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Uncertain Identity:
Medical Practitioners in *Doctor Thorne* and *Middlemarch*

A Thesis
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The Faculty of Arts and Humanities
University of Denver

In Partial Fulfillment
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Master of Arts

by
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Title: Uncertain Identity: Medical Practitioners in *Doctor Thorne* and *Middlemarch*

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ABSTRACT

The medical practitioners who play leading roles in the novels *Middlemarch* by George Eliot and *Doctor Thorne* by Anthony Trollope are examples of a new breed of professional medical men that emerged during the middle of the nineteenth century in England. The new class of general practitioners held licenses from the old hierarchical system of physicians, surgeons, and apothecaries, but they were the driving force in favor of reform and professionalization in medicine. The 1858 Medical Act was an important step on the path toward a new conception of the medical practitioner, and the development of that new medical identity opened the door for doctors as the principal characters in novels. Trollope's *Thorne* marks an intermediate conception of the doctor balanced between genteel tradition and professional reform, while Eliot's Lydgate embodies the new model of a medical protagonist whose personal flaws could be balanced by professional brilliance.

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The Rise of the General Practitioner

For twenty-first century audiences who eagerly consume a steady stream of novels, films, and television programs featuring medical professionals as their protagonists, the question of whether the professional life of a doctor is a worthy subject for a work of fiction is unlikely to enter their minds. The medical profession, however, was not always seen as inherently heroic, and until the second half of the nineteenth century the normal position for a medical character in a work of fiction would have been as a secondary character. The work of healing another person would have automatically implied that the doctor was subordinated to the well-being of someone else and that that character must necessarily be more important than the doctor. The hierarchy of the medical profession in the early nineteenth century mirrored the class system of English society, and the assumed norm granted a doctor a lesser social standing than his patients. In George Eliot's *Middlemarch*, on finding out that the new surgeon Tertius Lydgate is a gentleman from a good family, Lady Chettam, one of the county's leading aristocrats, declares, "One does not expect it in a practitioner of that kind. For my own part, I like a medical man more on a footing with the servants" (91). In fact, the process of medical reform and professionalization during the Victorian period shaped the role of the doctor into one of a socially prestigious scientific authority, and the fiction of that period provides a valuable insight into the formation of an image of the doctor that continues to hold sway in both modern fiction and medical practice.

The development of a modern professional identity for medical practitioners was a gradual process. While the societal role of the healer has roots too deep to allow for any revolutionary change, the incremental changes in the profession of medicine in Victorian England can be observed in the laws passed by Parliament. Although no single grand reforming law marked a decisive change, the 1858 Medical Act (also called the Medical Registration Act) serves as an important marker to indicate the evolution of the medical profession toward greater respectability and prestige. Beyond its significance for the profession of medicine, the new conception of the doctor that emerged during that time created new opportunities for novelists to tell the stories of an admirable and socially mobile type of character who had been absent from earlier works. The novels *Doctor Thorne* in 1858 by Anthony Trollope and *Middlemarch* in 1871 by George Eliot use this new image of the doctor to create central characters whose ambiguous social status allows them to interact with different social classes while providing a ready source of conflict because their social mobility entails social marginalization. Dr. Thorne and the surgeon Mr. Lydgate are both medical practitioners in provincial settings with tenuous aristocratic connections and no sizable income. The two medical protagonists' fictional experiences reflect the profound social and professional changes that occurred in Victorian England to create what are now thought of as the fundamental qualities of the doctor.

The medical profession in England in the nineteenth century still drew some of its authority from the traditions of antiquity, as reflected in Trollope calling his hero a Galen, after the legendary ancient Greek physician Galen whose theories on anatomy and physiology were not overturned until the sixteenth century and whose treatises were still a central part of the medical curriculum at Oxford and Cambridge well into the nineteenth

century (Bynum, *Practice of Medicine* 3). In practical terms, the field of medicine was governed by the descendants of the medieval guilds. At the beginning of the nineteenth century in England, it would have been more accurate to speak of three medical professions rather than one. At the top of the hierarchy were the physicians, who enjoyed the social status of gentlemen. Medicine had traditionally been one of the three acceptable professions, along with the church and the law, for younger sons of aristocratic families who would not inherit wealth. The Royal College of Physicians, founded in 1518, maintained the gentlemanly quality of the profession by limiting it to graduates of Oxford or Cambridge and tightly restricting the number of licensed physicians, with only 179 licensed members in 1800 (Jacyna 29).

If the physicians represented the gentlemanly class of medical professionals, the surgeons were the skilled craftsmen. In contrast to the detached quality of the physicians' classical education, surgeons were the hands-on practitioners responsible for treatments like setting bones and letting blood. For much of their history they had been linked to the barbers, only becoming a separate professional group in 1745 (Jacyna 30). For surgeons operating in an era before the use of anesthesia, it was far more important to be dexterous and skillful than learned. The standard training in 1813 was a five-year apprenticeship, with one year of attending surgical practice in a hospital, one course in surgery and one in anatomy being the only legally required education to become a fully-licensed member of the Royal College of Surgeons (Newman 18).

At the bottom of the hierarchy of medical practitioners were the apothecaries, who were socially stigmatized for their status as tradesmen. Similar to the surgeon's separation from their medieval association with the barbers, the apothecaries had divorced themselves

from the grocers and formed the independent Worshipful Society of Apothecaries in 1617 (Jacyna 30). According to that society's charter, the role of the apothecary in the treatment of disease was supposed to be limited to filling prescriptions that had been written by a physician. Apothecaries could charge for medicines, but any advice or treatment they provided would have to be billed as a charge for medicine because until the 1830s they had no legal standing to collect on any charges for services or attendance. The three different classes of medical practitioners mirrored the class structure of British society. As in the case of society at large, the most important division was between the gentlemanly physicians and the lower orders.

The neat three-part division of medical practice was not immune to the evolution that the preindustrial structures of British society were forced to undergo in the face of massive industrial development, and the great changes that reshaped the medical profession over the course of the nineteenth century could not have taken place without the influence of powerful economic forces. In theory the three types of practitioners divided the work of medical care, with physicians responsible for diagnosing internal ailments, surgeons providing treatment for wounds and external ailments, and apothecaries compounding and selling medicines without any authority to diagnose or treat patients. In practice those divisions were frequently blurred, particularly because the fees charged by each class of practitioners were not uniform, a fact that encouraged a patient-directed system of classification by severity of illness. Apothecaries provided basic treatment by recommending different medicines for less serious health problems, surgeons were called in for more acute illnesses, and physicians' services were reserved for only the most severe cases. Of course, there was a significant class element as well, with poorer patients purchasing the only care they could afford from apothecaries

and the aristocracy relying exclusively on the services of physicians for social as well as medical reasons.

The blurring of the lines between the different medical orders had begun when the apothecaries won a major legal case in 1703 that established their ability not only to dispense but also to prescribe medicines, a practice that was allowed to coexist with the legal rights of the physicians because the apothecaries charged their patients for medicine but not for advice (Poynter 10). Winning the right to prescribe medication was in some ways just the legal system catching up with what was already the standard practice, as even if the majority of the population had been able to afford the fees of the physicians, there were far too few of them to supply the medical needs of the more numerous lower classes. Although it happened slowly, the legal recognition of the apothecaries' right to prescribe medication marked the beginning of the rise of a new figure in the English medical system, the general practitioner or family doctor. The 1815 Apothecaries' Act established a standardized system of training, written examination, and licensing for all apothecaries, which led to an influx of 865 applicants in the first four years. At the same time there was a flood of highly skilled military surgeons who took up civilian practice after the conclusion of the wars in Europe (Lawrence 53). Before 1815 there were already many surgeons in the provinces who prescribed drugs as part of their practice, and because the Apothecaries' Act required a license from the Society of Apothecaries for a medical practitioner in any part of the kingdom to prescribe or dispense medication, any surgeon who wanted to engage in general practice needed to hold both licenses (Peterson 22). Additionally, the new educational requirements for apothecaries could be easily combined with the requirements imposed by the Royal College of Surgeons. Possessing both qualifications authorized a medical practitioner to treat the full range of

medical conditions, thus eroding the distinction between surgeons and apothecaries and establishing a legal foundation for the concept of the general practitioner, although at that time they were still mostly referred to as apothecaries or surgeon-apothecaries (Poynter 10-11). By the middle of the century the general practitioner had become the norm in the medical profession, with approximately 4500 of the medical men who completed their medical educations between 1846 and 1856 earning the two licenses needed to qualify as surgeon-apothecaries (“Medical Reform” 510).

