Representation of Medics in British and Bengali Literatures (the 1850s-the 1950s): A Comparative Study

Thesis submitted to Vidyasagar University for the Degree of Doctor of Philosophy in Arts (English)

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Certificate

To Whom it May Concern

This is to certify that Ms Pritha Kundu, a Ph.D participant in the Department of English, has been working under my supervision. Her thesis entitled “Representation of Medics in British and Bengali Literatures (the 1850s – the 1950s): A Comparative Study”, is an original work and it has not been published anywhere else. The thesis is meant exclusively for submission to Vidyasagar University for evaluation for the award of doctoral degree.

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Declaration

I do hereby declare that the thesis entitled “Representation of Medics in British and Bengali Literatures(the 1850s-the 1950s): A Comparative Study” submitted by me for the degree of Doctor of Philosophy in Arts (English) of Vidyasagar University is based on my own work under the supervision of Prof. Debashis Bandyopadhyay. This work is the result of original research and neither this thesis nor any part of it has been submitted previously anywhere for any degree or diploma.

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Introduction

> I swear by Apollo [sic] Physician and Asclepius and Hygieia and Panaceia and all the gods and goddesses, making them my witnesses, that I will fulfill according to my ability and judgment this oath and this covenant: […]
>
> I will apply dietetic measures for the benefit of the sick according to my ability and judgment; I will keep them from harm and injustice.
>
> I will neither give a deadly drug to anybody who asked for it, nor will I make a suggestion to this effect. Similarly I will not give to a woman an abortive remedy. In purity and holiness I will guard my life and my art[1].

−So proceeds the famous medical oath, attributed to Hippocrates, the Greek philosopher-physician of the 5th century B.C. Though the identity of the actual author of this oath is much-debated[2], it is still held as the manifesto of the ideal conduct of a physician. Hippocrates was celebrated as a natural philosopher of medicine, who brought the art of healing away from the ancient corpus of magical and religious orientations. Even so, the oath reflects the deep-rooted customary belief in the invocation of the Greek deities associated with health and hygiene, claiming their witness as a moral and spiritual authority behind the sacred duty of doctoring. The Hippocratic image of a doctor thus appears to be a bridge between the ancient supernatural arts of healing and the Classical period of Greek medicine when it became somewhat independent of the supernatural and the magical. As Jane Harrison's *Prolegomena to the Study of Greek Religion* points out, several modern technical terms of medicine had their origins in the Greek rituals and religious belief.

"Pharmacy" and "Pharmacology", for instance, are derived from the Greek "Pharmakos", a scapegoat-figure through whom diseases and evils were to be purged[3]. In pre-classical and Homeric times, there had also been ample references to the intimate association between religion and medicine, and healing was also an art like literature, music and so on. Apollo the god of art and poesy was also associated with healing. Orpheus was a poet, a lyricist and a healer whose divine strain of music could bring health and joy, and cast sorrows, illness and pains away. Later in Christianity, the religious and spiritual elements of cure got merged with the image of a doctor, in a deeper way. The ideal Christian physician was to be seen as a brother-figure to the priest: one doctors the body, and the other cares for the soul[4].

It is to be noted that in a close critical examination, "healing" and "cure" do not appear to be exactly interchangeable terms, though there is a tendency to confuse the two, even in scholarly writings[5]. Healing can be viewed as a restoration of the wholeness of being ─ of body, mind and spirit. In the Galenic physiology, the idea got associated with the need to restore a balance of the humours in human body. "Cure", on the other hand, implies a successful application of some remedy for a particular physical or mental discomfort or disorder. In a broader sense, however, cure can be of a moral and spiritual nature as well. It is through this shared concern of moral and spiritual aspects, perhaps, that "healing" was sometimes confused with the notion of cure; and this had often elevated the social, cultural and moral status of the figure of the physician. As David Greaves has shown in *The Healing Tradition: Reviving the Soul of Western Medicine*, the medical philosophy in ancient cultures was a discourse of moral and spiritual concern, along with the pathological.[6]

The philosophy of cure, in Classical thoughts and in Christianity, had enjoyed an overall respectable status – though there were some differences in the cultural

representation of the doctor-figure. In medieval England, saints and hermits were often associated with healing. However, a binary was usually maintained, between the divine or moral power of cure and medical practice as a profession. Since Chaucer's portrayal of the "Doctour of Physik", the professional doctor in the Western-English literary tradition has acquired associations with maladies – both physical and mental; with delirium, deformity and derangement. Sometimes he is a passive observer of the incurable troubles of existence/being, like the doctor in *Macbeth.* In the Victorian age, the doctor's role within the narrative becomes more complex with the improvement in the medical sciences and a growing interest in "case narratives". The doctor-character, sometimes represented as a good man, stands at odds with the social disease – trying to do his best but unable to transcend the squalor (*Bleak House*). Dr. Jekyll becomes the victim of his own experiment and cannot sustain his integrity. Wilkie Collins' doctors often function as agents of dark psychiatry. In Marie Corelli, doctors are often occult philosophers, or tragic figures of failure, unable to assume the role of a divine healer'. In Shaw's *The Doctor's Dilemma*, the Victorian doctor-figure becomes both pathetic and ironic, himself being poor, consumptive and unable to help his working-class patients properly. Moreover, in the Victorian literature of the Empire, the imperial anxiety over the tropical health-situation, and the British doctors' experience in colonial India, provide interesting political and psychopathological aspects of disease and cure, alongside the corporeal and the ethico-philosophical. Several fictional and autobiographical works by Kipling, P. M. Taylor and Flora Annie Steel are concerned with the outbreak of epidemics in India and the medical officers' physical-psychological stress and burden of serving the empire under a tropical sky.

In the Indian traditions of healing, especially in *Āyurveda* and *Yoga*, the issue of terminology is less problematic: *Ārogya* is a Sanskrit term which implies the

wholeness of a healthy condition, or a perfect order of physical, mental and spiritual well-being. In *Caraka-saṁhitā* (translated by P.V. Sharma), *Āyurveda* is described in the following *ślokas* (*Sūtra-sthānam*1.41-43):

> Āyurveda is that which deals with good, bad, happy and unhappy life, its promoters and non-promoters, measure and nature.
>
> "Āyus" means the conjunction of body, sense organs, mind and self and is known by the synonyms dhārī, jīvita, nityaga and anubandha.
>
> The scholars of Vedas regard the Veda of that Āyus as the most virtuous one which is said as good for both the worlds for the human beings. (Caraka 2014: 6)

Another term *Nirāmaya* (close to "cure") have philosophical and spiritual connotations[7], yet they had hardly been at odds with the material and pathological aspect of medical practice since the time of Caraka and Suśruta. In the *Sūtra-sthānam* (1.67), Caraka defines the goal of medicine through the following statement: "Medication can be of three kinds: sometimes it calms down faults, sometimes it vitiates the elements (*dhātu*), and sometimes, it maintains holistic health" (Caraka 9; paraphrase from original Sanskrit is mine).

The Buddhist monasteries in ancient India were also centres of several kinds of healing practices. As Kenneth Zysk has shown in *Asceticism and Healing in Ancient India*, Buddhist medicine also played an important role in the development of *Āyurveda* (4). Besides the Buddhist and Ayurvedic traditions, India has a wide range of pharmacopeia – including Unani, Siddha and several local, tribal healing practices. Bedias, Fakirs and several other nomadic groups can claim a certain expertise in their ancestral (and sometimes exclusively "secret" and "sacred") arts of medicine which are often associated with psychological and spiritual healing. The *Vaidya* is a curer of bodily diseases; and this concept is inseparable from the spiritual notion of "healing"

the mortal of the "disease of the world" (*Bhavaroga*) as preached by Indian mystics and gurus. In literature, the spiritual tradition is effectively mingled with social reality, psychological insights, material and topical concerns. In Tagore's *Dakghar*, the practical concern for physical cure and the transcendental concept of cure in the sense of "freedom" of the soul find allegorical expression through the discourse of two doctors or "Kavirajas". In *Arogyaniketan*, the doctor of the old school is challenged by the man of modern medical science, but his dedication to the transcendental philosophy of his noble profession ultimately leads him to find the Truth behind the mysteries of life and death and gain the new generation's respect as well. Banaphul's doctor-protagonist, Agniswar, has been shown as an incarnation of the curing force of purgation, symbolized as "fire". Manik Bandyopadhyay's doctor-protagonist Sashi (in *Putul Nacher Itikatha*), however disgusted with the grim narrowness of rural life – its diseases, meanness and superstition – finally learns to respect "Life" in all its health and hazard, beauty and deformity. Thus from Tagore to Manik Bandyopadhyay, we have a variety of social, ethical and spiritual insights involved in the portrayal of a doctor. Against this background, my research will investigate how far the literary representations can show some affinity, along with differences in the construction of the doctor-figure as a medical, moral, social as well as political subject within the narratives, in the Victorian and the Indian contexts, in relation to the social and cultural settings of the chosen texts. Before delving into the research, a critical overview of the works published so far in similar or related areas can be helpful.

Literature and Medicine has now become a broad area of interdisciplinary critical enterprise. The special focus on doctors and doctoring owes much to Foucault's seminal work, which brought a great paradigm shift in the study of the

medical discourse in the west. In *The Birth of the Clinic* (1963, translated into English in 1973) Foucault discussed the changing discourses of clinical practices in Europe, in the eighteenth and nineteenth centuries. Foucault's theorization of the "clinical gaze" explained the "power" and authority given to the doctor, as a perceiving subject, while the patient's body was reduced to an object, in a game of displacement. Several works by Roy Porter through the '80s and '90s also present detailed studies of the medical history and changing roles of practitioners in modern Europe, often with literary references. *Bodies politic: Disease, Death and Doctor in Britain,* his last work on the subject, before his death is a fascinating achievement in this field. Some literary studies, especially concerned with the use of medical idealism and realism in nineteenth century fiction are remarkable for their innovative approach. In *Vital Signs,* Lawrence Rothfield has offered a comparative analysis of nineteenth century novels in French and English, from the perspective of medical realism. Janis Caldwell's *Literature and Medicine in The Nineteenth Century* covers a range of medical-scientific fiction from Mary Shelley to George Eliot. Tabitha Sparks, in *The Doctor in the Victorian Novel: Family Practices,* studies the conflict between the private life and the professional identity of Victorian doctors, and shows how the doctor-character antagonizes the marriage plot in the novels. Meegan Kennedy's book, *Revising the Clinic* (2010) offers a critical study of the intriguing intersections between the style and mode of writing case-histories, and other medical documents, and non-medical, literary writings.

Roy Porter's *Bodies Politic* is a well-documented study, rich in illustrations of visual and literary representations, of the social and cultural attitudes towards health, disease, mortality and doctors in Britain from the seventeenth century to the end of the Victorian age. Though the time-frame is clearly stated in the title, Porter has

briefly but sincerely traced the cultural history of healing and doctoring in Europe since the Classical times, both in spiritual and pathological senses, and discussed the changing portrayal of the doctor-figure in literature, lithographs and painting through the early and later Tudor periods, and the Jacobean age – before coming to the 1650s. He uses the religious attitudes in early modern England to study the public notion of death and disease, and the role of the healer-figure in negotiating between life and mortality, but he is conscious about showing the changing perspective in medical sciences, as it gradually became secularized. The multiple aspects of his thematic concerns and interests, so crucially interconnected in the book, can be best summarized in the following passage from the introductory chapter:

> Rather, it [medical culture] offered itself, and was received by its public, whether supportive or suspicious, in a broader perspective, as a repository of texts and tenets, advice and apothegms, `sick roles' and `well roles', a corpus of identities, teachings and practices to be respected — or reviled — for their theatrical, spectacular and even magical aspects, procedures best interpreted in anthropological, dramaturgical, liturgical, spiritual and aesthetic terms. (2011: 22)

The middle chapters of the book are directly engaged in developing the subject-matter addressed in the title: they offer an enjoyable account of the seventeenth and eighteenth century medical practitioners — their professional styles and vanities, attitudes towards their patients and their science, the competitive market of practice, the need for patronization from the social elites and so on. More interesting, however, is the way Porter shows how the doctors were looked upon by society – how they were visualized in paintings and cartoons, and represented in literary works — and more often than not satirized. His extended discussions on the

eighteenth century mock-heroic poem on the medical practice, called *The Dispensary*, is not only an illuminated piece of criticism in the field of literature and medicine, it can also claim recognition in the corpus of literary studies in Augustan satire. Finally, Chapter 10 takes the narrative forward into the Victorian period. He refers to the period's self-reformative and self-celebrating zeal which extended into the medical practice as well: this was evident in the Medical Amendment Act of 1858, and the official attempts to free the profession from quackery or illegitimate practices. However, beneath the measures of control and reform, there was continuation of illegitimate practices, which reflect the oft-critiqued duality of Victorian culture. Porter mentions this but briefly, and his analysis falls short of capturing the complexities of the medical interactions with society, art and literature in the Victorian times. He has basically focused on only two aspects of the dynamic relations between the fields of medicine, literature, media and visual arts. At one level, he looks at the new technology of photography, and relating this to the Victorian emphasis on realism, he shows how the positive representation of medical idealism was enriched by the newly emerging image-consciousness of a profession in the age of photographic representation. The other side of this image-consciousness is shown through the brilliance of medical satires and cartoons in Victorian journals like *Punch*. As for literary representation of the physicians, Porter is exclusively selective and one-dimensional: he discusses Harriet Martineau's Dr. Hope (in *Deerbrook*) and George Eliot's Dr. Lydgate (in *Middlemarch*) as idealistic (also flawed in some aspects) doctor-figures, and makes such generalized comments as "the Smollettian brute was replaced by the medical man of the highest ideals, if also tragic flaws" (2001: 258). In doing so, he falls into the stereotypification of the Victorian doctor-figure as either as a social 'hero' or as a subject of social satire. In fact, both

Martineau and George Eliot had several other aspects of medical interest in their other writings, which are not given consideration in Porter's discussion. The intriguing aspects of psychoanalysis, mysticism, sensation, and imperial politics which shaped such remarkable medical characters as portrayed by Wilkie Collins, Marie Corelli, R.L. Stevenson, Mary Elizabeth Braddon and Arthur Conan Doyle, are also left out. On the whole, Porter's discussion of the Victorian Developments in medical profession and its cultural representation, is comparatively less substantial and less organized than the rest of his work. Apart from this shortcoming, reading *Bodies Politic* is a thought-provoking intellectual exercise for researchers in the field of literature and medicine.

Tabitha Sparks' 2009 publication, *The Doctor in Victorian Novel*: *Family Practices,* offers a close examination of the portrayal of the physician in Victorian fiction, taking into account several major and minor literary works of the period. Her focus is on the role of the Victorian doctor as a representative of objective, empirical science, and in this light, she shows the doctor-characters in conflict with the intersubjective, familial and emotional ethics of the typical middle-class Victorian life. Basically, her book examines the incompatibility between the marriage-plot in the Victorian novel, and the doctor-figure in general. The range and dynamics of Sparks' choices of literary texts and character-types demand critical appraisal. Her approach to Victorian medical science is nevertheless simplified at times, especially when she tends to see the medical profession as a monolithic disciplinary view of empiricism, objectivity, and materialist science. As a result, her study seems wanting in a broader and deeper interdisciplinary consciousness. In an attempt to offer literary interpretation of all that medically happens in the novels, the argument sometimes shows a tendency towards generalization and simplification.

A clearer balance between "literalizing the medical" and "medicalizing the literary" can be found in Meegan Kennedy's book-length study, *Revising the Clinic: Vision, Representation and Knowledge in Victorian Medical Narrative and the Novel.* She revisits the Foucauldian notion of clinical gaze in a new light, and seeks to explore what differentiates clinical vision and observation from ordinary sight, and also looks at the instances when the clinical intersects with the sentimental, the philanthropic, the psychological and other ways of seeing.

Kennedy's major argument leads one to think about the relationship between the author's vision of social realism, the objective and mechanical observation of a medical eye, and what can be called a "third mode of vision" – namely, "insight". Using the nineteenth century theories of vision and speculation, with reference to Daston and Claude, she aptly points out that in nineteenth century medical ethics, the growing importance of speculation, "invite(s) a sympathetic or humanist mode of investigation that acknowledges the subjective experiences of both narrators and their objects of study" (5). The final chapter of *Revising the Clinic* explores how a combination of medicine and psychoanalysis can bring new interpretations of "gaze", "insight" and "knowledge" in the imperial context. Kennedy examines Freud's 'unique model of vision' that on the one hand brings a synthesis between medical observation and curious insight and speculation, and on the other, "explores, reads, and maps the resistant wilds of a labyrinthine hysteria" (5). Her reading of the imperial romance in the late-Victorian period applies the Freudian notion of the unconscious to the imperial vision and representation of the exotic colonies.

The medical, pathological and psychoanalytic aspects of imperialism which Kennedy discusses in the last chapter of her book, has been the subject of fuller book length studies as well. However, most of the works on this subject are authored by

scholars from the social sciences background. *Psychoanalysis in Colonial India* by Christiane Hartnack has been a valuable contribution to this line of critical approaches. It begins by showing how the burden and 'guilt' of imperialism often affected the sanity and sensibility of the British civilians living in India, and afterwards moves into the history of the psychoanalytic studies and practices in colonial India. Sudhir Kakar's *Shamans, Mystics and Doctors: A Psychological Inquiry into India and its Healing Traditions* takes a reverse turn across time and history. It goes back to the pre-colonial, ancient times and explores the mystical, esoteric cults of 'healing' in ancient India. The Epilogue brings the journey back to modernity, showing how those early traditions can be understood in modern psycho-medical terms of the doctor-patient relationship. The book offers a close examination of the psychic, philosophical and ritual aspects of India's old traditions of healing, often with references to Ayurvedic, Tantrik and other esoteric literatures.

The majority of the social and medical historians have, however, concentrated more on the ways in which the colonial health situation was brought under the rulers' control. David Arnold's *Colonizing the Body*: *State Medicine and Epidemic Disease in Nineteenth-Century India* discusses the typical Eurocentric vision of medical control over colonial India, which has been critiqued by Indian scholars[8] like Poonam Bala, Biswamoy Pati, Madhuri Sharma, and Binoybhusan Roy – to name a few. *Nationalizing the Body*, a seminal work by Projit Bihari Mukharji assumes a significant role in the field of medical historiography: though a social historian, he has shown keen interest in the literary and journalistic representations of "daktari" medicine in the colonial period.

In *Nationalizing the Body*: *Medical Market, Print, and Daktari Medicine*, Mukharji contends the clichéd idea that western medicine in the colonies functioned

only as a device of power and imperialism. He revisits the lives, writings and works of Indian doctors who were educated in western medicine, but sought to vernacularize it, to show how the modern medical science was made "less alienated" and even "nationalized" in the native context. Mukharji engages himself in the study of the interactions between western medicine and several indigenous medical traditions as the Ayurvedic, Unani and Hakimi. The novelty of his approach lies in his attempt to follow an interdisciplinary mode of analysis. Trying to find how the native doctor's identity was constructed, he looks at the Bengali print culture as a whole, reading side by side the medical journals and periodicals, cheap guidebooks for domestic health and treatment, and some literary texts with medical references. However, the range of his selection of literary texts is rather limited, and his approach to them hardly goes beyond a summarized reporting of textual facts. Even within the corpus of specialized research-works in Bengali, there is a certain inadequacy of critical attention to literature and medicine on the whole. It appears that there has hardly been any attempt to study the tradition of medical characters or concerns portrayed in Bengali literature, in a historically or thematically conceptualised frame of research.

Literature and Medicine, as a field of study with particular reference to the role of the doctor, has not yet exhausted its scope. Though several studies of colonial medicine are available in the field of social sciences, a detailed survey of the literary representations of the doctors' roles – ethical, psychological, philosophical and political ─ in Victorian England and in colonial India, is yet to be done. So my research-work, titled *Representation of Medics in British and Bengali Literatures (the 1850s - the 1950s): A Comparative Study* seeks to engage with a relatively less explored area through a comparative study of doctors, disease and cure represented in both the literary cultures. The title of my dissertation uses the term "medics" instead

of “doctor” or “physician” with a purpose: of the variety of medical characters in literary texts selected for this research, there are both formal doctors with a medical degree or specialization and informal ones — occult-physicians and Ayurvedic practitioners. “Medic”, therefore, can be applied as a term which both formally and informally captures the variety of practitioners in their curative roles to mankind. The period mentioned in the title chiefly covers the mid and the late Victorian period in England, and the colonial period in India, though it extends to the 1950s to show the representation of medical characters of the colonial times in retrospection a few years after the Independence. The reason for selecting this specific time-scale is not far to seek: it is since the mid-nineteenth century that a remarkable paradigm-shift came over the discourse of medical epistemology, along with other sciences. This on the one hand brought new developments in medical authority and further moral and social responsibility to those who belonged to the profession, and also opened up spaces for questioning, rethinking, and the emergence of counter-discourses of alternative practices and experiments, on the other. This was manifested in the cultural and literary representation of the doctor-figures in the Victorian period. Similar tensions and discursive elements, under the conditions of colonialism, can be located in the history of medical practice in late-nineteenth century Bengal. The literary representation of the medics in the colonial period and even during the first decade after the Independence can be explored to find out whether the representation of doctors in early-twentieth century Bengali texts can be seen as existing in so-called seamless continuity with pre-colonial medical ethos and practice; or did the writers implicitly enter into a dialogue with the modernity of western medical practices? Throughout the research, there will be an attempt to explore certain questions like this, one of them asking how far the philosophical pursuit of cure (sometimes in a

spiritual sense) can contradict or qualify the worldly notions of failure and success pertaining to the curative role of the doctor, in a pathological sense. Another important question, which is rather embedded in the comparative nature of the research-topic can be framed thus: Is it possible to find any point of reconciliation between the two traditions (Western and Indian), concerning the doctor's role within the text?

The research questions can be seen as encapsulating the multidimensional nature of the study on doctoring and cure, and thereby reaffirming the difficulty of reducing the proposed area of examination to any single framework of critical theory. Since the publication of *The Birth of the Clinic,* Foucault's theory of "medical gaze" has become an oft-used paradigm for literary and cultural studies concerning medical characters. However, the doctor-patient relationship in nineteenth century British novels is often represented as so dynamic and complex that it would become a simplification to think that all literary portrayal of medics within the text(s) can be laid in a single pattern of subject/object binary. In Dickens and Gaskell, for instance, the doctor's eye does not always dissect and objectify the suffering body of the diseased; the medic's personality is represented as rather caring, sympathetic and humanitarian. In texts like *The Moonstone* and *Dr. Jekyll and Mr. Hyde*, the psychoanalytic dimension of the doctor-character points towards a collapse of the subject/object division that traditionally exists in the doctor-patient relationship. Moreover, the Indian philosophy of cure suggests a different kind of power-relation between the doctor and the patient where the Foucauldian theory does not explain the status of the medic-figure. The *roga-rogī* approach towards *ārogya* (healing) seeks to address the ailment from the point of view of the patient, and appeals to the inner power of the patient to participate in the process of healing. This does not mean that

the Indian system of doctoring is altogether free from any power-relation between the doctor and the patient; however it redefines the role of the physician in a new light. In texts like *Dakghar* or *Arogyaniketan,* representation of the Vaidya-figure embodies a philosophy of life that is able to look beyond diseases and sorrows of bodily cares, and understand a greater truth that lies behind death. And this is not something exclusive to the Indian medical philosophy: in various other cultures ─ including some esoteric systems of alternative cure in the West, the role of the medic can be seen as different from that defined by Foucault.

In recent times, some alternative theories of healing have sought to question the binary of the doctor-patient relationship in terms of a subject-object division played out as a game of displacement and gaze. David Greaves' book, *The Healing Tradition,* for instance, offers an insightful examination of the traditional role of the "healer" in western medicine, interrogating how it can be revived in the present age of biotechnology and professionalism in doctoring. On a further new note, Anne Harrington's *The Cure Within:The History of Mind-Body Medicine* (2009) studies the journey of "cure" across the East and the West, and develops a spiritual-somatic notion of physical and mental health ideally desired by mankind in general. Several articles in Makarand Paranjape's edited volume, *Healing Across Boundaries* (2015) deal specifically with "spirituality in terms of holistic or integrative therapeutic practices such as Āyurveda and Siddha, in comparison with the body centric or mechanistic ideology of modern bio-medicine", as stated in the editor's Preface (Paranjape xxiv). The present research based on the representation of medics in literary texts and cultural imagination proposes to draw its theoretical framework from such multiple possibilities of understanding the concepts of "cure" and "healing".

For research-methods, this study will combine critical survey and textual analysis (based on narratives read as "case-history") with conceptual understanding (concerning the philosophical idea of "cure") to investigate how far the literary representations can show some affinity along with differences in the construction of the doctor-figure as a medical, moral, social as well as political subject within the narratives, in the Victorian and Indian contexts. Having stated the research-objectives and methods in a rather generalized way, it is now important to propose the chapter-arrangement.

The present introduction has focused very briefly on the concept of cure – in its different senses, with specific material, cultural, philosophical, psychological and other affiliations, both in the Western and Indian traditions, with special reference to the doctor-figure as a certain social, ethical and professional identity. The intersections of literature, society and the medical science will be discussed in the first chapter, taking as its principal concern the Victorian developments on the theme of social and moral doctoring. This chapter will go into a close examination of Charles Dickens' *Bleak House*, Anthony Trollope's *Doctor Thorne* and George Eliot's *Middlemarch* to consider the doctor-characters, facing trials of their moral integrity and responsibility, against the evil and despair of the "social disease" difficult to cure by their individual goodness. The struggles of female physicians in late Victorian England, as represented in some "New Woman Doctor novels" have also been discussed briefly at the end of this chapter.

In Chapter two the psychological duality of the doctor-figure, with some incurable malady of his own which often merges his identity with that of the patient, is analysed considering Stevenson's *Dr. Jekyll and Mr. Hyde* and Wilkie Collins' *The Moonstone.* This chapter also considers the trope of "The Metaphysical Physician" or

the mystic as doctor, bent on merging spiritual and pathological cure with a occult-scientist's interest in the maladies of the soul ─ a character-type popularised in late-Victorian occult-fiction and sensation-novels. Sheridan Le Fanu's *In a Glass Darkly* and Marie Corelli's *A Romance of Two Worlds* are to be two important texts in this genre.

Chapter three delves into the modern (and postmodern) ethos of bioethics, in relation to the ethical dilemma of a doctor, or the medical system itself, when placed against a backdrop of rapid commercialization and technological advances in healthcare. Texts discussed in this chapter range from George Bernard Shaw's play *The Doctor's Dilemma* to novels by such physician-authors as A. J. Cronin and Josephine Elder ─ namely, *The Citadel* and *Doctor's Children*, based on their personal experiences. Aldous Huxley's science-fictional works, *Brave New World* and *Ape and Essence* have also been taken into account, to show how they represent a futuristic vision of medical and scientific totalitarianism.

In Chapter four, the focus is on the doctor's anxiety and concern for finding some remedy for the imperial maladies, especially in colonial India, in the light of some fictional works by Kipling and Flora Annie Steel. This chapter discusses how the colonial-Victorian notion of "doctoring the empire" was countered by a rather "nationalized" narrative of medical professionalism in the native contexts which produced a gradual familiarization of the *daktar*-figure. The counter-discourse of "swadeshi" doctoring finds a variety of manifestations in such works as *Bagher Baccha* by Jnanendranarayan Bagchi and *Agniswar* by the physician-author Banaphul, or Dr. Balai chand Mukhopadhyay.

Chapter five focuses on the representation of female physicians and their trials, troubles and challenges in colonial Bengal fiction. In an attempt to read

women's writings and memoirs as "history", this chapter ventures to follow the journey of two lady doctors in colonial Bengal, namely, Dr. Haimabati Sen and Dr. Jamini Sen, as depicted in their memoirs. The literary genre of "bildungsroman" thus converges with feminist historiography, and locates the experiences of women medics inside and outside what they understood as "home". With reference to some other lady doctors in real life and in fictional representations, the paper also suggests that the boundary between fiction and reality, gets blurred so often.

The sixth chapter, being the last, examines the doctor patient relationship set against a larger vision of life, death and beyond. The focus is on individual authors' take on the daktar-character, and the concept of cure across cultures. Apart from the celebrated roles of the two Kavirajas in *Dakghar*, and their contrasting views regarding cure and well-being, two short stories by Tagore, namely, "Dristidan" and "Malyadan" can also be read as significant texts. They narrativize the claims of the individual human being as a character, looking beneath the mere professional identity of a doctor, often problematizing, or even destabilizing the authoritative notion of the clinical eye attributed to the doctor. There is instead a critical yet sympathetic dealing with the inner complexities of both the doctor and the patient, which often leads to new philosophical and spiritual insights about human life, suffering and cure. This may lead either to a curative and reformative activism or towards a half-engaged, disturbed yet a somewhat stoically conscious acceptance of life as it is. This chapter will also try to point out affinities ─ thematic or otherwise, between some British texts of the Victorian period, and the Bengali texts under discussion, wherever applicable.

The sixth chapter also deals with *Arogyaniketan*, a text representing the colonial medical situation and its attendant tensions of modernity and tradition, as it reflects the traditional medical system's encounter with the Western medical

education. Colonial modernity, manifesting itself through progressive empirical sciences and medicine, had to face challenges from a persisting code of tradition, claiming its endurance and integrity even after the independence. Though the text provides at the end a somewhat peaceful philosophical way-out, moving beyond merely pathological ways of looking at disease, death and cure, the question remains: is there any possibility of finding terms that can help one understand better, the problems concerning the doctor's role vis-à-vis cure, and any probable reconciliation, despite differences in the cultural perspectives and situations that produced such narratives, and in reality itself? This is a prelude to the concluding chapter, which attempts a summary of the findings. The chief objective of the research is to critically examine, through a comparative and intercultural study of doctors, disease and cure represented in both the literary cultures. In light of Medical Humanism, the social, ethical, psychological, philosophical and political discourses around medical ethics can be revisited, in order to explore how far the chosen texts and contexts can be helpful to find any point of reconciliation, not only binary oppositions, in the two different systems of knowledge and practice – Indian and Western. Considering the review of works done so far in similar or related areas, and the multi-dimensional social and cross-cultural nature of interests involved in it, this thesis offers to contribute to an epistemological discourse of social and ethical relevance. It is also meant to examine the colonial and postcolonial dialogue between the Victorian medical ideas and realities through their literary representation, and the native traditions of doctoring seen through one of modern India's literary traditions in the Bengali vernacular. This can also be interesting from both national and cross-cultural perspectives. In other words, this work hopes to be of significance in a relatively less explored area of study regarding the representation of doctoring vis-à-vis the idea of

cure in literary works, keeping in mind its many dimensions concerning human life, well-being and society.

Notes :

1. Translated by Ludwig Edelstein, quoted from Ludwig Edelstein, *The Hippocratic Oath: Text, Translation, and Interpretation*, Baltimore: Johns Hopkins Press, 1943, p.3.
2. For a detailed account, see R. D. Orr, N. Pang, E. D. Pellegrino, and M. Siegler (1997). "Use of the Hippocratic Oath: A Review of Twentieth-Century Practice and a Content Analysis of Oaths Administered in Medical Schools in the U.S. and Canada in 1993." *The Journal of Clinical Ethics* 8 (Winter): 377-388.
3. Jane Harrison, *Prolegomena to the Study of Greek Religion*, 3rd ed., New York: Meridian Books, 1955, 95-106.
4. H. Brody's book *The Healer's Power* (New Haven: Yale University Press, 1992), for instance, examines the power and responsibility of the doctor-figure in some Russian and English texts, from a Foucauldian perspective of clinical authority. However, he uses the term "healer" in contexts where "curer" could have been more justified.
5. A similar observation is made by Roy Porter, in ***Bodies Politic: Disease, Death and Doctors in Britain, 1650-1900.*** London: Reaktion Books, 2001, p.131.
6. David Greaves, "Introduction" and "The Tradition of the Healer", in *The Healing Tradition: Reviving the Soul of Western Medicine*. Oxford, UK; San Francisco: Radcliffe Publishing, 2004, pp. 1-24, 67-76.
7. The common Sanskrit prayer-mantra "*sarve bhavantu sukhinah, sarve santu nirāmayāh*" ("let there be happiness to all, let all be healed/cured") indicates the use of the term *nirāmaya* in a larger idealistic context, i.e., prayer for the perfect well-being of

all humanity. The exact source is difficult to locate, the language suggests that it was composed in the post-Vedic period.

8. Bala's work *Imperialism and Medicine in Bengal: A Socio-Historical Perspective* (1991) is an important contribution to the history of colonial medicine. In *Contesting the Colonial Authority: Medicine and Indigenous Responses in Nineteenth- and Twentieth-Century India* (2012), she explores the idea of medical pluralism in colonial and postcolonial India, which took shape through a nuanced interplay of resistance and collaboration between the Western and the indigenous medical traditions. See also Madhuri Sharma's *Indigenous and Western Medicine in Colonial India* (2012) and Binoybhusan Ray's *Chikitsa Bijnaner Itihas: Unish Satake Banglay Paschatya Sikhsar Probhab* (*History of Medical Science: Influence of Western Education in Nineteenth Century Bengal*), Sahityalok, 2005 (original text in Bengali).
9. Some works on Banaphul, or Dr. Balai Chand Mukhopadhyay, who was a novelist and also a doctor by profession, have discussed the representation of medical characters in his works. *Banaphul: Jibon, Mon o Sahitya* (*Banaphul: Life, Mind, and Literary Works*) by Urmi Nandi, and "Banaphuler Jibonbed: 'Agniswar' ebong 'Hate-Bajare'" by Abhijit Tarafdar can be cited as critical writings that focus on the medical aspect of the physician-author's life and career.

Chapter 1

Social Doctoring and Victorian Literature: The Physician as Protagonist

Sir Luke Fildes, a renowned painter of the late Victorian age, completed an oil painting titled *The Doctor*, in 1887[1]. It captures in a glimpse the socio-historical milieu which shaped the identity of the General Practitioner in Victorian England since the 1840s. The painting shows a doctor attending the sickbed of a poor child. Though a candle is burning still, a natural light also comes in, suggesting that it is now dawn, and the child has survived the night. The doctor's figure represents a calm and soothing heroism at the face of death. He has spent, it seems, a sleepless night, nursing the sick child.

The painting not only depicts a positive and humanitarian image of the Victorian General Practitioner, but also conforms to the close association between medical reforms and social concerns in the mid-nineteenth century. The situation of the poor, their health-problems and the service rendered by the doctor in a philanthropic capacity had been brought together by the state's concern for public health during the epidemics. This was exercised by means of several laws and reforms since the 1830s, especially the Poor Law Amendment Act of 1834. The post of the "District Medical Officer" was created by this Act for a group of general practitioners whose duty was to look after the impoverished populace. Ideally this was a remarkable step towards achieving the social and philanthropic goals of the medical profession, at a broader democratic level. However, as Michael Brown points out in his essay, "Like a Devoted Army: Medicine, Heroic Masculinity, and the Military

Paradigm in Victorian Britain" (2010), the social status of the "Poor Law doctors" was rather problematic[2]: they were paid too poorly, and often neglected in the professional field by their superior colleagues – the family physician who served the aristocratic households, the consultant with a large private practice and of course, doctors who worked in reputed hospitals. The "Poor Law doctors" thus found themselves in solidarity with the public – the slum-dwellers and the working-class population, and at odds with the more elite section of practitioners.

Brown's informative survey, if extended to a deeper conceptual level, makes one understand what kind of a moral zeal could have given some encouragement to these "neglected" doctors, thriving at the lower levels of the professional hierarchy. Despite poor payment, little prospects of rising in the service and lack of proper recognition, most of these struggling middle-class practitioners showed a devoted commitment to their service to earn the people's trust and good opinion. This democratic nature of their service also required that they should work more as "general practitioners" than as "specialists". In the late 1840s and 50s, when further attempts were made to pass reformative medical acts and laws, it was not only to control unauthorized practices and corruptions, but also to sustain and brighten this positive image of "social doctoring", achieved by the good work done by the general practitioners.

This helped to create a self-sacrificing and humanitarian image of the middle-class general practitioner in several literary representations of the period — an image opposed to the self-interested, business-like attitude of the sophisticated urban doctors, accessible to those who could pay fees and give a call to the physician at their will. The profit-making nature of these elite doctors was often a target of satire in contemporary newspaper articles, cartoons and

literary caricatures[3]. On the other hand, there was the problem of quackery and illegitimate practices[4]. Against this backdrop, the "Poor Law doctors" sought to gain respectability through their good work, with a reformist zeal. So by the 1840s, though the position of a middle-class doctor was not very lucrative, it became an idealistic platform to enter the profession, for young middle class gentlemen without inherited property or aristocratic legacy. This attitude finds expression in Dickens' *Bleak House* (1852-53): when Richard Carstone wishes to study medicine, Mr. Boythorn as a well-wisher gladly exclaims,

> I rejoice to find a young gentleman of spirit and gallantry devoting himself to that noble profession! The more spirit there is in it, the better for mankind, and the worse for those mercenary task-masters and low tricksters who delight in putting that illustrious art at a disadvantage in the world. (166)

Richard, however, fails to continue his medical studies. He absorbs himself in legal matters and ends up miserably, out of a soul-killing frustration. If his case illustrates the pathos and perplexity of the professional prospect of medicine, it is no less depressing for the major doctor-figure in the novel, Allan Woodcourt. From Esther's narrative we learn that all his widowed mother's savings were spent "in qualifying him for his profession […] and although he was, night and day, at the service of numbers of poor people, and did wonders of gentleness and skill for them, he gained very little by it in money" (Dickens 235). Nothing though can distract Dr. Woodcourt from his mission. Unlike Richard, he does not give up at the face of odds and continues his service to society undeterred.

The social-medical scenario in which *Bleak House* is set, refers to the "diseased" state of mid-Victorian England. By the 1840s, repeated attacks of

cholera and typhus fever claimed many lives in Britain, and the worst sufferers were the "lower order" people, living in utter poverty and unhygienic sanitary condition amid the urban squalor. The very nature of the duty of the "Poor Law doctors" officers earned them a more enduring image of heroism, fighting the pestilence – in a pathological sense of trying to keep in control the spread of disease, as well as in a moral sense of combating social evil that exposed the poor to such dismal conditions. Critics like Priti Joshi and Michael Brown have shown that Chadwick's 1842 ***Report on the Sanitary Condition of the Labouring Population of Great Britain*** drew public attention to the service rendered by the Poor Law surgeons, whose duty among the sick slum-dwellers made themselves vulnerable to the disease[5]. Dickens' portrayal of Dr. Woodcourt conveys this reality vividly enough. Returning home from his journey as a marine surgeon, he finds himself in the midst of disease, contagion and pestilence in London. Unlike other sophisticated doctors, he moves across the slum-alleys at Tom-all-Alone's and looks for any opportunity to be "of some use" to the poor patients. There he finds Jo, and without any fear of contagion, does all that he can for him, before the boy dies. Woodcourt, however, has not "caught the disease" in doing so, but in contemporary medical journals like *The Lancet* and *The Journal of Public Health*, tragic stories of dutiful doctors who contacted the disease and became "martyrs" got wide circulation. Their service was felt to be all the more valuable during the epidemic situation. Cholera took an epidemic form in Britain in the autumn of 1847, followed by typhus in the winter of 1848; and the Parliament had to pass the Public Health Act as an immediate consequence.[6]

Critics have often sought to read *Bleak House* against this topical backdrop of social and medical mapping (Gilbert 2004: 116-17). A sense of pollution, disease and squalor looms large over the things, situations and locations surveyed by the panoptic vision of the omniscient narrator. This vision is characteristically a medical one: if diagnosis is one of the initial requirements of doctoring, the role of a doctor can be attributed to the third-person narrator who diagnoses ailments everywhere in the body of a sick society. From the sarcasm evident in the diagnosis of gout as symptomatic of aristocratic vanity and status (Dickens 215-16), the narrator's "medical" survey moves to a mixture of disgust and pathos in describing the apalling life at Tom-all-Alone's, neglected so long by the authorities of civic health:

> As, on the ruined human wretch, vermin parasites appear, so, these ruined shelters have bred a crowd of foul existence […] where the rain drips in: and comes and goes, fetching and carrying fever, and sowing more evil in its every footprints than Lord Coodle, and Sir Thomas Doodle … and all the fine gentlemen in office […] shall set right in five hundred years – though born expressly to do it. (217)

Several literary critics have been inclined to view the representation of "disease" in bleak house as a manifestation of societal ills, or a metaphor for urban pathology (Scwarzbach 93-104, Benton 68-80). What derives from such a critical approach, is a general emphasis on social doctoring, but little attention has been paid to the doctor-figure himself. So it can be an interesting exercise to study how the doctor-character negotiates his social duties as an individual within the text.

Dr. Woodcourt first appears in the text without a name, only as a "dark young surgeon" (137) who examines the dead law-writer, Nemo. He begins by commenting rather professionally on the cause of Nemo's death (an over-dose of opium), but his

true character shines out when he takes a sympathetic interest in the dead man himself as a fellow-creature. He considers it a "happy release" (138) for the man who has been living in such poverty and misery, and more like a pastor than a doctor, he seems to be concerned with the inner life of the dead, wondering whether he had experienced "a fall in life" (138). The doctor's vision goes deeper than the mere exterior of the patient's clinical condition, and this attracts a significant remark from the third-person narrator. The omniscient narrative eye does not fail to notice that "the young surgeon's professional interest in death" (138), which qualifies the detached, objective gaze of a medical authority in general is significantly "quite apart from his remarks on the deceased as an individual." (138).

Again, the very posture of Woodcourt sitting on the edge of Nemo's deathbed, and looking, "not unfeelingly" (138) at the face of the deceased one, putting his hand on "the region of the heart" (138) emphasizes the doctor's subjective feelings towards another person, even when he is dead. "Heart" bears a double-connotation – denoting both the anatomical organ which has now stopped working, and the metaphorically celebrated seat of human emotions and finer sensibilities. Woodcourt again mentions the word later in the novel, when he learns about the failure of the lawsuit of Jarndyce and Jarndyce. "My dearest life, this will break Richard's heart!" – the doctor whispers to Esther (850). Woodcourt has been both friend and physician to Richard. He knows how much injurious and soul-killing the shock would be, and his utterance of the word "heart" suggests something more than a doctor's concern for what may cause a heart-attack to his patient.

These instances in the narrative not only provide a positive image of Woodcourt's individual traits both as doctor and human being, but also bring about a reconciliation between the two kinds of vision involved in the Victorian medical

narrative, and points towards a "third kind of vision" as well. In Meegan Kennedy's theory, "curious observation" which involves the inquisitiveness of a scientific and realistic view often merges with "curious sight", which finally resorts to a kind of inner vision about man and his situation. Besides, she has suggested a third vision that derives from speculation[7]. Applying these categories to Dickens' gradual unfolding of Woodcourt's role as a clinically expert, sensible and speculative doctor-cum-man-of-feeling, it can be argued that the medical hero of *Bleak House* achieves the three-fold vision in a combined sense involving the clinical, the moral and the philosophical. This third level of vision, in a way, aligns him more with the figure of an archetypal healer, than a nineteenth century medical specialist or consultant.

Woodcourt's role as a healer is illustrated through several textual instances – especially in the death-scene of Jo. When the doctor finds and takes him under his treatment, it is too late. The street-boy who cannot even claim a "name'', or belonging to anybody, is given some kind of spiritual solace by Woodcourt who assumes the double role of the doctor and the priest at Jo's deathbed. He utters the "Lord's Prayer" for Jo, and the boy repeats it without knowing its meaning, but solely believing in the kindness of the doctor: "I'll say anythink as you say, sir, for I knows it's good" (637). He asks, groping for hope in darkness, "Is the light a-coming, sir?" Woodcourt replies, "It is close at hand" (637). Dickens was no orthodox Christian, rather his satiric portrayal of such pseudo-philanthropic ministers as Mr. Chadband and Mr. Pardiggle in *Bleak House* betrays his distrust of religious dogma. However, as Gary Colledge has shown, Dickens did believe in the spiritual possibility of solace in a simple, humanitarian and *New Testament*-sense of "real Christianity"[8]. His faith in a transcendental panacea which comes through bodily death but brings some promise of spiritual liberation, is evident in the death of his angelic child-heroine Nell (in *Old*

Curiosity Shop), in the martyrdom of Sydney Carton, glorified by a sense of Resurrection through Lucie's child (in *A Tale of Two Cities*), and also in Jo's death in *Bleak House*. Interestingly, here the role of a sympathetic doctor-figure adds to the thematic ethos of "healing" at the spiritual and psychical level. Despite the omniscient narrator's ironical tirade against society, state and order that follows Jo's death, what is still unmistakable, is some element of redeeming bliss in the final intimate bond achieved by the doctor and the patient.

