are accompanied by one article on the representation of women doctors in German literature of the same time, and by three articles on women and madness in literature from the eighteenth to the twenty-first centuries intersecting in the nineteenth century.

4 James Alsop's discussion of the historical Dr. Annie Alexander (1864-1929) from Charlotte, NC, is an example of the intersection of history, literature, and medicine. Alsop first introduces Dr. Alexander's biography to his readers as probably the first woman graduate of a medical college to practice in the American South. He then includes an unpublished and evidently autobiographical short story written by Dr. Alexander about a young woman doctor in the South ("Doctor Katherine"), and proceeds to analyze the story which Dr. Alexander, as Alsop suggests, wrote in order to present to young readers a positive example of a woman's career in medicine. Interestingly, in this story, one of the major obstacles for women doctors – the institution of marriage – can ultimately be reconciled with a medical career since the man Dr. Katherine is in love with is also a doctor and invites her both to marry him and join him as a doctor in his practice.

5 Meredith Eliassen's contribution changes the focus from the American South to the San Francisco of the same time frame – the late nineteenth and early twentieth century. Like Dr. Alexander in Charlotte, NC, Eliassen's case studies of two women doctors – Dr. Charlotte Blake Brown (1846-1904) and her daughter Dr. Adelaide Brown (1867-1940) – show how they mostly treated women and children, supported or even founded hospitals for women and children, and, in these specific cases, worked to reduce the health hazards in both breast and bottle feeding of children. The Brown doctors were instrumental in significantly lowering the infant mortality rate, promoting child welfare, and enhancing quality education for medical practitioners.

6 Gabriela Schenk's article looks at literary representations of medical students and women doctors in popular German-speaking fiction from the late nineteenth to the mid-twentieth century. Schenk argues that women with medical degrees at the time undermined the dominant power structures. Issues of power and women's equality found entrance, as Schenk suggests, into contemporary media and fiction. Her numerous examples reveal that

many women are most of all portrayed as nurses, often working for their husbands. The few successful women are often heavily criticized and accused of overstepping “natural” borders, and, in the end, are often forced to give up their careers for lack of adequate or even attractive role models and for the incompatibility of marriage and career. At the time, women in fiction written in German do not seem to have the possibility of succeeding in the medical profession. While women doctors in novels by U.S. American women writers of the late nineteenth century seem to be able to pursue a medical career in spite of all obstacles,¹ German literature does not seem to allow for the same kind of optimistic vision.

7 Michelle Iwen’s investigation into female hysteria introduces the final theme of this issue, namely women and madness. The three remaining articles unveil the strong presence of the idea of the (female) hysteric in literary and cultural as well as scientific discourses from the late eighteenth to the early twentieth century (cf. Showalter; Smith-Rosenberg; Wood). Although the shift seems to be radical, i.e., from women doctors to female patients, I see the connection in the argument used to criticize women doctors, on the one hand, and to confine women to asylums, on the other. In both cases, women were seen as breaking the gender norms of their time (cf. Forrey; Welter; Winnett), as behaving unwomanly and against nature. While women doctors were criticized, ridiculed, and often not married, female patients were simply locked away, displaced to heterotopian spaces keeping them under control so that they could no longer disrupt traditional social and political life (cf. Foucault).

8 Iwen explains the nineteenth-century tendency to confine “hysterical” women to asylums by reverting back to the late eighteenth-century United Kingdom. She suggests that the shift from the Galenic one-sex model, in which the woman is nothing but the inversion of the man, to the two-sex model with men and women becoming different, is responsible for a subsequent sexualizing and pathologizing of women’s bodies with the result, as Iwen sees it, of the feminization of mental illness. Late eighteenth-century English women’s literature, popular culture, and medical discourse reflect this trope of the incarceration of the deviant woman and pave the way for women’s internalization of this threat.

9 The last two contributors look into twenty-first-century literary representations of nineteenth-century hysteria from British and U.S. American perspectives. In her reading of three British novels published between 2002 and 2005, Nadine Muller discusses the relevance of this form of historical fiction that focuses on male doctors and female patients and argues

¹ Cf. the novels by Elizabeth Stuart Phelps, *Doctor Zay* (1882), Sarah Orne Jewett, *A Country Doctor* (1884), Annie Nathan Meyer, *Helen Brent, M.D.* (1891). The same is not true for women doctors in novels written by men, as in William Dean Howells’s *Dr. Breen’s Practice* (1881) or Henry James’s *The Bostonians* (1886). Cf. also Masteller.

that medical narratives strongly reflect the cultural politics of a society at a specific time. All texts, according to Muller, thematize the silenced narratives of the female insane, and, more importantly, not only reflect on the nineteenth-century British past but also on present twenty-first-century issues of gender and mental health, such as male misreadings of female patients' symptoms as well as the relevance of race and social class in the treatment of women's mental illnesses.

10 Last but not least, this special issue closes with Christine Marks who explores the U.S. American writer Siri Hustvedt's account of hysteria in the author's 2003 novel *What I Loved*. Hustvedt as well as Marks in her theoretically inspired analysis connect their reading of nineteenth-century hysteria to Charcot's Salpêtrière hospital in Paris with its stagings of female mental illness and hysterical symptoms. Marks goes beyond the performance character of hysteria and looks at related questions of identity, boundaries of the self, and the clinical gaze vs. the artistic gaze (as the novel is told from the perspective of a male art historian and includes a male artist who turns the results of the female protagonist's academic research on hysteria into a series of artworks based on photographs). Marks suggests that Hustvedt sees the only way out of the asylum and means to close the open boundaries of the self of a female hysteric in the act of cross-dressing as a man. Cross-dressing as one mode of gender performance (cf. Butler) undermines the theatrical stagings of hysteria and exposes the constructedness of both hysteria and gender.

11 A few conclusions can be drawn from the contributions to this special issue on literature, gender, and medicine. From a historiographical perspective, the first two articles reflect the U.S. American beginnings of women doctors in medicine toward the end of the nineteenth century and in the early twentieth century. Both analyses show the optimistic vision of these early women pioneers in the field, their success in spite of or, sometimes, because of the many obstacles put in their way. These obstacles rather than the success seem to dominate fiction in the German language of the same time based on gender stereotypes, nature and naturalness, and the threat of isolation, loneliness, and marginalization. From a look at women doctors in history and literature, the focus shifts to female patients affected and confined by fixed gender roles, incarcerated for deviance, and held under control by male doctors and their clinical gaze which often deliberately misread or staged symptoms for scientific purposes. Ultimately, all articles reveal not only gender as a socio-cultural construction and performance subject to and dependent on the distribution of power, but also science and medical research as not neutral in their interests but driven by engendered ideologies (cf. Winnett) resulting in – at least in the examples presented here – the

medicalization of literature and, most of all, the engendering of medicine. All articles suggest that women's narratives in the medical field – whether as doctors or patients – need to be recovered, released from the silencing male / clinical gaze, and re-interpreted from a more enlightened twenty-first-century point of view.

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Narratives of Class, Gender and Medicine in the American South: The Dr.

Annie Alexander Story

By James Alsop, McMaster University, Hamilton, Ontario, Canada

Abstract:

Dr. Annie Alexander (1864-1929) of Charlotte, North Carolina, was an early general practitioner specializing in the diseases of women and children in the U.S. South. Her life and career were marked by a sense of duty to her community, as an elite southern white woman and physician. The interplay of gender, class, race, and profession can be traced through Alexander's extensive unpublished essays, medical case records, correspondence and personal papers, and the published reactions of her (largely male) contemporaries. This study seeks to answer the questions: why did an elite southern woman follow a career path selected by few of her peer group, and with what consequences for her and her community?

1 Dr. Annie Lowrie Alexander (1864-1929) of Charlotte, North Carolina, is credited with being the first woman graduate of a medical college to practice in the American South. Although the truth of this statement is difficult to ascertain, Alexander was certainly acutely aware of her novelty and her status as a role model for young women. Over time, she was an outstanding success both as a practitioner and a businesswoman in the New South. Born into the eminent Alexander family of plantation stock in Mecklenburg County, North Carolina, the quiet grace, modesty, and "Southern womanhood" of "Doctor Annie" were frequently noted by male contemporaries. The United Daughters of the Confederacy turned out *en masse* for her funeral. At the same time, Alexander was an advocate for medical reform in the Progressive Era South, especially in relation to the health of women and children. Her endeavors for systemic reform found expression in campaigns for compulsory medical inspection of school children and co-operative rural public health nursing. Equally important to her as a health reformer was moral improvement, within families and especially among adolescent women. The story of Dr. Annie Alexander's career in Charlotte, 1887-1929, as a general practitioner specializing in the diseases of women and children is an important one to analyze. There exists, moreover, a second story, this one a work of fiction. Alexander composed the short story "Doctor Katherine" early in her professional career, possibly in the winter of 1886-87, following her graduation from the Woman's Medical College of Pennsylvania in 1884, internship, and licensing. The protagonist is a young southern white woman who made the unheard of career choice of medicine, attended the Woman's Medical College, Philadelphia, and overcame prejudice and private doubts to establish a practice in a southern city not unlike Charlotte. Alexander bestowed upon her fictional character the name of Dr. Katherine Caldwell. Alexander's paternal grandmother was a Caldwell, a family

illustrious in North Carolina's Revolutionary War history and the grounds for Alexander's later cherished role as a Daughter of the American Revolution. The autobiographical features of "Doctor Katherine" extended beyond curly fair hair and blue eyes, to the fact that the author and her subject each possessed a physician father who directed his daughter towards a career in medicine. The principal importance of "Doctor Katherine," however, lies not in autobiography; rather, it was Alexander's first known effort to interest southern adolescents, of her race, class, and gender, in medicine. As such, it will be examined alongside Alexander's non-fictional work in this field. This study, therefore, possesses three overlapping objectives. One is an examination of Annie Alexander's career as a single, white, elite woman in medicine, with an emphasis upon how she saw, and acted upon, the intersections of gender, class, and race. Another is to permit Alexander to speak to us in her fictional character of "Doctor Katherine." The final theme is the investigation of Alexander's views on women in medicine, in health, and in life; these were rooted in her time, place, and person.¹

Doctor Annie Alexander

2 Annie Alexander was born on 10 January 1864 in Lemley Township, Mecklenburg County, on the farm of her father, Dr. John Brevard Alexander (1834-1911). She died twenty miles away on 15 October 1929 in the bedroom of the home and medical office which she purchased in 1890, 410 North Tryon Street, Charlotte, Mecklenburg County. Her father graduated from the Medical College of South Carolina in 1855; he served in the Thirty-seventh North Carolina Infantry as a private, 1861-62, and as surgeon, 1862-65. Her mother, Ann Wall (nee Lowrie) Alexander (1834-93) was a granddaughter of North Carolina Superior Court Judge Samuel Lowrie (Dudley 13; Murphy 15). Alexander moved her parents into her Charlotte home in 1890. John Alexander was a druggist and general practitioner until his health deteriorated in 1898. He published extensively on local history and genealogy, public affairs, and religion. He was an unapologetic Confederate and a strident racist (*History* 370-82; *Reminiscences* 109-12, 237-39).² Alexander was home-schooled by her father and a tutor. Family tradition credits her father with the choice of medicine for his second daughter; in

¹ The author is pleased to acknowledge the assistance provided for this study by the Special Collections Department, Atkins Library, University of North Carolina at Charlotte, in particular for a Harry Golden Visiting Scholar Award for 2008/09 to study the Dr. Annie Lowrie Alexander and Dr. John Brevard Alexander collections. A travel grant from the Institute for Southern Studies, University of South Carolina, 2006, was instrumental for situating Dr. Annie Alexander within her medical world of the Carolinas.

² John Alexander, "Insane Negroes," "The High Order of the Human Race not Maintained," and "Sin Has so Corrupted Our Natures" (undated essays), and "The Mixing of Races Should Be Condemned" (1886): John Alexander Papers, Box 1, Folders 13 and 15.

1881 he secured for her a place at the Women's Medical College of Pennsylvania (Pendleton 43; Thompson 14).³ The surviving letters between Annie and her parents during her residence in Philadelphia reveal a close bond with her father, centered around their mutual interests in medicine, and a distant connection to her mother.⁴ Alexander secured a second-class graduation result in spring 1884, but was one of the favored few awarded a coveted internship at the Woman's Hospital of Philadelphia, 1884-85.⁵ During this year, she announced her intentions to practice medicine in the South, determining that only in a large, cosmopolitan city could she be reasonably certain of acceptance and a livelihood. She wrote in summer 1884: "I can't decide where to locate when I leave Philadelphia. I've thought of Baltimore, Atlanta, and Jacksonville, but there will be obstacles wherever I locate. My success will depend on my ability and the liberal views of the people among whom I will be." In the end, the choice was Baltimore.⁶

3 In 1885 Alexander accepted a poorly paid position as assistant instructor of anatomy at the Woman's Medical College, Baltimore, sat the Maryland licensing examination, and opened a private practice. John Alexander had provided his daughter with financial support since 1881 and this continued.⁷ Alexander's career took a sudden turn in summer 1886. Severe pneumonia and weight loss were followed by tuberculosis; the winter of 1886-87 was spent recovering at a relative's Florida home (cf. Pendleton 62-63).⁸ In the spring of 1887 the following advertisement appeared in the *Charlotte Observer*: "A nice young female physician, Miss Annie Lowrie Alexander, has located in this city ready to practice among women and children and consult about female disorders generally [...]. She has been educated in the best medical schools of the country" (qtd. in Kratt 12). The novice general practitioner boarded with a Mrs. Harvey Wilson and shared office space with one Mrs. Lathan (not a medical practitioner) in downtown Charlotte opposite the post office. Alexander was in the one southern city she had determined in January 1885 to avoid at all costs: "Charlotte, [because] the people there have more curiosity than sincerity and politeness."⁹ She was the first licensed woman physician in North Carolina's history; over time Alexander came to

³ Annie Alexander (hereafter "Alexander") to John Alexander, 2 Jan. 1884: Alexander Papers, Box 1, Folder 1. College entrance exams were not introduced until 1887 (Marshall 69).

⁴ Alexander Papers, Box 1, Folder 1.

⁵ Woman's Medical College of Pennsylvania (hereafter WMC) Archives, Minutes of Faculty Meetings, 1881-86 (unpaginated), entries for 7 Feb. and 8 Mar. 1884; WMC 1882, 20; WMC 1884, 4; WMC 1885.

⁶ Alexander Papers, Box 1, Folder 1.

⁷ Alexander Papers, Box 1, Folder 1: Alexander to John Alexander, 8 June 1886; WMC, Alumnae "Firsts" file card; Dudley 13.

⁸ Alexander Papers, Box 1, Folder 1.

⁹ Alexander Papers, Box 1, Folder 1, Alexander to John Alexander, 11 Jan. 1885.

relish that role, and to contribute to the developing story that she was the first in the south-east United States or, indeed, in the South.¹⁰

4 There appears to be no truth to the family story that Alexander struggled for her entire first year in private practice before earning her first dollar, such was the prejudice in Charlotte against a woman in medicine (Pendleton 63; Kratt 12). The first of her surviving patient casebooks covers the period January 1888 to November 1889. For the calendar year 1888, Alexander recorded 432 patient consultations, for an income of \$684.00. She did \$31.50 worth of charity work.¹¹ The evidence suggests that Alexander took whatever clientele she could. This is the only one of the extant casebooks where there are any significant number of adult male patients, or African-American women, albeit even at this stage in her career both were distinctly in the minority. Most of her case work was gynecological, but included as well bilious fever, consumption, the common cold, indigestion, carbuncle, debility, and a sizeable practice in neurology. By the time of her next surviving casebooks, 1914-22 and 1924-29,¹² Alexander was a very well established Charlotte professional, in practice at the two city hospitals, and physician to the Young Women's Christian Association, the Presbyterian College for Women, and the Florence Crittendon Home for unwed mothers.¹³ Her general practice between 1914 and 1929 was almost entirely in gynecology, obstetrics, and childhood diseases. Apart from immediate family, adult males had disappeared, and African-Americans were virtually non-existent. Alexander practiced throughout Charlotte, rural Mecklenburg County, and nearby South Carolina communities. Social class is harder to establish, for the physician rarely included signifiers. However, cross-referencing names and addresses from the casebooks with city directories establishes that Alexander's patients ran the range from the most prestigious families to the wife of the city's garbage collector. Her practice was weighted towards those who could afford her fees. For example, a large number of women, often recently married, appeared in the records only once, for a pregnancy examination and determination. Their health needs, and deliveries, were being met elsewhere. Alexander

¹⁰ Alexander's own role is suggested by the family narratives recorded by Pendleton and Thompson, and supported by the surviving fragments of an undated autobiographical description of herself (in the third person): Alexander Papers, Box 1, Folder 5. All accounts of Alexander, from her death to the present, emphasize that she was "the first," but the geographic scope ranges from the state of North Carolina to the entire South, and many accounts neglect to add the important qualities of "graduate physician," "licensed," and "southern born." In the standard biography (by Dudley) it is, for example, demonstrably not true that Alexander upon her return to North Carolina in 1887 "became the first woman to practice medicine in the South." She had been preceded by numerous non-graduate and/or unlicensed practitioners, as well as by several graduate, licensed women physicians who had not been born in the South.

¹¹ Alexander Papers, Box 1, Folder 13, patient casebook, 1888-89. This volume references, and has patient illnesses carried over from, an earlier volume for 1887 (not now extant).

¹² Alexander Papers, Box 1, Folders 14 (1914-22) and 15 (1924-29).

¹³ Alexander Papers, Box 1, Folder 11 (newspaper clippings), "Pay Tribute to Dr. Alexander," 15 Oct. 1929, "Funeral to Be Held Today for Dr. Alexander," *Charlotte Observer*, 16 Oct. 1929.

charged \$2.50 for this exam, and \$25.00 for delivery and post-natal care; her standard fee for a consultation was \$2.00.¹⁴ Overall, the practice may be described as overwhelmingly white, with a preponderance of women from the elites and the middling layers of local society – nurses, school teachers, the wives of accountants, and the like. It is difficult to locate in her records the families of mill hands or tenant farmers, of either race. These women and children may be present, but certainly not in sizable numbers; their existence and growth, however, was a striking feature of the new industrial Charlotte and its immediate hinterland.

5 Charlotte underwent rapid social and economic change in the 1887-1929 period. When Ann Lowrie married John Alexander in 1858, the city was a modest local agricultural community of slightly more than 1,000 people. By the time of Annie Alexander's death in 1929, the population stood at 82,000, surpassing every urban center in North and South Carolina. Charlotte was the nexus of four major railroad systems, and the heart of a textile manufacturing territory in the Carolinas' Piedmont of 770 mills (Hanchett 19-20, 90-92; Alexander, *History* 382; Blythe and Brockman 138). As early as 1896, Mecklenburg County was the third most important textile manufacturing county in the state; within a decade city boosters proclaimed that “[o]ne half of all the looms and spindles of the South are within one hundred miles of this city” (D. A. Tompkins qtd. in Hanchett 92). This was “an onward-driving, pulsating South in industry, agriculture and finances. [...] Charlotte is alive, aggressive, progressive. Charlotte citizens cooperate in matters which promote the civic, commercial, religious, and industrial welfare of the community” (Hill Directory Company 11-15). This marketing message failed to mention Mecklenburg County's long history of bitter industrial strife, or the serious social and public health problems which had grown alongside the population (Hanchett 18-104). Moreover, the declaration that Charlotte's labor was the finest in the country for prospective employers, “native, white, sober, industrious,” ignored both the strikes and the presence of 28,936 African-Americans, 35% of the city's population (Hill Directory Company 11, 16). Thus, in the period *circa* 1890-1930, Charlotte emerged as a large, progressive center in the New South, prominent in finance, housing construction, and the service industries, in addition to transportation, agriculture, and textiles. At the same time, it was necessarily ridden with racial and class divisions, and serious contestation over all aspects of social welfare, from education to health (cf. Hanchett).¹⁵

¹⁴ Alexander casebooks, 1914-22, 1924-29.

¹⁵ The relationships between the public health challenges and the economic transformation of Charlotte and its hinterland have not been the object of extensive scholarship, but can be traced in the surviving records of the Mecklenburg Country Health Department, the North Carolina State Board of Health, and the biannual published reports of the latter body.

6 Annie Alexander, the scion of the old country plantation aristocracy, embraced the new progressive Charlotte. Her education and professional stature placed her firmly within the urban elite, while her extensive investments first in rental housing and then in textile mills aligned her with the new economic order. Alexander's career was marked by professional and financial success. These topics had been her expressed anxieties while interning in Philadelphia: could she acquire professional recognition and a livelihood in medicine.¹⁶ It is reasonable to conclude that she was successful because she was in a good place at a time of opportunity, and because she worked very hard to achieve her goals. Alexander's first publication, in January 1889, was of an address which she had recently delivered at a women's college in Greensboro, North Carolina, on the theme of "Women Physicians" (discussed below). In March of the same year she contributed a paper on chronic inflammation of the lining of the uterus to her College alumnae association in Philadelphia ("Chronic Corporeal Endometritis").¹⁷ In 1894 she published on "Uterus, Hyperplasia of" in the *Charlotte Medical Journal*, and in 1897 on "Menstrual Disorders" in both that periodical and in the *North Carolina Medical Journal* (cf. Marshall 101).¹⁸ Upon the establishment of the Mecklenburg County Medical Society in 1903, Alexander was a frequent speaker at meetings, drawing upon her practice. She served as the founding first vice-president of this Society, 1903-05, and as its president in 1909-10, the period of the Society's first hookworm campaign (Strong 58, 62). In 1924 Alexander served as first vice-president of the Women Physicians of the Southern Medical Association.¹⁹ She was a frequent speaker on medical themes, mostly to audiences in North Carolina. When venturing further afield, for example in one presentation to the Charleston Medical Society on calcareous deposits in a young woman patient, Alexander was exceptionally cautious, providing only the medical facts, offering no analysis, and denying that the case was significant.²⁰ Her research included "Management of the Puerperinum," "Cervical Adenitis," "Symptoms of Lobar Pneumonia," "The Care of the Premature Infant" (1914), as well as "Summer Complaint" (1893), and "Pneumonia" (1896). Her last known research contribution was on three cases of "Tuluremia" (1928, 1929), a

¹⁶ Alexander Papers, Box 1, Folder 1, letters to John Alexander dated Jan.2, June 30, Nov. 9, 23, 1884, Jan. 11, 18, Feb. 25, 1885.

¹⁷ The paper was read and discussed in her absence.

¹⁸ WMC, Alumnae card file.

¹⁹ Alexander Papers, Box 1, Folder 3.

²⁰ Alexander Papers, Box 1, Folder 3. A slightly altered version, in her handwriting, was copied into blank pages of her father's last casebook, with the title "Calcareous Deposits in the Lungs": John Alexander Papers, Box 1, Folder 7 (unpaginated). All the manuscript essays by Alexander cited below are in her handwriting. Many lack exact titles. Unless stated, the essays are undated, but internal evidence, or case descriptions in her casebooks, often permit approximate dating.

serious infection transferred from live rabbits and present in 29 American states.²¹ As early as 1896 Susie Van Landingham, the acknowledged matron of Charlotte's social elite and wife of the city's leading cotton broker, paid Alexander a public tribute: "She has won for herself [...] an honored place among the [medical] fraternity and a practice that is both lucrative and successful" (qtd. in Henderson-Smathers 41).²² Upon her death in October 1929, the Mecklenburg County Medical Society acknowledged Alexander as one of its most enthusiastic, highly honored, and respected members.²³

7 Alexander was a competent and successful business woman. She was frugal in her personal expenditure; after the deaths of her parents she even took a lodger into her home. Beginning with the down payment on her own house and office in 1890, she bought real estate, owning at various times as many as twenty rental houses and commercial offices in Charlotte, all of which she managed herself. In 1921, Alexander's total revenue was \$4,868, and expenditure \$2,570, for a profit of \$2,298 (up from \$1,492 in 1920).²⁴ Her medical practice had brought in \$1,923.10; her rental properties yielded \$2,222.89. As was always the case, she invested all profits. In 1922, total receipts were \$4,830, expenses \$2,500, and profit \$2,330. For this year, the practice had brought in \$1,622.10, and rental properties \$2,379.54. In 1923 her practice provided \$2,047.85 and rental properties \$2,408.25, with a net profit for the year of \$3,096.51. Additionally, Alexander was now steadily selling off her rental properties (in 1923 she acquired a further \$5,741 from these sales) and re-investing in local textile mill stocks. In a speech intended to interest young women in a career in medicine, Alexander stated that the total costs of four years at the Women's Medical College, Philadelphia, would be approximately \$1,900 to \$2,300, covering all tuition, board, books, and incidentals. Upon graduation a teaching or laboratory position would immediately bring in a good income of between \$1,000 and \$4,000 a year. The financial returns from private practice would be slower to materialize, and the extreme range was from \$400 a year to \$10,000. One woman physician known to Alexander was said to earn \$20,000.²⁵ As a self-employed physician, Alexander wrote off on her income tax submissions the entire upkeep on her automobile, her telephone, depreciation on her rental properties, and part of her house

²¹ Alexander Papers, Box 1, Folder 3.

²² For Van Landingham's role in Charlotte cf. Kratt 20-22.

²³ Alexander Papers, Box 1, Folder 11, "Death of Dr. Alexander Subject of Resolutions" (undated newspaper clipping of Oct. 1929).

²⁴ This, and the following, information has been extracted or calculated from Alexander's personal financial records, 1920-29: Alexander Papers, Box 1, Folders 7, 8. Apart from some financial information included within her patient casebooks, these are her only financial records to survive. They reveal a very careful attention to detail, especially for expenditure.

²⁵ Alexander, "Woman [sic] in the Medical Profession" (circa 1920), Alexander Papers, Box 1, Folder 5.

expenses. Although any comparison is inexact, in 1927 the annual salary of the full-time Assistant Health Officer for Charlotte and Mecklenburg County was \$2,400; the prestigious part-time position of County Physician paid \$1,200.²⁶ It appears from Alexander's financial and medical records for the 1920s, that she was acquiring capital largely through careful attention to expenditure and making wise investment decisions, rather than attempting to maximize the work of her general practice. This afforded her considerable leisure for civic involvement.

8 In addition to her private practice, Alexander was active in medicine and public health within her community. Her actions in this arena are often shadowy. For example, the obituaries emphasize Alexander's importance for the creation and performance of the Charlotte Co-operative Nursing Association; however, there is nothing on her work itself in either the Alexander papers or the records of the Mecklenburg County Health Department. Too frequently, we know that she held a position of responsibility, as a trustee or board member, without being able to assess her involvement. Alexander was largely responsible for the health education program of the Charlotte Women's Club, and she was instrumental in establishing through that body the local sale of tuberculosis seals (cf. Henderson-Smathers 41).²⁷ She actively promoted the compulsory medical inspection of school children. In November 1917 this led to her wartime appointment as medical director of Charlotte's public schools, paid by the United States Public Health Service, with the standard (usually male) federal title of "acting assistant surgeon", and working alongside the city health department. The objective was to maintain a high level of health within the five-mile sanitary zone surrounding the army's Camp Greene. Alexander and the health department were able to use this concern in order to accomplish unprecedented health work in Charlotte's schools, including the medical inspection of thousands of children.²⁸ Public health, however, was never at the center of Alexander's career. She routinely devoted more attention to non-medical charitable activities than to the ones identified above. It is undoubtedly true that Alexander herself would have approved of the summation of her adult life in Charlotte, provided in the obituary news report of the *Charlotte Observer*: "she was recognized as a leader in the civic, social and business life of this city."²⁹ A fair summary of her adult life is

²⁶ Mecklenburg County Health Department Archives, Box 1, Folder 7, Minute Book, 1915-55, 3, 22-24, 47.

²⁷ Charlotte Woman's Club Archives, Box 1, Folder 1 (notices of Alexander's activities, 1900-1926); Henderson-Smathers 41.

²⁸ Alexander Papers, Box 1, Folder 11 (newspaper clippings, 1917-18); Mecklenburg County Health Department Archives, Box 1, Folder 7, Minute Book, 1915-55, 3; Charlotte City Board of Education Records, Box 1, Folder 7; North Carolina State Board of Health 1921, 17, 22, 26, 40-45, 47, 49-52; Alexander, "Medical Inspection of Schools," and a briefer, untitled, essay by her on the same topic (Alexander Papers, Box 1, Folder 2).

²⁹ Alexander Papers, Box 1, Folder 11, "Last Rites for Dr. Alexander Held Today," Oct. 16, 1929.

that these were her personal objectives, and through dedication and talent she accomplished them.

Commentary on “Doctor Katherine”

9 This short story evidently was intended for publication, presumably in a magazine with a readership of adolescent women. One fair copy, with several stylistic alterations, exists among Alexander’s papers, in her handwriting. In the top right margin of the first page, Alexander has added, “Miss E. Goheen 2301 Master St. Phil. Pa.”³⁰ Elizabeth Henri Goheen, of the Philadelphia suburb of Media, was a student at the Woman’s Medical College of Pennsylvania, 1892-96.³¹ It appears that Alexander’s intention was to send the story to Goheen. Whether it was dispatched and returned, or never sent, is not known. The paper is not listed among Alexander’s publications in the records maintained by the Woman’s Medical College (cf. Marshall 101). As far as can be ascertained, it does not appear to have been published. The purpose of the story appears to be straightforward: to provide a positive example of a woman’s career choice in medicine suitable for young readers.