Although the previous separation of roles was blurred by the rise of the general practitioner, the hierarchical quality of the medical profession remained. The majority of apothecaries, surgeons, and some physicians became general practitioners simply by combining the work that had previously been divided up among those three roles, but they worked beneath a new elite group of doctors who defined themselves in opposition to the model of the general practitioner. These upper-class practitioners with Oxford or Cambridge degrees maintained the gentlemanly avoidance of “work” and confined themselves to the traditional practice of physicians who only gave advice. This new clique of medical consultants was composed primarily of socially elite physicians and a select group of elite surgeons, both of whom exercised significant control over the profession in spite of their limited numbers because they controlled the councils of both of the London Colleges and most of the capital's major hospitals (Jacyna 31-32).

For the first half of the nineteenth century, the old tripartite system formed the superficial structure of the medical profession, but beneath the surface a new underclass of general practitioners was emerging. The general practitioners did the vast majority of the medical work while a tiny group of elite practitioners controlled all of the institutional

authority in London. Although no records were kept of the exact makeup of this unofficial class system, most of the 8000 Licentiates of the Royal College of Surgeons in 1834 held the additional qualification of apothecary that allowed them to function as general practitioners (Cline 276). In 1847, there were 638 members of the Royal College of Physicians and 200 Fellows of the Royal College of Surgeons, the majority of whom resided in London, and among those men was the consultant clique who controlled all of the instruments of professional government in spite of the fact that they represented less than five percent of those practicing medicine in England at that time (Peterson 8-10). This class divide between the general practitioners and the elite consultants was the key factor in the emergence of an outspoken movement for medical reform, a movement that positioned itself in opposition to the monopolistic efforts of the London colleges and their pursuit of narrow self-interest under the guise of upholding medical tradition.

As general practitioners began to develop a sense of professional identity independent of their different affiliations with the corporate institutions in London, that identity was reflected in the creation of new medical associations and publications that advocated medical reform. Organizations like the National Association of General Practitioners and the Provincial Medical and Surgical Association worked to resolve the uncertain professional status of hybrid surgeon-apothecaries and other medical men not adequately represented by the existing system. The greatest drive for reform came from provincial general practitioners, who formed a wide variety of local medical organizations to represent their interests (Peterson 23-24).

Of all of the different aspects of the medical reform movement, one of the most influential was the publication of the journal *Lancet*, founded in 1823 by the licensed surgeon

Thomas Wakley to promote efforts by the general practitioners to break the stranglehold on power held by the London medical colleges (Jacyna 31). Wakley's radical agitation for reform involved a steady stream of attacks on what he saw as the universal corruption of the monopolistic London colleges, especially the Fellows in the Council of the College of Surgeons, and the editorials in the *Lancet* also harshly criticized Parliament for its unwillingness to take legislative action to resolve the situation. In just one of many examples, Wakley called out Sir Robert Peel, the Secretary of State for the Home Department, for supporting the “monopolists” by rejecting “any reform in the College of Surgeons, which could recognise the principle of allowing the commonalty to vote for the election of the members of the Council,— thus denouncing, at the very threshold of inquiry, the only certain remedy for the tyrannous proceedings of the privileged rulers of that institution” (“LANCET: June 15, 1833” 373). While Wakley's harsh criticisms of Parliament and the London colleges represented an extreme position within the medical reform movement, the *Lancet* called attention to the deep division within the profession by constantly insisting on the need for ordinary medical men to have a voice within profession and for those institutions and the state to exert their legal authority to punish quacks and frauds who competed with legitimate practitioners.

One of the key elements of the medical reform movement was the emphasis on standardization of training. M.D.s from Oxford and Cambridge were the only degrees that the College of Physicians would accept. Those degrees consisted of a classical education in literature and mathematics and the study of traditional medical texts in Latin, requiring no scientific training or practical medical experience. Until 1834 it was possible for a candidate to take a Doctorate in Medicine at Cambridge without having any hospital practice, without

having attended a single lecture on medicine or one examination in medicine (Newman 10). This sad state of medical education was based on the long-established belief that it was more important for a physician to know how to behave as a gentleman than for him to have any scientific training or direct experience with medicine. As ridiculous as it sounds, some of the opposition to medical reform was based on the fear that more required medical education would bring the physicians closer to the general practitioners, thus driving gentlemen away from the profession and depriving medicine of the moral guidance of the upper classes. Speaking to its target audience of politically conservative gentlemen, the *Saturday Review* published an article in May of 1858 arguing that the medical reform legislation being debated in Parliament would “wholly obliterate the leading class” of the profession by creating more uniform standards of education across all three medical classes, “presuming that the standard of early education suitable to the general practitioner can be adequate to the most accomplished walk in the profession” (“Medical Legislation” 559). The requirement that anyone who wished to practice medicine should have practical training in that field posed a threat to the supporters of the universities of Oxford and Cambridge who believed that “classics and mathematics” provided “the best foundation of knowledge” in any subject that a gentleman might pursue (559). The *Saturday Review* gave voice to the obsession with maintaining the firm division between the gentlemanly physicians and the laboring class of general practitioners, which was one of the chief obstacles of medical reform, and it was a major unspoken element in the conflict between upper-class consultants who dominated the councils of the London colleges and the mass of general practitioners who provided the vast majority of medical care in England.

The state of medical education in England stood in stark contrast to the developments in medical research and education in Paris and Edinburgh. After the French Revolution overthrew the previous medical institutions, the Napoleonic Wars necessitated a massive investment in building up a new medical infrastructure to support the needs of the military. The new Paris School of medical education was founded to produce competent medical men who could perform all of the duties that in England were split up among the three professions (Jacyna 41). This new school of thought was led by heroic figures like the anatomist Xavier Bichat and became known as the Paris Medicine. After the restoration of the monarchy, Paris became the leader of the Western world in both medical practice and research, with a great number of practitioners coming from other countries to study there (Jacyna 48). British medical students were no exception, and for those with the strongest interest in medicine and the financial resources to support their education, a course of study in Paris was unrivaled as a mark of superior medical training. Although there was no unified curriculum, those who studied in the teaching hospitals of Paris brought back the principles of compiling detailed case histories based on physical observation of the patient and conducting regular autopsies of those cases that ended in death. Because the College of Physicians only recognized doctorates from Oxford and Cambridge, most of those aspiring general practitioners who had trained in Paris or other institutions outside of England instead opted to pursue the dual qualification of the surgeon-apothecary. The traditional model of the physician as the more socially elevated of the medical orders was thus eroded by the influx of surgeon-apothecaries who were sons of privileged families and had advanced medical training from non-English institutions. By the middle of the century among the staff at the prestigious Guy's Hospital in London it was more common for the son of a clergyman, doctor, or other educated

professions to be a surgeon than a physician (Newman 16-17). Even among those medical practitioners who had not trained in France or otherwise become disciples of the Paris Medicine, the principles of experimental science became increasingly prominent, and case histories were combined with a use of statistics to evaluate the efficacy of different treatments.