H. Brody has classified the qualities of a medical man as "healer" into three categories : Aesculapian – regarding the doctor's technical skill, mastery of his science and authority; charismatic – based on the doctor's personal virtues and the impression they create on the patients ; and social – in relation to the social status he occupies in the mind of the public[9]. The Victorian society considered the medical man as an epitome of all three virtues. M. J. Peterson comments that along with laymen, doctors themselves shared "a belief in the superior virtues of liberal learning and gentlemanliness and the inferiority of technical training and skill" (135). David Greaves argues that since the development in professionalism and specialization in the nineteenth century, it was possible only for the general practitioner to assume both the charismatic and the social role in a complex fashion (70). However, Dr. Woodcourt in *Bleak House* suggests otherwise. He is a surgeon, not a General Practitioner, yet in him one may recognize a coexistence of all three attributes, either directly or by inference. His "Aesculapian" skill is not much illustrated in the text, except in the instance where he promptly comes forward to nurse the wounded brickmaker's wife at Tom-all-Alone's, as if "establishing a surgery in the street" (617). However, his skill is often praised by his grateful patient Miss Flite, and of course, by Esther who admires him and later becomes his wife. His personal

"charisma" or ability to win the trust of the patients is embedded in Miss Flite's grand eulogy on Woodcourt's service to the sick and the poor – the victims of the shipwreck:

> There, and through it all, my dear physician was a hero. Calm and brave through everything. Saved many lives, never complained in hunger and thirst, wrapped naked people in his spare clothes, took the lead, showed them what to do, governed them, tended the sick, buried the dead, and brought the poor survivors safely off at last! My dear, the poor emaciated creatures all but worshipped him. (490)

The speaker's language and attitude in the passage show the height of what Brody calls "charismatic" about a doctor, in describing the heroic and almost a "saviour''-like image of a healer. A similar heroic image of the good physician can be found in *A Tale of Two Cities*, where Dr. Manette, himself a victim of the past atrocities of the aristocratic regime in Paris, comes back there after the Revolution, during the Reign of Terror, and assumes a glorious role: "Still, the Doctor walked among the terrors with a steady head. [...] Silent, humane, indispensable in hospital and prison, using his art equally among assassins and victims, he was a man apart" (*Two Cities* 269). However, the image of Dr. Woodcourt in *Bleak House* suggests something more: it shows how responsibility, the ability of care-giving and the will to go good – virtues otherwise secular, can elevate the status of an ideal medical man to the level of a Christian pastor-hero. Lauren Goodlad aptly suggests that through his compassionate attitude towards medical and social services, the doctor-hero of *Bleak House* acts as the agent of "pastoral care" which is contrasted to the shrewd and dispassionate table-talk of the Doodles and Foodles – representatives of the ineffective Parliament (535-8).

The social status of the doctor– the third category conceptualized by Brody – is also discernible from Dickens' concern with the ambiguities and problems involved in the medical profession and the state's attitude to the doctors' service to society. Woodcourt's good work gains general applause in public, but this cannot ensure that he will get official recognition or any kind of encouragement from the government. In England, people do not get awarded for such peaceful services as Woodcourt has done, remarks Esther (491). What is at the core of her comment is a critique of the unhealthy socio-political condition of the state in which the immediate need for sanitary reform and the poor citizens' health-problem are neglected, and abstract ideas of preaching philanthropy thrive; where MPs like Doodle and Coodle enjoy their parliamentary sessions in perfect idleness and a good doctor like Woodcourt goes unrewarded. The ideals of a reformist medical ethics have thus been upheld in the text in order to expose the "disease" in the system – the society in general. Woodcourt, however, is not an activist: unlike the critical perspective of social doctoring embedded in the third-person narrator's voice, he never critiques the system or campaigns to bring changes; he rather engages himself personally in the service and tries to do all the good he can, situated against a diseased and corrupt surrounding. Does it suggest that the project of social doctoring, after all, is a failure? The answer is never explicit, yet the function of the physician-hero shows that if any service to society is to be done, the duty falls on individual goodness.

The final words about Dr. Woodcourt's professional virtues come from his wife Esther who shares much of his generosity and kindness: "I know that in the course of that day he has alleviated pain, and soothed some fellow-creature in the time of need [...] from the beds of those who were past recovery, thanks have often, often gone up in the last hour, for his patient ministrations" (861-2). It is remarkable that

Woodcourt's ability to cure some particular disease is not emphasized here; what becomes more important is his quality as a ''healer'' who can soothe and alleviate pain, as N.D. Buscemi has also noted (46). The doctor's service to society in general is inseparable from his responsibility towards his patients at a personal level. Again, Esther's description of the way of his dealing with his patients harkens back to the idea of a sympathetic and compassionate perspective of doctoring which, unlike Foucault's concept of "medical gaze"[10], does not objectify and dissect the suffering body, but recognizes the need to comfort the mind of the sufferer. There have been various scholarly attempts to read *Bleak House* through a Foucauldian lense, making a connection between the notions of "surveillance", "disciplining" and "control" of the civic pathology[11] that can be associated with the critical and disinterested "medical gaze" of the omniscient narrator. If the text is read as a project of social critique through the detached medical perspective, Dr. Woodcourt's role within it provides an alternative vision of medical humanities that remains steadfast in its individuality and professional integrity even amidst the general muck that pervades the society.

When Dickens was writing *Bleak House,* professional ethics in medical practice and the social status of a physician in Victorian England were going through a process of gaining a new identity. As Porter shows, in several mid-nineteenth century medical journals and reports, a tendency to establish the profession in proper dignity was quite visible[12]. Especially after the Medical Act of 1858, the professional identity of the doctor in society came to be viewed in association with the dominant mid-Victorian idea of a gentleman. The portrayal of a physician-hero in Anthony Trollope's less-known novel *Doctor Thorne*, published in the same year, can be read as an illustration of the changing social prospects of a Victorian doctor in close

relation to other kinds of social changes including class-mobility, legal awareness and democracy.

Trollope's protagonist is a qualified physician, and he introduces a new kind of professional ethics in the Bersetshire countryside. He is constantly at odds with his other colleagues – particularly Dr. Fillgrave — regarding matters of drug-preparation and selling, fees, status and patronage. Thorne would prepare and sell drugs for the convenience of his rural patients, because drugstores were not in great numbers in the countryside, and the general practitioner outside the metropolis had to assume a hybrid role of the physician, the apothecary and the surgeon as per necessity, as Wadington argues (164). Doctors like Fillgrave wish to maintain the conventional hierarchy by keeping a strict division between the consultant physician who gives only advice and the apothecary who sells medicine. Dr. Thorne, on the contrary, dismisses any vain-glorious idea of status, which separates him from the lower-order medics (apothecaries, for instance) who are also part of the profession.

Again, Thorne's insistence on exact fee (his "seven-and-sixpence a visit" is lesser than the "guinea fee" charged by his colleagues) is misinterpreted as hunger for money. While others pretend to be respectable specialists disinterested in financial gains, and in fact are at the service of equally respectable (rich) patients, Thorne is honest and openly practical in money-matters; nor does he take special care of aristocratic patients who can offer patronage and pay the "guinea fee". As a doctor his attitude is liberal and democratic: all patients are equal to him, and whenever he enters a house as a professional medic, he considers himself as one at the same level with its owner – whether he is a farmer or a lord. Trollope's commentary on the professional life of his protagonist is but descriptive and leaves little space for interpretation and reflective speculation. However, it depicts clearly the relation

between medical ethics and the socio-economic scenario in provincial England at a time when reforms and debates in the profession were going on, new registers were created for licensed doctors since the foundation of the General Medical Council (1858), and tensions about the old order and the problems of adaptability with the new became part of the social dynamics. Interestingly, the notion of social and medical reform in colonial India, which was initially under the "Victorian" influence, gradually began to negotiate the native situation in relation to its social and cultural context. However, by the early-twentieth century, when reformist doctors like Deen Chowdhury and Sebabrata Das (and later, Banaphool's Agniswar) appeared in Bengali novels of social realism[13], they shared many traits of professional dignity with Trollope's Dr. Thorne.

Dr. Thorne's views in matters of medical ethics and attitude are rather anti-conventional. His democratic values are supported by such radical medical journals as *Lancet*, but "the *Scalping Knife*, a monthly periodical [which] got up in dead opposition to the *Lancet*, showed him no mercy" (34). His hybrid role destabilizes the medical hierarchy between the "graduated physician" and the "dispensing apothecary" – something similar to the class distinction between a "gentleman" and a lower middle-class man in Victorian society. David Greaves has studied the character as a representative of the ideal general practitioner during the reformist era of Victiorian medicine. Nevertheless, Dr. Thorne's role and identity within the text are often given to self-contradiction. His personal pride in his legacy is rather gentlemanly, which is not consistent with his professional ways. Nevertheless, he can shake off the conservative bias of family pride, and become a kindly guardian to his brother's illegitimate daughter, Mary. The girl later marries an aristocratic youth, Frank Gresham, who cares little about rank and pedigree. Frank's mother, Lady

Arabella Gresham tries her best to keep her son away from the Thornes, and rejects the medical aid of Dr. Thorne. Finally, however, her health complaints grow serious and she has to commit herself again into the doctor's caring hands. So in many ways, Dr. Thorne and her niece can be viewed as agents of social mobility and adaptability to changes – in professional, social and private life. Even so, one may ask whether Thorne's professional progressiveness comes paradoxically from his confidence of being a "gentleman", or whether Mary's marriage is really a blow against social hierarchies and bias, considering that she herself, after all, gets an inheritance, and becomes a lady. However, it is through these questions that the text, otherwise undervalued, can claim new approaches of reading, especially in the field of social and medical humanities.

The medical hero in Trollope's text can be read broadly at two levels: personal and professional. Unlike Dr. Woodcourt in *Bleak House*, Dr. Thorne's professional manner is not always worthy of his patients' thankfulness and blessing. He is "brusque, authoritative, given to contradiction, rough though never dirty…, and inclined to indulge in a sort of quiet raillery, which sometimes was not thoroughly understood" (35). Beneath this hard exterior he also carries a tender heart that is acknowledged only by those who have "real suffering": he often laughs at trifling complaints, but "no patient lying painfully on a bed of sickness ever thought him rough" (35). Interestingly his capacity to function as a healer in a wider sense, comes out truly when he is not acting professionally.

The case of Sir Roger Scatcherd, the alcoholic and self-destroying country-knight, illustrates this tender side of the doctor. When he dismisses Dr. Thorne, the doctor feels sorry for the patient's miserable condition and finds it difficult to explain to Lady Scatcherd "that medical etiquette would not permit him to remain in

attendance on her husband after he had been dismissed and another physician called in his place" (122). Lady Scatcherd still persuades him, saying "But you can slip in as a friend, you know; and then by degrees you can come round him, eh? Can't you now, doctor?" (122) And Thorne finally assures her that he will do all he can in the capacity of a family-friend. Thorne's identity here, as his patient's wife demands of him, becomes a complex combination of two selves: private and professional. This is not simply a narrative requirement to sentimentalize the human being beneath the doctor's cloak; here one may read the subversive discourse of the rebellious "body in pain" that is suspicious of the medical authority's ontological domination over it. In fact, Sir Roger's psycho-pathological degeneration has paradoxically led him to what may be called a Freudian "death-drive" (thanatos) which makes him resist any kind of medical control that would take away his only resource of temporary yet fatal comfort: alcohol. As Dr. Thorne helplessly observes: "A man can die but once. It is my duty to suggest measures for putting off the ceremony as long as possible. Perhaps, however, you may wish to hasten it" (117). Sir Roger's sending for another doctor (Fillgrave) is rather an ironic self-vindication to perpetuate the torture on himself and hasten the process of death: he knows well that a mere professional consultant will not personally care for his well-being, he will simply give advice and go away. Seeking to critique Foucault's thesis on clinical authority, one may interpret this as a failure of the medical surveillance and control. Since Stachered obstinately refuses to be treated and cured, Dr. Thorne has to cast his professional authority aside and behave as a well-wisher, to enter into the confidence of the patient.

In *Patient's Progress* (1989), Dorothy and Roy Porter suggest that the role of the physician attending a deathbed, from the late eighteenth century onwards and for the better part of the nineteenth century, was "not as doctor(s) but as friend(s)", in

order to comfort the dying patients (144). Heather Freeman's reading shows how this helps to humanize the otherwise detached, professional self and conforms to the Victorian social novel's "universal" tendency towards making things familiar[14]: the doctor needs to channelize his "service" through a more sociable and familiar role of a friendly advisor and confidante. In the provincial world, he is known to many, trusted by them, and he is thus capable of gaining common wisdom and forming a general idea about the condition of life. His advice as a well-wisher to his patients, especially to the Scatcherds and the Greshams, is finally able to restore health and happiness to many, "treating" the causes (vanity, class-conflict, egotism, lack of mutual and social understanding) that affected the mental and social health of the rural community. In doing so, of course, Dr. Thorne has to undergo an identity-crisis, which Freeman calls a "fractured" personality (21). However, its effect is ultimately rewarding. Through many difficulties, he nevertheless tries his best to execute Sir Roger's will in order to help Louis Scatcherd. Again, in his role as a guardian-figure he takes all care to bring together Mary and Frank, which also requires his professional skill to be of use to Lady Arabella. The moment of reconciliation between the forgiving doctor and the patient who proudly dismissed him once, and repents it now, is remarkable: Lady Arabella apologizes and says, "So now we are friends again, are we not?" In return,

> The doctor took her hand cordially, and assured her that he bore her no ill-will; […] And then the doctor used his surgical lore, as he well knew how to use it. There was an assured confidence about him, an air which seemed to declare that he really knew what he was doing. (468)

The initial attitude is that of a good-natured personality who can "keep the upperhand" in his power to forgive, and soon it changes to that of a doctor whose confidence and skill give him a caring authority over the patient. As the medical

examinations and consultations are over, Lady Arabella feels “more at ease” (468). It is difficult to say what gives her this sense of ease: the reconciliation with a good person, whom she offended once, or the restoration of a healthy doctor-patient relationship in which she can be frank about her ailments and listen to the physician’s assurance. Whatever it is, the double function of Dr. Thorne as a man in society ultimately bears a positive effect on the people around him. The strict division between the professional authority and the private man (or, the subjective and the objective) which often tends to simplify the nature of man as a social being is thus problematized in Trollope’s text.

The conflict between the subjective and the objective selves thus achieves a further subtlety and complication in the character of Dr. Tertius Lydgate in George Eliot’s *Middlemarch* (1872). The novel is celebrated for its faithful representation of medical knowledge as a dominant scientific perspective of the nineteenth century. Eliot brilliantly depicts the moment of Lydgate’s finding his “inspiration”: on a rainy day staying at home, he takes a volume of the encyclopedia only to pass the idle time, and the page he opens abruptly reveals to him a new world of anatomical knowledge through the word “heart” and its “valvae”. He finds his vocation, goes to Edinburgh and Paris, to pursue medical science with an idealistic zeal to make new discoveries and to serve mankind in the light of his science.

Lydgate is not simply given to insulated laboratory experiments, rather he is physically active to satisfy the requirements of his patients. He diagnoses Fred Vincy’s typhoid at the “pink stage”, and himself runs to the drugstore because no time is to be lost. He saves a poor woman, Nancy Nash, from the unnecessary hazard and expense of undergoing an operation, by taking her promptly under his care. His consultation with Casaubon and Dorothea clearly shows that he does not consider his

duty done only in giving medical opinion; he takes care that the patient must not have any mental agitation. Casaubon's psycho-pathological problem is so severe that he cannot find any way, according to Lydgate's prescription, to relieve himself from anxiety and suspicions, and his weak heart cannot bear it too long. In case of Dorothea, however, Lydgate is successful. Basically he uses an old technique of healing that appeals to the patient's own will-power, making him/her believe that he/she can co-operate with the doctor in the process of recovery. Caldwell mentions that Lydgate's methodology combines conventional medical techniques with new clinical practices associated with the medical reform movement: "When Lydgate examines Edward Casaubon, for instance, he combines scientific advances with techniques developed long before such technology" (163).

Eliot places her medical protagonist within a time-frame when the medical profession in Europe needed reform. The novel begins referring to the years preceding the Reform Bill (1832), and there were indeed thoughts on reform in society, economics, epistemology, science, and practices of everyday life. The medical humanities had already gone through shifts in perspective and social roles since the eighteenth century; and now it was time for the new-generation young practitioners to pursue their work and study in a way that would vindicate their conviction that "the medical profession as it might be was the finest in the world, presenting the most perfect interchange between science and art; offering the most direct alliance between intellectual conquest and the social good" (136). It is a passage used by several critics who are interested in Eliot's engagement with the idea of Comte's Positivism: the "modern" phase of human evolution is an age which uses rational sciences (including the medical) to further the process of civilization. However, James F. Scott and Tabitha Sparks have argued that Eliot's intention was not to valourize Positivism, she

rather used its ideas to test its validity and negotiate its limitations in the practical field of social life (Scott 59, Sparks 23-24). A close look at Lydgate as a medical character may help one penetrate the problems more deeply.

Lydgate plans to go on working for the people, keeping himself at (what he thinks to be) a safe distance from the jealousy, intrigues and backbiting in the commercial world of London. He arrives at Middlemarch and begins his career as a brilliant young surgeon, but soon he finds that his ideas are much ahead of time, and the small provincial society of conservative doctors is not yet prepared to accommodate him. In this, he can be called George Eliot's "modern man", individualist, progressive and yet a flawed character, as Clym Yeobright has been to Hardy. Like Clym, Lydgate is one who wishes to achieve progress for his individual self and the community, but the time and place are not fit for him. With an idealism which can be termed proto-socialist, he seeks to spread activities outside the metropolis, so that the peripheral provinces can have access to the social progress through medical reform. Lydgate, despite his claim to be a rational and strong-willed man of science, is an emotional and fallible character, and he plays into the hands of the shrewd banker Bulstrode, who financially helped him in the project of the New Fever Hospital. As Rosamond's luxurious expenses drives Lydgate into debt, he is compelled to take one thousand pounds from Bulstrode as a loan. The banker had formerly been associated with some shady dealings, and Raffles who knows that past, has come to his house and fallen ill. Lydgate, unaware of all this, is called in to treat Raffles, but the patient dies. Nevertheless, Bulstrode's story is exposed and people suspect that Lydgate has taken the money as bribe and tampered with the treatment. This casts him in a negative light and affects his practice and goodwill in

Middlemarch. Frustrated and demoralized, the doctor relentlessly scrutinizes his own self, with no concrete proof at hand to "clear" his character.

The portrayal of fallibility and moral dilemma of the protagonist had long been a subject of interest to many authors before George Eliot. Her uniqueness in depicting the same in a new light lies in the professional nature of the protagonist she has chosen. Lydgate's moral questions render his internal self doubly fractured: on the one hand his subjective self is under the objective gaze of his social identity and responsibility as a medical man, and on the other, his individuality as a human being critically examines the general rules and probabilities in matters of diagnosis, treatment, life and death in which medical knowledge cannot prove adequate all the time. His clinical opinion that the patient should survive, might have been wrong. Still, circumstances make him wonder whether his instructions regarding the dose of medicine he prescribed for the night have been properly followed. Again, it would be wrong to say without proof that Bulstrode tampered his instructions on purpose: it could have been only a mistake. Besides, the banker has a nervous breakdown following the brutal public humiliation he faced, and Lydgate as a doctor finds it impossible and unethical to disturb him with enquiries. He nevertheless is eager to return the money he borrowed from Bulstrode, but it has already been spent to pay his debts. Even though all these arguments are valid from an objective point-of-view, Lydgate's strong sense of a subjective logic haunts him constantly:

> "But *if he had not received any money* […] ─ would *he, Lydgate,* have abstained from all enquiry even on finding the man dead? […] ─ would the shrinking from an insult to Bulstrode ─would the dubiousness of all medical treatment and the argument that *his own treatment* would pass for the wrong

… ─ have had just the same force of significance *with him*?" (696; my emphases)

This is so a complex and brilliantly drawn a picture of the turmoil in human psyche. Lydgate sees that his reputation and practice are "utterly damned" and thinks, "Even if I could be clear by valid evidence, it would make little difference to the blessed world here" (697). Yet, his self-respect shrinks from making a submission to the social forces, as he interrogates and answers himself, "Is there a medical man […] in Middlemarch who would question himself as I do? [...] I shall do as I think right and explain to nobody" (698). It is against the mirror-image of his ideal self and an equally ideal image of his profession that he seeks to define, however obstinately, all his actions, though he cannot altogether dismiss the opinion of the world outside. The high value he sets on this ideal image becomes all the more evident in the "finale" of the novel, when he has finally cleared his character and reputation through Dorothea's help, left Middlemarch and gained an "excellent practice, altering, according to the season, between London and a Continental bathing-place" (781), and still considers himself a "failure": "he had not done what he meant to do" (781). His aspiration towards making new discoveries in medicine has been reduced to simply a publication on gout, and his zeal to help the poor without caring much for "paying patients" initially drives him into debt and defamation, and later he has to buy a practice among the metropolitan people of wealth[15].

The basic nature of Lydgate is idealistic, but practically he is at a loss. His journey through life can be interpreted as alluding to the common medieval allegory in which man has to choose between "the way of the soul" and "the way of the flesh", represented by the two heroines of the novel – respectively, Dorothea and Rosamond. Lydgate's assumption that the beautiful and worldly Rosamond – a realistic woman of

flesh and blood has the making of a better wife than the moralist and celestial Dorothea proves to be wrong, and this also undermines his "strictly scientific view of women" (144). In their engagement-scene, what forces Lydgate yield to Rosamond's passion is a consideration essentially of medical nature. His exact words to Rosamond at this moment are: "What is the matter? You are distressed. Tell me — pray." (Eliot 282). He holds Rosamond's slender frame in his arms, and the author pointedly tells us that he has been "used to being gentle with the weak and the suffering" (283). The doctor's clinical opinion of women – considering them anatomically delicate and mentally fragile in general – thus becomes a binding clause in his personal life as well, since he has made a choice to take care of a woman like Rosamond. Rothfield notices that the relationship between the husband and wife basically shapes a failed doctor-patient bond, in which there is no cure (113). However, he does not point out what makes even this "medical" bond so problematic.

Some instances in the novel can be brought forward to understand this problem. The doctor's marriage to Rosamond becomes his tragic "error of judgement": soon after the wedding, he painfully realizes that she loved his good looks and respectable family connections, not the medical man in him. At one point, confronted by oppositions from his jealous colleagues, he draws inspiration from Vesalius, the post-Galen medical genius who established anatomy on a more scientific ground, and had to suffer a great deal for his radical views. Lydgate enthusiastically tells Rosamond how Vesalius digged up corpses at night to perform dissection, how his experiments with chemicals earned him accusations of sinister practices with poison, how he was attacked by his contemporaries, and ended up tragically. Rosamond misunderstands the moral and professional zeal which makes Lydgate identify himself with the iconic Vesalius, and remarks, "I often wish you had not been

a medical man" (430). He cannot believe that Rosamond can really "love [him] without loving the medical man in [him]", and she completely dismisses the values of a medical man with a retort: "Well, Doctor Grave-face, […] I will declare in future that I dote on skeletons, and body-snatchers, and bits of things in phials, and quarrels with everybody, that end in your dying miserably" (430-31).

Though uttered jokingly, these words betray that Rosamond has an obstinate tendency to dismiss anything that is serious from a medical perspective, which becomes all the more self-injurious when she is pregnant, and does not listen to her doctor-husband's instructions. She loses her baby due to excessive horse-riding, without Lydgate's knowledge, and of course, against his prescription. Towards the end of the novel, she develops a hysteric neurosis which derives from the absence of openness and co-operation between husband and wife, or doctor and patient.

The general humanist approach to doctoring holds that the ability to sympathize with pain is central to the ideal kind of doctor-patient relationship. This is exactly where the relationship between Lydgate and Rosamond fails. Feminist critics have complained that Eliot has been too harsh on Rosamond. In a close reading of the text it appears that each of Lydgate and Rosamond falls short of understanding the pain suffered by the other. Lydgate's initial pledge of a "strictly scientific view of women" (Eliot 144) is collapsed when he has married Rosamond. In this, his choice has been more passionate than scientific. However, he cannot give up his scientific ideals and medical duties which cannot match Rosamond's standard of a good life and happiness. Rosamond's bitterness towards the medical profession derives from her frustrations with her husband who represents the profession. Lydgate's doctor-like prescriptions in family matters irritate her, and she contradicts his wishes all the time. Pressed by debts Lydgate proposes to sell their luxurious house and move to a simple

one, but Rosamond secretly persuades the dealer not to proceed, and instead asks Lydgate's rich cousins for financial help, without telling him anything. A letter comes from his uncle denying any kind of help, and Lydgate feels shocked and insulted to learn that Rosamond's "secret meddling" has made the matter worse. He turns furious, and Rosamond proudly defends herself, finally breaking into hysteric tears. For the next two hours, Lydgate has to comfort her just as a gentle doctor soothes a rebellious and unwilling patient, but the problem remains unresolved. Nor can Rosamond understand his suffering. Condemned by the charge of complicity with Bulstrode's shady dealings, Lydgate hopes to get some healing sympathy from Rosamond, but she remains cold and reluctant. So the disease that troubles the family-situation of the doctor is a psycho-pathological problem – a lack of frankness, communication and mutual support between husband and wife performing within a framework of a doctor-patient relationship. There is no sense of complete healing: the doctor who cures so many patients in the novel (except the unfortunate case of Raffles), fails to heal his own inner sufferings, nor can he fully restore mental and physical health to his wife, except in temporary phases of compromise. Their occasional disagreements followed by Rosamond's agitation and sickness require Lydgate's doctoring efforts coupled with a sense of compromise at the emotional and psychical level. Their married life thus becomes an endless symbolic cycle of a chronic malady, which both the physician and the patient must endure.

Some kind of healing effort, however, comes to the fore through the agency of Dorothea. When Lydgate is struggling to find a way out of his disreputable and unhappy situation, she is the only one to trust him. Vicar Farebrother observes that human character "is something living and changing, and may become diseased as our bodies do" (692). Dorothea replies, "then it may be rescued and healed" (692). She is

resolved to support Lydgate who once helped her to recover from the exhaustion and trauma (both physical and mental) she suffered during and after her husband's illness and death. Though she is in no sense a formally qualified medic, her offer of help to Dr. Lydgate bears a sense of openness between colleagues. "Tell me, pray", she says, "then we can consult together" (717). Her initial words exactly echo Lydgate's own verbal response to Rosamond's distress which Lawrence Rothfield finds "pointedly couched in the language of a physician" (113), earlier in the text. Moreover, the possibility of "consult(ing) together" and finding some remedy, gives Dorothea a common space where she can understand Dr. Lydgate's suffering through a shared interest in "healing". In fact, earlier in the novel Dorothea asked Lydgate about the possibilities of improving the sanitary condition of the poor by means of providing proper and adequate housing for them. Her generous contribution to Lydgate's fever hospital also testifies to her interest in medical philanthropy. Now, as a true friend of Lydgate's, she learns the truth about Raffle's case and proceeds to "heal" the doctor's injured reputation. She defends Lydgate, advances him the money so that he can pay the loan back, and in a friendly conversation with Rosamond, clears some of the misunderstandings in their marital life. Dorothea's role as a moral counselor and healer, beside the doctor-protagonist's failure to "heal" himself can be interpreted as a sign of Eliot's view regarding both the limit and possibility of social and moral doctoring in life . She is not too pessimistic about the positivist ideals: she moulds them according to the reality of the time.

Rick Rylance in his essay "The Theatre and the Granary: Observations on Nineteenth-Century Medical Narratives" (2006) has classified "medical narratives" into two broad categories. One refers to the dispassionate and objectifying framework established in Foucault's *The Birth of the Clinic*, where

the narrative focus is chiefly on the doctor's role as the presiding "subject" who is in power and control. Oliver Sacks, a renowned clinical neurologist and medical humanist celebrates another type of nineteenth century medical narrative where humane feelings and a personal relationship between doctor and patient were more important than a mere objectifying clinical gaze. He laments that the "tradition of the richly human clinical tales[16] [that] reached a high point in the nineteenth century" (Rylance 255) has now been lost, with the advent of impersonal neurology. In other words, he emphasizes the humanitarian richness in a medical narrative where the doctor-patient relationship is based on trust and sympathy. Rylance critiques both frameworks for their limited vision: Foucault does not look beyond the power-factor, and Sacks romanticizes the medical too much. In recent times, the rise of bioethics and narrative ethics in medical fiction demands a shift of focus, foregrounding the patient's experience rather than the doctor's.

From a bioethical perspective, the Foucauldian framework seems to exclude the possibility of any equilibrium of power between the "subject" and the "object" – namely, the doctor's gaze and the diseased body. However, a doctor, placed as a major character in a literary narrative of social realism, can experience both the subjective and the objective kinds of perception, which suggests an interesting co-existence between the individual and the social being outside the clinical space. The doctor-protagonist's loyalty his medical duties, sympathies towards his patients not as "bodies" but as "persons", social responsibilities and personal desires can give a broader perspective to what may otherwise appear a strictly "clinical" narrative with a limited vision. Viewed in this light, the three novels discussed in the present chapter, employing the theme

of social doctoring through a portrayal of individual doctor-characters, point towards an interesting aspect of Victorian realism in the writing of "medical narratives". It is different from the Foucauldian framework, but at the same time, by positing the individual practitioner and the social-medical scenario in constant interaction, it avoids Oliver Sack's kind of over-sentimentalization of the medical. The success of these medical narratives do not necessarily depend on the doctor's absolute power to cure any kind of ailment, but on a realistic and faithful depiction of how he struggles to find his position as a character in the narrative, representing both an individual and a sociological being.

Within the broadly recognized social role of the medic in Victorian England, however, a gendered pattern of labour-division was quite evident. The contribution of women in medical service, for a long time, was kept limited to nursing. In *Bleak House*, the happy marriage of Dr. Woodcourt with Esther Summerson testifies to such a pattern: Esther, kind-hearted and competent as a nurse (though she has no formal training) is projected as the proper and domesticated helpmate of her doctor-husband. The first woman doctor to get a registration was Elizabeth Garrett Anderson, in 1866; and this led to a reactionary stand taken by the authorities. Rules of registration were changed so that women could be prevented from entering the medical profession. What followed was a lengthy struggle between the "Edinburgh Seven" – a group of seven female students led by the "rebellious" Sophia Jex-Blake and the university authorities (Sparks 133-34). The Edinburgh University would not allow them even to sit with their male colleagues in classrooms. Discouraged by the universities in Britain, some of them sought to go abroad to obtain a degree in medicine from continental universities. The struggle is depicted with sympathy in Charles Reade's 1876 novel *A Woman-Hater*, where he imagines the fictional female physician Rhoda

Gale as one of the Edinburgh candidates. However, in doing so, he could not be totally free of the gender-bias pervading in his social milieu. The projection of Rhoda Gale as a “manly woman” in turn corresponds to the opposing claims made in *The Lancet* and other medical journals that women, for natural, emotional and physiological reasons are not fit to enter the medical profession, except as nurses, or “Health Visitors” – a rather “domesticated” role of a comfort-giver deemed appropriate for some educated and philanthropic middle-class women in the late 1880s and ’90s (Sparks 143). Even those who tried to support the cause of “lady doctors” (the term itself reflected how patriarchy was at play), recognized the need for training women as doctors for handling female diseases only.

The iconic figure of Florence Nightingale served as a model for those women who wished to contribute to the profession of nursing; but Nightingale herself was opposed to the idea of training women as doctors. Her attitude towards women doctors has often been read as anti-feminist. Actually Nightingale believed in the idea of “Nature the healer” (Holton 60-61), and considered disease as a reparative process instituted by Nature, in order to remedy bodily decay (*Notes on Nursing* 5) . Medicine, in her opinion, does nothing more than assisting Nature’s healing power; so what is more important is to provide proper nursing to the sick. Thus she prioritized nursing over doctoring, in a sense that nursing, nurturing or comforting could add a distinguished feminine grace to healthcare. Alison Bashford argues that Nightingale was not so much opposed to the idea of women as doctors, as she was against the very direction medical profession was taking (Bashford 97). Nightingale wrote to J.S. Mill,

> I wish to see as few doctors, either male, or female, as possible […] the women have made no improvement; they have only tried to be "Men", and they have only succeeded in being third rate men. They will not fail in getting

their own livelihood, but they fail in doing good and improving therapeutics. (qtd. in Bashford 97)

Nightingale preferred that women should be first-rate nurses than being third-rate doctors. Such ideas got into the representation of women doctors as "failures" in fictional works as well. In Charlotte Yonge's *Magnum Bonum* (1879), the aspiring female doctor and researcher, Janet, ultimately falls victim to a tragic fate. Her dream of fulfilling the unfinished task of her late father – the discovery of an elixir—is thwarted by her unfortunate choice of marriage and social pressures. She ultimately dies while working as a nurse during an epidemic. Being a qualified doctor, her ultimate self-sacrificing resort to a nursing job reflects the pathetic situation of the women medics even at a time when "new woman" causes were advancing slow but steadily.

The cause of women doctors, however, found its way to literary expression in a number of novels in the 1880s and '90s, including the anonymously penned *Dr. Edith Romney* (1893, possibly written by Anne Elliot), Margaret Todd's *Mona Maclean* (1892; published under the pen-name "Graham Travers") and Annie S. Swan's *Elizabeth Glen, M.B* (1895). Few of those novels could make a lasting impression in Victorian literature, and most of them remains unfamiliar to the present-day readers in general. In her article "Medical Women in Fiction", Sophia Jex-Blake, herself a physician, criticized these novels on the ground of an outsider's perspective. According to her, most of these novels, whether written by a sympathetic male author like Charles Reade or the "anonymous" author of *Edith Romney*, failed to capture the reality of the education, aspiration and struggles of the female physicians like herself. *Mona Maclean* was the only "new woman doctor novel" which earned her praise.

However, as both Swenson and Kondrlik have pointed out, Jex-Blake was Todd's close friend and literary agent (Swenson 142, Kondrlik 118). The life of Mona Maclean as a student is also loosely based on Jex-Blake's own experiences. "Unsurprising, then, is Jex-Blake's significant praise for Todd's novel and Jex-Blake's assertions of its accuracy in representing female physicians" (Kondrlik 118).

Hilda Gregg, another militant supporter of the woman doctors' cause sought to bring her protagonist outside the domestic and private setting. Georgiana Keeling, the protagonist of *Peace with Honour*, goes to Ethiopia with a diplomatic mission. After the sudden death of the male physician of the team, she assumes the role of the sole medical officer. Gregg also shows how a female doctor has to face challenges in a larger, unfamiliar social setting projected upon an exotic, colonial space. By and by, writings by female physicians and their supporters were gradually trying to undermine the social bias that women were essentially "unstable" and "unfit" for the larger societal need (Kondrlik 207).

The role played by Florence Nightingale during the Crimean War underscored the "social" nature of women's participation in medical care-giving. Though she objected to women doctors, her work among the war-veterans indirectly became influential a few decades after – that is, during World War I, showing how women physicians can contribute in significant ways to the defence of the British Nation, and in a larger sense, to suffering humanity. Nightingale's *Notes on Nursing* can be read as indicative of a new mode of bioethics realized and put to practice through proper and humanitarian approaches to nursing. The text shows how she combined her well-trained knowledge of the contemporary developments in "nerve theories" with a sympathy-based and humanitarian

mode of treatment, which helped to bring a soothing effect upon the patient's agitated nerves in order to alleviate the pain of body and mind. In the 1880s, when Sophia Jex-Blake was writing about the portrayal of female medics in literature, or when Hilda Gregg's novels were negotiating the place of a female medical professional in society, they also stressed the factor of "sympathy" – in which female doctors can claim a "specialization". This was indeed a gendered perspective harping on the traditional stereotype of feminine virtues. Still, it was necessary for female practitioners to reclaim their natural "femininity" since patriarchy attempted to label them as "manly" and "unnatural". From the time of Nightingale on the one hand and Sophia Jex-Blake and Elizabeth Garrett Anderson on the other, it required a long struggle for women in the medical profession, to get recognition not merely as nurses, but also as qualified and socially respectable doctors. The writings of Sophia Jex-Blake herself, Hilda Gregg and Margaret Todd's novels in the late Victorian period and later, memoirs by female physicians who served during the First World War – for instance, Dr. Caroline Matthews' account of her service under the Red Cross during the period 1914-1918 (Kondrlik 180-2) – led to new ways of understanding not only medicine and gender but also the medical profession as a whole. It can be said that such broader representations (both fictional and autobiographical) of women physicians in the late Victorian and Edwardian periods enabled them, in reality, to claim a more significant position in the professional field and more important roles to be performed in society in the decades to come.

Notes :

1. For detailed information, see Jane Moore, "What Sir Luke Fildes' 1887 painting *The Doctor* can teach us about the practice of medicine today", *The British Journal of Medical Practice* (2008) Mar. 1.58(548): 210–213, at < http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2249807/>.

2. Michael Brown, "'Like a Devoted Army': Medicine, Heroic Masculinity, and the Military Paradigm in Victorian Britain", *Journal of British Studies*, 49.3 (July 2010): 592-622, accessed from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2933820/> (Hereafter cited as Brown, "Devoted Army")

3. In Victorian journals like *Punch*, cartoons and medical satires reflected this negative image of the money-grabbing practitioner. Roy Porter in his chapter on "Victorian Developments" in *Bodies Politic: Diseases, Death and Doctors in Britain* refers to one such cartoon where a doctor and his wife discuss the cholera epidemic with a hopeful prospect of getting more cases, and money. A well-known literary caricature of sophisticated, society doctors can be found, for instance, in Thackaray's *Vanity Fair*.

4. This is a major issue in Dickens' *Martin Chuzzlewit*. George Eliot's *Middlemarch* also offers a critique of this problem which made the medical reform of the 1830s even more challenging.

5. Brown, "Devoted Army", endnote No. 31. Also see Priti Joshi, "Edwin Chadwick's Self-Fashioning: Professionalism, Masculinity and the Victorian Poor," *Victorian Literature and Culture* 32. 2 (September 2004): 353–70.

6. The information is from Christopher Hamlin, *Public Health and Social Justice in the Age of Chadwick: Britain, 1800–1854* (Cambridge, 1998), 245-74.

7. Meegan Kennedy, *Revising The Clinic: Vision and Representation in Victorian medical Narrative and the Novel*, Columbus: Ohio State Univ. Press, 2010, 4-5.

8. See Gary Colledge, *Dickens, Christianity and The Life of Our Lord*. New York: Continuum, 2009**.**

9. The classification is summarized well in *The Healing Tradition: Reviving the Soul of Western Medicine*. Oxford, UK; San Francisco: Radcliffe Publishing, 2004, pp 69-70.

10. Michel Foucault, *The Birth of the Clinic* (1963), trans. Alan Sheridan Smith, London: Routledge, 2003 pp 15, 35, 105, 202.

11. See F.S. Scwarzbach's essay "*Bleak House*: The Social Pathology of Urban Life", in *Journal of Literature and Medicine* 9 (1990): 93–104 and Pamela Gilbert's section on *Bleak House* in *The Citizen's Body: Desire, Health and the Social in Victorian England* (Columbus: University of Ohio Press, 2007), pp 140-147 can be cited as examples of this line of critical approach.

12. Roy Porter, 'Victorian Developments', in ***Bodies Politic: Disease, Death and Doctors in Britain, 1650-1900,*** London: Reaktion Books, 2001, pp. 251-263.

13. Chapter 4 will discuss how far the early-twentieth century Bengali novels with doctor-heroes can be considered as being "influenced" by the Victorian medical fiction , and how far they negotiate the colonial situation in their own terms and nativize the "daktari sahitya".

14. This is also suggested by Heather Freeman, in " "Prosaic Confessors": An Examination of the Medical and Legal Professions in Anthony Trollope's chronicles of Bersetshire", Diss. Vanderbilt Univ., 2009, p. 19-20.

15. A similar observation is made by Patrick McCarthy, in his essay "Lydgate, 'The New, Young Surgeon' of Middlemarch", *Studies in English Literature, 1500-1900.* 10.4 (Autumn, 1970): 805-816, accessed from <www.jstor.org/stable/449716>

16. Rylance has mentioned Oliver Sack's own narratives, but has not given clearly illustrated examples of such "richly human" medical narratives in Victorian fictional. He rather makes a broad category between the documental that belongs to the clinical accumulation of data regarding the medical reality (which he calls the granary) and the representation of such elements in sensational, the grotesque and also the fictional world for the public (which he calls "theatre"). See Rick Rylance,

"The Theatre and the Granary: Observations on Nineteenth-Century Medical Narratives", *Literature and Medicine*, 25.2 (2006): 255-276. *Project Muse*, <http://muse.jhu.edu/ journals/literature_ and_medicine /v025/25.2rylance.html>

Chapter 2

The "Metaphysical Physician" in Victorian Fiction: Psychiatry and the Occult

The Victorian age**,** as Dickens famously said, was at the same time "the epoch of belief" and "the epoch of incredulity"[1]. The period experienced, among many other paradoxes, an ongoing tension between science and spirituality. Bearing the legacy of the much-celebrated Enlightenment rationalism and the Cartesian division between body and mind since the eighteenth century, the Victorians dealt with a contemporary world rapidly unfolding new discoveries in geology, astronomy, biology and medical sciences. However, these could not completely erase the structures of spiritual belief from the human mind, rather they sought to reshape their appeal in terms of "alternative sciences" like mesmerism, phrenology, the occult and the psychiatric (pre-Freudian)[2]. In *The Other World: Spiritualism and Psychical Research in England, 1850-1914*, Janet Oppenheim explains how some Victorian intellectuals were struggling to find a kind of synthesis between "modern scientific knowledge and time-honoured religious traditions concerning man, God, and the universe" (59). If the early decades of the Victorian period gave ear to a trumpeting of progressive ideas like democracy, liberalism, positivism and materialism, the later decades felt the pangs of uncertainty and disbelief regarding the ideology of "Positivism" in science and society. The need of the time, then, was reflected in the search for new, synthetic philosophies that "could meet the specific demands of their day by satisfying a religious need in language", that would be "acceptable to science" (Oppenheim 62).

The emergence of the alternative sciences in the Victorian age, however, was not a homogeneous phenomenon. There were Rosicrucianism and Swedenborgian theologies (often deriving ideas from Eastern religions) that adopted the language and rhetoric of science, while some scientists like William Crookes, the President of the "Society for Psychical Research" from 1896 to 1897, took interest in the study of the spiritual and the psychical. In a close and critical understanding, "psyche" and "spirit" are not synonymous terms. However, they seemed to be overlapping in the imagination of the nineteenth century pseudo-scientists, regarding their shared consensus of anti-materialism. An ambivalent status was attributed to Psychology and Psychiatry, since such studies of the "inner self" tended to merge the scientific and the spiritual. On the other hand, since scientists and philosophers like Frederick Meyers and William James were among its exponents, the status of psychology would be varied: some would call it an aspect of neuroscience, for others, it would look like a philosophy of the individual self. As Robyn Hallim aptly observes, "Thus the old issue of dualism versus monism was reintroduced in a nineteenth-century way that confused philosophy, psychology and psychic experiences and muddled ontological issues with "scientific" evidence of the immortality of the soul" (80). Against this backdrop of intellectual and cultural unease, the pre-Freudian psychiatrist emerged as a transitional character hovering between the two realms of science and metaphysical spiritualism.

Samuel Posen in his encyclopedic work, *The Doctor in Literature: Career Choices* (Volume 3) observes that the image of a psychiatrist in European literature has been rather negative (107-112). It is true that psychiatrists were often looked down upon by the mainstream medical practitioners, nor could they claim full solidarity with the visionary spiritualist. However, Posen fails to appreciate the multi-

layered personality that is often found in medical characters who deal with the "inner life". The most famous literary portrayal of this sort is perhaps Dr. Jekyll in Stevenson's famous tale, *The Strange Case of Dr. Jekyll and Mr. Hyde*. Even before Stevenson, writing in the late 1880s, such characters interested Wilkie Collins and Le Fanu ─ masters of the Victorian gothic and the occult fiction. Collins' 1868 novel, *The Moonstone* presents a "metaphysical" physician, Ezra Jennings, who himself suffers from a neurotic disease, but is able to bring a spiritual and moral cure to his patients. The novel begins with a mystery concerning the precious Indian diamond, called the Moonstone. It was presented to Rachel Verinder on her birthday, and stolen by the night. Suspicion falls on several characters within and outside the family, including an itinerant group of three Indian priests who seek to restore the jewel to their sacred Deity. Rachel, later in a heated discussion with her former lover and cousin, Franklin Blake, reveals that she had seen him take the Moonstone from her drawer, and kept it as a painful and disgracing secret to herself. Blake cannot remember anything, and does not know how to prove his innocence to Rachel. He loses faith in himself and is on the verge of a psychosis. It is at this point that Dr. Ezra Jennings is introduced, and he gradually assumes importance as a friendly medical and moral advisor to Franklin Blake.