10 The manuscript is undated. The story was written early in Alexander’s professional career, after her education but before she became well established upon her career path in Charlotte. The Goheen notation implies that the manuscript was created after she left Philadelphia in 1885 and before Goheen left the College, without a degree, in early 1896. The narrative has Dr. Katherine establishing her practice within her home community in the South, not in a large city such as Baltimore (where Alexander began her career, 1885-86). “Doctor Katherine” may well have been composed during a period of reflection as she convalesced in Florida over the winter of 1886-87, or early in her efforts to establish a practice in Charlotte. It may be noted that the character Mary Berry gave Dr. Katherine Caldwell’s age as twenty-two when Caldwell returned to her state. Alexander was this age at the time of her health crisis. It may also be relevant that the only letters from a “male admirer” retained by Alexander in her papers were from the winter of 1888-89. This unidentified male appeared to be a physician, and he proposed marriage.³²

“Doctor Katherine” by Annie Alexander

It was the day before commencement at Parkhurst Academy. Several members of the graduating class were assembled in the grounds in front of the building talking of the future

³⁰ Alexander Papers, Box 1, Folder 6.

³¹ WMC, Alumnae card file, and Minutes of Faculty Meetings, entries for May 1894, Feb. 1895, May 1895.

³² Alexander Papers, Box 1, Folder 1 (the signature is unreadable).

before them. "I am going to be a teacher," said one. "I am going to be an artist," said another. "And I a professor of languages," said Mary Barry. "I shall marry," said Nettie Bell. "What are you going to do Katherine?" asked Mary Barry. "Study medicine." "Study medicine! Be a doctor! Who ever heard of such a thing!" "Are you in earnest or romancing?" asked Mary. "Yes, I am going to be a doctor. It has been father's desire all my life, that I should be a physician."³³ "Your father must be a mad-man to allow such a thing or to consider it for a moment," said Nettie Bell. The idea of a daughter in a Southern family doing anything outside of home or the schoolroom was unheard of. And to bring the idea closer home, for Katherine Caldwell the fatted daughter of Dr. and Mrs. Caldwell to study medicine was shocking. Katherine Caldwell was the second daughter in a large family of children.³⁴ She was shy and diffident toward strangers, gentle and quiet in manner, and was possessed of that excellent thing in woman, a voice soft and low. Her light wavy hair, coiled loosely at the back was her one crown of beauty. From her blue eyes shone her steadfast earnest soul.³⁵ "Yes, I am going to be a doctor. If you have recovered from your shock I'll tell you about it." Katherine's quiet serious face showed that she was not as brave at heart about going to Philadelphia as she would have her friends believe. The girls listened with interest as she told them of hers and her father's plans for her to enter The Woman's Medical College of Pennsylvania in Philadelphia in October. "Of course I shall only practice among women and children." "That is not fair," said Will Herndon,³⁶ who had stopped a moment in passing. "All the boys will want you to visit them." Will was just home from the University of Virginia where he had been studying medicine. "She could not prescribe for you Will, your pulse would go bounding away at such a rate and you would begin stammering at her first question," said Jennie Strong. "You see Will, it would never do," said "Dr. Katherine" as her friends begun calling her. "I could never make a diagnosis with such varying symptoms as you would present." "Diagnosis, symptoms! My! How doctory she sounds," said Jennie. Will turned and walked on with regret in his strong noble face. "Doctor [struck out: Margaret Winters] Mary Walker [inserted] is the only woman doctor I ever heard of," said one of the girls, "and she has short hair and dresses like a man." "Not exactly like a man," corrected Katherine. "And there are a great many woman physicians throughout the north and west, who are just as loveable and womanly as the women in our Southern homes whom our men love to honor." "I can't conceive of a doctor wearing skirts and feathers," said brown eyed

³³ The family story for Alexander is identical (cf. Pendleton 42, 62; Thompson 14).

³⁴ Alexander was the second (of three) daughters, with five siblings in total.

³⁵ For Alexander's curly golden hair and blue eyes cf. Pendleton 42, 62.

³⁶ The names "Will" and "Will Herndon" appear throughout the manuscript on top of an erased name.

Nettie Bell, who thought more of her beau than her books. “I would have no confidence in a woman as a doctor,” said candid Jane Smith. “Why not Jane?” asked Katherine. “Why because women haven’t the brain power necessary to make good doctors, and they are too nervous and scarry [sic].” “Doubtless you speak from an intimate acquaintance with yourself Jane,” said Mary Barry. “If you will take the trouble to make inquiries, you will find in schools where co-education exists that the women are not behind the men. In many instances they lead the classes. As for being nervous and scarry [sic], did Katherine appear so when little Ned fell from the tree and broke his arm so badly? No, Doctor McLean said she had set it as well as he or any other doctor could have done.”

* * * * *

Six months later Katherine Caldwell is in Philadelphia attending lectures at the Woman’s Medical College. The first lecture she heard was on “Protoplasm”. After listening to the lecture one hour she turned and asked the student behind her, “What is Protoplasm?” What a trial those first six weeks were! Loneliness, and homesickness and tears. She attended the lectures and studied the dictionary. Everything was chaotic. After a while things became clearer and a keen interest took the place of the homesickness. A new world was revealed to her. Sickness and suffering such as she never suspected aroused her deepest interest and sympathy.³⁷ Katherine’s greatest trial was the dissecting room. How the shivers ran up and down her spine as she heard the elevator rumbling up from the basement to the top story! One of the advanced students said, “There goes a subject to the dissecting room, let’s go up there.” “A no,” said Katherine, “dry bones are a great deal more interesting just now.” They were studying the skeleton then. “Oh she is chicken hearted. Let’s go. You may stay Miss Caldwell.” “Oh I don’t mind it,” said Katherine faintly, “I’ll go of course.” The sight that greeted her eyes was appalling. Several long marble tables, on each lay a subject carefully covered, but the human outlines were visible. It was horrible. It was the first time she had seen death. She walked over to the window and stood for a few minutes looking over into Girard College grounds, until she could get her nerves under control. By degrees she brought herself to look upon the ‘subjects’. How cruel and wicked it all seemed! Once these poor bodies were a joy and comfort to someone’s heart. But now – now – it was too much for her.

³⁷ The first lecture of the autumn 1881 term at the Woman’s Medical College was on 6 October, on gynecology: WMC, Minutes of Faculty Meetings, 1881-86. This was the first year that the College required student attendance at both a winter and a spring term of lectures. The chair in gynecology has been established in 1880. The Clinic Hall (referenced by Alexander below) was constructed in 1883. Cf. Marshall 69, 82-83. Alexander’s papers contain her notebook on academic and clinical lectures attended at the College, 1881-83 (Box 1, Folder 12). Most date from her second year and suggest a competent, informed student. The first clinical lecture attended by Alexander in 1881 was of a baby with skin eruptions; the second was for a blister on a woman’s ring finger.

She quietly left the room unnoticed. The worst part was to come. Later in the winter Katherine was assigned a part to dissect. It was awful. It seemed impossible for her to make the first cut. But after it was begun her horror and disgust were gradually absorbed by her interest in the wonderful and beautiful arrangement of muscle, nerve, vein and artery. Her first year at college quickly passed with lectures, clinics and laboratory work. The clinics at the Pennsylvania and Blockly Hospitals were open to the Woman's College students where they were not always well received by the Jefferson and University students.³⁸ One day a little missionary student from Virginia fainted. She felt it coming on and felt certain that if she did it would afford great fun to the Jefferson students present. Just as soon as possible she raised up off the seat where friends laid her. The only notice taken of her was: "Don't set her up too soon, it's often the cause of death," and without a pause the Professor went on with his clinic, presenting the symptoms and treatment of a typhoid fever patient before him.

* * * * *

Katherine is home for the vacation after two winters in Philadelphia. How she enjoys every hour! How beautiful seem the grass and trees and birds and soft springy earth, after a winter in Philadelphia where hard pavements, brick walls and English sparrows abound. Katherine looks just as she did two years ago. Some I told-you-so people are disappointed to find she has not put on bloomers. Her gentlemen friends have been slow in calling, fearing to find her changed from a gentle girl into a masculine woman. One evening a few days before her going to college for the last year, a party of young people called to bid her 'Good bye.' The evening passed all too quickly. It seemed like old times before Katherine went to College. The last good bys were said, but Will Herndon lingered. "Good by Katherine. I don't suppose I will ever see you again," said Will dolefully. "What's the matter," said Katherine, "you're not ill? Don't feel like dying do you? Let me feel your pulse." "I'd rather you would listen to my heart," said Will with a poor attempt to smile. "Katherine, will nothing induce you to give up this mad idea of ruining your life?" "If you call a noble useful life, which a woman doctor's life is, a ruined life, mine will be ruined. I have seen the necessity for women physicians and you must have seen the same in your college and hospital work." "It seems well enough for others to study and practice medicine but for you —. I wish I could persuade you that your happiness lies in another place. Katherine —." "Will it is useless," said Katherine quickly. "There is a niche for each of us and I must fill mine." "Katherine, don't tell me you will never

³⁸ Alexander was subsequently to write on the infamous challenge by these males to women students of the Woman's Medical College in the autumn term of 1869 with such passion, that some biographies have mistakenly believed she experienced the identical events. Alexander, "Woman in the Medical Profession": Alexander Papers, Box 1, Folder 5. For 1869 (cf. Peitzman 34-38).

marry. Some day you will [struck out: love and marry] but no man will love you better nor strive harder to make you happy than I would. The happiest lives are married lives.” “That may be true Will. Being an old maid I may miss a few joys but I shall escape many sorrows.” “I am going to open an office and begin work in Peoria soon,” said Will. “I had a letter from Tom Willets the other day telling me there was a good opening there for an active young physician. I will bury myself in my books and journals till work comes. How I shall long for work, hard work to try to forget the happiness I have missed.” “Good by Katherine,” a pressure of her hand and he was gone. Katherine sat gazing into the heavens through her open window. She neither saw the stars nor the silver crescent that hung in the west. She saw Will’s earnest pleading face. She thought of the happiness she might have had as his wife and wondered if the happiness would compensate for all the suffering and sorrow and heartache and tears that might come with it. Her heart answered “yes”; her head said “no.”

* * * * *

The three College years have ended and Dr. Katherine Caldwell is the proud possessor of a diploma entitling her to practice the science of medicine. After having spent a year profitably and pleasantly in the Woman’s Hospital of Philadelphia, her friends and acquaintances await impatiently for the coming of the first woman doctor in the state. Her impatience is due more to curiosity than any substantial interest.³⁹ With few exceptions every woman has said, “I hope she will succeed, but I could never trust a woman when I and my children are sick.” Mary Barry was the first of her friends to call. After the first greetings and asking and answering questions, Mary said, “Katherine you are to have a call soon from Mrs. Blake. I heard her say the day you came home she wanted you to attend her in her next sickness.” “They are new people here are they not?” “Yes, they came here from Kentucky two years ago. They have had very little sickness and have had your father Dr. Caldwell when they needed a physician. So look out for a call from her soon. By the way Katherine, she thinks you are a middle aged gray haired woman instead of a young girl of twenty-two with yellow hair and innocent baby eyes.” “Oh for old age and grey hairs,” laughed Katherine. “I suppose you have heard of Will Herndon’s success,” said Mary rising to go. “He deserves success.” “Yes, shortly after going to Peoria old Doctor Pratt took him into partnership with him and within the year the old doctor kindly went to heaven leaving his large practice in Will’s hands. His sister tells me he writes he is very busy and wishes he had a certain doctor whom he knows for a partner.” “I am glad to hear of his success, he deserves the best of everything. His nobility of character and tender sympathetic nature will endear him to his patients.” “A note for Doctor Caldwell,”

³⁹ Compare Alexander’s identical fear expressed to her father in 1885 (quoted above).

said a voice at the door a few days later. “Dear me,” said Katherine, “suppose it is the call from Mrs. Blake.” Taking the note from the servant’s hand she read: “Dear Doctor = Please call to see my wife as soon as possible. Yours, J. D. Blake.” “I wonder if it means me or father, it just says ‘Dr. Caldwell,’ and father is out. Mary Barry said they were going to send for me, so I’ll risk it and go.” She hurried on her hat and gloves, picked up her little black satchel which had been filled with all things needful anticipating this call and in twenty minutes rapped at Mrs. Blake’s door. “I wish to see Mrs. Blake,” she said to an old lady who opened the door. “My daughter is sick, bad off, and we’ve sent for the doctor, whom I expect every minute.” “I am here madam, I am Doctor Katherine Caldwell.” “You – Doctor Caldwell?” said the old lady in open eyed astonishment. “Why I supposed Miss Doctor Caldwell was – was –.” “That’s all right madam, I received Mr. Blake’s note asking me to call. Will you show me to Mrs. Blake’s room?” Dr. Katherine followed the old lady into the sick room. “Mary this is Miss Caldwell, Miss Doctor Katherine Caldwell.” Mrs. Blake turned her head to look at the woman doctor. “Mother,” she said, “where is the doctor?” “I am the doctor,” said Katherine, quickly drawing off her gloves and going to the bedside. “Oh! O— O— Oh—!! Why didn’t your father come? Mother sent for Doctor Caldwell.” “Dr. Caldwell is not at home,” said Dr. Katherine. “If I have made a mistake and am not wanted, I will bid you good morning,” picking up her little black satchel to go. The mother quickly laid her hand on the doctor’s arm and said, “Don’t go Miss Doctor, excuse Mary’s talk, she is suffering so she does not know what she is saying, please stay and do something for her.” Reluctantly Doctor Katherine stayed, fearing that if all did not go well that it would hazard her success in that most historic of Southern towns where such an innovation as a woman doctor was not looked upon with much favor. Oh! The mental agony and physical anguish of doctor and patient during the next half hour. It seemed hours to both. The anxiety and pain are at last ended with a heartfelt “Thank God,” and a feeble infant cry in a peculiar minor key. Dr. Katherine left the house an hour later, the patient happy with her little pink baby on her arm, and the new grandmother blessing and praising women doctors in general and “Miss Doctor Katherine” in particular. On calling the next day Mrs. Blake said, “Doctor you must pardon the way I acted toward you yesterday. You looked so young, so pale and scared that I became frightened myself. I feel well this morning. You have my entire confidence and will have my practice in the future.” That was Doctor Katherine’s first patient, the successful issue of which was the beginning of a successful career.

* * * * *

Three years passed, each succeeding one being more successful than the last. Doctor Katherine is devoted to her work. Her special delight is with little children who love her as their best friend. As she drives through the shady streets one hears on all sides “Hello Doctor Katherine” from these little friends of hers.⁴⁰ She has had a trying week. A terrible epidemic is scourging the city. Many adults and children have succumbed to the grim Angel. Returning home one morning after spending the night with a desperately ill mother and dying babe, she finds a letter from Doctor Will Herndon. A blush creeps into her pale cheeks. She hesitates before reading it. Tired and exhausted she throws herself on the lounge in her office. Suffering and joy, death and life, happiness and sorrow mingle painfully in her thoughts. She reads the letter the second time. Falling asleep the last lines mingle in her dreams. “You are more than wealth or life itself to me Katherine. All that Peoria needs to make it the hub of the universe is a nice little woman doctor. Won’t you come?” Bella Donna

Rules and Roles in the Piedmont

11 Annie Alexander was undoubtedly capable of, and suited for, a career in medicine. The first assessment was by Dr. Anita E. Tyng, a native of Providence, Rhode Island, the second vice-president and recording secretary of the Woman’s Medical College of Pennsylvania when Alexander entered in 1881, and the Physician-in-Charge and Alexander’s mentor at the Woman’s Hospital of Philadelphia in 1884-85. Tyng commented in March 1885: “[I] anticipate an honorable & brilliant one [a medical career] for her, because besides her mental accomplishment & good observing faculty, she has three other qualities of the good physician, dignity, gentleness, firmness, & a calmness & coolness in emergency which inspires confidence in others.”⁴¹ This is the only known assessment of Alexander which could have been applied equally to a good male physician. All others were highly praiseworthy, and all interpreted her as a woman physician. Susie Van Landingham in 1896 portrayed the practitioner’s success in Charlotte within the context of “a modesty that is impressive and womanliness that is emphatic” (qtd. in Henderson-Smathers 41). Alexander’s niece, who provided the main obituary notice for the North Carolina Medical Society, initiated (in print) the well established family tradition of “Dr. Annie’s” exceptional, heroic, struggle against prejudice: “Her invasion of the field of medicine, so long held by men, and with the laity slow to accept the woman doctor, required very considerable courage” (Stowe 164). Compare her assessment with that earlier by Tyng: “Love and kindness radiated from her presence in the

⁴⁰ Identical stories were later told of “Dr. Annie” by her former child patients (cf. Blythe; Thompson 14).

⁴¹ Alexander Papers, Box 1, Folder 1, Tyng to John Alexander, Mar. 19, 1885.

sick-room, inspiring confidence.” The result was the same; the construction was highly gendered. Both her niece and the Mecklenburg County Medical Society considered her an “unusual woman” (Stowe 164).⁴² It is as well that Dr. Alexander was not alive to read this last comment, for her self-assessment would never have placed these two words together. The editorial in *The Charlotte News* which marked her demise is worthy of quotation in full, as the considered judgment of an influential male commentator: More than the mere novelty of having been the first woman South of the Potomac River to enter the ranks of medicine for a professional career attached to the life and achievements of Dr. Anne [sic] Alexander whose passing here is so widely mourned. She brought into that profession such high resolutions and nobility of character, such proficiency in maintaining that warmth of relationship between practitioner and patient, that she became outstanding. There was a demureness about her and a humility, a seeking of not her own that glorified her in the esteem of her people. Long has she wrought her good works. For more than 40 years she has practiced her profession in the homes of the people here, moving among them with a majestic dignity and a proficient touch which enthroned her not only as a medical expert of superb order, but as a woman doing a great work in a womanly way – with tenderness, with soulfulness, and with love for her work no more dominant than love for those she served.⁴³

12 Dr. Alexander would have agreed with the interpretation that she, and all women in medicine, were responsible for performing “a great work in a womanly way.” The character Dr. Katherine feared that contemporaries would view her as transformed “from a gentle girl into a masculine woman.” Alexander consciously worked to avoid such an epithet. This appears to have been both a personal preference, and a public policy. She viewed herself as a white, elite southern woman, whose profession was medicine. Modesty was essential: women of her class and race were modest, and demonstrated this through personality, actions, and dress. This theme lay at the center of Alexander’s actions in the public sphere, and in her private practice, for the moral reform of girls and young women.⁴⁴ Parents were instructed to restrain, not cultivate, their children’s imaginative and artistic faculties: “Cultivate & insist upon orderliness in all things. Fitness, self control, & orderliness are the most important.”⁴⁵ Her unmarried pregnant teenage patients were wrongdoers and sinners.⁴⁶ A firm Presbyterian

⁴² “Death of Dr. Alexander Subject of Resolutions” (Alexander Papers, Box 1, Folder 11).

⁴³ Alexander Papers, Box 1, Folder 11, “Dr. Anne [sic] Alexander” (Oct. 1929).

⁴⁴ The theme runs through many of her public addresses and essays. Note, “Fifty Years Ago” and “Dress” (Box 1, Folder 2), “Indigestion Is the Pandoras’ Box of Human Ills” (Box 1, Folder 3).

⁴⁵ Alexander, Untitled 19-page address to the Charlotte Woman’s Club, beginning “Our Woman’s Club.” Alexander Papers, Box 1, Folder 5.

⁴⁶ For example, casebook 1924-29, 171, 180 (Alexander Papers, Box 1, Folder 15).

piety was a frequently commented upon, life-long, attribute (cf. Stowe 165).⁴⁷ Alexander's value system was traditional at its core. She wrote, "I believe no womans [sic] life is complete until she is a wife and mother. Some of us never attain to that completeness [...]."⁴⁸ Motherhood was a sensitive personal topic for Alexander. She once observed that the Charlotte Woman's Club was originally named the Mother's Club, and she and Miss Lily long, a nurse, were the only unmarried members: "I was asked what we two were doing as members of a mothers [sic] club. I answered that we had helped rear more children than any other member. [...] In heart and soul we [women] are all mothers."⁴⁹ She asserted that health and morality concerned women more than men, and their civic involvement was therefore indispensable: "Women should be on all Boards that have to do with women and children [in addition to working through women's clubs and civic leagues]. [...] Women's work is essential with children."⁵⁰ And, in medical practice, even in the South, a woman doctor was accepted "where she conducts herself as a true woman and physician should."⁵¹

13 In 1889, Alexander argued the case for women in medicine in terms of separate spheres. They were required because "[a] suffering woman naturally turns to [a] woman for sympathy." And, there were diseases peculiar to women which both should be, and better could be, treated by doctors of their own sex ("Women Physicians"). Moreover, women physicians had demonstrated great success in treating childhood diseases because "There is an instinct in women that gives them an insight into the sufferings of the little ones" ("Women Physicians" 1-2). The sentiments within "Doctor Katherine", expressed more briefly, adhere to these beliefs. A quarter century later, in a similar exhortation to young women, Alexander no longer cited the importance of providing women physicians for women patients. Now, the emphasis was upon medicine as a wise career choice for talented young women. Abundant well-paid jobs existed in public health, medical laboratories, hospitals, and medical colleges, in contrast to the overcrowded fields for women teaching in the humanities. Moreover, "[w]hile the work in any field of medicine is exacting, lack of monotony [...] lends a charm and inspiration which means joy to the worker, and without which the real zest of living must be lost."⁵² At present, she noted, twenty-five women were practicing medicine in North Carolina, without novelty and free from professional or lay prejudice.

⁴⁷ Expenditures in her financial records, 1920-24: Alexander Papers, Box1, Folder 7 (unpaginated); "Funeral to Be Held Today For Dr. Alexander": Alexander Papers, Box 1, Folder 11.

⁴⁸ Alexander, "Our Woman's Club" (Alexander Papers, Box 1, Folder 5).

⁴⁹ Alexander, "Our Woman's Club" (Alexander Papers, Box 1, Folder 5).

⁵⁰ Alexander, "Womans [sic] Aid in Civics" (Alexander Papers, Box 1, Folder 5).

⁵¹ One detached page of an address by Alexander on women in medicine, delivered to a South Carolina audience, circa 1890s. Alexander Papers, Box 1, Folder 5.

⁵² Alexander, "Woman in the Medical Profession" (Alexander Papers, Box 1, Folder 5).

14 Race and class figure subtly in Alexander's lectures on civics and social improvement. Although a supporter of women's suffrage and their advanced education as general principles (cf. Alexander, "Women Physicians"),⁵³ her focus was always directed towards women not dissimilar to herself. For example, when advocating for women to take up civic involvement, she wrote: "Women have more to do with the health and morals of *our race* than the other [male] half."⁵⁴ In a lecture to the Charlotte Woman's Club in 1912 on the importance of public tuberculosis education, she condemned the city's African-American population for inculcating and spreading the disease: "Their ignorance in regard to the disease is dense. They crowd together, sleep in the room with the sick one, who knows nothing of personal hygiene [...]."⁵⁵ After many negative assertions along the same lines, Alexander then briefly added, "I have seen [the same] occur among the ignorant whites of the city," and she called upon the Club to devise a practical method of educating "these two classes." The structure of the speech allotted blame disproportionately upon the African-American population, but clearly neither they nor the poor whites were within the pale. Alexander was a supporter of eugenics who believed that "The death dealing hand of nature [rightly] destroys the life of most of her offspring" as "the sick and the weak succumb to their insufficiency." However, "[a]s we conquer disease we preserve the unfit, in saving infant lives we save many inefficient ones to grow to maturity to propagate their kind and become a burden on society."⁵⁶ Frequent references to Mecklenburg County's "poor, ignorant and dirty" demonstrate a womanly, an elitist, and a professional requirement to assist, but no affinity.⁵⁷

15 Alexander, thus, was very much a part of her time and place. Women were to be educated not least because the educated mother was the best mother.⁵⁸ Their intellect was superior to males ("Women Physicians"), but excessive study during adolescence undermined health and made them prone to emotional, nervous disorders.⁵⁹ The woman in medicine possessed a special calling (in addition to the one shared with male colleagues) because she was a woman and because, from necessity, she came from society's well-to-do. If we accept the second-hand evidence that John Alexander was responsible for selecting in 1878 a medical career for a dutiful young daughter, aged fourteen (Pendleton 42; Thompson 14; Kent

⁵³ Alexander Papers, Box 1, Folder 11.

⁵⁴ Alexander, "Fifty Years Ago" (Alexander Papers, Box 1, Folder 2).

⁵⁵ Alexander, "What Can We Do to Prevent Tuberculosis?" (Alexander Papers, Box 1, Folder 3).

⁵⁶ Alexander, "Eugenics Comparably a New Word" (Alexander Papers, Folder 3).

⁵⁷ For example, Alexander, "Womans Aid in Civics" (Alexander Papers, Box 1, Folder 5).

⁵⁸ Alexander, "Womans Aid in Civics" (Alexander Papers, Box 1, Folder 5); Alexander, "A New Born Infant" (Alexander Papers, Box 1, Folder 3); Alexander, "Menstrual Disorders" (John Alexander Papers, Box 1, Folder 7).

⁵⁹ Alexander, two lectures on nervous prostration (Alexander Papers, Box 1, Folder 3), "Our Womans Club" 12-16 (Alexander Papers, Box 1, Folder 5), and "Fifty Years Ago" (Alexander Papers, Box 1, Folder 2).

94-96), it is worth speculating whether he could, or would, have done so in the absence of his aggressive self-assuredness at the top of the county's hereditary elite. For Alexander, herself, she encountered no exact role models: an analysis of career choices by elite women in North Carolina, 1865-95, could produce for medicine only Alexander (cf. Censer).⁶⁰ She, in "Doctor Katherine" and in her first publication of 1889, would look to the American North and West for models of women physicians ("Women Physicians"). However, she never considered a life for herself outside the South. In the South, perhaps especially for her in Mecklenburg County, Alexander possessed a role. She broke some rules. She entered medicine, and family tradition states that a portion of the family never again spoke to her or uttered her name (Kratt 12). She did not marry. The family tradition would have us believe John Alexander forbade marriage, for then the expense of a medical education would have been wasted (Pendleton 42, 62, 64; Thompson 14-15). In 1919 she adopted a three-year old orphaned boy, and she raised in her home the seven children of her deceased brother, Robert (Blythe; Thompson 15; Pendleton 64). Interestingly, Annie Alexander is assigned no credit (or no blame) for either of the transgressions – both were attributed to a strong-willed, long deceased, father. Alexander, herself, is for us today wholly silent on both career and marriage decisions, except within the pages of "Doctor Katherine."

16 Annie Alexander has left to posterity two works of fiction. The first is "Doctor Katherine." All that survives of a second story, which must date from after 1911, are two pages entitled "Chapter II." This is a love story told from a young heroine's perspective, of her devotion to and cherishing of a man. The text breaks off abruptly. Immediately after these two pages, a large number of leaves have been ripped out of the volume, and destroyed. This story is written in the unused portion of her father's last medical casebook.⁶¹

17 In 1890, 410 North Tryon had been situated in a charming residential neighborhood within a short walk of the city center.⁶² The Wall Street Crash, nine days after her death, speedily destroyed the value of hard-won investments. Alexander, who published relatively little and who consciously maintained a high public profile only in her own community, has almost wholly been ignored in modern scholarship. Within public memory in Charlotte, she is "the remarkable Dr. Annie," with a "rather heroic story," who sacrificed herself in order to achieve the impossible (Pendleton; Thompson; Blythe; Kratt 12; Anon., "Annie"; Kent 97, 104). What stands out in Alexander's life is not sacrifice, but duty: the dutiful daughter; the

⁶⁰ The vocational and educational context also worked against the development of directly applicable role models (cf. McCandless; Turner).

⁶¹ John Alexander Papers, Box 1, Folder 7 (unpaginated).

⁶² By the early 1920s she occupied the last private residence, surrounded by car dealerships, a barber shop, dry cleaners, service station, and light manufacturing.

dutiful mainstay of societies, charities, and hospitals; the conscientious physician. The message to adolescent girls of the 1880s in “Doctor Katherine” was that one did not have to be exceptional to succeed in medicine, and perhaps even “have it all,” both career and marriage.⁶³

⁶³ It is ironic that Alexander has been cast (after her death) as exceptional, particularly because she strove diligently to fit expectations, and because during her lifetime Charlotte’s male elite generally found it advantageous to view its sole woman physician as a model of the modest, reserved citizen, and southern woman.

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The San Francisco Experiment: Female Medical Practitioners Caring for Women and Children, 1875-1935

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Abstract:

Prior to 1911 when California women gained suffrage, women's health issues were rarely deemed important. In early 1875, Drs. Charlotte B. Brown and Martha E. Bucknell established the Pacific Dispensary Hospital for Women and Children as a public health model for indigent children and an urban clinical-training facility for female health professionals. This paper will look at how Dr. Charlotte Blake Brown (1846-1904) and Dr. Adelaide Brown (1867-1940), mother and daughter activists for women and children's health, shaped medicine in San Francisco. They had forceful personalities, yet their experiment to foster a community of female health care providers to directly serve women and children proved to be more fragile than anticipated. After Dr. Charlotte Brown's death in 1904, her daughter picked up where her mother left off despite opposition to take on the dairy industry throughout her career in long campaigns to regulate milk products.

1 San Francisco had shed most of its boomtown heritage to become a mercantile hub in the American West and gateway to the Pacific Rim commerce when, in February 1875, Dr. Charlotte B. Brown, Dr. Martha E. Bucknell, and other female community leaders established the Pacific Dispensary Hospital for Women and Children as a public health model of care for indigent children and an urban clinical-training facility for women. The well being of women and children was wrapped within broader economic empires of a few men who dominated the lucrative industries that shaped the California economy during the Progressive Era. Women's health issues were rarely deemed important until 1911, when California women cast their votes locally for the first time. Dr. Charlotte Blake Brown (1846-1904) and her daughter Dr. Adelaide Brown (1867-1940) were activists for women and children's health reform in San Francisco. They collectively improved access to health care for poor women and children by fighting for health equity over a fifty-year period. The Pacific Dispensary Hospital became an experiment to see whether female physicians with authority within a specific medical community could establish an enduring institution to educate female medical practitioners to care for women and children.