The application of scientific principles of observation revolutionized the practice of medicine, which had previously relied almost exclusively on the patient's narrative. Even well into the nineteenth century, the most important skill for general practitioners operating in the free market English system was the ability to impress patients with highly visible forms of treatment and sell them large quantities of medication, regardless of its curative value. This patient-centered approach was also a product of the economic structure of medical practice, in which patients outside of the hospitals possessed unlimited authority to dismiss their doctors if they did not like the diagnosis or proposed treatment, though only patients who lived in urban areas large enough to support multiple competing practitioners (and those who had enough money to bring in different doctors) could actually exercise this authority. While the more centralized authority of French clinical medicine allowed for a rapid transition between a medical practice centered on the individual patient's account of his or her illness and a practice of medical observation of bodily signs without reference to the patient's narrative, the case histories in early nineteenth-century Britain were marked by a complex mixture of patient narrative and scientific observation (Caldwell 143-144). This incomplete transition between the sort of patient-centered practice in which diagnosis and treatment could be conducted entirely by mail and the clinical observations that mark scientific medicine left the English general practitioner in an uncertain position relative to his

patients. The old model of the patient's social superiority over a doctor who had the social standing of a servant had been undercut by the growth of clinical authority, but a general practitioner in England did not yet possess the prestige of unquestioned expertise, another factor which contributed to the uncertain social status of medical professionals during the middle of the Victorian period.

Although the general practitioner had become the *de facto* norm in England by the middle of the nineteenth century, the political opposition of the elite medical consultants and the London colleges prevented any sort of legislative reform that would have codified the professional qualifications of a general practitioner and established a single licensing authority for the entire country. The two key goals of the medical reform movement were greater representation for the rank and file practitioners among the London medical institutions and the establishment of uniform standards of training and qualification that would separate the quacks from the legitimate practitioners. However, the government's chief medical advisor, John Simon, quite bluntly pointed out in 1856 that if medical reform legislation served only the interests of the profession then no such bill would ever pass Parliament (Roberts 40-42). In light of this political obstacle, the members of the medical reform movement framed their goals in terms of establishing professional standards that would protect the public.

While the self-interest of the medical profession had fallen on deaf ears, the politicians were quicker to respond to reform in pursuit of the new concept of “public health,” which had become prominent in the minds of the politicians after the state’s failure to provide for adequate sewage disposal in the rapidly expanding urban centers had resulted in a string of major disease problems during the decades leading up to the 1850s. The re-

framing of the role of the medical practitioner in terms of public health was crucial to the emergence of a new social conception of the doctor, and medical research into disease and public health issues extended the public's consciousness of doctors as agents of healing from the individual to the larger social organism. The combination of the professional motives and the public health issue provided a strong foundation for the sort of medical reform bill that would establish a new central licensing body. Such an institution would represent the interests of the majority of medical practitioners and would have the authority to enforce a single standard of qualification for all medical practice. However, the sort of drastic institutional restructuring in favor of a strong central authority that was called for so forcefully in the pages of the *Lancet* was opposed by populist free-trade advocates. On the level of the parties, neither the Whigs nor the Tories were unified in their positions on medical reform, which encouraged the efforts of individual free-market advocates like Radical MP Tom Duncombe, who argued that the only real solution to the monopolistic practices of the London colleges was to create a wide-open system of medical free trade in which market competition would be the sole judge of the value of a practitioner's credentials (Roberts 43-44).

Because of these different conflicting factors, the legislative process moved slowly, and four major medical reform bills failed in Parliament before Whig MP John Simon drafted a bill that would become the Medical Act of 1858 (Roberts 45). As is often the case when different conflicting interests are balanced in a single piece of legislation, the 1858 Medical Act was generally accepted as better than nothing, but it did not completely please any of the factions involved. The act did not create a new qualification or licensing authority, nor did it authorize the power of the state to punish unqualified practitioners as criminals unless they

attempted to claim qualifications they did not possess. Instead, the Act confirmed the licensing authority of the London colleges but placed all three of them under the control of a new General Medical Council, which would be composed of representatives selected by the universities, the fellows of the London colleges, and the monarch's Privy Council, without the reformers' goal of direct representation for the profession at large (Poynter 13). Even the most radical reformers like Wakley reluctantly accepted the 1858 Medical Act as being better than no reform at all. Although the Act did not immediately overthrow the existing system, the General Medical Council's authority to audit the examinations of the London colleges gradually led it to achieve the uniform educational standards that the reformers had sought (Roberts 49).

By undermining the outdated categories of physician, surgeon, and apothecary and insisting that membership in the medical profession should be defined on the basis of knowledge and training rather than class, the 1858 Medical Act opened the door for a new conception of the doctor in the public consciousness. The rise of the Paris Medicine and the association of the profession with the rising prominence of scientific research allowed even those general practitioners who were not gentlemen to enjoy greater social prestige based on their possession of special knowledge not available to the general public. As the focus in the doctor-patient relationship shifted away from the patient's narrative, it became possible for the professional life of a general practitioner to be framed in terms of the public health battle against disease, a struggle in which the doctor's professional aptitude could be viewed in heroic terms. But because the professional status of medical practitioners was not directly defined by the 1858 Medical Act, the social conception of the doctor remained in flux. The literary examples of Dr. Thorne and Lydgate provide two useful insights into how the

movement towards professionalization of medicine created new possibilities for novelists to ground the heroic quality of the protagonist specifically in his medical work. That process of professionalization expanded the gap between between the doctor's personal and professional life, allowing for the possibility that a medical protagonist might be heroic in one domain but not in the other.

Doctor Thorne

At first glance, the hero of Trollope's *Doctor Thorne* would seem to fit easily into the camp of gentlemanly physicians who resisted all reform and democratization of the medical profession. Trollope's titular character practices medicine under the title of doctor, indicating immediately that he is a licensed physician with a degree in medicine from Oxford or Cambridge. The first piece of information that the narrator relates about him is his connection to the Thornes of Ullathorne, “a family in one sense as good, and at any rate as old” as the best families in the county (16). Dr. Thorne's education and class would therefore incline the reader to develop certain expectations about him as a medical practitioner, but Trollope is quick to subvert any notion that his hero is a medical reactionary. The first lines Trollope devotes to describing Dr. Thorne's medical practice make it clear that he is one of the new breed of practitioners: “As was then the wont with many country practitioners, and as should be the wont with them all if they consulted their own dignity a little less and the comforts of their customers somewhat more, he added the business of a dispensing apothecary to that of physician. In doing so, he was of course much reviled” (27). In addition to his offense against the gentlemanly nature of the profession by lowering himself to the tradesman's work of an apothecary, Dr. Thorne further upset the competing physicians in Bassetshire by what they called the “low, mean, unprofessional, and democratic” act of setting his rate of pay in

proportion to the distance of the visit (27). The fees charged by apothecaries and surgeons were generally about three shillings, with significant variation based on the economic status of the patient and other factors, but a physician's status as a gentleman was closely tied to the tradition of the guinea (21 shillings) fee for a consultation, and while a physician's fee might be much more depending on the illness and the wealth of the patient, for a degreed and licensed doctor ever to accept any less was considered degradingly tradesmanlike (Peterson 210, 227).

Although the narrator claims Dr. Thorne as the hero of the novel, he also presents the reader with a possible hero in Frank Gresham, the heir to the squire of Greshamsbury. The plot of the novel is in many ways a conventional Victorian love-story. Frank and Mary Thorne, the product of a disastrous liaison between the doctor's ne'er-do-well brother and the sister of a lowly stonemason named Roger Scatcherd, love each other but are divided by obstacles of class and fortune. The squire's debt dictates that Frank must marry money to save the estate, but in the end Mary inherits a vast fortune that resolves all of their difficulties in a single marriage. In spite of Frank's position as the romantic hero, Dr. Thorne is the more central figure to the novel. In addition to the Greshams and the Thornes, the third of the novel's principal families is that of wealthy former stonemason Sir Roger Scatcherd, whose railway fortune eventually ends up with his unknown niece Mary Thorne after he and his son both drink themselves to death, thus saving the "Race of Scatcherd" from extinction (Trollope, *Thorne* 468). The doctor is the bridge between these three families of different rank and fortune, and his medical profession is essential to his ability to unite them all in the end.

