From Dissection to Connection: The Preservative Power of the Empathetic Gaze in Romantic Literature

A dissertation presented to

the faculty of

the College of Arts and Sciences of Ohio University

In partial fulfillment

of the requirements for the degree

Doctor of Philosophy

Brandy B. Fraley

June 2010

© 2010 Brandy B. Fraley. All Rights Reserved.
This dissertation titled
From Dissection to Connection: The Preservative Power of the Empathetic Gaze in
Romantic Literature

by
BRANDY B. FRALEY

has been approved for
the Department of English
and the College of Arts and Sciences by

Nicole M. Reynolds
Assistant Professor of English

Benjamin M. Ogles
Dean, College of Arts and Sciences
ABSTRACT

FRALEY, BRANDY B., Ph.D., June 2010, English

From Dissection to Connection: the Preservative Power of the Empathetic Gaze in Romantic Literature (197 pp.)

Director of Dissertation: Nicole M. Reynolds

“From Dissection to Connection: The Preservative Power of the Empathetic Gaze in Romantic Literature” examines the inherent conflicts between varying medical gazes at abnormal bodies during the Romantic period, and examines, specifically, how the empathetic gaze—a way of medical looking based on intuition, emotion, instinct and experience—evolves and works within Romantic texts to preserve abnormal bodies and maintain their disruptive energy. Through revisionary close readings of several texts including Mary Seacole’s The Wonderful Adventures of Mrs. Seacole In Many Lands, Maria Edgeworth’s Belinda, and Thomas de Quincey’s Confessions of an English Opium Eater, the dissertation differentiates the empathetic gaze from its colder clinical counterpart, explores its effect on various types of abnormal bodies, and supplements critical readings that attempt to reconcile Romantic texts with the medical science of the Romantic period.

Approved: _____________________________________________________________

Nicole M. Reynolds

Assistant Professor of English
ACKNOWLEDGEMENTS

I owe a debt of gratitude particularly to my dissertation advisor, Nicole Reynolds, whose knowledge about and unflagging enthusiasm for this topic enriched the entire process. I also appreciate the encouragement of my dissertation committee members, who walked me through the arduous revision process: Linda Zionkowski, Joe McLaughlin, and Michele Clouse.
For Mom, Dad, and Jason, whose love helped me get here; and most especially for the

One who knew that I would be here all along.
# TABLE OF CONTENTS

Abstract ..................................................................................................................................................3
Acknowledgments .......................................................................................................................................4
Dedication ..................................................................................................................................................5
List of Figures ...........................................................................................................................................7
Introduction ...............................................................................................................................................8

Chapter 1: The Dissection Table, Turned:  
The Empathetic Gaze in the Romantic Period ...............................................................................19

Chapter 2: Mami’s Autopsy: Mary Seacole’s Empathetic Gaze ..........................................................63

Chapter 3: "The Best Judge of Her Own Feelings:  
The Reproduction of the Clinical Gaze in Belinda ..................................................................105

Chapter 4: Fever Nests and Chimney Sweeps:  
The Urban Scope of the Empathetic Gaze ..............................................................................146

Conclusion ...........................................................................................................................................182
References .............................................................................................................................................191
<table>
<thead>
<tr>
<th>Figure</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Thomas Rowlandson’s “The Anatomist”</td>
<td>30</td>
</tr>
<tr>
<td>2</td>
<td>William Blake’s “A Negro Hung Alive By His Ribs to a Gallows”</td>
<td>56</td>
</tr>
<tr>
<td>3</td>
<td>“The Chimney Sweeper” <em>Songs of Experience</em> engraving</td>
<td>162</td>
</tr>
<tr>
<td>4</td>
<td>“The Chimney Sweeper” <em>Songs of Innocence</em> engraving</td>
<td>164</td>
</tr>
</tbody>
</table>
INTRODUCTION

I. THE EMPATHETIC GAZE IN ROMANTIC LITERATURE

Although the mutual influence of medicine and literature on one another is a concept extending back all the ways to the days of the ancient Greeks and forward into our own time, the Romantic period in particular tempts a discussion of this juxtaposition. In many ways, the unique confluence of historical circumstances such as the abolition movement, the French Revolution, and the Napoleonic wars combine with advancements in the medical field to create a framework during this period in which medical study permeates both the literature and culture of the time.

During this fruitful period, the abnormal body in particular became a subject of much medical study and importance, in no little part because the study of abnormal bodies offered insight and valuable understanding into the nature of disease, deviancy, and aberration. Indeed, exhibits of abnormal and grotesque bodies became part of a small economy that traded on the public and medical fascination with perceived aberrance and deviation from the medically- and socially-understood normative standard.¹

Of course, throughout the period, the predominant medical way of looking at abnormal bodies—best described as the clinical gaze—gained notoriety for its view of the body as a textbook or a specimen worthy of mutilation, dissection, and destruction for the sake of knowledge. Beneath this gaze, especially when it manifests textually, abnormal bodies disappear, lose all agency and become reduced to little more than spectacles and exhibits. Their absence creates a void in which the disruptive energy of

¹ Youngquist deals with this particular phenomenon, especially the economy of freakery at Bartholomew Fair, at length in Monstrosities.
the abnormal body is not only halted, but also replaced by a proper body that restores heteronormative order.

My project, then, seeks to detail an alternative way of looking at varying types of abnormal bodies: an empathetic gaze, rooted in the eighteenth-century sensibility movement and a tradition of midwifery, that begets focused empathy and identification with the other as well as the application of feeling, passion, and instinct. Distinctly different from the clinical gaze endemic to most medical looking, the empathetic gaze focuses on the preservation of abnormal bodies rather than the destruction or dissection of them. Medically and textually speaking, the simple result of this gaze is empowerment and preservation: empowerment of the abnormal body to possess and direct itself, and the preservation of the deviation or otherness that renders it pathological. Within Romantic texts, the empathetic gaze works both to preserve and embed the other within the text, forces empathetic identification from the reader, and maintains the disruptive social forces at play. More importantly, by creating a space in which marginalized figures can preserve their own bodily abnormality, the empathetic gaze provides these bodies with agency that allows them to develop bonds with other marginalized figures, shy away from the standard social hegemony, and subvert dominant (and often heteronormative) narratives.

The conflict between these modes of gazes and their textual impact will comprise the majority of this discussion and comes to the fore, perhaps unsurprisingly, in a seminal work of Romantic literature. In Mary Shelley’s Frankenstein, a text devoted to the themes of sensibility (or the lack thereof), empathy, and science run amuck, the entire narrative focuses on the creature’s frustration over his own lack of agency; he was simply created,
not of his own will, and assigned what he considers to be the inevitable fate to someone of his appearance: all of his exertions to prove his own goodness and usefulness to the human race prove, largely, fruitless. The discovery of this futility, the creature claims, generates both his hatred and his desire for destruction and revenge: “Inflamed by pain, I vowed eternal hatred and vengeance to all mankind” (116). And yet the creature’s sole desire is empathy; he desires a mate, created by Frankenstein’s hands, to

‘…content me. It is true, we shall be monsters, cut off from all the world; but on that account we shall be more attached to one another. Our lives will not be happy, but they will be harmless, and free from the misery I now feel. Oh! My creator, make me happy, let me feel gratitude towards you for one benefit! Let me see that I excite the sympathy of some living thing; do not deny my request!’ (120).

*Frankenstein* is a novel focused on gazing, and also the inability to gaze: de Lacey’s blindness, the creature’s gaze at himself and his maker, the maker’s disgusted gaze at his creature, and the world’s gaze at the creature all function as moments in which the act of looking becomes either an act of acceptance or rejection, a gaze meant to reject or a gaze meant to protect. The creature’s pain stems from the fact that by being gazed upon, he is deemed monstrous. The solace for his pain is to be found in equal measure. He wishes to be seen, not by humans, but by someone *like himself*. The creature understands on the most fundamental level that a gaze which identifies, which observes him with compassion, understanding, and identification, is a gaze beneath which he might find
peace and through which he might live. It is this gaze that he also continually seeks through his maker, noting periodically “the compassion in [Frankenstein’s] eyes” and seeking to encourage it.

Frankenstein, however, ultimately denies this wish, precisely because he sees such a reflected empathy as frighteningly dangerous. Sitting in a remote outpost, he begins to reflect on the potential consequences of the promise he made to his creature:

…a train of reflection occurred to me, which led me to consider the effects of what I was now doing. Three years before I was engaged in the same manner, and had created a fiend whose unparalleled barbarity had desolated my heart, and filled it for ever with the bitterest remorse. I was now about to form another being, of whose dispositions I was alike ignorant; she might become ten thousand times more malignant than her mate, and delight, for its own sake, in murder and wretchedness. He had sworn to quit the neighbourhood of man, and hide himself in deserts; but she had not; and she, who in all probability was to become a thinking and reasoning animal, might refuse to comply with a compact made before her creation. …even if they were to leave Europe, and inhabit the deserts of the new world, yet one of the first results of those sympathies for which the daemon thirsted would be children, and a race of devils would be propagated upon the earth, who might make the very existence of the species of man a condition precarious and full of terror (138).
The monster craves an empathetic gaze to counter the pain of the gaze that wishes to destroy him and annihilate him; Frankenstein fears that precise gaze because, he reasons, such a mutual sympathy could engender murder, wretchedness, and perhaps worst of all, children—more abnormal bodies that would engender more abnormal bodies and, ultimately, create a monstrous race that would destroy humanity itself.

Given that the “species of man” to which Frankenstein alludes embodies the very nature of English domesticity, it seems the doctor himself is aware that the disruptive energy engendered by such an empathetic gaze empowers disruption and subversion, and threatens the heteroproductive normalcy of the life to which he has grown accustomed, and in which he wishes to participate. Because of this, he erases the new creature from existence before she entirely enters it.

Yet Frankenstein himself functions as a unique figure in the text; undeniably a doctor and a possessor of the clinical gaze, he experiments, seeks knowledge, and robs graves with a tenacity that anatomists would no doubt have envied. And yet this possessor of the clinical gaze functions, too, as a midwife; he births his creature into the world using secretive, near-mystical means and possesses no little amount of empathy and compassion himself. Several times, his empathy leads him to spare or to at least listen to his creature, and Walton acknowledges Frankenstein as an “admirable being” who “will sympathize with and love [him]” (180). The creature himself acknowledges his maker as, paradoxically, “generous and self-devoted” (187).

Frankenstein, the key character in one of the Romantic period’s most seminal texts, embodies in himself all the contradictions and paradoxes inherent between the clinical and empathetic gazes. One might argue that this conflict destroys him as surely
as his own creature’s machinations do; the conflict between the clinical and the empathetic in Frankenstein renders him, constantly, unable to act decisively one way or another, and his inability to act decisively to ensure his creature’s happiness ultimately dooms his own. In Frankenstein, denying the potential for the empathetic gaze engenders chaos; the ultimate desire to protect the heteronormative order—of which the creature’s desire is a parody—results in destruction, death, and the loss of life. The doctor himself, torn between these varying impulses, ultimately finds himself the sacrifice in this war between ways of looking—he finds peace only, literally, when he closes his eyes for the last and final time on Walton’s ship.

If Frankenstein functions as one of the seminal texts of the Romantic period, a deliberate manifesto on the consequences of ambition and science gone madly awry, then it also functions as a repository for medical ideology and the warring clinical and empathetic gazes and a reminder of their vital importance in determining not only social order, but social disruption as well.

II. THE CRITICAL DEBATE

Admittedly, an exploration of the symbiosis between medicine and literature and the conflict between medical ways of looking in the Romantic period is nothing new and has, in fact, enjoyed a particular renewal with tomes such as Donald C. Goellnicht’s The Poet-Physician, Alan Richardson’s British Romanticism and the Science of the Mind, and even post-colonial works like Alan Bewell’s Romanticism and Colonial Disease. Moreover, a special niche of Romantic criticism has also occupied itself, medically and otherwise, with the presence and purpose of the abnormal body in Romantic literature.
particularly noteworthy in this regard are Richard Sha’s *Perverse Romanticism* and Paul Youngquist’s *Monstrosities*

Within these texts, the clinical gaze often bears the brunt of much examination, and many studies that examine the function of abnormal (and grotesque, or freakish) bodies also implicitly discuss the function of medical science during the Romantic period in suppressing, reforming, or exhibiting those abnormalities. Works such as Clifton Crias and Pamela Scully’s *Sarah Baartman and the Hottentot Venus*, for example, paints in bright and vivid colors the life of a woman whose history and character vanished for a time beneath consuming interest about her anatomy and her ethnicity, and in Youngquist’s narrative the abnormal bodies of such historical figures as Charles Byrne and Daniel Lambert take precedence. Additionally, a significant amount of research, including Lisa Forman Cody’s *Birthing the Nation*, traces the position of folk physicians, midwives, and marginalized medical practitioners and their gazes within the period, noting the evolution of their perception over time. However, even within the bounds of scholarship that attempts to excavate the narratives of abnormal bodies or to question, analyze, or discuss the means and methods used to study, display, and discuss them, little attention has been paid to how an empathetic way of medical looking might also affect these abnormal bodies.

My project, which will explore the nature of the empathetic gaze as well as its textual presence within the Romantic period, seeks to shore up that gap and offer readings of Romantic texts that will, ideally, supplement the current critical focus on medical ways of looking at the abnormal body. Additionally, I hope through my exploration of this topic to reintegrate and reimagine the positioning of medical science
and the Romantic period to one another. For a long time the critical understanding of Romanticism—predicated on Nature, imagination, the supernatural, and the sublime—seemed rooted in an understanding of the period as “a broad shift of attitudes” that encompassed rejection of Enlightenment thought and embraced the natural (Perry 7). Although the aforementioned current critical scholarship has gone a long way towards mending the schism between science, medical science, and the Romantic period, my hope with this project is to shed light on an aspect of medical looking characterized by emotion, intuition, and the wisdom of experience that will further mend the gap and explore the implications, in the Romantic period, of a way of medical looking that is neither unnatural nor destructive.

III. CHOSEN TEXTS

My exploration of the empathetic gaze within Romantic literature extends over a wide variety of texts written over a large span of time. The empathetic gaze, after all, does not unfold in a neat chronology or according to genre, but rather occurs uniquely in texts at precise moments of historical, cultural, and medical confluence. Broadly speaking, my decision to choose these texts was predicated on those factors of confluence—on the presence, in each of these texts, of the historical, social, and medical convergences that give way to the presence of the empathetic gaze. The texts central to this discussion, though of particular interest because of their place as either representatives of a specific genre, their focus on abnormal bodies, or their function as microcosms of a greater social order, by no means comprise an exhaustive compilation of the texts that encompass, or
would benefit from, an excavation of the empathetic gaze, nor of the textual figures
whose agency has been rendered void by the clinical gaze.

The first chapter of this discussion concerns itself largely with the symbiosis
between medicine and literature in the Romantic period, the historical and cultural
contexts that produce medical ways of looking, and the presence of the abnormal body—
the object of these gazes—within Romantic literature and the Romantic medical
community. To that end, I discuss not only current scholarship on abnormal bodies and
medical ways of looking in the field, but also discuss the historical roots of the
empathetic gaze within the eighteenth-century sensibility movement and the midwife
profession, as well as the association of the clinical gaze with the eighteenth- and
nineteenth-century anatomists and its evolution from a descriptive to a prescriptive, and
often punitive, way of looking.

In the second chapter, Mary Seacole and her 1857 autobiography The Wonderful
Adventures of Mrs. Seacole In Many Lands exemplifies the focus on the ethnic body.
Though Seacole figures prominently within the Victorian tradition, most of her formative
medical education occurs within the Romantic period. More importantly, Seacole best
exemplifies the positioning of the ethnic body within various forms of medical discourse.
Though she writes as a free woman in the aftermath of abolition—a sharp contrast to
ethnic Romantic writers like Olaudah Equiano—Seacole nevertheless confronts the same
medical dialogues and understandings of racial difference and hierarchy that initially
underscored slavery and the abolition movement. Moreover, precisely because she is
free to work in medicine, Seacole is uniquely situated to explore the Romantic themes of
racial difference and the ramifications of the clinical gaze in a way that many ethnic
Romantic writers are not. This chapter explores Seacole’s ability not only to preserve the abnormality of other ethnic bodies she encounters through her empathetic gaze, but to preserve herself as a distinctly ethnic body while rendering herself acceptable to her readers with markers of English domesticity and femininity.

Maria Edgeworth’s 1801 novel *Belinda*, characteristic of its genre and its period, occupies the discussion of the empathetic and clinical gazes, as well as their effects on female bodies, in the third chapter. This novel not only exemplifies pressing medical concerns of the period about mysterious female bodies and prominent women’s health questions, but also addresses the questions of enlightenment, rationality, emotion, intuition, and self-knowledge so prevalent in the tension between the clinical and empathetic gazes.

Finally, the fourth chapter deals with the urban body as presented, variously, by Thomas de Quincey in his 1821 *Confessions of an English Opium Eater*, William Blake’s 1789 “Chimney Sweeper” poems in *Songs of Innocence*, and Jane Austen’s 1818 *Persuasion*. Both Blake and de Quincey examine, in their texts, the *cause* of urban abnormality. Both writers occupy a unique niche as distinctly urban poets in the Romantic canon. Devoted to the city, they nonetheless recognize and note the problems that the urban landscape creates in the body of its denizens. Austen, on the other hand, deals with the *cure* of urban abnormality in *Persuasion*, a novel set largely in the resort town of Bath, famous for its healing waters. Despite their relative chronological disparity, these three authors encompass the cycle of urban abnormality and sickness from its source to its seemingly natural cure, and best exemplify the inherent link between location and the body.
Together, this wide variety of texts best serves to demonstrate the varied but fundamental workings of the empathetic gaze as it occurs in the Romantic period. Not exhaustive by any means, they nevertheless provide the groundwork for a full understanding of how the empathetic gaze and the clinical gaze conflict, coincide, and evolve together.
CHAPTER ONE:
THE DISSECTION TABLE, TURNED:
THE EMPATHETIC GAZE IN THE ROMANTIC PERIOD

I. “LAMIA” AND ACTS OF MEDICAL GAZING

In John Keats’ “Lamia,” the titular serpent-woman’s disguise is, ultimately, undone by the philosopher Apollonius. Though Apollonius is not a doctor, he’s the bearer of a penetrating, knowledgeable gaze; Lycius praises him as “a sage…trusty guide…and good instructor” (l. 375) and, upon Apollonius’ entry to the wedding party, he is hailed as having a particularly calm temperament. Slowly and methodically, Apollonius works out the problems of Lamia’s identity and of the strange wedding feast in much the same way a physician might. Ultimately, it is Apollonius’ gaze which diagnoses, seeks to know, labels, and ultimately polices Lamia’s body on behalf of Lycius. Immediately after the speaker describes the murder of a rainbow’s wonder by science and laments that “philosophy will clip an angel’s wings, / Conquer all mysteries by rule and line” (l 231-35), Apollonius “fix[es] his eye” on Lamia (l. 246). He looks at her—probingly, knowingly, searchingly—and discerns, if not her full nature, at least the secret of it. If her grotesque body is the disease, then he is the doctor seeking to eradicate it or know it, and eradicate it he does upon identifying her. For Apollonius’ looking, ultimately, proves violently destructive: Lycius, whom Apollonius is seeking to protect, drops dead after Apollonius intervenes, and Lamia herself blanches—literally—and then simply vanishes. In this case, Lamia’s grotesque body is not diagnosed, but misdiagnosed; Apollonius names her a “serpent” although she is a hybrid of both serpent
and woman (for she truly does exist outside his realm of knowledge), but the result remains the same. Lamia vanishes, and in her place exists a bizarre textual vacuum: is she dead? Where does she go? Does she return to her original form, which exists within the knowledge of no one else in the poem but the god who initially changes her? Or is her deprivation of form a punishment, a cursed disembodiment, her deserved ending? Lamia, whose name titles the poem, becomes a byword for lack, and the remainder of the poem, admittedly brief, is organized around her absence. The poem ends with the bizarre mockery of a wedding processional; Lycius’ friends support his dead body, still wrapped in its marriage robe, a funereal wedding with his corpse emphasizing for the reader the absence of the bride’s body.

Yet “Lamia” is a poem replete with looking, and others beside Apollonius possess watchful eyes. Lamia gazes a great deal, of course, but her lover Lycius gazes more. Interestingly, he does not see her at all—his mind remains too wrapped in lofty thoughts—until she explicitly requests that he do so (l. 244-47). His eyes “[drink] her up” greedily, “leaving no drop,” but still the cup remains full (l. 251-53). Lamia requests his gaze because his gaze reinforces her chosen identity: an identity chosen to lure him in and honed carefully throughout their conversations. The two speak in a language of looking; she teases him for not having seen her before in Corinth, and his constant gazing at her reinforces her charm and, intriguingly, her otherness; Lamia has to speak to convince him of her mortality and shake his lingering innate fears of her supernatural nature. During their blissful respite together alone, Lycius sees himself when he gazes at her, “mirror’d small in paradise” (l. 47), a near-narcissistic act of consummate empathy: his mortal self re-rendered in her own mortality when he gazes upon her. Ultimately,
Lycius’ looking—which Lamia initially demands—so reinforces Lamia’s identity to herself that the poem’s speaker declares her fully divested of her serpenthood: “Certes, she / was none” (l. 80). Lycius’ gaze, rather than destroying Lamia or rendering her textually absent, *reifies* and preserves her chosen identity, constantly representing her to himself and to herself as she wishes to be seen and has changed to be seen.

“Lamia” evidences one of the intriguing cultural clashes during the Romantic period: the interplay of and tension between two distinct medical ways of looking. Keats’ poem, and Lamia’s body, studies in dissection and the destructiveness of the clinical gaze; the absence of the serpent-woman textually, once looked upon by Apollonius, illustrates the enforced disembodiment begotten by that gaze, the vanishing wrought by seeing too deeply, and the flawed knowledge that results from this form of looking. The shift from Apollonius’ gaze to Lycius’ and the resulting ramifications, however, will comprise the bulk of this discussion. Subordinated to the predominant clinical gaze both medically and textually, the empathetic gaze lurks on the fringes, marginalized in literature as well as in the medical community, and remains largely unexplored in criticism. The abnormal body, often a site of the tension between empathetic and clinical ways of looking in Romantic literature, and in the medical community during this period, remains the most fruitful site of this discussion but has too little been read as an object of the empathetic gaze, being instead interpreted by critics within the predominant medical framework of the period.
II. THE EMPATHETIC GAZE

The empathetic gaze works—through focused empathy, identification with the other, and application of feeling, passion, and instinct—to *preserve* the body. Associated with the eighteenth-century sensibility movement and the practice of midwifery, the empathetic gaze possesses the power to strengthen non-familial bonds—of women with women, of other with other—through identification, emotion, and shared experience, and thus threatens the duty-based bonds of the traditional reproductive family. Moreover, the empathetic gaze focuses on salvation rather than discovery, instinct and will rather than methodology, and identification with the other in addition to, or sometimes rather than, identification with self. Medically speaking, the simple result of this gaze is empowerment and preservation: the empowerment of the abnormal body to possess and direct itself, and the preservation of the deviation or otherness that renders it pathological. Textually, the empathetic gaze works both to preserve and embed the other within the text, forces empathetic identification from the reader, and maintains the disruptive social forces at play. More importantly, by creating a space in which marginalized figures can preserve the bodily abnormality that threatens the heteronormative social structure and also develop bonds with other marginalized figures rather than recreate the standard social hegemony, the empathetic gaze provides a useful counter-narrative to the hetero-reproductive standard.² However, in order to better understand the nature of the empathetic gaze, one must first understand its history as a product of the eighteenth-century sensibility movement, its strong connections to and associations with midwifery, and

² Paul Youngquist in *Monstrosities* points out that abnormal bodies almost *always* threaten typical heteronormative social structure by their mere existence. If bodies are the “material through which relations of power circulate to reproduce cultural norms,” abnormal bodies “incarnate beliefs and values” that do precisely the opposite.
and its function as a backlash against the dominant medical purview exemplified most strongly by the anatomists of the eighteenth and nineteenth centuries.

As Lisa Forman Cody points out, the rhetoric of the empathetic gaze links it most closely to the eighteenth-century sensibility movement, when “sensitivity and sensibility [are admired] as signs of human beings’ refinement” but simultaneously double as an indicator of “acute nervous energy” (Cody 146) and an impediment to logical, rational, scientific thought (149). The concept of women as biologically incapable of producing rational, scientific thought (and the inherent assumptions of hysteria, sentimentality, and instability that accompany sensibility) stem from the same medical science advocated and expounded by eighteenth century physicians like George Cheyne in The English Malady. Between the “quick thinkers, the slow thinkers, and the no thinkers,” Cheyne argues, the first inevitably suffers the most from overt feeling (182). For him, feeling was a deeply material act, one that occurred through delicacy, weakness, and the varying qualities of the nerves. The “quality of one’s sensibility” soon becomes “a badge of rank” (Barker-Benfield 8). And, unfortunately, an excess of feeling and sentimentality, while an indicator of refinement, elegance, and delicate intellect, also becomes noted as a cause of malady, suffering, and nervous disorders. The sensibility phenomenon manifests strongly in novels of the period like Clarissa (Barker-Benfield 17) and so permeates popular thought as to become part of the lingua franca of eighteenth century English culture. The coding of this empathetic way of looking, then, in the recognizable rhetoric of sensibility—already deeply entrenched in eighteenth century medical and popular thought—provides a double-edged referent for those privy to the debate: refinement, but instability; empathy, but incapability.
The associations of the empathetic gaze with emotion, intuition—and thus instability and incapability—only find further purchase in the legends, myths, and rumors that surrounded midwifery, a branch of medicine to which empathy, instinct, and feeling were particularly endemic. The Book of Oaths, a compilation of oaths for various offices compiled and published in the early eighteenth centuries, offers an example of the oath administered to midwives by the Bishop or Chancellor of the diocese and further underscores the dangerous, primitive associations of midwifery. That the oath was specifically administered to female midwives, not males, is indicated by the relevant pronouns, and remains more interesting for what it prohibits, rather than what it permits: witchcraft, and the use of certain herbs (191-93). That the female midwife represents a dangerous sort of agency here is evidenced by what the oaths constrain her, specifically, from doing, and from what they suggest she will do. And, from the allusions in these oaths as well as the dismissive attitudes of mainstream medical professionals, it becomes evident that midwifery itself had dangerous associations and stemmed from a different, folk-oriented tradition that eschews the interference of both men and science and operates outside the socially-regulated boundaries of medicine. As a result, both the medical profession and the religious authorities sought to marginalize and delegitimize the practice. According to Jean Towler and Joan Brammell in Midwives in History and Society, “just as the Priest considered the white witch a theological charlatan, and

---

3 Social scientists Gunnar Heinsohn and Otto Steiger forward the theory in “Witchcraft, Population Catastrophe and Economic Crisis in Renaissance Europe: An Alternative Macroeconomic Explanation” that midwifery’s association with contraception and abortion tactics resulted in the persecution of midwifery by the modern state after the population loss of the bubonic plague in the 1300s. While other critics disagree with the concept of state-sponsored ‘witch hunts’ of midwives, the article further cements the link between midwives and the powers of life, death, and birth connected with primitive, folk methods outside the medical mainstream.
persecuted her in the name of the faithful, so the physician considered the unlicensed
healer a medical charlatan” (38).

Calling them medical charlatans, writes Digby, meant associating midwives with
quacks—medical practitioners not necessarily or always identified as fraudulent, but as
“the so-called fringe” (63). One of the most common grounds on which to base the
connection of midwifery to quackery, and one of the most basic elements in the debate
between these differing professions, was the midwives’ view of their patients’ bodies.
Lisa Forman Cody writes in Birthing the Nation that midwives were often condemned for
having “passions and…false feelings,” especially about the bodies of other women.

Quacks offered any number of nontraditional remedies, cures, and aids—some of
which helped, most of which did not. Quacks were often preferable to the populace for
any number of reasons; some patients wanted more affordable treatments, while for
others in the advanced stages of disease, any supposed cure was worth trying. Denigrated
for their shameless self-promotion and the constant selling of services, quacks were
quickly “distanced from the profession” (62) as physicians sought to expose the frauds
while advertising their own authentic services. Although physicians necessarily
perceived quacks as offering nothing of innate value and accused them of tricks and
scams, quacks nevertheless often offered useful, sometimes even helpful, services. “The
Faculty,” Digby writes, “was obliged to recognize reluctantly that quack or secret
remedies could do good” (65). Still, most physicians advised their patients to avoid
quacks, citing their suspiciously low prices and constant advertising as evidence of their
sham remedies and fraudulent practices. While the dangers were certainly real, and more
than one huckster undoubtedly endangered lives with false medical promises, fake cures,
and blatant lies, many practitioners dismissed as quacks—including midwives and practitioners of folk medicine—simply fell victim to marginalization by a greater medical establishment that dismissed them.

Drawn together by common experience and “motivated by [a] sympathy” that often resulted in their dismissal as quacks, midwives viewed their patients, according to establishment physicians, through the lens of “an unfounded and vague inner feeling.” This led the medical community to dismiss them for the possession of “irrational sensibility rather than reason” (Cody 149). Yet, the mere dismissal of midwives as over-emotional and well-nigh hysterical did not sate the virulent animus of the medical community. The bond between midwives and their patients, and the empathetic view of the body underscored by compassion, understanding, and emotion, resulted in still more denigration: midwives were compared to braying animals, mocked as lesbians for their extraordinary connection to other women, and deemed a “perversion of the ideal Georgian reproductive household.” Cody writes that according to the greater medical community, “women’s passion and sympathy…limit[ed] their capacities for the rationality required in…particular medical endeavors” (150). Thus, because of its association with emotion and experience rather than intellect and logic, the empathetic gaze became marginalized—and sometimes mocked—by the medical establishment of the eighteenth and nineteenth century.  

However, this empathetic view of the body, based on emotion, instinct, and an innate sense of identification and self-preservation, nevertheless functions as a direct backlash against the other, far more predominant

---

4 Sarah Stone’s A Complete Practice of Midwifery, discussed later in this chapter, articulates this perception and condemns those who depend unnecessarily on intellect and logic at the expense of experience and intuition.
medical gaze of the period, one which had already gained its share of public notoriety and immense distrust and one best exemplified by the reputation and function of the eighteenth and nineteenth century anatomists.

In Edward Ravenscroft’s 1762 theatrical farce *The Anatomist: or, the Sham Doctor*, the title character, accompanied by his servant Beatrice, exemplifies the opposing, clinical gaze as he waits with unnerving eagerness and enthusiasm for the arrival of a corpse:

> See all things are in order here in the Laboratory. Many Virtuosi will be here, to see my curious Dissection, and see the Lecture I intend to read on a dead Body, which every Moment I expect to be sent in from the Place of Execution. …the wrangling Disputations of self-conceited, obstinate Physicians who come to see my Operation, will at this distance less disturb the neighborhood, they will maintain their Notions with more Noise, than Betters in a Cockpit (10).

The ravenous anatomist depicted here, eagerly awaiting a corpse fresh from execution and the chance to disseminate firsthand his own anatomical knowledge to an equally ravenous pack of fellow opinionated physicians, was a familiar figure to English audiences of the eighteenth and nineteenth centuries. First performed in 1696, *The Anatomist* remained a stock performance piece in England well throughout the eighteenth century, and its continued presence in the English dramatic lexicon was but one farcical manifestation of a disturbing commonplace not merely among anatomists, but also within the medical community. Anatomists, in particular, embodied the distinct and dominant
clinical way in which the mainstream eighteenth and nineteenth century medical
community viewed the body: as a textbook meant for use, study, and, in some cases,
reformation and control.

According to Paul Youngquist in *Monstrosities*, the ravenous hunger for a corpse
to dissect during this period was not markedly unusual, and anatomists’ oft-unethical
pursuit of corpses was both renowned and reviled. “To the eye of the anatomist,”
Younquist writes, “there were no last requests. The [body] becomes a field of contest
between competing interests, the physical space of an encounter among forces that
regulate the matter of embodiment” (7). Particular anatomists and their oft-questionable
methodologies loomed hugely in the public imagination. The anatomist John Hunter
earned particular notoriety in this regard; he owned not only a teaching museum full of
specimens that still remain as a tribute to the advancement of science, but additionally
procured a good many of his specimens through questionable means and the use of near-
henchmen who, on occasion, surrounded the dwellings of the newly-dead in avaricious
gangs. Perhaps the best example of the voracious anatomist at work is exemplified in
Hunter’s pursuit of the body of Charles Byrne, the famed Irish Giant. Despite Byrne’s
wish that his body be either encased in a lead casket or thrown into the sea, and the steps
he took to ensure that end, Hunter and his assistant, Howison, ultimately bribed Byrne’s
companions to hand over the body. In a cloak-and-dagger operation conducted in an
alley late at night, the anatomist received the long-sought corpse, spirited it to his lab, and
proceeded immediately to “[chop] up the body and boil away the flesh, leaving only
bones” (Youngquist 6). Hunter’s deeds and the deeds of similar anatomists quickly earned them the name of body-snatchers, men of science who saw opportunity and education in corpses and reduced themselves nearly to grave-robbery to attain their ends. “The stealing of bodies [by anatomists] from graveyards was commonplace by the 1720s,” writes Ruth Richardson in Death, Dissection, and the Destitute, who notes that at that time bodysnatching had already become an established cultural phenomenon (55). Not only was it established, but also inevitable; Youngquist remarks tellingly that “the poverty of [the body’s] agency” is made manifest by the will of the medical community in the eighteenth and nineteenth centuries; no one can “evade the reach of the chirurgical fraternity. It will have [the] body, with or without [its] consent” (8).