2 Three and a half years after the Pacific Dispensary Hospital was established, kindergartner Kate Douglas Wiggin opened the Silver Street Free Kindergarten in the working-class Tar Flats neighborhood south of Market Street in San Francisco (Issel and Cherny 61, 105-06). Female medical practitioners inadvertently tread in the male medical domain, whereas Wiggin, who later became a best-selling author of children's books, utilized

an acceptable feminine vehicle for acclaim when she promoted the kindergarten movement. Wiggin wrote *The Story of Patsy*, a brief literary sketch to benefit the Silver Street Free Kindergarten, which was expanded and published in 1889 (Wiggin 12). In the story, Patsy with his “shrunken, somewhat deformed body,” presented Wiggin’s view of the spiritual potential of working-class children in the kindergarten, when Patsy actually personified the symptoms associated with bovine tuberculosis that was passed to humans via contaminated milk products. The Pacific Dispensary Hospital and the Silver Street Kindergarten both competed for support from the same local philanthropists, including Phoebe Apperson Hearst, Adolph Sutro, William Ralston, and Charles Crocker. The Pacific Dispensary Hospital went about the gritty task of educating parents and the city about environmental and industrial health hazards, while the Kindergarten nurtured a romanticized worldview of ethereal child garden in San Francisco’s slums. Dr. Adelaide Brown would address bovine tuberculosis by taking on the California dairy industry during the early twentieth century.

“The Pioneer”

3 Charlotte “Lotte” Amanda Blake, the daughter of pioneer medical missionaries, was born in Philadelphia in 1846. Her father Charles Morris Blake studied for the ministry before the excitement of the California Gold Rush led him to travel via the Isthmus route to California in early 1849. His wife, Charlotte Farrington Blake, a nurse, and their three children joined him in California during the fall of 1851. Blake established a boarding school for boys in 1851 that later became the Collegiate Institute in Benicia, California, and evolved into University of California’s Hastings College of Law in San Francisco (*History of Solano County* 166). The Blake family left California for several years to pursue healing Presbyterian missionary work in South America. Charlotte returned to the United States to attend Elmira College in New York, graduating in 1866. She married Henry Adams Brown and worked as a nurse. The Browns traveled to Arizona in 1867 where Charlotte worked as a nurse. During the 1870s, the Blake and Brown families reunited in California. Charles Blake studied medicine at Toland College in San Francisco, and worked as an Army chaplain until 1883. However, Charles was not alone in his medical studies; his daughter Charlotte also had aspirations to practice medicine.

4 Dr. Charles Blake established his medical practice in Yountville, California, a small coastal community north of San Francisco. The two families soon relocated inland to Napa, California where all of Charlotte’s children were born. Her eldest children, Adelaide and Philip were young when she began to read medicine with Dr. Charles Nichols. Her youngest

daughter was born before Charlotte discretely traveled to Philadelphia to study gynecology at Women's Medical College. Her children remained with their grandparents in Napa. Grandmother Farrington, as she was called, wrote to Charlotte in 1872, asking if she should tell anyone "out of the family of Lotte's purpose in being on the East Coast" (Children's Hospital of San Francisco, 1875-1988). Adelaide was seven years old when her mother graduated with her medical degree in 1874. Lotte's purpose would be revealed upon her return to California when she set about establishing a children's hospital in San Francisco.

5 Dr. Charlotte Blake Brown, along with Dr. Martha E. Bucknell and ten San Francisco women founded the Pacific Dispensary Hospital for Women and Children in early 1875. Located at 520 Taylor Street in San Francisco, the hospital provided free health care, charging only for medicine. During its first ten months of operation, most of the hospital's 267 patients were treated for ailments resulting from malnutrition. Aside from support of the men in their families, the founders of the clinic were on their own in this endeavor (Hendricks 61-63). Charlotte's husband, employed at Wells Fargo Bank, used his influence to get the bank to provide rooms for meetings of the Women's Medical Society.

6 Dr. Charlotte Blake Brown was rejected for admittance to the San Francisco Medical Society on the grounds that she was a woman in 1875. However, she proved to be a successful surgeon, obstetrician, and medical organizer. Brown worked in the "Chinese Quarter," serving as a physician and missionary to the Chinese community in San Francisco (Starr 47-48). Female physicians practiced medicine in Chinatown because Chinese husbands did not want their wives examined by male Caucasian physicians. The California State Medical Society drafted legislation standardizing qualifications for medical practice in California which made no mention of gender, resulting in the passage of "An Act to Regulate the Practice of Medicine" in 1876 (Cal. Stats. 1876, ch. 518, 792-94). Brown served as the first female chair of a State Medical Society in 1876, and performed the first "ovariotomy" by a female surgeon on the West Coast in 1877. She became one of five women trained in medical schools to be admitted to the San Francisco Medical Society the same year.

7 The mission of the Pacific Dispensary was to be an institution "for women, controlled by women, with women physicians" (Thelander 184). All attending staff, interns, and residents were female. The Pacific Dispensary Hospital reincorporated as the Hospital for Children and Training School for Nurses to include a more extensive academic mandate in 1885. While it served as the first training school for nurses on the West Coast, the original gendered mission of the Pacific Dispensary Hospital, chiefly, "to provide for women the medical aid of competent women physicians," was diluted. The hospital, located on a donated

property at California and Maple Street in San Francisco's inner Richmond District, could boast of having a nearby pasture of dairy cows in the Presidio. In 1889 an adjoining lot was acquired for a specialized orthopedic unit where children (like Wiggin's character Patsy) with crippling bovine tuberculosis received treatment.

8 In 1896, Dr. Charlotte Brown studied the health of adolescent schoolgirls 16 to 19 years of age in Oakland and San Francisco, to identify health problems appearing in immigrant and working-class communities that might be related to urban living ("Health" 1-7). She discovered that adolescent girls suffered from similar health complaints to professional women (teachers, telegraph operators, and dressmakers) that included dental, sinus, vision problems, and feelings of anxiety. Brown's case histories indicated patterns among the Sweden, Germany, and Ireland immigrant populations that were similar to school girls who had long hours of homework in addition to schoolwork and household chores. She statistically correlated bad diet, sleep, and exercise habits to irregular menstrual cycles and a national trend of young mothers in urban areas having difficulties in breastfeeding. By the mid-1880s, mothers in well-to-do families chose not to breastfeed infants, providing the opportunity for mother's milk to become commodity (Golden 139). Brown suggested some preventative measures including the erection of municipal-funded gymnasiums, health education programs, and creation of a local version of the "New England Kitchen," a community-based, take-out, low-cost food service located in Boston's working-class and immigrant neighborhoods ("Health" 6).

9 Social historian June Golden asserted that prescriptive child-rearing literature increasingly characterized middle- and upper class women as "frail," providing some women with a ready-made excuse to avoid nursing (Golden 44-45). The local shift from breast to bottle-feeding for babies brought disaster to families in the city's poor working-class neighborhoods when contaminated milk brought infection and disease. The promise of safer childbirth utilizing anesthesia and forceps further assisted the shift of the birthing chamber from home to maternity hospital, and male medical academics took increasingly dominant roles on hospital staffs when they affiliated with universities in the late 1890s. Female medical practitioners were strongly encouraged to move from active roles as physicians in hospitals to supportive roles as nurses, social workers, and public health advisors.

"The Implementer"

10 Adelaide Brown followed in her mother's footsteps, becoming a surgeon, obstetrician, and gynecologist. She attended Smith College in Northampton, Massachusetts, graduating in

1888, and then returned to San Francisco where she studied at Cooper Medical School (adopted by Stanford University in 1908), earning her M.D. in 1892. Adelaide interned at Northeastern Hospital in Boston, and then traveled to Vienna to study at “leading European gynecological clinics.” When Dr. Adelaide Brown returned to the San Francisco in 1894, she joined her mother’s medical practice located at 1212 Sutter Street in San Francisco. Adelaide worked as an attending physician at Alexander Maternity Hospital throughout the late-1890s, and delivered babies at San Francisco Children’s Hospital as early as 1899. In her first paper, “A Case of Stricture of the Esophagus following a Carbolic Acid Burn,” presented before the Women’s Medical Club of the Pacific in 1895, Adelaide explained how her mother provided mentoring when she referred a case involving a toddler who could not swallow food or milk due to an irritated esophagus. She joined the staff of Children’s Hospital full-time in 1910.

11 Nationally, pasteurization and regulation became a solution for epidemic infant mortality from diarrhea-causing diseases. Nathan Straus became the nation’s leading proponent for pasteurized milk and garnered the attention of leading progressives when in 1897 he reduced deaths by fifty percent at Randall Island Infant Asylum in New York City (Miller). Historian Julie Miller asserted that Straus applied his entrepreneurial skills to promote pasteurization, while Dr. Adelaide Brown focused on milk safety as a public health issue. She built a career campaigning for milk safety, but she opposed pasteurizing milk, asserting “it gave a false sense of security” since at the time the pasteurized product still contained tubercle bacilli and other streptococci. With an initial \$250.00 grant from Adolph Sutro (Populist, San Francisco Mayor, 1894-1896), she established the Milk Laboratory in 1894 where cow’s milk was treated to have the approximate chemical make-up of mother’s milk. After Dr. Charlotte Brown’s death in 1904, Dr. Adelaide Brown continued her mother’s momentum as an activist to fight for milk safety in California. She carried forward the medical torch becoming a pioneer in the development of preventative medicine in California.

12Prior to the 1906 earthquake and fire, San Francisco was entrenched in political corruption. The former president of the Musicians Union, Eugene E. Schmitz (Labor Union Party, San Francisco Mayor, 1902-1907) with support from working-class neighborhoods fostered an administration filled with graft and corruption. Meanwhile, George H. Pippy (a Progressive Republican) promoted San Francisco as a business-friendly city. Pippy, a corporate attorney, owned the Columbia Dairy. During the early-1880s, with “a horse, a wagon, and divers milk cans procured on credit,” he established the Columbia Dairy, which rapidly grew into a thriving business (*San Francisco* 302-07). By 1900, the Columbia Dairy was the largest west of Chicago, consisting of extensive delivery routes, with depots located in Oakland and San

Francisco that were furnished by milk dealers throughout the San Francisco Bay counties. Pippy worked with the California Promotion Committee to aggressively court German agriculturalists in order to improve the State's cheese production. In 1905 the California dairy industry earned an estimated \$18 million (compared to the \$40 million fruit industry), and the state imported \$1.5 million in dairy products (Irving 229, 233, 239).

13 The earthquake and fire on April 18, 1906 severely damaged the city's infrastructure. Children's Hospital suffered "grave damage," requiring extensive repairs and rebuilding. Adelaide's brother Dr. Philip King Brown lost nearly everything, but she lived adjacent to the Presidio, and stepped away from her regular work to run the city's emergency room and to manage logistics for the pool of emergency Red Cross vehicles.

We had an emergency medical department which Dr. Adelaide Brown ran, and several automobiles were put at our disposal and were used to move the aged or sick to homes or to the ferry. Fresh milk and eggs were brought to us daily, forty to fifty gallons, from a ranch across the bay, for babies and mothers, and also the Army requisitioned a certain amount of food to be sent us for distribution daily. (H. H. Brown 11)

14 "Relief and Rehabilitation," funded the emergency room and emergency hospital care, this served a double purpose of giving relief to the refugees and assisting the hospitals financially. Brown and Pippy shared in interest in milk safety. Pippy, a colonel in the National Guard, was instrumental in securing fresh milk for the refugees, so the Finance Committee sold surplus supplies of potatoes, flour, and milk to raise funds for other emergency needs:

It was natural to think that condensed and evaporated milk would be necessities of prime importance, but on account of local conditions were not needed in great quantities. The supply of milk from the ranches outside the city was not much diminished by the earthquake. By confiscation and by arrangement with dealers, an abundant supply of fresh milk was secured for distribution to the refugees. (O'Brien et al. 101-02)

15 The intensity and duration and the ensuing fires destroyed the City's infrastructure. Gas mains broke, adding fuel to the fire, and roads buckled making transport arteries impassible. All means of telegraphic communications ceased by eight in the morning, when all energy was enlisted for firefighting. Over 3,000 individuals perished and over 300,000 San Franciscans were rendered homeless after fires ravaged the city for three days. It was impossible to purchase supplies for ten days. Homeless refugees built temporary shelters on vacant lots and in parks before tents arrived. Refugees moved westward towards Golden Gate Park and the Presidio, where a makeshift emergency room under Brown's management was erected.

16 President Theodore Roosevelt, aware of local corruption, dispatched Dr. Edward T. Devine, the General Secretary of the Charity Organization of New York to direct relief efforts in San Francisco (United States House of Representatives 46). Only a year before, the Red Cross had been reorganized to be a clearinghouse for relief services to deal with natural disasters. As yet, the Red Cross remained untested. Roosevelt instructed Devine to consolidate funds and resources from twenty representative national and international Red Cross organizations for earthquake relief during a period of experimentation before the Army withdrawal. Roosevelt appointed an experimental relief commission, headed by Devine, which included Col. George Pippy, and a Mr. P. J. Moran to distribute emergency funds. On April 25, Roosevelt announced to the public that the Army had “succeeded in caring for 300,000 homeless in the last five days” (United States House of Representatives 44, 58; Young). Divine was called back to New York, so the Relief Commission turned over its work to the San Francisco Relief and Red Cross Funds Corporation on July 20, 1906. The Corporation was established in order to address issues of general rehabilitation, permanent shelter, employment, care of the sick, and the settling of insurance claims.

“Building Upon Her Political Capital”

17 Historian Rickey Hendricks stated that Dr. Adelaide Brown’s pure milk campaign commenced after the 1906 earthquake and fire severely damaged hospitals as well as the city’s sanitation system (64). Brown worked as secretary for the Medical Milk Commission of the San Francisco County Medical Society (1907-12), and in 1912 she became president of the California Medical Milk Commission. The question of milk safety came to the fore as scientists devised a new technique for detecting whether milk had been tainted with bovine tuberculosis and other deadly bacteria. At this time she became an active member of the Commission for Prevention of Infant Mortality, the Baby Hygiene Society, and the Milk Improvement Association. Brown chaired a sub-committee of the Citizen’s Milk Committee for the San Francisco Federation of Women’s Clubs, charged with the task of investigating San Francisco’s milk supply and its relation to public health (Leonard, ed. 132). The sub-committee inspected dairies in Marin, Alameda, Santa Clara, and San Francisco counties, and included dairies at Soledad Prison. Brown established the Mother’s Milk Bank, sponsored by the Federations Baby Hygiene Committee in 1908, which also provided a Visiting Nurse Service.

18 In 1909, President Theodore Roosevelt summoned Brown to attend the White House Conference on Children and Youth, and she helped to establish a “Day Crèche” for infants of

female cannery workers at the Telegraph Hill Settlement the same year. Dr. Adelaide Brown could not carry on her mother's vision of women physicians caring for women and children in this rapidly changing environment; she had to define and follow her own course. Brown, a proponent for women's suffrage, served as Vice President of the College Equal Suffrage League of California. Women in California gained the vote without assistance from the national women's suffrage movement. Supporters utilized billboard advertising, drew large crowds to rallies with free entertainment, distributed literature, and hired a railroad car to carry their campaign to small-town whistle stops. In San Francisco, liquor industry lobbyists thought they could defeat women's suffrage by controlling the urban vote (Weatherford 194). Indeed, San Francisco ballot boxes were guarded to prevent fraud or ballot discards that might cancel out the rural vote. The attention paid to rural areas paid off when votes were counted, and California women won the vote with a tiny margin of one vote per precinct. Brown remembered:

In 1911, when I cast my first vote at 43, not at 21 years of age, I was perfectly sure my state and my city would be more interesting to me, as a voter, than my nation. Time has emphasized this conclusion. ("Why I Am Voting")

19 Under the aegis of the County Medical Association, Dr. Adelaide Brown led the Milk Commission's initiative to deliver certified milk to San Francisco schools, hospitals, and settlement homes. She worked with the American Association of University Women's Certified Milk Fund Committee on a fundraising campaign to raise the difference between raw milk (\$.05 per quart) and certified milk (\$13 per quart) to supply milk to "boarded-out" babies of working mothers under the auspices of Associated Charities (today known as United Way). This fund also supplied milk to infants at the Telegraph Hill Settlement, the Florence Crittenden Home, and children's hospitals in Oakland and San Francisco (Hendricks 64).

20Pippy, wanting to remain on the forefront of emerging dairy industry technology, worked with Brown to stay ahead of Nathan Strauss. Pippy reminisced:

Strauss was genuinely surprised to find how downtodate [SIC] our big dairies were. He came to talk pasteurization of milk, prepared to acquaint us with the novelty. He found pasteurization of milk carried on in all the big San Francisco dairies. He found dairy conditions in San Francisco better than in New York or Chicago. We owe that to the splendid work done by the last few Boards of Health and by the excellent Milk Commission headed by Dr. Adelaide Brown. (O'Day 239-40)

21 Brown received support from the California Civic League to fill the vacancy on the State Board of Health in 1914. Appointed by Progressive Republican Governor Hiram Johnson, she served for sixteen years until Governor James Rolph encouraged her to retire because of her opposition to his policies (Jordan). The fate of female dominance at Children's

Hospital was determined in 1914 when the process of re-incorporation designated that the hospital would be developed into a permanent institution between 1885 and 1915. A period of “affiliation” commenced between 1915 and 1921, and the Regents of the University of California decisively eroded the original mission of the hospital to train and retain women as leaders (Hendricks 65). Once the women doctors realized that they were in a precarious situation, they desperately petitioned the Regents to maintain the independent female department heads. Members of the Society for the Advancement of Women in Medicine and Surgery in San Francisco argued that Children’s Hospital was “the only hospital for young girls where their need for medical attendance need never be under the care of anyone but a competent woman” (Headquarters Society for the Advancement of Women in Medicine and Surgery). Phoebe Hearst, ill and near death, acknowledged the hospital’s unique place in the community in a letter to her niece Helen Brown (who was also niece of Dr. Adelaide Brown):

I fully agree with you that in case it is made due recognition should be secured for the continued political opportunities for women physicians and the educational opportunities for women interns and nurses at the hospital.

22 Dr. Adelaide Brown was tapped to serve the State in a professional capacity when Gov. Johnson appointed her to the California State Board of Public Health (“A. Brown, “Why I Am Voting”). In this position, she helped to establish “well-baby” clinics in San Francisco and other communities in the region where foster mothers could learn about baby care and nutrition. Brown ran the Well Baby Clinic held at the Panama Pacific International Exposition in 1915 that included an educational exhibit of incubators that was seen by hundreds of thousands of visitors from around the world. Governor C.C. Young appointed Brown to serve as chairwoman of the State Children’s Year Committee in 1918. The Children’s Year, an initiative of the U.S. Defense Department, came out of the United States’ entry into World War I. The military draft detected a high rate of physical defects that could have been prevented in childhood. Brown promoted “birth registration” in California, often contradicting government assumptions that infant mortality and illness was connected to race (“Birth Registration in California”). The Children’s Bureau provided National Cards for states to survey the health of children less than six years of age. With Brown’s prodding, 40,863 children were surveyed in California, and educational literature on child hygiene and nutrition was provided to parents. In 1919, Brown met with Young to establish the Bureau of Child Hygiene as a division of the State Department of Public Health. Her statistical evidence justified the financing of be a permanent service for mothers and children as a culmination of the Children’s Year Program, and resulted in legislation to establish and fund a Child Hygiene

Bureau in California, “[a]n Act to provide for the establishing and maintenance of a bureau of child hygiene under the direction of the State Board of Health,” prescribing its duties and powers and making an appropriation therefore” (“Child Hygiene Bureau”). Additional “well child” and “well baby” clinics were established throughout the state, so that by 1930 there were 260 health centers throughout the state. Brown argued:

The value of the recorded birth certificate has not been realized as a possession of the child – a child’s right – but the draft, school attendance, working privileges, and Americanization all emphasizes the value. (“Birth Registration in California”)

23 Brown favored government regulation, but she raised the ire of many physicians in the state when she pushed for birth registrations during the Children’s Year campaign. Brown asserted, “[c]arelessness in regard to birth registration is at the door of the medical profession” (“Birth Registration in California”). As the Children’s Year commenced, California was not yet in the national registry because physicians in rural areas were not registering birth certificates and vital statistics with the California State Board of Health. Brown needed statistical information to substantiate her sometimes-unpopular conclusions and to get federal resources to support preventative pediatrics. However, by the end of 1919, California qualified for inclusion in the National Registry, which resulted in the funding of health centers for babies two weeks to eighteen months of age as well as nurse visits. The philosophy behind this was that free childcare education was a “privilege” in the United States.

“The Brown Legacy”

24 Both Dr. Charlotte Brown and Dr. Adelaide Brown should be remembered as caring physicians and generous teachers who promoted child welfare, health equity for women and children, and quality education for women in medicine in California. The numbers say it all even if the means for calculating infant mortality have changed: the Children’s Year was seminal to lowering infant mortality in San Francisco from 59 per thousand births in 1918; to 3 per thousand births at the time of Dr. Adelaide’s death in 1940; a figure lower than today’s infant mortality rate of about 6 per thousand births. For San Franciscans, this meant that Health Center nurses made “teaching visits” to homes within 24 hours of a mother leaving the hospital (mothers giving birth in San Francisco could remain in the hospital from ten to fourteen days, and weaning took place within two weeks after birth), to set up the home for the mother. This visit was referred to as “house-breaking” because the nurse prepared the kitchen, bathroom and bedroom for the baby’s care. The service was organized through

“Community Chest” (today known as United Way), and expert obstetrical nurses provided instructional visits after the mother and baby left the hospital. Brown argued that public education was free in the United States where the assumption was that “ignorance and poverty were not synonymous.”

Our hope is to have the hospitals realize [...] they owe some duty to the baby’s start in its own home, and add this instructive visiting to the service they are already rendering the doctor, the mother and the baby. [...] We regard this as an educational service and aim to help the mother to start skillfully and systematically in the care of her baby. (“Preventive Pediatrics”)

25 By 1921, the model for female medical practitioners caring for women and children established by Dr. Charlotte Blake Brown had been developed by the Pacific Dispensary Hospital for Women and Children, which transformed into Children’s Hospital of San Francisco that remains an enduring part of California Pacific Medical Center. Dr. Adelaide Brown continued to work at Children’s Hospital, but her focus was on public health issues in California. Dr. Adelaide Brown remained a powerful agent in “almost every forward movement in preventative medicine and public health” (Anon.). During the 1920s, Brown traveled throughout the Far East surveying health care for women and children and mentoring her students who continued medical missionary work in China, Indonesia, and India. Brown advised the California State Legislature on milk laws and ways to break up dairy price fixing in the state well into the 1930s. During the 1920s, Brown persuaded the Baby Hygiene Committee to teach birth control methods (also known as the “rhythm method” or “baby spacing”) at its Maternal Health Center, and she was a founder of Planned Parenthood in San Francisco. Generations of San Franciscans remembered the Browns as a family of caring physicians and generous teachers who promoted child welfare and quality education for California women in medicine.

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How to Fail: Female Medical Students and Women Doctors in Popular Fiction around 1900

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Abstract:

This article is based on novels in the German language, translations into German included, whose protagonists or important minor characters are woman doctors or female medical students. The time frame begins with the admission of women to (European) universities in the second half of the 19th century and extends into the middle of the 20th century. How did authors cope with this new figure, the female (medical) student, the woman doctor? The subject of failure shows up surprisingly often in early stories about female medical students and woman doctors. Following several subjects which were negotiated in the contemporary discourses of the time, I am going to demonstrate the ways that led women respectively female literary characters who wished to become physicians to failure: nursing, success (as strange as it sounds), nonexistent role models, and the fear of loneliness, all expressing conflicts due to gender stereotypes.

1 As the first German-speaking university to grant women degrees, the University of Zurich in Switzerland is frequently mentioned in fiction – if not by name, then by description: Johanna Spyri's protagonist Sina (*Sina* [1884]) and Ilse Frapan-Akunian's Josephine (*Arbeit* [1903]), for instance, study in Zurich. While passionate discussions about university access for women still ran high in Germany, a surprisingly pragmatic position was taken up at the (then small and new) University of Zurich. Women had been allowed to attend classes as guest auditors since the university's opening, and in 1867 the first woman, a Russian called Nadezda Suslova, was officially matriculated at the faculty of medicine (Verein Feminist. 17). Even if female medical students were still rare at the University of Zurich until far into the twentieth century, women were nevertheless at least able to study and graduate; the only other university in Europe that granted degrees to women was in Paris. Taking this progressive attitude, based in fact and mirrored in popular literature, as a starting point for analysis, this article about female physicians in (popular) fiction examines novels in German, including translations into German, whose main figure or important minor character is a woman doctor or a female medical student. The timeframe extends from the admission of women to European universities in the second half of the nineteenth century into the middle of the twentieth century, with the main focus on works around 1900.

2 The admission of women to medical studies was a vehemently discussed topic in the contemporary media, along with related conflicts concerning their training, professionalization, and social position. Power structures were shaken by the combination of

women obtaining a medical degree (which signifies power over the human body) and feminist demands for women's social, economic, and political equality. These social problems were also discussed and negotiated in contemporary fictional texts by means of the newly created character of the woman doctor and vice versa the literary discussions in turn took part in non-fictional discourses – or not, indicating which issues could and could not be negotiated in literature and/or in connection with women around 1900.¹ So when and on what terms did women doctors appear as literary characters? When did the newly established fact find its record in literature, i.e., fiction?

3 In this article, I will only briefly touch on the battle for and intense discussions about equal rights and higher education for women and all the attendant discourses conducted in politics, medicine, law, economics, etc., that have already been described in detail in many works. For the contextualization of the exemplary novels I have chosen for this article, I concentrate on the facts that explain and explicate my textual examples. The chosen works demonstrate the wide range of literature in which women doctors appear, including novels by both male and female writers, young adult fiction and general fiction, and translated works.

4 Researching my article, I was soon struck by the surprisingly frequent subject of failure that showed up in the early stories that came into my hands. The fact that authors sketched talented young women eager and determined to study, overcoming every obstacle to do so, only to let them fail in the end, caused more than just a mild irritation. Intelligent as well as highly motivated, the women nevertheless, after a brief struggle more with circumstances than with their own ambitions, give up their studies, profession, or own career in the end in order to marry or to further a man's career. This is the case even when the man is a son, as for Lisa Wenger's protagonist Marie Zuberbühler in *Die Wunderdoktorin* (1910):

Alles was ihr sonst Freude gemacht hatte, wurde ihr gleichgültig. Nur das Eine blieb für sie bestehen, dass der Sohn fort musste, hinausgedrängt durch die Mutter. Das durfte nicht sein. [...] Einmal, in einer schlaflosen Nacht durchzuckte es sie wie ein Blitz. In grellem Licht stand ein Ausweg vor ihr, und in demselben Augenblick wusste sie, dass es der Weg war, den sie gehen musste. Wie ein Messer schnitt es ihr ins Herz und nahm ihr den Atem. Mit weit offenen Augen lag sie und starrte ins Leere. Was da vor ihr aufstand und sie wie eine Riesin aus mächtigen Augen mahnend ansah, war die Entsagung. (290)

5 How did authors cope with this new figure of the female (medical) student or woman doctor? Why let her fail so often? Examining several subjects which were negotiated in contemporary discourses, I am going to demonstrate the ways, e.g., nursing, success (as

¹ For the idea of negotiation and circulation see Greenblatt.

strange as it sounds), exceptionalism, and nonexistent role models that led women, specifically female protagonists who wished to become physicians, to failure.

Nursing

6 Should women study medicine or are they instead destined to be nurses if they want or need medical education? A woman, as Professor Clementi remarks in *Sina*, should not cut the body open – she should heal the cuts:

“Sollte nun auch ein junges Mädchen den unabweisbaren Beruf in sich fühlen, Arzt zu werden, nun, so soll sie ihm folgen. Ich glaube zwar – zur Ehre der Frauen sage ich es – sie fühlen diesen Beruf in sich, indem sie den des Arztes mit dem der Krankenpflegerin in ihren Gedanken zusammenschmelzen. Wo ist die Frau, die nicht lieber verbinden und heilen als schneiden und brennen würde? Warum denn den Beruf wählen, in dem der Mann ohne Zweifel ungleich mehr und Besseres leisten kann und nicht denjenigen, in dem die Frau nie erreicht wird, wo der Mann sich gar nicht messen kann mit ihr?” (Spyri 125-26)

7 *Sina*, by Johanna Spyri, is the earliest novel that I examine. The famous author of *Heidi* published this novel in 1884. Sina wants to support her beloved grandmother’s charity work by becoming a woman doctor, but, devastated by her grandmother’s death, she leaves the university after a student who misunderstands her friendliness declares his love for her. In the end, Sina finds her true calling as the wife of Professor Clementi, whom she reencounters while tending an injured child, now carrying out the task of the nurse he had always wished her to be:

“Das Verbinden werde ich übernehmen, Herr Professor,” sagte sie, “wenn Sie denken, ich werde es gut machen.” “Das werden Sie ohne Zweifel,” entgegnet er herantretend, “meine Erfahrung hat mich gelehrt, dass Verpflegen und Verbinden von Frauenhänden am besten besorgt wird.” Er besorgte nun den Verband unter Sinas Augen und erklärte ihr genau, was hauptsächlich zu beobachten und was zu vermeiden sei. Diese Erklärungen schienen Sinelis Missfallen zu erregen. Plötzlich rief die Kleine ärgerlich: “Ja, ja, das weiss Tante Sina schon gut genug.” (207)

This episode depicts a pattern that will show up repeatedly: Nursing, understood as changing bandages and caring for children, is supposed to be the task of a woman, no matter if she is a doctor or not.