The fact that the doctor is indispensable to all of the novel's other characters was so clear that all of the initial reviews made a point of mentioning it. The reviewer for the *Athenaeum* recommends it as “an excellent novel” because “[t]he characters are real creatures of human nature, flesh and blood, vigorously and broadly drawn, but not caricatured,” especially Dr. Thorne, “the good genius of everybody in the book” (719). The *Saturday Review* agrees about the quality of the “excellently sketched” characters, but the fact that the novel does not properly respect the boundaries of rank and class is picked out as an unredeemable flaw. The reviewer accuses Trollope of investing the novel “with a sort of atmosphere which is not incapable of being condensed into the moral that people ought to marry for love and not for money, and that wealth and station are in themselves somewhat contemptible” (618). The review becomes something of a political rant against novelists like Trollope who undermine society by encouraging men to disregard “[a]ncient descent, longstanding connexion, great wealth, or even the encumbered remains of great wealth... in order to gratify mere personal feeling” (619). The straightforward marriage plot of the novel would seem unlikely to arouse such a passionate response, but the doctor's actions in moving between families of different rank and the unifying marriage he ultimately brings about are deeply threatening to those who seek stability in the traditional English class hierarchy.

The provincial medical world of Barsestshire, embodied by the rival physician Dr. Fillgrave, can see Dr. Thorne as only a grasping tradesman, but in his flexibility he is an example of a new type of medical practitioner who reconciles the roles of gentleman and professional. Dr. Thorne's social position is uncertain, as he is “fit society for the old squire of Greshamsbury” (28), while at the same time he is forced to succeed on the basis of his work rather than his name, having stubbornly cut himself off from his potentially lucrative

family connections to the Thornes of Ullathorne because they rejected his misbehaving brother. The doctor is not alone in failing to fit neatly into a well-established social category, as the squire's elevated position is undermined by the debt that threatens to strip him of his estate, while the drunkard stonemason Scatcherd has achieved knighthood and amassed a vast fortune. The doctor's uncertain identity makes for a useful character in a novel that addresses the concept of social mobility in Victorian society because his flexibility allows him to move between the squire of Greshamsbury and the new-money baronet Sir Roger Scatcherd, although not without difficulty.

Because of the threat to the status quo that a reform-minded newcomer like Dr. Thorne represents, one of the central conflicts of the novel is between him and Dr. Fillgrave, the voice of the medical establishment of Bassetshire. Dr. Fillgrave represents all of the traits of the old standards of medical practice, including both the dignity of pretending that the guinea fees from his patients are a happy accident rather than payment for service, and also maintaining the social inferiority of the doctor to his aristocratic patients, “whose shoe ribbons Dr Fillgrave would not have objected to tie” (28). The suggestion his name makes about his treatment leading his patients to fill graves rather than recover is another piece of evidence that Trollope rejects the medical status quo. Trollope also takes advantage of the ongoing political debate in the capital over medical reform to flesh out the professional conflict between the two fictional doctors, with Dr. Thorne drawing upon the real-world London medical journals like the *Lancet* in his war of letters with Dr. Fillgrave, and by extension with the provincial medical world. The journals that take Dr. Fillgrave's side in the novel are left unnamed, but it is not difficult to find articles arguing against the same sort of progressive practices that made Dr. Thorne's an object of scorn among his peers. In an article

about medical reform in July of 1858, the *Saturday Review* questions the value of physicians dispensing drugs and conjectures that “if delegates of the General Practitioners are to test the fitness of the student for his diploma or license, it is only too probable that their examination will be much more an inquiry into orthodoxy [in dispensing drugs] than an investigation of capacity” (“Doctors and Quacks” 30). Publications like the *Saturday Review* took it upon themselves to stand up for the dignity of the gentlemanly physician in the face of the “democratic” efforts of journals like the *Lancet* to reform the profession in ways that would secure greater representation for the general practitioners who actually provided most of the medical care. That real-world conflict over the fate of the medical profession is mirrored in the fictional conflict between Dr. Fillgrave and Dr. Thorne, and Trollope comes down clearly on the side of the reformers.

The uneasy balance between Dr. Thorne's status as a gentlemanly physician and his professional identity as a working medical practitioner mirrors Trollope's own career as both a gentlemanly novelist and a working civil servant. In “Trollope's Professional Gentleman: Medical Training and Medical Practice in *Doctor Thorne* and *The Warden*,” Timothy Ziegenhagen asserts that Trollope's medical men represent a new kind of Victorian figure for whom professional identity enables the concept of work to be reconciled with the position of a gentleman. The uncertain social status of a character like Dr. Thorne allows Trollope to embrace professional reform without rejecting the traditional class hierarchy of Victorian society, “forging an ideal of professionalism that is inclusive of both tradition and progress” (155). In addition to reflecting Trollope's own hybrid professional identity, this emphasis on non-revolutionary reform that did not seek to throw out long-held traditions would have been far more palatable to Trollope's Victorian audience.

Dr. Thorne's awkward position in between gentleman and tradesman is an essential part of his activities in the novel. Ziegenhagen highlights the incident in which Beatrice Gresham observes Dr. Thorne in the process of mixing his “villainous compounds,” but in contrast to her genteel aversion to the tradesman-like activities, Dr. Thorne greets her openly and without any sense that his work is undignified (364-365). This openness about the mechanical elements of his work is in direct contrast to the way that medical men like Dr. Fillgrave inflate their fees by making their work a sort of philosophical secret knowledge that must be kept secret from “profane eyes” (Trollope, *Thorne* 28).

Another element of the changes going on in the medical profession that would have been quite clear to an observer from outside like Trollope was the shift toward the medical practitioner as possessing an expert knowledge inaccessible to his patients. Although the “purely philosophical spirit” claimed by physicians like Fillgrave could often serve as an excuse for mystifying their work to elevate themselves, the rise of clinical science allowed doctors to place their work above the scrutiny of their patients (28). For example, when the general practitioner Mr. Rerechild discusses with Dr. Thorne the condition of their dying patient Roger Scatcherd, he prevents Scatcherd's wife from participating by speaking in obscure medical jargon: “did you observe the periporollida?” (263). Although the professionalization of medicine leveled many of the divisions between the different classes of medical practitioners, it also elevated medical practitioners' position in the power structure of the doctor-patient relationship. The increasing specialization of medicine created greater opportunities for doctors to use professional language to separate themselves from their patients. Trollope makes it clear that the practice is a general one among all his medical

characters, as Dr. Thorne “mystified the case as doctors so well know how to do” in response to Lady Scatcherd's request for the truth of her husband's condition (261).

Although at no point in the novel is the exact time-period made explicit, Trollope's references to the structure of the profession and the medical reform debates raging in the *Lancet* and other publications make it clear that the action takes place in the period of transition leading up to the 1858 Medical Act. The novel was written between October 20, 1857 and March 31, 1858, thus predating the Medical Act by almost half a year (Skilton xiii). Trollope composed *Doctor Thorne* while on assignment from the General Post Office to negotiate a treaty in Egypt for the delivery of mail by railway from Alexandria to the Suez Canal, and he says nothing in his *Autobiography* that would directly indicate any awareness of the political debates in London that eventually led to the Medical Act (116). The *Autobiography* does reveal that the marriage-plot narrative thread of *Doctor Thorne* originated from Anthony Trollope's brother Thomas, with whom he spent some time in Florence before continuing on to Egypt (115). During the 1850s, Thomas Trollope was a successful travel writer living in Florence, and he also wrote articles for the London periodicals about the movement towards Italian independence and unification (Neville-Sington). His villa, called The Villino Trollope, was visited regularly by English writers when they traveled in Italy (including George Eliot in 1860 and 1861), and that steady stream of information, along with his involvement in politics, indicates that he probably would have been quite familiar with the state of the medical reform movement in England when he supplied his brother with the narrative thread of *Doctor Thorne*.

The Letters of Anthony Trollope is similarly devoid of any direct references to medical reform, but there is evidence that he continued his regular reading of the *Times* while he was

in Egypt, as one of his letters in November of 1857 includes a request to send him any notices about his most recently published novel, *The Three Clerks*, because “I see here no London papers... only the Times and Atheneum [*sic*]” (61). Between his brother's interests in politics and his own access to the *Times*, it is reasonable to assume that Trollope was aware of the fall of the Prime Minister Palmerston's government in February 1858, which opened the door for Simon's medical reform bill to be introduced in March under the short-lived minority government of the Conservative Lord Derby (Roberts 45-46). At the very least, Trollope would have been aware of the general outlines of the Parliamentary debates that were raging over medical reform in London while he was in Egypt writing *Doctor Thorne*.