This specter is brought to comedic life in Thomas Rowlandson’s 1811 print The Anatomist, in which an over-eager physician, rummaging through his bag for his dissecting tools, ignores the pleas of the troubled woman at his shoulder as he prepares to dissect the all-too-alive “corpse” protesting on the dissection table. The poster on the wall directly behind the figures in the scene reads “A Course of Anatomical Lectures.” From above, a bust glares down in disapproval and a skeleton, perhaps a past candidate for vivisection, stands in the closet observing grimly.

---

5 Youngquist’s Monstrosities offers a fuller account of the extraordinary measures taken, against Byrne’s wishes, to procure his corpse for the cause of medical science.
While the artwork itself satirizes the same over-eagerness of the anatomist evident in Ravenscroft’s play, and the hapless situation of the young-man-turned-dissection-candidate functions for comedic effect, both play and artwork illustrate a growing public concern with the role and purpose of the anatomist in daily life and, thus, with the way anatomists viewed the bodies that were their stock-in-trade.
For many medical professionals in England during this period—hardly just anatomists—the body functioned as little more than a useful tool, a means to greater knowledge, an experiment in the making. The evolving state of medical education during the eighteenth and nineteenth centuries is, in part, to blame for this phenomenon (Digby 99). With the interests of medical students and medical faculty foremost above all, a startling amount of ignorance and acute self-awareness in the medical profession led to the need for medical experimentation (56). The need for medical experimentation led, of course, to the need for bodies both living and dead. As a result, the reading of the body as a medical textbook was even encouraged during the period. Long before the Anatomy Act of 1832, which legitimized dissection as a means to study anatomy, medical students were encouraged to view patients post mortem, being autopsied, and suffering the final stages of terminal illness (Digby 92). The experience was considered invaluable, and exemplified the scientific curiosity that characterized the medical community almost as much as its obligation to healing.

Many patients were aware of the danger inherent in being the object of the clinical gaze; several of them attempted to avoid doctors who seemed a little too keen on the knife. In one 1795 text, the writer claims in a letter that “[I] applied to an Emment Surgen at Wellingoborogh Wich sayd he Would Do the Best He could to cure me But he must Cutt me Wich I sayd I was not willin” (van Butchell 36). In cases of terminal illness, Digby writes, experimental treatments and attempts to treat or relieve the disease often “compound[ed] rather than ameliorat[ed] the sufferer’s problems” (87) and masqueraded as a basis for knowledge-gaining and curiosity. Often, patients did not survive surgery, and complications for unnecessary procedures were fraught (Digby
Treatment became a matter not solely of choosing the best or the most affordable physician or surgeon, but one who was more interested in the recovery of the body than the study of it.

Moreover, the empathetic gaze manifested itself as a backlash against the intrusion of men into the field of obstetrics, a traditionally female-dominated profession. In her 1737 treatise “A Complete Practice of Midwifery,” Sarah Stone, an accomplished midwife, sets forth a defense of her desire to author a treatise in a field becoming largely populated by men:

Almost every man who hath served his apprenticeship to a Barber-surgeon, immediately sets up for a man-midwife; altho’ as ignorant, and indeed, much ignoranter, than the meanest woman of the profession. But these young gentlemen put on a finish’d assurance, with pretence that their knowledge exceeds any woman’s, because they have seen, or gone thro’, a course of Anatomy” (xi).

Stone’s anger over the assumption that intellectualism trumps experience and a woman’s unique understanding of her own body is palpable throughout the text, as she attempts to offer a treatise to counter the words of anatomically-educated doctors storming the field in which she works. A good deal of Stone’s anger comes from the fact that, in times when “mother and child both die,” the female midwife present bears the blame for the fault, since the education of the physician shields him from culpability. In Stone’s view, an intimate and personal understanding of the female body and life within it was as

---

6 This remained true until the 1860s, when the use of anesthesia and antisepsis combined to make surgery a less risky and painful experience.
integral to midwifery and viewing the body as education and a basic understanding of
anatomy. Indeed, to rely on the simple understanding of science and anatomy alone as an
accompaniment to gazing is, for Stone, dangerous; she implies throughout the text that
such reliance encourages false confidence, excuses errors, and burnishes the reputation of
male-midwives often unnecessarily.

Nor was Stone alone in her thoughts. Although the number is small in
comparison to the number of treatises authored by male-midwives and other general
physicians, several texts echo similar claims and represent a small, if fierce, battle cry
against the intrusion of men into a traditionally female profession. A later 1772 text,
written anonymously by a woman, bears the title “The danger and immodesty of the
present too general custom of unnecessarily employing men-midwives” and articulates
many of the same claims. The author discusses the difficulty of “conquering prejudice”
(3) and bemoans the fact that, in current societal circles, “the Opinion had been adopted
that ‘Men were the most Proper Attendants on the Labours of Women’” (4). For the
author of this treatise, the entrance of men into the birth chamber is an act bordering on
the sinful and profane, and reeks of impurity—indeed, she claims throughout, the
entrance of men into the inner domains of femininity is an intrusion similar to rape, and
she associates it constantly with the degradation of virtue and the loss of modesty.
Moreover, the author shares Stone’s argument, and displays anger that there is “weight
laid on the Men’s knowledge of Anatomy as a reason why they should be safer than
Women” (9). To the contrary, the author claims, some men know nothing about anatomy
at all, and deceive their patients in this regard—sometimes in order to lay waste to virtue
and purity. Then, as if to prove that men have no corner on the study of anatomy, the
author delves into an involved discussion of the female body in an effort to encourage nursing. Before embarking on the rest of the text, she offers what she perceives to be her best qualifications for viewing and treating the body: not a knowledge of anatomy, but “a Heart warmed by a love for my fellow-Creatures—ever most ardently solicitous for their welfare and happiness, here and hereafter.” Here, the author offers and defines the most telling hallmark of the empathetic gaze: a gaze at the body characterized by intuition, experience, fellowship, and understanding. It is this way of looking and understanding the body, she claims, that can best the male-aligned clinical gaze dependent on both consuming and producing knowledge and study. To know one’s own self and to be able to gaze at the body of another with wisdom from experience, understanding, feeling, and intuition, is the best course of study one could ever require.

In eighteenth and nineteenth century society, then, the midwives and the anatomists come to represent two distinct medical gazes: one empathetic and rooted in sympathy, emotion, instinct, and identification, and the other clinical and based in concepts of progress, reason, knowledge, and rationality. Though the empathetic gaze ultimately becomes marginalized within the medical community during and after the rise of the male midwife, while the clinical gaze remains predominant, the tensions between these different medical methods of looking remain throughout most of the eighteenth and nineteenth centuries and extend throughout culture, particularly literature.

III. THE CLINICAL GAZE AND THE ABNORMAL BODY

Born of the anatomical tradition against which the midwife movement reacted so strongly, and associated with dissection, disrespect of the body, and knowledge at all
costs, as well as the blind progress of scientific advancement, the clinical gaze fixates distinctly on abnormal bodies and, in so doing, both upholds and promotes normative standards and disguises a great deal of subjective opinion as scientific knowledge.

For mainstream medical professionals, especially those working in obstetrics, the concept of empathy and experience as a means of healing seems untrustworthy, and even dangerous. John Astruc, in the introduction to his 1776 “Elements of Midwifry,” writes that his text is a “didactic work, designed for women, who are not very capable of commending a difficult and obscure way of reasoning” (vii). He notes earlier that most midwives receive their medical knowledge through

only an old method of practice, which was transmitted from hand to hand; and that it was a sad thing to see the young midwives obliged to purchase, by the most servile compliances, what the old ones were willing, or capable of communicating, which was frequently nothing at all, and always very little at most. (v)

Astruc’s tone is pitying to the point of condescension as he attempts to impart his knowledge to midwives whom he deems ignorant and untrained; that tone of condescension is replicated repeatedly in instructional texts of the period. The editor of the 1782 text “Aristotle’s Complete and Experienced Midwife” writes that “it is for your sakes, worthy matrons, that I am rendering this excellent treatise of midwifery into English.” Admitting that the general ignorance of midwives has advanced his business, the author says that nevertheless “the regard I had to the saving of the lives of so many
persons, as I saw every day in danger of perishing, by the committing themselves into the hands of unskillful midwives” inspired him to write (A2).

In the passage cited earlier, Astruc professes concern that the midwives’ knowledge is, essentially, handed down from woman to woman. He dismisses that mode of knowledge-communication in favor of the more modern method he espouses, that of scientific learning and study. The knowledge of a midwife is dismissed as unimportant and useless; the knowledge of a surgeon, to the contrary, holds high value. In order to possess the knowledge male physicians like Astruc deemed necessary, women would have had to attend medical schools and become certified in the same manner as male physicians, yet females were prohibited from attending these same schools and formally entering the medical profession until the early twentieth century. Accused of not having the necessary knowledge to practice medicine, midwives were for quite some time prohibited from attaining the knowledge that would have allowed them access into the field. This paradoxical withholding of training made them easy to disparage and dismiss.

Yet the very values of knowledge, education, and progress endemic to the clinical gaze come at a cost. Edmund Chapman, in his 1735 “A treatise on the improvement of midwifery,” implicitly identifies the much subtler, but much deeper cause of the division between midwives and their male counterparts in the medical profession: the latent division between a medical tradition that perceives itself to be both logical and scientific and a folk-oriented, orally-communicated one. The main fault of midwives, he claims, is

---

7 It’s worth noting here that, while eighteenth and nineteenth-century medical science might not seem logical, advanced, or knowledgeable in any sense of the word, it did indeed perceive itself to be so.
8 Women did, nonetheless, have a part in the medical profession. Several women masqueraded as male doctors during this period, others sought refuge as midwives, and in the nineteenth century the nurse in particular became a much-loved public figure. However, the entrance of women into full medical training and the medical academy took much longer to achieve.
their sense of self-reliance; “conceiving too Favourable an Opinion of their own Judgment and Abilities,” he writes, “[they] run great Hazards, or, at the best, call us in too late, and thus lose their Reputation and Practice” (vii). Women, he claims, have a capability for the natural, more primitive aspects of childbirth, but only men and the mainstream medical community are equipped to deal with anything that might require a more sophisticated, scientific hand like breech births, delivery problems, and infection.

Chapman then follows, immediately, into the list of achievements that medical science has provided to the practice of midwifery. Intriguingly, though, as he lists the surgical advancements, procedures and processes through which male physicians—through the rigorous application of concerted study, anatomical understanding, and available medical knowledge—have proven their superiority to midwives, he admits tellingly that this advancement integrates into the discipline other, less savory practices:

It must be acknowledged, there have been some who, being ignorant of the method of turning a Child, made frequent use of the Hook and the Knife, and several other shocking and barbarous Instruments, even while the Child was living; and I had, not long since, an Account given me by a person of unquestionable Veracity, then present, that a poor woman died under the hands of the Operator after some of the Limbs and Ribs of the child were brought away (xii).

While Digby notes that the use of surgical tools during deliveries, particularly the use of forceps, eventually helped reduce the mortality rate of infants and mothers (269), she also
notes the initial over-use and the lack of caution with which these instruments were applied, making some women reluctant to submit to them (278) and some eighteenth-century educators eventually increased their emphasis on the sparing use of these devices (267). Chapman, too, indicates overzealousness among male physicians in applying medical instruments, and notes that this has wounded his profession: “many unhappy Women have chosen to die, or at least to stay till the very last Extremity, rather than call for our Assistance” (xii). In many cases, including these Chapman mentions, the penetration of new and invasive tools—promoted as the natural evolution of progressive medical science by the progressive medical establishment—into the field of midwifery represents an intrusion and a danger.

The clinical gaze can also possess characteristics beyond the will to dissect and to know bodies; it can take on a more punitive, reformative aspect. Sander Gilman points out in “Black Bodies, White Bodies” that “medicine offers an especially interesting sort of conventions since we do tend to give medical conventions special ‘scientific’ status as opposed to the ‘subjective’ status of aesthetic conventions.” He goes on to note that medical study is “rooted in observed reality” and can be, thus, “determined by the historical position of the observers, their relationship to their own time, and to the history of the conventions which they employ” (137).

In the Victorian period in particular, the desire to learn from and reform the dangerously infected or diseased body remains one of the most the disturbing and prominent features of the predominant medical gaze. Judith Walkowitz identifies the nature of this gaze most clearly in Prostitution in Victorian Society. For Walkowitz, the medico-moral gaze—the militant, reformative evolution of the mainstream clinical
gaze—is most evident in the medical community’s treatment of prostitutes and the diseased poor during the Victorian period. The prostitute body in particular figures as a dangerous body anatomically speaking; medical professionals of the period find large or unusual female genitalia in ethnic and prostitute bodies a sign of “anomalous female sexuality” and, through examination of anatomical differentials, render the prostitute and her anatomy “yet another source of [public] pollution” (Gilman 142). Walkowitz points out that, both literally and figuratively speaking, the prostitute body with its exaggerated sexuality and anatomical ‘difference’ represents “the conduit of infection to respectable society” (4).

When abnormal anatomy and a sickened body renders itself a form of social pollution, doctors then become reformers as well as healers, and attempt to use the knowledge they gain in order to reform the dangerous body. Walkowitz identifies the social hygiene movement of the mid-to-late nineteenth and early twentieth century as exemplary of the moment the clinical gaze embodies reformist tendencies: “medical reformers joined with purity advocates in a concerted effort to educate the population as to the values of chastity as the best prophylaxis against V.D.” (254). With the advent of the Contagious Disease Acts in 1864, advocated by many medical professionals, the literal policing and reformation of the sickened and contagious body became legal. The forcible detention and examination of women (not all of whom were prostitutes) for venereal diseases exemplifies the medico-moral gaze run rampant, seeking both to cull knowledge and reify the normative standard of the body through the reformation of the diseased body under its view.
Both Anthony Wohl in Endangered Lives and Pamela Gilbert in Mapping the Victorian Social Body further explore the effects of the unrestrained, reformist clinical gaze. Confronted by a general lack of sanitation and the inevitable consequences of overcrowded, improperly managed urban living; outbreaks of typhoid fever and venereal diseases; and infestation and infection wrought by copious filth, the medical community and the predominant clinical gaze evolve into a necessarily militant, punitive, reformative force under which the empathetic gaze is, largely, eclipsed. With roots in the eighteenth-century sensibility movement and a new societal interest in sanitation and disease control, the majority of the conflicting tensions between medical ways of looking play out extensively and come to full fruition in literature written during the Romantic period, particularly when they are deployed against abnormal bodies.

Several scholars thoroughly identify how these debates are framed within various works of Romantic literature and discuss in which ways medical views of the abnormal body are represented, complicated, or integrated into the greater Romantic way of looking. Many of these works focus on particularly abnormal bodies as a means of representing the conflict of medical gazing. In fact, it may be fair to say that the most interesting bodies to the medical and literary communities of the Romantic period were not normative in any sense of the term. As Younquist writes, “the word ‘abnormal’ is of surprisingly recent coinage…[it appears in] an anatomical encyclopedia published in 1835 and [means] ‘deviating from the originary rule or type; contrary to rule or system; irregular, unusual, aberrant’” (xi). His Monstrosities explores at length the nature of abnormal bodies, particularly within the medical community, and how those bodies function as “the material through which relations of power circulate to reproduce cultural
norms” as well as how “norms of embodiment coordinate the agencies of the flesh, directing their energies towards normal” (xiv). While Youngquist delves into these issues at great length, only the most fundamental points of his work will be pertinent here: that the abnormal body remains an integral subject of the medical gaze and cultural interest both because “medicine…produces and enforces a cultural norm of human embodiment” and because the abnormal body provides a “material occasion for…operations” to determine normative standards (xi). Perhaps not coincidentally, abnormal bodies at this time also prove to be relevant tourist attractions and sources of income; entire small economies, events, and displays sometimes grew around communities of grotesqueries. Yet the abnormal body is of particular value to the medical gaze because it deviates from the normative standard and, thus, both upholds the normative standard and allows for study—and remedy—of deviation. Part of the value of the abnormal body exists in its function as a site for this kind of interest. The abnormal body (or, as Youngquist names it, the “curiosity, monstrosity, specimen” [xi]) serves as the ultimate medical textbook.9

“Anomalies,” claims Richard Sha in Perverse Romanticism, “were critical to the discovery of any [medical] knowledge. Without diseased or nonfunctioning organs, one could not know the organ’s function in the first place” (5). For Sha, though, such anomalies can serve an even more sinister function: “anything which did not speak to the function of an organ,” he notes, “was not knowledge” for the medical community. Thus,

9 For the purposes of this project, “abnormal” serves as the most useful term to identify bodies deviating from anatomical-social normative standards through illness, genetics, accidental circumstances, or aesthetics. Although several synonyms apply — including Youngquist’s powerful use of the word “grotesque,” which implies the inherent feeling of the social community towards these bodies — most of those synonyms focus solely on the aesthetic, “freakish,” aspect of deviancy, while “abnormal” encompasses subtler, less-evident aspects of the unusual body.
“nonfunctionality or perversion” exists “outside of epistemology itself” (65). The abnormal body, then, acts not only as a textbook to illustrate the normative standard by its own deviation from normalcy, but doubles as pathology worthy of study because it cannot be known. Youngquist agrees, concluding that “[the] culture of monstrosity [that] flourished on the fringes of polite society, in the back streets of the metropolis or the stalls of county fairs” functions ultimately under the eyes of the medical gaze as “a specimen, less prodigy than pathology” (8).

Under this definition, several different types of bodies become, endemically, abnormal by both Youngquist and Sha’s definition. Suffering and diseased bodies, of course, naturally fit the definition: either deformed or sickened, they represent the variables that medicine seeks to isolate, and the deviations through which the normative standard might be maintained and eventually reproduced. But other types of bodies, bodies not necessarily diseased can also be classified as abnormal, sometimes to the point of grotesquity. Female bodies and ethnic bodies, in particular, represent the abnormal in several aspects by their very nature. Both are mysterious and, to a degree, unintelligible to scientific modes of knowledge-gathering; one of the founding principles of male-midwifery in the eighteenth and nineteenth centuries is to uncover, catalogue, and understand the nature of the female body. Nowhere is this more evident than in the solely female act of conception and gestation, which confronts medical science with “the materials out of which one can imagine the profound truth and mystery of epigenesis, of making a complex organism from unformed matter which somehow assumes the shape and characteristics of the creature it came from” (Lacquer 146). The why of childbearing, of female disease, the intricacies of the female anatomy and, by association, the female
temperament—all are subject to sometimes wild medical speculation, defying singular answers and comprehensive understanding. The association of the female, additionally, with darkness and mystery, as well as generative powers outside the understanding of human consciousness, confers upon her the role of epistemological quandary. Woman remains the known unknown, and the female body, especially when it is distorted in passion and feeling, or when it becomes a conduit of disease and infection, suddenly inhabits a realm beyond the reach of pure scientific logic, and becomes a deviation from the hetero-reproductive norm. Thomas Lacquer notes in Making Sex that, prior to the seventeenth century, “to be a man or a woman was to hold a social rank, a place in society, to assume a cultural role, not to be organically one or the other of two incommensurable sexes.” After the seventeenth century, this model shifts; to be a woman is to be something wholly different from the masculine model, and the very function of not-maleness renders the female body aberrant and beyond certain aspects of understanding. Existing as an unknown within the realm of medical knowledge, then, with elements of mystery and darkness that remain resistant to the most tenacious medical gaze, the female body embodies abnormality.

For medical science, the ethnic body functions in a similar manner. According to Gilman, “the myth of difference from the rest of humanity is...composed of fragments of the real world [and] perceived through the ideological bias of the observer” (136). Frequently, scientists and medical professionals appropriate the oft-sensationalistic travel

---

10 Although Lacquer’s thesis has been widely challenged, the concept of “the unknowable woman” resonates throughout eighteenth- and nineteenth century literature. In Nature’s Body, Londa Schiebinger discusses how Linnaeus conceived of the woman as both “less than human” and “more than human” (44), mysterious and unreachable, and in Designing Women, Tita Chico analogizes the woman’s dressing room, “an overdetermined place of mystery,” as exemplary of women’s “incommensurable difference” and the incomprehensibility of female sexuality (44).
literature of the period as science, and use anatomy and biology to confirm the antithetical nature of the ethnic body to the English one (139). Linked with darkness, mystery, and primitive origins, the bodies of slaves and foreigners thus render themselves incomprehensible, if intriguing, to English physicians. To English perception, as Chinua Achebe argues in “An Image of Africa,” ethnic bodies represent the “primordial relative” of England, “grotesque echoes…of forgotten darkness,” and the “mindless frenzy…[of] first beginnings” (338). Not only did these bodies carry diseases and illnesses unfamiliar to English culture, but even small differences in anatomy, biology, physiognomy, and genitalia accounted for perceived deviance and a link to an earlier, primal period of human development incomprehensible to the civilized mind. This mode of classification is particularly evident in abolition texts, as well as texts that arise from the “two contemporary fields of inquiry, medicine and travel” (Wheeler 2). These bodies, moreover, carry the stigma of their otherness and, doubly so when they are female bodies, function as a natural deviance from the normative English social standard.

As far as bodies within the bounds of English society, another particularly abnormal subset exists that, for the purpose of this project, shall simply be referred to as urban bodies. More specifically, these bodies become abnormal—diseased, suffering, malformed, and infectious—through a nexus of ills induced solely through the perils of urbanization, industrialization and the urban condition. As “domestic filth [becomes] an accepted and unremarkable part of…life” (Wohl 86), illness abounds, and homelessness, prostitution, and the spread of disease become integral to urban social life. Though these crises come to a head—and to the need for a solution—in the Victorian era, the slow festering buildup of problems haunting the backdrop of the Romantic period results in the
direct malformation, degradation, and disease of bodies that become aberrant throughout and after their exposure to the urban spectacle. It is against this spectacle that Romantic writers struggle; in Romantic Metropolis, James Chandler and Kevin Gilmartin note that the “left-wing Romantic anti-urbanism” can be traced to the growing concept of the city as “the place of corruption” and gluttonous ruin of over-consumed luxuries (252), though anti-urbanism itself has a long history that extends far before the Romantic period. Importantly, for Romantic-era writers, the danger of urbanism rests not just in the physical excesses and perils of the urban landscape, but in the alienation, corruption and distortion begotten by urbanization that can twist both mind and body. To turn back to nature in the Romantic period is to embrace health in body, mind, and soul; the urban life begets disease, decay, and destruction. In all of these different manifestations, abnormal bodies during the Romantic period draw and maintain the interest of both the clinical and empathetic medical gazes primarily because of their deviance from the normative standard.

IV. THE PREVALENCE OF THE EMPATHETIC GAZE IN THE ROMANTIC PERIOD

Romantic literature, however, evidences the debate between the clinical and empathetic medical gazes deployed at these abnormal bodies most strongly due to a confluence of factors including the entrance of medical debate and discussion into
popular discourse, developments and conflicts within the medical community, historical events, and the unique symbiosis between literature and medicine.\textsuperscript{11}

Janis Caldwell points out that the Romantic period was particularly fruitful for the dissemination of medical literature to the public and that religion, in particular, served as a means through which medical debate enters popular discourse. During this time, she claims, religion and medicine share with the popular imagination the idea that “Nature is an open book, accessible to all readers” (9). In fact, a great deal of medical knowledge was disseminated in the guise of religious study. One of the greatest developers of this technique was Richard Owen, “one of the chief disseminators of natural anatomy in Britain” from 1820 to 1883, who gained popularity precisely because he could “[translate] continental anatomy into terms intelligible to British culture” through religious discourse (Caldwell 15).

Intriguingly, the popularity of travel literature during the period spawned its own peculiar medical genre: a rich body of medical literature on health travel that becomes exceedingly popular in the Romantic period (Dolan 16).\textsuperscript{12} Granted, larger debates about the direction of medical practice remained confined to members of the profession, but the desire to explore and understand nature, the popularity of travel literature, and the relative popularity of certain physicians resulted in a plethora of treatises, manuals and pamphlets that offered the common public basic health information, tips for maintaining good health

\textsuperscript{11} For clarity, “Romanticism” will be used in Seamus Perry’s sense of the term, as a “literary-historical classification which labels certain writers and writings of the later eighteenth and early nineteenth century” which encompasses “idealism and egotism, or perhaps primitivism and a return to nature” (3).

\textsuperscript{12} The popularity of health travel might also be linked to the burgeoning domestic travel industry in general; as a result of war with France, many citizens found extra incentive to stay home and enjoy domestic attractions, including health spas.
at home and abroad, and a basic understanding of anatomy. Moreover, physicians such as Astley Cooper, William Stark, William Cullen, and Adam Smith argued back and forth in treatises and papers about the best ways to reform or improve the education and methodologies of their profession, debating whether or not the current traditional curriculum and methodology supplied students with a full and proper education and attempting to analyze what elements the system might be lacking.

However, in addition to the general emergence of aspects of medical discourse into Romantic culture, some of the greatest clashes between the empathetic and clinical gazes occur during the Romantic period. Although male obstetrics thrived during this time, in some cases even triumphing over midwifery as the chosen option of childbearing women, the debate between two seeming oppositions remained vital; the “competition of midwives remained unwelcome” (Digby 269) and the economic situations of many women forced them to decide between the care of an established midwife or the intrusive presence of a man in the birthing chamber (257). Mary Wollstonecraft, the famed Romantic author of A Vindication of the Rights of Woman, suffered from this dilemma in particular—a dilemma that ultimately led to her untimely death. In A Revolutionary Life, Janet Todd notes that Wollstonecraft desired and demanded only a midwife, Mrs. Blenkinsop, to deliver her child. By all accounts the birth seemed to go well, but Wollstonecraft’s body retained the placenta, and Wollstonecraft decided to call a physician. Wollstonecraft herself approved of Dr. Fordyce, “between whom and herself

---

13 Elizabeth Dolan points out in Seeing Women’s Suffering that home health guides, such as William Buchan’s Domestic Medicine along with other texts authored by the physician Thomas Trotter and, earlier, George Cheyne, often had a popular place in literate Romantic households.

14 In Romantic Medicine and John Keats, Hermione de Almeida offers a fascinating description of the “intellectual ferment” both in and outside the medical community due to the proliferation of widespread scientific and medical journals as well as many textbooks and pamphlets made available through the inexpensive printing press (32);
there had been long sustained a mutual friendship” (183) but another physician, Dr. Poignand, advised against the decision, claiming that Fordyce “was not particularly conversant with obstetrical cases.” Ultimately, Godwin sent for Poignard, and describes his wife’s sickness with poignant clarity:

In the evening she had a second shivering fit, the symptoms of which were in the highest degree alarming. Every muscle of the body trembled, the teeth chattered, and the bed shook under her. This continued probably for five minutes. She told me, after it was over, that it had been a struggle between life and death, and that she had been more than once, in the course of it, at the point of expiring. I now apprehend these to have been the symptoms of a decided mortification, occasioned by the part of the placenta that remained in the womb (186-87).

Unfortunately, the sympathetic choice of Poignard, a family friend and a reasonable and educated medical professional, ultimately resulted in Wollstonecraft’s death. According to Youngquist, Poignard’s abrupt and perhaps unnecessary removal of the placenta—a procedure which many midwives thought dangerous and unnecessary—resulted in unmitigated disaster:

On the problem of the placenta hangs the balance of this woman’s life, a woman who had every reason to trust, if not quite all the functions of the female body, at least the collective wisdom of those who tend it. But…[Wollstonecraft] gave mother flesh up to obstetrics. (157)
Dr. Poignand’s lack of proper knowledge of obstetrics brings the Godwins’ decision to hire a ‘proper’ doctor at the moment of crisis into sharper, more poignant contrast. Although the Godwins’ situation was unique and their friendship with the physician certainly influenced their decision, the process illustrates the many factors, complications, and consequences faced by expectant mothers forced to choose between physicians and midwives.

Because of events like these, debates on medical care flourished. As the eighteenth century reached its end, Digby notes more and more of an attempt to reform the clinical gaze (or at least its reputation) as “public interest in medical education came to the fore” (56). Textbooks and curricula reflect this shift as physicians debated how best to educate themselves in viewing and understanding bodies, and an emphasis on at least mimicking the rhetoric of sensibility innate to the empathetic gaze works its way into the medical vocabulary as physicians begin to enter the fields of obstetrics and find themselves desperate to reassure women who feared the entrance of men into the birthing chamber. Additionally—and perhaps most importantly—the practice of medicine itself began to develop and change: the diagnostic approach to medicine began to shift away from a purely physician-centered model of examination as “clinical practitioners develop the two-part history and physical exam” (Caldwell 1) in an attempt to integrate both ways of looking into examination. This new diagnostic method pointedly takes into account both the patient’s understanding of his or her own symptoms and feelings, and the doctor’s material diagnosis of his or her illness, a seeming acknowledgement of the doctor’s lack of omniscience to know and treat the patient’s body on his own.
Finally, and key to the prevalence of warring medical gazes, is the advent of children’s medicine, a form of practice previously neglected within the larger medical community. Not coincidentally, this new medical approach accompanied the advent of the Romantic (and later Victorian) cult of the child; as the child in literature and popular culture came to embody innocence and almost-sacred purity, medical science, too, began to honor the child’s body as something unique, special, and worthy of not only cultural, but medical, study. This new approach that valued the body of the child demanded, at the least, attentiveness to the difference between the empathetic/clinical medical approaches and the understanding that a softer gaze often benefits the examination of infants and children. Miles Marley, one of few children’s physicians, wrote in 1830 that treatment of children, especially, demanded knowledge of “a language that may always be interpreted…such are the countenance, the expression of the eye, the numerous gestures and cries…” (iv). The diagnosis of children depended heavily upon the ability to read the language of cries, sighs, and wordless gestures, to understand through feeling or knowing one’s patient rather than through logical calculation. Little wonder that traditional medical practitioners found such patients daunting; in 1769, long before children’s medicine became an accepted part of traditional practice, the physician George Armstrong writes that some medical practitioners find treating children to be “working in the dark” because the “old means of investigating diseases [had] to a great degree fail[ed] them” (280). As the function of children’s medicine grows more significant to the medical community as a whole, the consequent attention to acceptable, beneficial, and useful ways to view the child’s body comes to attention as well.
In addition to these developments in medicine, however, and perhaps just as importantly, the unique historical considerations of the Romantic period lend a certain urgency to the debate regarding the implications of empathetic and clinical ways of looking. The French Revolution, described by David Duff as “the central historical experience of the [Romantic] generation” (23), initially represents an exercise—at least for some—in empathetic identification. At the outset, “many Britons, inspired by memories of the Glorious Revolution, regarded the events in France as an echo of their own struggle against monarchical tyranny” (Shaw 50). An understanding of and a sympathy for France characterizes much of the so-called radical support for the Revolution that existed during the period. That this support was quickly squelched speaks to the fears of identification with the other at the expense of natural security: the Alien Act and other legislative measures frequently invoked in wartime functioned largely to reassert the British national identity against and away from the other.  

A distinct awareness of the dangers of identifying too strongly with the other, and of the harmfulness of the other, underscores a fervent push for nationalism but simultaneously invokes an awareness of “us” and them,” constantly demanding a choice of identification and the placement of empathy. During the grind of the Napoleonic wars, extensive “propaganda and patriotism” existed to ensure national unity against the French (Shaw 55).  

Fears regarding the cost of empathy, and the representation of empathy with the other as an act of betrayal of the nation, heightened the stakes of the debate being waged on a micro-level in the medical community. To emphasize with the other, especially

---

15 The Alien Act refers to a 1705 law that required Scottish nationals to be treated as aliens and their property to be treated as alien property.

16 This propaganda manifested most vehemently in vitriolic handbills circulating during the period, several of which Youngquist reproduces in his text.
during a time of war, symbolized danger, irrationality, high feeling, and disregard for the general well-being of the body—in this case, the country’s body.

Moreover, the conflict itself invited “a complex psychological investment in the spectacle of war” (55). The war, glamorized by martial maneuvers, music, and parades, nevertheless introduced a series of bloody events into everyday British experience: the September massacres of 1792, the execution of Louis XVI, and the Jacobin Terror. With these atrocities came indelible images of heroically-maimed soldiers, doctors and nurses on the battlefield, and the absent dead. Youngquist writes that “the wounds of war become sites of national incarnation, apertures of flesh that graft the nation.” In this theatre of violence, wounds incurred in war became a medical spectacle that demanded identification of self with the country, empathy with one’s own rather than empathy with others (177). Simultaneously, the constant exposure of wartime injuries, paraded in an endless stream of names, bodies, and numbers, engendered a clinical lack of sensitivity that limited empathy. The medical way of looking at bodies shifted indelibly during wartime, and again co-opted the language of empathy against identification with the other, but invoked strong resonances about how the medical community—and the public at large—ought to view bodies (especially the bodies of its own).