8 Even Daisy, the best friend of the protagonist Hilde in Else Ury’s novel *Studierte Mädels* (1906) and who symbolizes the conflict between hegemonic ideas of femininity and academic, i.e., medical, studies for women, is not supposed to cut open bodies, that is to perform surgery. Thus, Daisy passes the knife to the male physician:

Es stürmte in ihm, seine Gedanken jagten sich – wie weich und zärtlich Daisy das eigensinnige Kind eben noch umfassen, und wie kaltblütig und ohne jedes

Wimperzucken sie ihm gleich darauf das scharf geschliffene Messer zugereicht hatte. Reimte sich Weiblichkeit und Frauenstudium nicht doch zusammen, lieferte Daisy ihm nicht täglich aufs neue den Beweis, dass er ihr mit seinem verdammenden Urteil unrecht getan? (222)

9 What would have been the young physician's reaction if Daisy had done the cutting herself? The conflict represented by the figure of Daisy is none: she is no threat and no competitor but rather hands over the knife and stays a nurse – even if a first-class surgical one. Daisy has already finished her *Physikum*, a preliminary medical examination, and works as a *Famulus* for her future husband. However, like Sina, Daisy is limited to changing bandages and reading fairytales to the children; she is the one who causes the least pain when she is examining them (220).

10 In *Nesthäkchen* (1921), Ury creates a similar plot, “recycling” the situation fifteen years later: perceptions of women doctors have not changed, as taboos against operating and inflicting pain have remained persistent. After a year of studying medicine, Annemarie interns for several weeks in a hospital as her future husband's *Famulus*. But what she does (like Sina and Daisy) is the work of a nurse in both meanings of the word – changing bandages and caring for, not hurting, children, as is pointed out again:

Die lustige Tante, die mit den kleinen Kranken scherzte und spielte, [...] vermochte [...] dem Urselchen, das so arge Schmerzen hatte, gut zuzureden, bis es dem Onkel Doktor sein “Wehweh” zeigte [...]. “Tante Annemarie soll das Pflaster auflegen, Tante tut nicht weh –” weinte das kleine Ding. (168)

11 Whereas in *Studierte Mädel*, Ury (being “braver” than fifteen years later) at least included a short scene about a practical lesson in anatomy in which the protagonist Hilde, the daughter of an oculist, is more accomplished than Daisy, there is hardly a word in *Sina* and *Nesthäkchen* about the medical studies the young women are supposed to be pursuing. Sina and Annemarie both attend botany lectures – which involve nothing of the human body. Instead, Annemarie's travel adventures and outings with other students, as well as her inexperience in housekeeping, receive long descriptions. Sina, for her part, is constantly tortured by guilt about her beloved grandmother's death: not being by her side, leaving her for her studies, and not supporting and sharing her grandmother's works of charity for the ill and poor. Sina is deeply shaken by Professor Clementi's disapproval of female medical students and leaves the university for a position as a language teacher – being obviously qualified for this work despite not having studied languages (working as a teacher being an accepted profession for women that needed no further explanation).

12 The affront presented by an educated woman is only doubled by the prospect of a female physician. Surprisingly, discussions about “decency” and the shocking prospect of a woman learning about anatomy did not apply to women who trained as nurses. The reason for this double moral standard is surely the threatening status of power which women doctors can achieve; a nurse, however well-trained she may be and regardless if she is more experienced than a medical doctor, is always relegated to a lower level in both the hospital and medical hierarchy as well as in social perception – not to mention pecuniary circumstances. Professor Clementi’s statement that women prefer to be nurses also expresses the then common opinion that “real” women were not professionally ambitious and, equally, did not care about a good salary. Their success was not supposed to pay off in terms of money or in higher professional and social prestige, i.e., in power.

Success

13 Even if the debate about whether women were intelligent and mentally strong enough to study slowly ebbed away (although enemies of higher education for women were still discussing the subject at the beginning of the twentieth century), it is highly unlikely that a woman around 1900 would be allowed to be more successful than a man – be it her fiancé, her husband, her son, or even some other competitor in the “trade.” For instance, Therese, a successful and admired woman doctor and scientist in Colette Yver’s *Der Kampf einer Ärztin* (1901/1938), will be slowly demoralized once her husband, a general practitioner, decides to compete with her:

Ferdinand, der die ganze Zeit über stumm zugehört hatte, stand auf und trat ans Fenster, als wollte er Luft schnappen. Ein Gedanken, der ihm gekommen war, als seine Frau so eifrig mit den Professoren diskutierte, liess ihm keine Ruhe. Er hatte sich gefragt: ‘Und wie schätzt sie dich wohl innerlich ein, wo sie sich mit ihren vierundzwanzig Jahren ohne weiteres neben alle diese berühmten Leute stellt? Dich, den armseligen praktischen Arzt?’ [...] Zum ersten mal erwachte in seinem frischen unverbrauchten Kopf der Ehrgeiz. Er wollte nicht länger der unbedeutende Allerweltsarzt neben einem Boussard bleiben und für ihn, Herlinge und all die andern nur der Mann der vielbewunderten Ärztin sein. [...] er musste bekannt werden, koste es, was es wolle. (150-51)

“Whatever the cost” – even if it be his wife’s happiness. And yes, Ferdinand’s new scientific project proceeds well, while Therese’s scientific career enters a decline because of her newborn child and her struggle with Ferdinand’s demands on her position as a wife. In the end, Therese even gives up her career as a general practitioner because of her husband’s insuperable wish for a traditional wife (whose model he finds in an acquaintance, spending

more and more evenings outside his own home), and agrees to be his assistant, thus supporting his scientific project.

14 Marie in Lisa Wenger's *Die Wunderdoktorin* is also a much more successful doctor than her male counterpart, i.e., her son, yet she resigns out of love for him. Marie lives in a region of Switzerland where she has the legal right to practice medicine without a degree. She develops her talent as physician by way of private studies and experience. Nevertheless, she gives up her successful surgery for her educated son who despises her practice (which paid for his education) and competes with her though he is not able to succeed alongside her.

15 In *Arbeit*, Ilse Frapun-Akunian's protagonist Josephine becomes the main provider of the family after her husband is convicted of a crime; upon graduating from medical school and working in the surgery that belonged to her husband, she is severely verbally abused by him when he returns from jail and sees her success. The socio-biological argument of nature in connection with a woman's behavior and professional position is clearly expressed in Josephine's husband's frustration when he calls her – a woman – inferior, subordinate, and a slave by nature who is not supposed to be strong or to rise above a man, no matter the circumstances (223). The fact that she beats him at his own profession, medicine, it is the crowning frustration.

16 Being a “feminine” woman meant having virtues like altruism and self-denial. Being ambitious and wanting a career of her own was unseemly for a woman and “against her nature” – so seems to be the message from authors of fiction as well as “well-meaning” contemporary public opinion and the opinion of influential socio-biological “experts” (Weedon 3). It is interesting that women have to be told so often what their nature is – making it clear that being a “feminine” woman was (and is) more often a social than a natural phenomenon. This struggle to be or stay a “real” woman and simultaneously follow a profession or even a career was – in fiction – often combined with an absence of positive role models – the protagonists mostly having no other educated women around them for support.

Nonexistent Role Models

17 Hilde and Annemarie are laughed at; Sina only meets with astonishment; Josephine with incomprehension; and Therese at first refusal, then criticism for being completely focused on her studies and not being “relaxed” enough to have other interests. They are attractive, at first sight, “feminine” women, and sooner or later all of them have troubles with men and desire. Unfortunately, being a “feminine” woman does cause conflicts, and there is no one to demonstrate how to handle this problem. For example, in *Sina*, the impolite and

unpopular Eastern European student Fräulein Valevsky is no role model at all, being rude to male students out of self-protection (Spyri 89-94). The newly assigned female chief physician in *Der Kampf einer Ärztin*, Dr. Boisselière, is portrayed as being equally unattractive: she is called a “bone shaker” (“So’n alter Klapperkasten von Medizinerin [...]” [Yver 300]) and described as an old maid and virago, a mannish woman. She, as other women, is classified in a deterministic fashion; she is “obviously meant to be an old maid by nature,” looking the way she does:

Fräulein Dr. Boisselière mochte mindestens ihre 45 Jahre hinter sich haben. Sie war ziemlich gross und knochig, sichtlich von Natur dazu bestimmt, alte Jungfer zu bleiben. Schlapphut, ein weisser Kragen mit schwarzem Selbstbinder, Herrenschnitt des Haars und ein Bartanflug über der Oberlippe unterstrichen noch den Eindruck des Mannweibs. Sie gehörte zur alten Garde der französischen Medizinerinnen, war erst Lehrerin gewesen und hatte sich ihr Studium sauer mit Stundengeben verdient. Ihre berühmten männlichen Kollegen begrüßten sie mit ausgesuchter Höflichkeit. (302)

Dr. Boisselière has become (or is) “a man” and is thus no role model at all for a feminine woman like Therese.

18 The other older woman doctor, the beautiful and talented Dr. Lancelevée, transforms in Therese’s perception from being a role model and shining figure into a smug and cold-hearted person as soon as Therese herself has decided to give up her own career:

Alle Augen hatten sich unwillkürlich auf die beiden gerichtet. Theresens Blick überflog rasch die Runde und blieb an dem selbstgefälligen Gesicht der Lancelevée hängen, in dem der Stolz über den doppelten Erfolg geschrieben stand, den Erfolg als Frau und als Berufsmensch. “Es ist kein Geheimnis,” sagte Therese mit einem seltsamen Lächeln. “Ich habe mich entschlossen, meinen Beruf aufzugeben, Papa.” (303)

Dr. Lancelevée is a real threat, being successful as a physician *and* as a woman. She openly admits to having a lover, a famous professor, and is against marriage for women doctors – for good reasons, as Therese’s example confirms. Men are rather intolerant of wives with a profession outside their domestic duties. Since Dr. Lancelevée is attractive, she must be demonized through her personality, becoming a fallen angel, resistant to the man who wants to marry her and turn her into a “wife.” The change in Therese’s perception is not convincing in the course of the story, but makes sense in the context of a gender discussion of female medical students and women doctors: Dr. Lancelevée cannot be likeable any more because the concept of the self-determined woman putting her own needs before those of a man, being successful privately and as a physician, and being likeable at the same time, is not allowed—it cannot exist. Only women doctors who selflessly love someone are allowed to be attractive;

hence Dr. Lancelevée's unexpected shift into being self-satisfied and cold-hearted underneath her beautiful features: She makes the man who loves her suffer by turning down marriage.

Be an Exception or Be a “Man”—and Be Single

19 Before Dr. Lancelevée fails as a role model, she is described as a woman who is out of the ordinary, without any other source of happiness aside from her specialization. She is a woman with a profession, not a woman with a private life (or a love life). That she could be happy apart from her professional success, being free, without a husband and a family, is simply not apprehended:

“Ich bin frei,” sagte sie, als sie Artout die Hand zum Abschied gab, “ich bin glücklich.” In der erleuchteten Eingangstür erschien die Zofe, eine bildhübsche Engländerin, mit Spitzenschürze; durch die Vorhänge sah man in das behagliche, von rosigem Lichtschein durchflutete Esszimmer. Dort setzt sie sich jetzt zu Tisch, dachte Artout, allein und schweigsam, aber nichts stört ihren Frieden. Auf jedes Glück hatte sie verzichtet ausser auf eines: eine aussergewöhnliche Frau zu sein. Und dieser Traum ist ganz in Erfüllung gegangen. (Yver 78)

Dr. Lancelevée's acceptance as exceptional, not as a “normal” woman with a profession was also a way to make women understand that a higher medical education was not meant to be for them – only under extraordinary circumstances and only for exceptional women.

20 Genia, the medical student and woman doctor in the novel *Viele sind berufen* (1933) by Hermann Hoster, is an exception as well, but in a different way than Dr. Lancelevée. Genia has traveled far, even killed a man, and she smells almost masculine, exotic, reminding one of leather, saddlery and horses, “ein beinahe männlicher Geruch” (87). But she is described merely as the main character's assistant, as *Famula* to her future husband (as Annemarie and Daisy in the earlier novels) or as his fiancée (at the end), and even disappears for quite a great part of the story. Her “taming” is as unconvincing as the change in the way that Dr. Lancelevée is perceived. With the figure of Genia, the “exceptional” woman is combined with “masculinity”; the gender stereotypes cannot categorize her independent and wild behavior according to her sex. Other women doctors are also called “men,” even if they are or try to be “feminine,” as the following examples show.

Be an Exception or Be a “Man”—and Be Single

21 Therese, who had her father's full support after initial opposition, disappoints him by withdrawing from her profession for the sake of her marriage. He had suggested the new female chief physician, Dr. Boisselière, simply to create precedence for his daughter's career, being “as proud of her as men otherwise are of their sons” (Yver 305). Käthe Schirmacher's

Ethel Rodd in *Halb* (1893) barely wins her fiancé's respect as an individual (something which she as a woman is not expected to be) and which he wants to fight, knowing no other strategies to cope with the "man" in his bride:

In dem Maasse [sic], wie er einen achtungswerten Gegner in seiner Braut entdeckte, erwachte sein kriegerischer Sinn. Sie standen *Mann gegen Mann*; es sollte ein ehrlicher Kampf werden, den er mit Aufbietung aller erlaubten Mittel seinerseits führen wollte! (59; emphasis added)

The absurdity of the contradictory conceptions of femininity is apparent in the words "man against man." If Ethel asks for respect, she is perceived either in a positive way as manly, or, in a negative way, as mannish. However, she cannot be described in accordance with her sex either: Gender stereotypes are not adequate for what she is or what she does.

22 Bettina (Tina) Capadrutt, a literary character intended to demonstrate exceptionalism in *Sinfonie der Liebe* (1953) and *Versunkene Melodie* (1957) by Marga Markwalder, is introduced accomplishing surgery: She is not simply a general practitioner, but a gynaecologist (like most specialized women doctors) and a surgeon (which only very few were, most of women doctors following the old taboo of women not being supposed to cut bodies open). A few passages from these "late" novels (published in the 1950s) serve to demonstrate the persistence of certain discourses. The old prejudice against a woman performing surgery still lingers, as the following conversation between a patient and her visitor shows:

"[...] es handle sich zwar um etwas Ungefährliches, um ein Myom, aber es wäre besser, man würde es gleich entfernen. Das hat man denn auch getan." "Wer hat das gemacht? Der Professor – ach, wie heisst er nur gleich – der Ordinarius von der Universität..." "Nein. Doktor Capadrutt, die Chefärztin." "Eine Frau! Mein Gott! Wie gewagt! Melitta!" "Aber, aber Elli, was würden unsere Freundinnen sagen, wenn sie deinen Ausspruch hörten!" "Nun – ja – schon – aber weißt du, nur unter uns gesagt: als Chirurgen, ausgerechnet als Chirurgen, möchte ich schon lieber einen Mann als eine Frau. Man hat doch immer das Gefühl, eine Frau könnte den Kopf verlieren. Ich wenigstens würde mich keiner anvertrauen." (*Sinfonie* 8)

23 Tina, a chief physician and "virgin goddess," looks like a statue of Hermes and behaves like an Amazon; she meets the love of her life in her late thirties, gives up her career with a heavy heart, and is rewarded by being allowed to continue her profession. Her husband not being a physician but an artist, a conductor, the marriage persists, but Tina has to give up her position as a chief physician and work part-time to follow her husband. She is described as beautiful and not at all mannish, despite her position – but she is nevertheless called a "man":

“[...] Deine Doktor Capadrutt ist also der *Mann* der Übersicht und der starken Hand – furchtbar zeitgemäss. Aber, unter uns gesagt, sind dir solche Frauen wirklich restlos sympathisch? Man dürfte diesen Gedanken zwar im Kreise unserer Freundinnen nicht laut werden lassen – aber, – du weisst schon...” “Du stellst dir unter Tina Capadrutt etwas ganz Falsches vor. Sie hat nämlich gar nichts Männliches an sich, aber keine Spur – nur der Kopf, der ja – im Profil erinnert sie mich an irgend etwas aus der Kunstgeschichte, [...]” (*Sinfonie 9*; emphasis added)

24 Dr. Capadrutt in her position should not be likeable and therefore continues to have to be defended for being so as well as being successful: Having all the positive qualities of a man, she is beautiful and does not look like a chief physician (whatever that means): “Man sieht es ihr tatsächlich nicht an” (*Sinfonie 10*). Nearly a hundred years after women entered the profession as physicians in real life, fiction mercilessly reveals the old images being kept alive, even if admittedly they are no longer socially acceptable in most modern circles.

Giving Up

25 Therese is slowly demoralized by her husband’s persistent demands, by being challenged by him professionally, by her daily work, and by losing her child. She gives up her career altogether – following the example of another woman doctor, even though this woman is a completely different type of woman, who only studied medicine as a stopgap because no one else “wanted” her. But being in a shy way attractive, this other woman doctor, Dina Skaroff, “naturally” gives up her profession to become a colleague’s wife, no longer competing with him but willingly and happily assisting him in future. Therese, being an admired woman doctor and an (at first successful) scientist by disposition, will also become her husband’s unknown (!) assistant, just like her colleague (Yver 322), motivating him in his scientific work as he never motivated her, giving up her own career, and violating her own “nature.”

26 But surrender risks a loss of esteem – long-term rebellion, being successful, and being devoted to one’s profession permanently changes the way these women are perceived by men: “Jetzt weisst du ja, wie lieb ich dich habe! Ein Stück meiner selbst, und nicht das wertloseste, habe ich mir ausgerissen, um es dir zu geben. Nun gehöre ich ganz dir, bin nichts mehr im Leben als deine Frau. Endlich!” “Arme Therese,” kam es gequält aus ihm heraus, “arme Therese! Ich bin entsetzt, wie ich dich so etwas konnte tun lassen. Das war ja gar nicht nötig! Das reinste Verbrechen! Wo du so an deinem Beruf hingst, ganz darin aufgingst! Er gab dir eine persönliche Würde, an die nicht zu rühren war. Wie konntest du das nur tun!” (Yver 307) The same also happens to Ethel Rodd, the attractive “free” American studying in Paris (she is not a medical student). Ethel’s failure in her studies and in her engagement to a German

officer leads to her complete personal collapse (after which she is treated by a woman doctor, sent for by another female student [Schirmacher 225]). Ethel decides to try to become more “feminine” again out of love. However, as soon as she gives up standing up to her conservative fiancé and visibly suffers under the effort of becoming more “feminine,” losing her liveliness and her charm by constraining herself (Schirmacher 77), the love and what little respect her fiancé has barely started to feel towards her (perceiving her as an individual or “man”) disappear.

27 Like Therese, Ethel violates her own nature to adapt to what is “natural.” Her fate is even worse than Therese’s, however: Ethel loses everything, her prospect for a degree, her fiancé, and even her health and her beauty, having been only half-focused on her studies and thus failing her exams (hence the title *Halb*). Therese is criticized for her focus on her studies and her discipline; Ethel for her attempt to combine traditional femininity and her studies—no matter how hard they try, these women cannot win if they want both love and a profession.

28 Josephine Geyer is a married woman and mother of four children, when her husband, a physician, is sent to prison for an unspecified crime. While he is away, she starts to study medicine in Zurich. Her father does not approve initially, but still wants to help his devastated daughter and thus ends up supporting her both morally and financially. Josephine is one of the few heroines to really suffer at university at the hands of men. While Else Ury’s fictional medical students are never attacked at university, Johanna Spyri’s Sina only has to deal with rudeness from extremely self-protective female students, and Colette Yver’s Therese is protected by her father’s position, Josephine is shocked and hurt by the disrespectful behavior of the anatomy professor and some male students toward the object of their study, a female corpse. When Josephine expresses her disgust, she is not only attacked by some male students but also criticized by her female fellow students for risking troubles for all of them in speaking out as she does (Frapan-Akunian 54-55).² Josephine introduces compassion (an emotion reserved in – male – medical circles for nurses) into the academic environment. Despite being adversely affected by the bad manners and the cruelties of certain (German) professors and male students against not only female students but also against poor patients, both male and female, she graduates and, using her husband’s former surgery, works as a woman doctor. Josephine successfully establishes her medical practice but she loses her youngest child as well as her influence over her eldest son and almost over her daughter, too.

² For the strong reactions that this scene provoked at the real university hospital in Zurich, see Kraft-Schwenk 78-82.

She will not divorce her husband, who comes back to her after five years in prison, not even when she finds out that he writes harsh satires of educated women. When she finally breaks down twice, she feels “ingloriously overpowered” and embarrassed by the thought of her husband helping her:

Dann fragte sie Rösli: “Jemand war gut zu mir, stützte mich, führte mich. War es der Vater?” Und sie errötete bei dieser Frage, sah, dass auch das Kind errötete und nickte. [...] Und sie stützte den Kopf und schloss die Augen, und es war ihr wie einer ruhmlos Überwundenen. (308-09)

Her husband Georges gains strength from her breakdowns, however, which she realizes and tries to prevent:

Vor diesen Anteilvollen Blicken, diesen mitfühlenden Worten floh Josefine, sie waren ihr die bitterste Bestätigung ihrer Schwäche. [...] Aber er wünscht es, er wünscht, mich heruntergekommen zu sehen.’ Und sie hielt sich steif aufrecht und bemühte sich, ruhig und heiter auszusehen, wenn Georges in der Nähe war. (305-06)

Arbeit has a mildly positive ending – Josephine decides to continue her work. But she pays for it, forgoes her secret love, remains married to a man she dislikes, and has massive problems with her children. There must be failure surrounding a woman doctor: If she does not give up her profession, failure in private life is the consequence.

29 The subject of failure turns up more than once in Hermann Hoster’s *Viele sind berufen*. While the exotic Genia does not seem to care for her profession anymore at the end of the story, a minor female character is given a pass in an unofficial third examination after the first two attempts fail: she will not pose any threat to men’s business. The examiners can afford to be generous since she will not rival a man; she is not ambitious:

Sie war früher Lehrerin, aber das hat sie nicht befriedigt. Sie ist ohne höheren Ehrgeiz, nur in einem ganz kleinen Walddorf hat sie praktizieren wollen und bei ihrer Schwester wohnen, die dort als Lehrerin amtiert, sie hat sich das sehr schön ausgemalt, es ist kein Arzt in der Nähe, sie wird keinem etwas wegnehmen, sie ist mit wenigem zufrieden. Der nächste Arzt wohnt drei Stunden entfernt, ein sehr alter Herr schon, und vielleicht trinkt er auch ein bisschen. [...] Das Fräulein ist ein guter Mensch. Sie wird sich in ihrem Dorf, wenn es nachts bei Wetter, Sturm und Regen zum viertenmal an ihrer Tür läutet, nicht mit einer faulen Ausrede drücken, sie wird keine Appendicitis verschleppen, und wetten, dass sie nicht trinkt! (338)

This “Fräulein” has got her excuse; she is allowed to practice her profession by the goodwill and generosity of men; not being ambitious and failing without their help, she poses no danger to them.

The Need for an Excuse

30 Women who start to study need explanations and excuses for their decision. As the following passage from *Studierte Mädel* suggests, they might justify it by saying it is better to do something useful instead of just killing time until getting married; or at least they could support themselves if they were to stay unmarried, as about half the female population did (Weedon 47):

“Warum soll deine Schwester nicht irgend etwas lernen,” hörte sie Günther Berndt weiter sprechen, “besser, als wenn sie die Zeit tots schlägt und herumflaniert. Auch Frauenstudium hat sicherlich seine Berechtigung – ach Unsinn, Mensch, rede doch nicht von den paar Gramm Gehirn, die der Frau fehlen, sie haben ohne dasselbe doch schon genug geleistet. Ich habe alle Achtung vor diesen tüchtigen Frauen, ich verehere sie – aber lieben – niemals – nie kann ein man ein studiertes Mädel lieben oder sie gar begehren; solchem emanzipierten Frauenzimmer fehlt eben jeder Reiz des Weibes!” (Ury 22)

This passage refers to socio-biological arguments against higher education for women as found in Paul Julius Möbius’ notorious publication, *Ueber den physiologischen Schwachsinn des Weibes* (1900). It also indicates the prejudice against “feminine” women who become unattractive, i.e., unsexed, by studying (Swenson 85).

31 Women’s only excuse to persist with their studies lay in being unattractive enough not to be desired by a man (hence the profession’s negative female role models, who are the only women who have an excuse for studying) or being so extraordinary that the man can respectfully dismiss the “goddess” as someone out of reach and an exception. For these “exceptions,” not attractive to men or in contrast beautiful, but aiming for a career, not being supposed to be interested in men and marriage, fictional failures of female medical students and women doctors can be read as cautionary tales about how love or the wish for a husband can threaten women’s academic studies. There was no “excuse” for a married woman who wanted to have a career, since being a wife was not seen as a civil status but as a “natural” profession for a woman. As long as being a wife is seen as a profession, a woman must make a choice; she cannot have a second profession in addition to her housekeeping. This “fact” could not yet be negotiated in the contemporary discourses, and if it was discussed at all, then only in a vague way. If fictional women doctors do not give up their profession, they pay the price with unhappiness and failure in marriage and motherhood. This is exactly what Sina’s grandmother points out when declaring wisely that Sina would like to be a successful and sought-after woman doctor:

“[...] Und dann, Sina, wenn du dein ganzes Interesse und deine Lebenskraft in deinen Beruf setzen würdest, und du wolltest doch einmal dein eigenes Haus haben, wie käme es dann? Vor lauter Beruf ginge in deinem Haushalt alles drunter und drüber, denn

Tag und Nacht, zu jeder Zeit müsstest du laufen, wohin du gerufen wirst, du wolltest ja doch dann eine begehrte Ärztin sein, nicht eine, die niemand braucht.” (Spyri 55-56)

32 The novels addressed to “young girls,” i.e., adolescents, make it clear from the beginning that protagonists like Sina, Annemarie, or Hilde are not really meant to be physicians. Even Ury, who in her early book *Studierte Mädchen* allows Hilde’s American friend Daisy to pass the first medical exam, makes it equally clear that this girl needs to support herself because she is an orphan. Daisy is therefore dependent, as Dina Skaroff in *Der Kampf einer Ärztin*, on a profession. Thus, these girls have an excuse to study. Daisy, a lovely girl, has the satisfaction in the end of hearing the man she loves admit that a woman can be both: beloved wife *and* faithful companion in the medical profession (Ury, *Studierte Mädchen* 225). But there is no word about Daisy continuing or even finishing her studies – will she only be her husband’s assistant, handing him the sharp knives as a better sort of surgical nurse? Or will she continue to be ambitious or even compete with her husband?

33 In the later novel *Nesthäkchen*, even the ambitious friend of the heroine is done away with – and there is absolutely no question and no discussion about the protagonist Annemarie finishing her studies before marriage or continuing them after getting married. Annemarie does not feel even slightly regretful about abandoning her studies despite having been so decisive about wanting to become her father’s assistant. There seems to be no fear of repentance: Annemarie is doing what is “natural” and there is no attempt to even try to find an excuse.

34 Of course, a married woman doctor was still allowed to use her brain – to foster her husband’s career, and to be an interesting companion, as Therese states after her renouncement and defeat, seeing young female students being “pretty as a picture”:

Wenn Therese aber die beiden bildhübschen jungen Studentinnen ansah, die kurz danach auf der Treppe an ihr vorbeihuschten, dann dachte sie in ihrem Herzen: ‘lasst die reine Flamme eurer Jugend nur glühen und lodern für euren idealen Beruf; entwickelt dabei in euch alles, was seine Aufgabe: Hilfe und Fürsorge für den Menschen, von euch verlangen kann! Tritt aber eines Tages, wie ich es für euch hoffe, die Liebe, der Mann in euer Leben, o so gebt euch ihm mit gleicher feuriger Ausschliesslichkeit ganz! Was ihr euch geistig errungen habt, geht ja nicht verloren; es gibt dem Zusammenleben, dem Heim erhöhten Wert, dauernden Reiz, auch ein wenig Glanz...’ (Yver 305)

Conclusion

35 At the end of the nineteenth and the beginning of the twentieth century, the figure of female medical students and women doctors became quite popular in literature, coinciding with a period of great activity by the first-wave feminist movement. Not only avowed

feminist authors but also conservative writers chose to portray their protagonists as women doctors. As Kristine Swenson comments about women doctors in the “New Woman fiction” in England, the figure of the woman doctor was becoming “part of the long and rich tradition of nineteenth-century women’s literature” (126). Whether the writer was progressive or traditional, and no matter what kind of book one examines, romantic novels for girls, young adult fiction, or socially critical novels, and no matter what type of literary character – exotic, brave, young girl, or mother – the subject of failure shows up quite often in these works. The women in these early stories about female physicians passionately defend their right to an education, to a profession, and to professional ambition. Yet in the end – failure or, putting it more kindly, renouncement. What is all this good for? What is the reason for all the pros and cons, often over more than just a few pages, only to come back to what is supposed to be “natural”?

36 It became impossible to combine the hierarchic dichotomy between men and women which developed in the course of the eighteenth and nineteenth centuries, as well as the corresponding gender stereotypes, with women’s claims to education and greater or equal rights. This generated multiple attitudes to cope with the clash between old and new concepts of what middle- or upper-class women could or should be, and failure seems to be a way, during this period, to negotiate terms of higher (medical) education for women in contemporary discourses. This literary strategy is used at least up to the 1950s (the limit of my research). As Chris Weedon states, taking Ilse Frapan-Akunian’s Josephine as an example:

[...] the processes of studying and practicing medicine are shown to have profound effects on Josefine’s family and personal life, making clear that the achievement of feminist demands for access to education and the professions without other changes in gender relations opens up yet more sites of conflict and struggle for women. (61)

37 Georges cannot compete professionally with Josephine anymore, so he writes anonymous lampoons of educated women as compensation. Ferdinand in *Der Kampf einer Ärztin* has to compete with his own wife, Therese, because he cannot be less successful than she. Women pay for their professional success in their private lives and they are isolated and severely suppressed if they are more successful than the men. Hence (in fiction) educated women who are already engaged or married have the strongest conflicts.