Although Trollope may not have known every detail of the piece of legislation that was being debated in Parliament while he composed *Doctor Thorne*, the conflicts and failed attempts at reform in the years leading up to the Medical Act are clearly visible in the passages describing Dr. Thorne's work and his conflict with Dr. Fillgrave. Much of Dr. Fillgrave's disdain for his adversary is grounded in the gentlemanly notion of the inherent inferiority of apothecaries, such that the term becomes pejorative: “that pseudo-doctor, that half-apothecary who lived in the village” (Trollope, *Thorne* 439). Dr. Fillgrave also embodies the hypocrisy of the gentlemanly physicians who sought to preserve the illusion that a doctor's fees were “an accidental adjunct to his station in life... [he] should take his fee without letting his left hand know what his right hand was doing” (28). In reality, physicians like Fillgrave “dearly loved a five-pound fee. What physician is so unnatural as not to love it?” (137).

Dr. Thorne is an example of exactly that sort of “unnatural” physician, and his “democratic” seven-and-sixpenny visits provide a sufficient income for him and Mary.

Unlike his professional rivals though, Dr. Thorne has no savings of “three or four thousand pounds in the Three per Cents” that would provide for his niece's future (88). Even at the end of the novel, after Mary has inherited the Scatcherd wealth and married Frank, the doctor continues his work: “[W]hen Mary suggested to him that he should retire, he almost boxed her ears... [and he] continues to extend his practice to the great disgust of Dr Fillgrave” (524). Dr. Thorne is a professional man who must rely on his skilled labor to support himself and his niece, and his commitment to his medical practice reflects the reformed image of medicine as work rather than a gentleman's pastime.

While Dr. Thorne's professional activities place him on the side of the reformers, his democratic tendencies do not extend beyond his medical practice. Trollope points out very clearly that although Dr. Thorne may have severed his ties with his Ullathorne cousins, he takes great pride in the superiority of his blood. “No man plumed himself on good blood more than Dr Thorne; no man had greater pride in his genealogical tree... no man had a stronger theory as to the advantage held by men who have grandfathers over those who have none, or have none worth talking about” (23). Although the doctor's pride leads him to behave in ways that offend the privilege of those who think of him as an inferior, like the squire's wife Lady Arabella, his political sympathies are entirely on the side of the Tories. Dr. Thorne enlists the support of the *Lancet* in his professional conflict with Dr. Fillgrave, but his interest in reform is limited to the day-to-day practice of medicine. When it comes to economic changes and social mobility that threaten to upset the agrarian class-based system, the doctor has little sympathy for meritocratic ideals or the market economy as a judge of value: “Other doctors round the county had ditch water in their veins; he could boast of a pure ichor, to which that of the great Omnium family was but a muddy puddle. 'Twas thus

that he loved to excel his brother practitioners, he who might have indulged in the pride of excelling them both in talent and in energy!” (23-24).

Trollope's hero is an interesting transitional figure in the evolution of the medical profession. Because of the novel's position just in advance of the 1858 Medical Act, Dr. Thorne can function as a reforming medical practitioner without being implicated in the political changes that would take place later. The doctor's position as the hero of the novel is largely a function of the evolution of the profession, and the social uncertainty of his intermediate position makes him useful to Trollope in ways that a lawyer or a priest would not be. At one point in the novel, Mary argues with her friend Patience Oriel, the Rev. Oriel's sister, about whether the doctor or the parson is the greatest man in a village. Mary argues that “if a parson was away for a month, no one would miss him; but that a doctor is so precious that his very minutes are counted” (126). Patience counters that “we in the church manage our parish arrangements better than you do. We don't let strange practitioners in among our flocks because the sheep may chance to fancy them” (126). While this arrangement may allow those in the church to enjoy more reliable work schedules, it is precisely because Dr. Thorne moves between different flocks that he is able to bring about the novel's happy conclusion.

Medical practitioners become useful characters to a novelist like Trollope because they can move between different groups without the stigma that attaches to most forms of social mobility. As Ziegenhagen points out, “Thorne is able to unite—literally, in the marriage of Mary and Frank—the old England with the new, the past with the future. The Scatcherd family gains blood and the Gresham family gains money” (162). The fundamental difference between Dr. Thorne and those who climbed the social ranks by accumulating great wealth

was that the doctor's social mobility was connected to his professional rather than his personal identity. A lowly stonemason like Scatcherd might amass three hundred thousand pounds and become a baronet, but he could never hope to be accepted into the social world of the aristocracy. It is not just the uncertain social status of the new type of medical men like Dr. Thorne that makes them useful characters, but rather it is the division between their personal and professional lives. Dr. Thorne's professional identity carries with it a measure of social prestige that is independent of the blood he takes such pride in, and that is why his social mobility is tolerated to a much greater degree.

While the passage of the Medical Act in 1858 would go a long way toward resolving the uncertain identity of medical professionals like Dr. Thorne, the qualities that made this new breed of medical professionals useful to novelists would endure. As the distinctions among apothecaries, surgeons, and physicians broke down, a medical practitioner's professional status was no longer directly related to his genealogy and social standing. Having independent personal and professional identities is the key to the sort of social mobility that a character like Dr. Thorne enjoys, and the professional identities of medical practitioners were not only clarified but also gained social value in the wake of the 1858 Medical Act. Although the reform of the medical profession was still far from complete by the time George Eliot completed *Middlemarch* in 1872, the Medical Act had produced important changes in both the medical profession and in the public's perception of it. The uncertain identity of medical practitioners was a product of the growing gap between their personal and professional identities, and the new social prestige of the profession allowed novelists to exploit that gap between the personal and the professional to create increasingly complex and compelling characters.

The Profession in the Wake of the Medical Act

Although the 1858 Medical Act was considered to be only a partial solution to the problems in the medical profession, it was immediately recognized as a piece of legislative reform with the capacity to alter dramatically the shape of the medical world. In the weeks following the act's passage, the *Lancet* declared that “it is not difficult to perceive that we have in this statute both a fulcrum and a lever which through future generations may be employed to the advantage of medical practitioners, but infinitely more in promoting the welfare of the community” (“AUGUST 21, 1858,” 205). That description of the Medical Act as a tool that might be used in the future to produce change is particularly apt. There was little in the act that directly changed the structure of the profession, but by establishing the General Medical Council and giving it the authority to audit the examinations of the different licensing bodies, it created the agent by which the chaos of different medical qualifications, training, and practice could be brought to order.

The limited nature of the Medical Act can be largely attributed to the conflicting influences of the medical reform movement push for more central authority and the political popularity of *laissez-faire* economic policy. The three classes of the profession and the London colleges that represented them theoretically had significant monopolistic power, but they had previously lacked the full power of the state to enforce their control. The different educational and licensing bodies also had competed with each other in a free market system that allowed irregular practice to flourish. The medical reform movement wanted the regulation of medical practitioners and control of standards to be centralized under the authority of a body of rank-and-file practitioners, but there was a competing political movement that argued that the problems in field of medicine were due to too much

regulation. In an article responding to the growing legislative push towards reform in April 1858, four months before the passage of the Medical Act, the radical journal *The Westminster Review* gave a lengthy summary of more than fifty pages on the history of medical practice, with the goal of illustrating the “common sense” position “that the medical profession is already suffering from too much law” (“Medical Reform” 480). According to the principles of liberalism (now called classical liberalism to distinguish it from the different meaning of the term in modern politics), which in the political lexicon of the time stood for eliminating all government interference in the activities of the free market, the only true reform that Parliament could enact would be the repeal of all existing laws that regulated the practice of medicine, such as the 1815 Apothecaries Act. In addition to blaming the state of the medical profession on government interference with the free market, the *Westminster Review* also decried the London colleges as fundamentally opposed to “the law of equity, which is violated so long as English physicians can legally practice in Ireland and Scotland, while Irish and Scotch physicians cannot *legally* practice in England” (“Medical Reform” 499). The liberal argument against the medical corporations, and any other government-sanctioned professional institutions, is summed up by the *Westminster Review*:

Vested interests, by their very nature, are ever opposed to the spirit of Reform, which can only subjugate them, after a long siege, by the artillery of argument and the strength of right. But only in proportion as they are artificially fortified by the State is their resistance injuriously prolonged, only then can they so completely deaden enterprise and stifle competition as to destroy the very life they were appointed to foster — replacing it by stagnation (“Medical Reform” 520).