Nor was wartime the only hallmark of the Romantic period. Domestic agitation regarding the rights of slaves reached a crucial point during this time. Although Britain and the United States agreed to abolish the slave trade in 1807, and Britain emancipated slaves in the West Indies in 1833, the years preceding were full of debate regarding the issue. Pro-abolition narratives and poems appeared with frequency as early as 1769, and Olaudah Equiano’s famous autobiographical work, The Interesting Narrative of the Life
of Olaudah Equiano, was published in 1789. Throughout the evolution of the debate, some slaves were being freed while others were being massacred; eventually the abolitionist movement grew in strength, and abolitionists began petitioning Parliament in 1788. The debate raged in all sectors of society and, naturally, became a focus in the medical community—in particular, for the resultant opportunities to study and catalogue the nature of ethnic bodies. Gilman’s “Black Bodies, White Bodies” takes a masterful look at the medical treatment of African bodies and female (prostitute) bodies; medical science, he argues, ultimately reifies its own initial unreasoned biases against Africans and “oversexed” women by deliberately cataloguing and identifying differentiation in “physiognomy…skin color…and genitalia” to justify a hierarchal scale of development in which Africans exist at the very bottom, and the more-anatomically-advanced English exist at the top (393). In the Romantic period this practice persisted, and the emergence of the ethnic body—and particularly the enslaved ethnic body—as an object of public interest during the abolition movement ensures its attention as an object of medical interest as well. The clinical view of the ethnic body becomes a matter of medical (and political) prominence. Medical looking also finds itself preoccupied during this time with the very notion of difference; no small number of medical and scientific treatises devoted themselves to the possible origins of racial differentiation. These works ranged from the reasoned to the ridiculous, such as J.J Virey’s contribution to the Dictionary of Medical Sciences, a catch-all text intended to educate readers on any number of subjects
of both popular and medical fascination, or any one of many standard, male-authored gynecological pamphlets.  

With the advent of the abolition movement and its attendant sympathies for downtrodden slaves, the same medical ways of looking remain in play, albeit to different ends. Jean-Jacques Rousseau, in “A Discourse upon the Origin and Foundation of the Inequality among Mankind,” writes that the reader must not “confound savage Man with the Men, whom we daily see and converse with” (29). Rousseau, of course, finds the differences positive, praising “the Hottentots of the Cape of Good Hope” for their excellent vision, and acknowledging that “Savage Man and civilized Man differ so much at bottom in point of Inclinations and Passions” (10). These comments echo what Eva Beatrice Dykes identifies as the growing Romantic interest in the noble savage, the concept that “because of his innocence, his freedom from the corruptions of civilization, and his proximity to nature, [the savage] was considered the ideal person and the epitome of perfection” (212). Interestingly, the same medical commentary that Gilman identifies in his work—of biologically differentiated lusts, passions, and feeling—remain in play within these conceptions, yet the notion of difference between savages and British men, initially derived as a justification of the current social order, becomes instead a justification of an inverse social order in which the noble savage, freer, truer, and more ideal because of his deep passions, resides at the top. Thus, the prominence of the slave body during this period invites an array of medical gazes, many utilized for political and social ends.

17 Gilman notes that Virey’s work is the first to comment “on the sexual nature of black females in terms of acceptable medical discourse” (139).
William Blake’s engravings for John Stedman’s *Narrative of a five year’s expedition* exemplify a similar conflict. Though the *Narrative* itself functions like an abolitionist text, attempting to humanize ethnic bodies to those who would enslave them, the engravings nevertheless erotically “and clearly prioritize Europe’s desirability within a race hierarchy” (Quilley 143). In the most famous engraving from the Stedman set, “A Negro hung alive by the ribs to a gallows,” Blake “depicts the central figure’s pain in such unbearable terms that the viewer must look away to the incidental detail surrounding the image, but in Blake there are no detached perspectives. What little reprieve there is from the sheer physical pain...is found at the bones and skulls scattered at his feet” (Lee 112).
In Blake’s attempt to set the suffering Negro apart as a martyr and a victim of forces beyond his control, he invites an empathetic gaze that simultaneously demands a voyeuristic consumption of the Negro’s body through looking. The focus on the Negro’s physical frame and at the bones of bodies come before forces an uncomfortably clinical ‘diagnosis’ of the Negro’s condition and his pain. By requesting empathy, Blake also invokes the latent tropes characteristic of the clinical gaze, an uneasily voyeuristic act that resituates the ethnic body as an anomaly worthy of display and study.
The historical backdrop of the Romantic period, then, replete with the bodies and casualties of war, and marked by sustained interest in the bodies of the different, offers many points of symbiosis for medicine and literature—ruptures where the debate over methods and manners of looking at the body (and the implications and consequences of those methods) surfaces and resurfaces in a variety of ways. Because medicine and literature in this period remain so closely entwined, in large part due to the state of affairs in the medical community and the particular historical events that propel these considerations to the forefront of the public imagination, literature written during the Romantic period offers a unique window on the percolating empathetic-clinical debate and its ramifications.

Most importantly, however, the many debates surrounding medical knowledge and application in the Romantic period manifest themselves in literature, which not only illustrates the interplay of warring medical gazes but also provides an ideal forum for exploring popular medical debates and their ramifications. Janis Caldwell acknowledges in Literature and Medicine in Nineteenth Century Britain that “several influential literary and medical writers [of the Romantic period] were allied in one project, that of negotiating between two distinctly different ways of knowing—between, that is, personal experience and scientific knowledge of the natural world.” Pointing out that the clinical world of medicine and the conscious, self-expressive (and empathetic) world of Romantic literature do not inherently contradict each other and by maintaining that Romantic writers maintain “a double vision” encompassing both of these worldviews, Caldwell indicates strongly here that literature and medicine function in a symbiotic way during the Romantic period, debating about ways of knowing, looking, and learning back and
forth to each other: “this dialectical hermeneutic,” she claims, “yielded innovations in both medical diagnostics and literary representation” (4).

One of the most-recognized Romantic poets, John Keats, famously embodies this duality, often grappling with it explicitly in his letters. Having studied at Guy’s Hospital in London under the tutelage of the famous Astley Cooper, Keats finds himself conflicted between his own acute poetic empathy and sensibility and the gaze that his would-be profession demands of him. The constant dichotomy occasionally takes him to near-disastrous ends. In a letter to Charles Brown, he writes:

My last operation was the opening of a man’s temporal artery. I did it with the utmost nicety, but reflecting on what passed through my mind at the time, my dexterity seemed a miracle, and I never took up the lancet again (qtd. in Scudder xvii).

In the same letter, Keats admits that during a lecture, “there came a sunbeam into the room, and with it a whole troop of creatures floating in the ray, and I was off with them to Oberon and fairy land” (Bate 65). Admittedly Keats might be easy to dismiss as a sub par, easily-distracted medical student, but it’s important to note that the reason for his distraction is based in what others identified as his immense sensibility—a capacity for feeling endemic to the empathetic gaze, but threatening and dangerous to the clinical one. His friends argued that this made him much less suited for medicine, and entirely more suited for poetry, though both his friends—and apparently some of his colleagues—remained surprised by his medical expertise (Bate 49-50).
Yet although Keats seems particularly appropriate for a discussion of the fruitful symbiosis of literature and medicine during the Romantic period and although he personally struggled with the tension between the two, he is by no means the only writer to offer a platform for medical debate in his works. In his poem “The Table Turned,” William Wordsworth laments that “our meddling intellect / Mis-shapes the beauteous form of things” (l. 26-27). Accordingly, he often advocates, particularly in “Expostulation and Reply,” a gentler and more accommodating epistemology, one dependent on the assumption that

The eye—it cannot choose but see;

We cannot bid the ear be still,

Our bodies feel, where’ere they be,

Against or with our will (l. 17-20).

If the body itself constantly accumulates and acquires knowledge instinctively, Wordsworth argues, then the seeker of knowledge must step away from the active accumulation of knowledge in books, “a dull and endless strife,” to listen instead to the wisdom of Nature, to receive every “impulse from a vernal wood.” This form of knowledge acquisition, “deeply rooted in the associationist epistemology of the Enlightenment” and shared to varying degrees with his contemporaries Keats and Samuel Taylor Coleridge (Kitson 37), stands in sharp contrast to the one Wordsworth decries, where sought knowledge is based not in Nature but in books and “barren leaves,” and wisdom is gained not through passive reception but through often-vicious action, the
deliberate disturbance of Nature. “We murder to dissect,” Wordsworth laments; he, like many Romantics, reacted sharply against “not science but Newtonian science,” the pursuit of knowledge which “banish[ed] the divine from nature...[and] emptied the world of its mystery” (Kitson 41) or, in other words, deprived the body of its innate humanness and the promise of its soul. The sharp diction in this particular poem summons up—not coincidentally—images of dissection rooms and dismembered corpses, stripped of identity beneath the eye of medical science; with those words the poet, alongside many prominent figures of the Romantic movement such as Keats, Shelley, and Coleridge, identifies and condemns implicitly the clinical medical gaze that destroys mystery and the sanctity of the body in its endless, devouring search for knowledge.

Although as Caldwell argues, Wordsworth later “moved in his poetry from a position that endorsed ‘wise passivity’ of observation to one that embraced a world ‘half-perceived, half-created,’” he nevertheless maintains—throughout smaller poems such as “The Table Turned” but particularly throughout The Prelude—a strong tension between the materialism of the medical world and the spiritual, expressive and artistic consciousness of his own period, taking active part in a debate between medicine and literature that flourished in Romantic culture (36). Nor was he the only artist to do so; Caldwell identifies similar tensions within the works of Mary Shelley, Coleridge, and Erasmus Darwin. Other scholarship, too, observes the unique link between Romantic literature and the medical community. In British Romanticism and the Science of the Mind Alan Richardson claims that “pioneering neuroscience” of the period boasts a distinctly Romantic character and that “literary Romanticism intersects in numerous and

---

18 Newtonian science, in this case, forms a foundational basis of the Enlightenment thought to which many Romantic writers both responded and resisted.
significant ways with the physiological psychology of the time” (1). Even critical works focusing solely on Romantic literature, and not medical debates of the period, inadvertently highlight the connections. Anne Mellor’s seminal work *Romanticism and Gender*, devoted to recovering the texts of the neglected female Romantic writers, notes the characteristic use and praise of reason in female Romantic writing, indicative of the realization that “women cannot obey the impulses and dictates of their feelings” without *first* thinking deeply on the consequences or implications of those actions (60). Mellor claims that this view runs contrary to the Romantic masculine rejection of “pure reason” meant to spare deadening of the imagination (146). Though Mellor’s text does not speak directly to the medical debates of the period, her outline of the warring viewpoints in Romantic texts—methodical reason versus passionate feeling, empathetic desire versus detached calculation—echoes the similar debate between the empathetic and the clinical gaze prominent in the medical community and more specifically elucidated in other texts of the time. Moreover, her accurate analysis of the response of female Romantic writers recognizes that these writers found themselves influenced by other writers such as Mary Wollstonecraft, whose own treatises and writings were implicitly shaped, as Richard Sha points out throughout *Perverse Romanticism*, by medical understandings of male and female biology and sensibility.

Romantic writers, then, composed their works in a period in which the debate between the clinical and the empathetic medical gaze was not only prominent, but was being made evident in disciplinary shifts: changes in the manner and means of medical education, the battle between midwives and male-dominated general obstetrics, the evolution of diagnostic techniques, and the advent of the specialized field of children’s
medicine. Furthermore, during the Romantic period in particular, medicine and
literature distinctly and constantly interacted with one another in order to pursue, imagine,
and broaden that debate as it centered on the abnormal bodies which populate Romantic
literature and, indeed, function as intensely charged sites of debate. For in Romantic
literature, no abnormal body exists that has not been dissected at least once, if not by the
medical profession that will possess it, then by the clinical gaze endemic to the text in
which it is produced and by the critic who follows after. Although the abnormal body
provides an ideal site for the empathetic-clinical debate to take place, revisiting these
bodies through the eyes of the empathetic gaze so constantly and completely
marginalized allows for revisionary readings of Romantic works previously viewed only
through the predominant lens of the clinical gaze.
CHAPTER TWO:
MAMI’S AUTOPSY:
MARY SEACOLE’S EMPATHETIC GAZE

One of the writers most uniquely situated to explore the conflict between the clinical and empathetic gazes in the Romantic period is Mary Seacole. Though Seacole’s autobiography, *The Wonderful Adventures of Mrs. Seacole in Many Lands*, often occupies a place in the Victorian canon, her text strongly evidences the medical dialogues and many of the understandings of racial difference endemic to the Romantic period. Additionally, Seacole’s life—and part of her autobiography—encompasses the Romantic period: she grew up witnessing many of the medical advancements of the Romantic period and, throughout the text, many of the medical acts she performs—including an autopsy—reference that early knowledge.

Forced to write and work in a society where the ethnic body was situated both as a spectacle worthy of exhibition by the medical community and a focus of sympathy in abolitionist debates, Seacole reinvests the ethnic body—her own and also others—with meaning by reestablishing its place within text, transforming it into a symbol of greater good, and simultaneously reifying its value and necessity to the heart of English culture. Textually, Seacole’s empathetic gaze at ethnic bodies resonates powerfully: fixing these bodies firmly within the narrative, she invokes an empathetic bond not just between herself and her patient, but between the reader and the patient. This bond not only preserves the ethnic body within the text and forces the reader to relate to the ethnic body on an emotional, instinctual level, but also allows Seacole to code—and thus preserve—
distinct ethnic identifiers as innate symbols of English femininity and domesticity. To understand Seacole’s deployment of the empathetic gaze at her own ethnic body and the ethnic bodies of others, however, one must first understand the unique situation of the ethnic body within Romantic literature and culture.

I. THE ETHNIC BODY IN ROMANTIC LITERATURE AND THE ABOLITION MOVEMENT

One of the most vexing representations of the ethnic body in Romantic literature appears in William Blake’s poem in Songs of Innocence, “The Little Black Boy” (1789). The child experiences, throughout his brief appearance in verse, a profound and disturbing identity crisis related directly to his skin color and his soul. “And I am black,” announces the little child at poem’s beginning, “…but oh! my soul is white” (2). The apparent contradiction of soul and body does not seem to bother the child, despite his acknowledgement of it; he anticipates a time, foretold by his mother, when “these black bodies and this sunburnt face” (15) will vanish, and freedom from his skin tone will result in a heavenly reconciliation of soul and body.

Yet the child does not entirely anticipate becoming white himself, or at least does not dare to lay claim to the hope. Rather, he claims, “[he] from black and [the other child] from white cloud [will be] free” (23). Then, he announces, he will be akin to, and beloved by, his paler counterpart. In the little black boy’s utopia, skin tone becomes irrelevant, and only souls matter, yet his attitude of subservience and deference remains; he closes the poem as he imagines stroking the “silver hair” of the other child and shading him from heat, and hopes, touchingly, “that he will then love me” (27-8).
The boy’s self-awareness in the poem disturbs readers. Aware of his body and his anatomy as a trial and an ordeal to be endured, he longs for the day when he can be divorced from such a thing and then find himself reconciled to his “white” soul—and, what’s more, devote himself to the protection of the embodiment of whiteness in the little white child. Admittedly, Blake rephrases the end of the poem; the little white boy is depicted as weak and faint, needing to be shaded and shielded from the heat before he can so much as “lean in joy upon [the] fathers knee” (26). The little black boy’s hardiness, and the lessons he learns from his long hours in the sun, apparently serve him well; nevertheless, his experiences, his aspirations, and his efforts have still reduced him to servanthood. In “Slavery and Romantic Writing,” Alan Richardson acknowledges that the ending of the poem “forestall[s] the false consolations of an ‘innocent’ reading” and “bring[s] the reader back to a sense of social reality” (462). In the poem’s dark and painfully satirical hierarchy, the white body remains a paramount ideal, with blackness—and sundry other ethnicities—signifying little more than a slow descent backwards into primitivism and depravity. The little black boy exemplifies the plight of the ethnic body in Romantic literature: ethnic bodies are deviant in every regard, and the concept of that deviancy is supported and maintained in no small manner by established eighteenth- and nineteenth-century understandings of race and anatomy necessary to both the slave trade and the abolition movement.

The proper, normal body of this time, according to Youngquist, is a white body, and by the measure of that white body “[ethnic] bodies turn monstrous and live beyond the pale of liberal society, without money, friends, or property” (57). The ethnic body is deviant in every regard: culturally, spiritually, and socially. Perhaps most importantly,
the ethnic body is deviant *anatomically*, and it is the clinical gaze which attempts to
discern anatomical difference between the ethnic body and the white body in order to
affirm, promote, and continue the justification of racial bias throughout the period.¹⁹

This medical sentiment regarding the primitivity and difference of ethnic bodies
resides in and resonates through several texts that remained popular during the Romantic
period, including works such as John Mitchell’s “Essay on the Causes of the Different
Colours of People in Different Climates,” which attempts to discern a root cause for
variances in skin tone, as well as various pro- and anti-slavery texts composed during the
debate over abolition. The clinical view of the ethnic body was, in fact, vital to the slave
trade; David Dabydeen writes that

> viewing the African as a primitive, sub-human creature was necessary to the
> whole business of slavery since it avoided or made easy any problems of morality:
> Christians were not enslaving human beings, for blacks were not fully human.
> (231)

In many ways, then, the mainstream medical way of looking at the ethnic body
underscores and supplements the moral standing of the slave trade and its lack of concern
with black slaves; the account of Alexander Falconbridge, a slave ship surgeon working
with the abolition movement, exemplifies the consequences of this common, medically-
begotten view in his written testimonial to the conditions on slave ships (including,

¹⁹ By this definition, ethnicity functions as a social construction supported by medical and scientific bias. Because of this, “ethnicity” signals bodies that are both non-white and non-European, as well as bodies marked socio-medically to be read by English subjects as non-English, with the understanding that during this period, Englishness is a signifier for white identity.
particularly, the slave ship that transported Olaudah Equiano to the Americas).

Falconbridge describes the conditions that ensued when illness struck the captive slaves:

> But the excessive heat was not the only thing that rendered their situation intolerable. The deck, that is, the floor of their rooms, was so covered with the blood and mucus that which had proceeded from them in consequence of the flux, that it resembled a slaughter-house. (284)

Falconbridge further supplements his account with various anecdotes of the way the slaves are fed (around buckets, like animals) and the way the slaves relieve themselves (where they are chained, since they cannot get to the buckets necessary for the purpose and “the necessities of nature are not to be repelled”). Both Falconridge’s description of the crew’s treatment of slaves as dumb, insensate brutes, and Falconridge’s own reliance on animalistic descriptions, associations, and overtones to describe the atrocities, exemplify the consequences of the mainstream medical view of the enslaved ethnic body as beastlike and primal, the value of no more than the sum of its animalistic bodily functions. Unfortunately, the description—given, undoubtedly, to draw sympathy and horror regarding the plight of the slaves—also serves, unintentionally, to reify the conception of the ethnic slave body as primal, animalistic, and wild.

Alan Richardson notes that “the literature of the anti-slavery movement did register fear of racial contamination, promote demeaning stereotypes of Africa and Africans, and appeal to reader’s crass economic self-interest” (467). In fact, accounts meant to provoke deep emotion and revulsion over the brutality and violence of slavery
often played up the same aspects as Falconridge’s account: uncontrollable bodily urges, filth, starvation, the ‘slaughter-house’ aspect of the slave process. Though the works certainly emphasize the brutal treatment of ethnic bodies at the hands of slavers and slave-owners, they also re-emphasize (perhaps unintentionally, and often implicitly) the stereotypical view of Africans as primitive animals worthy of study, a view that is simultaneously confirmed and perpetuated by the clinical gaze. This empathetic act of gazing meant to inspire sympathy, which mirrors the clinical gaze in some aspects, differs primarily in the results that it produces: while the empathetic gaze functions to preserve these bodies and seeks no knowledge from them, the clinical gaze functions both to normalize and to study these bodies.

This manner of medical looking—the clinical gaze that underscores both the simple, cruel economy of the slave trade—appears in texts during the Romantic period in a number of different ways. In a good many texts, especially those centering on Africans and the slave trade, the ethnic body simply becomes reduced to the sum of its body parts or bodily functions, with the ethnic subject completely submerged and made void. The body becomes no more than a body, which is to say, it becomes much less than a body, demeaned to a place of sheer triviality, primality, study, and curiosity. This theme seems particularly endemic to tales that boast the reeducation, reformation, or triumph of Africans and, through doing so, absorb the ethnic body into the text until it is no longer identifiable as an ethnic body according to ethnic stereotypes, or until it can no longer function apart from the text’s didactic message. Perhaps the best example of this is Maria Edgeworth’s short story “The Grateful Negro.”
The story itself is a near-biblical parable, the simple comparison of two slaveowners: one cruel and careless, the other thoughtful and kind. The cruel slaveowner’s slaves revolt and determine to plunder, burn, and destroy everything belonging to the white men on the island on which they are enslaved; the kind slaveowner’s slaves intercede to prevent the tragedy. Tellingly, in Edgeworth’s tale, the most ethnically marked body in the text—belonging to the “old Koromantyn negress,” Esther—literally disappears before the text’s end and never speaks again.

Throughout the work, Esther is portrayed as the embodiment of primitive African savagery: she practices obeah, depends strongly on the use of fetish charms, and traffics in poison. Esther also incites the slaves to rebellion and functions as one of the novel’s antagonists. Throughout, she is referred to as a hag with an “infernal” laugh, her occult knowledge linked to diabolical sources. Although she is taken prisoner at story’s end with the other chief conspirators, the reader never uncovers her fate. No mention of Esther is made again beyond her initial imprisonment, although Edgeworth makes a point to follow up on several of the other slaves. Not insignificantly, the sorceress remains in perpetual, open-ended imprisonment, her acts and her identity literally erased from the end of the text as though she never existed within it at all. The mysterious, incendiary negress—responsible for a great deal of the woe and trouble that the story discusses—evolves, by text’s end, into nothing more than a phantom, a dream of primitive savagery too dangerous to exist. A rebellious African—linked strongly to savage, primitive religious practices that serve to re-emphasize and exaggerate the nature that mainstream medicine claims their anatomy determines—simply vanishes when she breaches the boundaries of colonial control.
Yet the more insidious erasing of ethnic bodies in “The Grateful Negro” occurs when Edgeworth decides to contemplate what, indeed, makes a good African. Being too-familiar with what the clinical gaze has deduced as the composition of a typical African—bodily functions and desires, primality, exaggerated appetites—Edgeworth sets out to make her good Africans atypical. Thus, she reduces them from all the characteristics that the medical gaze assigns dangerous, ethnic bodies. Edgeworth’s good Africans resemble, indeed, Blake’s little black boy; their skin tone is dark but their souls are white, and thus, Edgeworth treats them as white characters with minor differences in shading.

Caesar—the titular character—embodies this voiding. Trusted implicitly by his master, Caesar ultimately chooses to stand with his owner against not only the primitive sorceress Esther, but his lover, Clara, and the gathered assemblage of slaves who, for all intents and purposes, make up his family. In the ultimate erasure of his own ethnic markers, Caesar adopts the ideals of the slave owner Mr. Edwards—not to further his own ends, but to further the ends of the slave system itself, based on the notion that “the sudden emancipation of the negroes would rather increase than diminish their miseries.” Actively and purposefully, Caesar chooses to perpetuate the very trade that oppresses him, both underscoring the inability of the primitive body to fend or function well without the aid of white oversight and his rejection of his own ethnic body. The grateful negro, is not, particularly, a negro at all; his role in the text hinges on denying the urges Edgeworth deems native to his primitive body, and choosing instead to function as a mouthpiece for the beneficence and decency of his white master, as well as the general possibility of mutually-productive and beneficial relationships between master and slave. As such, the
grateful negro is divorced entirely of his ethnic body and rent of his difference until he is a suitable mouthpiece for the (kind) domination of ethnic bodies; he becomes, himself, an extension of Mr. Edwards’ white body. Caesar evolves into a symbol of the lack of ethnicity, having triumphed over his anatomical urges and functions in order to better fulfill his (still-marginalized) role within the greater English social hierarchy.

Finally, it is worth noting that in some Romantic texts the ethnic body literally does not exist, or perhaps, cannot exist. In this case, the ethnic body has not been assimilated, transformed, caricatured, or by some other means made void, but rather never appears in the text initially—or, upon appearance, simply serves as a trick of narrative structure, a creative vehicle. When Wordsworth writes in the “Preface to the Second Edition of Lyrical Ballads” that “the principal object, then, proposed in these Poems was to choose incidents and situations from common life, and to relate or describe them throughout” (446), one understands that Wordsworth is referring only to carefully selected incidents and situations from a very particular kind of common life. Although Wordsworth does indeed use ethnic bodies as the subject of some of his poems in *Lyrical Ballads*, including “The Complaint of the Forsaken Indian Woman” and “The Wandering Jew,” his recognition of any sort of ethnic body is, at best, cursory. To borrow from Anne Mellor’s description of Wordsworth (and the masculine tradition of Romanticism), the ethnic body, much like the female body, “is eras[ed]…from discourse.” The ethnic body does not “exist as [an] independent, self-conscious human being with [a mind] as capable as the poet’s” (19).

Indeed, the ethnic body cannot exist in Wordsworth’s poetry, or in any poetry that “considers man and nature as essentially adapted to each other, and the mind of man as
naturally the mirror of the fairest and most interesting properties of nature” (455). The ethnic body does not embody the fairest and most interesting properties of nature; the clinical gaze finds it to embody the darkest and most frightening parts of nature, the least-known and most primitive parts, and as such the ethnic body is apt for display and exhibit and study, and perhaps even as a token poetic vehicle, but never as a proper subject or creator of poetry. Indeed, as the most lauded and perhaps most famous of all Romantic poetic dictates, Wordsworth’s immortal claim that “poetry is the spontaneous overflow of powerful feelings… and takes its origin from emotion recollected in tranquility” (460), exiles the ethnic body from the Romantic poetic text. The medical way of viewing the ethnic body—a way of looking that leaches broadly into popular culture through medical and particularly travel literature—denies the ethnic body the ability to recollect in tranquility, to quietly comprehend the vast flow of emotions due to an anatomy deemed incapable of doing so. Poetic feeling and understanding during the Romantic period is not meant for beasts. And yet, during this period, the ethnic body is characterized beneath the clinical gaze as little more and, thus, is submerged, caricatured, exaggerated, or simply nonexistent within many Romantic texts such as Edgeworth’s “The Grateful Negro.” And, in the void left by the treatment of the ethnic body, the normative standard is able to reassert itself; to paraphrase Youngquist, the pathological is either assimilated back into the norm, or simply eradicated.

Yet ethnic bodies do speak in Romantic texts, and without being voiced by white, primarily English authors. Most tellingly, they seem to speak most—and in the most complex ways—in abolition works. Part of this phenomenon is purely historical; with the advent of the abolition movement and popular agitation against the slave trade, the
literary market for slave narratives, pro-abolition texts, and firsthand slave accounts cracked wide open. Ethnic voices became not only helpful, but necessary, fueling the abolition fire with much-needed pathos and provocation. Richardson names several slave narratives that achieved some literary prominence during the Romantic period: Ottabah Cugoano’s *Thoughts and Sentiments on the Evil and Wicked Traffic of Slavery and Commerce of the Human Species: The Narrative of the Remarkable Particulars in the Life of James Albert Ukawsow Gronniosaw, An African Prince*; and the *History of Mary Prince, a West Indian Slave*. The most well-known and prominent of these autobiographical narratives is *The Interesting Narrative of the Life of Olaudah Equiano, or Gustavus Vassa, the African*, first published in 1789. Indeed, Richardson notes, during the Romantic period the ethnic, autobiographical narrative coalesces into a “frequently overlooked genre” of Romantic literature: the slave narrative. The harrowing, heartfelt, incendiary (and exotic) nature of these texts endears them to readers; the passions and sense of injustice they stirred suited them perfectly to the ends of the abolition movement.

Equiano in particular resists the temptation to eradicate or erase the ethnic body, even as attempts to render himself acceptable to the audiences of his own autobiographical work. In particular, he makes deliberate rhetorical moves to identify himself with his audience’s conception of Englishness: his portrait in the book’s frontispiece serves to code him as English, and his constant subtle removal of himself from the more magical and primitive aspects of his own culture, even as he worked within them, emphasized his Englishness while his ethnic body allowed him to inhabit an altered model of English subjectivity.
For Equiano, the medical gaze at ethnic bodies as understood by the abolition movement results only in debasement, cruelty, and the justification for enslavement. Equiano, in particular, was no stranger to the biases that reaffirm the primitive, beastly, and uncontrollable animal nature of the African body. His resistance to the notion of Africans as “beasts of burthen” promoted by “base-minded men” (203) and his invocation of the spiritual notion that “all [are] the children of the same parent” (197) show an implicit understanding of the scientific and medical system that upholds the hierarchy from black to white and allows, even demands, that ethnic bodies be treated as less significant, less advanced, and less important. It is this hierarchy, as well as the slave trade upheld by this hierarchy, that Equiano wishes to abolish.

Of course, Equiano does possess one of those darker complexions and, as he tells it, abruptly finds himself enslaved for his. The history he offers is bleak: kidnapped from family by domestic African traders and eventually traded off to European slavers, Equiano is forced to endure the harsh Middle Passage and the trials of slavery. Yet he shares a pride in his ethnicity, boasting to the reader of his people’s “hardiness, intelligence, integrity, and zeal” and noting that “we have no beggars” (25). Moreover, Equiano notes, “deformity is indeed unknown amongst us.” Acknowledging that “ideas of beauty are wholly relative,” Equiano recalls a particular memory: “I remember while

20 Roxann Wheeler in The Complexion of Race notes that this essentialist way of characterizing race is not the only understanding of race in the eighteenth and nineteenth centuries. She maintains that “various manifestations of ‘race’ in language and culture coexist…rather than solidifying into ‘the more consolidated, pure somatic form’” (70). Although Nussbaum’s point is well taken, the understanding of essentialist racism as it relates particularly to the treatment of ethnic bodies and to the slave trade remains a matter of importance due to the focus on particularly medical understandings of race that permeate popular culture.

21 Vincent Carretta notes in Equiano, the African: Biography of a Self-Made Man that Equiano might well have fabricated his African roots and his struggle in an effort to promote the abolition cause. Regardless of what his ‘real’ origins might be, Equiano’s deliberate choice to structure his narrative in this way remains the key focus and allows for the interplay of the clinical and empathetic gaze.
in Africa to have seen three negro children, who were tawny, and another quite white, who were universally regarded by myself, and the natives in general, as far as related to their complexions, as deformed” (25). His insistence on the aesthetic value of his own people against white and British ideas of beauty further emphasizes the value he places on his own ethnicity, and on his own culture.

Equiano’s autobiography serves not just as propaganda for the abolition movement but also as a chronicle of his own spiritual journey and highlights all the major moments of his spiritual growth and development. Throughout the text, Equiano maintains that his reliance on God and faith in God’s nature guided him through critical moments of crisis, and his self-expressed deep and abiding love for God motivated much of his actions, not just on his own behalf but on behalf of his fellow slaves. Several times throughout the narrative, Equiano’s spiritual and physical journeys collide; one such moment occurs on a trip with Doctor Irving to help cultivate a plantation in Jamaica, where Equiano encounters “four Musquito Indians,” one of whom is a prince: “a youth of about eighteen years of age” (153). Despite being chiefs in their own country, these men have been taken to England “by some English traders for selfish ends,” and Equiano is astonished to find that they have been spiritually neglected and abide only by “mock Christianity” (154). Equiano decides to minister to the prince in particular, and does so through a myriad of actions—teaching him to spell, encouraging him to look at the pictures in “Fox’s Martyrology,” and praying with him regularly.

These practices, notably, bear a similarity to the ones that influenced Equiano to convert to Christianity during his enslavement; here, Equiano deliberately adopts English spirituality in order to both to identify himself with English culture (and thus maintain the
freedom of his ethnic body) and, paradoxically, to preserve the ethnic body of the
young prince.22 Although the process by which Equiano—and his new friend—are
indoctrinated remains at its core colonial, Equiano possesses the paradoxical knowledge
that this knowledge is necessary to inhabit his ethnic body freely, without being enslaved.
Yet this desire to save and heal the spirit (and thus the body) as evidenced by his
encounter with the prince, while a hallmark of his Christian conversation, also evidences
Equiano’s roots. In Tropicopolitans: Colonialism and Agency, Srinivas Aravamudan
carefully notes Equiano’s “pre- and post-Vassa ethnic spirituality,” one which functions
“in the manner of a fetish” and exemplifies the progression from “the particular to the
general…from Igbo Equiano to British slave Vassa to manumitted African” (245).
Equiano is equipped to “perform…admonitory and prophetic action” and, more to the
point, Aravamudan implies, he does this not solely for the cause of evangelical
Christianity but, rather, uses evangelical Christianity as a tool for the cause of
“extinguishing this human trade” (246). The use of the spiritual, then, becomes a means
to liberate the corporeal. For Aravamudan, Equiano’s agitation for the extinguishing of
the slave trade is only a byword for renewing commerce and economy in Africa, and to
this end Equiano represents himself distinctly as “not just a literate but a literary
African,” proud to represent his countrymen.