38 What apparently could not be negotiated in literature around 1900 were women who were successful in their profession and also happy with their love life. Successful women who are not ready to give up everything for men must be unattractive, either in looks or have to be

made so in character, like Dr. Lancelevée, even at the cost of distortions in the plot and a resulting lack of female role models.

39 The popularity of women doctors as examples, i.e., representatives of higher education for women can be explained by their nearness and affinity to nursing. What was held against women was also used as a strategy to overcome the obstacles to higher education: by substitution, by presenting women doctors as nurses. Literary figures criticizing female medical students like Professor Clementi in *Sina* are “pacified” in later works by showing that women doctors are not different from nurses. These works assure the enemies of women’s education that even if women succeed in becoming physicians, they are primarily meant to be nurses. The new women doctors will mostly do something similar to nursing: i.e., care for children and change bandages. They will certainly not treat men. Even the practicing women doctors are mostly shown treating women and/or children only—a strategy also popular in “fact,” which allowed women doctors “an equal though distinct place within the profession” (Swenson 144) while keeping them out of much potential competition. Female medical students are shown as their future husbands’ assistants—so as not to be a threat to all those who see women doctors as competitors in the medical services market. Young adult fiction mostly avoids the conflicts between love (marriage) and career by simply denying that there could be a problem or by evading it, letting the protagonist give up her studies for other reasons and becoming what is supposed to be “natural” on her own “free” will. On the other hand, I assume that in a not-so-obvious way (“subversive” might be too strong a word) these novels are also encouraging (young) women to start higher education: These stories offer a means to fight the fear of becoming unfeminine in the eyes of the public or, more precisely, in the eyes of men; of being “emancipated” and not fit to be someone’s wife; and of never being loved and desired. They assure women that starting medical studies is not the end to any chance of finding a husband, so long as women still look and behave “feminine,” care for children, and do not perform surgery. That this picture of a woman doctor has little to do with reality is not important. It is an affirmation that the doors to love and marriage are not closed.

40To transform the anomaly of an educated, successful woman from an exceptional case to a commonly accepted phenomenon created insecurities which led to the contradictory situation in novels of female protagonists intelligent and determined enough to *start* academic studies and still “feminine” enough to give up as soon as a man expected them to do so for love. Women who fit neither the category of the traditional nineteenth-century middle- or upper-class woman destined to be a wife and mother nor the category of men who had a profession had to pay the price of being conspicuous and suspect because of an identity difficult to

categorize. The woman doctor causes insecurity about her “femininity” in the eyes of her contemporaries. This leads to helpless constructions in describing an educated woman: Being “like a man” or “manly” was simultaneously viewed as still being “feminine,” when seen in a positive way, and as “mannish,” if seen negatively. Fictive failure—be it as student or as woman doctor—arises from this identity problem, which develops as soon as a woman enters the higher medical profession. The reasons for failure reveal the conflicts and insecurities caused by having created something new before having clarified what this something might exactly be, or as Swenson puts it, to “seek to fit the irregular woman doctor into existing social and gender roles, [...] [or] actively question the roles themselves” (125). But altering the gender stereotypes is not yet an option, so the fictional characters show that the attempts to negotiate and combine the new profession with the old gender stereotypes lead to conflicts that can hardly be solved.

41 Many problems existed for educated women around 1900 (which continue into the twentieth century) in fashioning an identity among the different and contradictory perspectives on what and how women should be. These women’s search for a new position in the professions as well as in private life led to massive insecurities and coping strategies which are shown in these strange and sometimes even unconvincing means to make the fictional female medical students and women doctors fail.

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Women Writers and the Pathologizing of Gender in 18th-Century English Mad-Discourse

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Abstract:

One concern in the history of gendered psychiatric confinement is not that the field lacks good scholarship but that the extant scholarship is focused too narrowly on its height during the 19th century, neglecting the important temporal beginning of the trend in the 18th century. In the United Kingdom, it was in the 18th century that the move to confine became more widespread, prompted at the community, and more specifically, at the family level. This essay traces the philosophical changes in medical discourse as the move toward confinement began focusing more on the incarceration of women and the specific problem of their bodies as newly sexualized beings. Prior to the 18th century, the Galenic, one-sex model dominated both medical and social discourses. It was in the 18th century that women's bodies became pathologized which prompted the 'feminization' of mental illness. Interestingly, women writers of the period both reiterated and resisted this pathologizing of the female body through their mad-discourse, that is, their writing-about-madness. Although the ratio of female to male madhouse admissions disproves the prevalent belief in the mass-incarceration of the 'deviant' woman, Francis Burney, Lady Mary Wortley Montagu, and Eliza Haywood each reflect an emerging vision of this trope. It was the nature of confinement that so effected women's writing reiterating the concept of the deviant woman unjustly confined which, in turn, helped advance this idea in popular culture and eventually into medical discourse. It was this cycle which led to the trope becoming reality in the 19th century as women internalized this threat because of its unique dangers to what was believed to be their inherent female qualities.

The Development of the Madhouse

1 The development of asylum (madhouse¹) culture in England during the long 18th century can be viewed as a function of localized, small-group normalizing. Because of the lesser reliance on religious faith and the developing primacy of reason in Enlightenment values, the madhouse became the preferred method of the treating and safe-keeping of deviant or mentally-diseased community members, quite often women who refused or were incapable of fulfilling their expected social roles. In terms of the development of the psychiatric profession, the cusp of Foucault's classical age saw the transition of religious fervor in the routing of witches and heretics to the more widely accepted belief in the witch as madperson. Likewise, the shift was not automatic, but rather a progressive shift in attitudes; the belief in witchcraft was not abandoned but rather subverted and appropriated within the new discourse of rationality (Porter, *Manacles* 16). In this conversion, the witch or heretic becomes the

¹ Use of the term madhouse has a more open interpretation than the term asylum. Asylum was to become synonymous with the means of promoting rationality and improvement with its architecture and scope.

madperson, whose lack of rationality is the primary flaw that required confinement and treatment in the hope of the restoration of reason.

2 Prior to the 17th century, women were liable to be branded and punished as witches for any socially unacceptable acts or peculiar behavior. Through to the early part of the 17th century, European women were one of the ultimate subaltern groups, and were the large social group most frequently persecuted for misdeeds against the Church, a statistic often cited in gender studies on the subject. In her book *Women's Madness: Misogyny or Mental Illness?* Jane Ussher states that the medieval witch became the gold standard example for the idea of women as inherently evil and simply another manifestation of widespread misogyny.² She goes on to mention the process of confinement, trial, tortures such as blood-letting, dunking in water, and caning, enforced nudity during bodily searches, and eventual execution (52). One cannot help but recognize the similarities in the process for the routing of witches to the confinement and treatment of the madperson before the development of moral therapy during the 18th century; even the trial, no longer public, could still be seen in the scopophilic display of the madperson during public viewing at Bethlem Hospital. Ussher suggests that the epistemic change witnessed in the late 17th and early 18th centuries which shifted the overt power structure from the Church to Enlightenment values of reason did not in fact change the situation of women, but instead simply altered the form of misogyny. For Ussher, “madness, hysteria or insanity came to replace the catch-all description of ‘witch’ as a label applied to women who were in some way deviant” (60). I would suggest that this change in the root cause of deviance, madness vs. demonic interference, was not as limited to women as Ussher would have us believe. Reason became an inherent virtue, one not limited, though privileged, by men. Unlike the previous centuries, male deviancy became equally punishable through incarceration and/or confinement. The ultimate expression of this change was to appear with Freud’s psychoanalysis in the 19th century where the witch, far from being demonic, is simply a woman who exhibits “unacceptable behavior, illogical behavior founded on a *proton psuedos*,” or a false foundational belief (Bass 874).

3 The initial development of the madhouse trade illustrates this trend toward confining male deviants to the neglect of female confinement. The *Act for the More Effectual Punishing such Rogues, Vagabonds, Sturdy Beggars, and Vagrants, and Sending them Whither They Ought to be Sent* of 1714 allowed frenzied lunatics to be incarcerated in a “lock-up, bridewell,

² Although Ussher never cites actual numbers of women prosecuted or killed for witchcraft, she implies that they were by far the highest social group victimized. Alternate view points importantly take the social and economic standing of the victim (in addition to ethnic background) as a primary factor rather than only gender. For further reading on the subject please see Briggs.

or house of correction” along with other social disturbers such as those malcontents listed in the Act’s title (Porter, *Manacles* 7). This act was intended to detain the disturbers of the community in order to maintain social cohesion. As the madhouse trade expanded, so too did the numbers of those confined within public and private madhouses. The beginning of this population explosion of lunacy can be illustrated with the number of confined patients: in 1800 there were only a few thousand people confined for madness, yet by 1900, the number was nearly 100,000 (Porter, *Manacles* 2). One can assume that by the end of the long 18th century, the number had grown exponentially from the few thousand in 1800. This growth was instigated at the community level rather than at the state level. Indeed, it was not until 1808 that an act was passed to allow local community authorities to found asylums for care of the mad, and it was not until 1845, just after the end of the long 18th century, that Parliament *required* communities to establish them (Porter, *Manacles* 117). Thus it was the local communities that drove the move to confine the mad, rather than the authorities, permanently altering the previously established familiar care system.

Gender and the Development of the Madhouse Trade

4 One of the major concepts in Foucault’s *History of Sexuality* is the imposition of sexuality, and more importantly gender, within the changing microcosm of the family. With the development and preference for the nuclear family as the primary means of the control and correction of deviant sexualities, medical discourse appropriated the concept of moral therapy (110-11). Moral therapy, seen by some scholars as a more damaging and insidious form of oppression than the physical restraint common to the previous centuries, involved shaping the institution of confinement into a replicated family unit, placing the moral authority of the institution with the doctor or father figure. Duties and expectations were then assigned along gender lines. In addition to the influential testimony of the Tuke family in their moral reformation of the York asylum, this moral therapy led to a decrease in the use of physical treatments used in previous centuries (Digby 218). One could assume that the shift in treatment from physical to moral imposition accelerated the confinement of women as many families may have been reluctant to commit their sisters, wives, and mothers because of the physical tortures inflicted upon the mad and the belief in women as inferior men, and therefore less capable of withstanding the physicality of the madhouse. As such, when the treatment styles began to shift to a psychological coercion to reason, we see a noticeable rise in the confinement of women.

5 One cannot take Foucault's basis for the changing model of the family as the instigator for moral therapy without some critique. Naomi Tadmor suggests instead that 18th-century English society operated within a system of families based on household units which included the nuclear family, in addition to domestics, and non-blood related kin. The significant part of the "family" was that the household unit lived together under the authority of a householder, usually a male (Tadmor 151). However, this was not to prohibit women from the role of authority. The fluidity of households/families included the frequent periodic absence of a male householder due to shortened life expectancy, pandemics, and wars (Tadmor 151). This allowed women to fulfill their duty as householder, enabling them to work without social awkwardness.

6 Foucault maintains that the development of the madhouse trade can be viewed within the overarching trend of the great confinement. He places the date of the birth of this movement to confine as 1656 with the foundation of the Hôpital Général in Paris (*Madness and Civilization* 39). The significance of the Hôpital Général is that it was not intended as a place of medical treatment, but rather "a sort of semijudicial structure" or "an administrative entity" charged with maintaining social order that might be disturbed by the unemployed, idle, and mad (*Madness and Civilization* 40). The founding of the Hôpital Général was subsequently mimicked all over Europe which correlates with the shift in the pre-17th- and 18th-century habit of briefly jailing the mad, to the specific, often long-term, penal aspect of confinement. It was during the classical age that "for the first time, madness was perceived through a condemnation of idleness and in a social immanence guaranteed by the community of labor" (*Madness and Civilization* 58). Thus, Foucault maintains that it was the madperson's lack of labor and production that so offended the rest of the community. This idleness was partially behind the move to confine the mad; and was evidence of their "inability to integrate with the group" (*Madness and Civilization* 64). Critics have pointed out the problem of a sudden condemnation of idleness as a primary basis for confinement because of its non-universal applicability. The "socially helpless," such as the mad, poor, and idle, were confined prior to Foucault's date, albeit in smaller quantities (Midelfort 107). More problematic, however, is the connection between women's increasing confinement and the condemnation of idleness. Although women of this period were said to have had freer opportunities than their later counterparts in the late 18th and 19th centuries, their frequency of employment outside the family was still relatively negligible compared to their male counterparts. The vast majority of women could not have been considered idle or deviant when running households and raising families. I suggest that the condemnation of idleness

can still remain applicable as a deciding factor for women's confinement by reconsidering our view of production. Women, excluding those of the emerging middling class engaged in business, produced less exchangeable commodities than their male peers. In confining women it is the confinement itself which leads to loss of labor (madness) instead of madness (loss of labor) leading to confinement.³

7 Some critics disagree with Foucault's notion of the great confinement, most well-known among them is Roy Porter, noted English medical historian. Porter states that the great confinement did not occur in England in the 18th century, but instead the move to confine was enacted in the 19th century. Porter also disagrees with Foucault's theory of the rationale for confinement being a move to make productive the idle and mad. He notes that some asylums offered gardening and needlework as a distraction for the patients, rather than a means to employ their labor for resources (*Manacles* 8). Porter also cites a miscalculation in Foucault's analysis of the great confinement as being an effect of a change in regime. Porter states that Foucault cites the consolidation of central authority as an inciting factor in the legislation that created workhouses and asylums, yet disagrees with this idea as applied to England. He argues that the opposite took place after the Restoration in 1660; "localism and community action rather than programmes emanating from Crown or Parliament" were employed when dealing with social issues, including the confinement of the mad (*Manacles* 111). This can be shown in the high numbers of small, privately-owned madhouses compared with the static number of large public institutions such as Bethlem Hospital. While it is true that the Victorian age saw the highest percentage of confined mad and the explosion of licensed and unlicensed public and private madhouses, Porter seems unduly harsh in characterizing Foucault's notion as "hyperbolic" (*Manacles* 8). While Porter cites the statistic of only 400 people per year being admitted to private madhouses in all of England at the end of the 18th century as proof that the massive move to confine was not applicable to England because of its paucity of patients, it must be noted that record-keeping, especially in private madhouses, was shoddy to non-existent in some cases (*Manacles* 8). Likewise, this statistic takes into account only the private madhouses; not included are the numbers of quickly growing public madhouses.

8 The shift in the steady and relatively un-gender-biased confinement of the mad during the latter half of the 18th century to the exponential growth of confinement, specifically female, during the 19th century has been thoroughly examined by Jane Kromm in her analysis

³ Derrida disagrees with this assessment; Derrida states that follies "do not amount to the 'absence of the work' – that fate of madness in the classical period that Foucault speaks of. Instead, they make up a work, they put to work" (Derrida 90).

of visual representations of madness. Through examining various print portrayals of the madhouse and its inhabitants, Kromm identifies the 1780's as the critical turning-point in the popular conception of the madhouse inmate. From the previous, male-focused imagery of Foucault's animalistic madman and the melancholic, love-lorn madwoman, the imagery shifts with a stronger feminine representation to images focused primarily on depictions of promiscuous, animalized women (515). She suggests that this shift was initiated by the sexualized stage portrayals of Hamlet's Ophelia due to a relaxation of the theatre codes and furthered by the development of the moral treatment, in which female patients were encouraged to participate with the "family" of the asylum – the internalization of the doctor/staff's paternal moral authority was used as a means of behavior control. For Kromm, this shift clearly depicted in print art, elaborates the nature of the demographic shift in confinement during the period. However, I would argue that this position neglects several factors. One factor to consider is that Kromm's samples are only from male artists, though unsurprising given the period. This othering of the female figure is referenced solely within one social group, educated and reasonably-moneyed white males. Likewise, when one reviews women's writing of the period, the demarcated shift in the trope of madwoman is absent. Though by no means an exhaustive study, my review of women's writing about madness noticeably showed no defining change in depictions.

9 As mentioned previously, the Retreat at York presented both a more humane and more seductive form of controlling the mad. Even at the Retreat, woman's new place as an other-sexed being was fulfilled. Whereas Samuel Tuke states that men were encouraged to exercise and converse to maintain health, women were "employed as much as possible in sewing, knitting, or domestic affairs" (Ingram 243). This segregation, though not a new phenomenon, was nevertheless a product of viewing women as a bodied other, rather than as a malformed man, as previous thought in medical discourse, i.e., the Galenic, one-sexed model. By clearly differentiating between male and female patients at the Retreat, Tuke simply reinforced the contemporary construction of gender and sexuality. As Foucault states, "the deployment of sexuality has its reason for being, not in reproducing itself, but in proliferating, innovating, annexing, creating, and controlling populations in an increasingly comprehensive way" (*History of Sexuality* 170). Thus, Tuke's asylum as family unit was merely one manifestation of the new deployment of sexuality and its added layer of control over female patients.

10 It is evident that the development of confinement as a way to handle the mad was intended as a punitive measure rather than a means to treat or cure them. In its own creation and rationalization, "the house of confinement in the classical age constitutes the densest

symbol of that ‘police’ which conceived of itself as the civil equivalent of religion for the edification of a perfect city” (Foucault, *Discipline and Punish* 63). In this, confinement assumes authority over the madperson which was previously held by the Church while promoting Enlightenment values of reason and civic responsibility. While England was not the hotbed of dissension as was Foucault’s 17th- and 18th-century France, it nonetheless employed some characteristics of the explosive community. It was considered common knowledge that uncontrolled emotions were directly linked with madness: the 1750 *Treatise on the Dismal Effects of Low Spiritedness* comments on “madness as the vice of unbridled passions” (Porter, *Manacles* 26). Thus, when Lady Mary Wortley Montagu states that any young woman who considers running away with a man she does not intend to marry should be confined within Bethlem Hospital, she underhandedly comments on the rule of passion over reason (Porter, *Manacles* 27). The language is significant in that the would-be lover must be physically removed from the community and confined specifically within Bedlam or a Bridewell to remove the taint of her subversive ideas from the community at large, and more specifically, as a moral lesson to other young women. This lesson was easily observable and replicated through the habit of keeping the mad on view in public madhouses like Bethlem Hospital. As Porter states, until 1770, “almost unlimited sightseeing was allowed” with many English families spending the day at the asylum in order to observe the spectacle that was madness (*Manacles* 37). The spectacle of the madhouse was dramatic as patients were “manacled, naked, foul, sleeping on straw in overcrowded and feculent conditions” all the while being “jeered by ogling sightseers” (10). William Cowper comments that during a previous visit to Bethlem Hospital he felt that “the madness of some of them had such a humorous air, and displayed itself in so many whimsical freaks” (qtd. in Porter, *Manacles* 91). Thus it was both upper and lower class citizens that attended the spectacle at Bethlem Hospital, enjoying the safe exhibition of madness and the moral lesson it was said to provide.

11 The spectacle of the madman or madwoman served not only as a moral lesson in the inherent goodness of reason in humanity, but as a form of authorized scopophilia in removing the madperson from his or her “easy wandering life.”⁴ In the madhouse, women were viewed with an eye toward appearance and cleanliness, whereas men were viewed with an eye toward

⁴ Much criticism of Foucault’s *Madness and Civilization* has been based upon translation, specifically, the absence of English translation for the full manuscript, which runs about 600 pages. The English translation is less than half that length based on a 1964 abridged edition. Certain selections, such as the phrase alluded to above “an easy wandering life,” remain contentious. Some critics suggest this interpretation is evidence of a more problematic and faulty use of primary source materials on Foucault’s part. However, I recommend the excellent collection of essays *Rewriting the History of Madness: Studies in Foucault’s Histoire de la folie*, edited by Arthur Still and Irving Velody, for some enlightening discussion on the subject, specifically Allan Megill’s essay, “Foucault, Ambiguity, and the Rhetoric of Historiography.”

restraint and violence. In the *Report from the Committee on Madhouses in England*, the testimony of Henry Alexander focuses on the confined insane at the workhouse Leskeard in Cornwall. Alexander speaks of the confined madwomen noting their physical condition, chained on dirty straw, covered in filth, dejected, and emaciated (Ingram 252). The examiner did not speak to the women; indeed his entire basis for observation was on one woman's physical non-conformity to socially acceptable appearance and an unprovable idea of the cause of her madness being an ill-fated love affair. Throughout the report, men are spoken to while confined, such as the infamous William Norris, a man reputed to have been physically restrained in an iron cage for 14 years (249), whereas women were spoken *about* and described with a focus on their nudity and filth. This reflects Mary Ann Doane's suggestion that women are continually represented as a body "over-present, unavoidable, in constant sympathy with the emotional and mental faculties, the woman resides just outside the boundaries of the problematic wherein Western culture operates a mind/body dualism" (206). Thus under the male, medicalized gaze, women are *only* their problematic bodies, where as men are situated against the concern of violence and animality, their higher, reasonable mind separated from the manacled body.

12 Another issue that Porter mentions with regard to Foucault's application of the great confinement in England that must be addressed is the missing and/or late entrance of the state in the creation of public asylums. As previously stated by Foucault, the move to confine was instigated by the state to penalize and control the idle bodies and unreason of the mad; yet in England, the central authority did not become involved in the creation and implementation of public madhouses until close to the end of the long 18th century. Porter states that "the 'great confinement' was a drive by the powerful to police the poor" yet the poor were never the only class to be confined (*Manacles* 9). Both Lady Mar (Lady Mary Wortley Montagu's sister) and Frances Burney's family friend, well-known poet Christopher Smart, spent time in madhouses despite their confirmed upper-class status (Grundy 281; Abbott 1021). Because of the relatively late involvement of the state and the broad class spectrum of those people confined within either private or public madhouses, this move to confine was based primarily within the local communities. However, I do not find this a sufficient reason to completely discount Foucault's concept as Porter seems most willing to do. While the move to confine the mad in England was not so much the oppressive police action that Foucault suggests, it was instead a policing action founded at the local community and more importantly at the family level.

13 One subject that Porter does not speak at length about is the role of women within the asylum. He does make a caveat that the "male admissions notably outstripped female" until

after the 1850's. He also explicitly states that "Georgian asylum admissions lend no support to the view that male chauvinist values were disproportionately penalizing women with mental disorders, or indeed that the asylum was significantly patriarchy's device to punish difficult women" (*Manacles* 163). This was reflective of Samuel Tuke's 1819 design for a pauper lunatic asylum which planned for 150 people with equal distribution of men and women (Edginton 96). While this may be true especially in the early years of the rise in the madhouse trade, I find it difficult to believe that women were treated equitably with men. As Foucault states in *The History of Sexuality*, the 18th century saw a shift in gendered views toward women. He saw this shift as the "process whereby the feminine body was analyzed [...] as being thoroughly saturated with sexuality; whereby it was integrated into the sphere of medical practice by reason of a pathology intrinsic to it; whereby, finally, it was placed in organic communication with the social body" (104). Thus it is through the process of the analysis of women's bodies that the changing ideology took place.

14 With the subtle rise in women's admissions came additional scrutiny of women's mad-diseases, such as hysteria, previously thought to be caused by a wandering uterus. One explanation for the long popularity of the wandering uterus as cause of hysteria was the widely held belief in the one-sexed body. Prior to the 18th century, the Galenic, one-sex model dominated both medical and social discourse. The idea of the woman as a flawed man was proven by woman's inverted male genitals; "you could not find a single male part left over that had not simply changed position" (Laqueur 26). Illustrations from the period exaggerate the similarities; the vagina as the inverted penis, the ovaries as the testicles, etc. In this view, the uterus has no direct male counterpart, which may have led to an acceptance of the wandering womb, that is, in a one-sexed body; the organ that does not have its male equivalent must therefore be an abnormality and likely to wander from its seat in the abdomen.

15 In the 18th century, "as the natural body itself became the gold standard of social discourse, the bodies of women – the perennial other – thus became the battleground for redefining the ancient, intimate, fundamental social relation: that of woman to man" (Laqueur 150). It is with this change, such as when women's ovaries became medically recognized in their own right as unique reproductive organs instead of female testicles, that the differentiation occurred. This new pathology was apparent in the move to blame hysteria as a "defect of the nerves" being "chiefly and primarily convulsive, and chiefly depends on the brain and the nervous stock being affected" (Porter, *Manacles* 48). The new concept of hysteria was that of a disease of the female nerves rather than of the body. The new hysteria was considered to be "the disease of a body indiscriminately penetrable to all the efforts of the

spirits, so that the internal order of organs gave way to the incoherent space of masses passively subject to the chaotic movement of the spirits” (Foucault, *Madness and Civilization* 147). The physically wandering womb became an excess of sympathy in organs that were led by “animal spirits” and as such, the previously thought purely physical disease assumed its new status as a mental disorder or symptom of madness (Porter, *Manacles* 49). As Foucault states, “the entire female body is riddled by obscure but strangely direct paths of sympathy; it is always in an immediate complicity with itself, to the point of forming a kind of absolutely privileged site for the sympathies” thus one organ, affected by a shift in spirit could, in turn, disease its closest neighbor, and so on (*Madness and Civilization* 153-54). It was because of this shift in the root cause of hysteria, from caused by the womb to caused by “a chemopathology of the spirits and nerves” that men could also become victims of the disease (Porter, *Manacles* 48). As Porter mentions, although the shift away from the womb-center of the disease, women were still much more likely to suffer hysteria than men: men had their own supposed counterpart in hypochondria (*Manacles* 48-49).

16 This new view of hysteria as a disease of the nerves rather than as a physical ailment led to mockery by some as affectation. In 1728, a physician bemoans the trend of patients assuming the currently popular disease: “the old distemper call’d Melancholy was exchanged for Vapours, and afterwards for the Hypp, and at last took up the now current appellation of the Spleen [...]” (Porter, *Manacles* 86). Although hysteria was performed by some women because of its popularity in society and literature, there were however genuine sufferers. Mary Wollstonecraft is said to have suffered from “spasms and disordered nerves, constant nervous fever, a melancholy misery, accompanied by violent pains in her side, difficulties breathing, trembling fits, a rising in the throat (*globus hystericus*) and faintness” (Porter, *Manacles* 244). Porter reasons that the large numbers of women who suffered from hysteria were due to the fact that “being vapourish or hysterical were roles (sick roles) which women themselves sometimes adopted – as, of course, did men – to give vent to their feelings and to cope with life’s demands” (*Manacles* 106). Similarly, in *Hystories: Hysterical Epidemics and Modern Cultures*, Elaine Showalter states that “hysteria is a mimetic disorder; it mimics culturally permissible expressions of distress” (15). Thus, in assuming the role of hysteric, women were able to express their frustration with their life in a culturally acceptable form. As Showalter notes, “throughout history, hysteria has served as a form of expression, a body language for people who otherwise might not be able to speak or even admit what they feel. In the words of Robert M. Woolsey, hysteria is a ‘protolanguage,’ and its symptoms are ‘a code used by a patient to communicate a message which, for various reasons, cannot be verbalized’” (7). If

used as a protolanguage, when the hysteric is afflicted by *globus hystericus*, he or she is expressing, in a culturally permissible manner, the anxiety caused from the previous psychological trauma.

17 Hysteria became not just a disease that women were susceptible to, but rather a disease of women due to their new status with the break from the one-sexed body of man. With this change was the new understanding of hysteria as a woman's disease transmitted by nerves and sympathetic organs, allowing it to firmly enter the realm of symptoms of madness rather than physical illness. In furthering the move of the hysteric as a victim of nerves and excessive sympathy to the hysteric as the victim of previous, though unknown, psychological trauma, in the 19th century Freud and Breuer helped to delegitimize hysteria as a disease of the nerves and instead helped transform it exclusively to a disease of the unconscious mind. Breuer and Freud cite as proof that hysteria was the result only of a previous trauma when they found "that each individual hysterical symptom immediately and permanently disappeared when we had succeeded in bringing clearly to light the memory of the event by which it was provoked and in arousing its accompanying affect, and when the patient had described that event in the greatest possible detail and had put the affect into words" (Strachey and Freud 6). Thus Freud and Breuer were able to effectively "cure" the hysteric, something that was not even hoped for when physicians studied it in the 18th century.

18 Another example of this ideological change was the underlying current of a feminization of illness in George Cheney's treatise, *The English Malady*. Cheney does allude to the previously popular fluid imbalance theories in his work, but this treatise is significant because of his critique of social life as partly responsible for mental distress. He cites the "continu'd Luxury and Laziness" due to improved English prosperity as one of the primary seats of mental distress (Ingram 85). Likewise, Cheney blames the rich preparation of food as a cause for disturbance (86). Both the language he uses for the effeminate melancholy male and the domain of woman, that is, the preparation and display of food, serves to further demonize women. His essay appears to be written for men exclusively, not for men as the universal as in the one-sex model of society, but to men at the exclusion of women. Cheney's document illustrates the new two-sex model through his appeal to men exclusively and the critical eye toward effeminate traits and functions.

19 Another interesting example of the female body within the asylum in the long 18th century is the *Report from the Committee on Madhouses in England* from 1815. When commenting on the wretched state of patients in Bethlem Hospital, Mr. E. Wakefield notes typical abuses such as a male patient being chained by the neck to a trough, yet the abuses

suffered by the female patients focus on their exposed bodies. He briefly mentions that in the women's galleries women were shackled to the wall, but instead discusses, at length, their state of undress: "the nakedness of each patient was covered by a blanket-gown only; the blanket-gown is a blanket formed something like a dressing-gown, with nothing to fasten it in front; this constitutes the whole covering; the feet even were naked" (Ingram 247). The extreme interest and supposed shock in the nudity rather than the state of bondage of the female Bethlem patients is notable when contrasted to previous notions of the female body in the one-sexed society. Indeed the female body was frequently illustrated as nude, genitals exposed, and partially flayed in midwifery and anatomical manuals such as Estienne's *Dissection* series of illustrations (Laqueur 131-32). Importantly, illustrations of the flayed and eviscerated male body were equally eroticized as the female because they were of the same sex. It was only after the female body became medically categorizable and obtained its status as a separate sex that it became an object to be protected from view.