The movement in favor of centralized reform clashed in Parliament with the liberal MPs who resisted interference in the open medical marketplace, and the act that finally passed was a “triumph of [classical] liberalism. It perpetuated the eclectic system of education and

licensing that had gradually grown up between the universities, hospital medical schools, and medical corporations” (Bynum, “Rise of Science” 213).

The issue of qualifications and titles was at the forefront of the debate over medical reform, and two elements of the act were particularly important in that respect. The act preserved the power of the different licensing bodies, but it empowered the General Medical Council to compile the names of all properly licensed medical practitioners into a single register (see Appendix, Clause XV). Although the act did not directly criminalize irregular medical practice, it did make it illegal for anyone without one of the listed qualifications to present himself as a registered practitioner or to use any of the titles associated with recognized licenses (see Appendix, Clause XXXIX). The act may not have reduced the proliferation of different qualifications, but having a single register in which all medical men were listed together regardless of title was a major step towards a unified concept of the medical practitioner. This was further reinforced by a clause that legally established that the terms “duly qualified medical practitioner” or “legally qualified medical practitioner” could only apply to those registered under the Act (see Appendix, Clause XXXIII). Distinguishing between quacks and qualified practitioners was a major concern, as the census of 1851 had revealed that about two thirds of those practicing medicine admitted to doing so without a license, while according to some estimates “the proportion of unqualified to qualified was more nearly 9:1” (Cline 276). Both the register and the formal establishment of the term “medical practitioner” were particularly influential in shaping the general public's understanding of the profession, as the expressed goal of the act was that laymen should be able to consult the register and “be enabled to distinguish between qualified and unqualified practitioners” (“LANCET: AUGUST 21, 1858,” 205). Over the last 150 years the 1858

Medical Act has been amended so often that almost none of the original text remains in force, but the General Medical Council and its register of qualified practitioners are still an essential part of the medical system in Britain (Roberts 55).

The initial response to the Medical Act within the medical community varied significantly. In its article outlining the newly minted act, *The Times* began with the act's stated goal of distinguishing between qualified and unqualified practitioners, but the first feature of the law to be explained in detail was the provision that enabled physicians to sue in court to recover their charges ("MEDICAL ACT" 23 Oct. 10). This change had major social significance for physicians, who previously had not been allowed to charge fees that could be recovered in court because this practice would undermine the gentlemanly pretense that physicians did not work but merely gave advice. Much of the news coverage about the Medical Act was related to varying responses within the medical community about how the legislation should be interpreted and who should be elected to the new General Medical Council. The prevailing sentiment, reported on by *The Times*, of a meeting of London medical men on October 27, 1858 was that the government should be pressured to appoint general practitioners to the council so that the largest part of the profession would be adequately represented, but the old class divisions were on display when some surgeons objected to better representation for the licentiates of the Society of Apothecaries because "it would be unwise to associate more closely the medical profession and the Apothecaries' Company, which was now but a mere trading guild" ("MEDICAL ACT" 28 Oct. 9). An interesting development in the weeks immediately following the passage of the Medical Act was that while Wakley had expressed some reservations in his optimistic assessment of the act in the pages of *The Lancet*, he defended it vigorously in person at many of the meetings

of general practitioners in London. In the same meeting on October 27, he argued forcefully against a resolution for general practitioners to break away from the corporate bodies to protest the lack of complete representation under the act, “believing that the new Act would be productive of great good” (“MEDICAL ACT” 28 Oct. 9). In another meeting of members and Fellows of the Royal College of Surgeons on December 21, Wakley again defended the act against some members who felt it was a tool to serve the interests of the Council of the College, though he ended up voting for the meeting's unanimous resolution that the Council of the College had subverted the rights of the members and Fellows of the College by appointing a representative to the General Medical Council without consulting them (“College of Surgeons” 9).

The legislative element of the Medical Act was only one component of the change in the medical profession that took shape in the second half of the century. By the middle of the nineteenth century the doctor-patient relationship in England was shifting decisively in favor of the doctor, thus allowing novelists to create medical characters who were in no way secondary to those they treated. The introduction of anaesthesia in 1846 and antiseptic surgery in 1867 made new operations possible and reduced the mortality rate for major surgery to the point that it became therapeutically useful for a much larger variety of conditions (Bynum, “Rise of Science” 156-157). Part of the earlier superiority enjoyed by patients with respect to their doctors was based on the fact that, like Roger Scatcherd rejecting Dr. Thorne's advice to stop drinking, a patient was free to ignore any medical advice that did not suit him or that failed to produce immediately visible results. In the realm of surgery, the patient had to submit completely to the doctor's power, so any increase in the

number of conditions that could be treated surgically shifted the relationship in favor of the medical practitioners.

Patients also had to submit to a greater degree of physical intrusion by their doctors, as by the 1860s the French clinical model of diagnosis on the basis of direct physical examination had become an essential part of scientific medicine in England (Bynum “Rise of Science” 203). New diagnostic equipment like the stethoscope, invented in 1816 by René Laennec in Paris, and the achromatic microscope, a new type from the late 1820s that corrected for chromatic aberration, reduced doctors' reliance on the patient's narrative (Jacyna 42, 69-70). The growing emphasis on the doctor's supposedly objective clinical observation over the patient's subjective account created a new power structure in which the patient still had to listen to the doctor while the reverse was not necessarily true. These changes in the diagnostic and therapeutic practices of medical practitioners went hand in hand with the professional reform of the 1858 Medical Act to bolster the popular image of all practitioners as possessors of expert scientific knowledge which was beyond the understanding of those they treated.

By establishing a unified register of all qualified medical practitioners, the 1858 Medical Act implicitly unified the profession of medicine in the minds of the general public. Although quackery persisted, patients quickly learned to look for proof of registration from any medical practitioner who treated them, regardless of the practitioner's specific license and title. The fact of having one's name on the register was part of the social prestige that was increasingly attached to all branches of the medical profession. The *Lancet* was quick to pick up on the significant role in British society that a unified medical profession could play: “Medicine has been without any public life. For the first time in its history, the profession

will be collected into one organization, and grafted into the State, where we doubt not it will grow into its proper social and political importance” (“AUGUST 7, 1858,” 148). The concepts of public health and of doctors fighting disease for the good of society were not limited to convincing Parliament to pass the 1858 Medical Act, and while the social status of physicians like Dr. Thorne retained a large degree of uncertainty in the years following the Act's passage, by the 1870s one can detect a definite heroic element in the popular perception of the medical profession.

Middlemarch

The setting of George Eliot's sprawling “study of provincial life” may have been the years leading up to the Great Reform Act of 1832, but it is important to remember that it was published in 1872 for an audience that was well aware of the many changes that British society would undergo in the decades following that watershed moment, including the medical reform movement. The novel's historical setting is also important for the perspective it gives on the evolution of the medical profession as it was perceived at that intermediate stage. George Eliot's notes reveal that she relied heavily on articles in the *Lancet* from the 1820s and on other historical texts to depict accurately the state of medical practice and the reform movement during that period, and the novel is rich with references to the leading medical and scientific men of the day, the public health concerns about cholera and typhoid fever, and the innovative treatments that were being developed on the basis of new scientific research (Furst, “Struggling for Reform” 432).