In other words, Equiano manages to synthesize his past and his African heritage
with his later evangelical Christian identity. While the discussion about Equiano’s use of
his Christianity as a rhetorical tool or as an aspect of resistance to colonization belongs to
another project entirely, the pertinent point remains that Equiano’s conversion to

22 In Black Imagination and the Middle Passage, Maria Diedrich et al. do a remarkable job of discussing
how Equiano’s embrace of Christianity allows him to transcend the boundaries set in place by colonization.
Christianity does not supplant nor contradict his understanding or utilization of his earlier heritage. From that view, it is easier to regard Equiano as combining aspects of his pre- and post-slave identity in order to preserve and eventually free the ethnic body. In Black Imagination and the Middle Passage, the authors elaborate on Equiano’s soul-doctor role as a hybrid of his Christian spirituality and his African identity:

Equiano’s dual identity as an African and as a European is clear as well in his encounters with the Musquito Indians. Although there are common ties between Equiano and the Indians…Equiano adopts the position of mediator who introduces the Indians to the Holy Word. Unlike the figure of the colonizer, who would impose the new religion on the savage, Equiano is willing to acknowledge the moral superiority and religious fervor of the Indians. Equiano finds in the natural religion of the Musquito Indians echoes of his own African religion…and he considers these unenlightened Indians more enlightened than many Christians. However, in his fluid role of intermediary, he crisscrosses the lines between both religious practices as he personally transcend[s] the barriers separating the white man and the black Other (54).

In this way, Equiano first preserves his own identity as an African and a Christian, an adherent to the beliefs of his people who does not have to betray his current Christian identity. Equiano’s particular brand of soul-nurturing and his spiritual understanding of

---

23 Samantha Earley in “Writing from the Center of the Margins?,” in particular, does a fine job of examining how Equiano’s use of Christian rhetoric and varying discursive strategies resituate him as a central figure within his own text and within the abolition movement.
the world around him renders him acceptable to his readership, establishes a bond of common trust and spirituality, and simultaneously allows him to possess and utilize important facets of his African spiritual identity as well as the freedom of his body.

It seems Equiano is not entirely unaware of his ability. When confronted by a ruckus among Indians that he must solve, Equiano takes recourse to his spirituality yet again:

I menaced him and the rest; I told them God lived [in the sky], and that he was angry with them, and they must not quarrel so; that they were all brothers, and if they did not leave off, and go away quietly, I would take the book (pointing to the Bible), read, and *tell* God to make them dead (158).

After this account, and his subsequent victory in calming everyone, Equiano adds, perhaps wryly, “This was something like magic.” His awareness of religious rhetoric, the ability of a skilled speaker to manipulate it for useful ends, and the naivete of the people he is duping reveal his understanding that a mastery of Evangelical rhetoric and certain English attitudes is necessary to preserve both himself and his own cultural identity.

Equiano preserves his own ethnic body while coding it as acceptably English for the reader. His words—that he will instruct God to kill the Indians—are a sham. Equiano knows it, and, if there were any doubt, makes it clear for the reader. In fact, he admits, he borrows the strategy from something he read “in the life of Columbus, when he was amongst the Indians in Mexico or Peru” (157). The reader, too, is in on the joke, and the scene where Equiano declares his intent to the aghast Indians is worth a chuckle.
or two. However, with this moment Equiano creates a much-needed spiritual dissonance: he’s Christian (and his entire narrative supports this singular aspect of his identity), but he is aware that Christianity can be manipulated to induce the savage mind into torpor, calm, and obedience. Equiano simultaneously exists within Christianity, using it to calm the natives and thus reaffirming one of the core aspects of British identity, but he also exists outside of Christianity, able to wryly examine and understand his machinations and compare them to the magic and methodologies of his own culture. The Indians are outside Christianity—to the degree that they do not have a proper conception of what the Bible says, and can thus be manipulated by Equiano’s words—but also inhabit it with their behaviors in a way that the slave traders Equiano encounters cannot.

Blake offers a similar resistance to the erasing of the ethnic body in his engravings for John Stedman. Despite the fact that the engravings, like many abolition narratives, threaten at times to subvert themselves by reducing the ethnic body to a spectacle, they also strip the ethnic body of familiar British cultural markings to reveal the primal nature of the body beneath. By making art of these figures Blake humanizes them and renders them sympathetic to English audiences, but simultaneously captures the anatomical markers of visible racial difference.

II. THE ETHNIC BODY AS MEDICAL SPECTACLE

Unfortunately, the mode of clinical looking at ethnic bodies that problematizes abolitionist discourse and leads to the invisibility of ethnic bodies in Romantic texts—an invisibility that Equiano and other writers resist—also reduces the ethnic body to little more than a spectacle. In his later, scathing indictment of Joseph Conrad’s Heart of
Darkness, Chinua Achebe identifies this persistent trope quite succinctly when he claims that only in rare cases does Conrad allow his Africans to be anything more than “just limbs or rolling eyes” (340). In many slave narratives, as well as pro- and anti-abolition texts, including those mentioned above, ethnic bodies become little more than a compilation of grunts, groans, shrieks, incomprehensible utterances, and eyes, buttocks, breasts, and limbs. Indeed, in her autobiography, Mary Seacole refers obliquely to this trope when she find herself eating native fare at Escribanos; the roasted monkey’s grilled head, she says with a shudder, “bore a strong resemblance to a negro baby’s,” and she finds it “positively frightful to dip your ladle in unsuspectingly, and bring up what closely resembled a brown baby’s limb” (69).

Perhaps the most fascinating story to illustrate the ramifications of this way of looking, however, is the tale of Saartjie (Sarah) Baartman, the Hottentot Venus. Paraded through England and France as a sideshow in the early nineteenth century, Baartman exemplifies the ethnic body as the epitome of abnormality. The anatomical site of her “deviance” was her buttocks and genitals. In fact, so innate to the concept of “the primitive woman” were “extraordinarily large buttocks” and “remarkable sexual organs” (a concept that first appears in eighteenth- and nineteenth-century travel literature) that well into the twentieth century, doctors in Europe and America “excised women’s genitals to make them less pronounced, less like those of the Hottentot Venus, to better control their presumed sexual cravings and brute drives” (Clifton 2-3). To evolve away from the anatomy of the ethnic savage, whether naturally or artificially, is to socially and culturally advance. For her viewers and doctors, Baartman exhibits a primitivism long since thought lost to white society.
Clifton Crais and Pamela Scully offer a chilling, disturbing account of
Baartman’s exhibition before a curious English public:

Sarah Baartman stood many long afternoons and long into the evenings. People
paid their two shillings, the same amount as the special boxes at Richardson’s
Theatre at Bartholomew Fair. They walked in gasping at the naughtiness of it all,
women with eyes averted, men and women trying not to look too eager. Dresses
swished across the floor, walking sticks clapping as couples crossed the room into
the realm of the Hottentot Venus. Audiences stared at a woman in a very tight
brown dress. They stared at her yellow-brown skin and the way it seemed to
merge with the cloth. …the dress emphasized the Venus’s bottom, titillating the
viewer with the semblance of nudity. … “Turn around,” Cesars demanded [of
her]. … “Feel her posterior parts.”

A medical curiosity for the anatomical traits that differentiated her body from that of an
English woman, Baartman became a living exhibit of the fantastic. Medical science of
the Romantic period held that “the more primitive the mammal, the more pronounced the
genitalia” (133). Fittingly, then, medical professionals and scientists jumped at the
chance to investigate (and exhibit) living proof of this theory, particularly in Baartman’s
case. The anatomist and zoologist Georges Cuvier initially fastened onto Baartman to
examine her posterior and the function of the fatty tissue and “the famous Hottentot
apron” (133); his interest resulted in countless sketches, examinations, reports, interviews
and observations. Indeed, Cuvier’s motivations for studying Baartman reside in his desire, according to Anne Fausto-Sterling, to “render visible the hidden African nations and the hidden genitalia” in an effort to “disempower, to use observation to bring these unknown elements under scientific control” (36). For Cuvier, the progress of science enables the progress of colonization; the knowledge of Baartman’s body begets the possession and control of all that ethnic body symbolizes. But Cuvier was not the only professional with an interest in the Hottentot body. Baartman herself identified Alexander Dunlop, a Scottish physician, as the driving force behind her examination and exhibition before the English public. Originally a retired military physician, Dunlop used his skills to tend to “sick Hottentots” in South Africa and, upon realizing the “sailor’s titillation” over the Hottentot women in particular, embarked upon the notion of exhibiting Baartman for profit (Crais 54).

Even Baartman’s corpse was not spared the intrusive examination of medical science. When Baartman died in 1815, according to Crais and Scully, Cuvier eagerly dissected her body for his own studies, and then had her “remade in a plaster cast as the Hottentot Venus” (2). In death, the parts of her body that Baartman had managed to conceal during her very public life became fair game for discovery; Cuvier published reports on every aspect of her anatomy, including a page and a half description of her “hidden vaginal appendages” (Fausto-Sterling 37). The knowledge allowed Cuvier to “imperceptibly [separate] the tamed and manageable European woman from the wild and previously unknown African,” and create more evidence for “the claim of European

---

24 Not all of which were given willingly, and not all of which occurred without manipulation. Crais and Scully provide a fuller account of Baartman’s entire ordeal in their thoroughly-researched text.
25 Dunlop was misidentified by Baartman as English.
superiority on which European and American colonization, enslavement, and
disenfranchisement so depended” (Fausto-Sterling 38-39). As a result, Baartman
remained a byword for primitive African sexuality for years after her death, figuring
prominently in the Universal Exhibition in Paris in 1889 and later in the International
Exhibition of 1937. Subject to a medical hypothesis that has its origins in travel literature
and links primitivity to genitalia and resultant sexuality, Baartman’s body becomes a
series of—figuratively and literally—disembodied parts: a set of sexualized organs
displayed for the public to gawk at, and then a dissected, dismembered corpse intended to
reveal the secrets of the primitive, pre-evolved body. Beneath the clinical medical gaze of
this period, the ethnic body provides a source of entertainment and knowledge, as well as
a look back to a more primitive, secretive past that necessarily exists outside of evolved
and sophisticated English understanding.

Nor is this treatment of ethnic bodies confined to the African body alone.
Youngquist points out the treatment of the French body in English texts as a series of
anatomical tics and differences as well; while the African body is bestial, wild,
unrestrained, and exaggerated, the French body is “lean, dry, and fey,” characterized by
small stature, “a classic profile,” and a distinct lack of fortitude. This attitude reaches its
zenith in mocking characterizations of Napoleon Bonaparte as “‘Little Boney,’ waving,
perilously for him if for no one else, a laughingly huge saber” (172). While the French
body is assigned oppositional difference from the English body (as opposed to the
African body, which is assigned devolved difference), both kinds of ethnic, non-English,
abnormal bodies become caricatures and exaggerated, wanton displays of anatomical
traits. This textual treatment extends to a variety of ethnic bodies (including Irish,
Russian, and Indian), but the result remains the same: the ethnic body vanishes beneath the weight of its own caricature, voided of meaning, context, and implication until it serves as little more than a trope, stock figure, or entertainment.

Additionally, ethnic bodies became spectacle as part of the natural spectacle and pageantry of wartime affairs. Perhaps in an effort to justify certain aspects of the war to the folks at home, accounts of the war and war-related adventures additionally become prominent; war with France, according to Youngquist, sparks a hunger in Britons not only for the spectacle of war, but for the medical spectacle of war. To be wounded in battle, he points out, is “a strategic aim” that identifies one with the British national body, and the contemplation of war wounds and war dead becomes a “[site] of national incarnation” (177). Thus, autobiographies written during wartime—especially those by ethnic authors—provide a stage on which author and audience alike can, through the act of observing the spectacle of the war and war wounded, participate in the British national identity. Additionally, wartime literature satirized and mocked the enemy, bolstered a national sense of pride, and allowed readers to expand their horizons by learning about the world beyond their own borders. The hunger for war and war narratives ignited during the long years of battle with France persists into later periods, and allows for the eventual popularity of other war-related texts, including accounts of Florence Nightingale’s many acts of service, as well as her own self-authored works, and Mary Seacole’s autobiography.  

\footnote{Although Seacole’s work falls within the broad category of Victorian literature, her life spanned both the Romantic and Victorian periods, and the following discussion will elucidate the characteristics of her work most relevant to, and sharing commonality with, Romantic literature.}
Yet the popularity of travel literature during the Romantic period also bears credit for the emergence of ethnic voices, including those of Seacole and Equiano. In addition to a hunger for identification with the British national body, wartime sparked an intense appetite for knowledge of the world abroad. Ethnic writers like Seacole and Equiano, while taking care in their texts to identify themselves strongly with British culture against the exotic other, nevertheless invert the characteristics of the genre. By going out into the world not as white Britons, but as ethnic bodies, ethnic writers of the period doubly sate the British curiosity for news of other cultures: first by reporting the news of their own travels abroad, and second by recording their observations on British culture through the eyes of a cultural outsider.

This combination of historical events and occurrences unique to the Romantic period and its cultural moment allows for the emergence of ethnic voices—and, thus, ethnic bodies—in autobiographies, even if those voices must be carefully coded, manipulated, and arranged to work within the greater paradigm of English Romantic literature and a careful cultural tradition.

As an unfortunate result of abolition discourse based on modes of medical looking, and of the use of the ethnic body as a medical spectacle, ethnic bodies in Romantic literature all too often disappear or become assimilated into other, more dominant narratives. In spite of this, the work of Mary Seacole exemplifies the ways in which the interplay between modes of medical gazing allows ethnic bodies to preserve themselves and others by manipulating the domestic and feminine markers of English identity.
III. SEACOLE: BOTH ‘AUNTIE’ AND ‘MAMI’

Seacole’s 1857 autobiography covers her early life in Jamaica as well as her marriage and the eventual death of her husband, parents, and patroness, but the bulk of the text is devoted to Seacole’s travels in the Caribbean, Central America, and ultimately the battlefields of the Crimean War, where she plied her trade not only as a highly-skilled and sought-after medical professional, but as a businesswoman and hotel owner. Although Seacole most often falls into critical comparison with other nurse-authors, such as Florence Nightingale—and thus tends to be regarded widely as a writer belonging to the Victorian period—her upbringing, medical training, and formative experiences in Jamaica and the Caribbean before and during the 1820s belong to the Romantic period. Seacole is a writer with a foot in both eras, and her writing, complex as it is, exemplifies the latent ambiguities involved with fixing a particular author in any one literary period. More importantly, although Seacole’s writing evidences common Victorian tropes, themes, and touchstones, Seacole pushes back against the clinical gaze most evident in the Romantic period with her own empathetic gaze, refusing to become invisible within her own text and refusing to make a spectacle of the ethnic body. Textually, her empathetic gaze preserves ethnic bodies within her narrative: she invokes an empathetic bond not just between herself and her patient, but between the reader and the ethnic body as well, forcing the reader to relate to the ethnic body on an emotional, instinctual level. This bond allows Seacole to both maintain her own ethnic and cultural identity within the text while simultaneously rendering her acceptable to her larger British audience.

An ethnic body herself, Seacole was the daughter of a white Scottish officer and a free Jamaican Creole woman. She benefited socially from a light complexion, a fact that
did not escape her notice. Commenting frequently on the harassments endured by those with darker skin, she notes often that her level of social acceptability sometimes hinges on the fact that she is often referred to as the yellow woman. Moreover, Seacole seems to guard against slights typically applied to those of her ancestry, insisting that the energy of her Scotch ancestry overrides the laziness and indolence of her Creole heritage. Yet, despite her seeming acknowledgment of the traits deemed endemic to her color and her culture, she vigorously defends her identity. Having traveled to Cruces, in Panama, to visit her half-brother, Seacole found herself confronted by the beginnings of the cholera epidemic, and stayed for longer than she originally intended as she seems to have been the only medical professional on hand in Cruces with any means of treating the disease. As she prepared to leave Cruces for Gorgona, where she eventually established a hotel and continued to treat the sick, Seacole became subject to the following farewell speech from a “thin, sallow-looking American” (47):

"Well, gentlemen, I expect you'll all support me in a drinking of this toast that I du —. Aunty Seacole, gentlemen; I give you, Aunty Seacole —. We can't du less for her, after what she's done for us —, when the cholera was among us, gentlemen —, not many months ago —. So, I say, God bless the best yaller woman He ever made —, from Jamaica, gentlemen —, from the Isle of Springs —. Well, gentlemen, I expect there are only tu things we're vexed for —; and the first is, that she ain't one of us —, a citizen of the great United States —; and the other thing is, gentlemen —, that Providence made her a yaller woman. I calculate, gentlemen, you're all as vexed as I am that she's not wholly white —,
but I du reckon on your rejoicing with me that she's so many shades removed from being entirely black —; and I guess, if we could bleach her by any means we would —, and thus make her as acceptable in any company as she deserves to be —. Gentlemen, I give you Aunty Seacole!” (47)

Seacole, confronted by the latent understanding of racial difference both biological and otherwise and enraged by the speech despite its seeming good intentions, replies that “if [her complexion] had been as dark as any nigger's, [she] should have been just as happy and as useful, and as much respected by those whose respect [she] values” (48). Thus, despite Seacole’s necessary textual bows to the assumed lazy indolence of her Creole heritage, she both disproves the stereotype and, furthermore, strongly resists a system of hierarchy that seeks to separate or remove her from any sense of ethnic kindred.

Already subject to the general Romantic views about ethnic bodies largely shared by Victorians, Seacole encounters a more personal (if vexed) form of the clinical gaze during her attempts to join in with the efforts of Florence Nightingale’s nurses. Described by Seacole as “hard at work, evoking order out of confusion, and bravely resisting the despotism of death,” Nightingale appears, here as in other texts, as a veritable angel of compassion, strength, and healing (85). Yet during an encounter in 1855, Nightingale and her associates refuse Seacole’s offers of aid, not once, but many times, despite Seacole’s letters of recommendation. Seacole indeed only enables herself to help in Nightingale’s hospital when she deliberately, and without permission, engages in changing bandages for some of the men; “at some slight risk of giving offense,” she admits, “I cannot resist the temptation of lending a helping hand here or there” (88).
Though the attending doctor is at first alarmed, he later thanks her for her aid, but
never asks for her name, identity, or purpose. Indeed, no one in Nightingale’s coterie
seems to know or care to know Mary Seacole, and Seacole herself drifts through the ward
anonymously, seeking not to trouble the nurses and only interacting with those with
whom she is familiar by either previous experience or shared social station. When she
finally comes to present her recommendation letters to Nightingale, and to request
lodging for the night, she is at first questioned with “curiosity and surprise” by a Mrs.
B ____, then escorted in to see Nightingale herself, and from there on the encounter takes a
decidedly more poignant turn (90).

Seacole is told repeatedly there is no vacancy on Nightingale’s staff (and indeed
questions whether she would be told of one, if there was). Tellingly, Seacole refers to
Nightingale as “that Englishwoman whose name shall never die, but sound like music on
the lips of British men until the hour of doom;” it cannot escape Seacole’s awareness here
that no one here knows her name, at all (91). Seacole offers to nurse the sick in exchange
for a night of lodging; Nightingale’s verbal response, an offer to do anything that lies in
her power, belies the poverty of actual action. Seacole finally receives a room in “the
hospital’s washerwoman’s quarters” with the resident washerwoman and “some invalid
nurses” (91). She does not spend the night nursing, as she had hoped, but engaging in
conversation and sharing of biographies with her companions; she wishes ultimately she
had not laid down in bed because she finds it infested with fleas, “unbidden and
unwelcome companions.”

Beneath the eyes of the mainstream medical gaze as enforced by Nightingale,
herself undoubtedly a marginalized figure within the broader medical establishment,
Seacole becomes non-existent; her very identity, rooted and centered in her ability and skill to give medical care, is denied her. In Nightingale’s wards, she becomes little more than a transient traveler, nameless and useless, slipping in only to slip back out again. Nor was the interaction an isolated incident; in later letters to her brother-in-law, Nightingale accused Seacole of a lack of professionalism, indicating that she ran a brothel and encouraged drunkenness and bad behavior:

She kept—I will not call it a ‘bad house’—but something not very unlike it. …She was very kind to the men &c., what is more, to the Officers—& did some good—and made many drunk. (Robinson 122)

Though admitting that Seacole does have some usefulness, one of Nightingale’s main preoccupations seems to be the business aspect of Seacole’s identity, and her refusal to utilize or acknowledge Seacole’s medical skill or abilities, in addition to her condemnation of Seacole as a “bad character” (122), results in the invisibility of Seacole, in Nightingale’s view and in Seacole’s perception of Nightingale’s view, as a worthy nurse or a medical professional. Seacole records this voiding of self in her text, which is a record of her experiences as a nurse. By insisting on the validity of her own

---

27 Notably, however, Nightingale’s place as a marginalized figure in the medical establishment differs widely from Seacole’s, whose memoirs, history, and work were recovered and celebrated much later. In the words of Salman Rushdie, who said of Seacole in his Satanic Verses that “…Mary Seacole, who did as much in the Crimea as another magic-lamping lady… being dark, could scarce be seen for the flame of Florence’s candle” (292).

28 In Mary Seacole: The Most Famous Black Woman of the Victorian Age, Robinson claims that Nightingale’s treatment of Seacole is based in the sense of her own social superiority and maintains that the power balance between the two women resulted in Seacole’s necessary obeisance and self-effacement. While some of Nightingale’s later actions—including donations to a fund set up in Seacole’s name—undermine this view, her refusal to utilize Seacole’s expertise at a time when others both recommended and claimed need of it speaks volumes.
experience within text against the identity denied her by establishment medical figures, Seacole displays a sharp knowledge of identity politics and the erasure of ethnic bodies, and through the particular nature of biography, effectively subverts, or at least complicates, the rules of the game.

Seacole, too, was no stranger to clinical medicine or the effects of the clinical gaze. Throughout her autobiography she makes mention of the various tips and tricks she inherits through conversations with physicians, and offers her own critiques of, and praises for, various medically-approved remedies for various and sundry ills, including cholera. On occasion, she makes casual metaphorical mention of science-related subjects. Once, upon mentioning the sorry state of her clay-covered dress, she writes, “[It] looked as red as if, in the pursuit of science, I had passed it through a strong solution of muriatic acid” (13). Muriatic acid, more commonly known to contemporary science as hydrochloric acid, figured largely in many medical developments and uses during the eighteenth and nineteenth centuries, and even motivated the passing of the Alkali Act in England in 1863 while Seacole was still alive. For her to casually make mention of the acid in metaphor implies at least a surface knowledge of science, or her contact with it, that informs the more folk-oriented Creole knowledge of which she boasts. Moreover, Seacole quite often dismisses more clinical remedies in her travels, viewing such common cures as opium as dangerous and foolhardy, or simply deriding them as “medicines [that]…made [her] shudder” (31).

Yet no incident better illustrates Seacole’s vexed relationship within the clinical-empathetic medical debate, and her resistance to the ethnic body as medical spectacle, than the chilling account she gives of performing an autopsy on the body of a child:
And, meanwhile, I sat before the flickering fire, with my last patient in my lap—a poor, little, brown-faced orphan infant, scarce a year old, was dying in my arms, and I was powerless to save it. It may seem strange, but it is a fact, that I thought more of that little child than I did of the men who were struggling for their lives, and prayed very earnestly and solemnly to God to spare it. But it did not please Him to grant my prayer, and towards morning the wee spirit left this sinful world for the home above it had so lately left, and what was mortal of the little infant lay dead in my arms. Then it was that I began to think—how the idea first arose in my mind I can hardly say—that, if it were possible to take this little child and examine it, I should learn more of the terrible disease which was sparing neither young nor old, and should know better how to do battle with it. I was not afraid to use my baby patient thus. I knew its fled spirit would not reproach me, for I had done all I could for it in life—had shed tears over it, and prayed for it. (29)

Seacole seems to note, here, or at least defend against, the common accusations leveled at anatomists and physicians. She points out that the baby’s spirit won’t reproach her for the actions she takes with its body (unlike, presumably, the reproach Charles Byrnes’ spirit might level at its dismemberer) and imbues her decision to embark on the action with a sense of spiritual reconciliation and godly approval. She further emphasizes her feeling for the child—“I shed tears over it” (30)—as though to soften the cold, scientific cruelty of the act she is about to commit. Interestingly, she performs the autopsy and dissection in secret, bribing the man carrying the child’s body and enlisting his help with
the procedure. She again justifies the need for the autopsy, saying it must be done “to learn the secret inner workings of our common foe” (30). In her efforts to thus know and penetrate Nature, Seacole complicates her role as a nurturing mother-figure.

Most curious, though, is the manner in which Seacole discusses the autopsy. Her tone ranges from defensive to sorrowful to uneasy; she admits it is a “strange deed” to accomplish and fears that her action might make her seem “somewhat callous.” She softens her intent to do the deed with admittances that she has to screw up her courage and nerve to even get the job done. Yet she takes care not to discuss the results and procedure of the autopsy, refraining from the grotesque and elaborate detail that populates most clinical medical accounts of the same but that the readership of a travelogue might find objectionable. She points out specifically that this was her “first and last” autopsy and dissection and, pointedly, explains that her reasons for refraining from detail is because the procedure is something “every medical man well knows.”

Thus, Seacole indicates some familiarity with, if not the nitty-gritty details of the clinical medical gaze, its ramifications and results. For Seacole, the clinical gaze and the medical profession from which it stems boasts an inconsistent set of cures, devotes itself more to the lurid explication of details and discoveries than the actual work of healing, and exhibits cold, emotionless detachment over understanding, sympathy, and warmth. Yet this vexed relationship to the clinical gaze undoubtedly stems from her familiarity with the empathetic gaze and empathetic medicine, a familiarity that manifests in Seacole’s treatment of ethnic bodies.

In the initial chapter of Mary Seacole’s autobiography, she identifies herself strongly and clearly with the empathetic medical tradition. Citing her mother as an
“admirable doctress” gifted with all the considerable gifts of a Creole heritage, Seacole explains her own attempts to emulate her mother’s medical expertise—first on her doll, then on cats and dogs, and finally on herself (2). She learned “a great deal of Creole medicinal art” at her mother’s side, and eventually nursed her patroness, her husband, and then her mother through their last, final illnesses.

Seacole’s knowledge of medicine rests on the same foundation shared by midwives and purveyors of folk medicine; her skills are learned not in a school or through texts (or even through the examination of corpses), but at the side of her mother—the oral transmission of knowledge so scorned by male medical professionals. Nor are Seacole’s medicinal skills particularly “English” or widely-accepted in the mainstream; she points out throughout that her medical work stems from her Creole heritage, her Creole gift, and her mother’s knowledge of Creole folk cures and medicines. She gains her knowledge through direct experience with the living, though she also learns to deal with death, and her initial patients are those to whom she has strong ties and possesses deep affection. In regards to treating her much-loved childhood doll, she notes,

I have had many medical triumphs in later days, and saved some valuable lives; but I really think that few have given me more real gratification than the rewarding glow of health which my fancy used to picture stealing over my patient's waxen face after long and precarious illness. (3)

The desire to practice medicine, in Seacole’s case, stems not from the pursuit of knowledge or curiosity regarding the body, or even out of any social desire to banish
sickness or to maintain health, but rather, to alleviate suffering where she finds it.
Admittedly, such a desire codes her feminine nature strongly for readers, and she boasts throughout the text of her feminine soft heart (often functioning in contrast to her hearty, “stout” persona). Although her actions might be exaggerated to appeal to the sympathies of her readership, Seacole nevertheless identifies herself as operating clearly outside of clinical medical practice, and operating within the bounds of an empathetic one.

Textually, Seacole’s empathetic gaze not only preserves the ethnic body within the text, but also forces the reader to relate to the ethnic body on an emotional, instinctual level, simultaneously allowing Seacole to code herself with markers of English domesticity and femininity. The most striking example of this practice occurs during Seacole’s bittersweet narrative of the child autopsy, a performance of an act of associated with the clinical gaze but underscored by Seacole’s own empathetic one. After dismissing the typical clinical method and means of dissection, and firmly differentiating herself from those ends by refusing to provide details or unnecessary information about the process, Seacole discusses the autopsy in a tone of careful, deliberate empathy. Her struggle to actually commit the act of dissection emphasizes this bond; aware that the child’s body is only a shell and a husk, she nevertheless struggles with the thought of committing an obviously-violent act against another, and notes that she has to work herself up slowly to the thought of achieving her end. She makes a point to value and honor its spirit, maintaining that the body itself is now a husk, and therefore useless for anything but knowledge, and she claims the need of knowledge not for knowledge’s sake but to precipitate the saving of countless lives. She does not revel in the scientific or methodological elements of the process, and indeed deliberately conceals them from the
reader, perpetually undermining the embodiment of the child as an anatomical specimen. Where Cuvier’s dissection of Baartman’s body becomes an act of deliberate (and unique) racial exhibitionism, nevertheless characteristic of the period’s anatomical engravings that rely on detail, cataloguing, and microscopic outlines of the human form, Seacole presents the autopsy of the child’s body with a deliberate lack of these brushstrokes, drawing his form in only the broadest and most abstract lines.

Furthermore, her account deliberately thwarts the ends of the clinical gaze, obscuring not only process but product—she deliberately refrains from elaborating on the direct (perhaps unhelpful) results of her pursuit and coyly directs the reader away from that information by dismissing it as boring and already part and parcel of common clinical medical knowledge. Beneath Seacole’s gaze, the body of a small ethnic child is transformed from a body into a symbol of salvation, a martyr for a great and noble cause, as opposed to other ethnic bodies—like Baartman’s—sacrificed as a means to further their own suppression and disempowerment within a colonial system. In a chapter rife with descriptions of the suffering dead, Seacole claims that her autopsy is a “use” of the child’s body in a battle against disease, a battle in which illness and its “deathlike stillness” often triumphs. The death of the orphan child and the use of its body is a triumph against death. Immediately after the autopsy experience, Seacole writes that “the knowledge [she] had obtained thus strangely was very valuable to [her]” (31). Her experience with the child’s body, and its subsequent autopsy, rests in a careful, deliberate place in the text: after the initial, terrifying accounts of the cholera and the battle between life and death, and before Seacole’s own illness and the gradual fading of the epidemic. Seacole herself notes after accounting the autopsy that she has embarrassed herself with
early blunders in treating cholera, noting that more accurate knowledge could have saved lives; her own illness serves to exemplify the widespread inevitability of the epidemic. Yet, with her help, the epidemic did end, at least for a time. The speech of the American mentioned earlier—which unfortunately celebrates Seacole’s skills as a doctress at the expense of her race—says what Seacole will not allow herself to say and celebrates what Seacole accomplished “when the cholera was among us” (47). Too coy to gather the accolade herself, Seacole allows the uncouth American to say it for her. She fought and defeated cholera in Cruces. Moreover, she could not have done so without the sacrifice of a tiny brown boy whose autopsy was mentioned deliberately—not to titillate or to inform, but to commemorate his death and identity within the text. Seacole embeds the tiny orphan’s body as the turning-point in the cholera epidemic; instead of a mere casualty, the knowledge hidden with the boy’s body becomes the salvation of Cruces, and Seacole—not nearly so modest as her coyness would have her readers believe—becomes the empathetic doctor who transforms him into a unifying object of sympathy, nobility, and, ultimately, healing.