Women Writers and Mad-Discourse

20 Above even reason, the great confinement was about policing space; the placement of mad-bodies, the proper place for female bodies, the construction and regulation of asylums, all a function of the hope for the installation of correct behavior. Through the late 18th century, the mad as a population were not separated by gender. The 1815 report on madhouses notes that women and men were separated into gendered rooms where they were manacled together, but they were allowed mixed free time depending on the severity of their lunacy.⁵ This is reflected in Eliza Haywood's description of the madhouse in *The Distress'd Orphan, or Love in a Madhouse* (1726). In the *Distress'd Orphan*, the protagonist Annila is wrongly confined by her uncle because she would not marry his son so that he could inherit her estate. In order to free Annila, her lover Marathon has himself committed in the same madhouse to assist with her escape. Especially relevant for this study is Haywood's detailed commentary on Annila's incarceration in the madhouse in comparison to Foucault's idea of the ideal institution. Foucault suggests that the pinnacle of the transition in the control of bodies in the classical age is Bentham's Panopticon. The Panopticon was a means of correct training by employing a normalizing gaze making it the "perfect disciplinary apparatus" (*Discipline and Punish* 173). Haywood's madhouse, however, does not reveal an early concept of the Panopticon but instead develops an image of the anti-Panopticon. It is through

⁵ The true gendered separation within the asylum did not occur until the 19th century. Bethlem Hospital, the premier and best-known of English asylums, planned for entirely separate male and female wards, separated by a central station (Bethlem Royal Hospital).

the possibility of being under observation at any time that the patient or inmate adapts his or her behavior, internalizing the means of correction and allowing the observer to control behavior from a single point in space. Key to this process is the architecture of sight; the inmate must be easily visible at all times. This was impossible in Haywood's madhouse, as frequent mentions are made of the dark, dank, secluded apartments into which the patients were confined (50). When Marathon initially encounters Annila after his admission to the madhouse, he barely recognizes her because of the dim conditions (57). For Haywood, the private madhouse in which Annila was confined was a return to the dungeon which was intended "to enclose, to deprive of light and to hide" (200). The private madhouse was not intended to cure or even to incite correct and socially acceptable behavior, but to hide the inconvenient away. Because of the awkward placement of the rooms, the dark environment, and the enforced solitude of the patients, the dungeon is the Enlightenment's anti-Panopticon, suggesting that popular conception of the madhouse in women's writing did not clearly align with Foucault's analysis of the trend. It is important to note that the development of asylum construction was not the all-pervasive explosion as previously thought because it continued to compete with homecare and private madhouses. Beginning in the late 18th century, asylums were constructed more with an eye toward correction than incarceration, with attention paid to pastoral scenery and rooms designed to assist with mental coherency (Moran and Topp 9). Haywood, however, reflects a contemporary belief in the madhouse as a relatively private place of confinement, rigidly adhering to the social class separation.

21 Although the subtitle of the novella is *Love in a Madhouse*, Haywood very carefully does not use that inflammatory term in her initial description of the private asylum to which Annila was to be sent. Annila was to be removed "to one of those Houses which are prepared on purpose for the Reception of Persons disorder'd in their Senses" (49). While it may have been the publisher who tacked on the subtitle to make it more sensational, it is still worth noting that Haywood made a very specific choice in describing the madhouse in a roundabout manner. The reader would have understood that by mention of the "houses" Haywood intended to evoke the idea of a private rather than a public madhouse, which though unregulated until 1774 with the *Act for Regulating Madhouses*, still had some semblance of restrictions upon family members falsely committing the reasonable. Another manner in which the reader was cued to share in Annila's concern about being committed to a private madhouse was the statement not that she was to be committed to a house prepared for those who were mad, but for those people "disorder'd in their Senses"; a much more subjective status. While madness at its most base form required unreason, it was the inability to

communicate and animality which signified its presence, whereas being simply “disorder’d” was a much more insidious accusation, entirely subjective on the committer’s point of view, easily-proved and incredibly difficult to disprove on the part of the patient. It is not until Annila is confined within her chambers in the place of confinement that Haywood finally uses the term madhouse (50). By avoiding the direct term Haywood helps increase the horror of unlawful confinement for her readers so that they can more fully identify with Annila’s distress when the term is finally uttered only after she is physically confined. Although her description of the madhouse is necessarily sensationalist because of her genre of amatory fiction, Haywood’s writing reflected popular notions of the peril to confined women.

22 In addition to popular fiction, women writers evidenced concern about madness in their epistolary communications. Lady Mary Wortley Montagu, of the *Turkish Embassy Letters* fame, made frequent mention of maladies associated with mood. In a 1712 letter to her absent husband, the newly married and pregnant Lady Mary speaks of her efforts to prevent further incitement of the Spleen and Melancholy; she speaks of how her “constitution will sometimes get the better of [her] Reason,” suggesting that the melancholia she experienced was bodily based rather than a creation of her circumstances. She notes that

[t]he idle Mind will sometimes fall into Contemplations that serve for nothing but to ruine the Health, destroy good Humour, hasten old Age and wrinkles, and bring on Habitual Melancholy. [...] I lose all taste of this World, and I suffer my selfe to be bewitch’d by the Charms of the Spleen, tho’ I know and forsee all the irremediable mischeifs arising from it. (Halsband, ed., *Complete Letters* 173)

In this passage, Lady Mary reflects Robert Burton’s idea in the *Anatomy of Melancholy* of a certain disposition falling more-easily victim to melancholy (143). This conception of a melancholic personality was common to the developing medical literature of the time, especially with regard to women. Lady Mary is documented as having the relatively unique (unique in its documentation) duty of caring for the mental well-being of her mad sister Lady Frances Mar through frequent letters of encouragement and the climatic 1728 kidnapping in which Lady Mary took bodily custody of her sister from Lady Mar’s married family in order to have her confined within a private madhouse (Halsband, *Life* 134). In order for her to retain custody of her sister’s body, Lady Mary engaged lawyers and had her sister pronounced legally a lunatic, staking her claim for the temporary “ownership” of her sister (Grundy 275). Lady Mar was treated by Dr. Richard Hale of Bethlem Hospital, an early moral therapist who avoided the more mechanical and restrictive treatments in favor of sedation (Halsband, *Life* 135). According to Halsband, Lady Mar was treated in her home, but others maintain that she was placed in Dr. Hale’s private madhouse in Hampstead (Grundy 282).

23 Suggestions for physical and mental stimulus are a frequent theme in Lady Mary's letters to her sister. In a July 1727 letter, Lady Mary directs Lady Mar "as soon as you wake in the morning, lift up your eyes and consider seriously what will best divert you that day. Your imagination being then refreshed by sleep, will certainly put in your mind some part of pleasure, which, if you execute with prudence, will disperse those melancholy vapours which are the foundation of all distempers" (Wharncliffe 508). Here Lady Mary explicitly states that pleasurable actions will assist in relieving Lady Mar of the vapours which situates Lady Mary within the ideological shift that occurred mid-century in the field of medicine. These vapours, also known as the Spleen, illustrate that Lady Mary was cognizant of the newly popular concept of the "*machina carnis*, a machine of the flesh" replacing the previous notion of the humoural body (Porter, *Flesh* 51). By viewing the body as a machine, the basis of mental disturbance or lunacy became a physical ailment which indicated an awareness of physician-thinkers such as George Cheney.

24 One symptom of Lady Mar's illness was her difficulty with speech and human interaction. However hyperbolic it may seem, Lady Mar describes effectively isolating herself from the community at large in the previously mentioned letter to Lady Mary: "I fear a time will come when I shall neither write nor see anybody [...] my solitude comes from causes that you are too happy to have experienced, and gives me no other inclination but to doze upon a couch, or exclaim against my fortune, and wish [...] forgetfulness could steal upon me, to soften and assuage the pain of thinking" (Halsband, *Life* 127). This contradiction of both a fear and an embrace of isolation illustrates Lady Mar's melancholy, as according to Foucault, "[l]anguage is the first and last structure of madness, its constituent form; on language are based all cycles in which madness articulates its nature" (*Discipline and Punish* 100). Thus, it was Lady Mar's own language, and its evidence of unreason, that defined her melancholy within her letters to her sister which indirectly prompted Lady Mary to eventually pursue custody and responsibility for her mental well-being; however, it was Lady Mar's political position as a woman which led her constitution to be more inherently susceptible to madness.

25 Frances Burney had many interactions with madhouse culture which are documented in her journals and fiction. In addition to commenting on the confinement of her friend Christopher Smart, Burney was also a frequent witness to King George III's bouts of lunacy through her position as Keeper of the Robes (Wiltshire 75). Burney directly positions female madness in elite society in her novel, *Cecilia, or Memoirs of an Heiress* (1782). The protagonist Cecilia is an heiress bound by her uncle's requirement that her husband retain her

last name in marriage. After her uncle's death, Cecilia is led through a barrage of equally unsuitable guardians who proceed to steal her money and status. It is toward the end of the novel that Cecilia finally exhibits a psychotic episode when she is driven mad from ill-fated love. Cecilia runs through London without money or identification, even forgetting who she is and her circumstances, until she collapses, mute, in a shop (Burney 897). Interestingly, her rescuers, the shopkeepers, assume that Cecilia has escaped from "Bedlam" or a "private madhouse" because of her elite bearing and clothing (897) indicating the late 18th-century association of private madhouses with moneyed individuals. This is reflected in their next course of action; to lock her within their domicile until she is claimed by her proper keepers. They eventually post a newspaper advertisement titled "Madness" which described "a crazy young woman" is being retained by them for her own safety and "[w]hoever she belongs to is desired to send after her immediately" (901). Burney subtly mentions the growing trade of the madhouse industry when she has the new keeper post the notice about Cecilia only after she begins to worry on the "uncertainty of pay for her trouble" (901).

26 It is Cecilia's language transition which is of most interest. In the beginning of the novel, Cecilia is presented as the most level-headed and discreet of all the characters in her astute identification of her poorly-suited guardians and the effect they have upon her reasonable state. However, toward the end of the novel, Cecilia not only loses all sense of decorum in her dash through the streets, but she loses her speech at the height of her madness. Burney writes against the trope of woman silenced by her family by endowing Cecilia with the agency to silence herself. It is not until Cecilia is confined by the shopkeepers that she regains her voice, not in a reasonable manner, but launches immediately into a tirade where she "raved incessantly" and "called out twenty times in a breath" (Burney 900). In making Cecilia rave, Burney reiterates the idea of woman as basely emotional and nearer to madness; Cecilia becomes mad only from her ill-fated affair because it is tied to the sexualized emotion of "love" rather than because her guardians ruined her finances and reputation.

Conclusions

27 For some anti-psychiatrist critics like David Cooper, madness is a liberatory experience and a politically-conscious act. For Cooper, mad-writing is the only truly authentic form of expression untainted by Enlightenment (and Capitalist) oppression; "mad discourse skirts around, reaches above all this to regions where it finds nothing – but an important and specific nothing that is creative precisely in the measures that it is not destroyed by the normalizing techniques of the society" (21). He goes on to speak of madness as a

transformative act moving away from the Enlightenment trend of familialization in treatment (23), which has special applicability to feminist critiques of the patriarchal normalizing of the psychiatric institutionalization trend in the late 18th through mid-19th century. Cooper briefly mentions his own experiences with madness, notably never defining it, merely describing the liberatory sensations of freeing oneself from the constraints of fulfilling social expectations. This highlights the problematic aspect of writing of mad-discourse; it is difficult to adequately speak of madness without pathologizing or diagnosing the illness because of the pervasive quality of diagnostic medical discourse developed in the 18th century. If one hopes to avoid diagnosing after the fact because of inherent associated judgement and with the language of control utilized in such diagnoses, one may find it easier to leave madness undefined and simply examine the cultural variations it presents within itself. For Cooper, as for feminist writers on the subject, madness becomes another political position of the subjected body. This, however, was not evidenced in the women writers selected. In Frances Burney's and Eliza Haywood's fiction and Lady Mary Wortley Montagu's epistolary discourse on the subject of madness, women writers of the 18th century viewed madness not as liberatory, but as a physical affliction. Their writing showed an acknowledgement of the changing conceptions of women's bodies in Enlightenment discourse, but their writing of madness does not show the intensive progression in misogyny that one would expect to precede the huge growth of gendered confinement that characterizes 19th-century fiction.

28 One suggestion unrelated to the shift in gendered bodies in the 18th century is the idea of "mood sweeps" overwhelming social groups. Mentioned by Caudill with reference to the trend of a mood or emotion sweeping through the multiple social groups within the psychiatric hospital, this phenomenon is particularly based upon both the cues received which interpret both emotional and cognitive information. In this type of mood sweep, emotional information becomes more easily understood than cognitive information, which in turn spreads more quickly among both patients and staff (9). One could overlay this idea upon women's interpretation of the horrors inflicted upon their gender within the madhouse; although statistics note that most women were never confined, most women either knew of someone who was, or developed their concepts of confinement through popular culture. Because confinement was such an emotionally charged event, and women were thought to be ruled by their emotions, however much they may have internalized this trope, the idea of a mood sweep affecting the population is possible.

29 There is little evidence for the type of gendered confinement that many scholars have suggested at the end of the 18th century. Admissions records show that there was a rise in

female admissions which mildly out-paced the rise in male admissions during the period, a trend that continued through to the mid 20th century (Caudill 21). Necessarily these records are from the larger, urban, public asylums such as Bethlem Hospital and the York asylum because they were the earliest to be regulated, along with some of the earliest asylums to move away from physical treatment. Additionally, it is nearly impossible to account for the myriad of private madhouses which existed until the regulations of the mid-19th century; their admissions records are often non-existent as many served a small, informal population of the mad. It is possible that women's confinement proportion was demonstrably higher in private madhouses which could have helped propel the 19th-century trope of the unjustly confined (deviant) woman; however, this is an unsupportable conjecture and will remain just that until further archives are revealed, if they ever existed.

30 While women's proportion of admission did rise modestly above that of men, I believe that it was the nature of confinement that so effected women's writing enough to perpetuate the concept of the unruly woman unjustly confined which, in turn, helped advance this idea in popular culture and eventually into medical discourse, in a vicious, self-perpetuating cycle. It was this cycle which led to the trope becoming reality in the 19th century as women internalized this threat because of its unique dangers to what was believed to be their inherent female qualities. As evidenced by the women writers selected in this essay, the shift in the one- to two-sexed body became more pervasive in Enlightenment discourse. The body as other became more firmly entrenched as the female became defined only by her body. Women were doubly othered in their subjectivity viewed as seated solely within their politicized body while also believed to be victims of the newly antiquated and dismissed notion of female subjectivity as naturally ruled by emotions and irrationality.

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Hystoriographic Metafiction: The Victorian Madwoman and Women's Mental Health in 21st-Century British Fiction

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Abstract:

At the turn of the new millennium British fiction obsessively returns to the nineteenth and early twentieth centuries. In this revisiting, authors often show a special interest in medical discourses and narratives surrounding women and madness and the ways in which these contemporary discourses were informed by constructions of gender and sexuality. Hence, mad doctors, madwomen and lunatic asylums have become popular characters and settings for these hystorical metafiction, which thematise doctors' misreadings of patient narratives, that is, of both women's physical symptoms and their own descriptions of them. Medical discourses and narratives surrounding madness are, then, exposed as reflections of the male doctor's rather than the female patient's anxieties, and in a wider context they thus signify society's deepest fears and ideologies. Through a textual analysis of Michel Faber's *The Crimson Petal and the White* (2002), Sebastian Faulks' *Human Traces* (2005) and Maggie O'Farrell's *The Vanishing Act of Esme Lennox* (2004), this article points up that these recent examples of British historical fiction can themselves be read as gendered case histories of twenty-first-century British society and that, hence, they do not only critically explore past but also reflect present gendered issues concerning women's mental health.

Introduction

1 At the turn of the new millennium British fiction compulsively returns to and rewrites the nineteenth and early twentieth centuries, often to revisit, expose and critically comment on the dominant and shifting contemporary discourses of gender and sexuality. Neo-Victorian fiction in particular has become known for its almost obligatory illustrations of explicit sex, homosexuality, prostitution and female madness, but historical fiction concerned with the first half of the twentieth century (neo-Modernism, if one wants to follow the terminological pattern) has shown equal interest in representations of the historical development and legacy of nineteenth-century gendered discourses and narratives concerning the roles of patients, practitioners and institutions following Queen Victoria's death and World War I.

2 Scholarship of the last four decades has shown that throughout history medical narratives of mental illness, such as case histories, diagnoses or patient classifications, reveal as much, if not more, about the cultural politics of the society they were conceived in as about the patients and symptoms they are intended to describe.¹ As is evident in the amount of cross-disciplinary studies concerned with nineteenth-century gendered concepts and theories

¹ See studies such as Elaine Showalter's *The Female Malady* (1985), Michel Foucault's *Madness and Civilisation: A History of Insanity in the Age of Reason* (1961), or Lisa Appignanesi's *Mad, Bad and Sad: A History of Women and the Mind Doctors from 1800 to the Present* (2008).

of madness and its manifestations, the Victorians have become a particularly illustrative example of this phenomenon because of the ways in which their gender ideologies influenced and indeed determined their medical theories on women's mental constitutions. What this article seeks to investigate are the possible reasons for and significance of British twenty-first century fiction's return to periods in which the field of mental health came into being and developed into a splintered discipline, contested by neurologists, alienists, pathologists, psychiatrists and psychoanalysts.

3 All of the texts considered in this discussion engage, to different extents, in a voicing of the historically silenced narratives of the female insane and in feminist re-vision, performing what Adrienne Rich famously defined as "the act of looking back, of seeing with fresh eyes" (35). Set for the most part in the *fin de siècle*, Sebastian Faulks' *Human Traces* (2005) is concerned with misreadings of the female body and its symptoms and, through this, explores the power relations and manipulative narratives of the discipline which was, then, yet to become known as psychoanalysis. *The Crimson Petal and the White* (2002) by Michel Faber creates a more complex network of factors which create and contribute to the insanity of the novel's madwoman, from strictly physical afflictions to traumatic experiences and oppressive gender constructions. With its juxtaposed settings of 1930s and late twentieth-century Scotland, Maggie O'Farrell's *The Vanishing Act of Esme Lennox* (2006) demonstrates how medicine aids social norms and ideals by overwriting and hence eradicating the narrative and existence of Esme, a healthy girl who is incarcerated in an asylum for her adolescent rebellion against and struggle with the cultural expectations towards her sex.

4 My textual analyses aim to situate twenty-first century fiction within an interdisciplinary critical framework of questions: if, as Freud feared in his *Studies on Hysteria* (1895), psychoanalytic case histories can "read like short stories" (231), can novels in turn read like case histories of the societies and cultures of which they are products? If texts such as Charlotte Brontë's *Jane Eyre* (1848), Wilkie Collins' *The Woman in White* (1860), or Mary Elizabeth Braddon's *Lady Audley's Secret* (1862) were able to "put the many concerns Victorians had about insanity into dramatic perspective" (Appignanesi 87), then do their twenty-first century counterparts the same for issues surrounding women as practitioners and patients within the field of mental health in Britain at the turn of the new millennium? I will suggest that by returning to the nineteenth century, "the period when the predominance of women among the institutionalized insane first becomes a statistically verifiable phenomenon" (Showalter, *The Female Malady* 52), and to the post-war period, a time of "renewed conservatism about sex roles and gender issues" (*The Female Malady* 197), these

novels participate in the writing of what Showalter has termed hystories, that is, the histories of hysteria, whilst also being aware that they are themselves conditioned by socio-cultural context, first and foremost by postmodern and feminist theories, which they set out to critically explore. Combining the theories of Showalter *Hystories* and of the genre Linda Hutcheon has coined historiographic metafiction, these novels thus “express the age as much as the disorders they analyse” (Mark Micale quoted in Showalter, *Hystories* 7).

Overwriting the Female Body: Psychoanalytic Practice in *Human Traces*

5 The narrative of Faulks’ *Human Traces* follows the lives of Englishman Thomas Midwinter and the French Jacques Rebière. Both medical students, the young men discover their shared passion for the science of the mind when their ways cross at the age of twenty around 1880. Each of them is, initially, interested in the different theories and practices prevalent in the other’s country, but their intellectual paths soon divide as their careers progress. As Thomas explains, he and Jacques “are in the same room, but [...] looking out of different windows” (413), since Jacques’ “guiding light” (413) is Charcot and his Darwin. Throughout the plot, Thomas emerges as the contemporary voice of medicine as his theories are modelled on philosophical, humanistic and anthropological studies of more recent decades.² However, it is Jacques – the novel’s Sigmund Freud - on whom I would like to focus first and foremost. His desire to study the human mind is motivated by his determination to cure his older brother Olivier from a mental illness he developed in late adolescence. Olivier, who is forced by his father to live in chains in the stable, is important to the young doctor mainly because their mother, who died giving birth to Jacques, is metaphorically locked up with his brother, since Olivier’s memories of her are Jacques’ only access to information about her. Jealous of his brother’s recollections – however fragmented and incomplete – Jacques becomes obsessed with the search for a cure for Olivier’s mental disorder and, considering this desire for his absent mother, it is not surprising that towards the *fin de siècle* he is increasingly drawn to the then emerging discipline of psychoanalysis.

6 In the Austrian countryside sanatorium he and Thomas have opened together, Jacques takes on the case of Fräulein Katharina von A, also known as Kitty. In the first paragraphs of his report, he records her as “a young woman, aged twenty-five years, [who] had been complaining for some time of severe lower abdominal pain, accompanied by infrequent vomiting” (379) and “in addition [...] reported chronic joint pain in the shoulders, elbows and

² In his notes and acknowledgments Faulks cites Jaynes; Horribin, and the works of Professor T.J. Crow, Professor of Psychiatry at Oxford University, as the major influences for the theories Thomas develops and presents in the later parts of the novel.

fingers” (380). This is where Jacques’ scientific observations end. Instead of starting his treatment with a physical examination to either determine the physical cause of Kitty’s pains or to eliminate any potential physical reasons for her illness, Jacques immediately begins to probe his patient’s social background and life story to establish grounds for a psychoanalytic analysis of her problems. From the outset, he is convinced that Kitty is “a young woman of outstanding character” (379) as well as “of considerable education and self-possession” (380), but he also quickly forms the opinion that all these traits merely mask the hysteria which must be lingering underneath, that “the initial impression that this evidently thoughtful young woman gave to the world concealed an extremely troubled interior life” (382). Despite his observation that Kitty “seemed bemused by her symptoms” (381), he attributes her ability to bear her suffering to “what Charcot called the *belle indifférence* of the hysteric” (382, emphasis in original), that is, the patient’s lack of concern regarding the causes and consequences of his/ her symptoms.

7 An adaptation and amalgamation of the cases of Freud’s Ida Bauer (Dora) and Emma Eckstein, as well as of Josef Breuer’s Bertha Pappenheim (Anna O.),³ Jacques’ fictions regarding the connection between Kitty’s physical pains and her life and sexuality grow increasingly improbable as his treatment of her continues. Like Freud’s Ida, Kitty has had homosexual fantasies and encounters as an adolescent and, like both Ida and Bertha, she has experienced brief losses of her ability to speak. Similar to the case of Emma - in which Freud persisted there were psychological reasons for a bleeding which had, in fact, been caused by a half-meter gauze which was left in Emma’s nasal cavity after a surgery – Jacques insists in the psychological causes of Kitty’s afflictions, which are later revealed to originate from ovarian cysts and rheumatic fever. Like Freud, then, Jacques misreads the narrative of Kitty’s bodily symptoms. His determination to find traumatic sexual encounters as the causes of Kitty’s somatic troubles leads him to several astonishing interpretations of her relationships with friends, parents and lovers.⁴ Once his patient has told him about her affectionate relationship with her father, her fear of small animals, her homosexual desires and experiences as an adolescent, her subsequent habit of masturbating and her anger at her dying father’s replacement lawyer entering her bedroom without knocking, Jacques believes that this information provides him with “a fairly clear picture of the trauma that had precipitated her hysteria” (390). Not only that, but he is certain that this picture “must by now also be

³ See Lisa Appignanesi and John Forrester for detailed descriptions and analyses of these cases.

⁴ I will only refer to parts of the case history which are particularly illustrative of my point here. For the full case history see *Human Traces* 379-98.

taking shape in the mind of anyone to whom the outline of the case has been related” (390). Hence mistaking his approach and interpretation of the case as common sense, he finds that

beyond doubt [...] a traumatic incident had been deliberately suppressed by her conscious mind because she found the implications of it intolerable [and] this sum of psychological excitation, being denied proper release, had converted itself easily through the pathways of somatic innervations into the distressing symptoms. (391)

Yet, Jacques believes himself an objective observer, much like his idol Charcot, who despite his sensational stage performances famously explained: “I am absolutely only the photographer; I register what I see” (qtd. in Showalter, *The Female Malady* 151).

8 In his version of Kitty’s life story, Jacques claims that her abdominal problems, which first occurred when she heard of her father’s death, not a reaction to the loss of a man she had been close to, but are supposedly a sign of her desire for her father’s lawyer, Herr P, whom she has always disliked.⁵ Kitty’s anger at Herr P’s abrupt entrance on an occasion before her father’s death is, consequently, also easily explainable: not only was it actually Herr P – rather than his replacement – who entered the room that day but he also, contrary to Kitty’s memory and narrative, caught her masturbating. The aphonia Kitty reports to have experienced twice in her life is therefore, too, magically explained, since it is apparent to Jacques that at the time Kitty was caught masturbating, she was also fantasising about performing an act of fellatio on Herr P, which later physically manifested itself in the loss of her ability to speak. Finally, and possibly both most amusingly and disturbingly for the modern reader, Kitty’s fear of small animals apparently stems from the nickname “little weasel” (393), which she was given by Frau E, the woman with whom she had her first sexual encounter. To Jacques, the significance of this is that

in Katharina’s unconscious, the act of masturbating had become associated with the idea of small animals in their holes or burrows; doubtless Frau E-’s successful manipulation had involved the appearance of the clitoris from within its protective hood, like a timid animal that subsequently withdrew. (393)

Sexual fantasy, vivid imagination, and professional ambition merge, here, into one. Jacques plans to present and receive praise for his case history at a symposium in Vienna, an event at which the surely predominantly male audience would ponder collectively and scientifically over women’s “timid” and animal-like genitals during lesbian intercourse. Once Jacques has finished his “psychophysical resolution” (420) of Kitty’s case, the last step towards a cure, so he believes, is for her to accept his fiction as her own narrative, one he insists reflects the true traumatic events responsible for her physical illness. However, to his surprise, Kitty is

⁵ This is not dissimilar to the way in which Freud, in the case of Ida Bauer, argued that Ida’s desire for and relationship with Frau K was actually a displaced desire for Frau K’s husband, Herr K.

unwilling to believe his invention of events which never happened and he notes: “Fräulein Katharina [...] would not concede that the incident I had *interpolated* into her story was necessarily true [and] she was not in a position to recognise it as something she had actually experienced: I believed it would have taken hypnosis to achieve that” (397-98, emphasis added). Jacques’ unconscious intention with Kitty is therefore the same as Freud’s was with Ida, namely “to penetrate the sexual mysteries of [...her] hysterical symptoms and to dictate their meanings to her” (159).

9 Yet, despite these clear representations, Faulks lacks confidence in his readers (and in Kitty) to recognise the at best suspicious nature of the medical narrative Jacques has constructed. It is Thomas, who, having been asked by Jacques to give his opinion on the case history, instantly realises that Kitty is by no means a hysteric, but instead suffers from rheumatic fever and, as the hospital surgeon finds, has two cysts in one of her ovaries. With Thomas thus having heroically rescued Kitty from the potentially fatal misdiagnosis of his partner, Faulks feels the need to explain to us, step by step, the flaws of Jacques’ analysis in a painfully unsubtle way, namely by presenting us with Thomas’ written evaluation of the case. For Thomas, whom the modern reader is clearly supposed to trust and identify with, the problem with Jacques’ practice of psychoanalysis is his lack of consideration for physical symptoms and causes of illness, his misreading of them as a narrative which suits the needs of his theories and interpretations rather than serving an effective diagnosis and treatment of the patient. As Thomas aptly puts it, for Jacques even Kitty’s “apparent sanity is a symptom of her insanity” (429, emphasis in original) and, therefore, “she is trapped either way” (429). In fact, the only consistent rule underlying Jacques’ analysis of Kitty’s life, sexuality and dreams is, as Thomas cynically observes, that “everything is the opposite of what it seems – unless it is not, when it may be itself again. Anything can represent anything else – or its opposite!” (433). For Thomas, a firm believer in the potential of emotional care, it is not the act of talking as a therapeutic method which is at fault, but the fact that Jacques abuses his patient’s narrative to construct his own story. Jacques’ aim is, consequently, not to cure his patient by whatever means, but to find what he wants to find, that is, to alter Kitty’s narrative with his rigid, still underdeveloped theory rather than shaping his theory with consideration of her narrative. Thus mirroring the way in which “some of the openness to women’s words and feelings displayed in *Studies on Hysteria* had become codified in the interests of Freud’s emerging psychoanalytic system” (158), Jacques’ supposedly scientific case history, then, is more representative of the male doctor’s than the female patient’s fears and desires. Appignanesi argues that today, “depending on the interpreter or historian,” Freud is either

“the heroic conquistador of the secrets of the unconscious, the great innovator whose talking cure definitively altered the treatment of madness, or the manipulative fraudster who launched a movement out of a mixture of fabrication and speculation” (194), and in Jacques it becomes clear that, for Faulks, he is certainly the latter.