The initial response to the novel in the press was mixed, with most reviewers criticizing it for being too moralizing and didactic but praising the depth of the characters. In the *Saturday Review*'s anonymous review, the novel is lauded for being “like a portrait

gallery,” but “[n]o talent, not genius itself, can quite overcome the inherent defect of a conspicuous, constantly prominent lesson” (733-734). Because the novel is structured with two separate protagonists, many of the reviews compare the narrative threads against each other, especially in terms of identifying which of the two is the most tragic, but in all the early reviews, Lydgate is given much less attention than Dorothea, and when he is mentioned it is usually with reference to the parallels between the two central characters, such as when Edith Simcox in *The Academy* calls him “a masculine counterpart to Dorothea with the relative proportions of head and heart reversed” (3). Only the review in the *Spectator* finds Lydgate to be the superior of the two, judging him to be “the true hero of the story” because the story of his disastrous marriage to Rosamond is the most “unique” and “originally-drawn” tragedy in a work that rates “amongst the stars of the second magnitude” with only Shakespeare as a superior (Hutton 1555). Both the positive and the negative reviews get caught up in evaluating the novel in terms of the literary debates about the moral role of the novel, but while the depth of the characters is singled out for significant praise, remarkably little is said about how Eliot’s “study of provincial life” portrays the web of social connections that unites those richly drawn characters.

Much like the beginning of Dr. Thorne’s career as an outsider trying to carve out a place for himself in a provincial setting with an established population of medical practitioners, the medical co-protagonist of *Middlemarch*, Tertius Lydgate, arrives on the scene with impeccable medical credentials and a family name that affords him social recognition as a gentleman even though he lacks family wealth. One key difference between the two characters is that Lydgate is not a physician, and unlike the text-based academic study at Oxford or Cambridge of a physician like Dr. Thorne, Lydgate’s more hands-on

medical education took place in a surgical apprenticeship, followed by study in the teaching hospitals of London, the progressive medical program at the University of Edinburgh, and the clinics of Paris (145). This last element of his training is particularly important, as both his research methods and therapeutic techniques are based on the principles of the Paris Medicine. Following his period of studies, Lydgate would have presented himself for a licensing examination by the Royal College of Surgeons and another by the Society of Apothecaries, where he would have been required to present his certificates from London and Edinburgh and submit to an oral examination, but according to their protectionist rules, no certificates from foreign hospitals could be acknowledged by either body's Court of Examiners (Cline 278-279). In addition to the difficulty of going through the required training and passing the oral examinations, the diplomas from each of the London colleges also came at a significant financial cost, which was 20 guineas in 1830 (Eliot, *Quarry* 23). There was no legal benefit in the English system to having trained in France, but that unnecessary foreign training is important for establishing Lydgate's position on the cutting edge of medical knowledge, as French law made it much easier to obtain corpses for dissection, and the medical research community in Paris contained all the most eminent anatomists and pioneers in new therapeutic methods. Eliot establishes her character at the forefront of medical education, and in the novel he is generally referred to either as a general practitioner or by the formal title of surgeon. The use of those two terms and his diagnosis and treatment of internal ailments like Mr. Casaubon's heart condition and Fred Vincy's typhoid fever during the course of the novel make it clear that he is one of the new breed of dual-licensed surgeon-apothecaries.

That Lydgate is of a different sort from the typical country practitioners who make up the medical establishment of Middlemarch is made clear from the first time he is mentioned. In conversation with Lady Chettam, Mr. Brooke affirms that “he is likely to be first rate — has studied in Paris, knew Broussais, has ideas, you know — wants to raise the profession” (92). Putting this recommendation of Lydgate into the mouth of Mr. Brooke allows Eliot to illustrate important details about both characters. Mr. Brooke knows of Lydgate through a letter from the young surgeon's uncle, who is later revealed to be a baronet in Quallingham. The first few chapters of the novel had established Mr. Brooke as an important, if rather eccentric member of the gentry, and the report of the letter through Mr. Brooke confirms Lydgate's high family connections without any of the embellishment of pride that is displayed by Dr. Thorne. The mention of Paris and Broussais is equally significant. It establishes both the eclectic nature of Mr. Brooke's knowledge and the fundamentally foreign character of Lydgate's medical education, which would become one of the defining characteristics in the town's conception of the new medical practitioner. The idea that Lydgate wants to “raise the profession” is also a particularly important one, as it places him in the camp of those medical practitioners who are willing to upset the status quo to reform and develop the profession. This, together with his “foreign notions,” places Lydgate in immediate opposition to the established medical men of the town. Just like the conflict between Dr. Thorne and Dr. Fillgrave, Lydgate's efforts to improve the profession are opposed by the medical practitioners whose livelihoods are founded on the perpetuation of the medical status quo.

Eliot also carefully establishes Lydgate on the cutting edge of medical practice for the late 1820s. When Lydgate treats Mr. Casaubon following an attack of an unknown illness of

the heart, the examination includes the use of the stethoscope. By the 1870s, the stethoscope was such a common element of the diagnostic process that Eliot felt it necessary to include a parenthetical aside to remind her readers that use of that device “had not become a matter of course in practice at that time” (286). Lydgate's use of the device also links him to the cutting-edge world of French medicine, and that link is made even more explicit later in the novel when Lydgate explains to Mr. Casaubon that his illness is “fatty degeneration of the heart, a disease which was first divined and explored by Laennec, the man who gave us the stethoscope, not so very many years ago” (423). Broussais and Laennec are only a couple examples of the numerous historical physicians referred to throughout the novel. The first entry in Eliot's *Quarry for Middlemarch*, the notebook she used to compile her research about the medical and scientific knowledge and practice at the time of the novel's historical setting, is a list of names and dates of French doctors and scientists taken from an English translation of Renouard's *History of Medicine* and J. R. Russell's *History and Heroes of the Art of Medicine*, including Broussais and Laennec (37). Another key name on the list at the beginning of the *Quarry* is the anatomist Xavier Bichat, Lydgate's hero in the realm of medical research, whose “brief and glorious career” established the understanding that the fundamental nature of the human body is not a collection of organs which can be understood by studying them separately, but rather “as consisting of certain primary webs or tissues, out of which the various organs — brain, heart, lungs and so on — are compacted” (*Middlemarch* 148). With the advantage of four decades of hindsight, Eliot is easily able to position Lydgate as a disciple of the most successful researchers and as an innovator in the world of provincial medical diagnosis and treatment.

The goal Lydgate pursues in his medical research is based on Bichat's discoveries about tissues rather than organs being the fundamental elements of the human body, and he seeks evidence that the variety of different tissues can all be traced back to the “primitive tissue,” the basic tissue from which all the others can be derived. His quest presents one of the many parallels between characters in the novel, as the life's work of the scholar Mr. Casaubon is the discovery of the “Key to all Mythologies,” by which all of the myths and religions of the world can be reduced to their universal, fundamental elements. In the case of an Anglican mythographer like Casaubon, finding that key means reducing “a great diversity of race, custom, creed and fable... back to a single origin and squar[ing] events and myths with the Bible” (Harvey 319). The narrator treats Casaubon's quest for unified knowledge in the field of mythology as the pointless obsession of a dry, lifeless scholar, but the irony is that Lydgate is engaged in an equally fruitless quest for unified knowledge in the field of biology. Eliot devotes almost two pages in the *Quarry* to outlining the advances in cell theory made by several German scientists in the late 1830s, discoveries which would have confirmed that Lydgate's search for the primitive tissue was thoroughly misguided, as the fundamental element of all living bodies was actually the cell (25-26). Lydgate works in earnest with the best information available to him at the time, but the novel's readers would have recognized that he was trying to answer the wrong question. The fact that the key discoveries were made by German scientists makes the parallel with Casaubon particularly acute. Will Ladislaw points out the futility of Casaubon's efforts, which are being “thrown away, as so much English scholarship is, for want of knowing what is being done by the rest of the world. If Mr Casaubon read German he would save himself a great deal of trouble” (Eliot, *Middlemarch* 208). Lydgate's efforts are somewhat redeemed by the fact that they have not yet been

rendered pointless by other research, but Casaubon's willful ignorance of German means that he does not know that Otfried Müller's *Prolegomena zu einer wissenschaftlichen Mythologie*, which Eliot knew of because she had referred to it in a review of another work, had demonstrated in 1825 that mythologies developed independently, and thus rendered Casaubon “a complete anachronism, lost in the labyrinth of an exploded pseudo-science” (Harvey 320). Both researchers are asking the wrong question, but the narrator is far less critical of Lydgate than Ladislaw is of Casaubon: “What was the primitive tissue? In that way Lydgate put the question — not quite in the way required by the awaiting answer; but such missing of the right word befalls many seekers” (*Middlemarch* 148). The obvious parallel between the two characters tends to encourage a more charitable reading of Casaubon, but the chronologies of the discoveries in their respective fields leaves Lydgate in the superior position. Lydgate was operating under a flawed hypothesis, but he was doing the best he could with the technology that was available to him at the time. Part of the tragedy when his flawed marriage and financial constraints force him to give up his ambitions in favor of a fashionable practice and a treatise on gout at the end of the novel is that under different circumstances he might well have recognized his error and found “the right word” in time to become one of the pioneers in cell theory.