The most remarkable description of Dr. Ezra Jennings comes from Franklin Blake when he meets him for the first time:

> His complexion was of a gipsy darkness; his fleshless cheeks had fallen into deep hollows, over which the bone projected like a penthouse. His nose presented the fine shape and modeling so often found among the ancient people of the East, so seldom visible among the newer races of the West. [...] From this strange face, eyes, stranger still, [...] dreamy and mournful, and

> deeply sunk in their orbits — looked out at you and [...] took your attention captive at their will. (Collins 1999: 299)

What this description offers, at best, is an image of "otherness" and physical degeneration – the latter produced by the effect of opium. Much has been said about the fraught relation between opium and empire since the time of De Quincey; and Jennings is an embodied symbol of both. A man of mixed Eurasian origin, born in the colonies, the drug-addict Ezra Jennings is a social outcast. A typical Victorian Englishman like the old butler Betteredge does not like him, and even the lawyer Mr. Gruff, a professional man of reason and ability suspects Jennings' "metaphysical" method of executing a medical experiment. However, his view finally proves to be the most clear-sighted, and the closest to the buried "truth" which other characters fail to find. The prologue tells us that the Moonstone was originally placed on the Moon-god's forehead – the exact location of the "third eye" – a symbol of true vision and insight in Indian theology. The Indian priests, bound to their sacred mission, have been associated (however disapprovingly) with a visionary quality which may be called the "third eye". In a metaphorical sense, Ezra Jennings may also be seen as symbolically connected to such metaphysical insight which can penetrate the truth[3]. His "medical and metaphysical" theory on the "spiritualised influence of opium" is also viewed with a sense of dismissal and suspicion, but ultimately it proves true. It cannot immediately find the real villain, Godfrey Abelwhite, but it fairly proves Franklin's innocence and helps to shift the suspicion towards a proper and logical channel of investigation. There is an interesting paradox about Jennings: his past is in the dark, yet he takes the most important role in throwing light on the distorted reality concerning the major characters in the novel. Jennings has escaped some dire persecution and come under the shelter of Dr. Candy, the local practitioner. By the

time the romance between Franklin and Rachel is almost destroyed under terrible suspicions, Dr. Candy has developed amnesia, in consequence of an acute pneumonic fever affecting the brain. Almost an invalid, he is now under the caring treatment of his grateful assistant, Jennings.

Jennings has saved Dr. Candy's life solely on his own medical responsibility, opposed by the opinions of two other specialists. During his care-giving to the patient, he has developed an experimental method – verging on the psychical and even the "metaphysical"— of deriving meanings from the delirious ramblings of Dr. Candy. Jennings has collected his broken words and by deduction, produced a convincing case-report of what happened at that fateful party-night of the previous year. Franklin learns that he actually took the jewel, not with any ill intention but out of a concern for its safety. This action, again, was induced by a trance under the influence of opium. At the party, Franklin retorted at the medical profession and said that he would rather spend sleepless nights than trust any medicine. Dr. Candy, insulted, secretly added a certain dose of opium in Franklin's drink to cure his insomnia, which he took as a challenge. Unfortunately, his severe illness immediately after the incident prevented him to clarify things afterwards as he meant to do.

This convoluted chain of events in *The Moonstone* has been used by several critics to comment on the medical malpractice and almost "superstitious" use of laudanum in the nineteenth century (Smith 46-7). In such readings, Dr. Candy is made the prototype of a foolish and irresponsible medical man, whose act of playing a practical joke on a haughty patient like Franklin, results in dangerous and unpleasant consequences. However, Ezra Jennings comes to his defence. He tells Franklin Blake:

> Every medical man commits that act of treachery, Mr. Blake, in the course of his practice. [...] Every doctor in large practice finds himself, every now and

> then, obliged to deceive his patients, as Mr. Candy deceived you. I don't defend the folly of playing you a trick under the circumstances. I only plead with you for a more accurate and more merciful construction of motives. (Collins 1999: 355)

Smith decisively argues that Jennings' attempt to normalize Dr. Candy's act of medical malpractice reflects the dubious state of medical ethics in England: "If Candy is representative of "every" English doctor, then the medical profession is disturbingly subjective, unprofessional, and unregulated" (Smith 47). This kind of argument, though valid in some respects, seems too limited and one-sided, for one may as well argue that Dr. Jennings' sympathetic and well-drawn analysis of the true motive of his senior colleague and benefactor, and his further attempt to help the patient by rectifying the fault of Dr. Candy, are indeed generous examples of "medical ethics". In this reading, the words "obliged to deceive his patients" do not bear a connotation of medical corruption. They simply suggest that doctors sometimes need to act in ways unknown to their patients, to see how a new medicine works on their body and mind without a presumption about the effect. Jennings himself does the same when he keeps the news of Rachel's arrival to attend the medical experiment, out of Franklin's knowledge. Unlike Dr. Candy's little "deception" which by a dire chance became so serious, Dr. Jennings' trick proves to be beneficial: it brings a spontaneity in the healing of the damaged relationship between Rachel and Franklin.

Jennings' role initially as a medical assistant and later as a caring physician to Dr. Candy can be understood at a level beyond common loyalty, mutual sympathy and gratitude. In attitude, manners and language, they are widely apart. Dr. Candy's medical language is materialistic, curt and worldly: he tells Franklin plainly that "all his nerves were out of order and that he ought to go through a course of medicine

immediately" (70). Jennings, on the contrary, speaks in a dreamy and visionary rhetoric: though he seeks to vindicate his esoteric theories on the use of opium on medical grounds[4], his very tone and language suggest his "metaphysical" orientation. As the mystery is gradually unveiled, one may recognize that Jennings' importance in the narrative grows with the physical and mental degeneration of Dr. Candy. What Candy wanted to speak and do as a doctor, has been reduced to broken words stemming from his troubled subconscious: Jennings renders them more comprehensible. Dr. Candy's medical error and misdirected application of opium on Franklin resulted in tragic consequences in the Verinder family, and Jennings uses the same drug on the same person to recreate the scene of the trance-induced action and prove his innocence, setting things right once again.

After this, towards the close of the narrative the reader learns about the sacrificial death of Jennings from Dr. Candy's letter. It is probable that Dr. Candy has recovered much of his former health and mental stability through the constant self-sacrificial ministrations of Jennings (without taking care of his own damaged health), but it sounds almost mystical that Jennings dies just as his patient and colleague has come round. Dr. Candy, on his turn, has also done all that he can for the dying Jennings. The exact timing of Candy's full recovery, however, remains a textual aporia: an attempt to fill this gap seems to be leaning towards a psychical-spiritual interpretation of "doubling". Candy and Jennings – the two medical men, different in appearance, perspectives, ethnicity and beliefs, are complementary to each other; they together reveal the heterogeneous realities of the Victorian medical practice and point towards a strange interaction between the "materialist" and the "metaphysical" schools of medical perception.

Other kinds of "doubling" are also at work: Jennings' own narrative as a patient proceeds along with his case-reporting of Franklin's suffering, in which he plays the doctor. The two narratives of illness are linked together: the doctor describes his own suffering, and fears, "If I let myself sink, it may end in my becoming useless to Mr. Blake at the time when he wants me the most" (369). As a patient-cum-doctor who treats himself with opium, Jennings handles the case of Franklin using the same drug for a different purpose. His excessive intake of opium (which several critics have read as Collins' self-projection and spiritual sympathy with his literary predecessor, Thomas De Quincey)[5] is a means of alleviating his pains to make an otherwise withered life somewhat endurable. He could have died long ago, but he lives with a noble purpose. He loved someone, and there is no hope for reunion with her; yet he wishes to provide for "that dear person" before he dies. His self-sacrificial role as a benefactor to this unnamed beloved, and his equally selfless function as a healer of the emotional wounds suffered by Rachel and Franklin can be placed side by side. One may pertinently ask how far Franklin's psycho-pathological sufferings caused by a shattered love make him a mirror-image to his doctor. Jennings, as a doctor and a lost lover, an alienated, wretched figure, seems to take all the more delight in bringing remedy to another case of damaged love. His narrative ends with a thanksgiving, with a beatific sensation of "healing":

> Oh me, how I felt as the grateful happiness looked at me out of her [Rachel's] eyes, the warm pressure of her hand said, 'This is your doing'!
>
> My poor patients are waiting for me. Back again, this morning to the old routine! Back again, tonight, to the dreadful alternative between the opium and the pain!

> God be praised for his mercy! I have seen a little sunshine—I have had a happy time. (Collins 1999: 396)

Jennings' self-sacrifice is no lesser than that of the Indian Brahmins who have crossed the "black waters", have thrown away their caste in the service of their Deity, and after fulfilling the mission, have undergone the ritual penance for the loss of their caste-identity. Their wonderful loyalty to their faith and mission which they believe to be "sacred", stands as a contrast to the sick Victorian society torn by double-dealing, hypocrisy and corruption. The racial and cultural "other" indeed poses a moral problem to the British society depicted in *The Moonstone*, and Jennings is as much a part of this dynamics as the three Indians. However, his help to reveal the truth re-associates him with the society which has so far marginalized him. And his ultimate self-sacrifice highlights his function as a "pharmakos" which bears obvious connotations of "healing" and "purgation" in a ritualistic sense – that of maintaining the civic health in ancient Greece by sacrificing a "diseased" body. Other critics have also pointed out Ezra Jennings' function as a "scapegoat" (Prytz 21; Murfin 664).

Jennings remains the "healer" upto the end: his self-sacrifice has restored Dr. Candy to normal health and saved the Verinder family from further tragic consequences. Though he cannot pathologically cure himself, death comes to him as a happy relief and a transcendental experience, manifested in his last angelic smile. As Dr. Candy reports, "for six hours before his death his sufferings ceased […] The sunlight touched his face. A beautiful expression, an angelic expression came over it. He cried out three times, 'Peace! peace! peace!'… and the long trouble of his life was at end" (425). The doctor as a patient, has alleviated all his pains, after all.

Jennings' attitude and medical views are somewhat esoteric, as his thoughts and experiments with the state of mind in "trance" verges on what is called

"parapsychology" in modern times. It is not clear whether Collins conceptualized him as a psychologist or a philosopher-doctor. However, a more prominent figure of the "metaphysical physician", deliberately claimed and conceptualized so, appears in Sheridan Le Fanu's occult-fiction. The Anglo-Irish author Le Fanu, who went in and out of popularity with the passage of time, was once considered a successful exponent of the literary gothic in the Victorian times. The character of Dr. Martin Hesselius in many of Le Fanu's gothic stories can be read as an exemplary embodiment of all these conflicting yet overlapping concerns: the medical or pathological, spiritual and the psychoanalytic.

Dr. Hesselius is the unifying figure who connects the five uncanny tales published together as *In a Glass Darkly* (1872). The stories are written in the form of a collection of "case-histories", most of them narrated by the doctor's medical secretary, an ex-surgeon himself. Dr. Hesselius is introduced as a great scholar and scientist who, unlike the others in his profession, looks beyond the pathological. In "Green Tea", the patient's trust in the doctor derives from the physician's uniqueness which makes him different from his colleagues: "You are a philosophic Physician", says the clergyman-patient approvingly, "You give spirit its proper rank" (65). Hesselius acknowledges the existence of a spiritual cosmos behind the world of matter and considers the relation between the two as one of "interpenetration". In the doctor's own words, he believes that ─

> the essential man is a spirit, that the spirit is an organised substance, but as different in point of material from what we ordinarily understand by matter as light or electricity is; that the material body is, in the most literal sense, a vesture, and death consequently no interruption of the living man's existence, but simply his extrication from the natural body—a process which commences

at the moment of what we term death, and the completion of which, at furthest a few days later, is the resurrection "in power". (13)

These esoteric ideas were largely drawn from Swedenborg, whom Le Fanu himself used to read.[6] Though unfamiliar to most of today's readers, the mystical works by Emmanuel Sweedenborg attracted several literary men and women of the nineteenth century – namely, Coleridge, Wilkie Collins, Elizabeth Barrett Browning, Mary Elizabeth Bradden and Joseph Sheridan Le Fanu. In "Green Tea", Le Fanu uses Sweedenborg to explore the horrible consequences of opening one's "interior eye". Things of the other world become visible to him, and when the boundary between the individual self and the world of spirits gets dissolved, the spirits are believed to enter the human self and overpower it. While waiting in the clergyman's library, Dr. Hesselius discovers that Mr. Jennings has marked out a number of passages from Sweedenborg's *Arcana Caelestia*, of which one particular passage states: "if evil spirits could perceive that they were associated with man, and yet that they were spirits separated from man … they would attempt by a thousand means to destroy him; for they hate man with a deadly hatred" (28-29). It remains a matter of open interpretation whether the apparition that torments Mr. Jennings is a hallucination or really one of Sweedenborg's evil spirits, determined to destroy the human self.

Interestingly, in most of the case-(his)stories, the narrative voice of the medical secretary actually offers a second-hand report, and comments on the doctor's personality, qualities and methods of treatment. "Green Tea", separately published earlier (1869) is the first story in the 1872 collection, and it is also the only story where the doctor gives his first-hand account of a strange case. The patient, Mr. Jennings, is a clergyman frequently haunted by the apparition of a monkey. Nobody else can see it, but it follows him in a public omnibus, it perches on the page of the

Bible and prevents him to read on and thus compels him to leave his clerical duties in fear and agitation. By the daytime, it is black, and at night it has a terrible red glow about it, something that may suggest the hell-fire. In *The Living Novel* (1960), V.S. Pritchett calls the monkey a "very Freudian animal": it is "dark and hairy with original sin and symbolism" that "skips out of the unchaste jungle of a pious bachelor's unconscious" (104). Mr. Jennings is otherwise a learned and dutiful cleric of amiable disposition. There is no other textual evidence of his own responsibility regarding his plight than an excessive intake of green tea (which he later gives up), and reading some 'pagan' texts which, as he himself realizes later, are "not good for the mind— the Christian mind, I mean" (46), ending his confession with "God forgive me" (47). The black monkey can be interpreted in a different way as well: if it is a hallucinatory image of some pagan "evil spirit", it also ironically reveals the fears based on the deep-rooted Orientalist bias of the European Christian mind that the "heathen" East is backward and primitive on a scale of evolutionary history, chronology and civilization.

The doctor believes this case-history, questions the patient, learns about his habits and interests and then comes to a diagnosis, using a deductive method. In short, he does recognize the danger of exposing the mind to the unfamiliar and the unfathomable, just as the body gets affected by the indigestion of a foreign substance like green tea. However, as a man of science who needs to professionally channelize the spiritual and the invisible into a tangible medical case-statement, he advises Jennings that he must consider "his illness strictly as one dependent on physical, though subtle, physical causes" (78). Apparently this looks like a self-contradiction in Dr. Hesselius: on the one hand he insists on the substantiality of "spirit", regards the human face as the "powerful organ of spirit", and on the other tells his patient who is

tormented by a spiritual horror, to regard his sickness as pathological—though of a "subtle" nature. In a deeper sense, however, this reflects the discomfort in the zeitgeist itself, which has made the "metaphysical" physician conscious of the need to translate his spiritual theories into a materially recognizable method of treatment. To him, it appears to be the only way to raise the level of self-confidence in the panic-stricken patient, by assuring him that his malady is curable like any other corporeal disease.

The Vicar as patient, however, is no layman. He is a learned cleric and up to a point, he seeks to understand his malady in rational and medical terms. He even uses medical terminology when he describes his case to the doctor. He is a man of the religious order who understands science, whereas the doctor is a man of science who takes interest in esoteric theology and occultism. The moment he learns that doing research on pagan texts might have been the cause of Mr. Jennings' psychological and nervous breakdown, his interest in the case gets doubled. He himself reads the Swedenborgian texts, but as a stronger character with a disciplined, scientific worldview, he studies them simply with a zeal for learning; he has not let those esoteric ideas affect his mental and moral balance. Mr. Jennings, however rational and scholarly, belongs to the religious order, and so his mind is more vulnerable to the foreign and exotic spiritual ideas which ultimately overpower him with strange hallucinations. The affinities and differences between the physician and the patient, viewed from a modern psychoanalytic perspective, suggest that they are playing "alter ego" to each other. Once he gets the assurance of cure from the doctor, Mr. Jennings repeatedly asks him to come and stay with him, for he is afraid to be left alone. The text clearly shows that Mr. Jennings is much relieved, and the terrible hallucination never occurs to him, when he is in the good physician's company. Some recent scholars have found "queer" elements in this relationship[7], but what seems to be a

more valid interpretation, is the psychological dependence of a fragmented self on a curative, caring and guiding subject in whom the former finds his ideal "other" (the Lacanian "mother-figure") who can lend support and make him "whole" again. The fatal incident happens when Mr. Jennings is finally alone: the apparition tempts him to end his life (which is a ghastly parody of the Temptation of Christ in the Wilderness) and he submits to the diabolical suggestion. When Dr. Hesselius reaches the spot, Mr. Jennings has already slit his throat. His dead and severed body, lying in front of the doctor, is a visual portrayal of a broken being –fragmented and disintegrated in body, mind and soul, destroyed in want of "wholeness".

Dr. Hesselius has also been seriously affected by the strange affliction of his patient. At the beginning of the treatment and moral counseling, there comes a point when he feels disturbed at the sight of the patient's face: "One look of Mr. Jennings' haunted me. It had seized my imagination with so dismal a power that I changed my plans for the evening, […] feeling that I wanted a change of ideas" (38). He feels that the perturbed expression of Jennings' face has possessed even his nerves – though medical men are used to deal with many patients with painful expressions in their faces. This suggests that Dr. Hesselius sees something more troublesome than he usually sees in the faces of patients in general. Is it possible that he visualizes a distorted mirror-image of his weaker alter-ego in the face of Jennings? His sympathy towards Jennings comes from a shared interest in the occult, and his desire to handle the case of no ordinary person but a learned one like himself. He even laments at the end that "Poor Mr. Jennings" has not given him "full unreserved confidence" (95): he has "made away with himself" (94) without giving him the opportunity to complete his treatment; otherwise he would have cured him certainly. "If the patient do not array himself on the side of the disease, his cure is certain"– says the doctor, as if, in

desperate self-defence. While writing the conclusion, he tries to collect himself and offers a rational, medical explanation of the case. In the previous chapter, however, he has been utterly dejected and agitated, emotionally moved. Coming out of the dead clergyman's house, the doctor feels "like a man who has but half waked from a frightful and monotonous dream" (89). Can it be so that the death of Jennings and his failure to cure him disturbs the doctor's own "spirit" so much that he no longer writes his case-reports by himself, and afterwards leaves the job to his secretary? The invisible presence of the secretarial narrator who offers an introductory "prelude" to "Green Tea" and takes up the writing for the rest of the collection, thus becomes a missing link between the doctor's world of "spiritual" connection with his patients, and the material world of arranging the casebook for publication.

A critical survey of the representation of the "metaphysical physician" in Victorian fiction, as attempted so far, may reveal certain trends regarding the growing complexity and interpenetration between science and spirituality. The texts and their authors, however, have not earned similar reception and literary status: though unlike Dickens or George Eliot, Collins remains partly "canonical"; whereas Sheridan Le Fanu, despite the wide popularity of his uncanny stories at a time, could hardly claim the canon. With the ever-changing scenario in science, technology and society, changes also came in the reading public and literary tastes. By the late 1880s, a tension between the canonical and the popular literature became evident. Interestingly, the popular and the sensational novels of the late 1880s and 90s began to handle the "science and religion" debate with a new kind of energy that attracted the reading public. Michael Wheeler called it a "revival of romance" in the late nineteenth century, and he includes popular science fiction and fantasy as part of this phenomenon (161-9). Stevenson's 1886 novella, *The Strange Case of Dr. Jekyll and*

Mr. Hyde, illustrates the problem of classifying such texts, and this ambivalence regarding generic status also thematically parallels the identity crisis of the protagonist of the novella. Gordon Hirsh considers both *Frankenstein* and *Dr. Jekyll and Mr. Hyde* in terms of a scientific hubris, showing that "scientific research beyond certain limits may be a terrible mistake" (223). However, Dr. Jekyll cannot be reduced to a merely egotistic, hysteric, self-victimizing and flawed character. Since the rise of psychoanalysis as a mode of literary criticism in the twentieth century, much critical attention has been paid to the duality of human nature, repressed sexuality and atavism as portrayed in Stevenson's novella[8].

Nevertheless, what remains less-discussed is the point that Dr. Jekyll, for all his traumatic trials and misguided experiments, can still appear as a heroic champion of the special branch of his knowledge, claiming it to be "transcendental". The initial intention behind his experiment was oriented towards a kind of moral and spiritual healing. He wanted to free the good self of a human being from the inner disease of a "profound duplicity in life", giving it relief from the constant conflicts with its evil counterpart, so that the virtuous self can go undisturbed in his righteous path. This is indeed "transcendental": even in the midst of his suffering, he challenges his colleague Dr. Lanyon, "you who have so long been bound to the most narrow and material views, you who have denied the virtue of transcendental medicine, you who have derided your superiors — behold!" (Stevenson 41). Then he prepares and swallows the draught in front of Lanyon and makes him realize both the power and the horror of the metaphysical science. The scene of transformation, presented as a spectacle before a non-believer, has the sense of a "spiritual" vindication: Hyde, coming to his better self – that of Jekyll, undergoes a tremendous passion (suffering), but the control of the spectacle remains in his hand, whereas Lanyon stands helpless

and shocked. Using a credible man of science like Dr. Lanyon as his witness, Dr. Jekyll makes the reader consider his case with a profound and serious moral perspective on man's dual nature, thereby distinguishing his case-narrative from any ordinary gothic melodrama.

The last good deed of Dr Jekyll reveals that he is still concerned about his responsibility to mankind as a researcher and doctor. N. D. Buscemi points out that Jekyll, writing his case-history, leaves warnings for others in this line of medical experiment, to prevent the unleashing of another Hyde (99). What is more important, in fact, is the moral confidence of the doctor, regarding the positive aspect of his experiment. At one point, he offers a self-critique from an ethical and rather spiritual point-of-view: "Had I approached my discovery in a more noble spirit, had I risked the experiment while under the empire of generous or pious aspirations, all *must* have been otherwise, and from these agonies of death and birth, I had come forth an *angel* instead of a *fiend"* (45, my emphasis). Here, the word "must" is significant: Dr. Jekyll still believes that his experiment would *surely* have been successful and good for mankind if he could have pursued it with a more "noble spirit", that is, perhaps, without any thought of personal glory and pride. Dr. Jekyll, devoted to what he believes to be "transcendental medicine" has actually thrown himself into the darker and painful regions of the inner psyche. He has suffered from his own errors and egotism, yet his original motivation was positive, oriented to spiritual uprightness which he wanted to disentangle and release from the evil influences of life. As the agent of "transcendental medicine" and a tragic character in a moral allegory, his role appears to be more interesting than merely that of a "mad scientist".

In his "Introduction" to *Dr. Jekyll and Mr. Hyde*, Tim Middleton argues that Gothic fiction reflected the late-nineteenth century anxiety regarding the perilously

narrow line between civilization and barbarism (xi). In a similar vein, the occult fiction emerged as a fin de siècle which could negotiate many of the cultural and intellectual contradictions among the seemingly solid structures of Victorian belief and order. In *Rule of Darkness: British Literature and Imperialism, 1830-1914* Patrick Brantlinger suggests a complex interrelation between the imperialist ideologies and the occult: "To the ardent imperialist, […] the borderland itself becomes a new frontier to cross, a new realm to conquer... Just at the moment actual frontiers were vanishing, late Victorian and Edwardian occultist literature is filled with metaphors of exploration, emigration, conquest, colonization" (249)

Anne Harrington in her work *The Cure Within:A History of Mind-Body Medicine* discusses how Orientalist conventions of writing and thinking were being used in the United States and Europe by critics and radicals who effectively reversed the original moral logic of this tradition since the middle of the nineteenth century. In the late nineteenth century, Madame Blavatsky, Annie Besant and their supporters claimed that the literature of the East possessed stores of ancient wisdom that the West had long since lost or forgotten. By the early decades of the twentieth century, as colonialism was growing to be an embarrassment to Europe, the Western cultures showed a tendency to turn to a romanticized notion of spiritual Orientalism— "an Orientalism dominated by visions of ancient teachers, texts filled with occult secrets, meditating monks on misty mountaintops, and serene sanctuaries—gained a new lease on life, especially within alternative, countercultural circles" (Harrington 208). In the chapter titled "Eastward Journeys", focusing on mind-body healing Harrington shows that "the East is not only a spiritually but also a medically exemplary place. Its traditional doctors and spiritual teachers are skilled in ways of mind-body and holistic healing that we have lost, forgotten, or simply never known" (208).

Occultism and supernaturalism were popularized by the late nineteenth century authors like Rider Haggard and Marie Corelli, and in most cases the representative personality of the occult is someone ethnic and exotic. Regarding this complex relation between Occultism and imperialism, the role of an Oriental occult physician in doctoring the sick, neurotic body and soul – the diseased product of a decaying and internally fragmented Western civilization – becomes all the more significant in Marie Corelli's first novel, *A Romance of Two Worlds* (1886). Corelli's novels are often critiqued for her sensational, melodramatic style and her over-enthusiasm about spiritualist imagination, as she herself admits in the Preface to the third edition of the novel: "I have lately been accused by a leading critic of imagining a new heaven and earth, and passionately flinging them in the teeth of an obstinate reality that will not conform to them" (Corelli 14). At the same time, she got innumerable letters from the common reading public, many of them thanking her for the book which had been an elixir to their spiritual maladies. Some letters are quoted in the *Appendix* of the third edition of the novel, and one of them says:

> Your book, the 'Romance of Two Worlds,' has stopped me on the brink of what is doubtless a crime, and yet I had come to think it the only way out of impending madness. I speak of self-destruction—suicide. And while writing the word, I beg of you to accept my gratitude for the timely rescue of my soul. […] No one knew, no one guessed my intent, till one Sunday afternoon a friend lent me your book. I began to read, and never left it till I had finished the last page—then I knew I was saved. (313-14)

The gratitude of the reader expressed so sentimentally may be dismissed from a critical perspective, yet what remains significant is the point that the novel does have a therapeutic effect on the tormented soul. The story, whether to be classified as

a “supernatural romance” (Federico 16) or “scientific romance” (Stableford 8, 40-1), tells of a spiritual cure thorough the agency of a metaphysical physician, Heliobas, whose remedies for nervous and psychic ailments derive from the “Electric Creed” of Christianity. As the narrator-patient introduces it, the “Electric Creed” seems to have some correspondence with contemporary science as well:

> I was in no way alarmed at the idea of trusting myself to the hands of a physical electrician such as Heliobas professed to be. I knew that there were many cases of serious illnesses being cured by means of electricity – […] and I saw no reason to be surprised at the fact of a man being in existence who had cultivated electric force within himself to such an extent that he was able to use it as a healing power. (80)

Despite his wide knowledge in both scientific and esoteric subjects, Heliobas lacks the professional and formal qualification of a medical man. Unlike Dr. Hesselius or even Ezra Jennings, Heliobas does not have a medical affiliation. However, Corelli’s depiction of such a “healer” is not without the scientific context of her time. The idea of electric healing was not new in the Victorian age. In France, Mesmer had already used it in the 1770s: in his clinic patients had to undergo an electro-magnetic bath in a specially designed setting for treatment. Almost a century later, in 1870, scientists like Gustav Fritsch and Eduard Hitzig developed a neurological theory of electrical transmission within the cerebral cortex. Corelli directed such scientific findings towards an occult theory of healing: her spokesperson Heliobas suggests that such electrical transmission can occur not only within the cells of the human brain, but it can be exchanged between the Divine Brain (Godhead) and the human nervous system including the cerebral spheres (Stiles 158).

Heliobas' Electric creed is a bricolage of Biblical theology, contemporary physics and occult sciences, with some allusions to Eastern religions like Chaldeanism and Buddhism. God is a "Shape of pure Electric Radiance" whose appearance is always associated with "pure light" (228) in the Scriptures. Heliobas offers his eight-step theory to prove that Christ was an "Embodied Electric Spirit" (227-8). The star which guided the journey of the Magi was a radiant electric flame, and the wise men from the East recognized its significance because the ancient Chaldeans were well aware of the proto-science of what we call modern electricity. The angels who appeared to adore the birth of Christ were "the Singing Children of the Electric Ring" (228) around the Central Spirit of Electricity (God) created at the time of the Beginning. The most remarkable, however strange (even for a "willing suspension of disbelief") proof comes when Heliobas defines Christ's power to heal as an electrical exchange of "virtue". He explains that when a woman with a "long-standing ailment" (228) touched Christ's robe, she was cured instantly, but Christ felt that some "virtue" was gone out of him – "which is the exact feeling that a physical electrician experiences at this day after employing his powers on a subject" (229). The easy equation between virtue and electric power transmitted from one source to another sounds too fantastic, but if Fritsch and Hitzig's theory of electrical signaling in neuro-transmission can be accepted, Corelli's inspired blend of medical and spiritual healing seems to be successful as a literary device in a scientific romance of the late-Victorian period[9].

The Electric Creed can be called a kind of "synthetic philosophy", to use the words of Herbert Spencer – it is a new way of theorizing Christianity in the light of mysticism through the rhetoric of Victorian science. And Heliobas, the champion of this "scientific Christianity" is the ideal figure who blends the identities of a philosopher, a Chaldean-Christian sage, a "physical electrician" and a medical agent of healing. The unnamed female protagonist and the painter Celini in *A Romance of Two Worlds* were suffering from a neuro-psychological paralysis which led them to a

kind of dislocation from their creative spirit, and also affected the natural orientation of their souls towards faith. Heliobas' therapeutic effort basically aims at a re-synthesis of their souls with this creative spirit, by reestablishing faith in the Supreme Power behind all creation. If this can be read as a metaphorical way of healing the modern disease of alienation, psychic disorientation and fragmentation, Heliobas is more like a psychological counselor and spiritual healer than a mere electro-therapist.

The identity of Heliobas hovers between that of a scientist and a mystic sage. The first-person narrator who suffers from a nervous ailment causing depression and other psychic complaints, has tried the remedies of a specialist, Dr. R---, but to no relief. Through her fruitless consultations with medical specialists, Corelli seems to point out the limitations of "materialistic" medical practice which falls short of the insight into a patient's true spiritual self. The narrator knew nothing of Heliobas before she met Celini, the artist who had been cured by the philosopher-physician. Celini, now fully recovered, has himself been endowed with some healing power, as he applies it to the female narrator and give her a temporary relief. Later, when Celini refers her to Heliobas, he mentions that the latter does not call himself a doctor, but "simply a remedial agent" (74). However, his manners that make a first impression on the patient, are similar to that of a doctor: in case of Celini, he "scanned him" with a medical gaze and "felt [his] pulse" (73), and when the female narrator meets him, she is both surprised and relieved to see that there is nothing "darkly mystical" and cabalistic about Heliobas, rather he makes customary inquires about her health and observes her "with that sympathetic and kindly interest which any well-bred doctor would esteem it his duty to exhibit" (87).

Heliobas has indeed the qualities of both a conventional doctor and a spiritual guide: in the dream-vision, he addresses the female patient as "my child" and

continues to behave so during the treatment as well. This might have some Freudian undertones suggesting a kind of subconscious yearning of the unnamed, helpless young woman for a father-figure, but it may also suggest the paternal model of an ideal physician-patient relationship[10]. Heliobas' constant monitoring of his patient under a pair of "kind eyes" can be understood as a benevolent "medical gaze", which any other "materialist" physician would have exercised within a clinical space, with a more rigid and formal authority. Heliobas does this with a difference, of course: his "surveillance" over his patient chiefly takes the form of an affectionate moral monitoring. When the protagonist, after her recovery, expresses her desire to explore the other worlds, Heliobas allows her to fulfil her quest, but also warns her that a Faust-like motive for other-worldly knowledge may be dangerous. "I felt abashed as I met his steady, scrutinizing eyes" (172), says the protagonist. In other instances, however, Heliobas lets the patient's gaze meet his own; he does not objectify her diseased body and soul, rather he recognizes the patient's subjectivity as well. Earlier in the novel, when the protagonist thinks of asking him about the expenses of treatment, he says that he does not accept fees. Here Heliobas acts like those physician-monks in medieval times for whom accepting money from patients was against the Christian notion of "service". In a different register of medical culture, this refusal to accept money seems to align Heliobas with a Christian saint as healer, on the one hand, and with the ideal figure of a sage-like physician in the Ayurvedic tradition, on the other. Though the *Caraka Saṁhitā* recognizes the material concern of the medical profession (30.29), it also maintains that "receiving food, drink or money from the surrendered patient is also not proper" (Caraka 1.132; trans. Sharma 14).

The method of connecting the physician's "inner self" with that of his patient seems to have some affinities with the ancient Oriental philosophies of healing.

Corelli's mystical creed as influenced by Rosicrusianism, theosophy and Oriental religions like Chaldeanism and Buddhism has been discussed by several critics[11], but none perhaps has attempted to read the spiritual basis of his therapeutic activities in terms of Eastern medical philosophies. Corelli refers directly to Chaldean mysticism and Buddhism in her novel, in relation to what she believes to be "true Christianity". Her interest in Eastern religions and philosophies, however, was derived from second-hand knowledge at a time of spiritual crisis in the West, when European spiritualists were cultivating a renewed interest in the Eastern religions, and publishing manuals and books on them. In this regard, it would be too much to overestimate Corelli's research in Oriental spiritualism and philosophies, yet there are indeed certain elements in *A Romance of Two Worlds*, which, however intended consciously or not, reflect some vague allusions to the healing practices and philosophies of ancient India. In order to convince the patient that her soul and that of his own belong to the same circle of electricity, Heliobas urges her to "look steadily" at him, as he clasped her hand. The patient experiences something mysterious:

> As I gazed, a veil appeared to fall from my eyes. A sense of security, of comfort, and of absolute confidence came upon me, and I saw what might be termed *the image of another face* looking at me through or behind the actual form and face of Heliobas. And that other face was his, and yet not his; but whatever it appeared to be, it was the face of a friend… one that I must have loved in some distant time, for my whole soul seemed to yearn towards that indistinct haze where smiled the fully recognised yet unfamiliar countenance. (94-5)

A psychoanalytic approach may read this passage in terms of the Freudian alter-ego or the Lacanian "mirror image" (Lacan 91, 143). However, considering

Corelli's interest in Buddhism and Heliobas' Eastern connections, one may also sense a resemblance with the *janmāntara* or *jātaka* concept in Buddhist philosophy. Basically *jātaka* refers to a kind of transmigration of the soul (not exactly in the Pythagorian sense) across the recycling of birth and death, and Corelli's narrator uses the very word "soul-transmigration" (80) to describe an integral part of the spiritual healing Heliobas brings to his patients. *Jataka* tells the stories of Buddha's previous descents into the world, revealing how the other souls related to him at present had also been associated with him in previous birth-cycles. Through a vision of the previous cycles of birth, Buddha used to bring a healing effect to the troubled minds that came to him for solace. Further, the astral journey through which Heliobas lets his patient gain a wiser and stronger vision of the truth about the universe and the condition of human life, can be read as a strange parallel to the otherworldly journey Lord Buddha arranged for his brother and disciple, Nanda, in order to heal his diseases and desires of a material world[12].

The reciprocal exchange of gaze between the master-healer and the patient (who later becomes almost a worshipper of Heliobas) is both aesthetically and spiritually charged: it is a kind of *darśana*, a concept in Indian theology (also in aesthetics) of mutually exchanged gaze between the adoring self and the subject of adoration ─ in a spiritual sense, the deity and the devotee. *Darśana*, again, is one of the ways by which the healer in the Ayurvedic tradition makes his diagnoses. This is different from the "medical gaze" authorized and clinicized in the west, since this observation invites the patient's agency as corresponding to the doctor's. The gaze is not limited to the doctor: in the Yogic and Ayurvedic healing practices, there are indeed techniques like *Trāṭaka* or *Sūrya-darśana* prescribed as exercises good for both eyesight and spiritual strength – techniques that involve the patient's gaze. The

use of "sight" in indigenous healing traditions is often associated with sense-observation, but it can go beyond mere senses.

Another important way in which the Buddhist method of psycho-spiritual healing comes to resemble the method used by Heliobas, is the *Abhidhamma* model. According to J. P. Das, who has done seminal works on theories of mind, self and neurosciences, "the Abhidhamma is primarily concerned with indicating the process and method by which a being can come to the true knowledge (*panna*) needed for liberation from suffering" (145, italics mine). In *A Romance of Two Worlds,* the narrator-patient is basically suffering from mental, spiritual and neurotic ailments, which, according to the Buddhist *Abhidhamma* model, result in states of mind (*cittāni*) that are *akusala* (unwholesome). Through proper meditation and self-control, the *akustala* factors of mind can be diminished with the empowerment of the *kusala* factors. Heliobas tries to increase the *kusala* or wholesome or pleasant factors in the patient's mind so that she may be liberated from restlessness and worry (which can be understood as similar to *uddhaca* and *kukkucha* in Pali), dullness or inertia (*moha*). This can be accomplished by increasing such *kusala* factors as tranquility (*pasaddhi*) and loving kindness (*adosha*). Indeed, strong anticipations of neuropsychological therapeutics was found in the healing practices of Buddhism, although neurosciences obviously did not exist per se at the time of Buddha (Das 146). However, it can be said that Heliobas' treatment, derived from his store of eastern wisdom, owes much to the Buddhist model of therapeutics.

In a different approach, the way Heliobas proceeds on the basis of a spiritual connection with his patient, can also remind one of the Yogic and Ayurvedic cults of faith-healing. Ayurveda holds the "person" in high esteem: it is not an objectification of the diseased body but an understanding of the subjectivity of the patient as a whole

being. *Caraka-samhitā* points out that bodies vary from one person to another, and therefore an exact measure of the faults, problems and ailments cannot be static (*Sūtra-sthānam* 15.37-39). A skilled physician must acknowledge the problems individually. In the *Śarīra-sthānam* of *Suśrūta-saṁhitā* (trans. Kunjalal Bhisagaratna), the individual patient or "Purusha" is held in high esteem:

> The self-conscious self is possessed of infinite consciousness, is real and eternally subject to the process of being evolved out into a finite, organic individual through the dynamics of the combined sperm and ovum. The view is further corroborated by a dictum of the Śruti which holds that Purusha (individual) is nothing but a combination of a self-conscious self and the five kinds of matter (Mahābhūtas) formed into an organic body. This Purusha or individual, which is called Individual of action (Karma-Purusha), falls within the scope of the science and art of medicine. (1.16-17, 119)

Further, the Ayurvedic philosophy demands an active participation of the patient's own personality, his will and effort to heal himself, which the physician encourages and supports. What Heliobas speaks about Raffaleo Celini corresponds to such an idea: "I simply set him free for a time, knowing that his was a genius which would find things for itself or perish in the effort. I let him go on a voyage of [self]discovery, and he came back perfectly satisfied" (88). We see that Heliobas recognizes the uniqueness of each patient's pathological and spiritual condition, and treats one with subjective care and respect. "You do not need his [Celini's] experience", he tells the female narrator (88). His fundamental therapeutic method is electricity, but there are instances where he also combines methods of "rest-cure" and natural healing. Raffaello Celini has learnt from Heliobas the use of natural and herbal medicines to restore balance to the overwrought nerves. In Celini's narrative,

Heliobas' medical self appears to be more like that of an Oriental philosopher-physician than a scientist of electricity.

Besides electricity and mysticism, *A Romance of Two Worlds* also considers memory as a potential reservoir of healing power, which can provide a cure from within. The use of memory in psychotherapy was given an ambivalent status in Victorian England. The narrator of Corelli's novel also suffers from a nervous and psychological disorder, resulting in a spiritual trauma experienced in a world of dull materialism. In *The Moonstone* as well, we have seen that Ezra Jennings succeeds in relieving Franklin Blake of his agonies and guilt-feelings by stimulating his suppressed memory, buried in the subconscious. Though induced by opium, his is also a cure from within, brought to effect through a re-creative manipulation of memory, which helps the patient to re-member his fragmented and frustrated existence to live anew.

Victorian psychiatry was however divided regarding the use of memory in mental healing. Sir James Crichton Brown observed, "unburdening the mind of traumatic memories" does not help to relieve the patient rather it intensifies his trauma. For him, "in vast majority of cases it should be the aim of a rational psychotherapy to withdraw the patient's mind from the contemplation of an objectionable and painful past […] and to occupy it with […] sure and certain hopes" (qtd. in Clark, 300). Others like Dr. William Benjamin Carpenter and Dr. John Elliotson (a personal acquaintance and physician to Wilkie Collins) believe that memory can be used for the purpose of healing under the spiritualized influence of drug. In *The Moonstone* Jennings actually refers to these two real-life doctors to show that his method of experiment is not altogether magical or mystical.

In both the novels discussed here science is brought in alongside the spiritual, the psychical and the mystical. Though it is difficult to claim authenticity for such controversial practices of alternative cure, their persisting popularity can be recognized in the 19th century literary circles and among some scientists and physicians who could think beyond the established discourses of therapeutics. Memory thus remained a powerful aspect of cognition which led the future psychologists to explore a really interesting mode of looking at the human psyche and its variegated mysteries. Modern psychotherapy and trauma theories also owe a great deal to the Victorian conceptions and debates concerning memory and its effect in healing, which urges us to reconsider the role of the "metaphysical physician" or "occult healer" who worked at the intersections of science, psychology, spirituality and alternative therapeutics in nineteenth century England.

At another level the role of the metaphysical physician can be read as a curious blend between the Shaman and the psychoanalyst. Sudhir Kakar argues in his book, *Shamans, Mystics and Doctors*: "Both the Shaman and analyst establish a direct relationship with the patient's conscious and an indirect relationship with his unconscious – the analyst through listening, the shaman through oratory" (92). Like a shaman, a psychoanalyst also approaches the troubled mind of the patient enabling it to enter a different level of ritualistic or linguistic experience. This is exactly what Heliobas does with Celini and the female narrator[12]. In *The Moonstone*, Ezra Jennings applies similar kinds of linguistic experiments with the disordered nerves of Dr. Candy[13], and later, listens to the revelation of the "truth" from the language and action of Blake in a state of trance, within a ritual-like setting for reawakening the buried past . In *Structural Anthropology* Claude Levi-Strauss has pointed out certain affinities between the mysterious power attributed to both the shaman and the

psychoanalyst – one being a mystical master with a certain otherworldly knowledge and the other, an explorer of the unfathomable regions of the human psyche[14]. If texts like *The Moonstone* and *A Romance of Two Worlds* are studied within a fraught context of cultural anthropology and its evolution across time and space, the figure of the Oriental or hybrid-Eurasian scientist appears to be all the more significant in the Victorian context of "civilization and its discontents". The ethnic identity of Heliobas as a Chaldean occult scientist and that of Ezra Jennings as an alien figure (who is finally able to reconcile himself to the English society around him, by assuming the role of a self-sacrificing healer) seems to reinforce Gouri Viswanathan's observation:

> … the otherworldliness of the occult offered alternative possibilities for imagining colonial relations outside a hierarchical framework, [...] In reimagining colonial relationships, occultism performs a function similar to what Robert Young describes as culture's role in imperializing Britain, which allowed for a cross-fertilization of language, history, and literature without the racial degeneration caused by sexual contact. (2)

Occultism in late Victorian Britain thus functioned as one of the aspects of interconnection among the sociological, political, cultural and scientific issues of topical interest. Against this complicated scenario of science versus spiritualism in nineteenth century Europe, the figure of the metaphysical physician assumed a cultural representativeness through their literary portrayal. Of course, the materialistic and empiricist distrust of such pseudo-sciences was strong at a time of increasing scientific and technological developments; yet the existence of a doubt-ridden, spiritually distraught subconscious underneath the Positivist progress was unmistakable in the Victorian culture. While the materialistic, utilitarian civilization demanded a celebration of public causes in society, the sufferings of the lonely

individual psyche struggled for expression. The representation of the failure or success of the metaphysical or occult physician in the literary gothic and popular fiction can be understood as an "objective correlative" to the individual subject's desire to find a way of healing the "disease" of material life, from a crisis of faith, negotiating the tensions within the tripartite conception of being (body, mind and soul). The literary portrayal of such figures both reflects and undermines the attempted symbiosis between science and spirituality which betrays the very perplexity and discomfort of the troubled Victorian unconscious.