Even more intriguing, however, is the way in which Seacole transforms the ethnic body of this tiny child within her text. From origins as a “poor, little, brown-faced orphan infant” the child in Seacole’s view evolves into a “wee spirit,” then a “little body,” and finally a repository for hidden, mysterious, secret knowledge, a knowledge far removed from the sort that Cuvier sought to extricate, forcefully, from Baartman’s body even after her death (29). The body which clinical science has marked as frustratingly unknowable (and thus uncontrollable) can indeed be known (although perhaps not controlled), and has something important to teach. The primitive body contains something of irredeemable
value. And at its core, the little orphan is an ethnic body in every sense of the term. It is defined by embodiment, by its corporeality, by its materiality. Seacole emphasizes, repeatedly, that this body has no soul and that the soul has, indeed, ascended. Blake’s little black boy has no place here. No white soul, no white consciousness exists to illuminate this brown, undeniably ethnic body. Yet the very body which marks the child as ethnic, the same body coded with the markers of its lower place on a hierarchical scale of social order in the realm of clinical medicine, is the body which saves. And it saves nothing less than bodies on every rung of the social scale. Seacole textually ensures that the body is stripped of everything but its materiality before showing that this ethnically-marked, anatomically-differentiated body of the small brown orphan child can indeed save lives, even English lives, and provide lifegiving knowledge to a world in which it would have had no decent place. Even as the body comes to symbolize a noble sacrifice, with its ethnicity and its lack of societal value elided by its value in the saving of lives, Seacole preserves it in its very materiality as what it is: an ethnic body full of mysterious and life-giving knowledge. In a touching coda, Seacole takes pains to point out that she and her companion bury the body beneath a “piece of luxuriant turf” (30). Rather than dissect and display this ethnic body, Seacole returns its dignity, preserving it in earth as she does in text: as the turning-point of the cholera epidemic, a small savior, and a bastion of vital medical knowledge. In this case, Seacole’s deliberate insistence on her own empathy not only functions as a presentation of her ethnic body, but also as a means of reminding the reader of her innate femininity and nurturing spirit.

Other ethnic bodies reside within Seacole’s empathetic gaze, however, thanks to her unique experiences. After the cholera epidemic in Cruces and several travels and
business ventures, Seacole—determined to lend her aid to the wounded and fallen in the Crimean War—eventually traveled to the Crimea of her own volition to lend aid. There, on the front lines, she interacted with other ethnic bodies—bodies that were not brown, but villainized by Englishmen and woman for the simple fact that they were foreign bodies during a time of war. To be a foreigner during wartime, after all, is to epitomize the ethnic other. During war, as Youngquist puts it, “the pervasive cultural conviction” that the enemy “disfigures the health and wholeness of Great Britain” means that “war…is the best and only medicine” (173). The ethnic body—and in this case, the Russian body—is deviant in wartime because it is not English, and therefore harmful to the normative status of England; that body must, then, be destroyed. Yet Seacole does not attempt to destroy or eradicate these bodies. Rather, Seacole records a moving description of her treatment of ethnic bodies in wartime. “All death is painful to witness,” Seacole remarks, “even that of the good man who lays down his life hopefully and peacefully” (165). Immediately she upends what Youngquist identifies as the clinical condition of war—the determination to eradicate and annihilate the deviant body. Seacole professes an interest in preserving these deviant ethnic bodies, even the bodies that have fired at her and at soldiers she has come to know and love. Though she takes great care to emphasize her identification with English womanhood, Seacole is herself an ethnic body; her preservation of other ethnic bodies might be seen as an empathetic act of self-preservation. Unafraid to imply that even the enemy’s death is a cause of sorrow, she continues:
I derived no little gratification from being able to dress the wounds of several Russians; indeed, they were as kindly treated as the others. One of them was badly shot in the lower jaw, and was beyond my or any human skill. Incautiously I inserted my finger into his mouth to feel where the ball had lodged, and his teeth closed upon it, in the agonies of death, so tightly that I had to call to those around to release it, which was not done until it had been bitten so deeply that I shall carry the scar with me to my grave. Poor fellow, he meant me no harm, for, as the near approach of death softened his features, a smile spread over his rough inexpessive face, and so he died. (166)

Nor is this Seacole’s only account of lending aid to the Russians. Not much later she mentions attending to a dying Russian officer, who gives her a ring from his finger in exchange for her services. Seacole notes that his survival was unlikely, but writes that he “smiled far more thanks than I had earned” and notes that “many others, on that day, gave me thanks in words the meaning of which was lost upon me, and all of them in that one common language of the world—smiles” (166). For Seacole, healing is first and foremost not a transaction. She refuses compensation for the work that she does and, like many midwives and folk physicians during this period, often finds herself confronted with the necessity of helping those who cannot offer compensation for her trouble. Nor does she express any preference in healing. Rather, Seacole emphasizes a common rhetoric of sensibility among British, French, Russian, and Cossack: the rhetoric of gesture and gratitude, a language based in common understanding and shared feeling rather than logic, science, or law. By reinvesting these men with humanness, and with—
of all things—the ability to smile and express emotion, Seacole implicitly dismisses what Youngquist considers the inevitable caricature of the ethnic wartime enemy. By preserving the enemies as feeling, thinking beings with smiles on their faces, she restores the humanity of these men while not denying their ethnicity, demanding that the reader empathize with their pain, suffering, and gratitude while refusing to elide the truth of their position and part in the war.

Interestingly, Seacole juxtaposes these events deliberately with the plundering of dead Russian bodies by the French and also, presumably, by the English forces. Professing disgust at the crime of stripping the bodies of the dying and injured, she nevertheless makes a few attempt at plunder herself (167). Notably, she professes her own dissatisfaction with the practice and seems to imply that such an act amounts to a blasphemous act against the dead, emphasizing that her own attempts at plunder are weak, half-hearted, and do not result in much material gain. For Seacole, plundering itself is a deliberate assertion of her identification with the British national self against the warlike other—but the profanation of bodies by plunder, or the goal of material game, bears little relevance to her own personal mission. In making this slight but important distinction—by mimicking the act of plunder without gathering the spoils—Seacole codes herself as English but subtly reasserts herself against a tradition that declares the dead and dying fair game for theft; she attempts to preserve, through whatever means she can, the bodies under her control from the rude inspection of prying eyes and the removal of dignity after death. In her narrative, this interlude is juxtaposed curiously between battles, and Seacole’s treatment of the Russians occurs in the aftermath of the battle of the Tchernaya. In this case, the treatment of the Russian officers does not, as with the orphan Seacole
treats, symbolize a turning-point. Battles and artillery fire precede and follow the event. In fact, Seacole’s treatment of the Russian soldiers seems to be one small respite in an endless slog of gunfire, tension, and treatment of the wounded and dying. Yet Seacole’s mention of these Russians, and her humanization of them, preserve them in the text not just as men rather than monsters, but as sick men in need of a nurse—and what a nurse. Again, Seacole coyly immortalizes herself through these men, exhibiting the finest nurturing traits of British womanhood (handily witnessed by the Times reporter she spies on the scene). Repeatedly, she asserts her nurturing spirit and the identity of “Auntie Seacole,” as particularly English, noting that “a woman’s voice and a woman’s care” are synonymous with the English home (127). Frequently deploying images of herself as conscious of her clothing choices and her modesty, Seacole offers her audience a model of English female citizenship that her audience can expect and anticipate in the same manner in which they have anticipated Nightingale’s, while simultaneously subverting that model by her unique position as an ethnic body. In this, she differs from Florence Nightingale, who remained popular as an English figure primarily because she epitomizes English culture in a way that Seacole never does, or can, considering her ethnic identity. While Nightingale remains evermore “The Lady With The Lamp,” Seacole identifies as “Mami,” the Creole figure marked by her unusual, mystical knowledge, her wisdom, and her skin tone (163). That the men she treats during war are Russians as well as Englishmen or allies testifies to Seacole’s singular soft heart, her

29 In “‘A Female Ulysses,’ Catherine Judd offers a brilliant account of Seacole’s “oblique resistance” to English social norms, focusing on her rewriting of the Nightingale myth and the Homeric epic as focus points for her subversion of, rather than surrender to, the dominant culture.

30 Although the differences between Nightingale and Seacole are many and varied, most telling is the treatment of both women after their service in wartime. Seacole’s narrative and work rapidly faded from prominence and the public interest, and she suffered financially for her work in the Crimea.
mercy, and her devotion to healing, as well as her own place as an ethnic body. In preserving some aspects of the model of British citizenship and womanhood her readership comes to expect, Seacole also redefines her own subjectivity and reifies herself as an ethnic body with strong empathetic bonds towards other ethnic bodies. In healing Russian men, Seacole paradoxically strengthens England, becoming a living memorial of the British spirit worth fighting and dying for.

So deep is her compassion that Seacole even prevents a Cossack horse from being shot and, after having paid a French officer ten shillings to take it to the British Hotel for her, raises it as her own work animal and pet (167). Rather than leave the horse to die, Seacole first preserves it and then utilizes it, repurposing the animal while simultaneously emphasizing her respect for all living things. Seacole recasts the bodies of dying Russians not as the bodies of enemies, foreigners, or murderers, but as men. By emphasizing a common rhetoric between her Russian patients and her English ones, and by noting the gratitude that her patients show—as well as noting her own desire to help the suffering and the wounded regardless of ethnicity and othering—Seacole emphasizes their greater participation in humanity and in mankind in general, without eliding the injuries, wounds, and pains that mark them strictly as ethnic bodies during wartime.

Through preserving these ethnic bodies and reinvesting them with humanity, Seacole reinvests her own ethnic body—marked by its skin tone and devotion to folk medicine—with meaning as a curious emblem of the British spirit.

For Seacole—and for the many ethnic writers like Equiano before her—life was a long, hard lesson in the tensions of race, empathy, and understanding. With roots in empathetically-oriented medical traditions, and circumstances dictated by a society in
which the clinical gaze helped dictate the science that controlled their freedoms, she turns to autobiography as a way of reasserting her identity against those who would render her nameless or erase their identities from greater narratives. Because of her significant understandings of the empathetic gaze and its implications, Seacole is able to subtly and slowly reinvest the ethnic body with meaning by reestablishing its place within text, transforming it into a symbol of a greater good, and preserving its ethnic markers while simultaneously reifying its value and necessity to the heart of English culture.
CHAPTER THREE:

“THE BEST JUDGE OF HER OWN FEELINGS”: THE REPRODUCTION OF THE CLINICAL GAZE IN BELINDA

I. THE BREAST IN MARIA EDGEWORTH’S BELINDA

In the late eighteenth and early nineteenth centuries, the ethnic body was not the only abnormal body that invited medical study. The female body, too, provoked much debate and discussion, and in Maria Edgeworth’s Belinda the narratives that center on the breast—a prominent focal point of debate about anatomy, social roles, and femininity—exemplify the tension between the empathetic gaze and a more evolved version of the clinical gaze.

The ascendency of this topic in both medicine and literature accompanied health concerns of the period; breast cancer was a daunting fear for many young women, and accounts of mastectomies and various less invasive cancer treatments thrived in discourse principally through the letters, journals, and diaries of women familiar with the experience. Mastectomy, one of the most common but difficult treatments for breast ailments, provoked as much fear in women as the disease itself and was itself a hotly-debated topic among both physicians and the women they treated. The physician Thomas Munro speaks, in his Works, of one such woman who chose to submit herself to

31 In 1811, Frances Burney wrote an account of her brutal, barbaric mastectomy in a letter to her sister; the letter eventually becomes disseminated to both friends and family (Epstein 131).
32 Many ailments of the breast, particularly tumors, were generally diagnosed as cancer; Digby points out that physicians had no method to discern whether such tumors were malignant or benign. By the Victorian period, mastectomy had become the most common treatment for breast cancer, but Digby points out that even when the mastectomy was performed sparingly it was nevertheless “the most frequent of the few operations attempted before anesthesia” (273).
the ravages of a tumor rather than endure the pain of a mastectomy until the agony became unendurable either way:

She absolutely all the while refused to let it be cut off…[the advance of cancer] in a short time made her so miserable, that she was content to subject herself to the amputation of the breast, which was done successfully (485).

Successful mastectomies, however, proved rare; in many cases both “surgeon and patient lost contact,” several women reported the appearance of more tumors, and even more suffered from infection and disease brought about by lack of sanitation (Digby 274). Many women preferred conservative, traditional treatments for cancer rather than such a radical cure, but according to Digby, women in the eighteenth and nineteenth centuries “found less space to negotiate their viewpoint in the professional terrain of operatic surgery” (278). As a result, many women simply ignored their own ailment, or delayed treatment until mastectomy was nearly inevitable.\footnote{Digby reports, for example, that 22 percent of women admitted to the Middlesex Hospital Cancer Ward came seeking treatment six to twelve months \textit{after} discovering symptoms.}

Yet the horrors of breast cancer and its unenviable treatment methods did not serve as the sole topic of interest regarding the breast; breastfeeding in particular became a topic of concern during this period, and made its way into the realm of fiction. Julie Kipp, in \textit{Romanticism, Maternity, and the Body}, points out that many period novels function as a referendum on the multiple facets of the breastfeeding issue: the pressure on mothers, especially upper-class mothers, to breastfeed their own children, the stereotypes and myths associated with wet nurses, and the connection of child mortality to nursing
Julia Epstein notes in The Iron Pen that “late eighteenth-century medical writers discussed the nutritional and moral functions” of breastfeeding, even as they warned against “curb[ing] pleasure” during the process (78). And Elizabeth Kowalski-Wallace goes further to explore how the debate surrounding breastfeeding surpasses the merely medical, claiming that “as the issue of maternal breastfeeding is foregrounded in…medical texts, so is a series of themes about how the female body is to be positioned in relation to the family” (101).

Given the socio-medical fixation on the breast, diseases of the breast, and the utility of the breast during this period, it is of little surprise that Maria Edgeworth’s Belinda is a novel of contrasts and multiple narratives that center on the breast. Edgeworth herself knew several physicians, and so undoubtedly found herself exposed to varying degrees of medical discussion and debate, both specific and general. On the surface, Edgeworth’s novel functions, ostensibly, as a novel of manners. One of the central narratives focuses, after all, on the journey of the titular character as she learns to make her way in the world of high society and the marriage market, ultimately finding happiness in the arms of the once-irresponsible but appropriately besotted suitor, Clarence Hervey. Yet despite the novel’s title, the text gives the most time and the most compelling narrative to the dissolute, frivolous Lady Delacour and her wounded, seemingly cancerous breast: after sustaining the life-altering wound in a duel during a caper inspired by her radical, free-thinking friend Harriet Freke, Lady Delacour falls into a life of dissipation and despair. Her eventual recovery from the wound provides much of

---

34 Her sister, Anna, was engaged to Dr. Thomas Beddoes in 1793, and her father kept up an acquaintance with Dr. Erasmus Darwin (Oliver 32, 97)
the text’s momentum and, ultimately, a story of tragedy and redemption that refreshingly contextualizes Belinda’s enlightened, rational outlook.

Many critics agree that, fundamentally, Belinda is on many levels a novel about the breast. Kipp argues that the novel documents “the adverse, even tragic consequences of the pressure exerted on upper-class mothers to breastfeed against their inclinations” (42). This narrative, Kipp claims, results in the portrayal of the Lady Delacour as a “death-dealing mother,” one of many who abound in novels of the period (15). In “Colonizing the Breast,” Ruth Perry argues that the Lady Delacour’s story might be read as a festering resentment at the colonization of the body, and the breast itself as synonymous with poison and destruction (232), while Kowalski-Wallace argues, to the contrary, that Lady Delacour’s illness stems from immense guilt over an inability to breastfeed properly. The breast as poison, or as source of guilt, femininity, and sexuality figures heavily in Belinda, which references not only the cultural debates surrounding breast cancer and breastfeeding, but also larger issues related to femininity, domesticity, and motherhood. However, in exploring the symbolic value of Lady Delacour’s breast and the narratives that center on her vicious wound, critics neglect other, equally vital aspects of the medical narrative integrated into Belinda.

In Belinda, the breast not only serves as an emblem for the socio-cultural, domestic, and imperial narratives previously noted by critics, but also as a nexus between the clinical and empathetic gazes and specifically as a space in which Dr. X—, Lady Delacour’s physician, embodies an evolved, more reformatory version of the clinical gaze.

---

35 Several critics, including Ruth Perry in “Colonizing the Breast” and Susan Greenfield in “Abroad and at Home” also touch on the larger themes of colonialism in Belinda, emblematized not only by Lady Delacour’s breast, but by the loyal Juba’s body as well.
This gaze does not textually *erase* the abnormal body but instead reestablishes it as a proper body and, in so doing, creates an environment that renders females voiceless and against which they must push back with a rhetoric of reason and logic if they wish to be heard, further supporting the hegemony that silences them. This same gaze, which sees the male body as inherently more prone to logic, analysis, and rational thought, permits males and logical thinkers use and possession of the rhetoric innate to sensibility, even as through its application they devoice sensibility and render it silent. Moreover, in *Belinda*, Lady Delacour’s breast and its awful wound become the focal point of a triangulated act of gazing: within this triangulation, the clinical gaze polices dangerous erotic bonds and again reasserts the proper body against abnormality, while the presence of the empathetic gaze helps to maintain a disruption of the political and social realms both within and without these bonds. When that empathetic gaze withdraws, the clinical gaze not only provides a space in which the normative body can exist, but in which the gaze itself can thrive.

II. THE GOOD PHYSICIAN: DR. X—’S DEPLOYMENT OF THE CLINICAL GAZE IN BELINDA

On the surface, the relationship between Lady Delacour and her physician Dr. X— emblematizes the influence of the clinical gaze at the abnormal body as well as the battle between the medical mainstream and its wilder fringe elements. However, Dr. X— differs from type in his deployment of the clinical gaze, balancing his consuming desire for knowledge and understanding with good character, kindness, and general expertise.
Throughout the text, Dr. X—, emblematic of the ideal physician, embodies the noble physician and indeed functions as the largest contributing factor behind Lady Delacour’s recovery from the awful wound she receives to her breast during a duel. A favored friend of Belinda’s, Dr. X— is more than a mere doctor; that is to say, he is precisely the best kind of doctor because he excels in many areas beyond medicine. Dr. X— is a doctor not just of the body, but also of the mind and soul: he is a thoroughgoing humanist. He has “a great literary reputation,” and is shown throughout the novel engaging in academic debates about various subjects. A “well-bred man,” he possesses sensibility, manners, and good behavior in abundance, and finds himself much admired by all his company—not just because of his medical skill, but because he is a renowned writer and thinker (113). Belinda, in particular, is impressed by him, and acknowledges that Dr. X— is such a discerning, wise man and a judge of character that she need not “display…her abilities and accomplishments,” for the good doctor can discover them on his own (113).

Nor is his character divorced from his ability to practice medicine. In fact, his character imparts to his profession greater renown and skill. The novel’s narrator describes Dr. X—’s treatment of the Lady Delacour in the following terms:

Dr X—, well aware that the passions have a powerful influence over the body, thought it full as necessary, in some cases, to attend to the mind as to the pulse. By conversing with Lady Delacour, and by combining hints and circumstances, he soon discovered what had lately been the course of her reading, and what impression it had made on her imagination. Mrs Marriott, indeed, assisted him
with her opinion concerning the methodistical books; and when he recollected
the forebodings of death which her ladyship had felt, and the terror with which
she had been seized… he was convinced that superstitious horrors hung upon his
patient's spirits, and affected her health. To argue on religious subjects was not his
province, much less his inclination; but he was acquainted with a person
qualified by his profession and his character 'to minister to a mind diseased,' and
he resolved on the first favourable opportunity to introduce this gentleman to her
ladyship (327).

Additionally, he requests that Lady Delacour “abstain gradually from opium.” In all of
these instances, the doctor represents the mainstream medical model of the caring
physician, one indeed similar in practice to George Cheyne, famed for his prescriptions
of moderation and his alteration of patient’s habits and routines. The physician’s attention
focuses not solely on the symptoms and physical problems of his patient, but also on her
beliefs, fears, and reading habits. His diagnosis relies on equal parts deduction and
intuition—his “combining…of hints and circumstances”—and interaction with the
patient herself, and with her own understanding of her condition. In this, Dr. X— shows
himself a physician eager to gain his patient’s trust and maintain his reputation as a
sensible, knowledgeable, but caring man; he relies on both physical and intellectual cures,
demanding opium withdrawal but also prescribing proper company and proper reading.
In order to be an appropriate doctor, the physician must deal not only with the body and
its sickness, but also with the organic causes of it: the spirit, the intellect, the heart. In
order to do this, Dr. X— must himself prove beyond reproach, and a good deal of his
presence in Belinda serves to underscore his credibility, his humanity, his compassion and his good sense—even borrowing from the rhetoric of sensibility most often endemic to female caretakers and male midwives who adopt it to strengthen their own credibility with the women they treat.

Moreover, Dr. X—‘s position as Lady Delacour’s savior—in more ways, perhaps, than one—further establishes him as a hero, and the contrast between Dr. X— and Lady Delacour’s first doctor, a quack, further underscores the physician’s nobility and desire to place the patient ahead of personal gain:

In the meantime her ladyship's health rapidly improved under the skilful care of Dr X—: it had been terribly injured by the ignorance and villainy of the wretch to whom she had so long and so rashly trusted. The nostrums which he persuaded her to take, and the immoderate use of opium to which she accustomed herself, would have ruined her constitution, had it not been uncommonly strong (326).

The “wretch” preys on Lady Delacour’s vulnerability; hungry for money, he not only misdiagnoses her, but persists in deluding her as to her own condition. Deceiving Lady Delacour into believing that “she had a cancer…though her complaint arose merely from the bruise she had received,” the quack actually causes her harm: “He knew too well how to make a wound hideous and painful, and continued her delusion for his own advantage.” Nor does he solely delude Lady Delacour; his deception touches the maid Marriott as well, who says that she “was contradicted for [the quack’s] own ‘molument” when she claimed that her ladyship could not “have such a shocking complaint” (325).
Here the quack is charged not only with “ignorance,” but also with “villainy,” as though to underscore the nature of his accountability for the error, and also to emphasize the correlation between character and career. As a man’s nature goes, so goes his medical practice.

Moreover, the only remedy for this sort of wickedness is good character and, most especially, proper medical knowledge, the sort of knowledge Dr. X— possesses in abundance. Having realized the extent of the quack’s deception, Dr. X— laments that such a problem lasted so long. “If the Lady Delacour had permitted either the surgeon or him to examine into the real state of the case,” he claims, “it would have saved her infinite pain, and them all anxiety” (325). In this binary, the quack represents malicious intent, greed, and ignorance, while Dr. X— represents benevolence, compassion and—most importantly—knowledge. That this knowledge is accompanied by an assured arrogance and Dr. X—‘s understanding of his own necessity to any true healing process is leavened in the novel by the fact that Dr. X— lives up consistently to his opinion of himself, as well as to the opinions of everyone else around him.

And what opinions! The physician, in Belinda, becomes almost godlike in his influence and impact. When Dr. X— reprimands Mr. Hartley with “a tone of command,” and requests that he not leave to go anywhere, the narrator notes that Mr. Hartley responds immediately, and “more readily than to reason” (416). Hartley listens to Dr. X— more readily than to reason because the wonder of Dr. X— is that he is better than reason. The physician not only represents the surety of reason, wisdom and knowledge underscored by good character, education, discernment, and benevolence, but also, in Belinda, comes to represent the necessity of, the usefulness of, the mainstream medical
community as a second brain for the layman. Within the text, Dr. X— practically functions as an advertisement for all properly-educated and trained physicians within the mainstream medical establishment though he is, indeed, an anomaly. The latent implication of Belinda is that no doctor but Dr. X— could have ultimately helped resolve all these matters, and his presence and actions are integral to the satisfactory and proper ending to the story.

Admittedly, in addition to all the attributes that render him an atypical possessor of the clinical gaze, Dr. X— does exemplify some characteristics of the clinical gaze in a more innocuous form; his abiding interest remains not necessarily healing, but knowledge, and he traffics in it incessantly, constantly engaging in intellectual debates and name dropping. When visiting Lady Anne Percival’s home, Dr. X— encounters two of her children in possession of a fish in a fishbowl:

Dr X—, who was a general favourite with the younger as well as with the elder part of the family, was seized upon the moment he entered the room: a pretty little girl of five years old took him prisoner by the flap of the coat, whilst two of her brothers assailed him with questions about the ears, eyes, and fins of fishes. One of the little boys filliped the glass globe, and observed, that the fish immediately came to the surface of the water, and seemed to hear the noise very quickly; but his brother doubted whether the fish heard the noise, and remarked, that they might be disturbed by seeing or feeling the motion of the water, when the glass was struck (100).
Dr. X—, inspired by their interest, observes that this is “a very learned dispute, and that the question had been discussed by no less a person than the Abbé Nollet.” He goes on to relate “some of the ingenious experiments tried by that gentleman, to decide whether fishes can or cannot hear.” Admittedly, the passage bears a certain wry, tongue-in-cheek quality, and the warmth of Dr. X— in so seriously addressing the trivial inquiries of little ones, as though privy to a great academic debate, supplements his benevolent, giving image. Yet the passage in itself is also amusing and revealing: Dr. X— cannot resist any opportunity to enter debate and flaunt his knowledge, even about something so trivial as goldfish (or, to his view, something so significant as natural history and animal biology). Just as he enters into debates about poetry and academic matters, the physician enters into small and insignificant affairs armed with names, knowledge, and plenty of education. It is this knowledge that accords him respect and significant social standing. It is this knowledge, additionally, which allows him to offer a seemingly unending stream of thoughts and opinions, some of which bear questioning and thorough reexamination. For Dr. X—, as for most mainstream physicians, knowledge confers both power and advancement.

In a conversation with Clarence Hervey about Belinda that also incorporates more than a little high-blown sentiment and poetic grandeur, he dismisses the usefulness of poetic hope and metaphor by stating that “‘in judging of the human character, we must not entirely trust to analogies and allusions taken from vegetable creation’” (113). Here the physician’s logical, rational, and methodical approach to the perception of Belinda flies directly in the face of the enthusiastic, emotion-centered approach of Hervey, whose “fears are almost as precipitate as [his] hopes.” The kind of knowledge that Dr. X—
values is not based in feeling, instinct, and sensibility, but rather in observation and analysis. In fact, he notes to Hervey that “I must see your Belinda act, I must study her, before I can give you my final judgment.” Under Dr. X—’s eye, even the lovely Belinda herself is reduced to a specimen to be studied and analyzed.

In another conversation with Hervey, Dr. X— dismisses the usefulness of children’s portraits in hypothesizing the features of adults: “there is scarcely any possibility of judging, from the features of children, of what their faces may be when they grow up. Nothing can be more fallacious than these accidental resemblances between the pictures of children and of grown-up people.” In so saying, Dr. X— again dampens Hervey’s enthusiasm and unintentionally, perhaps, disappoints Mr. Hartley, whose “countenance [falls]” upon hearing the pronouncement. Intuition, imagination, instinct— for Dr. X— such notions have little intrinsic value, and no use at all in making judgments or taking action. Yet even though Dr. X—’s looking is characterized by the desire for knowledge—a trait characteristic of the clinical gaze—his character and his ability to prioritize his patient’s well being over knowledge-gathering renders him somewhat atypical.

The more malignant aspects of Dr. X—’s clinical gaze, however, come into play throughout the text as Dr. X— treats Lady Delacour and, eventually, cures her; though his gaze does not entirely erase her from the text, and does not mutilate or dissect her abnormal body in an attempt at knowledge-gathering, his gaze instead reforms her abnormality, reestablishing her a proper body and, in the process, erases her textual
presence by rendering her largely voiceless, a phenomenon starkly highlighted by her speech at novel’s end.  

If Dr. X— can be said to have a foil in Belinda, after all, that foil is not the malicious quack whose negligence and villainy almost kills Lady Delacour but, rather, Lady Delacour herself, who serves as the abnormal body beneath his gaze and amusingly compares herself in her earliest confessions to Belinda as Princess Scheherazade. The provocative associations summoned by the allusion—Scheherazade’s fame as both a Queen and a spinner of imaginative, near-endless stories spoken to save her own skin—emphasizes Lady Delacour’s role as the counter to Dr. X—‘s worldview and, thus, the counterpoint gaze to Dr. X—‘s clinical way of medical looking.

Given to vapidity, flights of fancy, and dissolution, Lady Delacour initially remains one of Belinda’s most tightly-bound quandaries. Arguably one of the most self-centered, selfish, and whimsical characters in the novel, she nonetheless carries the heaviest burdens: the threat of lingering death, a crumbling marriage, an embarrassing past. Her behavior—wild, inappropriate, and sometimes inexplicable—both contrasts with and lends support to Belinda’s central position in the novel as the voice of reason and the embodiment of good sense, proper manners, and general decency. Although she acts as a catalyst for many of the novel’s events, and indeed pushes many of them into motion herself, Lady Delacour often functions with little agency, captive to her woes, her circumstances, her past, and her sorrows. And, although she cloaks much of her past,

36 That Lady Delacour is a white, upper-class woman bears comment here; she is spared the mutilation and dissection perpetrated on ethnic bodies whose rehabilitation and reformation bear less cultural value and significance.

37 Jordana Rosenberg in “The Bosom of the Bourgeoisie” offers an extended analysis of Belinda as Edgeworth’s model of Enlightenment thought and an agent of demystification within the text.
her guilt, and her illness in secrecy, her voice throughout much of the text remains astonishingly frank and candid, if at times self-pitying and dramatic.

More importantly, Lady Delacour’s presence as an abnormal body resonates with a particular richness through the text; not only is she a woman, and thus a general anomaly in the realm of medical science, she also bears a grotesque, disfiguring wound on her breast. Referred to as a “hideous spectacle,” the wound effectively disfigures her body doubly—first aesthetically, and also sexually. While Lady Delacour’s gender renders her a mysterious (and sometimes uncontrollable) body, her wound degrades her body further—there is no question that Lady Delacour’s body, in many senses, represents abnormality to the point of grotesquerie. And, Lady Delacour’s admittedly unfortunate luck with childbearing, her unwillingness and inability to breastfeed, and her seeming lack of regard for her dead children also represent the darker, more mysterious aspects of the female body:

*I forgot to tell you* that I had three children during the first five years of my marriage. The first was a boy: he was born dead; and my lord, and all his odious relations, laid the blame upon me, because I would not be kept prisoner half a year by an old mother of his, a vile Cassandra, who was always prophesying that my child would not be born alive. My second child was a girl; but a poor diminutive, sickly thing [who later died] (40, emphasis mine).

Although many eighteenth and nineteenth-century women shared similar experiences, the abnormality within the female body that bears a dead child, a sickly child, and a healthy
child further illustrates the daunting mystique and unpredictability of the body as childbearing instrument; additionally, Lady Delacour’s own emphasis on her lack of desire to nurse the third child, and her self-proclaimed barbarism in refusing to raise her living child, further seal the understanding that some deviance, some flaw exists in her very bones. In many ways, the grotesque wound that Lady Delacour hides is a mere physical manifestation of the abnormality and deviance—manifested in her inability to properly reproduce and her manner towards both her children and breastfeeding—that form her very body and identity.

In her abnormality, and perhaps because of it, Lady Delacour is also, perhaps, one of literature’s worst patients. Dr. X— finds her particularly trying, and her dramatics—while providing some good-natured humor in the novel—often frustrate the designs of those around her. Initially Lady Delacour has to be persuaded into treatment for the wound on her breast, and even when in treatment, she resists the doctor’s recommendations. When Dr. X— recommends that the surgeon determine the cause of her wound, Lady Delacour is absolute in her refusal, and offers her reasoning:

'I will tell you my reason,' said she; 'and then you will have no right to be displeased if I persist, as I shall inflexibly, in my determination. It is my belief that I shall die this night. To submit to a painful operation to-day would be only to sacrifice the last moments of my existence to no purpose. If I survive this night,

38 Lengthier and more elaborate discussions of Lady Delacour’s perceived abnormality as it relates to English conceptions of femininity and motherhood can be found in Perry’s “Colonizing the Breast,” Kipp’s Romanticism, Maternity, and the Body Politic, and Epstein’s The Iron Pen.
manage me as you please! But I am the best judge of my own feelings – I shall die to-night’ (314).

Her declaration is met with skepticism, to say the least. Dr. X— regards her with both “astonishment and compassion,” and no little degree of condescension. Declaring that she is feverish and out of sorts, the physician commands both Belinda and the surgeon to stay by her until the flight of fancy departs. For Dr. X—, it is impossible to conceive that Lady Delacour might be speaking clearly and in her own mind, or that she might actually have seen the likeness of a dead man, Colonel Lawless, with whom she and Harriet Freke went on an ill-advised caper. Lady Delacour, aware that she is being humored and with “sufficient penetration to perceive that they gave not the least faith to her prognostic,” nevertheless exemplifies that she is not suffering from a feverish whim: she remains serious and capable in conversation, almost as if to clarify her own lucidity. Later, when the doctor changes his diagnosis of her whimsy from sickness to caprice—accusing her of punishing others through her own ill temper—Lady Delacour persists in her belief that she will die, citing a vision that has appeared thrice to prepare her for her impending doom. As if to further aggravate her solemn, sensible counterparts, she insists that “it is no vain imagination—I must die,” and recites a small snatch of poetry to that end before commenting, “You perceive that I am in perfect senses…or I could not quote poetry. I am not insane—I am not delirious.” To Dr. X—, who previously warned of the fallacious nature of poetic metaphor, this poetic provocation seems a textual rebuke of sorts, and a further indication of Lady Delacour’s determination to prove that she, and no one else, is “the best judge of [her] own feelings.” For Lady Delacour, despite all
attempts to convince her to the contrary, refuses to deny what she *knows*, to the best of her own information about her condition, to be true.