10 Despite this critique of psychoanalysis as male overwriting of women’s narratives, from a feminist point of view *Human Traces* evokes a sense of disappointment. The cases of Ida Bauer, Emma Eckstein and Bertha Pappenheim have all acquired feminist significance in their own rights: Ida’s story has become an admired expression of female homosexuality, her decision to walk out on Freud and quit his treatment has been championed by feminists of various camps, providing, as Emma’s case, “a paradigm case for catching patriarchy with its pants down” (Appignanesi and Forrester 146). Similarly, Bertha’s hallucinations and her frequent loss of the ability to speak her native tongue have been considered as feminist rejections of the patriarchal order (see Hunter). However, although Faulks utilises these cases in his construction of Kitty, the novel lacks a gendered critique of psychoanalysis and its power relations, as its interrogations of mental health practices remain strictly scientific ones. Accordingly, the story’s female characters are of little consequence. Unlike Ida with Freud, Kitty does not walk out on Jacques, but has to be rescued from his misdiagnosis by Thomas instead. Even though she does not fall in love with her psychoanalyst, like Bertha did with Breuer, she does eventually marry her heroic rescuer Thomas and, ironically, does not become the first female analyst as Bertha did, but is content with co-managing the sanatorium’s accounts. Sonia, Thomas’s sister and Jacques’ wife, as well as Kitty are generally portrayed as relatively witty and intelligent, but they always remain within the realm of the famous angel of the house and act as their husbands’ complements, not their equals. Sonia in particular is repeatedly noted to be perfectly content and fulfilled by her role as mother and (betrayed) wife. Thomas is the rescuer of helpless women throughout the novel, from his secret removal and employment of two misdiagnosed and ill-treated inmates (Daisy and Marie) from an English asylum, to Kitty, with whom he falls in love when he reads her case history before having really met her. Whilst the ambiguous power relations of psychoanalysis are critiqued, they are reinstated through Thomas’ relationships with these female characters. Daisy tells him towards the end of the novel: “You gave us a life [...]. It was like being born again into a better world” (771-72). The modest and good doctor supposedly employed his power for the right purposes, but nevertheless the women he has rescued now fall on their knees before him to display their infinite gratitude – an ambiguous liberation.

11 Through the novel's continuous and at times tedious representations of the minute details of medical theories on mental illness on the one hand, and its underdeveloped female characters and their always limited or ambiguous powers on the other, Faulks' novel, as a contemporary medical narrative, exemplifies – intentionally or unintentionally – the ways in which medicine, particularly in the area of mental health, can overwrite women's bodies and the stories they tell.

Models, Not Martyrs: Hysteria as Feminism in *The Crimson Petal and the White*

12 Faber's *The Crimson Petal and the White*, set in 1870s London, presents us with a woman whose physical afflictions, like those of Faulks' Kitty, are misread. Agnes is the twenty-three year old wife of William Rackham, heir of Rackham Perfumeries, who in the course of the story falls in love with a prostitute, the novel's heroine Sugar, whom he eventually installs in his home as governess of his daughter Sophie. Even before illustrating the nature of Agnes' suffering, the narrator makes it clear that those practitioners of medicine who consider themselves specialists in women's health are not to be trusted. Doctor Curlew, Agnes' physician, is cynically described as completely unqualified when it comes to the treatment of women, or indeed any human. Curlew is

highly skilled, with a long list of initials after his name. To give but one example, he can dissect a pregnant rabbit for the purposes of anatomical study in ten minutes and can, if required, pretty well sew it back together again. He enjoys the reputation, at least among general physicians, of being something of an expert on feminine illness. (80)

Unlike Faulks, Faber is not keen on providing a detailed fictionalised account of the medical analyses which deem his madwoman insane, but instead we are told that, for this story, it is the consequences of Victorian theories on women's mental health which are important. Where Faulks persists in educating us and, hence, silences his novel's women, Faber foregrounds the female patient's experiences rather than the doctor's theories: "You may be forgiven," the narrator tells us about Curlew's medical monologues, "for losing the thread of the good doctor's thesis, but rouse yourself for his conclusion" (80). His conclusion, in short, is that his concern is not really Agnes' wellbeing, but rather the influence her illness has on her husband, who may well irrevocably go mad himself if he does not follow Curlew's advice and rids himself of his hysterical wife by installing her in an asylum; unlike her, Curlew points out to William, "you and I have no womb that can be taken out if things get beyond a joke" (80). Curlew and other practitioners, then, do not work for the benefit of women patients, but for that of their male guardians.

13 Once we have thus been indirectly introduced to Agnes through these discredited male voices, we gain insight into her own narrative. His wife's worst lapses, according to William, have been when she "laughed when there was nothing to laugh about [and] didn't laugh when there was. Shouted nonsense, warned people against invisible dangers. Crawled under a dinner table once, complaining the meat had blood in it" (296), but we soon learn that there are at least four (partly interconnected) reasons for this behaviour which her husband and doctor label as hysterical: a tumour, her physician, Victorian constructions of middle-class femininity, and a traumatic childhood and adolescence. Similar to Faulks' Kitty, there is a misread bodily narrative, but this time it is due to medical discoveries which have not yet been made: "Inside her [Agnes'] skull, an inch or two behind her left eye, nestles a tumour the size of a quail's egg [...]. No one will ever find it. Roentgen photography is twenty years in the future" (219). Apart from this medical explanation for her behaviour, it is not surprising that Agnes' mental health is withering away slowly but surely, given the nature of the weekly treatments she receives from the ill-qualified Curlew. During his visits, Agnes must not only endure the application of leeches, but also "[roll] onto her side so that Doctor Curlew can reach deeper inside her [...]. He is trying to find Agnes's womb, which to his knowledge ought to be exactly four inches from the external aperture" (165).

14 Many of Agnes' troubles also originate in her upbringing as a middle-class Victorian woman. Knowing "nothing of her body's interior" (219), menstruation is a mystery to her and although Curlew could have enlightened her, he "never has, because he assumes his patient can't possibly have married, borne a child and lived to the age of twenty-three without becoming aware of certain basic facts. He assumes incorrectly" (236). Agnes' unawareness is a typical product of the "prudery and embarrassment [which] prevented many mothers from preparing their daughters for menarche" (Showalter, *The Female Malady* 56) and consequently her rationale for her menstrual cycle is that "bleeding is the manifestation of serious illness [...]. The affliction began when she was seventeen, was cured by prayer and fasting and, after her marriage, it stayed away for almost a year" (236-37). Thus left in darkness regarding the workings of her own body, Agnes is, ironically, still expected to perform her duty as a wife on her wedding night and bear William a child. Unprepared for any of this, the loss of her virginity, her subsequent pregnancy and the act of giving birth are all inexplicable and highly traumatic experiences for her, so traumatic in fact that the man responsible for them, William, "loses her trust forever [...]. However hard he tries to win her forgiveness, she can never forgive" (220). Agnes' diary entries show that she is at a loss for explanations even when the unborn baby is growing inside her: "*Riddle: I eat less than ever I*

did before I came to this wretched house, yet I grow fat. Explanation: I am fed by force in my sleep" (617, emphasis in original). Although William reflects that he "ought to have conceded that she was a flower not designed to open, a hothouse creation, no less beautiful, no less worth having. He should have admired her, praised her, cared for her and, at close of day, let her be" (136), this remorse does not stop him from raping his wife whilst she is drugged into a mixture of unconsciousness and sleep. Climbing into her bed, his apparently tender violation of her is what makes reading this rape scene all the more discomfoting:

'I'm going to ... embrace you now. You won't mind that, will you?' [...] He moves slowly, more slowly than he's ever moved inside a woman in his life. [...] When his moment of rapture comes, he suppresses, with great effort, his urge to thrust, instead keeping absolutely still while the sperm issues from him in one smooth, uncontracted flow. [...] A minute later, he is standing by her bed once more, wiping her clean with a handkerchief. (614-15)

15 Agnes' way of coping with Curlew's examinations, her distorted relationship with her own body and her husband is her retreat into the imaginary Convent of Health. Transported from consciousness to unconsciousness in a train to the convent, she is received there by gentle nuns who look after her and attempt to restore her health through something she is not provided with in the real world, loving care. Even in her diary, Agnes is unable to describe the traumatic experience of her daughter's birth through anything but the imagery of this imaginary world. When she feels the child "*pushing and lungeing in rage and terror*" (617, emphasis in original), she recalls a nun having

a way of causing my belly to open up without injury, permitting the demon to spring out. I glimpse the vile creature only for an instant: it is naked and black, it is made of blood & slime glued together; but immediately upon being brought out in the light it turns to vapour in my Holy Sister's hands. (617, emphasis in original)

What Agnes remembers as the child having vaporised in her fantasy is, in fact, her refusal to acknowledge any awareness of its existence. Consequently, daughter Sophie explains to Sugar, "Mother hasn't seen me since my birthday" (541), meaning not the last anniversary of the child's birth, but the day she was born. As William puts it, "in this house [...] Agnes is childless" (546). Considering that since their wedding night Agnes has refused to sleep in a room with William, it is tempting, here, to read her mental and spatial seclusion from her husband and their child the way H el ene Cixous has read Freud's female patients, namely as feminist heroines who find in hysteria a way of resisting patriarchal norms and gender roles forced on them. At the same time, though, the numerous illustrations of Agnes' pitiful life and the tumour afflicting her brain make the behaviour which Curlew and William have deemed mad not appear mad at all, but are rather the logical consequences of her traumatic

experiences of menstruation, sex, pregnancy and birth. Her outbursts of anger towards William appear perfectly justified to the reader since we know he rapes her in her sleep and installs his mistress in their family home.

16 Yet, the novel's verdict is neither that Agnes is a feminist heroine who has acquired a voice through hysteria nor, as in *Human Traces*, is she simply *wrongfully* diagnosed and labelled as mad. Agnes remains the madwoman of the story, not because of her outbursts or her neglect of her child, but because she is a religious fanatic. Raised first as a devout Catholic, her mother married a Protestant, Lord Unwin, after Agnes' father had died. Not only forbidden to practice her faith but also forced to adopt Protestant beliefs and practices, Agnes reflects that "it all went wrong after that terrible day when Lord Unwin told her [...] there'd be no more Virgin Marys, no more crucifixes, no more rosaries and no more Confessions for her" (288). One of her diary entries at the time, addressed to Saint Teresa, emphasises the confusion over her father's departure – which she does not yet recognise as death – and the linked loss of what she considers the true faith: *I dont know know what is become of us because he [Lord Unwin] has forbidden us to go to Church – the True Church – and instead he has taken us to his church and it is a shameless frord. [...] Where has my own dear Papa gone and when am I to see him again?* (528-29, emphases in original). As she grows up, Agnes' idea of religion slowly but surely distorts. She becomes convinced that her imaginary Convent of Health does exist outside her imagination and that the nuns there possess her second and immortal body, meant for the time when her first body shows signs of age and decay. Emmeline Fox, a religious widow, hence receives the following desperate request from Agnes: *"I happen to know that my Second Body is waiting for me at the Convent of Health. Please, please, please divulge to me where the Convent is. I am ready to go [...]. You are my only hope. Please grant me the Secret Knowledge I crave"* (582).

17 Agnes' religious delusions become worse when she ironically mistakes Sugar for her guardian angel rather than her husband's mistress. In her sympathy for Agnes, Sugar decides to enable her to escape from the Rackham home the night before William intends to have his wife taken to an asylum. Sugar sends Agnes on a train journey to the country side, where she is sure the young woman will find a convent, which Sugar promises is the Convent of Health. However, Agnes never completes this journey and is instead found dead in the river a few days later. A similar fate befalls the novel's male religious character, William's brother Henry. Convinced his large amount of body hair indicates he is a sexual, animalistic being and hence a sinner, Henry oppresses his feelings for Emmeline and eventually dies in a fire whilst dreaming of having sex with her. Significantly, it is Emmeline who is the only

religious figure in *The Crimson Petal and the White* who does survive – and even overcomes tuberculosis. Unlike Henry and Agnes, Emmeline is a Christian who transforms her faith into activism, rather than passive devotion, by participating in various charitable causes, such as the Women’s Rescue Society. Wishing that “only it could be resolved once and for all where we come from: from Adam, or from Mr Darwin’s apes” (179), Emmeline is a strong and independent woman who is able to combine a modern common sense and rationality with her belief in God, making her a character the reader is undoubtedly supposed to (and most likely happy to) identify with.

18 Faber certainly voices the narrative of the madwoman without overwriting her story by medical discourses. Although the novel highlights various reasons and justifications for the deterioration of Agnes’ mental health (oppressive gender constructions, trauma and the brain tumour), her escape into religious hallucinations and passivity are not potentially feminist acts of resistance, but are instead portrayed as strategies which eventually render her just as voiceless as patriarchal society and medical discourses have made her. In writing Agnes’ history, Faber’s novel thus supports Showalter’s assertion that “today’s feminists need models rather than martyrs” (*Hystories* 61), activists rather than victims

“Daughters who just don’t listen”: Policing Women in *The Vanishing Act of Esme Lennox*

19 O’Farrell’s *The Vanishing Act of Esme Lennox* takes us away from the Victorians and the *fin-de-siècle* to the 1930s and the turn of new millennium. Maggie O’Farrell’s *The Vanishing Act of Esme Lennox* focuses on the parallel and eventually converging lives of Esme Lennox and her granddaughter Iris Lockhart. A revision of Frances Hodgson Burnett’s *The Secret Garden* (1911), which tells the story of Mary Lennox, a difficult child who is disliked by her mother and who, after her family’s death in India, comes home to Britain and flourishes under love and education, O’Farrell’s novel takes a sinister turn where its predecessor grants its heroine happiness. At the age of sixteen, Esme is admitted to an asylum in Scotland by her parents, who are thus ridding themselves of their rebellious teenage daughter. Erased from her family’s history, Esme is not released until sixty later, when the asylum is due to be shut down and her only surviving family member, her sister Kitty, is in care because she suffers from Alzheimer’s. Iris, until then ignorant of Esme’s existence, is asked and reluctantly agrees to take care of her and so uncovers her relationship to the woman whom she first assumes to be her great aunt, not her grandmother. The novel’s narrative is

presented to us through a patchwork of Esme's memories of her childhood, the fragmented and incoherent memories of her sister, and the story of Iris.

20 As in *The Crimson Petal and the White*, the main reasons for the behaviour which constructs the novel's madwoman as insane are trauma and the gender norms imposed by society, but this time the young woman in question, unlike Faber's Agnes or Faulks' Kitty, is both mentally and physically in perfect health. Esme first becomes a nuisance to her mother when during the early years of her childhood in India Esme's little brother and his nurse die of typhoid. Her parents, absent from the house at the time, blame Esme for Hugo's death and decide to return to their native Scotland, where Esme – unlike her older sister Kitty - struggles to understand and adapt to the new rules of femininity forced onto her. Before their departure on a shopping trip to Edinburgh, for example, Esme is astonished to find that “her sister is wearing a grey beret. Where did she get it from and how did she know to wear it?” (94). Whilst Kitty is keen to do her duty and find a suitable husband, Esme refuses to play her part in the patriarchal marriage market:

Every afternoon their grandmother gets them to dress in their best clothes and makes them walk up and down the sea front, saying how do you do to people. Especially families with sons. Esme refuses to go on these ridiculous walks. They make her feel like a horse at a show. Strangely, Kitty loves them [...]. Her grandmother keeps announcing that Esme will never find a husband if she doesn't change her ways. Yesterday, when she said it at breakfast, Esme replied, good, and was sent to finish her meal in the kitchen. (129-30)

Like the garment which “looked like her blazer, it said it was her blazer but it wasn't” (150), the role society tries to assign to Esme is too small and constraining for her, one in which “she could barely move, barely breathe” (150).

21 Determined to make a respectable woman out of the daughter she perceives as a disturbance and embarrassment and who, above all, embodies the guilt she feels for having left her young son alone on the night he died, Esme's mother is willing to subdue the rebellious adolescent girl by any means available. When James Dalziel shows an interest in Esme, Mrs Lennox becomes sure that “a few months as James Dalziel's wife will be enough to break [Esme's] spirit” (185). Dressing the lamb before the kill, a “vicious sweep through Esme's hair” (185) accompanies her mother's promise that “we shall make her look pretty, we shall send her to the ball, and then [...] we shall marry her off to the Dalziel boy” (185), words which function almost as a forecast of the sexual violation which Esme has to endure by James at the ball. Having kissed him in a back room, Esme soon finds herself being raped:

She said, no. She said, stop. Then, when he grappled at the neckline of her dress, kneading at her breasts, fury flared in her and fear as well, and she kicked, she hit out

at him. He jammed a hand over her mouth, said, wee bitch, in her ear and the pain of it, then was so astonishing, she thought she was splitting, that he was burning her, tearing her in two. What was happening was unthinkable. She hadn't known it was possible. His hand over her mouth, his head ramming against her chin. (191)

Later, Mrs. Dalziel saves her and her son's respectability by telling Mrs Lennox that "Esme had had a wee bit too much to drink, made a fool of herself, and that she might feel better in the morning" (192). Unable to comprehend and process what has happened to her, Esme can subsequently not articulate anything but "a high-pitched noise that she couldn't stop, that she had no power over" (192). Ignorant of what happened – and unlikely to change their course of action if they did know – Esme's parents decide to admit their daughter to a lunatic asylum where, ironically, she – the rape victim – is supposed to "*learn to behave*" (196, emphasis in original), since her "mother was [...] sick to her back teeth of these fits of shouting and raging" (196).

22 However, whilst it is this traumatic narrative which is misread and overwritten by medicine when Esme is diagnosed as a hysteric, it is not where Esme's trauma ends. Kitty, six years older than Esme, is obsessed with the desire to become a dutiful mother and wife. Hence, she is jealous when James proves keen on Esme rather than her and struggles to understand how someone with no etiquette and no ambitions to marry can possibly appear more attractive than her, the woman who is eager to please and conform to any norms society creates for her sex. In her strife to live up to society's expectations, Kitty finds a husband, Duncan, but both are as ignorant as Faber's Agnes when it comes to conceiving a child. After a confused and unsuccessful attempt at the act three weeks after their wedding, Kitty visits a doctor and is told she is still a virgin. To his question "Have you not yet [...] had relations with your husband?" (246), Kitty recalls answering, "Yes. I said I had. I said I thought I had. Hadn't I?" (246). Thus, when she hears that her incarcerated sister fell pregnant after having been raped by James, jealousy overcomes her once more, although Esme, meanwhile, is not even aware she is pregnant until a nurse tells her that she is "to stay until the baby comes" (239), to which Esme replies "What baby?" (239). When she gives birth to her son within the confines of the asylum, he is taken away from her against her will and, unknown to Esme, given to Kitty, who raises him as her child. Thus, Kitty utilises the consequences of Esme's rebellion against Edwardian gender norms in order to compensate for what society considers her shortcoming – her childlessness – thus preserving her own propriety, her place in society, by exploiting a woman who has been banned from it.

23 Whilst the illustration of Esme's memories provides the silenced madwoman with a voice, the novel also presents and critiques the processes and medical narratives by which

Esme has initially been silenced and the consequences this silencing has for her. When Esme is due to be released from Cauldstone in the 1990s, Iris first believes she has been contacted by mistake, as Esme has been erased from her family so effectively that no one apart from Kitty knows of her existence, since – determined to keep her theft of Esme’s child a secret – she has told everyone, even Esme’s son, that she has no sister. “Mum says,” Iris explains, “that Dad was definitely under the impression that Grandma was an only one, and that Grandma used to refer to it frequently. The fact that she had no siblings” (57). At the asylum, Esme’s identity as her parents’ child and Kitty’s sister is literally eradicated along with the name her family and friends used to call her – Esme – which is replaced by her “official name, the name on [her] records and notes, which is Euphemia” (53). By becoming Euphemia, Esme ceases to exist in the world outside asylum walls, wiped from her family tree and reconstructed in the hospital’s medical records as first a hysteric and then a schizophrenic, who after sixty years holds “a variety of diagnoses from a variety of [...] professionals” (41). Even though Esme is depicted on a photo in Iris’ kitchen, Iris has never come to question who this girl on the photo standing next to her supposed grandmother is. Through her lack of existence in the family narrative, Esme is also made invisible to Iris’ eyes in the photo. Iris’ view of this unfamiliar woman is thus first one defined by the medical narrative which has defined Esme for the past sixty years. When Iris, still assuming Esme is her great aunt, first meets Esme, she is surprised not to find the asylum full of “gibbering Bedlamites [and] howling madmen” (49) and to see that Esme is not “someone frail or infirm, a tiny geriatric, a witch from a fairytale” (52). Iris’ stepbrother’s reaction when he hears that Esme is staying at Iris’ flat reflects a similar image of the supposed madwoman: “Jesus Christ, Iris,” Alex warns her, “you’re harbouring a lunatic you know nothing about [...] Iris, you don’t get banged up sixty years for nothing” (112).

24 However, Iris soon gains insight into the medical discourses and definitions which have predetermined her perceptions of Esme as a madwoman and finds that in Esme’s youth one could indeed be “banged up” indefinitely for nothing. Browsing through Cauldstone’s admission records, it quickly becomes clear to her that not only her relation but also many other women have been incarcerated for what appears to a late twentieth-century woman as common sense, intellect and a justified desire for independence and equality. Iris finds, for example, the record of “a Jane who had had the temerity to take long, solitary walks and refuse offers of marriage” (65) and further

reads of refusals to speak, of unironed clothes, of arguments with neighbours, of hysteria, of unwashed dishes and unswept floors, of never wanting marital relations or wanting them too much or not enough or not in the right way or seeking them

elsewhere. [...] Daughters who just don't listen. Wives who one day pack a suitcase and leave the house. (66, emphasis in original)

Similarly, Esme's entry reads under reasons for admission that she "*insists on keeping her hair long*" and that her parents found her "*dancing before a mirror, dressed in her mother's clothes*" (67, emphasis in original). To Esme's astonishment, women's attempts to break out of the domestic roles society assigned to them are no longer equivalent to hysteria. As two similar characters, Iris' and Esme's lives thus differ significantly due to the time and society they live in. Like Esme as a young girl, Iris declares that she hates weddings, "hates them with a passion [...] the ritualised publicising of a private relationship, the endless speeches given by men on behalf of women" (21), and, like young Esme, Iris is not, and has no desire to be, married. To Esme, all the opportunities Iris takes for granted in her life as a woman are "marvellous" (126), such as the fact that she has her own business, that she is under no obligation to get married and that she has lovers.

25 Although O'Farrell demonstrates how the narratives of women's mental health have been rewritten and redefined in the decades between the 1930s and now, *The Vanishing Act of Esme Lennox* does not attempt to give us the illusion that after the sexual liberation of the 1960s women have been freed of all their problems. Iris' love life and her relationships with men are complicated and subject to new, if other, cultural taboos and rules: She fell in love with her step brother Alex when they grew up together, and although both still seem to love each other and maintain a close relationship, Alex has married another woman. Iris' lover, Luke, is married but claims he will leave his wife, although Iris does not appear taken by the idea and eventually finds out by coincidence that Luke's wife is pregnant. Hence, the contemporary emancipated heroine still remains unhappily lonely, whilst the men she is attracted to live in traditional marriages.

Conclusion

26 Like the critical studies of Showalter and Appignanesi, Faulks' *Human Traces*, Faber's *The Crimson Petal and the White* and O'Farrell's *The Vanishing Act of Esme Lennox* are concerned with the exposure and criticism of Victorian and Edwardian male practitioners' misreadings of their female patients' symptoms. That is, they seek to demonstrate the ways in which women and their stories – physical and oral – were interpreted and rewritten by doctors and therapists as medical narratives and theories which complemented and conformed to dominant discourses of gender. In these texts, doctors and the dominant cultures they represent are therefore authors rather than scientists and their reports fictions rather than scientific observations, indicating the practitioners' rather than the

patients' anxieties and becoming, thus, as Lisa Appignanesi puts it, "expressions of the culture's malaise, symptoms and disorders [which mirror] time's order – its worries, limits border problems, fears" (5). Whilst Ursula Link-Heer has argued that studies concerned with the ways in which "women are constituted historically and discursively" tend to treat the history of hysteria either as "a patriarchal defamation and violation of real women who in truth were not hysterics, or one that uncovered supposedly genuine feminine characteristics behind the label 'hysteria' and identified with them" (192), the novels I have discussed here go far beyond this dichotomy. Instead they propose, like Showalter, a variety of different histories, that is, "cultural narratives of hysteria [... which] multiply rapidly" (*Hystories* 5). Their authors, then, can confidently be counted towards the community of critics who Showalter calls "The New Hysterians" (7) and are concerned just as much with "questions about the self, sexual and gender identity, cultural meaning and political behaviour" (7).

27 Hystoriographic metafiction, then, does not simply criticise gendered medical discourses of the past, but reflects on the ways in which gendered issues still surround the theory and practice of mental health. As studies such as Klonoff and Landrine's *Preventing Misdiagnosis in Women* (1997) and Russell's *Women, Gender & Madness* (1995) have shown, despite modern scientific advances, there are still illnesses and disorders which if not diagnosed and treated properly can lead to "a woman's being confined to a mental hospital for her entire life or even result in her untimely death" (Klonoff and Landrine, xix). Similarly, it is worth noting here that other examples of the genre not discussed here, such as Margaret Atwood's *Alias Grace* (1997), Claire Dudman's *98 Reasons For Being* (2004) or Jane Harris' *The Observations* (2006), also reflect the fact that race and social class are still factors which influence the treatments of women's mental illnesses in Britain and that female autonomy as well as power relations are still serious and complex issues in contemporary mental health practices.⁶ If traditional psychotherapies, as Appignanesi puts it, "attempt an understanding of the self that marries past with present" (481), then hystoriographic metafiction which critically investigates women's mental health in the present by revisiting the past certainly has the potential to reflect and help us understand circumstances and issues which define women's current positions as patients and practitioners in the medical profession.

⁶ For an illuminating overview of contemporary issues surrounding women and/ in mental health, see Liz Bondi and Erica Burman.

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Hysteria, Doctor-Patient Relationships, and Identity Boundaries in Siri

Hustvedt's *What I Loved*

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Abstracts:

In her novel *What I Loved* a fictional autobiography written from the perspective of a male art historian, American author Siri Hustvedt reinterprets the relationship between female hysterical patients and their male doctors at the French hospital La Salpêtrière at the end of the nineteenth century. Hustvedt's portrayal of the way doctors at the time – most prominently Jean-Martin Charcot – treated their female patients at the Salpêtrière reveals complex negotiations of identities; the author's examination oscillates between an emphasis on the doctor as the dominating mastermind of the hysterics' behavior and explorations of hysteria as an escape from a society in which women were overpoweringly restricted. In particular, the representation of hysterical patients in one of the main character's artwork – a series of paintings and installations on the theme of hysteria – highlights aspects of the doctor-patient relationship emerging as an extreme example of a self mastered by the other. The patient is displayed as an object of study (and photography), trapped by the clinical gaze, and a blank slate to be inscribed by the investigator (dermagrivism). Hustvedt's works highlight the fragility of identity constructions, always showing the self in relation to the other and emphasizing moments of transgression and undecidability. This paper puts Hustvedt's notions of self into communication with interpretations of hysteria as a disease affixed to a femininity allegedly characterized by impressionability, susceptibility, and a lack of moral agency.

1 In her autobiographical essay "Extracts from a Story of the Wounded Self," American author Siri Hustvedt confesses to her existential fear "that thresholds and boundaries won't hold, that things will go to pieces" (197). This anxiety over the fragility of boundaries finds expression in most of Hustvedt's works: physical thresholds and distinctions between self and other emerge as permeable and unstable constructs. When considering questions of the body and identity, Hustvedt emphasizes the inevitable transgression of physical and symbolical limits and the inseparability of the self from the world. The bounded self as idealized in a Cartesian worldview, safely detached from the body it inhabits, does not exist in Hustvedt's oeuvre. In an essay on the painter Philip Guston, she writes that "the world penetrates us. We eat, we smoke, and have sex. But language and images enter us too. They become us" (*Mysteries* 58). Rather than imagining an inner self that is somehow separated from the outside by fixed borders, Hustvedt thus envisions the self as a compound of physical matter and "idea-winds that gust through people's minds and then become scars on the landscape" (*Loved* 366).

2 The author's fascination with the penetrable boundaries of the self, in which the material and the symbolical interfuse, may find its furthest development in her contemplation of hysteria in the 2003 novel *What I Loved*. In the novel, a fictional autobiography written from the perspective of a male art historian, Hustvedt reinterprets the relationship between female hysterical patients and their doctors at the French hospital La Salpêtrière at the end of the nineteenth century. Hustvedt's portrayal of the way doctors – most prominently Jean-Martin Charcot – treat their female patients at the Salpêtrière reveals complex negotiations of identity boundaries, oscillating between an emphasis on the doctor as the dominating mastermind guiding the hysterics' behavior, on the one hand, and explorations of hysteria as an escape from a society in which women were overpoweringly restricted, on the other. This paper sets out to analyze the relation between illness and constructions of feminine identity in Hustvedt's interpretation of hysteria. It traces the relation between hysterics and their physicians as an example of a self which has become overmixed with its environment, in which the distinction between inside and outside has become blurred to the point of dissolution.