Notes :

1. This is from the beginning of Dickens' *A Tale of Two Cities,* London, Melbourne and Torronto: Wardlock and Co. Ltd. (n.d.) , p 11.
2. For a detailed discussion of these alternative sciences, see Robyn Hallim, *Marie Corelli: Science, Society and the Best-Seller*, diss. University of Sydney, 2002, p. 79-80.
3. A similar suggestion is made by Rikard Prytz, "Ezra to the Rescue: Three Facets of Moonstone", Bachelors Degree Project, Spring 2012, Stolckholm University, available at <http://www.diva-portal.org /smash/get/ diva2:5 50765/ FULLTEXT01.pdf>
4. In order to show that science sanctions his method of experiment regarding the "spiritualized" influence of opium on the human subconscious (Collins 358-9), Jennings refers to two eminent doctors of the Victorian times, Dr. William Benjamin Carpenter, and Dr. John Elliotson, the latter being a personal acquaintance and physician to Wilkie Collins himself. "Elliotson combined conventional medical methods with more controversial practices such as mesmerism and clairvoyance" (David Blair, "Notes", *The Moonstone*, Hertfordshire: Wordsworth Editions Ltd., 1999, p 438)
5. See David Blair, "Introduction", *The Moonstone,* p xiv.

6. For a detailed discussion of Le Fanu's interest in Swedenborgian mysticism, see W. J. McCormack, *Sheridan Le Fanu and Victorian Ireland,* Oxford: Clarendon Press, 1980.
7. See Helen Stoddardt, "The Precautions of Nervous People are Infectious: Sheridan le Fanu's Symptomatic Gothic", *Modern Language Review* 86 (1991): 19-34.
8. Some representative critical works of this kind are Elaine Showalter's "Dr. Jekyll's Closet." *The Haunted Mind: The Supernatural in Victorian Fiction*. Eds. Elton E. Smith and Robert Haas, The Scarecrow Press: Lanham, MD, 1999, 67-88 and Stephen Arata's "The Sedulous Ape: Atavism, Professionalism, and Stevenson's 'Jekyll and Hyde'", *Criticism* 37.2 (1995): 233-59, at <http://disciplinas.stoa.usp.br/pluginfile.php/93666/mod_resource/content/1/Sedulous%20Ape.pdf>
9. See Anne Stiles, *Popular Fiction and Brain Science in the Late Nineteenth Century,* Cambridge: Cambridge University Press, 2012, pp 158, 184.
10. This is a well-known legend in Buddhist literature. See Asvaghosa, *Soundaranandam*, dashama sarga (Canto 10), *Sanskrita Sahitya-sambhar* (vol. 9), Nabapatra Prakashan, Kolkata, 1980, 148-52.
11. Richard Michel Caputo's Ph.D. thesis "Spiritualism, Science and Suspense: Theosophy and Supernatural Adventure Story" (Stony Brook University, August 2011) and Sarah Willburn's "The Savage Magnet: Realization of the Occult Body in Late Victorian Fiction", *Women's Writing* 15.3 (2008) are representative of recent critical studies using this perspective. The influence of Buddhism on Marie Corelli has been discussed in J. J. Franklin, "The Counter-invasion of Britain by Buddhism in Marie Corelli's *A Romance of two Worlds* and H. Rider Haggard's *Ayesha: The Return of She*", *Victorian Literature and Culture*, 31: 1, March 2003, pp 19-42.
12. In medieval Christianity, learned clerics and monks often administered medicine to the sick people, and they were both addressed as "doctor" and "father". The paternal relationship between the physician and the patient has also been

emphasized in the Ayurvedic traditions in India. In *Śūtrasthānam* 29:7, Caraka says, by quoting Lord Atreya:

> The physicians of high descent, well-versed in scripture, having practical knowledge, expert, clean, skillful, self-controlled, well-equipped [...] dealing with all the living beings with friendly manner like parents, brothers and kinsmen. Endowed with such qualities, Agniveśa! are promoters of vital breath and destroyers of diseases. (*Caraka Samhitā*, trans. P.V. Sharma,Varanasi: Chowkhamba Orientalia, 2014, p. 232).

13. Heliobas' address to Celini during the process of a spiritual treatment verges on the verbal exercise of Shamanism: "Weary and overwrought frame, take thy full and needful measure of repose! Struggling and deeply injured spirit, be free of thy narrow prison! By that Force which I acknowledge within me and thee and in all created things, I command thee, rest!" (*A Romance of Two Worlds,* p 76).
14. Ezra Jennings' role as an explorer of the psychical experience by means of language is evident in the way he listens to the sick Dr. Candy's fragmented ramblings, puts them into record, and reconstructs the verbal expression, deciphering its meaning almost in a ritualistic manner. See *The Moonstone,* Hertfordshire: Wordsworth Editions Ltd., 1999, p 373-74).
15. Claude Levi-Strauss, "The Effectiveness of Symbol" and "The Sorcerer and His Magic", *Structural Anthropology,* New York: Basic Books, 1963, pp 167-85 and 186-205.

Chapter 3

"The Doctor's Dilemma" in Modern Literature: A Bioethical Approach

The medical profession and ethics in Britain, till the close of the nineteenth century, had been more or less traditional in nature. The cult of the "gentleman physician" as a champion of the Aesculapian, charismatic and social virtues (see chapter 1) in Victorian England continued to prove successful in the narratives of social realism up to the late 1890s. However, the growing importance of modern technology and market economy was gradually getting into the doctor-patient relationship. New discoveries in biomedicine and techno-sciences made clinical practice swifter but impersonal and mechanical, and the doctor's philanthropic orientation in general was rapidly giving way to a commercial and specialized medical enterprise. In London and other town-areas, there was also an increasing gap between the well-informed, wealthy and care-demanding section of patients and the underprivileged urban working class. Doctors appointed in hospitals and their colleagues in private practice faced each other with a competitive interest. The practitioners found themselves caught in a rapidly complicating web of class, status, professional ethics, social and mercantile forces. This resulted in a complex "bioethical" discourse in the medical field, and the literary and cultural attitude to the doctor-figure underwent a remarkable shift in the early twentieth century.

Studies in Bioethics have been a recent development, and the subject does have an interdisciplinary structure. According to Warren T. Reich, bioethics is "the systematic study of the moral dimensions — including moral vision, decisions, conduct, and policies of the life sciences and health care, employing a variety of

ethical methodologies in an interdisciplinary setting" (2950). On the other hand, Howard Brody, an eminent physician and medical humanist, has defined bioethics and literature in terms of an unavoidable ambiguity: the goals of bioethical and literary representations of medical themes cannot be exactly the same[1]. Opinions may vary regarding the levels of interactions between bioethical and literary studies. However, it can hardly be denied that "literary bioethics" and "bioethical literature" have now become fertile areas of research and investigation.

In her essay contributed to the book, *Bioethics and Biolaw through Literature*, Mara Logaldo has discussed both the affinities and disparities between Postmodernism and Bioethics. In 1971, the emergence of the term "Bioethics" in its present usage coincided with the foundation of the Kennedy Institute of Ethics in Wisconsin and Washington D. C., whereas Postmodernism took shape as a complex paradigm shift in literature, popular culture, discourse and epistemology throughout the 1960s and '70s. Both Bioethics and Postmodernism, however, share a distrust of the "grand narrative" – the former arose from a rejection of faith in a teleological and positivist science celebrated in the mid-Victorian period, and the latter took shape in a critical response to the traditional values and assumptions that dominated the West since the age of Enlightenment. "At the same time, they also rejected a theological view, preferring to it, at most, what has been defined as a 'negative', 'deconstructive' and 'eliminative' theology", observes Logaldo (298). Both Postmodernism and Bioethics are thus engaged in a critique of man's present position in the universe. However, the only aspect of Humanism that Bioethics retains in its modified terms, is the self-scrutiny of man as a biological, social and scientific entity maintaining a self-awareness, while Postmodernism – especially in its literary aspects, has replaced the "subject"-position — authorial or otherwise, with the auto-reflexivity of the "text".

Postmodernism aims at a decentralization of the human selfhood, whereas bioethical medicine tries to rethink the notions of safeguarding human life even against a hopeless and nihilistic universe. Howard Brody views the relationship between Bioethics and Postmodernism in a different way: though the term "bioethics" in its present sense did not come to be used before the 1970s, what is now called bioethics is basically a recent revival of a modernist medical enterprise. As he continues:

> The first target of postmodern criticism is, of course, modernist medicine, and bioethics comes in for its share of criticism as it is shown to have become an integral part of modernist medical enterprise and not, as it may have proudly and naively assumed during its recent renaissance, a critical attack upon and corrective of that medical system. (1997: 22)

The understanding of bioethical literature in the modern period, then, becomes both a movement towards the opening of new vistas of understanding Medical Humanities in relation to life and at the same time, a problem to bring that understanding to a reality that replicates it anxieties, constantly forming new bioethical challenges.

Shifting our focus from Bioethics in general to its specific literary representations, we may realize that the very attempt to associate the literary and the textual to the bioethical indicates a Postmodernist approach where everything can be considered a "text"[2]. As Downie and McNaughton have noted:

> [T]he analysis of a poem is a highly skilled and complex matter, especially since poems are resonant with irony and ambiguity. Indeed, perhaps the diagnosis of a patient's illness and the analysis of an ethical problem have this in common: each is more like the interpretation of a difficult text …. (135)

If the patient's problem is to be interpreted as a "text", so it is to be in case of "the doctor's dilemma" as well. Borrowing its heading from Shaw's evocative phrase,

the present chapter aims at a close literary analysis of some texts of the modern period – texts in which the doctor-patient relationship amounts to a bioethical problem. Terms like "literary bioethics" and "narrative bioethics" have indeed emerged in a postmodernist context of cultural studies (Sedova and Reymer 538). However, in order to trace the development of the bioethical rationale in literature, one may go back to the nineteenth and twentieth century literary works involving such medical themes and characters as "doctor", "disease", "cure" and "death". In this regard, the changing discourse of representing the doctor-figure in modern literature can be appreciated from a bioethical point of view.

The traditional tripartite structure of the professional hierarchy in Victorian medicine gradually evolved into a more complex discourse involving the consultant and the General Practitioner (GP). George Bernard Shaw's 1906 play, *The Doctor's Dilemma* shows how by the late nineteenth century the medical spectrum got complicated – with the professional elite in London, particularly around the "Harley Street" on the one hand, and the mediocre GP on the other. The prestige attached to this "small but dynamic" group of consultant elites derived not necessarily from their Aesculapian skill and knowledge, but rather, from the social status of the healing profession itself.[3] Alongside these two groups, there was a thriving politics in the medical circuit which was lucrative for the young practitioners, getting an attachment with the public hospitals. St. Mary's Hospital at Paddington, for instance, became one of the most prospective places for young socialist physicians[4]. Earlier in the nineteenth century the Fellows of the surgical and medical colleges were selected on the basis of social status, family connections, and sometimes, political affiliation[5]. As the century drew to its close, and healthcare and health-policies became more complicated and mercantile, a shift in the formulating principles of modern bioethics

was felt. The consultant elite achieved more power in a sense which was categorically Foucauldian, as it involved a composite notion of "power" and "knowledge" (Foucault 1980: 51, 69,108). Peterson points out that this power rested not on the doctors' capacity for curing and giving care, but rather on the dangerous propensity of the patients' dependence on the consultants for their life and death. It was less "the power to do, but the power to know, and therefore to judge" (Peterson 286).

By the twentieth century, the power, authority and ethical values of the doctors began to be questioned within a broad socio-economic scenario. George Bernard Shaw, being a member of the Fabian Society, figured as one of the most prominent critics of the medical establishment of that time. In *The Doctor's Dilemma* (1906), Shaw portrays the situation of a poor General Practitioner, Dr. Blenkinsop, who realizes the need of giving specialized treatment, but finds it practically impossible since his poor working class patients are unable to pay for the proper measures of medication. Nor would they come to him at all and get no medical assistance, if he prescribes such expensive measures. Dr. Blenkinsop, however, does all he can for his poor patients, considering his own limited resources. On the other hand, the high-class doctors have to make compromises with the demand of the well-to-do middle-class patients, in order to live by pleasing as many as he can. As Shaw puts it in his "Preface":

> …The doctor who has to live by pleasing his patients in competition with everybody who has walked the hospitals, scraped through the examinations and bought a brass plate, soon finds himself prescribing water to teetotalers and brandy or champagne jelly to drunkards; beefsteaks and stout in one house, and 'uric acid free' vegetarian diet over the way; ... never once daring to say either "I dont know," or "I dont agree". (68)

The central dilemma of Shaw's text is founded not only on medical ethics in an idealistic sense, but on the market-situation of the medical profession which creates a gap between supply and demand. One junior doctor under Dr. Almroth Wright, Shaw's friend and the Head of Pathology in St. Mary's Hospital, once complained that they often had to choose a certain number of patients for vaccination, since they had but a limited number of hospital beds at disposal[6]. Shaw often visited the Pathology department at St. Mary's and enjoyed informal conversation with the physicians. It is probable that the basic bioethical problem in *The Doctor's Dilemma* was partly derived from his interactions with Dr. Wright or his colleagues. Dr. Ridgeon in the play has discovered a remedy for tuberculosis, but the supply of material for vaccination being scarce, he can accommodate only ten patients – chosen ones. It is clear that Ridgeon's selection of ten patients out of fifty, leaving the other forty to die, is subject to a serious bioethical decision.

Ridgeon finds himself compelled "to consider, not only whether the man could be saved, but whether he was worth saving" (110). So the first criterion weighs the chance of cure, whereas the second is judgemental on the quality of a patient as a person[7]. This fundamentally goes against the principle of equality and impartiality in bioethics which gives each patient equal right to be treated. When Mrs. Jennifer Dubedat persuades him to treat her husband, an artist, the doctor says: "You are asking me to kill another man for his sake" (113). This notion of saving a patient at the cost of killing another almost raises Ridgeon to the level of a "saviour". The way he assumes himself to have absolute power to "kill" and to "heal", becomes his dilemma in a bioethical sense. The irony of Ridgeon's situation becomes evident when Dr. Blenkinsop, a colleague, mentions that he is also suffering from tuberculosis. Blenkinsop knows that he cannot afford the expensive therapy, so he

does not ask Ridgeon for his treatment. But his very position as a colleague and an honest, however poor, practitioner seems to speak for his case although he does not demand consideration or favour. When Blenkinsop has left, Dr. Cullen asks Ridgeon: "Well, Mr. Savior of Lives: which is it to be? that honest decent man Blenkinsop, or that rotten blackguard of an artist, eh?" (127). The play critically asks whether the doctors' claim to have power over the life and death of fellow human beings is really capable of making a proper value-judgement, and how far the medics can be trusted with such power.

The Doctor's Dilemma betrays Shaw's bitter attitude towards the medical profession. Each doctor displays absolute disregard for his colleagues and a ridiculously high level of pride in himself. The initial situation is one of harmony and hope: the doctors have come to their recently knighted colleague Ridgeon to congratulate him on his discovery. The situation soon changes into one of criticizing and abusing each other. In his "Preface" to the play, Shaw expresses his disgust towards this tendency among doctors:

> Anyone who has ever known doctors well enough […] knows that they are full of stories about each other's blunders and errors, and […] the theory of their omniscience and omnipotence no more holds good among themselves than it did with Molière and Napoleon. But for this very reason no doctor dare accuse another of malpractice […] to make the medical profession a conspiracy to hide its own shortcomings. (9)

What appears to be even more bizarre is the doctors' attitude to their own errors. In the colleagues' meeting at Ridgeon's house, the doctors (except the poor and honest Blenkinsop) casually share anecdotes of the mistakes they have made in their medical career. Dr. Walpole seems to derive great amusement from his own

fault, when he mentions jocularly how he once forgot to remove the sponges from a patient's body after surgery. When Ridgeon warns B.B. that anti-toxins are dangerous if they are not used at the right time, the later retorts casually: "Everything is dangerous unless you take it at the right time" (98). Ridgeon is disturbed to see such an attitude in his colleague, but he himself once applied to a female patient an erroneous treatment that "instead of curing her, […] rotted her arm right off" (89). The doctor's cavalier attitude to the case comes out when he makes a nonchalant remark that the patient has been able to earn money by displaying her disabled arm at medical lectures (89). Even Ridgeon's final decision to cure Blenkinsop instead of Louis Dubedat, derives from no sudden awakening of fellow-feeling, or a sense of duty to a worthy colleague. As John Allett rightly observes, Ridgeon has made the right choice for the wrong reason[8]. Ridgeon is infatuated with Mrs. Dubedat and wishes to get rid of the artist, saving Blenkinsop instead. Another doctor, B. B. takes interest in Dubedat's case and offers to treat him. Even then, there is no sense of consolation and real hope. B.B. deliberately maintains that he is going to use Dubedat as an object for experiment: "To me you are simply a field of battle in which an invading army of tubercle bacilli struggles with a patriotic force of phagocytes. Having promised to your wife… to stimulate those phagocytes, I will stimulate them. And I take no further responsibility" (146).

Within the text, it is not clear whether B.B.'s experiment could have been an alternative therapy for tuberculosis, because finally he resorts to Ridgeon's method, mishandles it and Dubedat dies. Later, when Ridgeon confesses his love to Jennifer Dubedat and says that he has indirectly killed her husband by letting another doctor use his method, she dismisses him with a strong admonition: "Doctors think they hold the keys to life and death; but it is not their will that is fulfilled. I don't believe you

made any difference at all" (176). Her reproach to Ridgeon can equally be applied to any other elite and vain-glorious physician: none of them makes any difference. For Shaw, the contemporary medical system was either inefficient or dangerous, since it got corrupted by the doctors' self-serving will and misguided value-judgement. The concern is not merely of human consideration; it is rather a bioethical problem, asking how far the self-proclaimed specialist's "power to know" can be granted to exercise a "power to judge" the values of life and death, and to determine one patient's "worth" over another.

In *The Doctor's Dilemma*, Shaw presents two dramatic narratives at conflict. The narrative concerning Dr. Ridgeon's interest is at odds with the narrative that involves the Dubedats – the patient and his wife. In the traditional nineteenth century medical narrative, the doctor was generally given the privileged position to judge for the patient, but his goal hardly clashed with that of the patient. When the doctor's narrative becomes hostile to that of the patient, it becomes a bioethical challenge to "protect" the patient's interest, as Henry Beecher suggests in his essay "Ethics and Clinical Research" (1354-60). In literary bioethics, the growing demand for privileging the patient's narrative "can only be understood if the doctor is seen as poised to take advantage of a patient for unscrupulous reasons" (Charon 205). So a literary text like *The Doctor's Dilemma*, written in the first decade of the twentieth century can be read as one that triggered those issues of medical ethics and healthcare deficiencies, which have now become important considerations related to bioethics.

The breach of trust between doctor and patient was a growing problem in the early twentieth century, showing little sign of improvement in the next two or three decades including the inter-war period and afterwards. Lawrence Rothfield observes that by the end of the nineteenth century Capitalism began to co-opt professionalism

onto its side, and “the physician, who stood for an alternative to marketplace individualism in the earlier period” (149) now assumed a rather contrary role, “standing as the epitome of liberal individualism in an era of emerging corporate and international capitalism”(149). The art of healing also underwent a transformation – from a progressive and authentic science to an auxiliary one, and from an ideal profession to a less significant social praxis – and this found expression in modern literature through a “new wave of antagonism against medicine and medical professionals”(Rothfield 150).

With the modernization and rapid commercialization of the medical profession, the idealistic figure of the Victorian GP or the good family-physician was no longer the central consciousness in modern fiction dealing with medical concerns. In addition to the tension between the self-interest of the physician and the expectation of the patients, a new anxiety grew up between the increasingly technological and biomedical focus on disease and care of the patient. The development of innovative medical instruments such as the compound microscope and the method of chemical staining for examining tissues brought a technological evolution in clinical epistemology. The introduction of X-rays into medical practice in 1895, electrocardiography (ECG) in 1910 and the sphygmomanometer in 1912 transformed the methodologies of diagnosis and brought a new impetus of motorized accuracy in the measurement and perception of disease.

Such technological progress indeed generated a more efficient medical practice, but this entailed a condition in which physicians would become accustomed to perform in a way more mechanical and routine than interpersonal and subjective. Besides, as a result of the overall disintegration and lack of stability in society, politics and administration during the interwar period, healthcare service in Britain

suffered from mismanagement, abusive interference by third parties, pressure from the pharmaceutical industries and business-oriented medical centres, local politics and the largely ineffectual and self-serving body of public health authorities. These led to the status and work of the physician being questioned, intervened and limited. As a consequence, the medical practice became conditioned by mercantilist forces, and profitable to politicians in the healthcare administration. A realistic literary representation of this situation needed the experience of such physician-authors like A. J. Cronin whose most remarkable work, *The Citadel* (1937) is to be discussed later in this chapter. Before that, it is necessary to have a clearer understanding of the factors of changes in the social, cultural and medical scenario that marked a visible decline in the portrayal of the doctor-figure in the 1920s and the 30s.

In the social history of medicine in the West, the focus has long been "iatrocentric" – that is, depending on the skill and quality of the medics. Besides, the medical profession "has been portrayed in institutional or organizational terms as a homogeneous body evolving towards scientific competence" (Shortt 6). However, this assumption of "homogeneity" in all medical and scientific enterprises has now been highly debated, and instead of a medical process centering on the doctor's role, the issue of "social iatrogenesis" has come to the fore. As Ivan Illich suggests, social iatrogenesis is often confused with the diagnostic authority of the healer. He instead focuses on the iatrogenic creation of disease, suggesting that modern medicine tends to create illness as a social reality in order to prove its own validity. The changes in the medical scenario are "dependent variables of political and technological transformations, which in turn are reflected in what doctors do and say"; and the medical intervention itself results in "an extending proportion of the *new* burden of disease […] in favor of people who are or might become sick" (Illich 15-16). In that

case, the respectable figure of the "healer" in earlier societies has been transformed into a bureaucratic agent of social and cultural iatrogenesis, legitimizing an ever-thriving population of patient consumerism.

In bioethical terms, healthcare and wellbeing in human civilization constitute a pathological, social as well as moral enterprise and therefore, it bears obvious ethical dynamics of doing both good and evil. According to the Foucauldian scheme, the clinical authority, like religion or state-laws, has a controlling power over what is considered to be normative, sane, healthy, disciplined and proper[9]. So the physician, like the governor or the priest, can also exercise a judgemental perception over normativity, health and sickness. In the twentieth century the medical profession was gradually becoming bureaucratic in nature, with its growing materialistic concern and exploitation of disease as an object of profit-making. However, to a certain section of common patients it was still believed to be based upon some abstract notion of trust and confidence, the loss of which would have been disturbing for both sides. It is on this slippery ground of professional integrity, that the question of bioethics creeps in. As to the literary representation of medical themes, one may interrogate those aspects of bioethics which can provide a better conceptualization of the physician-figure as a cultural manifestation of the changes in social and medical history during the "modern period".

In literary Modernism, it has been a common critical consensus to associate the early decades of the twentieth century with a fragmented and distorted reality. The depiction of the professional life of medics in modern literature also reflected this phenomenon in general. The outbreak of the First World War in 1914 affected humanity with an irrecoverable damage of health and stability, bringing as a consequence a diseased condition of trauma. In *Reconstructing the Body,* Ana

Carden-Coyne examines how in the years following the First World War, wounded bodies and the medical innovations (facial surgery, for instance) used to "rebuild" and rehabilitate them, were made a matter of exhibitionism and medical propaganda. Although this helped to establish a positive rhetoric for overcoming the physical predicament perpetrated by the war, and success of the doctors who participated in this project of rehabilitation, it could be psychologically agonizing to the patient's own traumatic memory, now being subject to medical publicity and display. On the other hand, medical care-giving to the victims of the war and the ambivalent status of military psychiatry have interested several scholars[10] like Peter Lesse and Fiona Reid. Jones and Wessely argue that the theoretical and technical developments in medical psychiatry by the time of the First World War were not enough to address the problems of the shell-shocked patients suffering from a post-traumatic neurosis. They also discuss how cultural perceptions of war and trauma affected the diagnosis of the military doctors, as well as had an impact on the way patients themselves understood (or, failed to understand) their own symptoms and disabilities[11]. Doctors interested in psychiatric care-giving were still a minority, and the patients were generally treated under the broad category of nervous disorder, which Sir William Bradshaw, the renowned nerve-specialist in *Mrs. Dalloway* calls "not having a sense of proportion" (Woolf 79).

Literary representations of medics during and after the War, in most cases, have been far from positive – a trend which reflects both the helplessness and ethical disorientation of the medical profession, facing a reality too bleak, diseased and lacking prospects of doing something substantially good. Virginia Woolf's *Mrs. Dalloway* represents two different aspects of medical treatment given to the figure of a "broken man" – the shell-shocked soldier, a problem and threat to the post-war

British masculinity, an object of pity. Woolf's scathing medical satire undermines the professional jealousy and narrow-mindedness of the doctors[11], which she herself experienced during her illness. In the novel, learning the General Practitioner Holmes' opinion on Warren-Smith's case, the specialist Sir William retorts: "Those GPs —", although in fact both doctors are equally mistaken in their diagnosis. Dr. Holmes, the GP in *Mrs. Dalloway* does not believe in mental illness at all, he calls it a "funk"; and Sir William Bradshaw, the nerve-specialist hypocritically avoids the word "madness". He blatantly refuses to pay any attention to what the patient has to say, and speedily prescribes complete seclusion and rest, before dismissing the Warren-Smiths. He considers mental illness a form of rebellion and radicalism against the status quo, which must be brought to submission – which he calls normality and "proportion". The failure of the doctors to restore health to the war-victim Septimus Warren-Smith can be related to the author's own bitter experience of undergoing an ineffective psychological treatment, resulting in her distrust in the unfeeling and dully authoritative nature of medical treatment, which several critics have already discussed[12]. Woolf does not hold her disgust when she sardonically characterizes Dr. Bradshaw:

> To his patients he gave three quarters of an hour, and if in this exacting science which has to do with what, after all, we know nothing about – the nervous system, the human brain – a doctor loses his sense of proportion, as a doctor he fails. Health we must have, and health is proportion; so that when a man … threatens, as they often do, to kill himself, you invoke proportion, order rest in bed, rest in solitude, … rest without friends, without books, without messages; …. (81)

Septimus Warren-Smith's suicide shows the collapse of the traditional and idealistic relationship between doctor and patient, which has become rather adversarial in the novel. The only person who tries to understand Septimus is his wife Rezia. Realizing that her husband is actually better and happy when he is not under the dominating medical eye, she resists Dr. Holmes. The doctor authoritatively demands to see him and makes his way to the patient's room. And Septimus, as if to protest against this disgracing medical network of power, throws himself out of the window. Even a few seconds before Dr. Holmes' entry, Septimus has not been thinking of death. It is the doctor who breaks into his private space – his otherwise happily running stream of consciousness, and compels him to commit suicide. The doctor's failure to provide comfort and cure and the pathetic claim of the patient's voice to be heard and understood can be read in terms of a paradigm shift in the history of medicine. Within the recent theoretical spectrum of literary bioethics, a shift of importance to the patient's story, voice or point-of-view is held to be instrumental to the restoration of ethicality in a medical narrative. Samuel Shortt has quoted Frances Smith's observation that patients in general "loom small in medical history" (6). However, modern medical historians and bioethicists are increasingly becoming conscious of the limitations of the "iatrocentric" model. Viewing the patient as a whole person has become a bioethical challenge, which, instead of focusing objectively on symptoms, requires an attempt to analyse the patient's problem in his own terms. Howard Brody argues that "modernist medicine cannot at its core take patient autonomy seriously" (1997: 23). It only pretends to show some consideration to the patient, by allowing him to tell his story "in some selected and ritualized settings" (23). In order to rethink its position, bioethics needs to make either a radical choice between the patient's autonomy and the doctor's complete authority, or, as one

may add, find some way to form a balance of power between the two. In *Mrs. Dalloway* the doctors' dismissal of the traumatic patient's voice and the patient's self-destruction thereafter seem to pose such a bioethical dilemma.

Woolf's "Dr. Chapter" remains a cult-narrative on the medical egotism and fallibility in postwar Britain. Besides, there was a growing tendency of portraying doctors as possessing an "evil genius" in modern sensation novels, science fiction and mystery tales. Earlier in popular crime fiction, as in the Sherlock Holmes casebooks and later, in Dorothy L. Seyers' detective novels throughout the late 1920s and the '30s, doctor-figures were often associated with medical criminality. In "The Adventure of Speckled Band", Holmes specifically points out: "When a doctor goes wrong he is the first of criminals. He has nerve and he has knowledge" (270). Dorothy L. Seyers' 1923 novel *Whose Body*? portrays Sir Julian Freke, a surgeon and neurologist as a vengeful murderer: knowing the human anatomy well, he can murder in a more "scientific" way than a common criminal. Francis Iles' 1931 crime-fiction, *Malice Afterthought* details in clinical terms the sadomasochistic psychology of Dr. Bickleigh who murders his wife Julia in a planned way. Though such popular mystery-stories and crime-fiction are difficult to be regarded as a well-researched and organized body of criticism against medical malpractice, there is however some truth in the fact that they somehow reflected the general suspicion and unease about the sinister nature of medical fraud and criminality growing in the interwar period. Developments in new forensic experiments, vaccination, vivisection and their misuse by some unscrupulous medics also fanned the popular fears about the dark character-type of malicious doctors.

These fears were reframed in terms of a dystopian worldview where medicine and biotechnology have taken the role of a totalitarian government, in Aldous

Huxley's *Brave New World* (1932). As Mustapha Mond the Controller holds, "God isn't compatible with machinery and scientific medicine and universal happiness. You must make your choice. Our civilization has chosen machinery and medicine and happiness"(158). In the imaginary "World State" the Bloomsbury embryo centre, human cloning centres ("hatchery") and human management institutes are strategically located in a futuristic London, constituting a "panopticon"-like structure, with the "eye of authority"[13] active all the time, keeping individuals under constant surveillance. To many, Huxley's text anticipated the rise of Fascism and the atrocities perpetrated by Nazi doctors during the Second World War (Stripling 51-52), when the use of genetic engineering and pathogens for evil and morbid purposes stimulated debates over the destabilization of the traditional moral component in medical ethics. Indeed, the scene at the hospital where the old "savage" Linda is dying, visited by a horrified group of "civilized" people, seems to foreshadow the horrors of the Nazi concentration camps. The doctors, scientists and experimentalists in *Brave New World* are part of a system in which medical science has become a relentless machinery without any kind of consideration for human individuality, feelings or emotions. Though written in 1932, Huxley's text represents a time in the future when human life is governed by biotechnology and biomedicine coupled with a mechanical force. The situation closely resembles what Lyotard has called the "motricity of the modern world" – an auto-replicative technological advancement in which machine has taken a life of its own – which postmodernism seeks to duplicate in an endless web of simulacra (Lyotard 1467). In the context of biomedicine, this is a premonition of the strange dynamics in the doctor-patient relationship where both identities are deprived of subjective consciousness, and what is more, the very existence of medical ethics.

Huxley's *Brave New World* depicts a fictional World State in which eugenic possibilities are controlled by pharmacological governance, where babies are "hatched" in bottles, and adults are brought into "order" by using a hallucinatory drug called "Soma". Describing the power of this medicine, Dr. Shaw remarks: "Soma may make you lose a few years in time, […] But think of the enormous, immeasurable durations it can give you out of time. Every soma-holiday is a bit of what our ancestors used to call eternity" (Huxley 1932: 104) The doctor's use of the word "eternity" reaches the height of the irony: in the name of letting the citizens enjoy such "eternity", medical authorities shorten the normal span of human life, but create the illusion of a prolonged "happiness" as long as one is under the influence of "Soma"[14]. Through his doctor-figures in *Brave New World,* Huxley has deliberately caricatured George Bernard Shaw and H. G. Wells. Both were interested in a bioethical vision of eugenics: Shaw was critical of the deficiencies in his contemporary medical service, but he believed in the eugenic possibility of scientific and creative evolution. His theory of "Life Force", influenced by Bergson's idea of "Elan Vital" gave way to his futuristic imagination in plays like *Man and Superman* and *Back to Methuselah.* Huxley presents a satirical and degenerate version of the Shavian ideas through two characters – Bernard Max and Dr. Shaw, both owing their names to George Bernard Shaw. Bernard the psychologist, however, at the end, gets disillusioned with the ideas of power and self-importance, and becomes a tragically alienated Alpha-plus sample. The portrayal of "Dr. Shaw" has been a parody, whereas Huxley's engagement with H.G. Wells' utopian ideas begins as a parody and gradually resorts to a "pastiche"[15]. As Huxley himself puts it, Wells' too optimistic vision of the utopian future in *Men Like God* evoked in his mind "an almost pathological reaction in the direction of cynical anti-idealism" (Aldous Hurley Annual

2001, 1) but in course of writing, the motivation took a life of its own: the idea became "so fascinatingly pregnant with so many kinds of literary and psychological possibilities that [he] forgot *Men Like Gods* and addressed [himself] in all seriousness to the task of writing the book that was later to be known as *Brave New World"*(*Aldous Huxley Annual* 2001, 1).

Huxley has not made any direct reference to the writings of Shaw and Wells, but he has given them a medical status. Bernard Max, the psychologist and "Dr. Shaw" – representatives of the scientific and medical authorities in the all-powerful World State, decide the value of human lives. Dr. Shaw introduces the old and alcoholic Linda to a high dose of the hallucinogenic drug "Soma", knowing very well that such excessive intake of the drug can cause death. In "Plato's Pharmacy", Derrida has critiqued the ambiguity inherent in the Greek word "Pharmakon". Derived from the same root of "Pharmakos" (scapegoat), the word may mean "philtre", "drug", "recipe", "charm" or "spell", "medicine", "poison" – a variety of connotations producing a slippery and ambivalent play of contradictions: remedy/ poison, good/ evil, positive/ negative and so on (Derrida 1981, 99). "Soma" can ironically be associated with such ambivalence, and when a doctor prescribes it, with full knowledge of its remedial and poisonous potential, his role seems to pose a threat to the very ground of bioethics.

John's protest against Dr. Shaw's prescription brings out the doctor's view that it is better for Linda to die as quickly as possible since she is no longer active and productive and therefore, unworthy of living in the World State. He admits that his science cannot rejuvenate, and so it is the only reasonable choice to "finish her off" (103). Dr. Shaw, nevertheless, is glad to see a sample of senility in a world so proper, ordered and disciplined. From a bioethical point-of-view, it can be said that the doctor

dehumanizes the old woman and negates her right to life, and in turn, gets de-humanized himself. Dr. Wells' role is that of a failed medical advisor who prescribes "Pregnancy Substitutes" to Fanny for eugenic purposes, but the process runs into an ectogenetic error, and the whole experiment is reduced to futility. In his satiric novel of ideas Huxley thus makes medicine, science and technology assume authority supported by a totalitarian government, and deliberately paints the doctor-figures in a sinister, negative or ridiculous light. Such dehumanization of one doctor-figure, and representation of the other as a pastiche of the long-celebrated Victorian image of the research-minded medic is somewhat indicative of a postmodernist turn. This can also be read as critique of the "grand narrative"[16] of literature and medicine in the nineteenth century and the heroic status attributed, in most cases, to the professional medic.

In a postmodern context of medicine and biotechnology, Ivan Illich has noted in 1975 that medical fraud, negligence and malpractice have always been part of medical history, but the society at large has long been absorbed in the utopian vision of "healing" until the mechanization and depersonalization of the medical profession became too prominent. He further adds that in the new age of highly mechanized biotechnology, the doctor has been transformed "from an artisan exercising a skill on personally known individuals into a technician applying scientific rules to classes of patients" and due to this, "malpractice [has] acquired an anonymous, almost respectable status" (24). The suggestion is obvious: medical fraud, negligence or fallibility, which was previously considered "an abuse of confidence and a moral fault" (24), has now been subject to rationalization in terms of "random human error" or "system breakdown", where "callousness" becomes "scientific detachment", and incompetence is called "a lack of specialized equipment" (24-25). Illich's critique

of the present medical system is well-documented, though at times it sounds too pessimistic. However, much of what is going on in the medical scenario of our time, is not very different from Huxley's imagination of a system in which the concepts of care-giving, parenting, doctoring and nurturing human life have lost much of their old credibility.

Huxley's *Brave New World* was too futuristic and dystopian: however, the picture of a pervading corruption over the medical profession became indeed prevalent in the early decades of the twentieth century. Politics also stepped in to fan both the popular ambitions and fears of rising or falling in the medical market. When A. J. Cronin, a physician-turned-novelist came to write medical fiction largely based on his own experience, he could not restrain his bitterness towards the medical politics of the interwar period in Britain and Wales. His famous work, *The Citadel* (1937) starts with the portrayal of an idealistic doctor who later succumbs to the temptations of money and flesh, and finally realizes his folly. In an interview published in *Daily Express*, Cronin said: "I have written in *The Citadel* all I feel about the medical profession, its injustices, its hide-bound unscientific stubbornness, its humbug […] The horrors and iniquities detailed in the story I have personally witnessed".[17]

The plot of the novel is rather simple and of an episodic structure: Andrew Manson, the doctor-protagonist of *The Citadel* begins working as a General Practitioner in a Welsh mining town, finds himself in the midst of many disadvantages and yet seeks to maintain fair practice. Through the doctor's eye, Cronin also draws attention to the poor condition of social welfare measures in interwar Britain, and its ill effects on public health. The novel is set in the 1920s – and in that pre-Penicillin era, treatment of epidemics among the working-class poor was a

great problem. Manson realizes that the unhygienic water-supplying sewer is the cause of chronic typhoid in the locality. He fights on behalf of the working people who do not get proper water supply. Dr. Denny, another junior GP befriends him and they together blow up the sewage to stop the flow of contaminated water so that the spread of typhoid can be checked. Manson's medical skill and well-meaning attitude impress the common folk, but soon he has to resign due to conflicts with the higher authorities.

Cronin faithfully portrays the struggles of a young doctor to improve himself, his desire for a higher degree and his research-minded aspirations. Manson studies hard for the MD degree, and begins his research caused by concentration of coal-dust in the air. The local board of authorities brings a false charge against him and forces him to leave the research project. However, he slowly raises himself in the professional hierarchy – from the poor mining town he moves to London, becomes familiar with the elite group of practitioners and buys a practice among the upper-class community of patients. Initially he is demoralized and frustrated to see that in urban hospitals, his professional colleagues make money at the cost of letting people suffer. He finds that "it [is] the hardest thing in the world to secure admission, even for the worst, the most dangerous case" (Cronin 218) if the patient does not have enough financial backing and a society doctor's recommendation. Manson laments in disgust: " They're not full up. They have plenty of beds at St. John's for their own men […] Here am I with this strangulated hernia and I can't get a bed […] And this is London! This is our voluntary hospital system" (219).

Manson's dedication to his profession and sympathy for his patients make him cry out for the patients' need – he refers to one of his cases using the first-person pronoun, as if he himself is suffering ("Here am I with this strangulated hernia").

However, Manson's idealism gradually gets eclipsed by the corrupted system. Once he gets involved in the game of money and lust, embarking on an affair with a rich and pampered female patient, his distance from his wife Christine, also becomes evident. A former schoolmistress in the Welsh countryside, she still sticks to the traditional values: in a face-to-face argument with Manson, she accuses him of *"falling victim to the very system [he] used to run down, the thing [he] used to hate" (263). Here the symbolic significance of the title of the novel also comes out. The citadel* symbolizes a fortress of ideals in Christian humanism: in case of the doctor protagonist, it can be viewed as a metaphorical fortress or castle on the top of a hill – signifying especially his professional duty and integrity. Christine reminds him of his forgotten ideals: *"Don't you remember how you used to speak of life, that it was an attack of the unknown, as an assault uphill — as though you had to take on some castle [citadel] you knew was there, but couldn't see, on the top — " (263).*

Manson's troublesome and rather pessimistic journey through his medical career characterizes him as a lonely individual, a typical figure of the disillusioned modern hero. At one level it embodies the perennial Christian theme of temptation, passion and redemption – though in a very bleak and spiritually bankrupt modern world, with very little hope for ultimate salvation. At another level, it is a narrative problem, involving the identity-crisis of the protagonist, who, by the very nature of his profession, makes it a bioethical dilemma. The surgical error which stands out in Manson's career illustrates this bioethical problem too well: a patient with a bleeding cyst was brought to Manson and Ivory. The latter, an unscrupulous "guinea-chasing" surgeon, performs a botched operation and the patient dies consequently, while Manson can do nothing but watch on as Ivory's assistant. The disastrous effect of the surgical fraud shocks Manson, and brings him back to his long-buried conscience. He

finds it difficult to stand by Ivory any longer, and in revenge, Ivory reports against him to the Medical Board for referring a case of tuberculosis to a scientist, who has done groundbreaking works on the disease, but is not a qualified doctor. Personal tragedy also strikes Manson: his wife dies in an accident. He sells his London establishment and goes over to a West Midland town, with a vow to remain honest to his profession for the rest of his life.

Cronin's portrayal of Dr. Manson, for all his awareness of society and the medical system as a whole, seems to offer what we may call the notion of a "personalized bioethics". The writer himself is a physician, and the protagonist he represents is partly a self-projection. In the essays collected in *Stories and Their Limits: Narrative Approaches to Bioethics,* most of the contributors have attempted to reconcile Medical Humanities and Bioethics with a mode of personal medical narratives. In general, the recent bioethical focus of narrative has begun to prioritize the patient's story. However, Dietrich Bonhoeffer's approach to the experience of "those who suffer" shows that the ethics of a medical narrative can include both the patient as victim of medical errors, and the repenting doctor as a victim of his own folly[18]. Rita Charon has offered "narrative ethicality" as a model for medical empathy which can be helpful to restore faith and "intersubjective nearness" in a doctor-patient relationship: "Governing clinical actions at all times, narrative ethicality endows the practitioner with an eternal awareness of the vulnerability and the trust of self and other" (34). Cronin's narrative brings out this 'eternal awareness of vulnerability' which makes the helpless doctor feel sick, merging his inner suffering with that of the unfortunate patient who dies on the operation table. When all is over, Dr. Manson "stared feverishly, […] sick, shattered , on the verge of a collapse. He could not

escape the vision of Harry Vilder, walking unaided to the table — […]and then ten minutes later, sagging on the stretcher, a mutilated, butchered corpse" (298).

Viewed in this light, Manson's awareness of his own vulnerability, his physical and psychic disintegration after the botched operation, his feeling of sickness coupled with nausea and headache, his sleepless nights, his repentance and an impassioned, personal outrage against the corruption in the medical education and professional system –all these point towards an empathetic identification of the suffering doctor with the victimized patients, creating the possibility of a bioethical equilibrium.

The aesthetic merits of *The Citadel* can hardly be overestimated. Its style and characterization do offer realism and vividness, but the art of composition, on the whole, is considered mediocre. Cronin's too disheartening portrayal of the contemporary medical situation was also critiqued by reviewers[19]. Even so, the text became a bestseller and was popularly believed to have paved the way towards the foundation of The National Health Service in Britain under the Labour Party, in 1948. Such matters have been addressed by political and medical historians[20]. Towards the end of the novel, the dissatisfied doctor-protagonist unleashes a passionate tirade against the existing medical system, which, in some ways, seems to foreshadow the *Beveridge Report on Social Insurance and Allied Services* (1942). The way Sir William Beveridge proposed a new health service, shares some affinities with Manson's ideological stance. However, it would be too much to assume that a fictional character inspired a reformist proposal, resulting in the implementation of the National Health Service in Britain[20].