Lady Delacour’s extreme self-awareness and perceptiveness is telling. She is not, as events will later prove, hallucinating; she does indeed see *something*, or, rather, someone—Harriet Freke dressed in men’s clothes, tramping around outside. More to the point, Lady Delacour is entirely accurate in her diagnosis of her own nature and mindset. She, alone of all her companions, proclaims her clarity, understanding, and sobriety; Dr. X—not only disregards her own claims regarding her health, but diagnoses her initially as nervous, feverish, and then as capricious—catchall terms often used to explain away the instincts, intuition, and imagination prevalent in females. Barker-Benfield points out in *The Culture of Sensibility* that, as the rhetoric of sensibility permeates medical culture, diagnoses of nerves, capriciousness, and feverishness more often than not simply indicate a recognition of the mysterious nature of the female body; the diagnoses themselves code a latent understanding that any fluke of the female condition can simply be assigned to a disorder of sensibility and feeling. From the eighteenth century onward, nervous disorders themselves become simultaneously debilitating and useful to women; while they provided women the chance for respite, community, and solitude, they also reified conceptions of them as weak, easily prey to emotion, and beyond any logical medical understanding. Dr. X—’s diagnosis of Lady Delacour first as nervous and then as capricious implicitly functions as his admission of his *inability* to understand her. For Dr. X—, the supremely logical and analytical mind, Lady Delacour proves incomprehensible to all but herself.
And, notably, nearly all of Dr. X—’s suppositions regarding Lady Delacour are incorrect. Although the physician may well know the nature of illness, Lady Delacour knows herself as well as the nature of her own mind and body, and her understanding of her own condition and its effects—while augmented by events occurring outside her understanding—is not inaccurate. In this, Lady Delacour holds more knowledge than the physician himself. And, in fact, within the paradigms of given knowledge, one might say that Lady Delacour’s understanding of her own condition is entirely correct, while Dr. X—, in his condescension and his ‘understanding’ of the female mind, misdiagnoses the situation not once, but twice. Lady Delacour does see a vision, and the vision resembles a man. She misunderstands the identity of her visitor to be a dead man come back from the grave, but her misunderstanding is certainly forgivable; she is ill, under the effects of opium, and haunted with memories of her seemingly unforgivable past. Dr. X—, meanwhile, repeatedly chalks up her vision and proclamations to nothing more than a disturbed imagination. Were it not for Lady Delacour’s insistence on the vision, and the fact that Belinda happens to catch a glimpse of the disguised Harriet Freke, Dr. X—‘s diagnosis would remain acceptable—would, indeed, have dictated circumstances rather than Lady Delacour’s understanding of the matter.

Perhaps most damning in the novel’s portrayal of Dr. X—‘s gaze, however, is the fact that despite his manner of looking he cures nothing at all, because there’s nothing to cure: an empty victory at best, and a display of impotence at worst. After Lady Delacour’s ‘surgery,’ as Helena and Lord Delacour wait anxiously for news, Marriott comes to inform them that all is well. Assuming the surgery has already occurred, Lord
Delacour and Helena marvel over the fact that the lady endured it “without so much as a single shriek,” only to be told by Marriott that “there’s no need of shrieks, or courage either, thank God….Dr. X— says so, and he is the best man in the world, and the cleverest” (323). For Lady Delacour, ultimately, there is no need for lifesaving measures, and Dr. X—‘s contribution to her health is simply to reassure her with his own authority (which echoes Marriott’s previous claims) that she has been duped and nothing devastating, in fact, is wrong with her. Marriott’s praise in this case is amusing; Dr. X— earns the title of best and cleverest man by doing absolutely nothing at all and by echoing her own diagnosis.

It is Marriott, and not Dr. X—, in this case, who first identifies the misunderstanding of Lady Delacour’s complaint, but it’s Dr. X— who must verify it for it to become a reality; he thus becomes the healer of the condition, whose expertise is necessary for the process of recovery. In Belinda, the clinical gaze determines reality through what it sees: if the clinical gaze sees a healthy body, then the body is healthy, and if the gaze sees a diseased mind, the mind is diseased. If any other sort of gaze views the body as either healthy or diseased, that gaze remains irrelevant. In Belinda, Dr. X— serves as a savior simply by seeing what already is, by studying and analyzing what previously exists, and then concluding its actuality in a way that confirms his own superiority. By ultimately looking at Lady Delacour and agreeing with Marriott’s initial assessment that she is not terminally ill, the physician heals her without performing a single medical act aside from looking. The moment is an ironic one: the clinical gaze by itself is enough to settle her recovery, but it undermines Marriott’s previous diagnosis by its implied penultimate ‘superiority’ and Marriott’s acquiescence that the physician is
“best” and “cleverest” even at the relative dismissal of her own abilities and understanding.

Most disturbing in this particular passage is that Dr. X—’s clinical gaze allows him the right and ability to speak over Marriott, replacing her assertions and understandings with his own (seemingly more valuable) ones; here, as he repeats this act on a grander scale to re-voice, and essentially silence, Lady Delacour, the harsh and reformatory aspect of the clinical gaze comes to the fore. After observing his patient, he analyzes her visions and assertions in the language of nervousness and sensibility, coding her as weak and deluded, though in fact her claims regarding the matter prove, in all reality, that she is at least somewhat lucid and self-aware. Dr. X—’s analysis of Lady Delacour proves damaging in several ways: not only does he subvert her voice in the text with his own, and thus convince Belinda, Helena, Marriott, and the surgeon that she is deluded and nervous, but he also—by identifying her as victim of a nervous illness—effectively reminds her and her family of her dissipation, since the diagnosis of nerves in the female body also codes “an appetite…for consumer pleasures” and “pleasure-seeking wishes” (Barker-Benfield 30-31). In this way Dr. X— not only reduces Lady Delacour back to the sum of the pleasures and frivolities which define her reputation, but also burnishes his own reputation as a voice of truth, reason, and logic in opposition to this mindset.

In both Belinda and other Romantic novels, the clinical gaze sees the female body not only as mysterious and unknowable, but also as biologically wired for deep feeling, high passions, and overwhelming emotion. Although in the early eighteenth century this biological understanding of the high sensibility in women, propagated by physicians like
Cheyne\textsuperscript{39}, implies wealth, affluence, creativity, and imagination—as well as susceptibility to irrationality, nervousness, and overwhelming passion—by the Romantic period it also comes to code a certain textual voicelessness for women. Though Lady Delacour certainly ‘speaks’ at novel’s end—she gives the final speech, and has a hand in arranging Belinda’s marriage—these incidences only prove her reintegration into the domestic sphere that renders her speechless. She no longer speaks for herself and her own deviant body, but for the proper female body and its place in society. The clinical gaze, viewing the female body as both a fount of mystery and susceptible to its capacity for high feeling, renders the textual voice of the female mute through its knowing authority and essentially erases the female’s presence in the text in favor of a superior masculine voice that can study, analyze, and “know” the female body.\textsuperscript{40} Contrast Dr. X—’s treatment of Lady Delacour’s perceived nervousness with the treatment certain nervous male figures in Romantic literature receive. In Jane Austen’s \textit{Emma}, Emma’s father, Henry Woodhouse, possesses a nervous sensibility that makes Lady Delacour’s pale in comparison: “His spirits required support. He was a nervous man, easily depressed; fond of every body that he was used to, and hating to part with them; hating change of every kind.” Mr. Woodhouse, gifted with a sympathetic physician who caters to his needs on all occasions, is upset by even the happy news of his daughter’s marriage; frets constantly over changes in the weather, food, and routine; finds brisk walks “shocking”; and has been, as Austen puts it, “a valetudinarian all his life.” Yet his nerve-

\textsuperscript{39} Anita Guerrini offers an intriguing analysis of Cheyne’s analysis of female nerves and sensibility in \textit{The Hungry Soul}, acknowledging that not only are women in Cheyne’s view more biologically predisposed to high sensibility because of finer, more delicates nerves, but also because they are psychologically more susceptible to “luxury and other social pressures which led to hysteria” (281).

\textsuperscript{40} Dr. X—’s way of looking might indeed be said to embody Mellor’s conception, articulated in \textit{Romanticism and Gender} of the gendered struggle present in Romantic writing as a whole: a struggle in which female writers must adopt a Wollstonecraftian rhetoric of sense in order to be heard.
inspired beliefs and needs determine his daughter’s very wedding day (and nearly postpone her marriage):

When first sounded on the subject [of Emma’s marriage], he was so miserable, that they were almost hopeless.---A second allusion, indeed, gave less pain.---He began to think it was to be, and that he could not prevent it---a very promising step of the mind on its way to resignation. Still, however, he was not happy. Nay, he appeared so much otherwise, that his daughter's courage failed. She could not bear to see him suffering, to know him fancying himself neglected; and though her understanding almost acquiesced in the assurance of both the Mr. Knightleys, that when once the event were over, his distress would be soon over too, she hesitated--she could not proceed.

By contrast, Dr. X—discounts Lady Delacour’s complaints by coding them as frivolous and dramatic, and rewriting his own narrative on top of them: rather than see a vision, she is merely feverish; rather than have a justified fear of death and doom, she manifests caprice. Mr. Woodhouse, by contrast, has his nervous fears verified and supported; his fears triumph to a degree over Knightley’s logical and methodical assurances, and his subsequent nervous panic over a rash of chicken-coop robberies ultimately results in both the settling of the wedding day and the return of his daughter and her new husband to his home, Hartfield. Lady Delacour’s nervous narrative is dismissed and reinterpreted by Dr. X—; Mr. Woodhouse’s nervous narrative determines the final narrative of Emma. Lady’s Delacour’s fears and beliefs, endemic to her abnormal body and springing from
its mystery and its biological nature, require dismissal and disavowal, regardless of whatever truth they might indeed hold; Mr. Woodhouse’s comically nervous fears, not biologically endemic but imbued with their own special kind of logic, secure and cement his desires and wishes. The contrast between Woodhouse’s nervousness and Lady Delacour’s brings into stark relief the understanding that such sensibility in women will not be endured because it interferes with their public and private role in a way that male sensitivity does not.

Most poignant in this discussion of nervous sensibility in the eyes of the clinical gaze remains the fact that Lady Delacour, despite being accurate in her perception of a vision near her room, is dismissed and, ultimately, transformed beneath the clinical gaze as a result of the apparitions whose sight she has claimed. Despite the proof of her sighting and the capture of the roguish Harriet Freke, Dr. X— merely refocuses his attention on the nervous sensibilities innate to Lady Delacour’s abnormal female biology. In prescribing cures, Dr. X— takes into consideration the “forebodings of death which her ladyship had felt” and the “terror with which she had been seized” and decides that “superstitious horrors” hang upon her spirits (327). As a result, he prescribes both a change in reading habits and in company, requesting that “a person qualified by his profession and his character to ‘minister to a mind diseased’” be sent to converse with Lady Delacour. Rather than credit Lady Delacour with at least some truth regarding the nature of her observations—for surely she deserves some consideration having had the disguised Freke hovering outside her rooms and being overwhelmed every day by thoughts of her impending tragic death from her injury—Dr. X—’s clinical gaze sees only the evidence of high sensibility and delusion, and reacts accordingly. In this case,
the clinical gaze not only deliberately avoids the full diagnosis of Lady Delacour’s vision, but rather focuses on clinical assumptions regarding the sensibility of the abnormal female body in order to prescribe habits intended to help her function as a more virtuous wife, mother, and friend. Ultimately, Dr. X—‘s clinical gaze does more than attempt to learn, study, and heal Lady Delacour’s body; the clinical gaze seeks to reform it, stifling the abnormal and mysterious elements of her disposition while encouraging those which define her role as a wife and mother. The true triumph of the clinical gaze in this case is not the anti-climactic discovery of Lady Delacour’s lack of terminal disease, but rather the diagnosis of her abnormal body as contributing to her dissolution, and the restoration of that body to its proper place in the social order.41

III. BROKEN BONDS: THE TRIANGULATED EMPATHETIC GAZE IN BELINDA

That isn’t to say, of course, that the empathetic gaze at the abnormal female body has no place in Belinda or in Romantic texts. The theme of female friendship is vital to Belinda, and it is within these homosocial bonds that both the clinical and empathetic gazes manifest and influence the function of normal and abnormal bodies. In “ ‘Something More Tender Still Than Friendship,’” Lisa Moore identifies two different kinds of what she calls “romantic friendships” within Belinda and other, similar novels: the first, a friendship noble and virtuous in every way, devoid of transgressive agency and devoted to reinforcing familial bonds through the mimicry of sisterhood; and the second, a transgressive, disturbing, relationship that functions as a “self-conscious representation

41 Though this might not be a total triumph given Lady Delacour’s refusal to submit to surgery; she evades pain and, possibly, further disfigurement.
of homosexual desire” (501-503).\footnote{In the article, Moore focuses specifically on the second type of friendship, one she considers neglected in the broader realm of criticism on female romantic friendship.} In Belinda, the bond between Lady Delacour and the title character embodies the innocence and virtue of the first type of friendship; the bond between Lady Delacour and Harriet Freke, on the other hand, embodies the transgression and disruptive desire of the second. The three women occupy a troubling, triangulated bond, with Lady Delacour as the center; the result is a “troubling equation [involving] two characters who are supposed to be moral opposites” (506). Within this triangulation, defined by the two romantic friendships Moore identifies, Lady Delacour’s empathetic gaze at Freke allows Freke to function as a disruptive force of the abnormal body within the confines of their inherently disruptive social bond; Belinda, by contrast, in possession of an atypical clinical gaze that mimics Dr. X—’s, seeks to nullify disruptive force. Ultimately, in Belinda, the presence of the clinical gaze polices homosocial bonds that might prove dangerous or disruptive to male-dominated society, and also reinforces proper female bodies; the empathetic gaze, however, perpetuates the preservation of the abnormal female body and all its disruptive force both within and without a transgressive social bond—at least until the gaze is withdrawn, providing a space in which the normative body (and the clinical gaze) might reassert itself.

The bond between Lady Delacour and Harriet Freke encompasses so much disruptive and transgressive energy at least partially because it is a bond, on its very surface, between two abnormal female bodies.\footnote{For a more in-depth discussion of the aberrance of the Freke/Delacour homosocial relationship, see Ruth Perry’s “Colonizing the Breast,” in which Freke embodies Delacour’s attempt to escape her heteronormative role, Katherine Binhammer’s “Thinking Gender with Sexuality,” or Susan Greenfield’s “Abroad and At Home.”} Lady Delacour’s abnormal body, with its disfiguring wound, actually pales in comparison to Harriet Freke’s, whose abnormality
symbolizes and parallels her aberrant genderplay. Indeed, in Belinda Freke is presented as a particularly unusual and highly reviled sort of abnormality: one who “has laid aside the modesty of her own sex, [but] ha[s] not acquired the decency of the other.”

Freke exists between two poles of gender, and—as her resonant last name indicates—the placement renders her an even more incomprehensible riddle than the typically mysterious, unknowable woman.\footnote{44 The word “freak,” phonetically recalled by Harriet’s last name, bears connotations of caprice, abnormality, and departure from the normative standard as far back as the early 1700s.} \footnote{45 In this, Freke merits, perhaps, the same response Mary Wollstonecraft provoked from Richard Polwhele in his vitriolic “The Unsex’d Females:” Survey with me, what ne’er our fathers saw, / A female band despising NATURE’s law, /As "proud defiance" flashes from their arms, /And vengeance smothers all their softer charms” (11-14). Morris, in fact, theorizes that Freke serves as Edgeworth’s satire of distinctly Wollstonecraftian ideals (505).} Declaring herself a champion for “the Rights of Woman,” Freke is nonetheless accused by Lady Delacour of having “no more feeling than this table” (65). Freke parades through the text bereft of sensibility, feeling, and the “false delicacy” inherent to the mystique of womanhood, while assuming the “brass” behaviors and audacity of the male sex. Yet despite her self-identification with the movement Mellor identifies in Gender and Romanticism—a movement of women who, like Mary Wollstonecraft, determine to adopt for themselves a rhetoric of logic, caution, and virtue—Freke never quite acts in a manner consistent with logic, caution, or virtue, seeming to prefer a rhetoric of audacity, candor, and harshness. Moreover, while the medical abnormality of the female body often lies in what is unknown and unrevealed, Freke becomes abnormality doubled: as a female she still bears an unknowable body, but her choices to reveal her body—both literally and figuratively—further confound any real understanding of her nature.
One of the most exemplary moments of Freke’s abnormal body occurs when, in a discussion with Belinda and some of the others, she prepares to take her leave at the end of a conversation:

'I know nothing of the Lacedæmonian ladies: I took my leave of them when I was a schoolboy – girl, I should say. But pray, what o'clock is it by you? I've sat till I'm cramped all over,' cried Mrs. Freke, getting up and stretching herself so violently that some part of her habiliments gave way. 'Honi soit qui mal y pense!' said she, bursting into a horse laugh. (236) 46

Here, Freke deliberately mis-references her gender and draws attention to her more masculine behaviors in an attempt to unsex herself, or at least imply ambiguity about her nature, yet her female body is underscored by the sudden unfortunate (if perhaps not accidental) movement of her clothes. The breach is unallowable precisely because her body is female and must not be viewed in such a manner. Freke’s indelicate stretching and her masculine, overt movements and behaviors subvert the very masculinity she attempts to portray by indicating the constraints of her femininity. And, throughout the novel, many of Freke’s audacious, “brass” behaviors serve the same purpose: in efforts to subvert her abnormal female body, or in attempting to work around it, Freke simultaneously reveals it and draws attention to herself, eventually replacing Lady Delacour as the novel’s spectacle and reminding the readers that, in one way or another, the female body is always an object of display and investigation. In a curious way, her

46 Freke’s “Lacedaemonian ladies” refer specifically to women from Sparta in ancient Greece, a militant society characterized by battle prowess and a strongly masculine culture.
behaviors (perhaps not unintentionally) draw *more* attention to her gender, just as her attempts to flout convention spawn a new trend that Lady Delacour refers to as “harum scarum manners.”

Later, Freke, too, suffers a double-abnormality just as Lady Delacour does—her deforming leg injury occurs during her efforts to unmask Lady Delacour’s perceived infidelity. As with Lady Delacour, the injury damages a part of her body fundamental to her character and self-perception; Freke’s legs are, for her, a way of manipulating and playing with gender. She laments, in fact, that the injury will spoil both her “beauty” and her ability to wear men’s apparel; this wound does disfiguring damage to both her personas. Like Lady Delacour, Freke finds herself doubly- and perhaps triply-bound by medical abnormality: the innate medical abnormality of her sex, the abnormality of her deliberate androgyny, and the abnormality of the wound she appropriately incurs through one of her vengeful capers.

In spite of Freke’s abnormality, however, or perhaps because of it, the relationship between her and Lady Delacour bears an intensity and a depth almost unparalleled by any in the novel. More importantly, their relationship is marked by Lady Delacour’s act of empathetic gazing. Lady Delacour, of course, bears no traditionally mainstream medical knowledge whatsoever to accompany this gaze at the body of Harriet Freke—or, if she does, that knowledge has come through the hard-won pain of her own experiences: the birthing and loss of two children, and her own long struggle with the illness that has come to define her existence. As the midwives defined it, a knowledge of anatomy and science is not *solely* necessary to the healing process, although such

---

47 Moore’s excellent analysis of Freke’s character in “‘Something More Tender Still Than Friendship’” offers a useful analysis of her cross-dressing, her ‘masculine’ behaviors, and her sexual irregularity.
knowledge occasionally has merit; experience and understanding, however, is.

Indeed, the same sensibility and capacity for feeling that frustrates Dr. X—'s designs, and ultimately motivates him to reform the ailing Lady Delacour, characterize her as particularly susceptible to empathy and understanding. Worth noting again is Lady Delacour’s extreme, sometimes startling, self-perception; though she maintains before the public eye the negative aspects of heightened sensibility—dissipation and frivolous, sometimes overly-dramatic merriment—she acknowledges both to herself and Belinda that this identity is, to a degree, false:

May you never know what it is to feel remorse! The idea of that poor wretch, Lawless, whom I actually murdered as much as if I had shot him, haunts me whenever I am alone. It is now between eight and nine years since he died, and I have lived ever since in a constant course of dissipation; but it won't do—conscience, conscience will be heard! Since my health has been weakened, I believe I have acquired more conscience. I really think that my stupid lord, who has neither ideas nor sensations, except when he is intoxicated, is a hundred times happier than I am (65).

For Lady Delacour, the experience that defines her miserable, guilt-ridden life also produces in her more sensation and deepens her capacity for feeling. Aware of this, she parades a public mask of charm, dissipation, and elegant indifference to cover a maelstrom of internal sensations and feelings that, as constant as they have been, tire her out to the point of wishing for death. Yet the tragedy that, to Lady Delacour’s view, ruins
her life, also provides her with what some might say is a particularly honed capacity for feeling, sympathy, and empathy: only someone with her experiences can feel deeply in the way that she does.

This capacity for deep feeling, notably, motivates many of Lady Delacour’s actions. Although she notes it initially serves as good politics to befriend Freke, she also acknowledges that her heart and her imagination prompted the interaction. This admission characterizes a good many of Lady Delacour’s actions, such as taking in Belinda; although all seem motivated by some hope for personal or social gain, compassion, concern, and even charity often belie them. Her capacity for feeling even inspires her to save Freke from almost-certain social ruin before their friendship sours:

Without betraying her confidence, I may just tell you what is known to everybody, that she went so far, that if it had not been for me, not a soul would have visited her: she swam in the sea of folly out of her depth – the tide of fashion ebbed, and there was she left sticking knee deep in the mud – a ridiculous, scandalous figure. I had the courage and foolish good-nature to hazard myself for her, and actually dragged her to terra firma (66).

In Belinda, Lady Delacour’s sensibility and understanding move her, time and again, to mend not bodies, but social rifts, awkward silences, arguments, and problems. With her own life in a shambles, she nevertheless seeks throughout the text to work as a healer of spirits and hearts, diagnosing wrongs and working to piece together the lives of others, and preserving other, abnormal bodies.
The empathetic gazing that marks her relationship with Harriet Freke is something that Lady Delacour mentions in her first discussion of Freke with Belinda:

I believe it was this "aching void" in my heart which made me, after looking abroad some time for a bosom friend, take such a prodigious fancy to Mrs Freke. She was just then coming into fashion; she struck me, the first time I met her, as being downright ugly; but there was a wild oddity in her countenance which made one stare at her, and she was delighted to be stared at, especially by me; so we were mutually agreeable to each other – I as starer, and she as staree. (41)

This arrangement of gazes remains interesting precisely because Lady Delacour hardly seems the sort to stare at anyone in admiration, preferring to be the center of attention herself. Yet—despite their falling-out and the hostility that eventually comes to exist between them—throughout the text Lady Delacour keeps her gaze (figuratively if not literally) on Freke’s figure. What initially starts as admiration and emulation soon sours into animosity, contempt, and hatred, but Freke remains an object of fixation in Lady Delacour’s universe, and the event in which Freke was involved—the frolic with Colonel Lawless and his eventual death—maintains a place at the forefront of Lady Delacour’s consciousness. In this confession to Belinda, Lady Delacour goes so far as to suggest that Freke has become, metaphorically, a part of her, but admits that “you see I am the comic muse, and mean to keep it up – keep it up to the last – on purpose to provoke those who would give their eyes to be able to pity me.” Despite setting her eyes continually upon Freke, Lady Delacour arranges her public appearances for the eyes of others,
determined to keep appearances and maintain a particular type of reputation that runs in strict counterpoint to her personal private life and woes. Accustomed to being gazed upon, by Dr. X—, Belinda, and countless others, Lady Delacour nevertheless chooses to keep her gaze upon Freke, a move that is voluntary, if somewhat calculated. Admitting that she finds it better socially to befriend Freke than to make her an enemy, Lady Delacour insists that “[she] has no right to give herself credit for good policy in forming this intimacy; [she] really followed the dictates of [her] heart or [her] imagination.” Thus, Lady Delacour deliberately sets herself up to watch Freke, and to learn from her.

Accordingly, Lady Delacour’s behaviors quickly change; the bond she forms with Harriet Freke is both disruptive and transgressive. At first astonished by Freke’s manner, which “made [her], like an old-fashioned fool, wish [she] had a fan to play with,” she immediately notes that “all this took surprisingly well with a set of fashionable young men,” and thus determines to “reform [her] manners.” In fact, Lady Delacour obsesses over Freke’s behaviours to the point that she imagines what they will inspire others to say about hers:

Lady Delacour's sprightly elegance – allow me to speak of myself in the style in which the newspaper writers talk of me – Lady Delacour's sprightly elegance was but pale, not to say faded pink, compared with the scarlet of Mrs Freke's dashing audacity (41).

Desperate not to be, as she calls it, socially “excommunicated,” Lady Delacour determines therewith to “publicly [abjure] the heresies of false delicacy.” In this, Freke
serves as a virtual midwife for Lady Delacour’s new public persona—the same persona that eventually leads to the escapade resulting in Colonel Lawless’ death and ultimately the duel that disfigures her. The homosocial bond between the two women, marked by this act of empathetic gazing on Lady Delacour’s part, births all manner of transgression; Lisa Moore points out that their bond leads to the usurpation of the positions of men, as well as personal and political violence (507). The bond retains its disruptive, transgressive energy precisely because of Lady Delacour’s empathetic gaze at Freke; her looking empowers, encourages, and even preserves and encourages the abnormality of Freke’s body. Nor does Lady Delacour’s gazing cease with the end of their friendship; she still gazes at Freke, and Freke remains a disruptive presence in the text, not only as an abnormal body within the text, but as a pathogen. Where Lady Delacour’s vanities and frivolities are, for the most part, self-damaging, Freke’s malice and ill intent signify even deeper abnormality (the lack of strong feeling that should be innate to her female body) and threaten to ruin and infect everyone in the text. This disruptive energy is dangerous enough when she is friends with Lady Delacour, not to mention without the mitigating influence of such a bond. Within the confines of a transgressive romantic friendship between women and subject to the view of the empathetic gaze, Freke’s abnormality fosters disruptive energy that explodes outward to effect change politically and socially; outside of the bond, still subject to the gaze, Freke’s abnormality fosters disruptive energy that threatens to infect and disrupt the lives of everyone else in the text. Although Lady Delacour remains the key object of contempt, Freke’s disdain sweeps up everyone in the text from Lady Delacour herself, to the innocent surgeon and the maid Marriott, to Lord Delacour and Helena to the title
character herself. Freke is a cancer, threatening the happiness of an entire web of characters, and accordingly must be dealt with as a disease.

Yet it is through the progress (and eventual end) of her relationship with Freke, and its culmination at the end of the novel, that Lady Delacour’s empathetic gaze is fully realized and its merits and effects made clear only when it is withdrawn. Lady Delacour’s empathetic gaze at Harriet Freke’s body within (and without) the boundaries of a transgressive homosocial bond results not only in the preservation of Freke’s abnormal body and disruptive energy but also the replication and reification of that abnormality by Lady Delacour; the withdrawal of that gaze from the abnormal body, however, deprives Freke of attention, agency, and the capacity to cause any more meaningful mischief. The withdrawal of Lady Delacour’s empathetic gaze at Freke’s body occurs in the aftermath of the arguably most significant moment of the text, at the climax of Lady Delacour’s illness. The key factor in Lady Delacour’s supposedly feverish vision, of course, is the disguised Harriet Freke, bumbling about in an effort to figure out the identity of Lady Delacour’s supposed paramour. Lady Delacour assumes the intruder is the specter of the dead Colonel Lawless, for whose death she assumes responsibility. Although the text does not maintain that Freke attempted to emulate Lawless purposefully, the fact that there exists “a resemblance in their size and persons…which favored the delusion” and constant mentions of Freke’s cruel and mocking manner in the name of frolic, inspires curiosity over whether the resemblance was, indeed, intentional. At any rate, the striking similarity between the two further

48 In Monstrosities, Paul Youngquist offers some interesting analysis of the ‘communal’ aspect of abnormal bodies in setting such as Bartholomew Fair, where the presence of gathered abnormal bodies creates a strong, thriving community that thrives on its own abnormality while, simultaneously, offering a spectacle for the view of the proper body.
invalidates Dr. X—‘s immediate and faulty assumptions of Lady Delacour’s whimsy and nervous sensibility by re-emphasizing Lady Delacour’s justifications for her assumptions. Yet the purpose of Freke’s frolic, she confesses, is not to haunt Lady Delacour but rather to learn the nature of Lady Delacour’s secret business:

Mrs Freke had learned a confused story of a man's footsteps having been heard in Lady Delacour's boudoir, of his being let in by Marriott secretly, of his having remained locked up there for several hours, and of the maid's having been turned away, merely because she innocently went to open the door whilst the gentleman was in concealment. Mrs Freke was farther informed by the same unquestionable authority, that Lady Delacour had taken a house at Twickenham, for the express purpose of meeting her lover: that Miss Portman and Marriott were the only persons who were to be of this party of pleasure (256).

This information delights Freke for several reasons, and ultimately inspires her clandestine appearance; her aim, she admits, is “detecting the intrigues, and afterwards…publishing the disgrace, of her former friend” and additionally “revenging herself upon Miss Portman, for having declined her civilities at Harrowgate.” Giddy with the contemplation of Lady Delacour’s final ruin and the thought of Belinda’s “reputation…materially injured,” she sets out upon her flawed quest only to find it a failure in every aspect: her information is incorrect; Lady Delacour’s ‘lover’ is her surgeon, who bursts out laughing when informed of Freke’s charges; Belinda is not an
aid in crime but a help during a time of illness; and the meticulously-planned frolic results in her capture and exposure (283).

The response of Lady Delacour to these events essentially nullifies Freke as a disruptive presence within the text; by withdrawing her empathetic gaze, Lady Delacour swiftly and effectively neutralizes Freke in the aftermath of her former friend’s venture. Freke, mortified by the failure of her caper and her information, and further humiliated by the mirth her foolishness has occasioned, begins to focus with more and more intensity on her own injury, and the inevitable outcome of her venture:

The dread of being seen by Lady Delacour in the deplorable yet ludicrous situation to which she had reduced herself operated next upon her mind, and every time the door of the apartment opened, she looked with terror towards it, expecting to see her ladyship appear. But though Lady Delacour heard from Marriott immediately the news of Mrs Freke's disaster, she never disturbed her by her presence. She was too generous to insult a fallen foe (321).

Freke, to whom Lady Delacour’s gaze has always been turned, suddenly dreads being seen, starkly and suddenly aware of her own abnormality. Despite her lack of regard for getting into absurd and ridiculous situations—sometimes with the company of Lady Delacour, such as the frolic involving Colonel Lawless—Freke now finds exposure no longer to her taste. Deprived of the destruction of her former friend, she finds herself on the verge of complete ruin, and rues not only the damage to her leg but the damage to her reputation and her dignity. For all her lack of concern over embarrassment,
embarrassment under the eyes of Lady Delacour remains unbearable. And yet Lady Delacour, granted the immediate opportunity to gaze, does not.

Whether the act of looking away serves initially as a mercy or a judgment remains questionable. Belinda remains ambiguous to that end, leaving Freke’s fate up in the air. Freke leaves the residence the next morning, as soon as her injury will allow it, to be away from prying eyes, and the narrator declares that “without regret we shall leave her to suffer the consequences of her frolic.” The reader, duly convinced of Freke’s justifiable suffering, feels no little surprise later on to see that she is back again at her old games, instigating forged letters and yet more of her “frolics.” Lady Delacour’s gaze—or her withdrawal of it—nevertheless continues to nullify Freke’s disruptive agency. Despite Lord Delacour’s interference and the jailing of one of her partners in crime, Freke, for her part, is spared any significant notice again; Lady Delacour lets the incident pass largely without notice:

Lady Delacour thought her fallen so much below indignation, that she advised Belinda to take no manner of notice of her conduct, except by simply returning the letter to her, with ‘Miss Portman's, Mr Vincent's, and Lord and Lady Delacour's, compliments and thanks to a sincere friend, who had been the means of bringing villany to justice’ (354).

Having earlier mentioned that Freke “was now suffering just punishment for her frolics,” the narrator here interjects, somewhat indignantly: “So much for Mrs Freke and Mr Champfort, who, both together, scarcely deserve an episode of ten lines.” Indeed, the
narrator seems to be in agreement with Lady Delacour’s general opinion that Freke’s actions are so ridiculous as to be beneath contempt, and yet Freke garners a much greater share of the text than ten lines—indeed, most of the significant aspects of her story are related to Belinda and thus to the reader by Lady Delacour herself. Despite her superficial dismissal of Freke, and despite her insistence on Freke’s nature as an abnormal body even among women, Lady Delacour—whose gaze remains fixed on Freke throughout the text—initially preserves Freke’s abnormality within the text both inside and outside the boundaries of a transgressive homosocial relationship, but then nullifies the disruptive agency of that abnormal body by withdrawing her gaze. Rather than destroy Freke as a cancer, Lady Delacour simply renders her ineffective, devoid of disruptive agency both through aberrant female friendship and her own abnormal body.