3 Narrated from the point of a view of art historian Leo Hertzberg, the novel is set in the New York art world and deals with questions of identity, love, loss, art, madness, and perception, among other themes. Violet Blom, the lover and later wife of Leo's best friend, the artist Bill Wechsler, writes her dissertation about hysteria at the French hospital La Salpêtrière. Bill takes this as inspiration to create a series of art works on hysteria. In the second half of the nineteenth century, La Salpêtrière became (in)famous for the way its doctors treated hysterical patients—through hypnosis, dermagrphism, public stagings, and photographic documentation. At the Salpêtrière, hysteria was turned into a staged performance of symptoms, with doctors as directors and patients as actors. As Elizabeth Bronfen describes the relationship between doctors and patients,

the patients styled their attacks according to the questions posed to them by the physicians, supporting and sustaining their desire by behaving the way they surmised these physicians [...] wanted them to behave, watching and learning from each other, becoming ever more dramatic as they saw the effect their performances had on the audience. (183)

In *What I Loved*, Hustvedt conceptualizes the relationship between female hysterical patients and their doctors at the Salpêtrière as a performance of transgression, in which the hysteric is converted into an object of the clinical gaze, a canvas for the doctor's artistic skills, and a

spectacle of a self without boundaries.¹ Violet points out how strongly the hysterics' symptoms were related to the expectations of their doctors. Talking about one of the most famous patients, Blanche Wittmann, she remarks: "They called her "the Queen of the Hysterics." She was featured in Charcot's demonstrations of hysteria and hypnosis. [...] But after Charcot died, Blanche Wittmann never had another hysterical attack.' [...] 'She adored Charcot and wanted to please him, so she gave him what he wanted'" (275). The mutability of symptoms and the complete absence thereof after the death of the master physician Charcot highlights the heteronomy at work between doctors and patients at the Salpêtrière. Their relationship was coined by the hysteric's modeling of her behavior according to her physician's suggestion, an opening up of her identity boundaries that transformed her into a spectacular performer of the physician's desire.

4 Making a spectacle of oneself is, according to Mary Russo, "a specifically feminine danger" closely connected to a "loss of boundaries" (318). This remark reverberates with an idea of women's bodies as being more open than men's (see, for example, Margrit Shildrick's *Leaky Bodies and Boundaries*) and female ego boundaries as more permeable than male ego boundaries (see, for example, Nancy Chodorow's *Reproduction of Mothering*). Doctors' representations of the hysterics, as Janet Beizer points out, characterized their patients as "incontinent slave to her secretions, unable to control her dripping, flowing, spurting, oozing bodily fluids" (41), which served to underline the notion of the female body as "intrinsically pathological" (Hurley 120). The body of the hysteric is thus located in the midst of a far-reaching debate over feminine identity and social norms. "If the body is synecdochal for the social system *per se* or a site in which open systems converge," Judith Butler holds, "then any kind of unregulated permeability constitutes a site of pollution and endangerment" (132). While Butler applies this to criticize constructions of "homosexual pollution" (132), the concept also appears to match the sexually open and unregulated body displayed by the hysterics and their accordant marginalization in society (they were, after all, institutionalized in asylums). The pathologization of the female body reinforced the epistemological control of medical science and a patriarchal social order that denied female agency: "the doctor symbolizes truth, health, the moral and spiritual foundations of society while the hysteric is the fallen woman/villainess, infecting the social body" (Diamond 10).

¹ Hustvedt's references to hysteria and other medical disorders such as anorexia nervosa are carefully researched. In the back of the book, she lists a number of scientific publications that she consulted in her research; for her interpretation of hysteria, Hustvedt also profited from her sister Asti Hustvedt's research – whose unpublished Ph.D thesis serves as the basis for Violet's dissertation – research in the Salpêtrière Hospital archives (*Loved* 370).

5 Hustvedt's protagonist Violet draws attention to the miserable conditions under which most hysterics had to suffer before being institutionalized. Hysteria, she claims, may have been ““a permissible way out”” (54). This way out, however, turned out to lead most hysterics into deeper confinement; no matter how suffocating and traumatizing their lives had been before their institutionalization, their situation can hardly be described as improved by the kind of treatment they received at the Salpêtrière. The real way out, and this is a significant aspect of the novel, was to escape both from the Salpêtrière and the confinements of society in general by cross-dressing as a man, thus disguising the femininity to which the illness seemed to be tied.

Boundaries of the Self

6 Since questions of the self and its boundaries seem so immanent to a perception of hysterical identity as prototypically feminine, I regard Hustvedt's conception of boundaries as crucial to her renegotiation of the doctor-patient relationship at the Salpêtrière. In *What I Loved*, Violet states that ““Nowadays girls *make* boundaries,’ [...]. ‘The hysterics wanted to explode them”” (81). The force of this explosion lies in the discursive struggle unfolding on the body of the hysteric. How does Hustvedt present the hysterics' struggle to explode boundaries? Which boundaries are to be exploded and which are in need of protection? Hustvedt's concept of boundaries is marked by a conflation of the physical and the symbolical – the body is inseparable from its symbolical functions. In her collection of essays on painting, *Mysteries of the Rectangle*, Hustvedt quotes from Mary Douglas's seminal work *Purity and Danger*: ““All margins are dangerous. If they are pulled this way or that the shape of fundamental experience is altered. Any structure of ideas is vulnerable at its margins. We should expect orifices of the body to symbolize specially vulnerable points”” (80). This quotation exposes the vulnerability inherent in margins, a susceptibility to threats from the outside that fundamentally shapes the identity of hysterics at the Salpêtrière. At the same time, it reads the body in its symbolical function. The body becomes a site of recycling and transfiguring both physical and ideational material. It is in this exchange between inside and outside that the body's interactions assume discursive signification and the body becomes a cultural medium.

7 The danger and vulnerability inherent in boundaries are also central to Hustvedt's latest novel, *The Sorrows of an American* (2008). Subjectivity, Hustvedt demonstrates, needs borders. The novel's protagonist Eric—a psychiatrist whom Hustvedt has called her “imaginary brother” (qtd. in Cooke n.pag.)—reflects on a dialogue with a patient: ““Some

days, it's like I don't have any skin. I'm all raw and bleeding.' This comment had helped me. I had talked to her about following a metaphor. No skin, no barrier, no protection. The borders are important" (155). Erik's conversation with his patient reveals to him the need for a protective borderline between self and the world. This notion is fortified by Erik's contemplation of an instance of pathological border crossing in a schizophrenic patient:

The forms of things – the outlines. We can't live without them. 'Don't touch my nose, you shit!' one of the inpatients had screamed at me after I had briefly scratched my own during the interview. I was a young psychiatric resident then, and his words passed through me with a jolt. After that, I learned how precarious it all is – where we begin and end, our bodies, our words, inside and outside. (184)²

The maintenance of such distinctions between inside and outside, self and other, is exceedingly manipulated in the case of the hysterics at the Salpêtrière. Instead of encouraging the formation of protective borders, the physicians there are shown to do everything they can to invade their patients' private physical and mental territory. Although transgression and intersections between self and other are essential parts of life, identity also requires an inner core, an "inner sanctum" (Hustvedt, *Loved* 48), which is what the doctors at the Salpêtrière repeatedly attempt to get access to and control via the body.

8 Michel Foucault theorizes the mutual dependence of boundaries and transgression in an essay on Georges Bataille: "The limit and transgression depend on each other for whatever density of being they possess: a limit could not exist if it were absolutely uncrossable, and, reciprocally, transgression would be pointless if it merely crossed a limit composed of illusions and shadows" ("Preface" 27). Similarly, identity thrives on both limits and transgression; its very existence depends on outlines and boundaries, yet at the same time these boundaries are always already crossed. Taking the idea of transgression to the level of the social order, the hysterics serve as living reconfirmations of the boundary between normal and abnormal—they strengthen the taboo (see Bataille: "*The transgression does not deny the taboo but transcends and completes it*" [55; italics in original]).

9 Jean Starobinski has observed that "A living organism exists only by the virtue of the margin (dictated by the species, by the genetic code) through which it determines, defines and opposes itself, becoming individual: limit, finiteness, individuality, the struggle waged against the outside—all these are correlative" (342). Hustvedt is aware of both the need for margins and the inevitability of those margins to be crossed. She turns to pregnancy as a moment in which the limit between self and other is trespassed. In "Yonder," another autobiographical

² In a related scene in *What I Loved*, Bill's schizophrenic brother Dan exclaims: "You cut my hair!" when Bill comes to the hospital with short hair (301).

essay, she points to the particular feminine experience of being two in one during pregnancy that marks woman's identity as defying secure borders between self and other: "When I was pregnant with Sophie, I felt it was the only time I had been physically plural—two in one" (*Yonder* 11). However, she extends this idea beyond the realm of femininity by pointing to the universal human experience of life in the womb: "By its very nature, original space, maternal space, is nonsense; human experience there is undifferentiated and so can't be put into words. It lives on in our bodies, however, when we curl up to sleep, when we eat, when some of us bathe or swim. And surely it leaves its traces in our physical desire for another" (11). French philosopher Sylviane Agacinski also portrays the transgression of boundaries as a universal ingredient of human existence. "The boundaries of my physical existence have already been crossed by the other" (50), she writes. This boundary crossing which lies at the very beginning of all human existence results in the questioning of safe assumptions of a separate and autonomous identity – an insecurity at odds with a Cartesian consciousness grounded on a clear distinction between inside and outside. Hustvedt regards human existence as shaped by an original state of symbiosis and a desire to recover the unity disrupted at birth – tugging subjectivity away from autonomy and isolation to a space in which identity is fused with the other. However, in the case of the hysterical patients at the Salpêtrière, as will be illustrated in the following, the natural desire to return to a state of undifferentiated being, the desire to explode the boundaries of the self, is bound to end in a disaster, since identity requires limits – crossable limits, yet limits nevertheless.

Speaking or Muted? The Language of the Hysterical Body

10 In a series of artworks on hysteria, Bill gives expression to the way that the hysterics found their identities encroached upon by the various "therapies" administered at the Salpêtrière. In one of his artworks, a box ten feet high and seven feet wide, he shows a small doll with blond curls, screaming in agony:

Her eyes were screwed shut and her mouth was stretched wide in a silent scream as she clamped her arms around a pole that divided the little room in half. In her fit she had contorted her body to one side so that her dress had twisted up around her waist, and when I scrutinized her little face more closely, I saw that a long bloody scratch ran down one of her cheeks. On the walls that surrounded her, Bill had painted ten shadowy male figures in black and white. Each man was holding a book and had turned his gray eyes toward the howling girl. (*Loved* 72)

The portrayal of the howling creature prey to the gaze of scientific observers fixing their gray eyes on her from all sides gives an intense expression to the disempowered position of the hysteric patient. The books hint at the doctors' epistemological power – they watch and judge, they

record and chart, and thus assign meaning to hysterical identity. In a “classical” allocation of the female as the objectified target of the male gaze, this artistic representation makes the observer complicit in a scene of voyeurism – since the people looking at the artwork share their position with those of the shadows on the wall. Like the men in the box, they are mere shadows, their identities hidden and protected. Bill’s rendering of the hysteric in the midst of the male shadows does not allow for hysterical body language as a sign of empowerment: the doll’s scream is silent, her body is contorted, exposed, and hurt. However, although the hysteric’s body seems powerless and victimized, it does convey its message of pain—though ignored by the clinical gaze, it may be perceived by the more empathic gaze of people looking at Bill’s art.

11 Another of Bill’s artworks exhibits four Barbie dolls lying on the ground, each blindfolded and with their mouths taped; three of the mouth tapes have words printed on them: HYSTERIA, ANOREXIA NERVOSA, EXQUISITE MUTILATION, while the last one is blank (*Loved* 73). The hysterics are muted by the discourse of medical classification. The question of who speaks through the hysterical body has been a central concern in a number of interpretations of hysteria. The hysterics’ various symptoms have been interpreted as a specific body language, and much has been written about hysterical semiotics and the hysterics’ use of a repertory of signs to communicate. Manfred Schneider, for example, in his essay “Hysterie als Gesamtkunstwerk: Aufstieg und Verfall einer Semiotik der Weiblichkeit” (Hysteria as a Synthesis of the Arts: Rise and Fall of a Semiotics of the Female), writes about the medical lecture of women’s bodies and the register of female suffering as a poetry album (882). He also calls hysteria the register of deceiving female forms of expression, a rhetoric of female desire, and refers to the rule of metaphor and the pathological symbolism of sex (883). In a similar vein, Peter Stallybrass and Allon White read the hysterics’ behavior as an endeavor to speak through the body; they conceptualize hysterical symptoms as an “attempt to produce their own pastiche and parody in an effort to embody semiotically their distress” (174). Susan Bordo argues that the symptomatology of hysteria – along with disorders such as agoraphobia and anorexia nervosa – “reveals itself as textuality” (93) and that the “bodies of disordered women in this way offer themselves as an aggressively graphic text for the interpreter—a text that insists, actually demands, that it be read as a cultural statement, a statement about gender” (94). The Surrealist thinkers André Breton and Louis Aragon have even called hysteria the “most poetic discovery of the 19th century” and a “supreme mode of expression” (qtd. in Filipovic 194). Yet the question remains whether the message conveyed by the hysteric’s body was received or ignored. Elaine Showalter points to the fact

that French feminists like Hélène Cixous and Julia Kristeva have defined hysteria “as a female signifying system outside of language” (86) and have created an *écriture féminine* inspired by a wish to find a voice for the silenced language of the female body. Janet Beizer stresses the semiotic struggle between hysterical incoherence and a medical appropriation of the hysteric’s body language:

The silences and incoherences of hysteria were perceived as an invitation to narrate: it is precisely because the hysteric cannot tell her story that this story, in the form of a blank to be filled in, is so readily accessible as narrative matter. But also, it is because the hysteric’s story is not *only* hers – it is a more inclusive cultural story that, repressed, can be spoken only in the Other’s name – that the hysteric is so readily appropriated as narrative screen. (9)

What this passage, like the other texts considered here, brings to the foreground is the tension between the signifying power of the body and the discursive repression of its voice through the medical institution. The transformations enacted upon the body through a variety of symptoms figure as signifying practices in a network of socio-political power relations—the body is always infused with cultural meaning. In a Foucauldian vein, the body is commonly viewed as a parchment on which discourses and social pressures are inscribed, a textual construction that is beyond the control of the individual. This idea is prominent in the application of dermagrAPHISM – the practice of tracing the hysteric’s supposedly more impressionable skin with a blunt instrument to make letters and paintings visible on her body – repeatedly exercised at the Salpêtrière. In *What I Loved*, Bill expresses the violence immanent in such an inscription of the body in his artwork.

DermagrAPHISM: Turning the Hysteric into an Art Object

12 The cruelty of the clinical gaze and the objectification of the female patient highlighted in Bill’s artwork are most clearly enunciated in his representations of dermagrAPHISM. In one of the hysteria boxes, he shows a naked woman straddled by a dressed man: “She was lying on the floor as the young man straddled her back. Gripping a large pen in his left hand, he appeared to be writing vigorously on one of her buttocks” (*Loved* 72). When Leo and his wife Erica visit Bill’s studio to have a look at some of the hysteria exhibits, Erica and Violet have a conversation about dermagrAPHISM, in which Violet draws a parallel between the body of the hysterics and works of art: “‘They turned living women into things,’ she said. ‘Charcot called the hypnotized women ‘artificial hysterics.’ That was his term. DermagrAPHISM makes the idea more potent. Doctors like Barthélemy signed women’s bodies

just as if they were works of art” (74).³ One source of inspiration for Bill’s portrayal is Georges Didi-Huberman’s *Invention de l’hysterie*. As narrator Leo points out: “The book had been written by a Frenchman, Georges Didi-Huberman, but what interested Bill were its photographs. They all had been taken at the Salpêtrière Hospital in Paris, where the famous neurologist Jean-Martin Charcot had conducted experiments on women suffering from hysteria” (50). Didi-Huberman, as the subtitle of his book reveals, analyzes the *Iconography of the Salpêtrière* – a collection of photographically documented case histories – examining the “extraordinary complicity between patients and doctors, a relationship of desires, gazes, and knowledge” (xi). One of Bill’s hysteria boxes described by Leo is based on an actual picture taken at the Salpêtrière:

Drawing close to her, I peeked into a small room, harshly lit by a miniature ceiling lamp that shone on an old black-and-white photograph that had been pasted to the far wall. It showed a woman’s head and torso from behind. The word SATAN had been written in large letters on the skin between her shoulder blades. (Hustvedt, *Loved* 71)

The traced and imprinted skin of the patient is defenselessly exposed to the observer’s gaze – the identity of the hysteric is reduced to its impressionable and manipulable outer surface. Not only is the woman’s body inscribed with the word SATAN, which evokes the idea of a self possessed by an evil power, denied of self-control and agency; in addition, this inscription is captured in a photograph, which, as will be illustrated below, heightens the sense of an identity determined by outside forces, of the woman as an object to be observed and judged against her will. Leo’s further description of the installation illuminates the transformation of the hysteric into an art object effected by dermagrphism:

In front of the photo was the image of another woman kneeling on the ground. She had been painted on heavy canvas and then cut out. For her exposed back and arms, Bill had used pearly, idealized flesh tones reminiscent of Titian. The nightgown she had pulled down over her shoulders was the palest of blues. The third figure in the room was a man, a small wax sculpture. He stood over the cutout woman with a pointer, like the ones used in geography classes, and seemed to be tracing something onto her skin – a crude landscape of a tree, a house, and a cloud. (Hustvedt, *Loved* 71)

The installation focuses on the topography of the female body mapped out by the clinical observer. Art and medicine are conflated in the body of the woman – the man uses the pointer to create an image on the skin, thus reducing his patient to an empty canvas for his own creation. Drawing attention to this peculiar practice at the Salpêtrière,⁴ Hustvedt lays

³ Charcot called the Salpêtrière a “museum of living pathology” (quoted, for example, in Bronfen 174).

⁴ Janet Beizer notes that “late twentieth-century medicine finds the condition [dermagrphism] in approximately 5 percent of the general population” (20) – it is thus not a phenomenon reduced to hysterical patients at the Salpêtrière. In the novel, Violet demonstrates it on her own arm (*Loved* 74).

particular emphasis on the various similarities between the objectification of women practiced in both the medical field and art. Transforming the body of the woman into a supposedly blank slate⁵ used for inscription, writing on the body plays a central role in metamorphosing the female patients into art objects. The doctors assume creative control over their patients by treating them like a canvas to be inscribed with a meaning dictated by the hand of the master physician. More than just a physical cover of the body, the skin is the symbolical field between the self and the world (cf. Benthien 7). It is a site of contact, a site of exchange: “*In between* the outside and the inside, the contact surface – whether it be membrane, film, or skin – is alike the place of exchanges, of adjustments, of sensory signals, and the place of conflicts or wounds” (Starobinski 342; emphasis in original). As Benthien argues in her literary history of the skin, the skin has been developed into a central metaphor of separation, especially in the twentieth century (7). According to Benthien, in the eighteenth century the skin was still seen as a porous layer with manifold openings (51) – this notion of permeability has been increasingly suppressed. The inscription of the skin, the penetration and marking of this symbolical field with a writing instrument, suggests authorial control of the doctor and the impressionability of the patient.

13 The symbolical power assigned to the skin as dividing line between inside and outside can again be tied to the discursive powers at play in the body in general. As Butler holds, in her reading of Foucault’s notion of the body and culture in “Nietzsche, Genealogy, History”: “In a sense, for Foucault, as for Nietzsche, cultural values emerge as the result of an inscription on the body, understood as a medium, indeed, a blank page; in order for this inscription to signify, however, that medium must itself be destroyed – that is, fully transvaluated into a sublimated domain of values” (130). This transvaluation is exercised very directly on the body of the hysteric – the presence of the body and any kind of message communicated by the body are muted by the enforced transformation of the medium into a blank page. Although both Foucault and Butler use the term “inscriptions” in a metaphorical sense, the literal, physical realization of impregnating a person’s body with a text authored by the doctor stands out as a forceful encroachment on that person’s identity.

14 Hustvedt furthermore extends the scope of this male fantasy of objectification and subjection to a prominent myth of male creation: the Pygmalion myth. Leo observes,

Medicine had granted permission to a fantasy that men have never abandoned, a muddled version of what Pygmalion wanted—something between a real woman and a beautiful thing. [...] I thought of Ovid’s Pygmalion kissing, embracing, and dressing

⁵ For an elaborate account of literary representations of woman as a blank slate to be inscribed, a passive creation of the male artist, see Gubar’s “‘The Blank Page’ and the Issues of Female Creativity.”

the girl he had carved out of ivory. When his wish comes true, he touches her new warm skin and his fingers leave an imprint. (*Loved* 74)

In a reverted version of this myth, the doctors at the Salpêtrière turn their Galateas from living beings into statues. Rather than creating life, they create art. Although the imprint the physician leaves on the hysteric's body is a sign of the skin's vulnerability, the lasting impression of dermagraphism is one denying the living interior of the patient, reducing her to the surface. Peter Brooks regards the myth of Pygmalion as the story that best exemplifies what Brooks calls "the interplay of eros and artistic creation":

What presides at the inscription and imprinting of bodies is, in the broadest sense, a set of desires: a desire that the body not be lost to meaning – that it be brought into the realm of the semiotic and the significant – and, underneath this, a desire for the body itself, and erotic longing to have or to be the body. (*Body Work* 22)

While the desire in the case of the doctors seems to be a desire of mastering the patient's body, it is not free from erotic undertones. The erotic desire connected to the sensation of leaving an imprint on another person's body evokes another scene right at the beginning of *What I Loved*. The stimulating connection between leaving a mark on the skin and leaving a mark on the canvas already emerges on the first page of the novel, when Violet describes her feelings as she was painted by Bill: "I wanted you to turn around and walk over to me and rub my skin the way you rubbed the painting. I wanted you to press hard on me with your thumb the way you pressed on the picture ..." (3). The erotic tension present in this scene is complimented by Leo's reaction to seeing a bruise in the very same painting that Violet is referring to: Leo gets aroused and has sex with his wife Erica. "Later," Leo writes, "Erica said that she thought my response had something to do with a desire to leave a mark on another person's body. 'Skin is soft' she said. 'We're easily cut and bruised'" (6). These hints at the erotic potential in marking another body but also at the skin as a site of violence and injury foreshadow the practice of dermagraphism at the Salpêtrière. Furthermore, Violet's posing as a model for Bill's art constitutes a counter model to the hysterics' conversion into art objects. Rather than emphasizing elements of objectification and domination, Bill's art work becomes a true co-production; mapping out "a territory between her [Violet] and me [Bill]" (15), the work of art melts the identity of the artist and his model, as emphasized by the title of the painting: *Self-Portrait* (4).

Hysteria and Photography

15 Bill's *Self-Portrait* series stands in stark contrast to the photographic representations of the hysterics in the Salpêtrière. While Bill's portrait of Violet seems to come into being in

an interactive field between himself, his model, and the observer, transcending the gap between self and other, this gap is strictly upheld in the photographs of the iconography. The medium of photography is employed to further enhance the implications of other-determination and loss of agency caused by the practice of marking the hysterics' skin. As shown above, Bill's interpretation of hysterical identity at the Salpêtrière displays the hysterics' agony in the grip of their doctors' violent inscription and photographic documentation. The possibility of violence inherent in photography is an issue that Hustvedt also explores in two other novels. In *The Blindfold*, her first novel, the protagonist Iris feels bereft of her identity due to a photograph taken by George, an acquaintance of her boyfriend. The photographic representation seems to gain control over and disrupt her identity: "I don't know where I am anymore, and that picture is part of it." [...] "You robbed me," she accuses George (78). The fixed representation of the self as caught in a photograph becomes an instrument of terror. Significantly, Elizabeth Bronfen indicates that Iris's comportment regarding the photograph resembles that of a hysteric: "[...] she begins, much along the lines of the classic hysteric, to somatically enact the murky interface between fiction and reality which this image comes to represent for her. The photograph initially takes on the function of a fetish in her fantasy life" (285). Moreover, in Hustvedt's recent novel *The Sorrows of an American*, protagonist Erik is shocked when confronted with the idea that one of his patients has seen his photograph in an exhibition – the photograph had been taken and published without his consent: "It's hard to describe the loss I felt at that moment. It was as if I had been robbed of something very dear to me, and without even having seen the image or the images, I felt the burn of humiliation" (257). In both cases, photography implies an intrusion into one's privacy, delivering a part of the self to the world in a representation that is beyond the control of the person photographed.

16 Taking these examples into consideration, the horror and agony of the hysterics appear to be caused by the theft of agency procured by the iconography at the Salpêtrière. Susan Sontag characterizes photography as a medium of power: "But a photograph is not only like its subject, a homage to the subject. It is part of, an extension of that subject; and a potent means of acquiring it, of gaining control over it" (351). Photographs, according to Sontag, redefine reality "as an item for exhibition, as a record for scrutiny, as a target for surveillance" (351) – they freeze the fleeting moments of time into a single, graspable, and observable instant, thus relinquishing their subject to the objectifying gaze of the other. James Elkins's conceptualization of photography as a material intrusion on the identity of the subject intensifies the notion of violence in representation: "Every photograph is a little sting, a small

hurt inflicted on its subject, but even more: every glance *hurts* in some way by freezing and condensing what's seen into something that it is not" (29). This resembles Didi-Huberman's characterization of the clinical gaze at the Salpêtrière: "The clinical glance is already *contact*, simultaneously ideal and percussive. It is a stroke [*trait*] that goes directly to the body of the patient, almost palpating it" (28-29). Although a conception of the gaze as contact bears the possibility of subverting notions of the distancing power of ocularcentrism (see, for example, Luce Irigaray's reflection on tactile vision in *An Ethics of Sexual Difference* 185-92), quite the opposite is the case at the Salpêtrière. Here, the doctors' gaze takes effect as intrusion and violation of the hysteric's embodied identity. Photography is installed as an enforcement of "museological authority of the sick body, the museological agency of its 'observation'" (Didi-Huberman 30). In the moment of being fixed in the gaze of the photographer, the subject loses its authoring capacity. The assumption of such authority through photographic representation is inevitably violent. As Sontag makes evident, "there is something predatory in the act of taking a picture. To photograph people is to violate them, by seeing them as they never see themselves, by having knowledge of them they can never have; it turns people into objects that can be symbolically possessed" (14). This symbolical possession robs the hysteric of the ability to assume control over her identity and leaves her prey to the gaze of the readers of the iconography, including us. Her identity having been reduced to being "body-for-others" in the photographic representation, the hysteric is shown to be unable to occupy a stable position as center of relations, as center of reference.

Conclusion: Feminine Subversion, Cross-Dressing, and Escape

17 Inscribed, symbolically possessed, catalogued – what could the hysterics do to save themselves? The final box of Bill's hysteria series shows a person dressed in a top hat and a long coat walking out through a door (*Loved* 71). What the observer first thinks to be a man turns out to be woman in disguise, escaping from the hospital (73). As Violet explains, it is a representation of Augustine, probably the most famous inmate at the Salpêtrière. Violet, who is particularly fascinated with Augustine's story, describes her as the "pinup girl for hysteria" (50), since she was the most photographed patient at the Salpêtrière.⁶ Elizabeth Bronfen points out that

[...] Augustine seems to not only function as the medium for a culturally given iconography that speaks through her but she also knots together the phantomatic presences of two other scenes, serving as the medium for Charcot's phantasy of a

⁶ A Google image search will exhibit Augustine starring in the "attitudes passionelles," as captured in one of the iconography's photographic plates.

standard, universal formula of hysteria as well as the medium for a message emitting from her unconscious. (196)

Augustine thus epitomizes the complicated constellation of hysterical identity: a subjectivity balancing on the threshold between the language of her unconscious, her culturally determined symbolical value, and the Pygmalian dream of her physician.

18 As Violet tells the reader, Augustine ““escaped from the Salpêtrière dressed as a man”” (73). Significantly, the path to freedom is taken via disguising her gender: abandoning the stylized symptoms she performed as an icon of hysteria, Augustine at the same time abandons her feminine identity. By dressing up as a man, she performs one final act that liberates her from medical observation and the restraints that come with it. Augustine’s story of escape exemplifies other “tales of women who made daring escapes from hospitals and husbands, fathers and employers” (51) that Violet encounters during her research. They all share the element of cross-dressing as a strategy to gain freedom: “They chopped off their hair and disguised themselves as men. They climbed over walls, jumped out windows, and leapt from roof to roof. They boarded ships and sailed out to sea” (51). The hysterics who thus dressed up exploded yet another boundary: they crossed the limit of gender. In a society in which identity was so restricted and determined by gender divisions, cross-dressing must be seen as an act of rebellion against the discursive pressures weighing on the female subject. By crossing the boundary of gender, these patients finally also crossed the boundary between imprisonment and freedom, escaping the confinement of the medical institution.

19 As Hustvedt suggests in her essay “Being a Man,” “there are times when the body feels like a limitation” (95) – at a medical institution in late nineteenth-century France, the “cultural expectations that burden femininity” (Hustvedt, “Being a Man” 96) certainly weighed heavily on the female patients. Iris, the protagonist of *The Blindfold*, also dresses as a man, which changes her behavior and identity profoundly. Hustvedt analyzes her protagonist’s cross-dressing as “defensive, an escape from the openness, fragility, and boundlessness she connects to her femininity” (“Being a Man” 102). This brings us back to the beginning: conceptions of the female body as open and boundless have been crucial to interpretations of hysteria. Like Iris, the patients at the hospital may have sensed that by sidestepping their gendered identity, they could also sidestep their weakened and objectified positions in society. Hustvedt’s look back at the Salpêtrière in *What I Loved* reveals the patients to be ambivalent subjects in whom the private and the public, the inside and the outside, clash in a struggle between individual rebellion and discursive regulation. The “idea-winds” of the time carried along stories of feminine madness and disempowerment – a

performance of masculinity may have helped the hysterics to strengthen their boundaries, yet the scars on the landscape of the self could not be undone.

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The upcoming issue of *gender forum*, “**Literature and Medicine: Women in the Medical Profession**” – **Part II**, will continue the debate on the intersections of medicine, literature, and gender with a collection of essays focusing on personal narratives. Here, all contributions emphasize the healing power of grief and illness narratives in their various sub-genres, such as written testimonies, diaries, blogs, and artists’ books, thus in a multiplicity of autobiographical or auto-ethnographical writings.