What is more interesting, however, is the fact that *The Citadel* marks a certain juncture where the history of medical fiction in England reached, having undertaken a

journey of considerable significance. The kind of literary survey attempted in the first three chapters of the present dissertation, however limited, reveals a certain change in the literary and cultural attitude to the professional medic over the time. In the mid-Victorian times and even by the end of the nineteenth century, most doctors shared a community-living with their patients. The figure of a Victorian doctor making house calls on horseback or travelling by horse-drawn carriages between provincial towns was a prominent image. This reflected a close communion between doctors and patients, which allowed the doctors sympathize with the familial, psychological, social and moral dimensions of their patients' lives. House calls used to strengthen trust and the possibility of faith-healing in an ideal doctor-patient relationship, reinforcing a kind of medical paternalism or even a secularized "pastoral care". The doctor's sympathy and genuine effort to provide comfort could satisfy the patient, since the possibility of cure was limited. If only a handful of critical cases could be handled successfully, the doctors could easily earn high reputation and goodwill among the patients. Such was the career of successful fictional medics as Dickens' Dr. Woodcourt or Trollope's Dr. Thorne. However, in the early decades of the twentieth century, which was a time ripe for technological advancement and progress in biomedicine, the demand for cure grew so high that the expectation of the patients could not be served simply with an ethical liability. Moreover, the new avenues in medical science opened up different levels of approach towards the sick body: one mode of treatment could bring relief to certain symptoms, but there was a further risk of exposing the body – and even the mind– to other kinds of ailments and discomfort. New experiments in germ-theories evolved in a constant warfare between "antigen" and "antibody", rendering the sick body ever-dependent on medication. In other words, the very idea of a "panacea" and the ideal image of a "healer" were no longer

at work. At the same time, the task of medicine has grown problematic with the development of "medical consumerism". Roy Porter aptly points out:

> Doctors and 'consumers' are becoming locked within a fantasy that *everyone* has *something* wrong with them, everyone and everything can be cured. Medical Consumerism – like all sorts of consumerism, but more menacingly – is designed to be unsatisfying. The law of diminishing returns necessarily applies. Extending life becomes feasible, but it may be a life exposed to degrading neglect as resources grow overstretched and politics turn mean. (1999: 718; italics Porter's)

A historicized analysis of the rise and fall of the "medical hero" in literary texts, from the mid nineteenth century to the 1930s, shows that such a decline was no simple matter of changing values along with the shift in socio-economic and cultural standards. If in a novel like *Middlemarch,* set in the time of medical reforms in Victorian England, medical ethics posed a certain ideal and the doctor's moral quest could be measured against it, the twentieth century medical capitalism made bioethics itself a problem under new and disturbing conditions of life, mortality and being – as depicted realistically in *The Doctor's Dilemma* or *The Citadel*. The First World War added a more traumatic morbidity to the bioethical problems: the qualities of "health" and "sickness" were no longer simply pathological, mental or spiritual, they rather became existential. The Second World War changed the very concept of medical ethics. The Nazi practices of human experimentation heightened the anti-vivisectionist fears of the late-Victorian period which anticipated that such experimentation would proceed from animals to human subjects. Doctors like Josef Mengele and Ferdinand Sauerbruch indeed used human subjects to examine the serological reactions of different races to various fatal germs. In his post-World War

II science-fiction *Ape and Essence* (1948), Aldous Huxley's narrator deliberately condemns the "biologists, pathologists, physiologists" (31) who come back home from their work to enjoy familial and marital bliss, only to return the next morning to their laboratories, trying to find "how yet greater numbers of families precisely like their own can be infected with a deadlier strain of *bacillus mallei*" (32).

The Second World War not only threatened humankind with technocratic horrors, but it also shattered to pieces the basic human instinct to take care of a new-born, to keep the next generation safe and alive. In *The Encircled Heart* (1951) by Josephine Elder[21], set during the Second World War, Philippa, herself a pathologist, becomes pregnant by her lover who has been killed in the war. She seeks help from her doctor-friend Marion, who refuses to abort the foetus. Being desperate, Philippa undergoes abortion at her own risk, and dies of sepsis and haemorrhage. Even a proper medical support (blood transfusion and the application of sulphonamides) seems to be helpless at the face of the human tragedy perpetrated by war. However, Elder's 1954 novel *Doctor's Children* is somewhat optimistic. Here the author portrays the struggles of Barbara, a General Practitioner who, after her husband deserts her, resumes her professional work under the National Health Service launched in 1948 and tries to raise her children as a single parent. The novel faithfully depicts the post-World War II condition of England with all its anxiety, unemployment-problem, anti-social activities and frustration, along with an attempt to reorganize the medical system.

Sometimes it is said casually that wars are often good for medical developments. It was true that the successful use of antibiotics upon the army proved to be positive during World War II. At the same time, debates concerning the ill-uses of medical and scientific powers paved way for serious bioethical debates in the

decades to come. Eminent physicians like M. H. Pappworth in England and H.K. Beecher in the United States took leading roles in the bioethical protest against the use of mentally deranged human subjects for medical research. Thus the value of medical science as a progressive and benevolent enterprise grew problematic with technological advancement and its ill-uses. Cell-theories, germ-sciences and electrographic measuring instruments seemed to depersonalize and fragmentize the holistic concept of health. Moreover, these have taken away much of the human element from the medical profession, posing further challenges to medical ethics, which led to such a nightmarish vision of medical totalitarianism as in Huxley's *Brave New World*, and a more apocalyptic picture of an imaginary, scientific "Third World War" in *Ape and Essence*, from which Dr. Poole and Loola struggle to escape. These intriguing concerns of literary bioethics in the early decades of the twentieth century have shown little signs of alleviation in the present era of evidence-based medicine and growing difficulties in medical ethics. Now-a-days bioethics encompasses issues related to life and death, abortion, euthanasia, organ transplantation, test-tube babies, sex-reassignment surgery and so on — which not only raise questions of ethicality but also problematize the "order of nature". The present-day need to understand the moral and psychosocial dynamics of healthcare and the doctor-patient relationship, therefore, can also help to create a renewed awareness in literary texts employing bioethical themes, and the ambiguous position of the modern doctor as represented there.

Notes:

1. Howard Brody, "Literature and bioethics: Different approaches?", *Literature and Medicine*, 1991, 10: 98–110.
2. See Nathan Emmerich, "Literature, History and the Humanisation of Bioethics", *Bioethics* 2011, 25(2), p 114.
3. M. Jeanne Peterson, *The Medical Profession in Mid-Victorian London*, Berkeley, Los Angeles, London: University of California Press, 1978, p. 4.
4. See E. A Heaman, *St. Mary's:The History of a London Teaching Hospital*, Montreal and Kingston, London, Ithaca: Mcgill University Press, 2003.
5. Peterson, op. cit., pp 130, 141, 148. See also Samuel Shortt, "The New Social History of Medicine: Some Implications for Research" at <http://journals.sfu.ca/archivar/index.php/archivaria/article/viewFile/10807/11704>
6. Roy Maxwell, "The Doctor's Dilemma: Clinical Governance and Medical Professionalism", *Ulster Medical Journal* 2011; 80(3), p 154.
7. The question of 'worth' as a category in healthcare-giving has also been discussed by Terrance McConnell, "Allocating Scarce Medical Resources by Worth: Shaw's Critique in *The Doctor's Dilemma*." *The Journal of Value Inquiry* 42.1 (2008), pp. 91-103.
8. John Allett, "Bernard Shaw, *The Doctor's Dilemma*: Scarcity, Socialism, and the Sanctity of Life," The *Journal of Value Inquiry* 35 (2001), p. 240 .
9. Michel Foucault, *The Birth of the Clinic: An Archeology of Medical Perception* (1963/1973) Trans. A. M. Sheridan , London, Routledge, 2003.
10. Peter Lesse's *Shell Shock: Traumatic Neurosis and the British Soldiers of the First World War* (Basingstoke: Palgrave, 2002) and Fiona Reid's *Broken Men: Shell Shock, Treatment and Recovery in Britain 1914-30* (London and New York: Continuum, 2010) are valuable works that focus on the medical enterprise during and after the First World War and the experience of the war-victims.

11. Lyndall Gordon's *Virginia Woolf: A Writer's Life* relates Woolf's own mental trauma and the "hopeless meddling of doctors" to the role of doctors in *Mrs. Dalloway.* Relevant extracts from the work are included in *Mrs. Dalloway* (ed.) Brinda Bose, Delhi, Worldview Publications, 2012, 194-204.
12. See Edgar Jones and Simon Wessely, *Shell Shock to PTSD: Military Psychiatry from 1900 to the Gulf War* (Hove, East Sussex: Psychiatry Press, 2005).
13. Michel Foucault, "Panopticism," in *The Foucault Reader*, ed. by Paul Rabinow (United States: Penguin, 1984), pp. 206-214.
14. The word 'soma' bears etymological and phonetic affinities with the Greek root "soma" meaning "body" in a medical and biological sense. Again, the name given to a happiness-yielding drug goes back to the Vedic origin of "Soma" – a herbal drink used in the Vedic rituals, which was believed to be consumed by the gods and godlike sages, making them feel the bliss of eternity.
15. For the difference between parody and pastiche, see Frederic Jameson, *Postmodernism, Or the Cultural Logic of Late Capitalism,* Durham, Duke University Press, 1991, pp. 133-153.
16. Jean-Francois Lyotard, *The Postmodern Condition: A Report on Knowledge* , trans. G. Bennington and B. Masumi, Mineapolis: University of Minnesota press, 1984, p 37.
17. See "Teacher's Notes": Level 5. Penguin Readers' Teachers Support Programme, *The Citadel*, p 2, available online at < http://w ww.penguinread ers.com /pdf/downloads/pr/tea chers-notes/9781405879859.pdf >
18. See Nancy Berlinger, "Preface", *After Harm: Medical Error and the Ethics of Forgiveness,* Baltimore and Maryland: John Hopkins University Press, 2005.

19. See L. Eyles' criticism of *The Citadel* in *The Times Literary Supplement*, 1937 Aug 14, as quoted in S O'Mahony, "AJ Cronin and *The Citadel*: did a work of fiction contribute to the foundation of the NHS?" *J R Coll Physicians Edinb* 2012; 42, p 174 .

19. See S O'Mahony, ibid., pp 172-78, and R. McKibbin , "Politics and the medical hero: A. J. Cronin's *The Citadel*", *English Historical Review* 2008; CXXIII:651–78.

20. The implementation of the NHS in Britain was, however, a matter of political calculations. According to Roy Porter:

> Only in Great Britain, however, was it (the Second World War) followed by a dramatic reorganization of civilian medical services. […] Whether the National Health Service outlined in the Beveridge Report would have been implemented had the Conservatives won the general election of 1945 is doubtful; the Labour Party enjoyed a landslide and set about implementing it. A bill was introduced,in April 1946 ; on 6 November it received the royal assent and the appointed day for its inauguration was 5 July 1948. (1999:652)

21. Josephine Elder was the pen name of Olive Gwendoline Potter (1895-1988), who distinguished herself basically as a children's author. However, she wrote some social novels for adults as well, based on her own experiences as a doctor. Alongside her writing career, she continued to work as a General Practitioner in Sutton, Surrey from 1930 to 1983.

Chapter 4

Doctoring the Empire and Nationalizing "Daktari": Fictional Medics in Colonial British and Bengali Literatures

The imperial anxiety concerning the tropical health situation has been a pregnant area of research in the field of colonial medicine, which attracted several historiographers and social scientists, especially David Arnold, Mark Harrison and their followers. Evident in their writing is a kind of Eurocentric bias: the introduction of European medicine and healthcare policies to the sub-continental colonies has been viewed as an imperial strategy of governing the colonial subjects. David Arnold's much-debated work *Colonizing the Body* (1993), as the title itself suggests, emphasizes the "supremacy" of western medicine in the colonial context, considering the State's role in introducing and practising European medicine as instrumental to the imperial project of strengthening the British Raj in India. A medical control over the colonies was not only a strategy for offering benevolent and palliative care to the native people, rather it was necessitated by a greater need for the health and safety of the British subjects stationed in India. As Arnold says elsewhere, imperial power depended not only on the ability to possess territory, but to conquer mortality as well[1].

The constant monitoring and surveillance of the colonies from a medical point-of-view gave rise to a concept that may be called "doctoring the empire". This, in a typical Orientalist fashion, tends to mark the Orient as a dark, diseased, underdeveloped area, and seeks to establish the government's medical care facility as one important aspect of the paternalistic image of authority and control, self-consciously created by the colonizers. In the context of imperial doctoring, the literary portrait of the British medical officer in India, especially in the writings of Kipling

and Flora Annie Steel, can be read as a figure associated with the maladies, fears, sufferings and sometimes, representative of a heroic self-sacrifice. They illustrate a disturbing scenario reflecting the demands of imperial service on the bureaucratic agents of healing, as Upamanyu Pablo Mukherjee has rightly pointed out in his book, *Natural Disasters and Victorian Empire* (88). However, what seems to be more interesting to explore is how this medical imperialism was represented in the literary documents of doctoring created by native writers, generating complicated reactions to imperial intentions. A theoretical framework based on Foucault, Lacan and Žižek can be helpful to understand the role of the British officials in India in general, and those in the medical profession in particular.

One of the greatest challenges of imperial medicine was to take care of the health and well-being of the British subjects in service, labouring under the tropical climate. Anderson cites a Medical Report on the Sanitary State of the Army in India, which says, "for the first five years the soldier is a very good man indeed in India, but after that he begins to break down [...] the longer a soldier remains in India, the worse he gets" (129). The white man's health in the tropics was at a perpetual disadvantage; and though some acclimatization theorists during the early phase of imperialism believed that immunity and endurance can be cultivated gradually with the help of proper diet, hygienic habits and precautionary measures, their confidence was shaken with every new attack of disease, epidemic and endemic. The *Report on the sickness and mortality of the European Army of India during the ten-year period 1870-79* stated:

> Excluding cholera, hepatitis was the principal cause of death in the European army of India, during the ten-year period 1870-79, 13.59 per cent. of the deaths being due to that cause. Enteric fever and suicidal deaths and other

> deaths by violence come next on the list causing respectively 12.59 and 11.79 per cent. Next come apoplexy, dysentery and fevers, not enteric; about 9 per cent. of the total deaths being due to each of these causes. (Bryden and Stephen 18)

Such reports on the sickness and mortality of British troops in India clearly reveal that the image of India and other tropical countries as "the white man's grave" had a serious impact on the colonial imagination. Upamanyu Pablo Mukherjee refers to a letter by Kipling, expressing that the imperial service in India had cost the best men of the British civilization: "For what else do the best men of the Commission die from overwork, and disease, if not to keep the people alive in the first place and healthy in the second?" (Mukherjee 91). Doctors and soldiers, due to the very nature of their service, are those on whom this "white man's burden" falls most visibly: especially for the medical officers, the anxiety is multi-faceted. He has to do his duty to his fellow-British patients, and to a larger mass of the native population during the frequently visited tropical epidemics, and above all, to himself — his own mental and physical health, his sense of logic and scientific reason. In Kipling, the effect of tropical fever on the British medical officers living in India becomes a symbolic experience which brings together the physical strain due to hard work and the existential pain of alienation in an unfamiliar land, cut off from their own country and people. The word "symbolic" here is crucial: a Lacanian-Žižekian interpretation can find here a misjudged psychopathological state, a falsified attitude which seems to take the "symbolic" for the "real". This can be further illustrated through some of Kipling's short stories set in colonial India – stories in which medical characters under the imperial service play a crucial role.

"The Phantom Rickshaw" (1888) tells of a young British civilian, haunted by the ghost of a lady whom he cruelly deserted. He is treated and nursed by Dr. Heatherlegh, whose "invariable prescription to all his patients is, "lie low, go slow, and keep cool" (Kipling 2009:2). However, this cannot cure the haunted Jack Pansay, for there is a perpetual misunderstanding between the doctor and the patient. The doctor, as a representative of empirical science and also an agent of authoritative, clinical power in a Foucauldian sense, never accepts any other possibilities than those his avowed belief in scientism can approve of. He firmly reduces all the visions and mental torments of his patient to optical delusion and hysteria. He also criticizes the system of the imperial service, declaring his firm conviction that Pansay was down with overwork and anxiety. "Overwork started his illness, kept it alight, and killed him, poor devil. Write him off to the System--one man to take the work of two and a half men" (2). The fictional doctor's opinion sounds very similar to what Richard Keller says about the British physicians in colonial India: from their real experience they felt that hard labour under a tropical climate was more impracticable than injurious to European health[2]. This was the reason why "deranged" Europeans at asylums were kept away from hard labour as far as possible[3]. Dr. Heatherlegh's common advice to his "nervous" patients ("lie low, go slow and keep cool") is not far from the general methods of care-giving that were offered to mental patients, especially the Europeans staying in British India.

It is interesting to note that Dr. Heatherlegh's theories regarding such cases of mental disturbance as Pansay's, and his method of treatment for psycho-pathological ailments can be seen as anticipating the early phases of psychiatric treatment in British India, which started officially a few decades after the composition of this story. Christiane Hartnack suggests that the treatment of "mentally disturbed" British

patients was planned in a way that would relieve them from "the uncomfortable climate and heavy workload" (25). Owen Berkley-Hill, one of the pioneers of formal psychiatric treatment in early-twentieth century India, gave special importance to rest, prolonged bathing, good nutrition and exercise in his list of remedies for neurotic patients (Hartnack 36). In Kipling's story, Dr. Heatherlegh's process of treatment is almost the same: he treats Pansay with "liver pills, cold-water baths, and strong exercise" and gives "strict injunctions as to diet" (16).

There are further points of resemblance between Kipling's story and Hartnack's historical account of the early phase of psychotherapy in British India. Before the modernisation and institutionalisation of mental treatment in the early twentieth century, British lunatics were kept in private hospitals, and there were scandals regarding the unhygienic environment of those establishments. Hartnack observes that in the nineteenth century, the asylums for the British lunatics in India were poorly managed: "... filthy, congested quarters – abandoned stables, vacated barracks or unused prisons [...] had been converted to serve this purpose." (26). One may wonder whether Dr. Heatherlegh in Kipling's story kept a hospital of this kind: "a hospital on his private account ─ an arrangement of loose boxes for Incurables, his friend called it ─ but it was really a sort of fitting-up shed for craft that had been damaged by stress of weather" (Kipling 2009:2).

There is no clear indication of what kinds of patients he kept – they are simply called "incurables". Waltraud Ernst's seminal work on the European asylums in colonial India suggests that asylums were places of temporary refuge. In most cases, the patients were not completely cured, and after their temporary stay at the asylums in India, Europeans were sent back home for better treatment. As Debjani Das aptly argues, this "repatriation of deranged colonial servants to Britain" shows how the

burden of colonial work "took its toll on the British" (6). Such cases of incurable mental disorders were too disturbing for the British administration to be made public; there was a hush-hush, scandalous way of discussing such matters. In Kipling's story, the absence of a clear statement about Dr. Heatherleh's "incurable" patients, and the stealthy gossip through which the description passes off, makes the reader suspect something of an older-day asylum, considering Heatherlegh's special skill in treating the mentally agitated patients.

Dr. Heatherlegh apparently impresses one as the typical good-natured late-Victorian physician, who not only attends the patient under constant watch and great care, but also takes interest in his personal well-being. The patient's own ideas about the nature of his malady do not agree with the doctor's, and after a certain point in the long treatment, Pansay feels that Heatherlegh has no power to cure him, stubbornly saying, "I declined firmly to be cured" (21). Yet he cannot but be thankful for the doctor's kindness: "I call him a fool; but he attends me still with the same unwearied smile, the same bland professional manner, the same neatly trimmed red whiskers, till I begin to suspect that I am an ungrateful, ... evil tempered invalid" (3). However, the doctor's interest in Pansay's case, as he says later in the story, is more a scientific curiosity about a "queer phenomenon" – an object for medical study ─ than a general philanthropy. It is possible to read the doctor's function as the Foucauldian icon of clinical power and control over the sufferer's body, mind and symptoms, making them subject to constant displacement, dislocation and fragmentation. Moreover, he also acts in a way that can be called medical espionage, keeping strict vigil into the inner world of the British subject's disturbed psyche, though he may not be consciously doing so. The idea may be clarified if one examines the nature of the phantasmal vision that pursued Jack Pansay.

The vision is a meticulously detailed one: it consists of the sickly, broken-hearted Mrs. Wessington sitting in her hired rickshaw, complete with the "jhampanies" and the four Indian attendants, giving the ghostly scene a typical "native" air. Her servants died of cholera, following her own death, and the rickshaw got destroyed – as if to continue the loyalty of the native men and vehicle to their deceased Memsahib. They together form a ghostly world of "otherness", with many layers in it – the dead white woman because of her deserted, heartbroken condition and gendered humiliation, and the coolies because of their race and status of servitude. The idea of colonial servitude perpetuating into the other world beyond death is both hilarious and uncanny. Nevertheless, Pansay's illness interpreted as an "eye-brain-stomach business", through the "good offices" of the doctor, gets circulated all over Simla in a way that shows how the doctor has taken care to save his patient from the stigma of being branded as a "lunatic". Pansay himself finds it disturbing for his position as a civil servant; the ruler's status could have turned more vulnerable had the scandal spread faster, for "the exposure of members of the ruling race to such humiliation undermined the claim of European superiority over Indians and also stood in contrast to their own self-image" (Hartnack 26).

Pansay's narrative of fantasy counters the doctor's perspective of empirical and medical realism. Dr. Heatherlegh's attempts at doctoring the mind of a disturbed British subject, can be read as a dutiful British medical officer's effort to bring the patient back to normal life and thereby to ensure the safety and dignity of the colonial masters' self-image and order. Pansay's refusal to be empirically cured is supported by his persisting self-identification with the "other" world of "fantasy" – where the dead woman, her rickshaw and native coolies only exist, and all others – the British society at Simla, the balls, the conversations, and even Dr. Heatherlegh do not exist

at all. The "real" becomes the ghostly and the shadowy, whereas the phantasmal world claims to be "real". A Lacanian reading of this phantasmal phenomenon can possibly interpret the conflict between the two worlds – one of the colonial order and authority, of Dr. Heatherlegh and his medical realism, and the other of the dead, the neglected, and the low – as a struggle between the "absolute Other" and the "other" (Lacan 40) . Pansay's self-image as a "presumably sane, healthy, educated civilian" collapses in the struggle, and he ends up in recognizing his distorted "mirror-image" among the "dead" and the "other", losing all contacts with the so-called "real" world. Again, trying to read this using Žižek's notion of "fantasy", especially in the context of racial/imperial psychology[4], one may appreciate the complicated relation between the doctor, the patient, the cause of the patient's malady and the colonial setting.

In "The Phantom Rickshaw" the doctor's repeated dismissal of the patient's own version of the case, is also a kind of "fantasy" – a fantasy that pretends to be rational and authoritative, a fantasy that causes a "willing suspension of disbelief" in itself, refusing to recognise its own flaws and limitations. Lacan reads fantasy as a "fascinating presence" which merely fills up the void – the "lack" in the Other. Žižek, however, suggests that the "lack" is not merely suggesting the void in the "Other", but it undermines the constancy of the subject-position as well, which in turn problematizes the symbolic order – the Big Other. Lacan's definition of the "Real" does not seem appropriate to Žižek, who redefines it as "simultaneously both the hard, impenetrable kernel resisting symbolization *and* a pure chimerical entity which has in itself no ontological consistency"(1989:169). He further argues, "this is precisely what defines the notion of traumatic event: a point of failure of symbolization" (169) which we find in the strange case of Jack Pansay who undergoes this trauma and

finally collapses in the process of determining what is "fantasy and what is really "Real". What Lacan calls "going-through the fantasy" contains the experience of such a distortion in recognizing the object of fantasy: as Žižek points out again –

> the subject must undergo the experience of how the ever-lacking object-cause of desire is in itself nothing but an objectification, and embodiment of a certain lack; of how its fascinating presence is here only to mask the emptiness of the place it occupies, the emptiness which is exactly the lack in the Other— which makes the big Other (the symbolic order) perforated, inconsistent. (1989:195)

The notion of fantasy works in a different way in Kipling's "By Word of Mouth". The story is about the dead wife's call to the surviving husband, who, being a doctor, has failed to save her. The husband does not have the phantasmal vision by himself, he is informed through his servant. However, he is obsessed with the idea of answering the dead wife's message, accepts the duty to take charge of an epidemic situation, catches the infection, and dies. So the dead Mrs. Dumosie remains the object of desire for her doctor-husband, and it is the gap or void in their relationship which contains the transcendental element of fantasy. Dr. Dumosie's death-drive is both a desire and a defence against desire – "the desire structured through fantasy is a defence against the desire of the Other, against this "pure", trans-phantasmic desire (i.e. the "death drive" in its pure form)" (Žižek 1989: 118). A detailed survey of the story will be helpful for a better understanding of the theoretical notions discussed here.

In "By Word of Mouth", Mrs. Dumosie died of typhoid: her husband, Dr. Dumosie could diagnose the disease only when it was too late. The neighbours initially blamed the doctor, calling it a "criminal delay" (Kipling 1909: 431), but he

bore it so patiently and continued to do his duties so calmly that the public attitude soon changed from criticism to sympathy. The twist in the story comes when the dead memsahib's ghost sends a message to her husband through the servant: "Ram Dass, give my salaams to the Sahib, and tell him that I shall meet him next month at Nuddea" (433). The memsahib's phantasmal appearance to the servant instead of the sahib himself seems to trigger the Lacanian question *"Che Voui?"* [What does (s)he want?] which haunts Dr. Dumosie. He spends sleepless nights, perhaps hoping that some supernatural message will come to him as well, but the memsahib never appears. Instead, Dumosie's transfer-order comes, asking him to go from Silma to Nuddea in Bengal, on special duty, to take charge of "a nasty outbreak of Cholera" (435). Dumosie takes it to be the pretext of fulfilling the desire of his dead wife to meet him. He accepts the order, goes to Nuddea, and dies there, or rather, "join(s) his memsahib" (436), at the end of the story .

The relationship between the doctor's private life and his profession may not be so innocent as it appears. The narrator describes Dr. and Mrs. Dumosie as a quiet couple, but a reader's suspicion may be roused seeing the way Dumosie neglected his wife's initial symptoms. Dumosie's fault can be defended by generalized comments on the helpless and difficult situation of the doctors in the tropical colonies: "Nearly every household in India knows that Doctors are very helpless in typhoid. The battle must be fought out between Death and the Nurses minute by minute and degree by degree" (431). There were seven cases of typhoid in Simla at that time, and "all did their best" (431), including the nurses and doctors, with Dumosie himself among them, and the crisis was over, causing the death of Mrs. Dumosie alone. This might have been just an unfortunate case which grew worse in no time, and the doctor had nothing to do. Still, the question remains: Did the doctor do *his* best for his own wife?

Had he been able to diagnose the symptoms even at a very early stage, still there would have been little certainty of Mrs. Dumosie's life. A sense of guilt, nevertheless, was heavy on Dr. Dumosie's mind, since he calmly tolerated the neighbours, accusing him of failure in case of his own wife. He was perhaps ready to undergo some atonement for his guilt, the wrong he had done to his wife — which is suggested by the stoical way he accepted the servant's report about the memsahib's ghost and waited for the "strange meeting", as one awaits one's nemesis. It is this psycho-pathological element of the suffering of the doctor-figure that distinguishes the tale from a simple ghost story.

Certain similarities can be recognized between "The Phantom Rickshaw" and "By Word of Mouth": in both stories, the neglected and dead woman's ghost appears to take the lover/husband into her own world, which can be read as a ghostly revenge upon the living soul. Again, the ghostly female "other" seems to have a sympathetic connection with the colonized other. In "The Phantom Rickshaw", the Indian coolies are loyal to their memsahib even after death, and in "By Word of Mouth", the dead memsahib appears and trustfully talks not to her husband, but the native servant Ram Dass. Both stories place the imperial ideology of medical service in a problematic relation to the gendered and the racial other, in one way or another. The role played by the two doctor-figures, however, are remarkably different.

If Kipling's doctors are bound to the imperial web of palliative care on the one hand and anxieties about the disease of strangeness and alienation they have to deal with, Flora Annie Steel's fictional and non-fictional writings are replete with the concern of domestic doctoring practiced by the British women in charge of the household hygiene. For the white community living in India, the fear of poor sanitation and contagious diseases was great. The European medical administration in

the colonies often considered the delicate British women the most vulnerable part of the white population in the colonies; they were thought to be more dangerously susceptible to the infections of the tropics than men. Moreover, the British woman concerned with her own household hygiene, and sometimes trying to extend some medical help to the loyal native servants in their need, found herself in a complicated contact zone. Anna Leonowens, in her *Life and Travel in India* recounts an incident which reflects the curious relationship between the benevolent memsahib-as-doctor and her native teacher. When her Sanskrit teacher Govind, a Brahmin pundit, falls ill, she goes to visit him, with a "small bottle of brandy, a physician's mixture at hand for cholera morbus, and some quinine" (130). Govind's mother does not allow the memsahib to prescribe any medicine for him; and the patient, too, is determined to die, rather than taking a single drop of brandy. The memsahib then helplessly watches that a soothsayer, a doctor and a priest arrive to treat Govind. The priest prays for the sick, the physician prepares some herbal drugs and makes Govind swallow them, while slapping and beating him. The soothsayer performs some rituals of exorcizing evil spirits from the body of the patient. Leonowens goes on to write, in wonder:

> Strange to say, violent and absurd as were the remedies administered to poor Govind, he not only bore them patiently, but seemed better; […] The next day, when I started off, I fully expected to hear that Govind had passed away; but when I reached the outer gate of the yard enclosing Govind's dwelling I found the pundit, although looking weak and feeble enough, seated on a small stone holding in his left hand three blades of kusah-grass. (137)

Leonowens' account thus reveals a curious aspect of native resistance, empowered by faith in traditional ways of medication and ritual aspects of healing. Such remedies, however "violent and absurd" to the western mind, prove to be successful. At the

same time, it should also be noted that the memsahib's gesture of genuine sympathy cannot be accepted by the Brahmin's family. Colonial tensions and cultural differences are at play; and these seem to create an unbridgeable gap between the Europeans and the Indians, the colonizer and the colonized.

Flora Annie Steel, in her autobiographical work *The Garden of Fidelity* considers the colonial *zenana* a dark and unhygienic space of disease and disorder, from which the white women must keep themselves away, and take proper measures of domestic doctoring and nursing the sick in their own households. She acted as a self-taught medical missionary deeply concerned with the female healthcare and hygienic problems in the Indian households, and the British families living in India. In the novel *The Host of the Lords*, the character of Edra, a female medical missionary, can be read partly as her self-projection. The affinity does not go much further: the heroine figures as a new woman – self-confident, generous and strong-willed, but her medical mission is not central to the plot. However, the novel features another British doctor, George Dillon. In the very first chapter of the novel, the doctor admits that he has not understood the Indians in two years, nor does he want to: "So long as we don't understand them […] and they don't understand us, we jog along the same path amicably. […] There is really no good in understanding most things" (1-2).

Dr. Dillon, however, gets somewhat seasoned and tempered in course of time and experience, and manages to overcome some of his initial misgivings about the natives. While treating a dying but reluctant Indian who cannot be saved, he realizes that disease, suffering and death are great levelers that know no racial discrimination. However, the general attitude of fear and antipathy between the British and the Indians is too deep-rooted to be wiped out. Steel's novel projects this uneasiness and

lack of belonging to the indigenous environment, a negative feeling that possessed the British and created an unbridgeable gulf between the two cultures.

During her stay in Punjub, Steel befriended several doctors, and expressed special gratitude to one of them, who gave her instructions and manuals, encouraging her to do the domestic doctoring by herself, when the attack of Punjab fever broke out:

> Looking back I rather wonder at my own self-confidence, or rather, cheek, in using quite dangerous drugs. But I really did know something, despite the fact that I had no training — except that given me — oh so kindly, so ungrudgingly by medical friends. Why my dear doctor at Ludhiana had once dumped down half a library on my bed, and said [...] 'here, read them yourself — you know quite as well as I do what's the matter'. (61)

Steel's concern was to keep the white woman's household neat and clean, free of infections. As opposed to the memsahib's "disciplined" household that can be controlled by the imperial measures of health-guidelines and medical advices, the Indian *zenana* remains a space of fear , resistance and subversion, as one may find in Steel's novel *Voices in the Night: a Chromatic Fantasia* (1900).

The novel deals with the onset of bubonic plague in the fictional colonial town, Nushapur. Steel brings into play the imperial anxieties about controlling the epidemic situation, the medical measures taken by the government and the resistance they face from the native population. Ironically, while the image of India as a dark, diseased and contagious space posed a threat to the imperial medical topography, it was also true that the British empire itself often acted as the carrier of alien diseases to the native colonies. Alfred Crosby's theory of "ecological imperialism" underlines the very idea that Europe, by virtue of its technological and economic expansion,

conquered new territories and at the same time, transported alien germs from one territory to another, spreading disease ecologies (Anderson 146-7). The bubonic plague that provides the medical setting of Steel's novel, can be cited as an example of such an "alien disease", which entered India in 1894, through the imperial trade route from China. Thus, the empire's own role in transporting the disease and its palliative measures to control the same contradict each other, destabilizing the very logic of medical imperialism.

Steel's fictional narrative faithfully depicts how the government's effort to survey the native households, to find out the diseased bodies and hospitalize them for proper seclusion and treatment, is met with resistance from the native quarters. The native population ─ especially the women are suspicious about this medical control and surveillance: they refuse to be hospitalized; foreign medicine is "poison" to them, and the medical officer's intrusion into the interior space of the native households, in order to find and pick up patients, is viewed as an attack on the chastity of the *zenana*. In the novel, Steel juxtaposes two spaces as potential sites of threat and contamination: the bazaar and the harem. The two sites metaphorically correspond to the exterior and interior spaces of the indigenous society. At another level, if the bazaar is a thriving, open space for dialogic interaction, multivocality and the social dynamics of public consciousness, the *harem* may symbolize the Freudian unconscious. Interestingly, in both space, the most remarkable challenge or resistance comes from the native women: Dilaram, the straightforward, seductive and outspoken courtesan is a woman of the bazaar – she takes an important role in thwarting the government's palliative policy to provide medical aid to the infected city. Dilaram, a powerful source of information, has been asked to point out the infected households, and she refuses to help the medical officers. She instead plays a subversive role,

causing a spread of rumours that the plague is a façade under which the Sahibs seek to recruit prostitutes for their own pleasure: “the Sirkar […] would be sure to make the plague — which the doctors had discovered that very day, though, God knows, folk had been dying that way for a week — an excuse to search respectable houses for recruits to Miss Leezie's profession” (272).

The role of Dr. Sullivan, though a subsidiary character in the text, becomes nevertheless significant, as he finds himself caught between his duties as an imperial medical officer, and a man who is often helpless, facing resistance from different quarters in a strange land, against an unreadable reality of the native life and beliefs. As he confesses at one point: “We do what we can, as it is, but what can you expect when the men get sitting about the bazaars, and eating and drinking filth?” (156). He can lecture and convince Grace Arbuthnot, the Governor’s wife who visits the hospital, about the dangers of the epidemic, and the process of medical survey and treatment he has adopted. The doctor’s “kind eyes” can captivate the lady’s attention, but soon the “methodical calm” with which he maps the suffering of the patients and make them readable, gets into her delicate “nerves”. The doctor is however successful in “disciplining”[5] the doubts and fears of Lady Arbuthnot, the female British subject (who can be guided and governed accordingly) about the good work he is doing, but his attempts at medical governing encounters challenges from the native bodies, unreadable in terms of the western clinical perception. The British doctor’s attempt to bring the “diseased” native town into a proper course of medical governance faces a striking challenge from the *andarmahal* inhabited by the native *zenana*. When the medical team enters the *haveli* in order to detect the hidden infected bodies, we hear the old maid-servant “Khojee's screams of sheer terror as she woke to find the doctor feeling her pulse ... ‘Poison me not! I will die! Yea, I will die without poison!” (286).

The ultimate and the strongest resistance comes from the lady of the palace, Noormahal, who jumps into the well and commits suicide rather than letting her body "governed" by a British male doctor. The failure of the European medical gaze to penetrate and control the native bodies in illness remains a trauma, a deep subconscious anxiety of the palliative medical care offered by the government in the colonies. This can also be seen as raising questions about the staunchly imperial approach of historians like David Arnold, celebrating an effective colonization of the native bodies by the power of European medicine.

Arnold's point-of-view has not passed unchallenged; Indian medical historians like Poonam Bala and Projit Mukharji question the tendency of looking at western medicine only in terms of monopoly and power. Bala's work *Imperialism and Medicine in Bengal: A Socio-Historical Perspective* (1991) is an important contribution to the history of colonial medicine, arguing that the idea of absolute British supremacy in colonial medicine has been biased, partial and limited in many senses. In *Contesting the Colonial Authority: Medicine and Indigenous Responses in Nineteenth- and Twentieth-Century India* (2012), she explores the idea of medical pluralism in colonial and postcolonial India, which took shape through a nuanced interplay of resistance and collaboration between the Western and the indigenous medical traditions. Though there was initially a contestation of interest between western medicine and the indigenous traditions of healing, gradually spaces of interaction had opened up, and the transformations that both the traditions underwent, led to a healthy discourse of medical pluralism in early-modern India. Seema Alavi in her article "Medical Culture in Transition: Mughal Gentleman Physician and the Native Doctor in Early Colonial India" has shown how the Islami medical tradition initially received blows from the colonial establishments in North India, but later by

the 1830s, the British medical scholars realized the immense potential of Arabic medical learning, and patronized the translation of Arabic and Urdu medical texts. Some British residents in Northern India even felt that in case of tropical diseases peculiar to this native zone, they should also consult Unani Hakims in their need. As to the status of old Ayurvedic systems in colonial Bengal, Binoybhusan Ray and Subrata Pahari have done valuable works. Ray's *Chikitsa Bijnaner Itihas*: *Unish Shatake Banglay Paschatya Shikshar Prabhab* is an important Bengali text on the colonial government's policies and responses towards the native herbal medicine and its practice. Pahari has also dealt with the ambiguous nature and status of the traditional native ways of cure in a colonial setting, in his 2001 book *Unish Shataker Banglay Sanatani Chikitsa Vyabasthar Swarup.* Projit Bihari Mukharji has brought new insights: discussing the role of the native doctor/daktar, he traces the development of a nationalized medical discourse, in his book *Nationalizing the Body: The Medical Market, Print, and Daktari Medicine.* The book discusses the making of the identity of the "native doctor" which developed through contestations, resistances as well as assimilation and conformity. It shows, with ample historical information, how the suspicious and alien figure of the foreign-trained doctor, or the jargon-smattering quack in westernised attire, gradually assumed a positive image especially during the late nineteenth century social and cultural reforms in colonial Bengal, which also brought changes in the medical scenario.

Mukharji notes in his book that the term *daktar*, as a self-descriptive category, appeared in Bengali print around the 1860s (76). Generally, in the colonial period *daktar* referred to a native practitioner claiming affiliation to western medicine. Some native doctors (lesser-degree holders) attempted to combine *daktari* and *kaviraji*, and wrote manuals of basic treatments, nursing, indigenous medicine — "reformed" and

"modernized" with the help of western medical education (Mukharji 86-87). There was in print a number of popular medical manuals like *Chikitsa Darpan* and *Chikitsa Kalpataru* written by native doctors, providing a guideline of some basic treatments. Many quacks, who disguised themselves as qualified doctors depended on such books for the treatment of common patients who were unwittingly lured into their predatory traps. Literary representations, especially farces during the late 1880s tended to project *daktars* claiming or pretending to have western medical knowledge in a negative light. This element of hybridization (practice of quackery beneath westernised attire and use of stethoscope as a symbol of authenticity and power) caused suspicion among the people, and for a long time, people in general believed in the familiar native hakim or kaviraja rather than going to a stethoscope-using daktar. In Bengali farces like *Thengapathic Bhuinphnor Daktar* (1887) the villainous protagonist bears a name ironically significant: Pranharan (taker of life). The title of the farce, with deliberate irony, refers to the medical science (indicated by the suffix "pathic") of beating up (from the Bengali word *thengano* which means to beat up) the upstart doctor. The doctor, who is ideally supposed to be the healer and so, a "life-giver", can become a destroyer of life if he exploits this profession for his own profit, by cheating people. As Mukharji has shown with textual references, Pranharan is dressed in European attire, he uses a smattering of strange medical jargon, and keeps fat medical books on his dispensary-table to pass of undoubtedly as an authentic doctor. This, however, alienates him from the simple villagers, who grow increasingly afraid of him. He is ultimately exposed, beaten up and driven away: thengapathy is now judiciously applied to the upstart doctor himself.

In Rajkrishna Ray's "prahasan" (farce) *Daktarbabu* (1889), Joy daktar, unlike Pranhoron, is a qualified medic trained in western pathology, but he has little

professional ethics, and less ‘character’ as a person: female patients are not safe under his “treatment’’. This character is pitted against rural “kaviraj” who is more reliable and friendly towards the people. Thus plebeian native doctors were alienated from both the common people and the highly-qualified medical coterie. On the other hand, the over-sophisticated *bilat-ferot* (returned from Britain) doctors, or qualified native doctors blindly imitating western attitudes not only in their medical practice but in every aspect of manners and lifestyle, also faced a certain alienation in larger society. In the early twentieth century, fictional works by such British authors as E. M. Forster and George Orwell, continued to portray characters like Dr. Aziz (*A Passage to India*) and Dr. Veeraswami (*Burmese Days*) appear as both ironical and pathetic representation of wearing a “white mask’’ to decorate ‘‘brown skin’’. In Bengali literature, such representations dated back much earlier — a fictional example from the 1890s is ‘‘Dr. Nandey’’ in Shibanath Shastri’s novel *Nayantara*. Dr. Nandey finds it detrimental to his dignity to pronounce his original Bengali surname ‘‘Nandi’’; and despite his genuine foreign degree, appears to be a ridiculous imitator of the British and therefore makes himself disagreeable in society. Thus both the corrupt quack and the over-erudite foreign degree-holders became types associated with social anxiety, notwithstanding the rise of medical education and practice in colonial Bengal.

It is to be understood how demoralising such negative images could have been for the genuine, qualified and responsible doctors. From the time of the “Young Bengal” movement (1830s) to the rise of the “Nababidhan” (New Regulations) among the Brahmos (1860s), the orientation of the medical students and practitioners seemed to be directed towards the progressive, philanthropic and reformist ethos of the nineteenth century. Corruption within the profession was likely to be demoralising for qualified doctors, mostly coming from the enlightened, middle-class gentry. So there

was also a conscious attempt on the part of some well-known representatives of the medical profession, to establish their credentials, both as intellectually active and effective doctors and as people concerned with social welfare, to mitigate the negative impression caused by the false and plebeian practitioners on the one hand, and the *bilat-ferat* high-brow pseudo-sahib doctors on the other. However, for the young generation of the Bengali *bhadralok* society, learning western medicine was gradually becoming prestigious, and this appealed to the 19th century ethos of enlightenment, philanthropy and social-reform. So there was also a conscious attempt on the part of learned Bengali doctors, to establish their credentials, both as intellectually active and effective as doctors concerned with social welfare, and mitigate the negative impression caused by the false and plebeian practitioners. The publication and success of such medical journals as *Bhishak Darpan*, written in the vernacular (the 1890s), was effective in furthering this reformist and intellectual mission towards a revival of the noble dignity claimed by the profession. Mukharji considers these to be ways of "nationalizing" daktari medicine, as native doctors were trying to de-alienate (make less alienated) themselves in society (96). Thus, the revival of traditional medical literatures in the modern age of printing, helped to form a community (more "real" than "imagined", in case of a certain discipline) of the learned medics and scholars, which led to the project of building a nationalised discourse of medicine during the colonial period. Reading Charles Leslie's account of Syncretism in modern Ayurveda, one may also find that by the first decade of the twentieth century, the social "de-alienation" of native doctors trained in Western medicine was also supported by the "swadeshi" aspiration to modernise and revive the indigenous medical traditions, in the light of western medical knowledge. The foundation of The Bengal Chemical and Pharmaceutical Works by Acharya Prafulla Chandra Roy; Kaviraj Gananath Sen's

endeavour to incorporate modern anatomy and physiology into Ayurvedic texts; and the plan for a national university aiming to include "Oriental learning and medical education" in its general science-course — all these marked a growing nationalistic desire to bring the western medical knowledge in some kind of healthy interaction with the Oriental medical traditions[9]. However, within this umbrella term "Oriental", a kind of regional and cultural preference was visible: in the Bengal Presidency the Ayurvedic system assumed more importance than the Unani or Hakimi cultures, except among some poor, marginal populations and the Muslim quarters in society, and some highly dedicated educational institutions like the Calcutta Madrasa and the Calcutta Medical College. In different parts of India, indigenous medical traditions like Ayurveda, Unani and Hakimi were being appropriated as parts of the Nationalist agenda. As David Hardiman puts it:

> In 1918 and 1920, the Congress passed resolutions that asserted the 'undeniable claims to usefulness' of Ayurveda and Unani Tibb, with a call to establish schools, colleges and hospitals for the instruction in and practice of such medicine. The All India Vedic and Unani Tibb Conference was in tune with this wider political agenda. (27)

In Northern India, the status of Unani was better, and alongside the regional elite's patronization of the Persian and Arabic medical texts, the National Medical Institution (NMI) in Delhi created among the newly passed native doctors (belonging to both Hindu and Muslim communities) an interest to learn and revive their old cultural texts of healing. As Alavi enumerates, "this was more than evident in the late nineteenth century when hakims used the Persian, Arabic and Urdu strands of medical culture to contest colonial medical drives in the period of high nationalism" (897).

Coming back to concentrate on the literary portrayal of native doctoring in Bengali, one may notice that this enthusiasm regarding the "nationalization" of daktari took not too long to get reflected in literature. The sympathetic, and often "nationalized" representation of daktars in Bengali literature of the 1890s and the early twentieth century seems to offer a counter-discourse to the image of the British medical officers in Late-Victorian imperial writings. Several short stories by Prabhatkumar Mukhopadhyay are concerned with the "nationalization" and "familiarization" of the doctor-figure in different ways. In "Bhikhari Saheb" (1895) he presents Henry, a British doctor in India, who suffers from temporary amnesia and identity-crisis, behaving like a beggar. A generous Brahmo Bengali gentleman gives him shelter and work, and makes him accustomed to native attire. The doctor becomes a part of the Bengali household, and the babu's daughter grows fond of him. It is through this girl's illness that his medical memory is suddenly restored. Henry is present by her sickbed all the time. The condition grows critical, and every time the local doctor changes the medicine, Henry observes it closely, and the entire process somehow restores his medical perception. The climax comes when Henry challenges the local doctor for applying wrong medicine, and takes up the treatment upon himself. The girl gets well and the doctor also gradually comes out of his identity-disorder. Thus, doctor Henry's own "disease" gets cured by his re-association with his profession, mixed with genuine love and care for the patient concerned.