The withdrawal of Lady Delacour’s gaze in this instance, the passive removal of it from the abnormal body, resembles the presence of the clinical gaze within Belinda, deployed not just by Dr. X—but by Belinda herself. Throughout the text Belinda embodies a clinical way of looking that mimics and seeks to emulate Dr. X—’s, and does so specifically within the bond of female friendship. Throughout the text, in fact, her gaze at Lady Delacour’s mirrors and supports the physician’s especially during the most advanced stages of Lady Delacour’s presumed illness: Belinda’s responses and reactions to Lady Delacour’s visions almost directly echo the replies from the physician whom she has said, throughout the text, that she wishes to emulate. Yet that gaze also finds itself tempered by Belinda’s own empathy; she promises to keep the secret of Lady Delacour’s illness, thus creating an empathetic bond between herself and Lady Delacour. That bond,

---

49 This emulation is, for all intents and purposes, quite deliberate; throughout the text Belinda admires and attempts to mimic what she sees as the great virtues and characteristics of the physician.
however, becomes subsumed beneath Belinda’s own clinical gaze, a natural manifestation of her function in the text as a symbol of rational thought and Enlightenment reasoning. Her look at Lady Delacour serves much the same function as Dr. X—’s, and so bears less analysis here; however, Belinda’s clinical gaze at Harriet Freke exemplifies how the clinical gaze, directed at an abnormal body that cannot be reformed, simply erases that body textually and reestablishes a normative, proper body in its place.

Freke, after all, finds herself in Belinda’s ill favor due to her actions, mannerisms, and general behavior, as well as her history with Lady Delacour. In fact, Freke’s interaction with Belinda

rouse[s] [Belinda], upon reflection, to examine by her reason the habits and principles which guided her conduct. She had a general feeling that they were right and necessary; but now, with the assistance of [others], she established in her own understanding the exact boundaries between right and wrong upon many subjects. She felt a species of satisfaction and security, from seeing the demonstration of those axioms of morality, in which she had previously acquiesced. Reasoning gradually became as agreeable to her as wit; nor was her taste for wit diminished, it was only refined by this process. She now compared and judged of the value of the different species of this brilliant talent (239).

---

50 See Jordana Rosenberg’s “The Bosom of the Burgeoisie” for a more elaborate explanation of Belinda as a rational, demystifying force within the text. Mellor also discusses the function of Belinda, and its title character, as Edgeworth’s deployment of pro-Enlightenment ideology.
Freke’s existence does not inspire empathetic feeling in Belinda, but rather furthers her notion that logic and methodical thought—of the same sorts deployed, she thinks, to great end by the physician—best develop character and conduct. In Belinda’s purview, Freke’s audacity, ribald wit, and general boldness do not qualify her to share a perspective with Dr. X—, but rather qualify Freke to function as a mirror or a measurement for Belinda’s own good character, the measure of what she shouldn’t become. As a result, Belinda’s gaze reestablishes the virtue of the proper body, even her own, against the abnormal, but also essentially renders Freke mute within the text, nullifying her disruptive energy by transforming her abnormal, disruptive behaviors into the equivalent of a moral fable. When Belinda sees Harriet Freke, she sees an abnormal body in need of replacement by a proper body.

By the end of Belinda, this evolved form of the clinical gaze has triumphed. Dr. X— and Belinda, possessors of good, solid character and a clinical gaze intended not to dissect and eviscerate but to reform and reestablish the proper body, succeed: Lady Delacour reforms by novel’s end, her wound cured, her place as wife, mother, and domestic figure firmly established at novel’s end, her transgressive friendship broken. Lady Delacour has been cured, her empathetic gaze—once directed at the abnormal body of Harriet Freke—now transmuted into the gaze endemic to less-transgressive social bonds and proper bodies. And Harriet Freke, the text’s most abnormal, disruptive body, a pathogen whose wild energy perpetrates violence on men, politics, and bodies within the bond of friendship and women, friendships, and reputations outside of it, literally vanishes from the text. She has been erased, and is no more. In Belinda, the clinical
gaze has, finally and frighteningly, evolved—not just into a gaze which preserves and seeks to reproduce proper bodies, but into one which can also reproduce itself.
CHAPTER FOUR:  
FEVER NESTS AND CHIMNEY SWEEPS:  
THE URBAN SCOPE OF THE EMPATHETIC GAZE

I. THE SICKENED CITY AND THE URBAN BODY

In Illness as Metaphor, Susan Sontag writes of the early-nineteenth century medical response to tuberculosis:

When travel to a better climate was invented as a treatment for TB in the early nineteenth century, the most contradictory destinations were proposed. The south, mountains, deserts, islands - their very diversity suggests what they have in common: the rejection of the city. (73)

Since, as Sontag notes, tuberculosis is viewed as an inherently urban disease, the best cure necessitates an abandonment of the urban landscape—one must reject the city in its entirety. For many medical professionals during the Romantic period, the new trend of recommending travel cures indicates that a direct link exists between the perils and problems of urban life and the presence of contagious, infectious diseases like TB. This idea does not have its roots in the anti-urbanism of the eighteenth or nineteenth century; in fact, the link between TB and urbanization originates in “long-standing medical discourses…[f]rom Hippocrates onwards” (Gandy 19). However, during the Romantic period particularly—when TB increased in public visibility and interest because of its associations with artistic creativity and genius—the disease became a phenomenon
around which anti-urbanization coalesced. Identified as a “wet disease,” TB gradually became associated with the bad air and overcrowding endemic to “humid and dank cities” (Sontag 15), the prime result of all the negative conditions that contribute to urban life. In this case, TB seemed less the problem than the city itself; to remove the sufferer from the city precipitated the hope of a cure. Nor was TB the only health problem attributed to urbanization. The issues that reached their peak point during the Victorian period—lack of sanitation, overcrowding, pollution, and contagion—haunted the Romantic period as well, accompanied by the specters of excess consumption and overindulgence.51

During the Romantic period, however, urbanization was not linked solely with physical illness and suffering, but with spiritual illness and suffering, as well. Chandler and Gilmartin point out that Romantic writers and artists inherited a theme that can be traced back to classical times, and display the “Enlightenment radical rational distrust of the city as a place of corruption” (252).52 This distrust of the city to a large degree hinges on two key factors: the conception of the city as a place of excess and overindulgence, and the conception of the city as a place of alienation and isolation. The anti-luxury polemic that Chandler and Gilmartin identify had its roots in the mainstream medical profession; Cheyne prefigured even the Romantics in indicting excessive consumption and relentless progress as a particularly English problem. Specifically, the physician notes that

51 Tony Wohl’s Endangered Lives: Public Health in Victorian Britain, provides a devastating description of all of these issues at their peak.
52 Chandler and Gilmartin identify Shelley and Wordsworth, in particular, as Romantic poets who view urbanization as antithetical to utopia, knowledge, and self-understanding.
[English] wealth has increas’d, and our Navigation has been extended, we have ransack’d all the Parts of the Globe to bring together its whole stock of materials for Riot, Luxury, and to promote Excess. The tables of the Rich and Great (and indeed of all ranks who can afford it) are...sufficient to provoke, and even gorge, the most Large and Voluptuous Appetite. (34) 

Relentlessly advocating a “simple, plain, frugal, and honest” regimen, Cheyne challenges England’s relentless progress forward into consumerism and overindulgence. These arguments, of course, outlived Cheyne long into the Romantic period and even after: Christopher John Murray notes that Romantic physicians were distinguished by their beliefs, like Cheyne, that “disease…consisted in a disproportion of the vital forces or principles (sensibility, irritability, reproduction); health was the equilibrium of those forces or principles” (718). Moreover, Janis Caldwell notes that John Abernathie, a particularly popular Romantic surgeon, worked within the sensibility tradition Cheyne epitomized.

If, for the Romantics, nature can encompass law, wisdom, peacefulness, and understanding, then the urban landscape represents a remove from all of those things, a remove that Wordsworth condemns in his “Preface”:

---

53 Cheyne’s chapter “Increase of Nervous Disorders” in The English Malady provides a lengthy and in-depth discussion of luxury, excess, and the resultant increase in nervous disorders. 
54 Caldwell notes that John Abernathie, a particularly popular Romantic surgeon, worked within the sensibility tradition Cheyne epitomized. 
55 Like many of his contemporaries who also worked as Cheyne’s medical descendents, Abernathie grew popular for recommending adjustment of diet (and a reduced consumption of luxury goods) as a means of restoring equilibrium to the body.
For a multitude of causes, now unknown to former times, are now acting with a combined force to blunt the discriminating powers of the mind, and unfitting it for all voluntary exertion, to reduce it to a state of almost savage torpor. The most effective of these causes are the great national events which are daily taking place, and *the increasing accumulation of men in cities*, where the uniformity of their occupations produces a craving for extraordinary incident, which the rapid communication of intelligence hourly gratifies. 56 (449, emphasis mine)

For Wordsworth, the city creates unnatural appetites, removes humans from that which is natural, and blunts his own faculties to the point of “savage torpor.” The influence of the urban landscape, initially viewed as one that begets progress and advancement, works in the opposite way for Wordsworth, reducing man to a near-primitive state of apathy and stealing from him his natural abilities and curiosities. Shelley offers similar mourning in his *Defense of Poetry*, lamenting that although “nature is still unsubdued and existing in all her beauty and magnificence,” men are “excluded from her observation by the magnitude of cities, or the daily confinement of civic life” (51). For these poets, urbanization represents a barrier against that which is *most* necessary. The city sickens not only the body, but also the mind and the soul.

The urban landscape as a source of illness, sickness, and contamination is a trope that persists strongly throughout the Romantic period, and—as a result—the urban body itself becomes both a product of and a symbol of the landscape in which it resides, embodying both spiritual and physical abnormality. Through illness and sickness, the city

56 Anthony Harding’s *The Reception of Myth in British Romanticism* offers a fuller discussion of the natural law encompassed in nature.
inscribes on the urban body the city’s own vices, rendering the flesh alternatively ethereal or grotesque. Additionally, the urban landscape affects the composition of the body, rendering it weakened, distorted, and in some cases mutilated to the point of freakishness. Finally, and most subtly, the urban body finds itself subject both to the over-indulgence and excessive consumption—or, alternatively, the excessive poverty—endemic to urbanization, and suffers from the alienation begotten by its severance with nature.

In Romantic texts, this abnormal urban body takes a variety of forms, but always exemplifies both spiritually and physically the perils of urbanization, primarily because it has been rendered abnormal by the effects of urbanization. While the mainstream medical gaze renders the urban body invisible and unseen, or attempts to correct it—thus restoring the urban social order to a normative standard—the empathetic gaze preserves the deviant body as a disruptive social force necessary to maintaining social order.

Of particular interest to this end are Thomas de Quincey’s *Confessions of an English Opium Eater*, William Blake’s “Chimney Sweeper” poems from *Songs of Innocence and Experience*, and Jane Austen’s *Persuasion*. Both de Quincey and Blake, writing as distinctly urban poets with an investment in social improvement, focus on their beloved London, replete with the tensions of colonialism and imperialism; Austen sets her sights on Bath and its unique, illness-centered economy. De Quincey, Blake, and Austen in many ways represent the geographic cycle of sickness in the Romantic period: de Quincey and Blake write about London, where disease begins; Austen writes about

---

57 Gandy and Zumla in *The White Plague* identify how TB manifests itself, at least textually and narratively, in varying aesthetic versions of deviancy dependent upon class and social status.

58 In *Monstrosities*, Paul Youngquist analyzes the oversized body of Daniel Lambert, a grotesquerie symbolic of lavish urban excess.
Bath, where disease ideally ends. Both of these urban centers produce or perpetuate abnormal bodies; in all these narratives, the empathetic gaze allows these abnormal bodies to thrive, protects them from punitive forces, and enables social tensions that both preserve abnormal bodies and help maintain social order.

II. LONDON: THE HEART OF ADDICTION

One of the most fascinating urban bodies in this regard belongs to the opium addict and prolific writer Thomas de Quincey, often critically dismissed as “the sad penitent of substance abuse, or, more recently, the pale-mouthed prophet of imperialist dreams” (Youngquist 108). Although de Quincey has long been a subject of critical study, both for the confessional nature of his narrative, his critical expertise, and his relationship with opium and the opium trade, very little work—with the notable exception of Youngquist’s exquisite chapter on de Quincey in Monstrosities—has centered on de Quincey’s body, arguably the most central subject of his narrative in The Confessions of an English Opium-Eater. 59 In this particular text, de Quincey renders his sick, atrophied body the object of his own—and the narrative’s own—empathetic gaze, preserving it textually by co-opting the mainstream medical gaze and subjugating it to his own.

59 Current critical trends seem to focus on de Quincey’s relationship with opium as it relates to the Orient and colonialism; in particular, John Barrell’s The Infection of Thomas de Quincey traces de Quincey’s response to Eastern culture and his racial paranoia as a microcosm of English imperialist culture; Bewell also notes in Romanticism and Colonial Disease that de Quincey “articulates the threat that the East poses to English culture” (155). Frederick Burwick and, much earlier, John E. Jordan, offer intriguing analyses of de Quincey’s use of knowledge and his interactions with other texts. Youngquist focuses intensely on de Quincey’s body in Monstrosities but, notably, devotes his attention to the material aspects of de Quincey’s cognition, and the formation of his appetites, such as they are, whereas I focus on de Quincey’s textual record of his bodily appetites as a defiant act against mainstream medicine.
Although de Quincey’s life was by no means limited to the city, he fashions himself as a distinctly urban body in his narrative; London defines, ultimately, who he is, and what he will eventually become, and it is the turning point through which he makes his confession. In the early pages of his narrative, he makes this link quite apparent:

And one thing is clear, that amidst such bitter self-reproaches are extorted from me by the bitter anguish of my recollections, it cannot be with any purpose of weaving plausible excuses, or of evading blame, that I trace the origin of my confirmed opium-eating to a necessity growing out of my early sufferings in the streets of London. Because, though true it is…the re-agency of these London sufferings did in after years enforce the use of opium…” (13)

De Quincey did not live in London his entire life; he spent time in, among other places, Manchester, Chester, Wales, and Oxford. Yet London remains the central setting in the narrative of his addiction and eventual struggle to recover from opium; moreover, and perhaps most importantly, Quincey names London as the primary cause for his eventual addiction. It is in London that de Quincey meets with the hardships—starvation and struggle—that will eventually beget the ailments resulting in his need for opium and, eventually, his opium addiction.60

---

60 De Quincey claims facial neuralgia as his reason for turning to opium. Youngquist notes that critics debate this reasoning; neuralgia may, or may not, have been the cause; De Quincey’s constant stomach ailments also provide a possible motivation.
Not coincidentally, London also gives to de Quincey the druggists that supply his habit. “Three respectable druggists,” he notes, all from differing areas of London, assure him that

the number of amateur opium-eaters (as [he] may term them) was at the time immense; and that the difficulty of distinguishing these persons, to whom habit had rendered opium necessary, from such as were purchasing it with a view to suicide, occasioned them daily trouble and disputes. (x).

London, then, provides not only the cause of the ailments that necessitate the habit, but the motivation to continue the habit that eventually disturbs, distorts, and warps his body (and psyche). Nor is de Quincey unaware of this; in fact, he seems deliberately to set up London as the scene of his fall from grace, and as a symbol of the influences (and the addiction) over which he as no control: “London—sole, dark, and infinite—brood[s] over the whole capacities of my heart” (68).

The city he describes in such mysterious, seductive terms was a monstrosity all its own. In his biography of Keats, Walter Jackson Bate offers a particularly telling description of London at the time the poet arrived to study at Guy’s Hospital. The contrast between Keats’ former dwelling in the rural village of Edmonton, and London—which Keats referred to in a sonnet as a “jumbled heap/ Of murky buildings”—is profound:
Nearly three hundred coaches a week left or arrived at Southwark itself; and this does not include the number that passed through it on the way to and from the City. Vast numbers of wagons and carts bearing produce also entered through the High Street. The winding, narrow streets on either side, together with their adjacent alleys and courtyards, were lined with tenements; and parts of the Borough were a principal haunt of the large underworld of London. The open ditches used for both sewage and garbage were considered the worst in England; at least there were far more of them for the area. One of the constant grievances of the prisoners at the Marshalsea was the large fetid ditch nearby, to which they attributed the fevers and ‘putrid sore throat’ that affected them. (44)

While the Romantic city can certainly be considered a place of “political vitality,” diversity, and a conduit for “new ways of thinking and being” (Chandler 252-53), the city also sickens. The fetid air from ditches, garbage, and sewage bred infection and ill health. The English physician Cheyne, writing as early as 1733, details this problem as he captures the effects of an urban lifestyle on the body in sickening detail:

To all these considerations, if we add the present custom of living, so much in great, populous, and over-grown cities, London (where nervous distempers are most frequent, outrageous, and unnatural) is, for ought I know, the greatest, most capacious, close, and populous city of the Globe, the infinite number of Fires, sulphureous and bituminous, the vast expense of tallow and fetid oil in candles and lamps, under and above ground, the clouds of stinking breaths, and
perspiration, not to mention the order of so many diseas’d, both intelligent and unintelligent animals, the crowded churches, churchyards, and burying places, with putrifying bodies, the sinks, butcher-houses, stables, dunghills, &c., and the necessary stagnation, fermentation, and mixture of such variety of all kinds of atoms, are more than sufficient to putrify, poison, and infect the air for twenty miles round it, and which, in time, must alter, weaken and destroy, the healthiest constitution of animal of all kinds. (55).

The very air of the city will infect; simply being a part of the environment will eventually weaken, sicken, and destroy the hardiest constitution. For Cheyne, the urban environment is an active agent of contamination and destruction: it begets everything most unnatural to health and to healthy functioning.

Additionally, London suffered the medical consequences and mirrored the complexities of colonization. In *Romanticism and Colonial Disease*, Alan Bewell notes that “‘the fever-nests’ of urban England were not fundamentally different from the pathogenic ‘nature’ of the tropics” (49). With conditions made severe by poverty and ignorance, urban centers often functioned as “seedbeds of epidemics that spread outward to threaten the entire urban social order” (50). Typhus and endemic fever, in particular, threatened to rival TB in terms of contagion during this period; though the existence of the two diseases often went unnoticed on a larger scale, Bewell notes that urban doctors slowly uncovered the “silent mortality” especially among the working classes. As a place where “the boundaries of colonial contact had become fluid,” the urban landscape itself
represents a space in which “commerce, travel, and pathogenic exchange [are] global,” and in which “the destabilizing power of [colonial] ‘hybridity ’ erupt[s]” (51).

Yet London itself creates de Quincey’s monstrous, abnormal body. The city—and the starvation and want that it provokes—wreak havoc on his flesh and render it monstrous. Youngquist points out that in London, “eating becomes a health hazard” for de Quincey; he starves for so long that, when he eventually does eat, his body responds violently and unfortunately to the food (119-20). In other words, London has rendered his digestive system abnormal—his bodily functions have become, in London, destructive to his own health. Later, after suffering the illnesses, sickness, and general weakness innate to a long period without food and much shelter, de Quincey finds that opium itself begins to exact a toll for its previously restorative properties: it reduces him to “an infirm condition” (241).

De Quincey, thus, constructs himself as a distinctly abnormal urban body: without London, one might argue, and without the harmful effects of the urban condition on his anatomy, Confessions might never have been written or necessary. London renders the body abnormal and foreign to itself, and London provides the means to alleviate the suffering of that abnormality—which, ultimately, renders him more abnormal still. Throughout the autobiographical work, de Quincey paints London as a seductive, if dangerous, lover: alluring, enticing, entirely damaging. And, of course, the narrative use of London as the source of his body’s abnormality—as the source of opium procurement, hunger, and disease mentioned earlier—is quite clear; although de Quincey dissembles throughout the text and claims not to be offering excuses for himself and his decisions (just as he claims that opium is the most enjoyable drug that one ought never to enjoy),
London *does* share blame in his narrative for his current condition. Ultimately, his experiences there, and the havoc that the city has wreaked upon his body (through opium and other influences) offer him an excuse for behavior that might otherwise been seen as entirely worthy of condemnation.

Yet even as he textually constructs his own body, de Quincey manages to preserve it as a source of abnormality and deviancy by co-opting the mainstream medical gaze and, effectively, transmuting it. As a writer, de Quincey is charming, witty, urbane, and—most importantly—devastatingly self-aware. Critics such as Bewell and Barrell, who read the book—and justly so—as a manifestation of racial unease or as a poignant confessional might indeed miss that self-awareness at first glance. Notably, De Quincey pays attention not only to the construction of his own body, but, amusingly, how the mainstream medical community might view his abnormal body. In a wry aside, as he concludes, de Quincey coyly offers his body to medical science:

> Yet, if the gentlemen of Surgeons' Hall think that any benefit can redound to their science from inspecting the appearances in the body of an opium eater, let them speak but a word, and I will take care that mine shall be legally secured to them -- that is, as soon as I have done with it myself. Let them not hesitate to express their wishes upon any scruples of false delicacy and consideration for my feelings; I assure them that they will do me too much honour by "demonstrating" on such a crazy body as mine; and it will give me pleasure to anticipate this posthumous revenge and insult inflicted upon that which has caused me so much suffering in this life. (118)
De Quincey’s offhanded loathing of his own body seems, at first glance, both startling and disturbing, yet it provides an effective armor against the early intrusion of mainstream medical science into the corporeal evidence of his addiction. To prevent his own body from being subjugated by others, de Quincey must subjugate himself. In this case, de Quincey’s empathetic gaze, preserving him from the clinical gaze by co-opting its rhetoric of cold dismissal and alienation from the body, demands alienation from self in order to achieve preservation of self. His insistence that he be allowed to finish with his own body before the medical community is allowed to have it satirizes the voracious clinical gaze and its desire to possess, dissect, and know; de Quincey, however, wants to finish learning his own body before he allows the privilege to anyone else.

Additionally and perhaps most important is the equivalency de Quincey makes here between autopsy and “posthumous revenge.” De Quincey anticipates that the act to be committed upon his body by the medical community is a malicious one, perhaps even a violent one; to commit his body to that gaze, and the implications of that gaze, is to fulfill his own desires for revenge on his own flesh. In offering himself to the mainstream medical community—and not fighting, as Byrne did, only to have his body possessed in spite of his best efforts to the contrary—de Quincey retains his agency and his control over his abnormal body.

Intriguingly, though he teasingly offers his body to medical science, that offer lacks any real potency because de Quincey has already dissected his own body even as he constructs it within the text. Confessions is a textual autopsy; the author leaves no stone unturned in his examination of his own abnormality, his own perverse appetites, and his own deviancy. The mainstream medical gaze may well possess or attempt to
know this body, but de Quincey has possessed and known it first and, as his text makes clear, he understands it best; his mimicry of the mainstream medical gaze, and his awareness of his own body’s workings, preclude the need for the autopsy he so casually volunteers for at text’s end<sup>61</sup>. Indeed, de Quincey volunteers his body to science because he is aware that, given this text, science will not need it. In embodying the clinical gaze and turning it on his own abnormal urban body, de Quincey transmutes the clinical gaze into an empathetic one; rather than reinscribing himself as a normative body, de Quincey reifies his own presence as a perpetual deviant and, thus, preserves it—for only by occupying the role of addict can de Quincey claim sole knowledge of his own body and authorship of his own text. Indeed, de Quincey is aware that his narrative demands an addict—to restore him to the role of a proper body collapses his carefully-constructed version of self. By preserving himself as a deviant within the urban social order, and applying to himself the very punishment his body would otherwise receive first at the hands of medical science, de Quincey frees himself from the fetters of mainstream medicine and not only possesses the credibility to share his own narrative, but also uses this platform to advocate for social improvement, and to maintain his own deviancy<sup>62</sup>.

Like de Quincey, the poet William Blake admires London in spite of all its flaws, and styles himself a particularly urban poet. He is fascinated by the urban landscape, which makes him unique among other Romantic writers. Yet Blake does not approach

<sup>61</sup> That both de Quincey’s body and his narrative hold value to medical science is of little doubt; addiction narratives at this time remain largely scarce.

<sup>62</sup> Whether de Quincey ultimately succeeds in the stated goal of his text is an issue that was debated even by scholars of his own century, some of whom argued that his narrative implicitly encourages substance abuse and ultimately betrays no real regret.
the urban landscape in the same way as, for example, Wordsworth or Shelley\textsuperscript{63}; Chandler and Gilmartin laud Blake, in particular, as a “maverick radical urbanis[t]” (253) and he enjoys a place in the Romantic canon as a distinctly urban poet. In fact, Chandler and Gilmartin identify Blake’s character Los, in particular, as “the poet of the city,” and credit Blake with linking the “poem of modern life” to the urban landscape itself (255, 258). Blake allows for visions of utopia and unity in an urban setting all commonly depicted by Romantic writers as unnatural, destructive, and diseased. Northrop Frye perhaps captures Blake’s feelings about the city most poignantly:

> London meant something bigger to [Blake]. It was one of the whole succession of cities in the world that man keeps building up and knocking down again, but it was still more than that. London became for Blake what Jerusalem was for the Old Testament prophets: it was a symbol of the eternal city in the human mind, the home of the soul and the city of God. (173-74)

As a consequence, Blake’s poems about urban life are peppered with urban bodies, but the most poignant—and the most strikingly abnormal—bodies belong to the children who weep in his poems. The chimney sweep, in particular, in Blake’s titular poems in *Songs of Innocence and Experience*, exemplifies the usefulness of the empathetic gaze in rendering unseen urban bodies visible; like de Quincey, he deploys the empathetic gaze

\textsuperscript{63} Wordsworth in particular approaches the urban scene with some vehemence, idealizing Nature and pastoral scenes throughout much of his poetry. Similarly, Shelley locates the sublime in isolated scenes of Nature rather than in urban landscapes.
as a means to preserve a deviancy that protects deviant bodies from punishment and
simultaneously supports the urban tensions that allow those bodies to thrive.

In both of these poems, the bodies of the unfortunate boys—as well as their
bodily abnormalities—emphasize the nature of their labor and the environment in which
this labor takes place. In the first, the speaker describes a fellow chimney sweep with a
shaved head, and his own habitation “in soot” that can spoil hair (and lungs) (4). In the
second poem, the speaker describes a small chimney sweep crouched in the snow,
nothing more than “a little black thing” (1). Soot itself is innate to descriptions of the
urban English landscape; for the chimney sweeps to be covered in the grime identifies
them with the very chimneys they sweep, the foundational groundwork of the city itself
and the very hearths (and heart) of the city’s dwellings. Additionally, the shaved head of
the child in the first poem indicates other, implied health concerns. Luxurious hair that
“curl’d like a lamb’s back” (6)—which has no place in a world made of dirt and grime—
also functions as a symbol of the potential for filth and vermin such as lice and mites. The
chimney sweeps embody, quite literally, the filth and wretchedness of the city itself, and
are so overwhelmed with it as to become, in some ways, inhuman. Blake’s chimney
sweep in *Songs of Experience* emphasizes the abnormality of his body: the boy, coal-
black in a field of snow, looks unnaturally hunched as though the sack he carries is a part
of his body, and his darkness focuses the reader’s attention to his body, the filthiest thing
amidst the buildings; his coloring is duplicated only by the black clouds above and the
walls of the buildings themselves.
Figure 3: Blake’s engraving from “The Chimney Sweeper” in Songs of Experience. Lessing J. Rosenwald Collection, Library of Congress. Copyright (c) 2007 the William Blake Archive. Used with permission.
These images in the poems contrast, of course, with the idealized images of childhood that Blake presents alongside them. In the first poem, the young chimney sweep Tom Dacre dreams of fellow chimney sweeps transported to the heavens; “Leaping and laughing” they run and “sport in the wind” (15, 18). The bodies of these children are pure and white: they play, know no physical hardship, and bear none of the burdens of their profession. Similarly, the lament of the chimney sweep in the second poem, who contrasts being “happy upon the heath” and “[smiling] in the winter snow” (5-6) with his own present condition, presents the reader with a phantom image of another child not covered in soot and burdened by misery, one for whom happiness comes easily and the snow indicates purity. These clear contrasts not only provide the reader with a heightened sense of the bleak condition of the chimney sweeps, but also emphasize the connection of an innocent child to a heaven that, even if attainable through death, is undesirable and is made “of…misery” (11); the chimney sweep remains earthbound, citybound.
Figure 4: Blake’s engraving of “The Chimney Sweeper” in *Songs of Innocence*. Lessing J. Rosenwald Collection, Library of Congress. Copyright (c) 2007 the William Blake Archive. Used with permission.
Both poems, according to Nelson Hilton, occupy themselves with the "trauma" of "children abandoned by their parents [to]...daily harm in unimaginable working conditions" (107). More importantly, with the two "Chimney Sweep" poems, Blake works carefully within a genre of literature organized around the abolition of child labor that begins in the Romantic period and extends throughout the Victorian. In both poems, the chimney sweeps are defined bodily, and also by their bodily abnormalities. Blake’s constant emphasis on the blackened appearance of the chimney sweeps in the poems is not coincidental; such a reference not only emphasizes the “utterly alien” nature of bodies transformed by child labor, but also ties them to another abnormal body familiar to the reader: the ethnic body. In aligning these small, abnormal urban bodies with ethnic bodies—in aligning the chimney sweeps of his poems with the little black boy—Blake forces an empathetic gaze from his English audience. According to Tim Fulford in Literature, Science, and Exploration in the Romantic Era, “if readers had imagined [through abolition writing] that black men could be their brothers, then they might believe that the boys, so dark and filthy that they seemed utterly alien, were also kin” (Fulford 249). Blake has an interest in portraying these boys as bodies abnormal to the point of alien; these abnormal urban bodies, symbolic of “the ‘foul air’ of the slums where [they] lived,” demand the reader’s understanding and empathy (Fulford 258). The demand for the reader’s empathy is necessary, for only a deep understanding of kinship and one’s own relation to the chimney sweeps can prompt the reader to action on their behalf; if, as Bewell claims, London absorbs and regenerates the gluttonous

---

64 England’s Climbing Boys by George L. Phillips provides an account of the long movement for the abolition of child labor in England, and also discusses the function of the chimney-sweeps in that movement.
excesses of its own imperialism, then the salvation of England’s own chimney sweeps might be a small step towards redemption. In this, writes Fulford, the anti-child-labor movement resembles the abolition movement, and demands audience identification with both. To paint the children as black with soot, to make them literally black, is to imply that they, too, are slaves—helpless and downtrodden beneath the system, treated like animals, and in desperate need of advocacy, assistance, and freedom. For Blake, who abhorred slavery and devoted labor to creating depictions of slaves, the similarity cannot have been coincidental. Indeed, the slaves immortalized in Blake’s engravings for John Gabriel Steadman place the dark bodies of slaves against light, almost unnecessary backgrounds; similarly, Blake’s chimney sweeper demands the reader’s focus. His darkness in a world of white makes the background pale, literally, in comparison.

Interestingly, though, this trope in general depends on the reader’s innate understanding that the boys are not ethnic bodies: that their abnormal urban bodies are only temporary. Their “alienating blackness” only goes, literally, skin-deep; though the boys sense their ultimate transformation occurs in death, the reader knows that once washed and bathed, the chimney sweeper can become “whiter than white” in a way that the ethnic body cannot. More importantly, the moral degradation endemic to the urban slums—and evidenced in the behavior of chimney sweeps whose minor crimes and acts of theft or vandalism belie any ‘angelic’ nature—can be wiped away; these boys serve as the “passive targets of [advocates’] reforming benevolence” Fulford notes that “on the back of the crippled chimney sweep, the successful rhetoric of a movement for social change was carried”—not because the boys ultimately resemble ethnic bodies, but because they are “token black[s] who [can] be scrubbed” (249-50).
This view of the temporary nature of the urban abnormal body actually hinges on the conception of the child’s body innate to the Romantic period. During this time, mainstream clinical interest in the bodies of women and children flourished. Particularly, anatomists such as Smellie and Hunt invested a good deal of effort and research into cataloguing the nature and existence of these previously mysterious, unknowable bodies, going so far as to present a series of graphic anatomical plates detailing the pregnant womb after having dissected the body of a dead pregnant woman. Children, whom the author of one eighteenth-century treatise on smallpox addresses as “fellow-creatures,” represent “the greatest consequence to society” and encompass enormous potential (Armstrong 1). While many of their conditions, according to eighteenth-century physician John Armstrong, render their bodies analogous to those of adults—and indeed result in their sometimes being treated as small, miniature adults—children are, nevertheless, a mystery. Helpless and needy, Romantic children are expected to “enact impossible fictions” (McGavran 27) and embody innocence, hope, and the promise of a simpler, purer time. Thus, in an effort to protect children from undue peril, medical pamphlets in the late-eighteenth and early-nineteenth century become a motley assortment of moral and medical information, from advice about childbirth and infant diseases to guidebooks on how to correct childhood deformities to information about curing fevers and bringing up proper, well-behaved children.65 It is this notion of the child body—encompassed in the mainstream medical view of the child as a small, helpless, innocent—on which the foundation of typical anti-child-labor texts rest: the

65 Alexander Hamilton’s A Treatise of Midwifery offers information on how to treat small children, and William Moss offers perhaps the most explicit work on this topic: An Essay on the Management, Nursing, and Diseases of Children.
Romantic child, after all, “is regarded as uncorrupted, innocent, authentic, and
contrasted with an adult world of guile, artifice, and the ‘civilization’ underpinned by
capitalist industrialism” (Bignell 115). Underneath the abnormal urban body, the works
generally imply, rests the body of a child—inherently pure, inherently unspoiled, and
inherently innocent.