The identity-disorder of a British doctor in India, dressed as a Bengali under the service of a Bengali babu, can encourage modern readers to place the story in the context of the imperial anxieties over the tropical situation of health and disease. Christiane Hartnack's *Psychoanalysis in Colonial India* cites several cases of madness and identity-disorder among the British civil servants in India, in relation to the

"disease" of imperial stress and anxiety. Sir Henry's identity crisis, his journey from being a doctor himself to a mental patient, and his role-playing as a native Bengali man can be read as a very close fictional example of Hartnack's factual observation: "The British patients, ... thus 'stripped native' were also an embarrassment for the representatives of the Raj" (26).

As to fictional writings, Kipling was indeed read and critiqued by the Bengali authors and intellectuals in the late 1890s. However, it is difficult to say whether Prabhatkumar Mukhopadhay was particularly familiar with Kipling's characterisation of British doctors troubled and obsessed with alien diseases and germs in an unfamiliar land. Still, Mukhopadhyay's comico-pitiable manner of characterizing the "bhikhari sahib", the babu's delight in collecting such a character-specimen, and the sahib's own willingness to become a Bengali can be read as a response (however unintended it might have been) to the Kiplingesque portrayal of British medical men in India. Henry's own words, which should not be dismissed merely as a madman's utterances, betray the colonial anxiety and guilt-feeling which became another kind of "white man's burden" in India: "Oh yes Babu, I'll become a Bengali. Our race hates the Bengalis too much. I'll make some atonements for the sin of my people" (Mukhopadhyay 298, translation mine). This has the potential of intriguing several critical issues like counter-colonization and an ambiguous mock-nativization of a British doctor, himself turned into a "mental patient" in the colonies, taking shelter in a Bengali household, and recovering through a relationship of mutual dependence and service at the time of need.

If "Bhikhari Saheb" gives a playful account of "nationalizing" a British doctor, later in "Hate Hate Phal" (1908), Mukhopadhyay presents a sympathetic image of a true "swadeshi daktar". Dr. Haragovinda Chattopadhyay is a government-

employee, but patriotic at heart. Despite his swadeshi feelings, as a doctor he is equally dutiful to a poor station-worker and an arrogant ‘’Sahib’’ who assaulted a Bengali gentleman without provocation, and in turn got beaten up by some nationalist volunteers. Duty-bound, the doctor nurses the Sahib and makes further arrangements to send him to hospital, but sternly refuses the police-officer (daroga) who asks him to give false evidence at the court. The ‘‘daroga’’ raids the doctor’s house, and arrests his sons on false charges. Ironically, however, the daroga falls seriously ill that night, and has to send for the same doctor. At first unwilling to treat the person who has caused him such suffering, the doctor ultimately yields to the tearful entreaty of the daroga’s wife. He takes charge of his treatment and saves the police-officer’s life. The doctor’s sons are finally released for want of proof against them. In some ways, Haragobinda daktar is a prototype of Banaphul’s famous medical protagonist Agniswar: patriotic, strong of principles, uncompromising, dignified. Another aspect of the nationalist discourse finds expression in the image of the revolutionary protagonist Sabyasachi in Saratchandra Chattopadhyay’s *Pather Dabi* (1935*)*. Sabyasachi has a medical degree; and though he does not hold a practice, people address him as “daktarbabu”. In a metaphorical sense, his mission of organising the freedom movement is a kind of “doctoring” the sick motherland, curing the disease of imperial oppression.

Coming back to the social history of *daktari* in colonial Bengal, it can be said that a major change took place in the aftermath of the First World War. The effects of the War had been rather indirect on India, the experience was disturbing but not so shattering and horrible as it was for Europe. The change was felt more in the field of social economy, lifestyle and professional life than anywhere else. The medical profession represented in literary works of the 1920s often tended to reflect the

economic pressure on the medical market, grossly affecting the physicians' professional ethics. By the 1920s and 30s physician-authors like Jnanendranarayan Bagchi and Banaphul took the pen to put their own experiences to paper. Deen Chowdhury, the young MB in Dr. Jnanendranarayan Bagchi's "daktari novel", *Bagher Baccha* (*The Tiger-cub*) can be cited as a positive example of the idealistic doctor-figure who considers his profession as a form of "desh-seva" (service to the nation).

Dr. Bagchi's novel, based largely on his personal experiences as a doctor, was little known in the Bengali literary canon during the 1920s. However, he can be regarded as one of the pioneers of "medical fiction" in Bengali, authored by a doctor himself – a tradition later developed and flourished in the hand of Banaphul or Dr. Balaichand Mukhopadhyay. *Bagher Baccha* looks at the problems and corruptions within the medical market with a keen awareness of social reality. In order to survive in the professional field and do something really good to the people, the young doctor-protagonist finds that he must be involved in a moral struggle against his powerful, renowned and exploitive senior colleague – Dr. Nibaranchandra Sengupta, who presides over a large chain of dispensaries, providing the young and aspiring doctors with a chamber, some medicine and other equipments, under the contract that they will hand him a major amount of their earning. Deen soon discovers that Dr. Sengupta does not even hesitate to cheat the patients with coloured water in the name of medicine. Through the eyes of Deen, the author not only portrays the unprincipled workings of commercialism and greed in the medical world of Kolkata, he also explores issues of social stigma and a decline of moral health at different levels of the urban society.

Interestingly, as a Bengali youth born and brought up amongst the indigenous cultural belief-systems in rural Bengal, Dr. Chowdhury realizes that faith-healing and natural healing are not to be discarded altogether, simply because they are not acceptable by the western medical system. In rural India, faith is a great power that gives strength to the populace, and to serve the people of the nation, one must be respectful of their belief-systems as long as they can provide mental or spiritual strength to suffering humanity. Thus the protagonist tries his best to reform the situation both as doctor and man. His noble mission of serving society and the nation with all dedication and honesty stands out amongst an otherwise "sick" and increasingly commercialized medical market. Bagchi's "daktari novel", now a forgotten text, indeed succeeded in introducing a new kind of perspective in Bengali literature – the ''daktari'' perspective which is rather nationalized. The social role of doctoring, as we have already seen in the first chapter, was a familiar theme in Victorian fiction, as exemplified in texts like *Bleak House, Dr. Thorne* and *Middlemarch.* What the native authors added to this was a typically Bengali-Indian situation, with love and dedication to their motherland. This was another aspect of "provincializing Europe" (to borrow the phrase from Dipesh Chakraborty), with a curious manipulation of the imagined spaces of the national and the local, through the familiarization of a foreign perspective.

The physician-novelist Banaphul (Dr. Balai Chand Mukhopadhyay) whom Tagore singled out for his "scientific temperament", brought a new "rasa" to the world of Bengali literature – the "daktari rasa". A number of his novels are based on his own experiences as a doctor in the rural areas of colonial Bihar and Bengal; but they do not appear to the reader as narratives of mere experience. They have aestheticized the worldview of a medical man with a literary genius. Doctor-

protagonists appear in his novels like *Trinakhanda* (1935), *Nirmok* (1945), *Agniswar* (1958) and the like: of these, *Nirmok* can be taken for special consideration because it is a novel that bears several points of affinity with such celebrated medical novels by British authors as already discussed in the previous chapters, namely *Middlemarch* and *The Citadel*. It is difficult to say whether Banaphul actually read *The Citadel*, published in 1937. However, he was indeed an avid reader of Victorian fiction, and he attempted to write Bengali adaptations of some Victorian novels. It is rather possible that Banaphul had familiarity with George Eliot's well-known work *Middlemarch*, featuring so prominent a medical character as Dr. Lydgate.

Dr. Bimal Mukhopadhyay, the protagonist of *Nirmok* is a newly passed-out medic who gets his first posting at a rural hospital. He is deeply disturbed by the sheer poverty and helplessness of the people – his patients. Initially he tries to improve the health-condition of the locality, provide expensive drugs from his own salary, and seeks to balance family life with professional duties. The pressure of local politics is also huge: there is an instance in Bimal daktar's life that is almost similar to a situation Dr. Lydgate had to face in *Middlemarch*. Lydgate, the newly arrived doctor in the village of Middlemarch finds himself caught up in the seamy local politics; and though he personally likes Farebrother, he has to cast his vote for Tyke, a candidate favoured by Bulstrode, whom Lydgate must please in order to run his hospital safely. His attempt to keep a good relation with the influential banker Bulstrode ultimately drives him to an unfortunate case which clouds his reputation. Similarly, Bimal needs to please both Badibabu and Nandibabu – opponents in the local municipality, because of the municipality's control over the hospital. In doing so, he takes several wrong decisions, and his professional honesty is at stake. Besides, the growing demand of expensive and private medical service among the rich patients creates a

lucrative world of success. The temptation of rising in society is too much for the young doctor, and he gets involved in attending the affluent and upper-class patients at the cost of neglecting his duties at the hospital. In many ways, the situation of Bimal daktar is also reminiscent of Dr. Andrew Manson in *The Citadel*. However, unlike Lydgate, Bimal is not driven into debts, and unlike both Lydgate and Manson, he is not interested in new discoveries or in reforming the existing medical system. An ordinary but basically honest professional, he seeks to keep his work ethics intact but politics and mercantile demands do not let him remain true to his personal ideal.

The twist comes at the end, when Bimal himself has caught a skin-disease which his colleagues mistake for leprosy and make him feel like a condemned one. To escape humiliation and find some relief, he detaches himself from everything and retires to his paternal home, now inhabited by an old compounder whom he calls "uncle". This uncle accepts him with kindness, and offers to treat him. While recovering under his devoted care, Bimal realizes the difference between "service" and "professionalism". During his sojourn in the country-house, the simple rustic life – far from the world of professional ambition and commercialized medical practice – gives him solace and peace of mind. After his recovery, he does not go back to his work, rather he becomes a part of the agricultural community in his native village. He says towards the end, "It is not so that I have forsaken doctoring altogether, I do practise, but no longer I do it as a business" (474). Now he makes use of his medical knowledge as a "Vidyā". According to the Vedic literatures, *Vidyā* is an insightful expertise in some special branch of knowledge, a sacred orientation which opens itself for the sake of one's own satisfaction and doing good to others.

Bimal daktar's wife dies of childbirth, but he has been able to gain a stoical acceptance of life's joys and sorrows. He can successfully handle a case of delivery in

the village and saves the life of a farmer's wife on the same day. The doctor's troubled journey through the complexities of life and profession finally endows him with a worldview that elevates his "daktari" perspective to a wider philosophical approach to humanity – which is essentially rooted in its Indian-ness.

Banaphul's daktari novel *Agniswar* (1958), recapitulating the colonial era but published in the post-colonial period, marks a certain juncture in the history of "medical fiction" in Bengali which underscores the significant journey undertaken by the native doctors in society and literary representations. It chronicles Dr. Agniswar Mukherjee's uncompromising and dignified career, fraught with several conflicts with the British officers. As his name signifies, Dr. Agniswar bears a fiery spirit that knows no submission to injustice and power. He is an efficient doctor and medical reformist, a modern man of scientific disposition who can critique both the superstitions and weaknesses in his own culture and the inhuman imperial policies of the British. Being a government medical officer, he has a heart full of nationalist sentiments beneath his westernised dress and lifestyle. On several occasions he has demanded equal respect for Indian medical officers and the British ones, and opposed the government's unjust decisions. Under the pen-name ''Khapkhola'' [uncased (sword)], he writes on anti-government issues in a revolutionary periodical, and secretly helps the revolutionary activists. In one such instance, the uniqueness in the doctor's character comes out shining: one of his female patients, Sunanda, an educated girl of a well-known Bengali ''bhadra" (genteel) family, comes back to him after a long interval. The doctor's sense of high morality gets a shock to find that Sunanda, still unmarried, has been pregnant. He nevertheless admits her and does his duty as a doctor but cannot save the patient. Sunanda has kept a box in the doctor's custody, requesting him to hand it over to her friend, Khagen. Agniswar has felt no

interest in the box until Khagen comes, and reveals that the box contains a revolver. Now the doctor learns that Sunanda has sacrificed her chastity in the course of acting as a secret messenger for a revolutionary group. Knowing the whole story, the doctor dismisses his earlier impressions, and grows respectful towards the girl who has thus served the nation with her own flesh and blood. In another instance, he has saved a young revolutionary from the police. The wounded freedom-fighter was brought to the hospital under Dr. Agniswar's charge; and he lets him escape, even risking his own service. There has been a police enquiry, but Agniswar's efficiency, personality and reliability as a doctor finally clear him of all charges.

Agniswar is a twentieth century medical hero negotiating colonial modernity, a man of ability and reason who fights against the British monopoly in the government service of India. He is bold enough to protest against the sahib's insulting attitude towards his own countrymen: a British officer insulted one of his assistants, Dr. Latif, and Agniswar repays that "uncivilized" (*abhadra*) Englishman, by teaching him a proper lesson. Once again, when the British-dominated Railway Board has been indifferent to the sick Indian coolies suffering from a cholera outbreak, Agniswar forces the administration to consider the situation seriously: he will not issue a single fit certificate until the native workers' health really permit them to join the work. He is equally outspoken against racial discrimination in the government service, and proud to be an Indian. The character is believed to be modelled on a real-life Bengali doctor, Banabihari Mukhopadhyay[10]. The author, Banaphul alias Dr. Balai Chand Mukhopadhyay, being a medical man himself, was able to make a realistic representation of the colonial medical situation. He upholds the status of the native doctors, and portrays how some of the enlightened and reform-minded medics did

sustain their respectability and self-dignity, by rising above the demands of their colonial masters. Anderson writes:

> The Imperial Government had no intention of extending equality of opportunity throughout the various offices of state regulated employment, and remained determined to reserve the top echelons for the white officers and bar even the best qualified Indian from rising higher than the "appropriate" lower deck. Throughout the [colonial] period, racialism proliferated and even where Indians were employed alongside their European counterparts, their status was compromised by a pay differential. (144)

Some pioneering Indian scientists and physicians like Acharya Jagadish Chandra Bose and Dr. B. N. Bose suffered such racial discrimination[11], but they campaigned strongly against such unfavourable policies of the government with a nationalist zeal coupled with an awareness of self-respect and equality. Keeping the reality in mind, such faithful literary representations of doctor-figures like Dr. Agniswar do offer a strong counter-discourse against the overarching imperial control over the medical field.

On the whole, it can be said that a brief survey of the fictional works using medical realism is not enough to do justice to the complex thematic orientation of imperial doctoring, its anxieties and counter-discourses. However, the limitations of such a study as attempted in this brief chapter can be helpful in raising questions about the ways of understanding the fraught relation between imperial medicine, identities of doctors and patients within a colonial context and locating further issues of critical exploration.

Notes:

1. See David Arnold, *Imperial Medicine and Indigenous Societies*, Manchester, 1988, pp 14-15.
2. Žižek's critique of the Lacanian notion of fantasy appears most remarkably in his 1989 work, *On the Sublime Object of Ideology*. For further discussion of ideological fantasy specifically concerning racism, see Slavoj Žižek, "Love thy Neighbour? No Thanks!" in Christopher Lane (ed.) *The Psychoanalysis of Race*, New York: Columbia University Press, 1998, 154-75.
3. Richard Keller, "Madness and Colonisation: Psychiatry in the British and French Empires, 1800-1962", *Journal of Social History* 35:2 (Winter 2001), pp 295-326 .
4. See Debjani Das, ''Introduction'', *Houses of Madness: Insanity and Asylums of Bengal in Nineteenth Century India,* New Delhi: OUP, 2015, p 5.
5. See Waltraud Ernst, *Mad Tales from the Raj: European Insane in British India, 1800-1858,* London: Routledge, 1991.
7. Flora Annie Steel, *The Garden of Fidelity. Being the Autobiography of Flora Annie Steel,* Kessinger Publishing, 2008, p 61, as quoted in Narin Hassan, **"Female Prescriptions: Medical Advice and Victorian Women's Travel", in *Nineteenth Century Gender Studies*, 5.3 (Winter 2009).**
8. For the concept of disciplining the subject, see Michel Foucault, *Discipline and Punish: the Birth Of the Prison*, trans. Alan Sheridan Smith, New York, Vintage Books, 1979.
9. See Charles Leslie, "Interpretations of Illness: Syncretism in Modern Ayurveda", in Charles Leslie and Allan Young (eds.), *Paths to Asian Medical Knowledge* (Berkley, Los Angeles, Oxford: University of California Press, 1992, p 187.
10. Dr. Banabihari Mukhopadhyay was Banaphul's teacher and mentor in the Medical College. For details on this point, see Urmi Nandi, *Banaphul: Jibon , Mon o Sahitya* (Kolkata: Karuna Prakasani), 1997, pp 187-89.
11. D. Kumar, "Racial Discrimination and Science in Nineteenth Century India." *The Indian Economic and Social History Review,* 19 (1982). pp. 63-82.

Chapter 5

"Lady Doctors" in Colonial Bengal: Narratives of their Own

Medical education for women in colonial India started largely as a direct consequence of the missionary project undertaken by their "European sisters". In her essay titled "**Female Prescriptions: Medical Advice and Victorian Women's Travel" (2006)**, Narin Hassan shows how the early travel writings by white women in the colonies used to posit domestic health and the condition of the native *zenana* among their major concerns while living in India. Their writings also reveal how the domestic medical chest they used to keep for home use and sometimes, their simple medical work among the native men and women done with a missionary zeal became a way to carve a useful position for female doctors in the colonies overseas. During their stay in the colonies, their role as such amateur medics at a domestic level, in a way, helped to pave the way for the training of female doctors and nurses in colonial India. Hassan also quotes from a text by William Arthur, titled *Woman's Work in India* (1882), where a reference is made about one "Mrs. Parker, wife of a missionary at Moradabad" who had "prepared the way for a lady physician by successful practice of her own" (84, qtd. in Hassan 2009, n.pag.). She used to visit cholera patients and distribute medicines in the native villages, as part of her missionary work. Dr. Frances Hoogan maintained that the existing medical system in India had failed to reach out to its womenfolk (Hassan 2011, 61). Thus, during the latter half of the nineteenth-century, the memsahibs working among the natives were able to formulate a gendered colonial perspective about native women and their situation, by focusing on their medical need and their suffering without proper treatment.

Since the late 1870s, the poor health situation of the Indian *zenana* became one of the major reformist concerns of an enlightened group of white missionaries who felt the need of engaging British women medics in the colonial service. At that time, the medical profession in Britain (and elsewhere) was under a male monopoly. The male physicians kept even gynaecological and obstetrical cases in their own hands, leaving only the nursing job available for women medics. Dissatisfied with such gender-discrimination at home, some of these female doctors readily accepted the better opportunities to use their medical skill through missionary works in the colonies. In 1881, the Maharani of Panna sent a message to Queen Victoria through Elizabeth Bielby (a missionary doctor), urging the Queen to do something to provide medical help for Indian women. Mary Scarlieb, who came to India with her barrister husband, was one of the pioneers who not only studied medicine to serve India but also assumed a significant role in the campaign for the introduction of medical education for Indian women. She visited Queen Victoria and convinced her to support her cause, which became a turning point in the introduction of medical education for native women. The Queen did not get involved directly in the project of training native women to become "lady doctors", but her support helped her to promote the idea fervently. Scarlieb records such incidents in her autobiography *Reminiscences* (1921) which remains to this day a valuable testament about the social and cultural tensions involved in the history of women medics in colonial India.

The project was, however, not an easy matter: during the colonial period, women in India received the facilities of medical training amidst a long-drawn and highly contested debate among the medical officers, government employees and philanthropist-reformists both on public and private domains. The powerful objections from Indian patriarchy and tradition were to be weighed against the claim of

modernity, trying to advance the cause of women's right to health and education. This had been documented in a number of letters, newspapers and petitions preserved in the colonial archive. These accounts mostly focus on how the cause was viewed and negotiated by British administrators, missionaries, philanthropists, as well as Indian reformers who were eager to spread western education and health care facilities for Indian women[1].

Between 1880 and 1890, the written documents on medical education were primarily concerned with the unhealthy and pathetic condition of the Indian *zenana*, and the need for training women medics for serving those poor and helpless women. For instance, the travel-journals and letters (1880s) of Lady Dufferin, who took initiative in giving medical education to Indian women, can be cited as examples, showing how during her travels across India she encountered the suffering of the native women in matters of health and hygiene. In 1882, Mrs. J.T. Gracey, a missionary, wrote in an article published in *Leonard's Illustrated Medical Journal*, vol. 3, issue 3:

> It is fact that very little has been done to alleviate the condition of heathen women. It is estimated that thousands of women die annually throughout the East for want of proper medical attention [...] All European ladies who have been permitted to break through this seclusion and within the veil have borne the same testimony. They all sadly tell of suffering sisters, whose diseases will easily yield to careful and skilled medical treatment, but who are doomed by their seclusion to the unrelieved torture of living death. (62)

Narin Hassan's book *Diagnosing Empire* has quoted extensively from Lady Dufferin's letters and journals to establish her concern (Hassan 2011: 83-85). The Brahmo reformers writing on the need for female medics also focused on the social

and conventional impossibility of male doctors treating certain female diseases. Therefore, the demand for female doctors was great (*The Brahmo Public Opinion,* 1883). In 1882 the letters of A.W. Croft, the DPI, to the Principal of the Calcutta Medical College were also supportive of the women's cause. However, the causes were not welcomed by all. The *Indian Medical Gazette* attacked the notion that women were being trained as doctors, and claimed that they were rather fit for being nurses. It revealed the gender discrimination within the medical profession. The Dufferin Fund was founded in 1885 for providing medical training to the willing Indian women, setting up female hospitals, and financially supporting the project. This initiative got mixed responses from the contemporary newspapers and reports: some reformist Indian men were eager to lend moral support, while the conservatives denounced it as a kind of intrusion by the colonial government into the sanctity of their home.[2]

By the mid-1890s, the scope of getting admitted to Campbell Medical School encouraged women in greater numbers (more in comparison to the poor number of female students during the initial years) to enter the medical profession. Among the accounts available from this period (1895 - 1910) we get the voice of journals that were sympathetic to women's education and other rights – chiefly *Bamabodhini Patrika* which regularly published small articles on the female students who passed out from the Calcutta Medical College and the Campbell School. The colonial archive is apparently "full" with such accounts – the reports and letters by British officials[3], writings by European women doctors[4], and the views of Indian men, both reformers and conservatives[5]. What is less easier to get, is the voice of Indian women themselves who became pioneers, through several struggles, in the study and practice of medicine. Some information is available about the early lady doctors like Dr.

Kadambini Ganguly (1861-1923), Dr. Anandibai Joshi (1865-87), and Dr. Rukhmabai (1864-1951). However, they had not left their own memoirs. Mala Dutta Roy's seminal work on Dr. Kadambini Ganguly has brought to light some letters, petitions and articles written by the doctor, revealing her struggle to get recognition as a professional medic. Some personal letters by Anandibai Joshi are available, and they chiefly represent her private concerns and emotions regarding her ambition – going to study medicine in a foreign land, and to come back to serve "Mother India". The letters also throw light on her wonderful personality which combined her humble and loving respect for her husband that is typical of a Hindu wife, along with an individualist assertion of her dreams and desires, unusual for a simple and modest-living Marathi Brahmin woman in 19th century India. Her voicing of her own dream of becoming a woman doctor seems to be free from conventionality that shaped the general male bias against women's education in the society she lived in, but nor did she directly engage in criticising the patriarchy**.** Much later a novel was published based on her life, titled *Anandi Gopal* , by S.J. Joshi.

In the period between the late 1890s and the early 1920s, writing memoirs and diaries were not too uncommon among educated Brahmo ladies, and also among advanced and extraordinary Bengali-Hindu women[6]. Nevertheless, memoirs by medical women construct a limited archive, out of which we are going to read at length two memoirs , one by Dr. Haimabati Sen, retrieved by Geraldine Forbes, and translated by Tapan Roychowdhury, and the other, by Kamini Roy (the well-known female poet of early twentieth century Bengal) who published a short biography of her sister, Dr. Jamini Sen in *Bangalakshmi* (1339 B.S.) based on Jamini's own unpublished memoirs and diaries. As to fictional representation, female doctors appeared in a few texts in the colonial period, of which the remarkable one is *Saguna*

by Krupabai Satthianadhan, published in 1895. This was the first autobiographical novel in English, by an Indian woman. In Bengali literature, such characters – however small in number-- began to appear since the late 1890s. And most of these representations were domestic in nature — that is, lady doctors were viewed within the limited structure of family or the household-system primarily as nursing and caring figures rather than contributing to a larger social/cultural history of colonial medicine.

The "familiarization" of the female doctor-figure related to her personal/emotional life can be seen as a complicated issue in "Himani" (1899), a short story by Prabhatkumar Mukhopadhyay. The protagonist is a Bengali Christian, but her kindness and efficiency have gained her trust and popularity among the female patients of the local Hindu households as well. Himani faces a professional and emotional trial as she comes to treat Nabadurga, the ailing wife of her own former lover, Manibhusan. The man is unhappy in marriage, he cannot forget Himani, and stays in his workplace away from his wife. Himani herself comes to call Manibhusan from his sojourn, apprising him of Nabadurga's critical condition. She pragmatically requests him to show no sign of their former acquaintance. When it is required to transfuse blood into Nabadurga's body, Himani willingly acts as the blood-donator. She refuses to take assistance from any "superior" sahib-daktar, but relying on the ability of a newly passed out local doctor confirms her trust in and solidarity with her native colleagues. The native doctor executes the blood-transfusion with success, but Himani feels so weak that she has to remain in bed, with a bandaged vein. Soon she realizes that she is about to die. Seeing Manibhusan's suffering and anxiety for herself, Himani decides to donate not only her blood to Nabadurga, but her "soul" as well, so that Manibhusan can love his wife after Himani's death. The story ends in

Himani's suicide by tearing the bandage and opening her vein, and Manibhusan's subsequent fall into a mental disorder. Nevertheless, he learns to love his wife by virtue of a mistaken identity: now he calls her wife "Himani".

Self-sacrifice and nobility of heart constitute both aspects of Himani's character – her role as an ideal, dutiful doctor who can risk her own life to save a patient's, and her nature as a virtuous loving woman who can choose her own death in the hope of clearing the tensions in the married life of the man she loves. Within a plot of middle-class familial or domestic love, duty and relationships, Himani's personal and professional lives are entangled in a complex interaction, rendering her position ambivalent as far as the family-discourse is concerned. Her marriage with Manibhusan is not possible because he is a Hindu, married man. With shattered hopes of marriage and family, she dedicates her life to the service of the ailing people. Her decision not to have a "family" of her own comes from her frustrated love, but it also alludes to the general course of the struggling life of those women – and they were not many—who came to the medical profession.

In real life Dr. Bidhumukhi Basu and Dr. Virginia Mary Mitter had to confront similar obstacles, both in society and family. They were also looked upon as "alien" and "lowly" even by their intended clientele – the "Andarmahal"— women of conservative Hindu households. Lila Majumdar in her autobiographical work *Pakdandi* (*The Uphill Road*) recounts an anecdote about Dr. Kadambini Ganguly that she had gathered through family connections. Dr. Ganguly once had an experience which reflected the social bias against lady doctors: she was given a house-call to attend a case of child delivery, and after the work was done, the women of the house treated her like a midwife, calling her "dai", and asking her to clean the place where

she was served food (Majumdar 102). They could not believe that any respectable woman could have been a doctor.

In *Mahila Daktar: Bhin Graher Basinda* (*Lady Doctor: Alien from Other Planets*) Chitra Deb points out that "lady doctors" in the 1890s hardly had a happy family-life: either they remained unmarried, or had to suffer and compromise under a social/familial situation dominated by patriarchal prejudices. In course of time, the social and familial prejudice against lady doctors was somewhat moderated: they gained some respect, yet they were looked upon as strict, "manly" and exceptional figures— not naturally fit for family. In this regard, one may recognise affinities between the situation of female doctors in England and their so-called "backward sisters" in India. Like Rhoda Gale in Charles Reade's *The Woman-Hater* or Janet in Charlotte Yonge's *Magnum Bonum* (discussed in Chapter 1), Prabhatkumar Mukhopadhyay's portrayal of Himani as a lady doctor is also doomed to a frustrated and unfulfilled life . Creating the lovable image of the "lady doctor" in fiction has been successful by adding a romantic note to make her de-alienated or less unfamiliar. Himani's character is both image-making and image-breaking: she leads a dedicated and austere life of sacrifice outside wedlock, she has extreme self-control, but at the same time she carries within her heart a deeply emotional nature, the painful memory of a lost love, and a familiar and dependable relationship with the "Antahpur"-inhabitants of Bengali-Hindu households.

In colonial Bengal the female medics had to face innumerable odds and obstacles, yet the characterization of the lady doctor in literary imagination was rather positive, however stereotyped. Kaliprasanna Dasgupta's 1921 play titled *Lady Daktar* presents Gangadasi as a caring and kind doctor who promptly comes to the aid of a pregnant woman, when her health condition requires immediate medical care. At the

end, it turns out that the lady doctor was the first wife of the said patient's husband. She had been kidnapped and thought to be dead, and neither her own family nor the in-laws kept searching for her any more. Rescued by a matronly lady doctor she was trained to become a professional medic, now able to earn her livelihood and live independently. In this text, too, the female medic is shown to be excluded from a natural and happy family life. When Parashuram (the pen-name of Rajshekhar Basu) – distinguished for his wit and humour – portrayed a lady doctor, Miss Bipula Mallick in his humorous tale "Chikitsa Sankat" (1924), he also depicts her "success" in curing the male patient by taking care of him for life, that is, by marrying him. She leaves her practice, and the author comments with a humorous touch: "Now she treats no other patients, but her husband only". For a long time, it remained a kind of general consensus that an independent and successful medical practice for a female doctor is antagonistic to a happy married life. So even in the 1960s and 70s, although facilities for women coming into the medical profession increased to a considerable degree, literary texts like *Haspatal* and *Megh Kalo* (novels by Niharranjan Gupta, popularized through their cinematic adaptations) still continued to depict the emotional struggle of women medics, without success in love or marriage.

Fictional representations, however, cannot be considered as archival material to reconstruct a social history of female medics in colonial Bengal; for that one needs to focus on memoirs and autobiographical works. In his article "Between Memory and History" Pierre Nora comments that "modern memory… is archival', only so far as it can manifest itself in "the materiality of the trace, the immediacy of the recording, the visibility of the images" (13). The specific context of reference, for Nora, involves the "sites of memory" in nineteenth century France celebrating its historical architecture: catacombs, monuments and the like. However, Nora's general

approach is to read history and memory as two opposing categories (8-9), although towards the end of the essay he admits,

> … memory has never known more than two forms of legitimacy: historical and literary. These have run parallel to each other but until now always separately. At present the boundary between the two is blurring; …History has become our replaceable imagination – hence the last stand of faltering fiction in the renaissance of the historical novel, the vogue for personalized documents, the literary revitalization of historical drama, the success of the oral historical tale. (24)

For the present chapter, this "vogue for personalized documents" is the key phrase. Personalized documents – especially memoir and autobiography are literary genres which, placed in a historical context, can be read as an alternative history where a subjective and more intimate kind of memory gives a new and interesting dimension to the otherwise objective and factual method of traditional historiography. Interestingly, "memory as history" has also acquired a gendered identity in a sense that historical memoirs written by women had for long been labeled as personal, affective and even "amateurish" in comparison with the universal, impersonal quality of mainstream history, dominated by male historians. Things have changed in the light of modern feminist history studies. Historians like Bonnie Smith and Antoinette Burton have taken major steps in the field of feminist historiography. In her book *Dwelling in the Archive*: *Women Writing House, Home, and History in Late Colonial India* Burton discusses the memoirs of Janaki Majumdar, Cornelia Sorabji, and *Sunlight on a Broken Column*, a novel dealing with partition memory – by Atia Hossain. She shows how in these narratives, the spaces of the house and the "zenana" became the archive of female experience in national, diasporic and partition history.

Majumdar, Sorabji, and Hossain lived through the late colonial history and the upheavals of a period prior to the Independence of India – a period troubled with the intersections of tradition and modernity, nostalgia and a radical quest for identity. However, Burton goes beyond the specific theme and context of her primary texts, and suggests a broader conceptual framework regarding the limits and possibilities of feminist history, as she argues:

> Far from being simply 'personal', subjectivity is produced and lived as history … And just as "storytelling is the making and remaking of the gendered self in social relations", so is history implicated in the production and reproduction of women's cultural imagination. (28)

From a literary perspective it is interesting to explore how these memoirs, very close to literary genres like "autobiography" or "bildungsroman" are able to project a journey in history, in which private spaces like family and home are constantly in negotiation with public spheres like medical college, hospital, wards and chambers. In the west, the proto-feminist quest for identity and self-assertion found expression through women's writing of memoirs or autobiographical novels which flourished as important literary genres in the nineteenth century. The question is: how far it is possible to recognize a trend of "feminist bildungsroman" in the context of colonial Bengal, especially in the writings by lady doctors?

The memoir of Haimabati Sen (born as Ghosh) is a testimony to the oppressions that women were subjected to, and their resistance against oppression. Written in the 1920s, it remained unknown during her lifetime and came to be finally translated and published almost eighty years after her death. This chapter intends to examine the memoir as a different kind of archival material, where personal memory creates a notion of how to read history—the gendered struggle for education and

financial independence especially in the context of women's medical profession in nineteenth century colonial India. Geraldine Forbes' "Introduction" to the memoirs of Haimabati Sen, and an article by Indrani Sen ("Resisting Patriarchy: Complexities and Conflicts in the Memoir of Haimabati Sen") have discussed several issues depicted in the memoirs in detail. However, this chapter is going to focus chiefly on Haimabati's career as an extraordinary woman who transformed himself from the miserable status of a "child widow" to the respectable position of a "lady doctor".

Haimabati was not writing "history". In the dedication page titled "Om Tat Sat" she clearly stated that the purpose of her writing was to bear witness to God's help throughout her sufferings and struggles, making her "insignificant life" worth-living. This was not merely a Brahmo lady's conventional invocation of the Almighty, Haimabati was truly sincere about her faith. However, the planning of her memoir does reveal a historical awareness. While recollecting her family and ancestors, she traces their lineage to Maharaja Pratapaditya. The initial chapter of the memoir also describes how badly the colonial rule affected the agricultural life of rural Bengal. Her grandfather Sibanath Ghosh fought against Rainy, an infamous indigo cultivator – a fact confirmed by historians. The rebellion was financially devastating for Sibanath's family and descendants. Haimabati grew up seeing the family's declining glory and reputation. However, her father was a liberal man who taught her at home before her marriage.

For Haimabati, who was outgoing and rather free as a child in her generous father's house, marriage meant a miserable suffocation which pushed her into the dark and gossiping space of the zenana in her claustrophobic in-laws' house. Within a few months her debauched husband died of pneumonia and liver abscess – leaving Haimabati a virgin child-widow. From now on, she had to live a life of tremendous

hardship. She also lost her guardian-figures one by one – her parents on the one hand and mother-in-law on the other. Her relations treated her harshly and deprived her of home and property.

In literary terms, this is the turning point in Haimabati's "bildungsroman" (narrative of growth and development) as she resumes her journey by literally going out on the road—in search of a better and independent life. Interestingly, the traditional binary between "independence" which is related to an extrovert, public life and "homespun life" which indicates submission and stagnation (a gendered division, much illustrated by Western Feminism) does not work in Haimabati's story – her quest for independence and identity is also a search for a home, for kinship and familial ties. She moved to Benares, where she succeeded in forming new kinship-bonds, creating a "home" (her landlord and landlady treated her as a daughter-figure) for herself. There she was able to earn a modest but respectable living by working as a teacher to girl-students. However, she was always eager to find opportunities for better education. Learning about the Brahmos' progressive work regarding female education in Calcutta, she left Benaras and set out for Calcutta.

Haimabati's wandering alone across the country in search of education, without any male-protection, was not safe. As she tried to contact some open-minded Brahmos for help, she got a few well-wishers, and eventually, her marriage was arranged in 1890, to Kunjabehari Sen, a poor but idealistic Brahmo missionary. Here one must remember that widow-remarriage was a disturbing issue in the late nineteenth century. Though it had been legalized in 1856, in reality it was hardly welcome among upper caste Hindus, though some Brahmos, either to show their progressive nature, or out of genuine good sense, were interested in this[7]. For Haimabati, this marriage was important because it provided her with a home—"This

marriage became a powerful bond in my life and changed its course. I now thought of myself as a householder" (239). For the reader, however, as the narrative proceeds, it becomes clear how elusive even this idea of a home was in reality: Haimabati's husband was not worried about having a family-establishment of their own, he would rather go on to pilgrimages, or he would push the wife into a charitable home set up by the Brahmo missionaries, called "the Shelter", much to her disgust and humiliation.

Haimabati's memoir also shows that the Brahmo patriarchy, though apparently liberal than Hindu male domination, was not all that wonderful and resourceful. Her husband's impractical and eccentric nature threw her into a life of instability and uncertainty without sufficient financial support. The need of getting a stable income for herself and her husband, led her to choose a medical education, for, "Many girls had joined medical schools at that time and I decided I would do the same" (290).

Before going into Haimabati's medical education and career, a brief survey of her predecessors may be helpful[8]. Although Kadambini Ganguly was the first female student of the Calcutta Medical College (hereafter CMC) she was not awarded the MB (Bachelor of Medicine) degree, instead she was given license to practice as a less prestigious GBMC (Graduate of Bengal Medical College). The first two female MBs of the CMC were Bidhumukhi Basu and Virginia Mary Mitter. They passed in 1890. Virginia Mary's career was one of compromise and sacrifice. She left her profession to make her family happy. The name of Bindubasini Basu, Bidhumukhi's sister and also a student of CMC, had passed into oblivion, but Chitra Deb has discovered from archival records that she actually received her MB degree in 1891, and stayed in Calcutta till 1906, before moving to Dehradun (Deb 107).

The number of female graduates from the CMC was small, and the reason behind this was not only the conservative society but also the fact that the entrance test for CMC required a BA degree. This was accessible mostly to educated Brahmo ladies and Indian Christians. The Campbell Medical School, when it decided to admit female candidates in 1888, a better opportunity was created for ordinary Bengali women, even married women who had a basic education in the vernacular and wanted to have some kind of professional career. This was a facility which helped Haimabati to her choice of a medical career. In order to reduce the pressure on the CMC, vernacular classes were shifted to the Campbell Medical School. Campbell classes were conducted in the vernacular by Indian teachers. This institute trained students in the rudimentary knowledge of medicine and basic surgery, with its graduates receiving the "inferior" VLMS degree rather than the MB or MD degrees which were conferred on graduates of the CMC, taught in English by British teachers (Forbes 2008:114-17). Despite the obvious disadvantages they faced (low status, poor salary and threats of sexual harassment), these Campbell "lady doctors" played an important role in the districts and in rural areas (Forbes 2008: 117-18). Their greatest advantage was that they "had grown up in Bengal, they knew the language and usually the local dialect where they practised" (Forbes 2008: 136) and found it easy to enter the *zenana* for home visits. Haimabati's memoir reflects these historical issues in an intimate way through her personal journey.

Haimabati got admission to the Campbell Medical School in 1891, already a mother. The number of female students was four, while there were twelve males in her class. At the end of the first year, in her own words, she "stood first in the examination and was awarded two scholarships for this" (298). Later, in the final examinations (1894), she topped the class, and qualified for the gold medal. However,

Haimabati's success infuriated her male colleagues, and the way they reacted was a shameful display of crude gender discrimination in Calcutta at a time known as the "Bengal Renaissance". The male students were on strike, protesting against a woman's being qualified for the gold medal. And the newspapers joined the uproar, supporting the boys' cause. The issue grew out of control and the Inspector General and the Lieutenant Governor had to intervene. They negotiated with Haimabati and kept her satisfied with silver medals instead of the gold one she actually deserved. Nevertheless, the authorities were "kind" enough to grant Haimabati's compensatory request that she would be given a monthly scholarship of Rs 30 in exchange for the gold medal, so that she would be able to attend lectures at the Calcutta Medical College. This incident would have never been known without Haimabati's personal memoir as archive. Even the *Bamabodhini Patrika* (Issue 354, July 1894), a supporter of female emancipation, made a brief and safe report— "Smt. Hemabati Sen has this time passed from Kolikata Campbell Medical School with special credit. She has received five silver medals for securing high position, and she is also awarded with the silver medal, given by the governor-general" (235, translation mine).

After a few years' struggle for private practice in Calcutta, Haimabati joined the newly established Hooghly Lady Dufferin Women's Hospital, Chinsurah as a lady doctor "on a pay of fifty rupees a month" (H. Sen 325). The job gave her free living quarters, and opportunity to run a private medical practice alongside. Her role as a doctor is also marked by a negotiation of spaces: the hospital and the female ward became her resort, her home. She records how it started with her arrival:

> The hospital was not yet open. The medicines, utensils, bed clothes … were all lying in bundles. […] I got things arranged in my hospital and opened the outdoor ward. The hospital had fifty beds and four female patients […] One of

> them was Phulkumari — blind in both eyes. Babuni was another: both her knees were rigid from rheumatism … The third was Kalidasi, she was suffering from tertiary syphilis … The fourth patient had goiter. (327)

The way she remembers the details about her patients is almost like keeping records for a personal archive. She was conscious of her position as the sole in-charge of the zenana ward, its problems and concerns, which is reminiscent of Cornelia Sorabji's proclaimed role as the sole authority of the colonial zenana and its legal problems[9]. However, Haimabati's manner and language betray more intimacy and a sense of tender responsibility than authority. Her memoir is a detailed account of what the colonial zenana hospitals were like. As Geraldine Forbes puts it:

> The staff of this hospital consisted of the lady doctor, a compounder, a nurse or dresser, a Hindu cook (food for the Muslim patients was sent from the male wing which continued to be called the Imambara Hospital), a 'dai' (midwife), a sweeper, and a coolie. The entire staff, with the exception of the compounder and the dresser, was female. (2012: 522)

Haimabati also recounts how the intrusions of the male doctor from the nearby Imambara hospital (this person had some evil intentions to harass her), became alarming for the female hospital's reputation, and she had to lodge a complaint against him to the Civil Surgeon.

From the memoirs we also have a clear picture of Haimabati's works as a doctor. Generally, she used to pay home visit to those women patients who were kept in rigid seclusion. If a patient needed constant medical care, she would not hesitate to accommodate her in her own family quarters, which were above the hospital. Gradually the "home" and the "hospital" began to converge in her own quarters. She brought her motherly heart to the treatment of her patients as well. Every morning

several patients used to come to her quarters and wait downstairs, she would come down with hot water and food for the patients and helped them to wash up. She was able to introduced a sense of health and hygiene among the poor patients. Her unusually detailed memoir provides a first-hand account of how an Indian woman doctor provided proper medical care to an exclusively female clientele living under the norms of seclusion.

Besides the dangers of sexual harassment that the "lady doctors" had to suffer (as exemplified by the Imambara surgeon's attempts), Haimabati's personal narrative as a record of "memory as history" also exposes other kinds of corruption in the medical profession at that time. Her most remarkable record which can claim entry to a conventional archive, was this: a child of 11 died in the hospital after marital rape by her husband – it was like the infamous Phulmani Dasi case of 1890 which triggered controversy over the minimum age of a girl-wife for the consummation of marriage[10]. This incident recalled by Haimabati occurred after the passing of the Age of Consent Act of 1891. So it was to be recognized as a criminal offence for a husband to have sexual intercourse with his child-wife until she was 12 years of age. However, Haimabati was forced to maintain silence, to prevent the matter being reported to the police. A false certificate issued by the Civil Surgeon stated that the girl was fourteen and the cause of her death was "septicaemia from normal menstruation" (334). For this, the Civil Surgeon was paid Rs. 5,000; the assistant surgeon got Rs 1,000 and Haimabati was offered Rs 500. Shocked that "they had taken a bribe and given a false death certificate", she refused to accept the money, but her superiors bullied her to take it, despite her protests. Eventually, however, what disturbed her more was what her husband would think of her, if he knew that she had

accepted the bribe-money. According to Indrani Sen, “In other words, fear of the husband’s disapproval, seemed stronger in her than a sense of moral outrage” (60).