And it is in that depiction of the abnormal urban-cum-ethnic body as a temporary
state, as an attribute that can be erased, that Blake’s chimney sweep narrative differs from
other, similar poems and stories in that genre. Blake’s chimney sweep in Songs of
Innocence is an ironically cynical truth-teller; he embodies pragmatism. Camille Paglia
points out in Break, Blow, Burn that the structure of the poem itself implies the boy’s
attitude towards his profession; despite a “singsong” tone more closely associated with
children’s rhymes and poetry, the “matter of fact” tone of the words “implicates the
reader in the poem’s crimes—a confrontational device ordinarily associated with
ironically self-conscious writers like Baudelaire” (56). Although he relates the
sentimental and sorrowful story of his own past and of being sold to sweep chimneys
when he could “scarcely cry weep weep weep weep” (3), his past grief diverges sharply
from his present, practical tone. It is the chimney sweep who tells Tom that his haircut
will serve a practical purpose; the reader has the impression that while the narrating
chimney sweep might have once cried over his condition, he is either too weary or too
cynical to cry any more. Most importantly, although the poem can be read as
superficially hopeful—Tom has a pleasant dream about the heavenly possibilities for the
young who suffer on earth—critics generally acknowledge the last line of the poem as an
instance of irony (Hilton 107). Tom, warm because of his happy dream, stands in stark
contrast to Blake’s narrator, who is older, more cynical, and trapped in the present, which is indicated sharply by his comment: “So your chimneys I sweep” (4). This irony is further sharpened by what Hilton identifies as Blake’s use of rhyme scheme: his simple phrasings, and his imitations of children’s song and prosodies haunt even as they remind the reader of what now remains unreachable. 66

In the second poem, the chimney sweep does not entertain even little Tom Dacre’s illusions of heaven; aware that “God & his Priest and King…make up a heaven of our misery” (11-12), he condemns his parents for “cloth[ing] [him] in the clothes of death / And [teaching him] to sing the notes of woe” (7-8). Divorced from every form of spiritual and filial authority, this child who once “was happy” (5) is no longer; his experience, a forced fall from grace, has resulted in his distance from every important societal institution. A “little black thing” surrounded by snow, he embodies lack of purity, darkness, and forbidden knowledge.

Blake, by presenting the audience with these urban abnormal bodies and linking them with ethnic bodies through an obvious but impermanent blackness, forces the reader to share his empathetic gaze, a stance made explicit by the chimney sweep’s cry in Songs of Innocence. Paglia identifies the repeat of “weep weep weep weep” not solely as a reproduction of the boy’s childish lisp, but also as “a thunderous indictment of Blake as poet-prophet: Weep, you callous society that murders and enslaves its young; weep for yourself and your defenseless victims” (55). However, rather than offer the promise of a child’s body beneath the temporary urban abnormality, Blake reveals that what lies underneath is neither child nor adult, but some mixture of the two, lost to innocence and

66 Hilton, in his discussion of Blake’s Songs of Innocence and Experience, traces Blake’s use of rhyme scheme and glees to create deliberately childlike songs.
experience both. Blake’s chimney sweeps cannot be made clean again; the soot has worked its way into their very bones. Though little Tom Dacre might well dream of a world in which his friends are transformed into angels, and in which an angel promises him a similar fate, the chimney sweep narrator of that poem nestles the dream within his own narrative: one of harsh reality in which true childhood and innocence are a memory, and the promise of heavenly reward for suffering becomes repeated as a cynical, ironic end. The chimney sweep of the poem in *Songs of Experience* has become a “thing,” a creature beyond childhood—a voice alienated from all the social institutions to which an innocent child should belong and the bearer of condemnation and accusation.

Lost somewhere between innocence and experience, or perhaps, as Blake implies with his poems, embodying both simultaneously, the chimney sweeps find themselves confronting some of the same contradictions as Frankenstein’s monster. Born and sold into labor in innocence, they find their innocence destroyed by experiences that alienate them from everything around them—family, spirituality, and community. Yet their experiences do not provide them with the wisdom and understanding of adulthood even as they remain surprisingly free of the self-justifications and rationalizations of adulthood; bodies marred and made strange by their life devoted to urban grime, the chimney sweeps no longer encompass potentiality, but lack and loss. Although Blake demands the reader’s empathetic gaze by employing aspects of anti-child-labor tropes, and by associating the abnormal urban body with the ethnic body, he preserves the abnormality of these children by depriving them of a return to innocence; his use of rhyme scheme, simple phrasings, and his imitations of children’s songs and prosodies haunt even as they remind the reader of what now remains unreachable. In doing so, Blake lends an even
more powerful credibility to a poem that demands social change, and also subverts
the dominant view of the medical gaze which, through its view of children as pure but
vulnerable creatures in need of protection, guidance, and instruction, also robs them of a
textual agency that Blake confers by preserving these bodies as agents of deviance and
symbols of societal ills through their implicit association with the ethnic body. The
Romantic child as idealized angel is necessarily characterized by “a distance from the
social world, seeming immateriality…[and] transcendence,” but Blake visually and
textually links these children to their urban environment by the blackness and grime that
defines their surroundings, inviting the audience to associate them with victimized ethnic
bodies and then respond with according sympathy and understanding.

III. BATH: ECONOMICS OF THE CONVALESCENT

While de Quincey and Blake’s carefully constructed empathetic gaze at the
abnormal urban body ultimately encourages or maintains the preservation of the deviant
body as a symbol of societal ills, the empathetic gaze deployed at abnormal urban bodies
in Jane Austen’s Persuasion functions on a more subtle level, even though it works to the
same end. Interestingly, although perhaps not surprisingly, the clinical and empathetic
gazes function mostly at the fringes of Persuasion. The novel itself focuses, in large part,
on the narrative of Anne Elliot, an unmarried woman in her late twenties whose father’s
profligacy has pushed her family into debt. Through a series of related events and an
eventual move from her home, the Kellynch estate, Anne eventually becomes reunited
with and reconciled to her old love, Captain Wentworth. During her time in Bath—
where Anne’s family hopes to live in an appropriately prestigious manner while
retrenching their expenses—Anne has the good fortune of running into an old acquaintance: Mrs. Smith. In *Persuasion*, Nurse Rooke embodies the aspects of both the clinical and empathetic gaze and preserves Mrs. Smith’s urban body; as a result, Mrs. Smith can perpetuate on a micro-level the economic activity that keeps herself and Bath afloat. In doing so, she maintains herself as a deviant body symbolic of societal ills.

After a period of affluence, Mrs. Smith finds herself in unfortunate circumstances, and she explains her unhappy situation to Anne:

She was a widow, and poor. Her husband had been extravagant; and at his death, about two years before, had left his affairs dreadfully involved. She had difficulties of every sort to contend with, and in addition to these distresses had been afflicted with a severe rheumatic fever, which finally settling in her legs, had made her for the present a cripple. She had come to Bath on that account (197).

Of great importance here is the fact that Mrs. Smith is herself an urban body. Along with TB and typhoid fever, during the Romantic period rheumatic fever was itself emblematic of urban disease and blight, as well as colonial excess, and remained one of many urban maladies that respite away from the city is intended to cure. The mention of the disease evokes distinctly urban and colonial associations; Bewell references the sickness as a natural outcropping of colonialism, the exotic made domestic. Additionally, Mr. Smith’s unwise financial choices—couched in terms of excessive luxury and overindulgence—fit neatly into the anti-luxury polemic that characterizes urban life; Mrs. Smith points out to

---

67 Bewell writes wryly in his notes that, for English citizens during this period, the sea is intended as a cure for everything, including rheumatic fever.
Anne that she “live[d] in the world” and “associated only with the young and…a thoughtless, gay set, without any strict rules of conduct” (261). Victim to the dissipation endemic to the urban lifestyle, Mrs. Smith later suffers poor health seemingly as a direct result of the choices made during her marriage.

More importantly, Mrs. Smith’s choice of residence—Bath—also bears some examination. A distinctly urban site itself, Bath represents the best of what the city has to offer: “elegant urban geometries, brilliant and diverse social life, and contemporary fashion” (Dekker 78). Anne, who views Bath as an “imprisonment,” finds that her relatives do not share her lack of regard; in fact, they regard Bath a diverting social community:

Uppercross excited no mention, Kellynch very little; it was all Bath. They had the pleasure of assuring that Bath more than answered their expectations in every respect. Their home was undoubtedly the best in Camden Place; their drawing rooms had many decided advantages over all the others which they had seen or heard of; and the superiority was not less in the style of the fitting up, or the taste of the furniture. Their acquaintance was exceedingly sought after. Everybody was wanting to visit them. They had drawn back from many enjoyments, and still were perpetually having cards left by people of whom they knew nothing. Here were funds of enjoyment! (175-76)

Lost in this jubilant description of Bath is the fact that Bath functions not only as a thriving urban center, but also as a health resort. Originally, the healing waters at Bath
“were dedicated to the [Roman hybrid] deity Sulis Minerva;” as a place where
“religion, healing, and recreation interacted;” after the Romans left, the baths fell into
ruin until they were revitalized in 1597, when Parliament passed an act allowing the poor
and diseased free use of the baths. By the seventeenth century “the waters were
controlled by the city of Bath,” and in the eighteenth century the town became a center
not of spiritual healing and religious activity, but “a healing and social center” where
physicians, beggars, and the ill and not-so-ill came to partake of both the waters and the
thriving culture (25-26). Barker-Benfield identifies Bath as “an urban pleasure resort”
that functioned as “a powerhouse for male [and female] manners,” and a veritable slew of
“pleasure facilities [including] assembly rooms, shopping parades, public walks, and
gardens” (30).

Mrs. Smith embodies this key purpose of the city, and also the cruelty of a world
in which women are victimized by financial and social circumstance. She has come to
Bath to convalesce, but has turned her convalescence into a minor economy of its own,
mirroring the larger social economy of Bath based on the business of illness and healing.
Having learned to knit and make several arts and crafts items from Nurse Rooke, she

[makes] little threadcases, pin cushions, and card racks…with the means of doing
a little good to one or two very poor families in this neighborhood. [Nurse Rooke]
of course has a large acquaintance, of course professionally, among those who can
afford to buy, and she disposes of my merchandise. Everyone’s heart is always
open, you know, when they have recently escaped from severe pain, or are
recovering the blessing of health, and Nurse Rooke thoroughly understands when to speak. (200).

For Mrs. Smith, Bath provides a small income supplement; Nurse Rooke functions as a saleswoman, offering her small selection of arts and crafts to those who might be able to purchase such goods. Mrs. Smith manufactures the goods; Nurse Rooke, it seems, knows how best to sell them for charitable purposes, especially in a social center where the sick are vulnerable and susceptible to knowledgeable caretaker figures. The last line of this passage, which precedes Mrs. Smith’s description of Nurse Rooke, holds a startling ambiguity; one imagines that Nurse Rooke has been a capable handler of Mrs. Smith’s own open heart as she recovers from her illness, but the use of that line as a conclusion to the previous passage implies that open hearts are particularly vulnerable to purchasing Mrs. Smith’s small crafts, and that Mrs. Rooke is particularly adept at identifying such moments.

Mrs. Smith’s illness-fueled economy in Bath figures importantly here because in this regard, Mrs. Smith embodies the abnormal urban body of Bath itself. In The Culture of Sensibility, Barker-Benfield notes the peculiar nature of this urban center. As a resort for pleasure-seekers with a thriving tourist industry, Bath functions not on the principle of curing illness, but on perpetuating it, or at least the appearance of it. The spa towns, Barker-Benfield notes, became a well-established joke; women, or “women aspiring to be ladies,” found it beneficial to “visit to take the waters” regardless of any actual illness. In short, Bath became a means by which women in particular “[mask] their pleasure-seeking wishes under questionable illness” (30-31). Physicians soon learned to take advantage of
this and, rather than “scratching [their] head[s]” in consternation over the popularity of the city, eventually learned to “profitably…replace ridicule for specialization” (31). Bath itself was an abnormal body composed of the seeming sick; the ongoing maintenance of Bath’s economy depended on the perpetual abnormality of the body. Though Bath was ostensibly meant to cure such abnormalities, the curing of them entirely would have rendered Bath itself obsolete.

Although Mrs. Smith herself hardly resembles the idle pleasure-seeker masking her desire under a false front of illness, she does embody in herself the Bath urban body and its economy; her own fragile economy of arts and crafts can only support her here in a town of the sick and convalescing and can only be maintained in a place where the charity that she wishes to provide is necessary. Moreover, her ability to provide charity emphasizes the tragic nature of the circumstances through which she has fallen to this point. Poor elsewhere, Mrs. Smith finds in her own ongoing abnormal urban body an ability to maintain herself that only exists within this particular urban area, and also a place in which she symbolizes the cruelty of an outer world unfriendly to impoverished widows. The body of Bath, composed of—but simultaneously dependent on—the abnormalities it claims to cure, must maintain this economy of illness to perpetuate its own force as an urban center. Similarly, Mrs. Smith, herself an abnormal urban body, redoubles her own alienation; her sickness provides her with an economy that health elsewhere might not provide her. To facilitate and preserve Mrs. Smith’s textual function, Nurse Rooke—Mrs. Smith’s constant companion—de deploys both the empathetic and clinical gazes. Mrs. Smith describes her companion thusly: “She is a shrewd, intelligent,
sensible woman. Hers is a line for seeing human nature, and she has a fund of good sense and observation…” (199).

Nurse Rooke, indeed, knows everything about everyone and instantly delivers this information to Mrs. Smith; even Anne herself is not exempt from the process. When Anne arrives to pay a visit to Mrs. Smith, in fact, she finds that her situation is well-known, and that Nurse Rook has already gleaned every tidbit of available information about her, a mimicry of the all-consuming clinical gaze. Mrs. Smith explains that her information comes from

Mrs. Rooke, Nurse Rooke—who, by the by, had a great curiosity to see you, and was delighted to be in the way to let you in. She came away from Marlborough Buildings only on Sunday; and she it was who told me you were to marry Mr. Elliot. She had it from Mrs. Wallis herself, which did not seem bad authority. She sat an hour with me on Monday evening, and gave me the whole history. ‘The whole history!’ repeated Anne, laughing. ‘She could not make a very long history, I think, of one such little article of unfounded news.’

Mrs. Smith said nothing. (256).

Mirroring Mrs. Smith’s small sickness-based economy of arts and crafts, Nurse Rooke traffics in gossip and information. Mrs. Smith produces arts and crafts and gives them to Nurse Rooke to sell; Nurse Rooke produces information and gives it to Mrs. Smith to use. Beneath the gaze of this nurse, in Bath, nothing exists that is not already known, disseminated, and put to its proper purpose; while physicians and anatomies
dissect corpses, Nurse Rooke dissects knowledge and information, and yet her information and conclusions are not always correct—particularly not in Anne’s case. In this, Nurse Rooke mimics the medical gaze: voracious in its pursuit of knowledge, intent on the consumption of information. The element of discomfort Anne seems to feel with being the object of such scrutiny, and the earlier mention of Nurse Rooke’s shrewdness in “understand[ing] the right time to speak,” temporarily renders the nurse an intimidating, daunting figure of seemingly unassailable authority despite her the fallibility of both the information she receives and her understanding of it.

Nurse Rooke’s desire for knowledge, however, does not destroy or consume. Rather, the knowledge she receives does no harm to those from whom she learns it and, additionally, actively preserves the abnormal body of Mrs. Smith in Bath. Not only does Nurse Rooke provide Mrs. Smith with a small economy, she also provides Mrs. Smith with the means of making herself important to others. If anything, Nurse Rooke provides Mrs. Smith with a surplus of information; several times during their conversation, Anne has to decline additional information that, while at hand, does not interest her particular inquiries. Additionally, Anne both deplores and mistrusts this information; chiding Mrs. Smith for trusting gossip, she points out that we must not expect to get real information in such a line. Facts or opinions which are to pass through the hands of so many, to be misconceived by folly in one, and ignorance in another, can hardly have much truth left.
Yet Mrs. Smith’s knowledge proves itself both useful and revelatory. Although the entirety of the plot, as critic K.K. Collins argues, does not hinge on the necessity of Mrs. Smith’s revelations, the knowledge is nonetheless extraordinarily useful; Anne claims that the information “will help her know better what to do” and that her line of conduct will, resultanty, “be more direct” (276). Although Mrs. Smith’s past experiences of affluent life now matter little, her knowledge of affairs in Bath—given to her by Nurse Rooke—permits her to put them to use in order to clarify the situation for Anne and thus make herself useful, integral, and significant to a broader narrative.

In *Persuasion*, Nurse Rooke and Mrs. Smith almost exist as one entity, both of them providing information and uses for information and services that the other lacks. Though Nurse Rooke’s gaze at Mrs. Smith might strikingly mimic the clinical gaze, the bond of gossip between them underscores the identification they hold with each other and the empathy they share. According to Casey Finch and Peter Bowen, gossip in Austen’s novels is a gendered trope and operates “as a hidden form of authority”; gossip allows women to indulge in a “genuinely alternative mode of communication.” The communication dismissed and trivialized as frivolously, laughingly female—unimportant and diversionary—becomes “a serious and privileged form of knowledge” for those with the ability to use and manipulate it correctly. Forming a mild system of “surveillance” and “social control,” gossip creates its own community and invests those who participate in it with a powerful form of authority (544). Both Nurse Rook and Mrs. Smith participate in this gossip network, and each of them are integral to the other: without Mrs. Smith, Nurse Rooke’s gossip has no real audience, and without Nurse Rooke’s gossip, Mrs. Smith’s experiences of ruin serve no greater purpose. Both identify with each
other’s need for relevance and usefulness. Nurse Rooke’s gaze at Mrs. Smith’s
abnormal urban body preserves that body by maintaining its usefulness in spite of, or
perhaps because of, its deviancy. Then, through that deviancy, and through their
empathetic bond with each other, the two women not only maintain a micro-economy
that mirrors Bath’s macro-economy, one that paradoxically requires the perpetuation of
illness in order to heal illness, but also reify Smith’s role as a symbol of societal tension.

In all of these narratives—de Quincey’s Confessions, Blake’s “Chimney
Sweeper” poems, and Austen’s Persuasion, deviant bodies thrive both as disruptive
forces, loci of urban tensions, and as symbols of societal ills that need to be rectified.
Blake’s “The Chimney Sweeper” in Songs of Innocence and Experience, de Quincey’s
Confessions of an English Opium Eater, and Jane Austen’s Persuasion all function as
narratives of appropriate social behavior; de Quincey’s narrative seeks—at least in
principle—to warn other addicts about the painful path of struggle and addiction that he
himself understands, Blake’s poems seek to instill a heightened social consciousness in
his readership, and Austen—as in many of her novels—gently mocks prevailing social
customs on her way to exemplifying truly virtuous modes and methods of conduct. In all
of these narratives, deviant bodies thrive and serve as agents of social order, controlling
forces that maintain or encourage—within urban centers—beneficial social behaviors and
customs. Despite being rendered abnormal by the urban conditions in which they
function, these bodies are maintained textually by the empathetic gaze. De Quincey’s
empathetic gaze at his textually-constructed body masquerades, wryly, as clinical, and
deprives the clinical gaze of its agency (and thus coercive properties); Blake forces the
reader to deploy an empathetic gaze at the bodies of child laborers by invoking abolition
tropes intended to remind readers of shared humanity and connection. Austen, embodying a blend of gazes in the figure of Nurse Rook and in the social connection between Nurse Rooke and Mrs. Smith, preserves the bodies of two women as necessary to the Bath economy and to the presentation of societal ills and tensions. In all three texts, these authors preserve deviancy as an encouragement to social improvement; in the later Victorian period, policing deviancy—and eliminating it—will become the inevitable means by which social improvement is maintained. In the Romantic period, however, the abnormal urban body—by virtue of the very properties which render it abnormal and disruptive to sociocultural norms—retains its own disruptive force through the empathetic gaze and, simultaneously protects deviant bodies from punishment while reminding the reader of an obligation to confront social ills, thus rendering itself acceptable in its very abnormality.
I. A SYMBIOSIS BETWEEN MEDICINE AND CULTURE

During his tenure as a medical student at Guy’s Hospital, John Keats did a lot of writing. Bate, in his biography of Keats, offers an amusing look at the future poet’s earliest writing in medical school:

At first glance, Keats would seem to have taken his lecture notes on whatever page fell open, and then, when the book was filled, to have started to insert further notes between the lines of those made earlier: the inference being that he was either completely indifferent or hopelessly confused. …Keats first neatly copied out a syllabus for the forthcoming lectures. He obviously assumed that the syllabus was the important thing—perhaps all that was really necessary—though he left space here and there throughout it, as well as before and after, in case anything crucial needed to be inserted. Then, showing up at the lectures in the crowded amphitheatre, he finally began to write as he saw others writing. …next to [his notes] he sketched little pictures of flowers and fruits” (Bate 47).

Messy and disorganized, yet produced by a student eager despite of his confusion to learn and record new knowledge, Keats’ medical notes sound disastrous, if not downright dull.
Yet this writing evolves over time, and Keats—already guilty of enhancing his medical notes with doodles—casually entangles his careful observations with more emphatically poetic content. Bate notes that during [lectures], said [his friend] Stephens, Keats would occasionally scribble some doggerel rhymes on his own syllabus or that of a friend. At least Stephens himself had one such specimen: “Give me women, wine and snuff / Until I cry out ‘hold enough’! / You may do so sans objection / Till the day of resurrection; / For bless my beard they aye shall be / My beloved Trinity” (50).

The poem is admittedly silly, a careless little scribbling perhaps meant to elicit a laugh during class and hardly something that, one imagines, Keats would have wanted taken seriously in any regard. And yet this very literal textual mingling of medicine and poetry, the juxtaposition of scraps of verse and rhyme interspersed with detailed medical notes on bone setting and physiology, embodies the messy, sometimes-muddled relationship between literature and medicine that could only have existed during the Romantic period.

In particular, the rise of women and children’s medicine as prominent medical disciplines worthy of study during this period, the medical shift in diagnostic heuristics from an empirical to a dialectical format, and the “intellectual ferment” of medical ideas in the public consciousness that de Almeida identifies in Romantic Medicine and John Keats contribute to the foregrounding of medical issues in the public consciousness. From breastfeeding and mastectomies to autopsies and exhibits, the ideas bandied in literature returned to provoke and mirror some of the most pressing concerns and debates
of the Romantic medical community, as well. Caldwell appropriately identifies the
Romantic period as being characterized by a unique symbiosis featuring “startling and
incongruous reproductions of the natural and the spiritual” in which “medical diagnostics
and literary representation” together represent the “interpretive method which tacked
back and forth between physical evidence and inner, imaginative understanding” (i). In
other words, then, Romantic writers in particular benefit from the link between medicine
and literature, between empirical study and debate and the emphasis on imagination and
inner impulse; in this period as in no other, the concerns of medicine and literature
influence each other.

That the abnormal body became a focal point of medicine and literature in the
Romantic period also seems natural. The medical community in particular gains little
knowledge from looking at proper bodies; deviance, as Younquist demonstrates
throughout Monstrosities, remains the focal point for medical science and the quest for
knowledge. The Romantic period, then, finds itself populated with abnormal bodies in
both medicine and literature: Saartjie Baartman on exhibition as the Hottentot Venus, the
monstrously tall Charles Byrne, Blake’s depictions of contorted slaves, and Dr.
Frankenstein’s monstrous, corporeal creature, a murderer and a child at once. Abnormal
bodies, in the late eighteenth and early nineteenth centuries, function not only as an
object of curiosity for the medical world, but also for the literary imagination. Yet
deliberate readings of Romantic works with a consideration of medical assumptions and
ways of looking at abnormal bodies allow for a plethora of readings of Romantic
literature that reveal not only the skewed trajectory of medical science, but how
medically-based understandings of class, gender, and race affect culture. Though this is
certainly not a phenomenon unique to the Romantic period, the major shifts in the medicine, history, and culture that occur during this time best reveal the symbiotic gestalt between medicine, literature, and culture, and how each of these elements influence and balance each other.

II. THE CRITICAL ROLE OF THE EMPATHETIC GAZE IN ROMANTIC LITERATURE

Because of the myriad historical events and circumstances during the Romantic period that foster a mingling of medicine and literature, and also because of the intense medical focus on abnormal bodies, two distinct, medical ways of viewing the abnormal body emerge and permeate not only popular culture, but Romantic literature as well. Although these two distinct gazes do not necessarily exist as a polarity, and sometimes even function simultaneously or supplement each other (and, in some cases, come to mimic each other) they both serve different functions within medicine and literature.

The benefit of reading these texts with an eye towards the deployment of the empathetic gaze, as this discussion indicates, also results in intriguing, provocative shifts within the texts themselves. Beneath the empathetic gaze, the ethnic body recovers its own agency and embeds itself firmly within narrative; Seacole demonstrates that in her own text, where her deployment of the empathetic gaze serves not only to preserve abnormal bodies with whom she comes in contact, but herself as a textual bodies with agencies in their own narrative. In Maria Edgeworth’s Belinda, a novel focused—despite its title—on wounds of the breast and the abnormal female body, the empathetic gaze sustains disruptive, transgressive social energy of the most aberrant kind, and deliberately
threatens and disorders the typical heteronormative order until that energy can no longer be sustained in the face of the evolved, reformatory clinical gaze. Moreover, in de Quincey’s *Confessions* and Blake’s poetry—both tributes in their own fashion to the urban cityscape—the empathetic gaze becomes a means through which social improvement and advocacy is encouraged, while in Austen’s *Persuasion* Nurse Rook embodies a distinctly evolved clinical-empathetic gaze in order to maintain deviancy and preserve Smith’s place as a tragic figure and victim of societal ills.

The recovery of agency in these texts by means of the empathetic gaze also has implications for these genres that might be further examined and analyzed: in what ways do abolition and child-advocacy literature work together to restore agency to marginalized figures? How do wartime autobiographies perpetuate medical assumptions about various cultures while simultaneously undermining them?

By examining where the empathetic gaze appears in various Romantic texts, as well as how it functions, scholars can reread texts with a deliberate eye towards exhuming marginalized figures and narratives that the clinical gaze, and its larger ideological framework, has submerged or annihilated entirely. This allows not only for a more multifaceted understanding of the Romantic period and its inherent ideologies in general, but also encourages rereadings of canonical works in new and fruitful ways. Moreover, reading with an awareness of the clinical gaze and its textual function also helps to unravel a larger narrative about how and in which ways medical ideologies influence texts during the Romantic period. To restore the empathetic gaze, then, to reify its preserving power in text and to recognize its function in preserving disruptive energy and aberrance, as well as recognizing where it fails to do so or mimics the clinical gaze,
functions as a defiant way of rereading texts, of returning subversive and disruptive energy to narratives and figures deprived of their agency.

Additionally, reading these stories and uncovering the marginalized empathetic gaze within various works (as well as the presence of marginalized medical practitioners, and their patients) tells a different story about Romanticism and medical science. In Romanticism and Gender, Mellor notes that the female Romantics deliberately adopt a rhetoric of logic in order to provide a counter for the traditional Romantic male-authored narratives; this rhetoric, of course, though Mellor does not explicitly make this connection, mirrors mainstream medical understanding and its emphasis on logic, rationality, and the deliberate assumption of reason over feeling. Mellor also notes that male Romantic authors adopt the rhetoric of sensibility and feeling, a rhetoric implicitly associated, as discussed in this particular project, with the empathetic gaze. Reading with an awareness of the empathetic gaze and its implications, then, and which writers adopt and deploy it, seems to be a particularly intriguing way of reading Romantic texts.

Moreover, by refocusing on the empathetic gaze within texts, as well as its cultural associations within the Romantic period, fringe medical practitioners and the culture of folk medicine that fall victim to the broader, consuming power of the clinical gaze also return to a greater prominence. Although midwives and folk physicians during the Romantic period have deserved scholarly criticism, many of these figures fall victim to the assumptions engendered by mainstream medicine and often appear, even in scholarly work, as quacks, frauds, or comic figures when they are not dismissed entirely. Combing through Romantic texts with an eye to the medical ideologies at play, and reading marginalized medical figures within Romantic texts as agency of disruption,
chaos, and aberrance, provides another interesting link between the text and the period in which it was created, and the text itself as a microcosm of the larger world and ideology in which it functions. The text itself becomes an artifact of medical assumptions about gender, class, and race, and illustrates how those assumptions might affect, or does affect, living bodies. A reading of Romantic texts in general with an eye towards how they have been influenced and shaped by medical assumptions and views of the eighteenth and nineteenth centuries might well shift the fundamental understanding of the characteristics of and the purpose of Romantic texts. Such an understanding might shape our own views about the medical and scientific biases, and the history they possess, which inform our own period.

Finally, by rereading texts with an eye to the textual function of the empathetic gaze, the reader deliberately adopts another form of gazing. The habit of reading with an awareness of the presence of the clinical gaze, and with a cultivated mindfulness towards the agency and disruptiveness that the empathetic gaze represents, encourages a subversive mode of reading that focuses on characters devoid of agency and marginalized narratives. Through this manner of reading, scholars practice a form of empathetic gazing themselves that not only mirrors the gaze of other empathetic figures and demands identification with abnormal bodies, but also keeps readers mindful of the disruptive potential within a text and within the period itself.

III. INVITING DISRUPTION

While this particular discussion focuses largely on defining the nature of the empathetic gaze and exploring how that gaze functions—apart from and sometimes in
contrast with the clinical gaze—to sustain disruption, return agency, and provide a counter-narrative to the heteronormative standard, the continued excavation of the empathetic in Romantic texts will undoubtedly offer insights of value into other texts, as well. Most importantly, this kind of rereading prompts a useful shift to interdisciplinary study within Romantic scholarly debate.

The mingling of medicine and literature so prevalent to the Romantic period proves of great interest not just to scholars of literature, but also to scholars of medicine, ethics, and history; particularly, Romantic literature embodies and illustrates the way that medical understandings and medical knowledge change, influence, and shape culture, especially understandings of deviance and abnormality, and offers a history in how the definition of medical ethics and medical understandings have changed over time due to inherent cultural biases and normative standards. The temptation to treat medical ideologies as a fringe aspect of Romantic literature in fact devalues their immense importance to the study of the period. In a time when English culture finds itself confronted by the good, the bad, and the unbearably ugly potential of medicine—its transformative power, its capacity for healing, and also its potential for destruction, devaluation, and death—the attempts of English authors to grapple with the questions raised in medical schools, by physicians, and even on the battlefield about the value and usefulness of different kinds of bodies remains vital in the present time.

---

68 Frankenstein, in particular, seems to crop up a great deal in medical ethics classes, and to serve as a myth for over-ambitious future physicians: The Frankenstein Syndrome explores Shelley’s novel as a jumping-point for a discussion of genetic engineering in animals and H. Davies asks “Can Mary Shelley’s Frankenstein Be Read As An Early Research Ethics Text?”. The physician Ira J. Kodner, the director of Washington University's Center for the Study of Ethics and Human Values, has offered lectures on that center on Frankenstein as a text about medical ethics.
Ultimately, examining the empathetic gaze and how it works textually not only excavates figures erased and annulled in certain works, but provides a space for examining disruption and marginalization, and also allows for several new narratives to be written: not just about Romanticism, but about medical science during the Romantic period as well, and the marginalized, delegitimized narratives of both fringe medical practitioners. A mindfulness of the empathetic gaze, and concerted attempts to excavate the narratives of abnormal bodies from the textual grave to which the clinical gaze and mainstream medical ideologies have consigned them, can only help illuminate the vexed, complex, and sometimes troubling symbiosis between literature and medicine in the Romantic period.
BIBLIOGRAPHY


http://galenet.galegroup.com.proxy.library.ohiou.edu/servlet/ECCO


Chapman, Edmund. *A treatise on the improvement of midwifery*. London: printed for John Brindley, at the King's Arms in New Bond-Street; John Clarke, under the Royal Exchange; and Charles Corbett, at Addison's Head against St. Dunstan's Church in Fleetstreet, 1735. [ECCO].

<http://galenet.galegroup.com.proxy.library.ohiou.edu/servlet/ECCO>
<http://galenet.galegroup.com.proxy.library.ohiou.edu/servlet/ECCO>


Dekker, George The Fictions of Romantic Tourism. Stanford UP 2005


Sontag, Susan. Illness as Metaphor New York: Picador 2001


<http://galenet.galegroup.com.proxy.library.ohiou.edu/servlet/ECCO>

Towler, Jean and Joan Brammall. Midwives in History and Society. New York: Routledge, 1986