Haimabati’s persona in the narrative reveals two contradictory aspects of her position and situation in the social and medical history for women in 19th century Bengal. In a sense she was radical, taking decisions for herself, rejecting Brahminical Hinduism, remarrying a Brahmo, and pursuing at great risk her ambition to get educated and become self-sufficient. During her wanderings in search for education and a better life, after she left Benares, she met a woman “ruined” and deserted by the man she hoped to marry. Haimabati immediately becomes sympathetic and calls her “sister”, showing true female solidarity. From her own experience of being a child-wife, subjected to the traumatic experience of a middle-aged man’s lust and attempted marital rape, she had grown quite outspoken against the custom of child-marriage. Her critique of the conditions of child-widows is even sharper, and rather radical, coming from a woman at that time: “Shame on you, Hindu society, great is your glory! A girl of ten will have to pay for the marriage of an old man of fifty. I bow a thousand times at the feet of parents who would in this way turn a daughter’s life into a desert” (98).

As a lady doctor, Haimabati does not conceal her grudge against the monopoly and power enjoyed by her male colleagues. In one instance, the senior male doctor was paid Rs 1,000 for a case of delivery; he gave the midwife Rs 100, while the lady doctor (Haimabati) got only Rs 50. Recalling this kind of gender-discrimination in her profession, Haimabati complained in her memoir: “Lady doctors and midwives were but pawns in the hands of the male doctors …when I thought of these things, I lamented the fact that we were born as women” (317). Nevertheless, in her household

matters, she remained a good wife and mother, who managed both *ghar* and *bahir* and handed all her earnings regularly to her never-do-well husband.

The impression the reader gets about Mr. Sen is not a good one: initially he appears to be an idealistic missionary who married a widow considering it a part of his noble mission, but had no responsibility of a householder. Later in the narrative, he shows the true colours of his male ego, abusing Haimabati for nothing, beating her at times, and jeopardizing her professional life. At one point he got involved in a brawl with Haimabati's superior at her workplace, and it was she who saved him from a legal action, by apologizing for his conduct. He knew that he would never be able to earn himself, yet it was no longer bearable to his male ego to live on his wife's income. Haimabati does not use any harsh word to describe these feats of her husband, but her sense of irritation is not always hidden, though she tried to wear a stoical calm and accept everything as God's will. Her willing compromise with her husband's abuses shows how internalized patriarchy could be: being otherwise so self-sufficient she kept herself subservient to the man who, she believed, showed the "generosity" of remarrying her and providing her with a respectable status in society. These contradictions and complexities in Haimabati's life, also noticed by Indrani Sen (60), point towards an intriguing paradox in feminist history. Her struggle for identity, extraordinary despite all these contradictions, shaped her personality in two ways: by resisting patriarchy and by compromising with it.

Regarding marriage and family affecting or problematizing lady doctors' career in 19th century Bengal, there are some general agreements that married women had to sacrifice their professional life to a greater extent than unmarried women. Virginia Mary Mittter's case corroborates that, and the sacrificial story of another married lady doctor named Sushila Devi was published in *Bamabodhini Patrika* (Deb

118-19). Haimabati was a Hindu widow who converted to Brahmoism and got remarried. Although she had a long career, she suffered a lot. On the other hand, Bidhumukhi and Bindubasini Basu and Jamini Sen remained unmarried and were supposedly free to have independent and long careers. However, Jamini's life was exceptional which refuses to fall into so generalized a division. For Jamini, the notion of "family" was wider, more nuanced and equally binding. She willingly devoted herself to a larger family which included not only her parents, siblings, their children but also so many orphans and destitutes she took care of. She had other kinds of problems in her career, in professional and gendered terms; and it was mentally very stressful for her to bear the agonies alone, due to her extremely introvert and brooding, sensitive nature. During her lifetime, her innermost pangs, desires and needs were hardly revealed even to her close relations, and she did not allow her personal documents like memoirs and diaries to be published. It was only after her death that her elder sister Kamini Ray published a short biography of hers, "Daktar Kumari Jamini Sen" ("Doctor Miss Jamini Sen") in *Bangalaksmi* in the Bangla Sal 1339, from Baishakh (April-May) to Shravan (July-August). Kamini quoted at length from Jamini's notes and papers that were so far concealed. Her memoirs were written both in English and Bengali, and Kamini translated the portions which were originally in English, into Bengali. Although some of Jamini's Bengali writing were made available to us by her sister, her original English writings are difficult to come by. So I have no other option than to retranslate them here. The relevant issues of the periodical are at present available at the Bangiya Sahitya Parishad Library, the Jatiya Siksha Parishad archive and the Gurusaday Datta Folk Art Society, in parts—which, when taken together, make a whole[11]. In 2005, the short biography of Jamini Sen, compiled as a whole, was included in a book, *Kamini Rayer Agranthita*

Gadyarachana (*Uncompiled Prose Works by Kamini Ray*), published by the School of Women's Studies, Jadavpur University. Citations are used from this book, because it is convenient to cite from one source, rather than from three different issues of a periodical.

Jamini was born in 1871, the second daughter of Chandicharan and Bamasundari Sen. Chandicharan was a Brahmo and supporter of female education, but he was against the medical career of women. He wished that his daughters would rather go for literature and teaching. This shows how even among the advanced Brahmos, studying medicine was considered less respectable than studying literature. The elder sister Kamini wanted to study medicine but stepped back with a sigh; she did not have the strength of mind to pursue her dream against her father's will. Jamini was different and more confident about choosing her own way. However, Kamini helped her sister in doing what she herself could not do, she supported Jamini to convince their father.

Jamini entered the Calcutta Medical College in 1890/91 and bore herself in a manner that kept all discourteous male colleagues at bay. As Kamini Ray writes, "Her dignity was such as her male colleagues were hesitant of coming to her […] even to discuss necessary matters" (62, English translation mine)[12]. Jamini passed in 1896 (Kamini gives the year as 1897) and tried to have a practice in Calcutta, but she found that "people do not call lady doctors in general; if only the male family physician is not available, a lady doctor recommended by him can be called. There is also injustice regarding fees". It was unbearable for the self-reliant Jamini to depend on male doctors to get a "case". So she went to Solapur, and then to the newly founded Women's Hospital in Nepal, in 1899. From this time, her life was also one of constant movement, trying to find a "home" in the hospitals and among the patients she

worked for, but never having peace of mind and satisfaction. In Nepal, alongside her hospital duties, she privately treated the Royal family. As a lady doctor, she had easy access to the *andarmahal* of Maharaja Chandra Samser Jong, and the royal ladies would try to get intimate with "Daktarin Miss Sen", but she would never disclose to others what she heard from inside. Kamini Ray as an educated Brahmo lady and a poet maintained decorum and propriety in her language, while describing Jamini's experience in the royal andarmahal. Under the colonial lens, the Oriental zenana was seen as a place of darkness, dirt, disease and scandals, which was notorious especially in aristocratic and royal families. In this light, one may read Jamini's dignified silence and speech-control as a hidden archive, powerful in its impenetrability rather than its potential for disclosure. Due to her illness, she resigned from her job and came back to Calcutta in 1909.

Soon she felt the necessity of acquaintance with the new developments in medical science. Her patriotism was strong, and being an introvert and a reserved person, she did not feel comfortable at all to go to Europe and live among unknown people if it was not for acquiring better and higher education, and applying it to the health-care of the women of her country. Kamini Ray quotes from Jamini's memoirs:

> Science is constantly developing but I have not been able to keep pace with time. The time so wasted must be restored. The scarcity of female doctors is a major problem in our country. Good female physicians are needed for gynaecological matters. Since my student life, Operative Surgery and Gynaecology have progressed a lot, so if I really wish to help my native sisters, I should learn the modern methods … study and observe them in specialized foreign institutions. (64)

The clarity of her thought and the nobility of her motto are remarkably evident from her own writing. In 1911, she started for Europe. Her memoird, unlike Haimabati's and like those of Janaki Majumdar and Sorabji, has some elements of transnational (if not diasporic) experience, at least on temporary basis. She agreed to write about her journey at her elder sister's request, but could not find time to write much. From Dublin she got the LM degree, and from Glasgow University passed the fellowship examination and was awarded the Fellowship of the Royal Faculty of Surgeons and Physicians. According to Kamini Ray, Jamini was the first Indian woman to be awarded this fellowship. The next year she went to Berlin to have further experience in the processes of treatment and surgery. The sudden death of her adopted daughter caused her to return from Berlin. This girl was a strong bond for an unmarried mother-figure like Jamini, and her death was a severe blow which almost shattered her, made her doubtful of God's Grace, and finally led her through a traumatic phase to a spiritual and philosophical understanding of life. To illustrate this, Kamini Ray quotes at length from Jamini's own memoir, which being too personal, may not reflect any historical concern or even facts about her medical career, but will provide an insight into her heart. Jamini wrote this portion of her memoir on her return sea-voyage. She was by that time exhausted of lamenting her loss, and God's injustice on her lonely life. The sea—the archetypal symbol of the ebb and tide of mortal life – had however a soothing effect on her soul. One night, she had a dream: a Divine Presence seemed to be consoling her—

> "Listen, my child", said that glorious divine personality, " no good work goes futile. […] You are given tenderness, affection and sympathy: dedicate these to the noblest cause […]

> The soul is immortal, she (the dead child) will live in your memory. For her sake, try to bring happiness to other children, so that she, though 'dead' for this world, will remain in your heart as an inspiration for your noble work. (K. Ray 67, English translation mine)

This dream-experience inspired her to extend the idea of "home" and "family" into her professional responsibilities viewed in humanitarian ways. She took under her care many destitute children, whose mothers died in her hospital, and who were not claimed by any other guardian. She built a house named "Vishramkutir" in Puri, where she provided a shelter to these children, herself bearing the expense of their education, and often staying with them on leave.

Coming back from Berlin, Jamini joined the Womens' Medical Service (WMS) and in 1914; she was transferred to Agra. The whole tenure of her service is a story of displacement. She was transferred several times from one place to another, without proper reason or justice, only to serve the interest of the colonial authorities. This will reveal the helpless situation of the native lady doctors, though some of them, like Jamini were as much or even better qualified in relation to their British counterparts in India. Three British lady doctors, due to some misconduct on their part or unpleasant occurrence, were transferred from Agra to Simla in summer, and Jamini was sent in their stead. Six months later, when Jamini got settled there, the problem regarding the white ladies was solved, they came back to Agra and Jamini was transferred to Simla in that winter. In Simla, she found that no arrangements had been made for her living. She got two unused and locked rooms in the hospital cleaned and made worthy of habitation, and devoted herself to develop the infrastructure of the hospital. Her dedication to her work was such that she often considered the precincts of the hospital her temporary home. Wherever she was transferred, she was especially

careful of creating a healthy architecture around her professional identity, building new blocks, indoor and outdoor wards, saving money for buying necessary furniture like operation tables – as if, the hospital-space was her own home. The detailed account of these matters in her memoir may be seen as a different kind of architectural construction of "archive" in which she invested her sincerity and dedication.

Jamini hated to be a sycophant to the white authorities, and this created problems for her. Despite her popularity and good work at the hospital, she was again transferred to Shikarpur in 1916. The period of her service in Shikarpur is significant because it is at this time that Jamini tried to make some regular entries in her personal archive. She described in detail what improvements were made in the hospital in her time, which was later discovered by her sister in a file stowed away with a seal "Not to be opened" embossed on it. In those private documents, she recorded her work in order to judge herself, and make further decision concerning whether to stay there for the sake of her patients or ask for a transfer as the weather of Shikarpur did not suit her own health. This record, made available through her sister, speaks volumes for the dedicated service Jamini and her native colleagues rendered to the country, whose work for the most part remained unnoticed by the conventional colonial archive. Let us again see what Jamini wrote on February 6, 1917:

> The hospital has grown unexpectedly popular. Ladies from gentle families are coming to stay in paid cabins. In 1915, there were 213 indoor patients, in 1916 the number has been 478. The most remarkable improvement is about the maternity ward … here death of childbirth due to septic has been a major problem about women's health. In a short time, I have been able to bring consciousness among them. I have served them and gained their trust. If I stay

on, I will be able to help them further. Moreover, there is problem everywhere because of the British authority's interference. Shikarpur is safe and free in this regard[13]. (qtd. in K. Ray 79, English translation mine)

Due to a conflict with the authorities over her familial duties, Jamini resigned from the WMS and went to Europe for a second time in 1921. She received a diploma in Public Health from Cambridge and a certificate from the London School of Tropical Medicine. Upon her return in 1924, she accepted the charge of "Buldeodas Maternity Home" founded by the Calcutta Corporation. She worked hard to make this institution really a "home" for would-be mothers – a well-disciplined place of care, health and comfort. She trained some nurses, and wrote a manual called *Prasuti-tatva* (*Thesis on Maternity-care*). Overwork and stress affected her health; she took leave and went to Puri for a change, but even there she was invited to be associated with the local hospital. She tried to fulfil her responsibilities until she was too ill and brought back to Calcutta, where she passed away in 1932.

The two memoirs discussed here can be called "archival" in their thematic negotiation of spaces— between private sites recorded in memory and their constant correspondence with the public life of the two female doctors writing their own lives. Neither Haimabati Sen nor Jamini Sen consciously meant to write "history": for Haimabati there might have been a slight hope for getting her memoir published, for Geraldine Forbes found among her notes and papers an ambiguous reference to somebody who was interested to publish her poems and short stories. Jamini had never wished to publish hers. However, the historical importance of both memoirs, as writings by female medics in colonial Bengal, is unmistakable. It should be remembered that the notions of Western feminism should be applied with caution to such narratives in a native context. The idea of selfhood and a rejection of

submissiveness, which is traditionally seen as a feminine virtue, is a major preoccupation of Western feminism. However, both Haimabati and Jamini, despite their self-respect and dignity, exhibit a tendency towards an ultimate submission to some divine power. Their faith was not as absolutely expressed as Rasasundari Devi had done[14], but it was surely a strong source of inspiration and courage in their life. For a Hindu or Brahmo woman in 19th century Bengal, there was little contradiction between education, a scientific mind, self-dependence and faith in the Almighty, which may not be so easy to reconcile for a modern feminist trained in the Western ideas.

In feminist terms, Haimabati's memoir is a story of rare courage, integrity and self-reliance of a 19th century woman from a rural and less privileged background than Jamini's. Due to her own sufferings and narrow escapes from sexual exploitation, she is sympathetic and open-minded to the problems of other women, even "fallen women" in the eyes of society. Her opinions are quite articulate against the patriarchal oppressions in both private and public life, but her own compromises with the abuses of her second husband remains intriguing for a feminist reader. Regarding Jamini, only two points concerning the issue of "feminism" are deliberately made: that she remarkably maintained her dignity and strong character during her student-life under the co-education system, and that she never tolerated the idea of being subservient to some male colleagues to get their patronizing recommendation for a case. Her struggles against patriarchy were rather subtle and intellectual. Probably because of her well-educated urban family-background and sophistication, she did not have to face the kind of crude problems which Haimabati had to. Her moves in career and decisions which are a testimony to her strong and self-dependent character should be read as symbolic stances against patriarchy—

which may not necessarily be a male figure or institution but a symbol of authority and power. Her decision to study medicine against the will of a real father does not mean a collapse in the relationship between a father and a daughter, for Jamini remained otherwise devoted to her family, and her father seemed to have accepted her choice in due course. This choice is better to be understood as symbolic resistance. Likewise, her conflicts with the colonial authorities and the higher officers are important because the resistance came from a native woman of colour, who represents a subject seen as "triply bound" by the structures of power in a colonial state.

Finally, it may not be wrong to say that the two memoirs speak with intimacy and sincerity about the conditions of medical education for women and works done by female medics in colonial Bengal from the late 19th century to the early decades of the 20th century. The nature of education and the kind of service for Haimabati were different from that of Jamini, but both tried, in their own ways, to extend health-service among the remote, the poor, and the secluded population of their native sisters. And for both lady doctors, the professional identity was ideologically or culturally enmeshed with gender identity – both of them, being married or unmarried, a real mother or an adoptive mother-figure, could identify themselves with the archetype of Bengali woman as nurturer and care-giver, enfolded in a home-like space, within domesticity or in a professional workplace. The creation of a female protagonist's bildungsroman – though she is a lady doctor or a professional, seems to be inevitably circumscribed by the physical spaces of the "home" in its different forms, within the historical and cultural space of colonial Bengal .

Notes:

1. Geraldine Forbes "Medical careers and health care for Indian women: patterns of control", *Women's History Review*, 1994, 3:4, p. 515-16. Accessed from <http://dx.doi.org/10.1080/09612029400200067>, August 24, 2013.
2. Maneesha Lal (1994) "The politics of gender and medicine in colonial India: the Countess of Dufferin's fund, 1885-1888", *Bulletin of the History of Medicine*, 68 (1994), 29-66.
3. See Letter from DPI to Principal, Medical College, Calcutta, proposing the admission of women, 5 May 1882, WBSA, General Education, March 1886, A 5-7, quoted in Samita Sen and Anirban Das, "A History of the Calcutta Medical College and Hospital, 1835-1936" in Uma Dasgupta (ed.), *Science and Modern India: An Institutional History, c.1784-1947*, New Delhi:, Pearson Longman 201,pp.496-8.
4. One of the early activists among the European lady doctors working for India was Mary Scharlieb. Her accounts however did not appear in publication till the early 20th century. Her autobiography called *Reminiscences* (London, 1924) discusses the early phase of struggle for medical education among women in the 1880s.
5. See also Himani Bannerji, " Fashioning a Self: Educational Proposals for and by Women in Popular Magazines in Colonial Bengal"; *Economic and Political Weekly*,1991, 26,43.
6. One of the most remarkable memoirs by 19th century women is by Rasasundari Devi, *Amar Jjiban*, in Nareshchandra Jana et al. (eds.) *Atmakatha*, Vol.1,Calcutta, Ananya Prakashan, 1981.
7. Sekhar Bandyopadhyay, "Caste, Widow-Remarriage and the Reform of Popular Culture in Colonial Bengal" in Bharati Ray (ed.), *From the Seams of History: Essays on Indian Women* (Delhi: Oxford University Press), 1995, pp 8-36.
8. I have given merely a summary of the early medical education for women in Colonial Bengal, only as far as it is relevant for my project. Detailed works on this have already been done, for example: "Education to Earn: Training Women in the Medical Professions", and "Medicine for Women: 'Lady Doctors' in the Districts of Bengal" in

Geraldine Forbes, *Women in Colonial India: Essays on Politics, Medicine, and Historiography* (New Delhi: Chronicle Books), 2005; reprinted, 2008, pp 114-17 and pp 121-33. See also Antoinette Burton, "Contesting the Zenana: The Mission to Make Lady Doctors for India, 1874-1885", *Journal of British Studies,* Vol. 35, No. 3 (Jul., 1996), pp. 368-397, and Sujata Mukherjee, "Medical Education and Emergence of Women Medics in Colonial Bengal", occasional paper, August 2012.

9. See Antoinette Burton's chapter on Cornelia Sorabji in *Dwelling in the Archive*: *Women Writing House, Home, and History in Late Colonial India*. New York: Oxford UP, 2003.
10. Discussed in Tanika Sarkar, *Hindu Wife, Hindu Nation: Community, Religion and Cultural Nationalism*, 2001; Reprinted (New Delhi: Permanent Black), 2005, pp 191-225; and pp 226-49.
11. Some issues of the *Bangalaksmi* have been digitized by the Digital Library of India. I am grateful to Smt. Anindita Bhaduri of the School of Women Studies, Jadavpur University for helping me to download the pages featuring the memoir.
12. English translations from "Daktar Kumari Jamini Sen" are mine.
13. Shikarpur was a place of high temperature and therefore not suitable for the British. The white officers refused to stay there and only native medical officers were sent there. So there was freedom to work and a better work-environment.
14. See Tanika Sarkar, *Words to Win*: *The Making of Amar Jiban, a Modern Autobiography*. Delhi: Kali for Women, 1999.

Chapter 6

Doctor-Patient Relationship in Literature: Visions of Life, Mortality and Healing across Cultures

> "Two distinct and separate parties interact with one another – not one mind (the physician's), not one body (the patient's), but two minds and two bodies."
>
> – Jay Katz, *The Silent World of Doctor and Patient* [1]

The doctor-patient relationship is the primary mode of cognition that is at the heart of the discourse of medicine and bioethics. Healthcare is constructed around encounters between practitioners and patients, and the relationship between them is integral to how the cultures of healing are at work and represented in literature, in history and social sciences around the world. Life and mortality are two great questions of being that perennially haunt the human existence; and physicians play the most significant role in negotiating between the physical and the metaphysical worlds of being, suffering and trying to find cure and comfort as long as life goes on. The cultures of healing across time, space and nationality — explored however differently by medics, philosophers and literary artists, illustrate the social and cultural history of man struggling in a world afflicted by maladies – physical, social, spiritual. This is precisely the larger setting in which doctors have to locate their position. Throughout the previous chapters, what seems to stand out is the question of literary bioethics, that is, how the doctors/healers perform their narrative journey within a text, and in the social-cultural sphere to which they belong. Several issues related to doctoring have been discussed so far, with close references to some literary texts where medic-figures play the central, or at least some significant role. A selection of British and Bengali texts has helped the present researcher look into the cross-cultural dynamics

of the medical role in its variegated aspects. Now it becomes inevitable to go back to the research question stated in the Introduction: how far is it possible to discover affinities, despite obvious differences between the different cultures of healing and their social manifestations? In other words, is it possible to find elements of a comparative bioethics, concerning the philosophy and aesthetics of healing in India and in the West?

With the gradual disciplining and institutionalization of empirical sciences in the West in the eighteenth and nineteenth centuries, "seeing" the world through the lens of rational and scientific observation came almost exclusively under the domain of medical gaze. This is Foucault's famous observation in *The Birth of the Clinic* (as translated into English in 1973) where he illustrates the doctor-patient relationship in terms of power, and the subject-object hierarchy. The diseased body is in disorder, in a state of displacement, and its subjectivity is erased as it becomes subject to the doctor's examination. In several literary works of the nineteenth century, such representations of doctor-patient relationship are to be found as corresponding to the Foucauldian pattern, that is, turning the patient's subjectivity into an object of the doctor's authoritative gaze. However, since Foucault himself has elsewhere insisted on the double meaning of "subject" (1982: 212), it is possible to problematize the doctor-patient relation and attempt to come to terms with one's own subject-object position within the established discourse of medical gaze. It is interesting, however, to examine how literary representations of doctor-patient relationships across cultures and nationalities have interrogated the notion of "seeing" as an alternative mode of vision.

Opthalmology as a special branch of medical science established itself quite seriously in the Victorian period. Wilkie Collins' *Poor Miss Finch* (1872) is a

"medical surgical novel", and the surgery is operated on the eye. Beneath the story of medical administering of a reluctant female patient by male guardians and an authoritative male eye-specialist, there are more complex concerns of power and subversion, appearance and reality, light and darkness which are metaphorically parallel to truth and deceit and gender-relationship in the Victorian society. Oscar, Lucilla's lover has been treated with chemicals causing his fair complexion turn bluish, and despite her blindness, Lucilla has a strange aversion to dark shades. Nugent, Oscar's identical twin plans to win her affection: he calls a German specialist for her treatment. Though hearty, well-meaning, and confident of his opinion, this benevolent doctor is nevertheless complying with the exploitive and deceitful male gaze of Nugent that is always watching Lucilla, and planning to present himself as Oscar in front of her restored eyes. Thus Nugent is using the doctor's gaze as a means of winning Lucilla for his own purpose. Both Nugent and Dr. Grosse are engaged in treating Lucilla in a way that becomes a subject-object discourse, rendering Lucilla, both as patient and woman, objectified.

The doctor warns the patient's family and friends that her nerves should not be agitated by letting her see such people as may be shocking to her. Though his medical apprehension is correct, he fails to see Lucilla's subjective "I", which is more valuable to her than the visual eye. She wishes herself to be blind again, for some intuitive vision tells her constantly that Oscar is no longer the same as he was. In reality, the person who poses as Oscar is Nugent. A terrible sense of deceit, doubt and dissatisfaction with Nugent-as-Oscar strains Lucilla's sensibility to the extreme of spoiling her recovered eyesight again, which undermines the power of medical gaze and ministering. However, her loss ultimately proves to be her gain, when she is reunited with Oscar, and considers it a bliss not having to look at his discoloured

body, but to stay satisfied with the image of his true love which her inner eye only can "see":

> I wish to see him—and I *do* see him!—as my fancy drew his picture in the first days of our love. My blindness is my blessing. [...] it keeps my own beloved image of him—the one image I care for—unchanged and unchangeable. […] I look back with horror at what I suffered when I had my sight—my one effort is to forget that miserable time. (445-6)

Dr. Grosse, however, sticks to his own opinion, and persuades Lucilla to let him try another surgery: "If my operations had failed," says the German doctor in his peculiar English, "I should not have plagued you no more. But my operations has [sic] not failed: it is you who have failed to take care of your nice new eyes when I gave them to you" (431). Lucilla refuses to undergo a second operation, and when Madame Pratolungo adds that Mr. Sebright (the family doctor whose opinion differed with that of Dr. Grosse about the success of the experiment), and another competent authority called for consultation "declared unhesitatingly that she was right", going on to ask, "Which was in the right—these two or Grosse—who can say?" (432). Such confusing nature of "rightness" tends to question the true value of medical perception itself. The medical gaze is no absolute and monolithic power to determine the "truth" about a suffering subject.

Lucilla's refusal to Dr. Grosse can be interpreted in a deeper way than the reason she gives concerning her love: she will not commit herself to medical administration again, since the first experiment has disillusioned her about the darker realities of a deceitful world, more abominable than a bluish complexion. Now that she has found her love again, it is better to go without eyes. Her resistance to any further medical assistance posits a challenge to the doctor's eye, which may diagnose

the ailment only at the physical level and provide a temporary cure. At the end, Lucilla is happy without her eyes, she has found her way to be the subjective "I", and learned the truth of self-healing, independent of the controlling medical gaze.

A thematic affinity can be recognized between Collins' *Poor Miss Finch* and Tagore's "Dristidan", though it was rather unlikely that Tagore had familiarity with the former text. The concept of the "inner eye" gets a more profound treatment in the light of Tagore's aesthetic philosophical vision deeply influenced by India's time-honoured traditions of spirituality. The ophthalmic metaphor of seeing is central to the short story "Dristidan" (1898). It is written in the first-person narrative of a doctor's wife, Kumu, who has lost her eyesight due to her husband's wrong treatment. The repentant doctor-husband seeks to compensate this loss with a vow of never-failing love and care to the blind wife. He also calls her "my Devi", for the pain and loss she calmly bears in order to alleviate his burden of guilt. The wife, overwhelmed by the husband's love and sincerity at that point, accepts this deification through her loss of the external eye, and the opening of the "third eye" which, in the Indian spiritual and philosophical tradition, symbolizes the "inner vision".

In reality, the deeper grows Kumu's insight into the ways of everyday life, and sharper her moral understanding, she gradually becomes aware of the widening gap between herself and her husband. At other points in the story, the doctor's professional attitude slackens, and he appears to be morally effete, negligent of his duties and medical ethics, while remaining afraid of the superior virtues of his deified wife. Whenever he bears a guilty mind, whether in his practice or private life, he feels that the wife's eyeless gaze is all the time surveying him. The story ends with the doctor almost on the verge of forswearing, but finally coming back to his wife again with a renewed love and understanding. Though the plot is basically domestic, the

doctor's professional status is of no little importance as far as the story can be read as an interesting counter-narrative to what Foucault would call the "doctor's gaze", or "clinical gaze". The doctor-figure is usually associated with the empirical, scientific gaze – which represents the clinical eye's rational, scientific power and authority over the diseased, the deviant, the anomalous. Here the doctor-husband's clinical and personal control over the wife's well-being proves to be a failure. In a sad but profound irony, the wife, losing her eyes, seems to achieve her "vision" which has a certain power and dignity – a terrible and godlike state above the mean and the quotidian. Now she is able to "see", judge and try to correct her husband's moral, personal and professional follies, his tendency to fall into temptation and corruption. The wife's eyeless yet visionary gaze over the husband's life, which the man desperately seeks to ignore by almost breaking his vow, but ultimately cannot ─ seems to reverse the usual order of the male gaze over the female body. So in "Dristidan", the doctor-husband's failure to take care of the patient-wife's eyesight and his consequent repentance coupled with promise of steadfastness in love, helps to open her inner eye. Now she takes up the challenge of ethically "doctoring" the doctor's way, trying her best to keep him away from the diseases of folly and meanness. In both texts, the patient's subjectivity becomes an impetus to her agency, and enables her to experience "healing" from within.

Tagore understood healing as a divine experience of being relieved from the sickness, narrowness and stagnation of a material and mechanical existence. In his letters he wrote how the vast openness of the Padma banks brought a healing touch to his care-ridden life. For him, healing was an experience aestheticized and humanized by nature, art and human love. The doctor-patient relationship in his "Malyadan" exemplifies this. While medically examining the orphaned girl, "Kurani", brought up

in his cousin's family, Jatin-daktar is embarrassed by his light-hearted cousin's repeated jocular attempts to "marry" the two, instigating the girl to garland the doctor. The course of life separates and reunites them: after a long time, doing his duties in a plague-hospital, the doctor suddenly finds the girl as a patient. He takes her to his own quarters, and does his best, but Kurani's condition has been too critical for recovery. Sitting face to face with the dying patient whose innocent admiration he once neglected, the doctor finally accepts that withered garland which Kurani has been carrying as a token of old memories. The girl dies the next morning, and looking at her calm and satisfied countenance, the doctor contemplates: "[God] has taken what is His own, not depriving me, too" (384, translation mine).

Tagore's most enduring portrayal of doctor-patient relationship, however, appears in his celebrated play *Dakghar* (*The Post Office*). Written in 1910 (and translated into English by Devabrata Mukerjea, published by Macmillan in 1914) the play is a symbolic-allegorical representation of spiritual healing: the diseased, confined and circumscribed soul of humanity seeks relief from the sickening material world of mortal existence. The ailing boy Amal, confined to complete bed-rest but always yearning for freedom, serves as a symbolic representation of the human soul desperately craving its way to eternity. The two physicians (*kavirajas*), representing two different worldviews, stand for the dual aspect of treatment (*chikitsa*) and healing (*arogya* – in the sense of freedom from ailments).

The first physician seeks to maintain the authoritative discipline of treatment; he prescribes that the sick child must be kept inside. Access to open air is strictly forbidden. All the time the physician cites the scriptures, to authenticate every restriction he imposes upon the boy. Amal's uncle, Madhav is rather sympathetic; he

tells the physician that it is very hard to keep a little boy indoors all the time. The physician replies:

> What else can you do? The autumn sun and the damp are both very bad for the little fellow for the scriptures have it:
>
> " In wheezing, swoon or in nervous fret,
>
> In jaundice or leaden eyes ─" (Tagore 1914: 5)

Madhav as a layman believes in conventionality and obeys the physician. Amal, however, struggles to find a way to communicate with the pulsating life that runs around – in the world of nature and living beings. The open window becomes a symbol through which his imaginative mind can assert its freedom from the limiting adjuncts of the sick body. He learns from the watchman who moves in the street that the king has launched a new post-office to communicate with his subjects. Amal believes that the king's letter will come one day, carrying the message of his freedom. His only desire is to get well and become the king's postman. Finally the royal physician comes to announce the arrival of the king. As he offers to attend the sick boy, we notice a marked distinction between his approach to treatment and what was done by the former physician. He enters the sickroom with a call for openness and freshness, which appeals directly to the patient's spiritual craving for perfect health. Immediately a bond is set up between the doctor and the patient — a bond that is both secret and sacred. This is clearly shown in the conversation between the royal physician and Amal:

> State Physician: What's this? How close it is here! Open wide all the doors and windows. [Feeling Amal's body] How do you feel, my child?

Amal: I feel very well, Doctor, very well. All pain is gone. How fresh and open ! I can see all the stars now twinkling from the other side of the dark. (83)

Knowing that Amal is going to die, the royal physician lets him have his will. Death here does not mean a cessation, an end in itself, but a beginning of a new order of being, a transport to the "other side of the dark". The word "death" is absent from the last scene; "sleep" has replaced it. As Amal drops into "sleep", the royal physician ritualizes the situation in a highly evocative, poetic language: "Now be quiet all of you. Sleep is coming over him. I'll sit by his pillow; he's dropping asleep. Blow out the oil-lamp. Only let the star-light stream in. Hush, he sleeps" (93).

Critics differ regarding the nature of death as represented in *Dakghar*. W.B. Yeats singles out deliverance as the central theme of the play; and he adds a political dimension to the spiritual allegory acted out in the absent figure of the king. He identifies the king with the colonial monarchy whose regime Amal transcends, by submitting his soul to the realm of the king of kings. Some critics even question the very logic of Amal's dying. K. Srinivasa Iyengar believes that Amal's death is unnecessary for the thematics of the play[2]. N.S. Iyer questions the role of the royal physician: is he a bringer of death or deliverance?[3] On the other hand, much has been said about the use of spiritual symbolism in *The Post Office*, in relation to Tagore's own faith in the Upanishadic philosophy of cyclical being. Tagore believed in the aesthetic and spiritual notion of healing in the light of his Upanishadic understanding. The death of his youngest son Shamindranath was a terrible shock in his personal life, and he found consolation and peace in the healing power of nature – a manifestation of divinity, a totality of being. Death for him was a journey to spiritual freedom. As Roxana L. Cazan observes: "Rabindranath Tagore follows the cyclical philosophy

according to which death is a return home, to a space he equates with an ocean, where life can start again: […] So is Amal's life meant to follow this trajectory, so that in death he can actually return "home" "(70).

All these approaches are thought-provoking in their own terms, but none perhaps pays a proper emphasis on the spiritual dimension of a medical relationship – that is, the communion between doctor and patient. In terms of medical humanities in a broader sense, the relationship cannot be merely concentrated on the body. David Armstrong writes, "As in the nineteenth century, reconstruction of death went hand in hand with a reconstruction of life […] a movement from natural to pathological death marked the separation of the body from nature and its constitution as an object in which could be instilled movement, behaviour and subjectivity" (94). This idea may be extended to the notion of intersubjectivity in bioethics which allows both doctor and patient, at an ideal level of empathy, share the knowledge of pain, suffering and mortality. In other words, the knowledge of death passes beyond the level of the body and sublimates itself into an aestheticization of medical understanding in spiritual terms, which sometimes can be identified with the desire for peaceful death to overcome the pains of struggling within a tormented corporeal existence. *Dakghar* itself proved to be an elixir, a performative mode of trauma-treatment during World War II, when the Polish doctor Henrick Goldsmit (alias Janusz Korczak) chose the play as a means of providing what now-a-days is known as "cultural therapy" to the orphan children of Warsaw under Nazi Germany. *The Post Office* performed in the Warsaw ghetto marked a significant moment when Tagore as a champion of universal humanity did enter "the awfulness of the contemporary history" (qtd. in Plotz 251). The Warsaw ghetto was a quarantined area for secluding the Jews as a "sick" race, who, according to the Nazi doctors, were prone to several contagious diseases. The

situation of the poor children living in Korczak's orphanage actually resembled the setting of *The Post Office*. They were not allowed to go outside because the open streets were dangerous for them. German soldiers marched there, inflicting arbitrary tortures upon the Jews. A perilous stench from abandoned corpses wafted the air; beggars huddled together around dustbins. The children, confined to the orphanage, could pathetically identify themselves with Tagore's Amal[4].

Dr. Korczak combined the attributes of both the physicians in *The Post Office*. Like the village physician, he had to keep the boys confined for their safety, but like the royal physician he was truly sympathetic to the spiritual need of the children, their longing for the open sky and a little air. His choice of *The Post Office* to be performed by the children also reflects his intellectual affinities with Tagore's idea of childhood. Korczak, a Jewish-Polish physician, pediatrician and communist-humanist, nevertheless shared with Tagore a romantic vision of childhood (Plotz 253). Tagore's *Sishu* and *Sishu Bholanath* (English version: *The Child*) celebrate childhood as a manifestation of true divinity which is essentially simple, playful, innocent and childlike. In *The Child's Right to Respect*, Korczak also writes that childhood is "white, bright, unquenchable" and "holy"; children are the "real princes of feeling, the poets and thinkers" (1929/1992:186). Besides, both were keenly sensitive to children's suffering and humiliation as a result of their personal experiences of a constrained childhood.

The performance of *The Post Office* by the sick and traumatized children of the orphanage, after all, could not bring any miraculous change in their lives. The play was performed on July 18, 1942 and all inhabitants of the orphanage were sent to the Treblinka concentration camp on August 6, to die in the gas-chambers. Dr. Korczak did not leave the children alone, he remained with them till his last breath. Some well-

wishers implored him to escape and save his own life, to which he replied: "You do not leave a sick child in the night, and you do not leave children at a time like this" (qtd. in Betty Lifton, *Life and Death*, n. pag.). Such an utterance indicates Dr. Korczak's identification with the royal physician in *The Post Office* – a friend, philosopher and guide to the ailing child, remaining with him till he breathes his last. In reality as well, the boys of the Warsaw orphanage and their physician-mentor did not break down at the face of death, just as Amal accepted his end as "one who has received the call of the open road". Newerly recounts how the children, accompanied by Korczak, marched to death: "Neatly clad in their best clothes they marched in fours, steadily, under their flag – the gold four-leaf clover on a field of green, as dreamed by king Matthew" (qtd. in Plotz 251). If Amal's acceptance of death as "deliverance" was an aestheticized, silent protest against the "hoarded world of wealth" as Tagore himself called it (*Selected Letters* 172), for Korczak and his boys it was also a protest against Nazi oppression, a protest inspired by the words written on the invitation card at the time of the performance: "We are not in the habit of promising anything we cannot deliver. We believe that an hour's performance by one who is both a philosopher and poet will provide an experience of the highest order of sensibility" (qtd. in Plotz 251).

When asked why he chose the play, Korczak replied that he wanted the children learn how to face death without fear.[5] Here lies the universality of Tagore's text. A real-life doctor's sympathetic attempts to provide some kind of spiritual solace and confidence to the traumatized childhood fated to perish in the concentration camps thus brings together the clinical, the psychological and the spiritual, lending a universal and humanitarian significance to doctoring as more than a profession: it is

indeed a profound perspective of life, experienced through trauma, suffering and death, in search of some greater truth beyond.

Going back to the social history of modern Bengali literature in the inter-war period, it can be said that a major change took place in the aftermath of the First World War. The effects of the War had been rather indirect in the Indian context; the experience was disturbing but not so shattering and horrible as it was for Europe. The change was felt more in the field of social economy, lifestyle and professions than anywhere else. The medical profession represented in literary works of the 1920s often tended to reflect the economic pressure on the medical market, grossly affecting the physicians' professional ethics. The identity of the Bengali *daktarbabu* in the fictional works published during the late nineteenth and early twentieth century got shaped through some complex dynamics of colonial and cultural interactions. As we have seen in chapter 4, medical professionalism gradually found its position and recognition in colonial Bengal chiefly on the basis of two aspects: the inclination to scientific truth and perception claimed by its gentlemen-practitioners (a considerable number of them coming from the enlightened middle-class families), and the philanthropic orientation towards an understanding of life and human condition as a whole. Looking at the literary representation of the daktar-figure as a cross-cultural entity is therefore not a simple matter of character-analysis. It becomes rather a discursive practice in which an individual, or a character-type becomes the social and cultural index of measuring reality as manifested by literary insights, as one may recognize in Manik Bandyopadhyay's universally acknowledged magnum opus – *Putul Nacher Itikatha*.

Sashi daktar in *Putul Nacher Itikatha* finds himself caught up in the claustrophobic world of sickness, limitations, suffering and mortality in a typical

feudalistic village. A disinterested, scientific and somewhat naturalist approach towards life and its demands on helpless human beings, viewed through the perspective of a doctor-protagonist has been a common critical framework of reading the novel. *Putul Nacher Itikatha* deserves a position in the canon of "the mainstream world literature in its sources of conflict: father against son; education against tradition; village against city; man against fate and the inexhaustible enigma of woman and man" (qtd. in Bhattacharjee 13), as expressed in the introductory note to the novel's English translation, published by the Sahitya Akademi in collaboration with UNESCO. The emergence of Manik Bandyopadhyay in the world of modern Bengali fiction marked both a welcome continuation and a radical departure from the urbane, modernist and post-Tagorian cult of the "Kallolians".

The plot of *Putul Nacher Itikatha* is woven in a rich and layered pattern of relationships, desires, choices and needs within a limited and apparently stagnant rural society. However, the novel foregrounds the doctor-figure's individuality along with his professional and character-specific stance towards life as a narrative strategy of raising and negotiating a series of questions – scientific, psychoanalytic, philosophical and even existential ones ─ about the mystery of "life".

Sashi, a native of the village Gaodia, comes back from Calcutta as a newly passed-out doctor who aspires for a better, urbane and sophisticated life. But circumstances keep him stuck to the village. His initial reaction to the stagnant and unhygienic village-life is one of despair and ennui – "These illiterate men and women, ponds and dams, groves, woods and fields – must he spend the rest of his life here?" (Bandyopadhyay, *Itikatha* 13, translation mine)[6]. Sashi wishes to leave the village but gradually he feels himself inevitably circumscribed by the rural world with all its drab

monotony and meanness. His student-life in Calcutta has given him some kind of enlightenment, but the basic structure of his character is rustic. These two aspects of his character create an insoluble crisis in his life. As a young and enthusiastic mind committed to scientific studies, he seeks to learn and explore the mysteries of human pathology and psychology. But does he really know his own mind, or of those who are around him in the rural setting? The "Araby"-like image of "Calcutta" – the symbolic "heterotopias" with its alluring features of modernity and a kind of bourgeois romanticism that appeared to be so crucial to the middle class ambition in the 1930s – seemed to beacon Sashi to a life of individual success and achievements. Bandyopadhyay has brilliantly depicted his frustration and despair after coming back to the narrow, unhygienic and superstitious claustrophobia of the feudal-agrarian village community. He tries to introduce the basic principles of healthcare and create awareness about hygienic habits in the village, but fails. It takes a long time to make him understand that life in Gaodia is no less intriguing as an arena for the human drama. Against the backdrop of an apparently stagnant rural society, the reader is drawn into the hitherto undiscovered mystery of life rendered through complex relationships and characters.

Sashi's role as a doctor gives him a special advantage to enter into those complexities of village life which otherwise could have been unknown to him. However, the "privilege" which he enjoys as "daktarbabu" sometimes becomes a hindrance to his spontaneity as a human being. His education and sophistication make him both adorable and distant to his neighbours. He feels the gap in relationship every now and then, whenever he seeks to assert himself as a dutiful physician and man of science. Clashes between modern medical science and the age-old native traditions of healing become evident when Sashi takes the responsibility of curing the local

Kaviraj's wife, suffering from a deadly small-pox. Jamini Kaviraj, out of a shrewd jealousy, wants to keep his young wife untreated and makes all kinds of mean attempts to stop Sashi from treating her. Sashi's father, Gopal, who is alleged to have been engaged in some kind of illegitimate relationship with Jamini's wife, makes obscene remarks about his son's "advances" towards the same woman. The way Sashi continues to fight the disease as well as antagonism from both Jamini and Gopal, can be read as an Oedipal struggle against the old and the traditional – the "father-image". He is finally able to cure Jamini's wife, but the disease has already damaged her good looks and one of her eyes. Earlier, Sashi and Jamini's wife did have a kind of genuine affection towards each other: Jamini's wife said once: "You are almost a son to me" (Bandyopadhyay 1970: 33). Now that her life is saved, she turns into a nagging and irritating patient, repeatedly complaining that the doctor has not paid proper attention to her case. Sashi feels disturbed and tries to avoid her. At one point she asks, "You had so much tenderness for me, where is that now, my son?" (109): The question brings out the eternal dilemma between appearance and reality, head and heart, professionalism and the human philosophy behind it. Sashi's partial success as a doctor throws him into the irrecoverable incompatibility between personal and emotional expectations and the professional limitations.

Manik Bandyopadhyay conceptualized his doctor-character to be a "mercenary soldier" in the constant struggle between man and what is "more than man", life and death, disease and well-being. The word "mercenary" does not necessarily suggest something derogatory, rather it adds to the abstract and wide-ranging concept of "healing" a concrete, material and even personal orientation. A doctor is a man whose duty is towards his science and society, his profession, and above all, towards himself. His failure or success affect him more than what the others

say about his work. However, his notion of professional dignity remains vague and often confused: he does not know that he actually wants to maintain his own image to himself. There are unscrupulous people like Bhuban Barujye (Bannerjee) who represent the old feudalistic and self-serving rural gentry, and take a village-doctor's service for granted. He continues to employ Sashi to treat cases in his family, but never pays his fee. Sashi has treated most of the cases successfully at the cost of medicine out of his own stock; only one case of death by accident he has not been able to prevent. Years after, under a stressed condition of mind, he suddenly gets impatient and demands his fees before the Bannerjees leave the village forever, but the situation makes him feel ashamed about it. The sight of the bereaved mother whose son he could not save, stands above all other things that caused his bitterness ─ ingratitude and exploitive attitude on Bhuban's part. The image of human suffering epitomized in the figure of the mother who has lost her child seems to reproach the doctor's professional attitude now, as he insists on money. So his professionalism and humanity seem to be at odds all the time, and he finds the conflict entering into his personal relationship with others, including his family members. Children in villages are often given to careless parenting, resulting in unhygienic habits, and many of them suffer from overfeeding or underfeeding. Sashi begins with his own household, and tries to convince his family members about the necessity of maintaining balanced diet and proper care for children. His efforts are met with scorns and suspicions, and his father gets disturbed: "Does he wish to do daktari within the family?" (71) Sashi's soldier-like zeal to fight against disease – both pathological and moral, receives the most significant shock when he fails to cure his own sister, physically and mentally shattered as a result of a forced and corrupted marriage. Bindu's health does not improve under the affectionate care of her doctor-brother, nor is her mind at ease; she

feels herself alienated in the parental home and finally goes back to her brutish husband.

The most enigmatic aspect of Sashi daktar's helplessness in balancing professionalism with personal feelings is embodied in the character of Kusum. Her husband Paran lacks authority and confidence, and he depends much on Sashi's judgements both as family-physician and friend. Kusum often calls on the doctor to consult her "pains", posing a strange kind of attraction for him: Sashi cannot understand how far her "pains" are pathological or conscious efforts to draw the man within the physician and thus express her love. When Kusum stands close to him and asks, "Why is my body so ill-at-ease, Chotobabu, when I stand beside you?" (93), Sashi misunderstands her completely, and contemplates, "Don't you have a mind, Kusum?"(93). He mistakes Kusum's love as some kind of unbridled mental disturbance, and takes on the role of a counselor. In his repeated attempts at doctoring the mind of Kusum, Sashi comes to learn how much his own mind is in need of proper health.

Sashi's response to Kusum's love is one of hesitation and confusion. This continues for ten years and finally Kusum's love for Shashi gets blunted for want of mutual sympathy and reciprocity. Kusum leaves the village, and things become unbearable for Sashi; he also decides to go away and begin his life anew. The birth of his father's illegitimate son, whom Sashi himself as a doctor has brought out of the womb, becomes a moral and existential crisis for him. He longs for leaving the village and makes arrangements accordingly, but circumstances thwart his aspirations and blocks his way. "Inexorable forces that shape the destiny of man compel him to stay and join the puppet dance of the village's dull residents" – says Nirmal Kanti Bhattacharjee (14), echoing the common critical stance taken by several scholars who

take the title of the novel in a literal sense. The title obviously raises the question: does Bandyopadhyay suggest that man is a mere puppet in the hand of a relentless Providence? This makes the author's approach appear fatalistic, as expressed through the voice of one character, Ananta: "We are nothing but puppets, Someone sitting behind makes us dance" (184). However, the doctor-protagonist Sashi, with his scientific bent of mind, retorts: "I would like to have a confrontation with Him if I could" (184). The retort, however bold it sounds, does not make him a capable challenger against the powers of the relentless Universe: he, too, is a creature of the circumstances which he cannot control. Nevertheless, the author's own comment about the title makes it even more intriguing:

> Not the novel itself, but the title of the novel confused everyone … "Manikbabu must have portrayed human beings as puppets at the hand of Providence"… Such was the judgement of critics. But those who did not make judgements and kept the novel alive for twenty odd years, knew better. They understood that it was a protest against those who make people dance like puppets. Not a vigorous movement, but a sustained and sympathetic protest. (qtd. in A. Bhattacharya 179, translation mine)[7]

Now one may reconsider the general pessimism that pervades the wealth of critical works done on *Putul Nacher Itikatha*. If the novel is really a "sustained and sympathetic protest", where does it manifest itself within the text? Some critics have singled out the sub-plot concerning Moti and Kumud, the young bohemian couple who can ignore the stale conventions of a stagnant society, and choose a life of adventure and energy instead. There have been attempts to uphold the triumphant union of Kumud and Moti as a positive "foil" to the despairing, failed relationship of Sashi with Kusum. But does the narrative suggest nothing but failure and "existential"

crisis as far as Sashi is concerned? *Putul Nacher Itikatha* (1936) predates Camus' *The Plague* (1946), where Rieux, the doctor-protagonist at times betrays close affinities with the ways Sashi talks and feels in the earlier text, though there can be no direct influence[8]. Shashi perpetually suffers the inside/outside dilemma of belonging or not belonging to the rural community, but despite his disinterested, clinical observation of life and situations around, he is different from a Camusian existential character. He is not totally dispassionate and cynical, he is deeply in love with life, but frustration and circumstantial hindrances make him behave otherwise at times. Towards the end of the novel, we see that Sashi has found some meaning in life through his responsibility for the village-hospital.

The hospital has a history. And that history, despite its apparently self-contradictory elements, marks one important aspect of the "sustained and sympathetic" message that encourages mankind, even amongst all odds, to try and work for a better life. The hospital is founded as a memorial tribute to Jadav pundit, who had the strongest opinions against the modern medical science during his lifetime. His self-immolation itself has been an attempt to prove the glory of the ancient *Suryavijnana*, which is supposed to lend its worshipper a prophetic power to know and accept the moment of his own death, with a sage-like calmness and feeling of transcendence. Sashi, being a doctor, understood that this self-willed death (*icchamrityu*) of Jadav is actually suicide by an excessive intake of opium. Nevertheless, he cannot but forgive this falsehood, considering the sublimity that surrounds such a "glorious death". To the weak, self-centred and vulnerable common people, Jadav's death has brought an aspiration for something grand and almost divine. Sashi has learnt to respect Jadav in a different way after his death – not in absolute faith but in doubt, and overcoming it for the sake of a greater cause. Despite

their differences, Jadav Pundit had a special affection towards the young doctor, and he wished that all his material possessions and savings would be donated for the purpose of establishing a hospital, under the supervision of Sashi. The hospital, therefore, becomes an objective correlative for the synthesis of contraries: the ancient faith in the concept of a holistic well-being that can transcend the fear of death and mortal diseases, inspires and makes way for the foundation of a modern medical institution, devoted to public health and welfare in a scientific manner. The hospital has also been the only space where Sashi can find his worth rewarded. "There had been work and responsibility in [his] life, and once again life got filled up with them" (217), says the author, as if to remind Sashi that through the hospital, he can find consolation and meaning in life. The matured Sashi-daktar no longer walks at a restless pace, he plods his way slowly, in a stoical mood. His "eyes are in search of mankind" (217).

Emphasis on this humanitarian perspective was something crucial to the development of "daktari sahitya" (medical fiction) in Bengali. Sanskrit words like "Sevā", "śuśrūsa" and the like smack off a faith in the spiritual existence of mankind – they speak of a tradition that respects and gives space to the patient as an individual. The importance of "faith" in healing had been a long-sustained issue in indigenous medical practices. This was, however, not ignored altogether by some practitioners who felt an interest in alternative medicine in the West. As the eminent physician Sir William Osler wrote in 1910: "Nothing in life is more wonderful than faith- the one great moving force which we can neither weigh in the balance nor test in the crucible ... Faith has always been an essential factor in the practice of medicine" (1470).

There is a generalized assumption that modern western medicine is materialistic and based on clinical knowledge whereas the indigenous healing

traditions in the East depend much on a philosophical, spiritual concept of holistic cure. And as a result of colonial modernity, the traditional cultures of healing were gradually pushed aside. Such a clear division, however, is problematic, for medical historiography in colonial Bengal shows a curious admixture of western scientific thoughts and the dynamic pluralism amongst the indigenous medical practices. As scholars like Charles Leslie, Poonam Bala, Biswamoy Pati and Projit Bihari Mukherjee have shown, the relation between western medicine and Indian healing cultures are not to be determined in simple terms of dominance and submission. In literary representations, one may find a special kind of interface between the Victorian notions of literary/social/medical realism and the Indian philosophy based on the cultures of healing, developed as a transcendental worldview which is at the same time grounded in the ordinary and the mundane, taking into sympathetic consideration the life of the diseased, the poor and the imperfect.

Tarashankar Bandyopadhyay's *Arogya Niketan*, another celebrated novel with a medical man as its protagonist has gained almost an epic-status, since its theme is not merely contemporary or social but perennial. With a magnitude of scale, events, timescape and characterization, it is a meditation on human life and relationships in a world ravaged by the attacks of disease, suffering and above all, death. Indian philosophy has a long tradition of death-consciousness, which in turn aspires to a realization of the greater mystery behind life and creation. *Arogya Niketan* became instantly famous when it was published in 1953 in Bengali, and brought the author the Rabindra Puraskar and Jnanapitha Puraskar. Soon the novel got translated into other Indian languages, including Hindi, Malayalam, Marathi, Gujarati, Tamil and Telugu. In 1973, its English translation appeared under the title, *The Sanatorium*.

The central character of the novel is Jeevanbandhu Dutta, the last surviving member of a reputed family of physicians, respectfully called "Masai". The word "Masai" derives from the Sanskrit term *Mahasaya* that means a man of greatness or nobility. The family practice used to run in the front chamber of the physician's house, come to be known as "Arogya Niketan" or "the centre for healing". Jeevanmasai, a gifted physician who incorporates some elementary knowledge of allopathy which he learned from Dr. Ranglal Mukhopadhyay and some secret, miraculous remedies popular among the shamans, into the vast pharmacopeia of traditional Ayurveda. He specializes in "Nadi pariksha" or pulse examination; he can feel the pulse of the patient and diagnose the cause of illness, its severity and fatality. Through a deep meditation on the vibration of the life-force (*prana*) in the artery, he can perceive the footsteps of death. He is not only a great physician but also a moral counselor who has helped many of his patients gain back health by changing their injurious lifestyle, as well as to prepare the dying soul for going to rest in peace, having settled matters as far as possible.

Drawing upon the great Indian epic Mahabharata, Bandyopadhyay portrays Death as a deaf and blind goddess, created by Lord Brahma in order to keep the creation going. The colour of her body and hair is reddish grey; her footsteps can be sensed only by the gifted physician who has attained to "Siddhi" (the highest achievement in the field of a spiritual experience, or a special kind of knowledge) in the science of healing. As Jeevan's father Jagatmasai used to say: "Death has to sign a treaty with a gifted medic. Where the disease is curable, he says, 'goddess, it not yet your time, please go away'. And when life really comes to its end, Death has her right, and the physician has no more to do" (70). Throughout his life as a physician, Jeevanmasai remembers these words. A humble descendant of a Vaisnava family, he

realises his limitation, his inability to have a vision of the divine Almighty ─ "Paramananda Madhava" (God as absolute bliss), but he can experience eternity through his dedication to his vocation. The footsteps of Death – slow, sure and swift, seem to ring in his ears, and he can feel how the all-consuming embrace of Death comes to relieve the fatally ailing patient from all pains of being.

In this novel, Death is portrayed in a number of ways. During the description of a cholera epidemic, Jeevanmasai works day and night to give some relief to the sick and the dying, but seemed to fall short of the ravaging disease. The helpless situation of the village made him imagine Death as a grotesque madwoman chasing the poor human beings, flying for life. In his long life as a physician, he has seen how differently people accept death. There are people like the old hermit of the local temple, the strong-willed Rana Pathak and the old, stoical "Miasahib" (a Muslim gentleman of a reputed family) who can embrace death heroically, or with a calm smile of acceptance. Others, the weak and the guilty ones – those who have invited diseases into the body through a wrong lifestyle, do not have the mental strength to fight death, nor to accept it heroically; they die like poor and insignificant creatures. In a tragic irony of life, Jeevanmasai's own son Banabihari, a doctor himself, could not live up to the expectations of his illustrious father. He became prone to drinking alcohol and several other liaisons, which caused his premature death. There are also cases of innocent death, in which a child or a guileless youth may also fall victim to death. Modern medicine has been able to alleviate such dangers to some extent, yet the mystery of death remains largely beyond human control.

Jeevanmasai's long engagement with scenes of death experienced through the causes, types and symptoms of diseases can also be read in terms of a lover's amorous involvement with the beloved. Death appears to the hero as the elemental female, the

femme fatale. The two women in his life are identified in his imagination with *Byadhi* (disease) and *Mrityu* (death). Athar-bou, Jeevanmasai's dissatisfied, nagging wife is like a chronic disease in his life, whereas the seductive girl Manjari, whom the young Jeevan loved madly but got heartbroken by her betrayal, is compared to death. In his old age, a curious chance brings him face to face with the withered and sick Manjari, who is now a pathetic shadow of her former self. Jeevanmasai forgives her in silence and prays for her quiet and peaceful demise. He gives farewell to the idea of "Manjari as death" as an illusion, and waits for the true beloved – Death as a gateway to eternity. As his own end draws nearer, Jeevanmasai behaves like a devoted mystic, eager to consummate his ultimate union with death. He speculates in eager anticipation on her touch, and smell and sound.

The novel, on the whole is as much a reminder of human mortality as it is a celebration of live and human endeavour to fight death. In response to Jeevan's impassioned description of the helpless humanity flying from death during the epidemic, his teacher Dr. Ranglal said: "Do you see the flight only, and not the human effort to withstand death? Man has been trying to invent new modes of therapy and vaccination, in his relentless effort to battle the inevitable. Death cannot be stopped; death will remain. But man will try to prevent disease" (286).

Bandyopadhyay's depiction of the endless war between death and medical science has lent a characteristically modern element into the otherwise universal and age-old thematics of the novel. The name of the protagonist, Jeevan (life) is symbolic – his desire for life and fascination for death, in psychoanalytic terms, becomes suggestive of the dual aspect of human existence –"eros" and "thanatos". Despite his age and dignity, Jeevanmasai bears an affectionate intimacy with the simple and the ordinary. He accepts the young widow Abhaya's invitation to dine at her place on the

occasion of her "Savitribrata" – a folk-ritual performed by women in the hope that their husbands, like the mythical figure of Satyavan, whom Savitri won back from the hand of Yama, may be able to overcome the clutches of death. Abhaya who has lost her husband in this life, hopes to get him back in the next life – a long and fruitful one. Jeevanmasai as an experienced medic knows that decay and death are inevitable, yet he confirms Abhaya's simple and genuine faith in the blessed fruit of Savitribrata, as he utters the following words: "As a physician I know, Death does not care for vice or virtue; she comes through the path of decay. Where decadence is powerful, death is invincible and inevitable. Yet I wish today, time and again, let this be true: let Death be defeated by your virtue, let your husband live despite the power of degeneration in life" (Bandyopadhyay, *Arogya* 307-8).

So it is wrong to assume that Jeevanmasai has some kind of fascination with Death only, he is also a man with a profound love for mankind, the humble joys, sorrows and desires of common human beings. He has sublimated his pangs of a failed relationship into the study of Ayurveda; his knowledge and experience of treating the sick people have given him a status beyond the level of the ordinary. Yet he longs for the common things of life, as revealed in his gentle care for the young nurse Sita, his interest in doing good to the family of Ramhari, his long and pitiful glance at the old face of Manjari whom he sees again, after so many decades. And this is how *Arogya Niketan* becomes a grand meditation on human life in its fullness.

The novel also examines the perennial conflict between tradition and modernity, through the medical career and opinions of Jeevanmasai as opposed to modern medicine represented by Pradyot daktar. The young doctor seems to rage a battle against traditionalism; and he contests the opinions of Masai all the time. The old medic, though at times he gets hurt by the rough and arrogant behaviour of Prodyot, lets the young

doctor have his way. Unshakable is his loyalty to the rich heritage of the Ayurvedic tradition which he received as a legacy of his learned father, Jagatmasai; yet he has the openness to appreciate modern discoveries in medical science. Even Pradyot who wishes so eagerly to prove Masai wrong, has to admit his superior ability of diagnosis during his own wife's illness.

The philosophical core of *Arogya Niketan* lies in Tarashankar Bandyopadhyay's masterly handling of the three conceptual spheres that were at work to shape the age he has seen in his young days – an age of transition from tradition to modernity. These three spheres are science, religion and society. Set against the backdrop of a historical timescape drawn rather realistically: the novel depicts the pluralism and conflicts within the colonial social history of medicine. With a typical British Orientalism, Western scholars like Arnold and Harrison tried to show that the rapid growth of modern European medicine in colonial India pushed the indigenous medical practices to a self-defensive position. Charles Leslie contends that the growing power of western medicine in India by the beginning of the twentieth century made it difficult for Ayurvedic or Unani medicine to claim any pure, pristine or authentic strain of surviving wisdom that was still there in their repertoire of cultural knowledge. So the revivalists of the indigenous medical systems, however charged with a nationalistic spirit, had no choice but to incorporate the theories and equipments of western medicine on a comparative basis, to speak for the nobility of their systems. Ayurvedic revivalists – conscious of the changed and changing imperatives of the colonial situation and keeping in view a progressive future for modern India – were not against coexistence and synthesis between the foreign and the native traditions. It is precisely this position in which Jeevan Masai finds himself in *Arogya Niketan*. The theme of generational gap runs through the narrative, but

there is not only clash of will but also acceptance and cooperation. The old Vaidya Jeevanmasi gains respect and recognition from the young doctor Pradyot, in the last part of the novel. But it would be wrong to read it as a propaganda of celebrating the triumph of the Ayurvedic school of medicine and philosophy over the less insightful and more antibiotics-based treatments of alopathy. In fact, Jeevan in his youth nurtured ambitions to become a modern-day doctor like the bicycle-riding fashionable Dr. Ranglal Mukhopadhyay. His father, the famous Vaidya Jagatmasai was liberal enough to let his son pursue modern medical studies. The disaster in Jeevan's personal life – the incident concerning Manjari and Bhupi Bose forced him to forsake his dream, and devote himself, staying at home, to the study of their "Kulavidya" (a branch of knowledge studied and put to practice, specialized by a family through generations) – Ayurveda. But he did not give up his enthusiasm for modern medical science: he won Dr. Ranglal's approval and admiration during the diagnosis of a critical case, and despite their difference of age, they came to a friendly relationship of mentor and learner. Young Jeevan learned the basic elements of Western medicine from Ranglal daktar. Besides, as part of their family heritage he received some "totka" and "mustiyoga" – mystical medicines sacredly used by the shamans and sannyasis in rural areas. Thus Jeevanmasai's role as a medic combines insights of three different systems in his professional practice. He shows keen awareness of the astounding discoveries taking place in the field of the modern medicine, and the extent to which the advancement made by allopathy has helped in alleviating human pain and suffering. He sticks to his method of diagnosing illness, and the partly scientific and partly mystical imperatives which lend validity to his approach. At the same time he fully acknowledges, and pays tribute to the wonderful results brought about by the ongoing research and investigation in modern medical science.

Jeevanmasai, an old physician haunted by visions of life and death with all that is archetypal, mysterious and elemental in the concept of being, is nevertheless open to modern bioethics which makes the doctor a soldier against the inevitable.

Death-awareness which is at the heart of the novel, is an archetypal and universal concern. However, there are sections with topical and historical references – especially to the cholera epidemics that ravaged several parts of lower Bengal in 1905. It shows how such disasters reflected the imperial tension and anxiety, much due to the government's inadequate planning for providing palliative care to the suffering people. Pratik Chakrabarti writes in his article *Curing Cholera: Pathogens, Places and Poverty in South Asia*: "[Epidemiology] was essential to the purposes of power and governmentality. It also provided the moral continuum by linking colonial diseases with climate and culture" (n.pag.). Chakrabarti also shows how the British authorities named it "Asiatic cholera", trying to prove that the Gangetic basin was the "home" of this disease. But this attempt at localizing the disease could not hold grounds for long, and it became notoriously associated with colonial expansion itself. As Ishita Pande argues : "This was a scandal; the British Empire could no longer present itself as the agent of civilization, bringing light to benighted parts of the globe. Suddenly, it was a source of contagion, spreading disease to the civilized world" (103).

With all its historical contextualization, representation of the cholera epidemic in *Arogya Niketan* also points to a curious aspect of colonial mimicry charged with much irony. In the cholera-stricken village Devipur and its adjacent areas, there was little help from the government medical officers; perhaps the fear of contagion kept them indifferent. Only a small group of medical volunteers and some newly passed-out Bengali doctors fought the

battle. Jeevanmasai joined them and the peoples' faith in his ability as a healer had an effect somewhat therapeutic in itself. It is interesting to note that even at that time of crisis, people gave the local doctors such nicknames as "Dr. Bard", "Dr. Mannard", "Dr. Lukis" and so on – in jocular imitation of the real-life figures of British doctors working at that time in Calcutta. This is a curious case of colonial mimicry where the ironical dream of being treated by the high-class, urbane, "sahib" doctors expressed itself through such imagination of looking at the native doctors as impersonating the former.

Finding the epidemic difficult to handle, Jeevan masai rushed to Ranglal daktar, his teacher of allopathy, for consultation. He was open to the application of modern medicine whenever required, but continued to stick to his faith in spirituality and fatalism. The epidemic was so alarming that even the best effort put up by the doctors could not prevent death, though it helped to reduce the rate of mortality to some extent. So we see that besides applying Ranglal daktar's prescription, Jeevan masai joins the "sankirtana", praying for the well-being of the people, for which the staunchly scientific-minded Ranglal daktar teases him. Jeevan replies that faith is a great spiritual support in healing, and when man is so helplessly under the power of an epidemic (which he describes as an agent of Death) spirituality becomes the last resort (Bandyopadhyay, *Arogya* 141).

Finally comes the question of mortality which is universally acknowledged as a great divider between doctor and patient, the healthy and the sick, the young and the old, the heroic and the ordinary. Such divides are key-elements in any literary/cultural representation of the doctor-patient relationship viewed against the vast backdrop of life, death, questions of existence and fatalism – whether it is in

Tolstoy's *Death of Ivan Illych*, Camus' *The Plague*, Manik Bandyopadhyay's *Putul Nacher Itikatha* or Tarashankar Bandyopadhyay's *Arogya Niketan*. In light of this existential problem of illness, "the Sick Role" had been a problematic discourse for the sociologists who used to see the doctor-patient relationship as a dyad of contrasted roles in society, in terms of caring and dependence, or productivity and non-productivity, positive and negative. A variety of intersubjective roles played by doctors and patients in so many canonical literary narratives dealing with medical themes and concerns can show that the Parsonian argument that sickness always creates a problematic group of people withdrawing from social demands and expectations, and constantly seeking dependence on doctors, thus defining the doctor's curative social role in turn. In Tolstoy, doctors cannot help the patient in his journey to the unknown, the greater truth behind life; in Camus' *The Plague* Dr. Rieux deals with ennui and sickness around and within himself, sensing it as an incomprehensible question of existence; in *The Post Office*, the State Physician and the dying boy enter a relationship of some mysterious sympathies from which the others are excluded, which transports the soul from sickness to eternal rest and liberation. The "sick role" operates in dynamic ways in *Arogya Niketan*. Some patients accept death as the ultimate truth in life and resign calmly; some would fight disease heroically and sometimes get cured, sometimes do not, but celebrate the vital force of life before death, and some others behave like cowards. They invite death into their body by wrong living habits, and remain unproductive and morally weak in their social roles, both in life and death. A doctor's experience gains validity from all these kinds of connections, and he has to view life, health and mortality, development and its anomalies – all in a holistic way. And finally when Jeevanmasai himself awaits death with the calmness of a saint, the loving tenderness of a devotee and the

long-experienced tenacity of being a physician himself, the doctor-patient relationship attains to a deeper, philosophical mode of intersubjectivity.

A close reading of such narratives where human suffering and possibilities of healing viewed though the greater questions of life and death give a sense of multiple subjectivities, help us understand what the proponents of modern bioethics aim at. According to Rita Charon ,

> Awareness of mortality, although very different for doctor and patient, need not separate them. […] Instead of seeming to gloat about their own freedom from evident disease, doctors might reach to attain an equilibrium between their two deluded beliefs about death and then help patients achieve a balanced perception of their own relation to their ends. […] And yet, if death seems often to divide, it also unites as the universalizing, ultimately humanizing element of life. (2006: 25)

It is this humanization to which today's interdisciplinary mode of "Medical Humanities" commits itself, trying to bridge such seemingly polar opposites as literature and medicine. Modern bioethicists have come a long way from the Foucauldian mode of clinical authority and power attributed to the physician, or Talcott Parsons' model of "sick role" as a dependent and non-productive existence in society. If suffering is subjective, the doctor-patient relationship, at best, can be intersubjective, one depending on the other in a mutual recognition of being. Such mutual recognition is necessary in order to come to terms with human suffering, and the act of braving the conditions of sickness requires some aestheticization of experience through literary or cultural representations which would enable both doctor and patient to understand life as a shared journey and find the "truth" about one another. The conceptualization of some "aesthetics of healing" which may

transcend the limited and objective experience of sickness and mortality would also help modern bioethics look for a variety of meanings attributed to life and mortality in different cultures and modes of human experiences.

Notes:

1. Jay Katz, 'Introduction', *The Silent World of Doctor and Patient*, Baltimore and London, John Hopkins University Press, 2002, p. xlv.
2. K. Srinivasa Iyengar, *Rabindranath Tagore: A Critical Introduction*, New Delhi, Sterling Publishers, 1965.
3. See the section on Tagore's plays in N.S. Iyer, *Musings on Indian Writings in English (Drama)*, vol. 3, New Delhi, Sarup and Sons, 2002.
4. A detailed account of this can be found in Judith Plotz, "Tagore in the Warsaw Ghetto: Janusz Corczak's Post Office", in *Rabindranath Tagore: Universality and Tradition* (eds.) Patrick Colm Hogan and Lalita Pandit, London : Associated University Presses, 2003, pp. 250-263.
5. See Betty Lifton's 'Introduction' ('Who Was Janusz Korczac?') to Korczac's *Ghetto Diary*.
6. Translated portions from original Bengali texts, if not otherwise indicated, are mine.
7. The passage is from Manik Bandyopadhyay's 'Atmasamalochana' (Self-Criticism), where he commented on the title of *Putul Nacher Itikatha*. It has been discussed by Jugantar Chakraborty in 'Chinna Lekha' (Scattered Writings) in *Saradiya Ekshon*, 1384 Bangla Sal. Anindya Bhattacharya in his article "Kathane ki ghote: 'Putul Nache Itikatha'" ("What happens in narration: Putul Nacher Itikatha") has quoted portions of that passage from Bandyopadhyay's "Atmasamalochana". I have used Bhattacharya's article as a secondary source and translated the passage into English.
8. See Nabaneeta Deb Sen's comparative study of these two novels , entitled "Iswarer Pratidvandhi: Sashi o Rieux"("God's Opponent: Sashi and Rieux"), in *Naba-neeta*, Kolkata, Mitra o Ghosh, 1999, 304-316.

Conclusion: Towards a Comparative Medical Humanities

In 2005, Richard Horton, physician and editor-in-chief of *The Lancet* delivered a lecture in front of an audience of researchers in literature and medicine and medical practitioners at King's College, London. He called for a new literature of public health for the present global era. While discussing literary works that provide a vision of universal humanism, he singled out medical fiction that would generate human empathy by enabling us to understand the health and suffering, discontent and mortality of people living in different parts of the world. Commenting on how Horton's lecture represents "a new effort in medicine and the humanities", Alvan Ikoku, a former medical student and at present an Andrew W. Mellon Fellow in the Humanities at Stanford, says that the call for a marriage between medical humanism and literature is helpful to engender an emotional response in readers, which health specialists may also find ethically reliable, since their work must hold on to financial, technological as well as and human resources. "It is essentially a call", continues Ikoku , "to return to a notion of how literature seemed to work in the 19th century"[1], citing works of authors like Charles Dickens and Elizabeth Gaskell, for whom ethical and humanitarian concerns regarding public health and sanitation became a significant aspect of social realism in literature. Such concerns, in the modern context of developments in tropical medicine, psychopathology and alternative therapeutics, may extend their scope beyond traditional healthcare practices and include a variety of experiences and multiple points-of-view.

So there has now been an increased interest in exploring new avenues in medicine and literature. Medical humanities and bioethics have emerged as complementary and often overlapping fields of interdisciplinary studies. These new fields have entered into a discourse with such critical issues as the "dehumanizing"

tendency of the medical system, due to a rapid advancement in technologies and corporatization of healthcare, protection of rights of the research-subjects and patients, the question of life and death, the patients' psychological and spiritual need of comfort, community care, euthanasia, proper distribution of medical resources and so on. The emergence of Medical Humanities as a new discipline reinforces the fact that humanities itself is a highly contested term. In 1980, the Rockefeller Commission on the Humanities stated that the humanities —

> reveal how people have tried to make moral, spiritual, and intellectual sense of a world in which irrationality, despair, loneliness, and death are as conspicuous as birth, friendship, hope, and reason. We learn how individuals or societies define the moral life and try to attain it, attempt to reconcile freedom and the responsibilities of citizenship, and express themselves artistically. (qtd. in Cole, Carlin and Carson 3)

In the 1980s and '90s, George Engel and Eric Cassell, chief among the exponents of the non-clinical (the social, the psychological and the like), insisted that medicine alone cannot bring a holistic cure; a sympathetic understanding of the patient's social and emotional background must be integrated into the healthcare system. "In other words", as Cole, Carlin and Carson put it, "there has been a paradigm shift away from what might be called medical reductionism to medical holism, where patients are not reduced to diseases and bodies but rather are seen as whole persons in contexts and in relations"(8). There is also a curious contradiction which may strike us if we try to historicize the emergence of the medical humanities. In the 1960s and '70, when it was taking shape as a discipline, the grand narrative of "humanities" itself was already getting problematized, facing several postmodernist counter-discourses. So the attempt to interrelate the humanities to an idea of

healthcare and human well-being cannot be free from the traditional and much-critiqued notion that "humanities" can indeed provide a holistic, man-making education. However, its great advocates have always tried to maintain that humanities can help any human-centred profession to become more humane. In recent years, however, scholars of medical humanities have grown self-critical. For instance, Catherine Belling suggests that "we must attend to resistance, even provoke it, if humanities teaching is to promote critical inquiry as well as neutral reflection", which, in turn, "can develop an orientation toward uncertainty, knowledge, and action that characterizes the best physicians" (Belling 2010: 939). Rita Charon, one of the major exponents of "narrative medicine" commends narrative competence for medical ethicists, whereas Johana Shapiro argues that without "narrative humility", there lurks a danger of falling into the traps of textuality, rendering the authenticity of the patient's story unreliable and questionable at times (Shapiro 2011: 68-72).

Katherine Montgomery offers several methodological stances in order to examine the relation between literary studies and medical ethics. Literary studies are essentially interdisciplinary, so is medical ethics. Knowledge in literature is characterized by detailing, contextuality and situationality which limit abstraction and generalization. Medical ethics, in making value-judgements as well as diagnoses, can find it beneficial to adopt this literary approach. Again, literature offers its readers a continuous reflexive enquiry: "Values may authorize the reinterpretation of a text; … [which] may call into question or ignore the very conclusions and values that had seemed so obvious before. A comparable attention in medical ethics to assumptions about knowledge and representation might be interestingly productive" (Montgomery 42).

Moreover, literature encourages a rationalization of emotions and imagination, thereby broadening the concept of reality and human experience. Rationality, which theoretically demands a proper balance of the empirical and the intellectual, however, is not always so easy to maintain in our everyday life, for there remains a conflict between the practical/the empirical and the intellectual/the philosophical. Nadelhaft and Bonebaker offer an interesting point regarding this debeate: Robertson Davies, the eminent Canadian author and humanist, once put a question to an audience of medical professionals: "Can a doctor be a humanist?" His own answer to the question was "yes", but with a condition. In order to achieve the goal of being a "humanist", he thought, the doctor should shift his intellectual allegiance to the realm of 'wisdom' of humanities from the world of empirical science (Nadelhaft and Bonebakker 1). It is indeed debatable how far it is practically possible to look for a reconciliation between these two different epistemic goals. What Davies said was not something strange, rather it falls within the purview of a long tradition in the west, which since the times of Socrates and Plato, had suggested a possible intersection between philosophy, literature, language and medicine. In *Phaedrus,* Socrates says that medicine is like rhetoric, because: "In both cases there is a nature that we have to determine, the nature of body in the one, and of soul in the other, if we mean to be scientific and not content with mere empirical routine when we apply medicine and diet to induce health and strength, or words and rules to implant such convictions and virtues as we desire" (Hackforth 146).

Further, the ambiguities embedded in the word "Pharmakon", as Derrida and Roland Barthes have severally pointed out, suggests similar concerns in textuality, narrative, semiotics and hermeneutics. Coming to the Indian traditions of healing, we may also recognize a close relation between literature and medicine since the Vedic

period[2]. The *Rgveda* contains a number of hymns honouring the twin deity "Aśvi", known as the gods of medicine. Again, some hymns in the *Atharvaveda*, the last of the four Vedas, are magnificent examples of poetry dedicated to the processes and rituals of healing. One of those hymns, for instance, wonderfully brings about the interconnection between the spirit of life, sound, mantra, poetry and healing. The brilliant poetic flavour of the Vedic language, however, cannot be captured in translation: "Hail to thee, o vital spirit (*prāna*), thou that maketh sounds by entering into the nets of cloud. When the god of Sun, who is the vital spirit of the entire creation, maketh sounds through the clouds towards the medicinal herbs and plants, they get fertilized" (*Atharvaveda* 11.4.2-3; English translation mine).

The sound effect (*svana*) of a mantra or hymn was used for synchronization (i.e., bringing into harmony all physical and mental attributes of the biocosmic body) which is also the aim of healing (restoration of holistic harmony in body, mind and spirit). The great Indian epics, the *Rāmāyana* and the *Mahābhārata*, and the Buddhist literature also introduce us to several ancient healing practices, in which the sages, monks and vaidyas had a certain expertise. The word "Rasa"' (in the sense of "Taste") assumes a significant aspect of Ayurvedic physiology and a healthy food habit; the same word constitutes the core of a celebrated aesthetic theory in Sanskrit literature. In his essay "Change and Creativity in Early Modern Indian Medical Thought", Dominick Wujastik discusses a popular 17th century Sanskrit text called *Vaidyajīvana* (*A Doctor's Life*), composed by the Maharashtriyan physician-poet Lolimbarāja. The text contains beautiful verses addressed to the poet's beloved, verses reflecting his personal feelings combined with his medical knowledge.

Apart from the Vedic, Sanskrit and Pāli texts of medicine, there are rich literary traditions belonging to other Indian systems of healing (Unani, Siddha,

Rasaśāstra and the like). References to tribal and indigenous medicine and various alternative healing practices – shamanism, mustiyoga and the like, are numerous in folklores and oral literary traditions of India. It is indeed difficult to delve into the wide range of healing practices at work throughout the country; and tribal and folk-literatures about medicine mostly belong to oral traditions. However, in "mainstream" Bengali literature of the 1940s and 50s, references to folk-medicine can be found, showing that such folk-wisdom about diseases and medication was an integral part of the rural life (and still is). Banaphul's doctor-protagonist Agniswar, at the end of the eponymous novel, gets disillusioned with the "civilized" society. He roams about the country as a kind of "scholar gypsy", accompanied by a group of Bedias, and learns about their herbal medicine. In *Arogyaniketan*, Tarashankar Bandyopadhyay refers to some mustiyogic practices and local remedies with almost miraculous effects, popular among the rural people but beyond the imagination of the urbane, educated medical practitioners. It cannot be denied that in Bengali literature, there is a general tendency to romanticize such alternative healing practices, without going deeper into them; but these literary texts of course draw our attention to the overlapping junctions of "popular medicine" and "literary aesthetics".

Where, then, should we place literature in the context of medical humanities? And how can literature bear any significance in the world of diagnosis and treatment, health and illness? The answer perhaps lies in the very nature of pain and suffering, which often seems to threaten us as an incomprehensible, amorphous void. The challenge of medical humanities is to help both doctor and patient (as well as bystanders) in overcoming this "endless formlessness and present tense of the experience of pain and suffering" (Nadelhaft and Bonebakker 4). The art of literature, which is traditionally "mimetic" or representational in the west, and induced with a

sense of "being with" in India (*sāhitya* < *sahita*+*snya* etymologically connotes a sense of togetherness) offers a sense of form, dimension and support to that human experience of plight which otherwise seems to be beyond endurance. Sometimes, in its most realistic approach, representation of medical themes and characters in literature provides a measure of survival. For instance, in Dickens' *Bleak House*, Eliot's *Middlemarch* or Cronin's *Citadel*, Manik Bandyopadhyay's *Putul Nacher Itikatha* or Banaphul's *Nirmok*, life goes on in spite of death, trials, diseases and corruptions at personal, social and ethical levels. The central character, being a physician himself, experiences all seamy and diseased sides of life, and emerge a wiser and if not always a triumphant hero, at least a more enduring subject. Sometimes the author's personal experience of suffering – as physician, as patient or as both, offers a more subjective orientation to the narrative. In *The Moonstone*, Collins' personal sufferings due to his opium-addiction gets sublimated into a peculiar aesthetics of pain and healing, trauma and purgation expressed through Dr. Ezra Jennings' narrative. In Tagore's *Dakghar* (*The Post Office*), a sick child's irrecoverable physical illness paradoxically grows into a rare experience which is both self-therapeutic and transcendental on a spiritual plane. *Arogyaniketan*, drawing on different approaches to healing, shows how life gains its best fruits through a vision of pain, suffering and death, which teaches us the aesthetics of survival.

Throughout this dissertation, the present researcher has sought to insist that literature and medicine, with special reference to the various cultural and social roles played by doctor-characters, is a deeply layered world. There have been attempts to review the development of such literatures since the middle of the nineteenth century, a time noted for so much that happened then in human history. The rise of the professional medic as protagonist on the one hand, and the emergence of the

alternative healer appealing to the dissatisfied and distorted backwaters of civilization have been discussed in relation to the complexities embedded in the social system and its demands that we often encounter even today, in different ways. This has led to a critical examination of how these narratives claim authenticity from medical science and knowledge of therapeutics (sometimes of an alternative sort) and at the same time, manifest several moral, religious, and existential levels of meaning. Time and again, attention has been drawn to the ways in which such narratives function to shape characters — doctors, alternative healers, patients – and also readers. In a sense, these literatures belong to all humankind.

Literary narratives with medical themes and characters, when viewed against the larger discipline of medical humanities, appeal to us not merely as sequences of fictional events. As narratives, they not only tell stories, but bring together domains of diverse experiences that we otherwise find difficult to conceptualize through a holistic vision: the clinical and the ethical, the biological and the biopolitical, the physical and the mental. Some kind of aesthetic transport is also available; without this the reader's experience of going through such narratives remains incomplete. It would be too much to imagine that a text like *Dakghar* or *Arogyaniketan* or *The Citadel* will bring a miraculous cure to an ailing subject; but they can induce in us a sense of aestheticized healing which makes life and its maladies more bearable and manageable. In *The Cure Within*, Anne Harrington speaks of the effect such stories have on mind and body: these narratives

> allow everyone — doctors, patients, and the readers — to recognize and speak about the reality of mind-body effects, but to do so in ways that do not require us to confront head-on the age-old dualisms of our culture that we know are wrong, but do not quite know how to fix. If this is right, then it suggests that

> we are likely to continue for a long time to use stories across all levels of the culture of healing as devices for bridging the lacunae in our thinking. (212)

It is true that we cannot always bridge those aporial fissures of our understanding; and it is from this point that literary or cultural hermeneutics may embark on a self-critical journey. This dissertation has tried to show that the narratives of doctor-patient relationship do not merely describe those experiences and actions that we can find in reality, but also those which might have been there, suggesting a world more endurable and balanced. So it can be said that the significance of medical humanities lies in its search for the narratives, in order to embrace them as part of its ever-expanding domain.

Given that there are indeed some affinities in the experiences of doctors and patients across spatial and cultural differences, one may ask: what is the purpose of such a comparative exercise? What will this yield for us in reality? A small anecdote from *Sri Sri Ramakrishna Kathamrita* (*Gospels of Sri Ramakrishna*) throws light on the same question, with a positive outlook. Dr. Mahendralal Sarkar, an eminent physician in nineteenth century Calcutta, came to treat Sri Ramakrishna during his last illness. Initially a proud sceptic, he gradually got attracted to the unique sensibilities of his patient, and especially his extraordinary humanitarian approach to spirituality, through a comparative vision of all religions. At one point the doctor said, just as the experience and exercise of comparative religions have made Sri Ramakrishna so unique in his understanding and insights, comparative biology can be helpful to have a better understanding of all "life-sciences" including medicine (*Kathamrita* 947). What Dr. Sarkar wanted to emphasize is the importance of openness, empathy and understanding in medicine that might make possible a more humanitarian healthcare system. Coming to medical humanities viewed through

literary cultures, one may thus recognize how far doctoring and healing can be understood in relation to social, cultural, moral and even spiritual sympathies that work for humanity at a wider level than we can see apparently. Alongside this, a comparative approach to literary bioethics can make us realize how in literature, different forms of narrative have been used to represent the otherwise formless world of pain and suffering. Since literature offers us characters along with form, it is also notable how the writers work at the intersections of different subject-positions: doctors, patients, nurses, by-standers. Doctoring itself is a collective experience demanding a comparative measure of understanding, and literary representations of doctoring obviously open up a rich a dynamic world of psychological, ethical and even deeper sensibilities, of those who go through illness or sickness or handle it, withstand it, cure it.

The experience of illness and suffering and the desire for well-being is a universal concern that brings together thoughts and insights from different branches of humanities: philosophers, historians, literary artists and performers who represent human life and society in their multifaceted dimensions can thus participate in the intersectional grids of bioethical and medical humanities, sometimes using their own experiences. Going back to what Robertson Davies said, we may understand that wisdom, unlike the empirical knowledge of science, also involves feelings and reflection, which again are closely associated with the domain of intellect. “Davies urged his listeners to integrate those realms into the living tissue of empathetic practice”(Nadelhaft and Bonebakker 1). In recent years, there have been unprecedented developments in medicine and healthcare, yielding both positive and negative concerns. The nature of expectation has changed, technology seems to have occupied the human space, throwing at stake the question of relationship between

man and medicine. Amidst this changing scenario of healthcare technology, a deep dissatisfaction has already affected both sides – doctors and patients, since the human encounters have now been so limited.

The question of medical humanities, in its current form, has its origin in the US and the UK. However, recent scholars have warned against the notion of western neo-imperialism embedded in its advocacy of medical humanities, and Alan Beakley calls for a democratization of medical humanities. If globalization of thoughts can be taken as one way of achieving conceptual democracy, there emerges a potentially powerful arena of comparative medical humanities. In a postcolonial time when various Asian cultures are trying to highlight the greatness of their own heritage, their value-systems and the rich traditional approaches concerning bioethical norms, we need to be more careful and sensible to consider how medical humanities can be made acceptable transculturally. In a recent paper, Jens Schlieter has offered four methodological standpoints to propagate a comparative approach to bioethics: 1) cross-cultural bioethics (normative); 2) bioethics from the perspective of intercultural philosophizing (hermeneutical); 3) comparative bioethics (as part of comparative philosophy; history of ideas); 4) bioethics in culture (descriptive; science of culture). However, he wonders whether bioethics can be universally acclaimed like human rights. According to him, philosophers and scientists in different cultures find it difficult to come to a consensus in this regard, and a considerable difficulty lies in the fact that bioethics has not become an established field of philosophy[3]. So it is for medical humanities. In world culture, there are several reservations and debates regarding this; medical humanities as an established field of cultural studies is yet to be accepted. A proposed idea of comparative medical humanities, therefore, may appear to be too far-reaching an imagination to pursue at present, but perhaps no so in

future. To help to promote an interest in medical humanities across different cultures, some significant textual and conceptual modes of understanding have been offered in the present study. Though this can be done somehow at the theoretical level, it remains to be established concretely on the cultural and religious levels. This in turn relies on how people in different cultures and religions understand life and well-being. So it is this potentially thriving area of comparative medical humanities where the natural and the cultural, the individual and the social can try to find answers to inexplicable questions, and where a healthy dialogue between man and the "humanities" may take place most effectively.

Notes:

1. The quotation is from Barbara Wilcox's report ("Stanford fellow investigates how literature shapes transnational fields of medicine") published in *Stanford News* (July 7, 2014), available at <**http:// news.stanford.edu/ news/2014/July/ malaria-literature-medicine-070714.html**>
2. For details, see Kenneth Zysk, *Medicine in the Veda: Religious healing in the Veda.* Delhi: Motilal Banarisidas, 1996.
3. Jens Schlieter, "Bioethics, Religion and Culture: From a Comparative Perspective", trans. Anand Amaladaas, *Polylog: Forum for Intercultural Philosophy* 6 (2005), at <http://them.polylog.org/6/fsj-en.htm>

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