A particularly important element of Lydgate's conception of the medical profession is the unity between medical treatment and medical research, and Eliot makes sure that he is at the forefront of available technology with his research tools as well. In the chapter that presents Lydgate's quest to build upon the work of Bichat by seeking the “primitive tissue” from which all others are derived, Lydgate's research technique is described by the narrator as “diligent application, not only of the scalpel, but of the microscope, which research had

begun to use again with new enthusiasm of reliance” (149). Lydgate's scientific interest in microscopy also provides an opening into the friendship he develops with Reverend Farebrother, an amateur student of natural history. In their initial meeting, they bond over Farebrother's collection, particularly a “lovely anencephalous monster” that Farebrother gives to Lydgate in exchange for “some sea-mice — fine specimens — in spirits [and] Robert Brown's new thing — *Microscopic Observations on the Pollen of Plants*” (172-173). Additionally, although Eliot does not specifically mention that Lydgate possesses an achromatic microscope, a later scene with Lydgate and Farebrother involves the vicar paying the doctor a visit with “some pond-products which he wanted to examine under a better microscope than his own” (349). There is no direct evidence in the novel as to exactly what sort of microscope Lydgate possesses, but the description of Farebrother's “neat fitting-up of drawers and shelves, and the bookcase filled with expensive illustrated books on Natural History” indicates that Farebrother does not skimp in pursuing his hobby (172), so if Lydgate's microscope is better than his it seems reasonable to infer that it is one of the new instruments.

Beyond simply placing Lydgate at the leading edge of scientific research, his use of the microscope forms a parallel with Eliot's activity as a novelist. In “Microscopy and Semiotic in Middlemarch,” Mark Wormald points out the different ways in which the narrator of the novel uses microscopy as a metaphor for understanding the action of the novel. The most obvious use of the metaphor comes early in the novel when the narrator describes the actions of Mrs. Cadwallader with respect to Dorothea's impending marriage:

Even with a microscope directed on a water-drop we find ourselves making interpretations which turn out to be rather coarse; for whereas under a weak lens you may seem to see a creature exhibiting an active voracity into which

other smaller creatures actively play as if they were so many animated tax-pennies, a stronger lens reveals to you certain tiniest hairlets which make vortices for these victims while the swallower waits passively at his receipt of custom. In this way, metaphorically speaking, a strong lens applied to Mrs. Cadwallader's match-making will show a play of minute causes producing what may be called thought and speech vortices to bring her the sort of food she needed (59-60).

Wormald points out how Eliot's decision "to make her narrator an amateur microscopist, one who deploys the language of microscopy to similarly polemical social effect throughout the novel" works to parallel Lydgate's research in a way that highlights the social errors that end up thwarting his scientific ambitions (518). As a scientific researcher, Lydgate may have applied the right methods to the wrong question, but in his social life he commits the graver error of failing to apply the same rigorous standards of empirical observation in his interactions with other people that he relies on when using his microscope. His trade with Farebrother is a model for the way his background leads him to overlook important details in his social life. Brown's *Microscopic Observations on the Pollen of Plants* was an important work in the later development of cell theory, and while the fact that Lydgate possesses what was then a relatively obscure work which had only recently been published by an academic journal in Edinburgh speaks to his advanced scientific knowledge, he is blinded by his fascination with Farebrother's "lovely anencephalous monster." Eliot's readers would have been acutely aware of the severity of his oversight, as the article had been recently reprinted in a popular 1866-68 edition of Brown's collected works (Wormald 506). It is perhaps too harsh to compare Rosamond to a brainless monster in a jar, but Lydgate's lack of awareness as he stumbled into marriage with a woman who was superficially charming but intellectually incompatible with his scientific ambitions is another case of the same sort of blinkered perception that causes him to trade away one of the key works that would lead to

the development of cell theory. Lydgate fails to recognize that, as in his microscopic work, his social perception must account for distortions and imperfections and utilize different degrees of focus.

Not all of Lydgate's unusual therapeutic techniques are based on cutting-edge research from Paris however. In one of the cases that the narrator picks out as an example of Lydgate “having shown himself something better than an everyday doctor,” he treats Mr. Turnbull's pneumonia by letting the man's robust constitution do the work and observing the results (Eliot, *Middlemarch* 451). He is astute enough to recognize that such a course of action would flatter Turnbull about the strength of his constitution, and Lydgate makes him a partner in the experiment of abstinence from drugs, being “acute enough to indulge him with a little technical talk” (452). Although Turnbull recovers and is happy to have learned “many new words which seemed suited to the dignity of his secretions,” he strengthens the enmity that the other medical men feel towards Lydgate by declaring that the young practitioner “knew a thing or two more than the rest of the doctors — was far better versed in the secrets of his profession than the majority of his compeers” (452). The idea of letting the body heal itself without the “aid” of strong drugs or dramatic treatments like bleeding ran counter to all accepted medical notions at the time, and it would have been seen by Lydgate's professional rivals as evidence that his fancy foreign ideas were dangerous, all the more so because they inspire Turnbull to boast about his treatment at every opportunity. As radical as Lydgate's treatment of Turnbull may have seemed, it was actually neither new nor foreign, as it followed the practices of “the English Hippocrates,” Thomas Sydenham, whose mid-seventeenth century medical philosophy was that “whenever he considered that medicine could not materially affect the disease, he did nothing at all” (Cline 280). The standard

practices of the medical establishment in the 1820s were founded upon “heroic” treatments and prescribing large quantities of drugs. Thus Lydgate finds himself in particularly heated conflict with his peers not just because his advanced tools and unorthodox therapeutic techniques generally produce better results but because they run directly counter to how the established medical men of the town had been practicing their profession for decades.

The advanced nature of Lydgate's medical practice is limited neither to the therapeutic techniques nor the physical tools that he uses. The key element in the conflict between Lydgate and the Middlemarch medical establishment is his decision neither to dispense drugs directly to his patients nor to take a percentage from the druggists who fill his prescriptions. One of the flaws in the medical profession that Lydgate hopes to combat is observed by the narrator: “[S]ince professional practice chiefly consisted in giving a great many drugs, the public inferred that it might be better off with more drugs still if they could only be got cheaply, and hence swallowed large cubic measures of physic prescribed by unscrupulous ignorance which had taken no degrees” (Eliot, *Middlemarch* 146). Part of the opposition to Lydgate's new method is based on the fact that until a “recent legal decision” (147), only physicians could expect to be paid just for attending on patients and the only way for a surgeon-apothecary to charge for non-surgical treatment was to make it all part of the bill for the drugs he sold. In “An End to Converting Patients' Stomachs into Drug-Shops: Lydgate's New Method of Charging His Patients in *Middlemarch*,” Leslie Katz identifies a note in *Quarry for Middlemarch* that points towards a *Lancet* article about the 1829 decision *Handey v Henson* (54). The notes to the novel only identify the legal decision as “one of the many legal cases following the reforming of the Apothecaries Act of 1815” (Eliot *Middlemarch* 843), but the first page of the *Quarry* includes the following note pointing to the specific

case: “Professional remuneration. Decision of Ld. Tenterden in the cause of Handey vs. Henson, 1829” (21). The *Lancet* article in question describes the case of Mr. James Handey, a surgeon and apothecary who successfully sued his patient Mr. Henson over an unpaid bill for medicines and attendance (“January 16, 1830” 539). The case set a new precedent that general practitioners who were licensed as apothecaries were legally entitled to charge for non-surgical attendance, and the *Lancet’s* editorial comment on the case celebrates it as a breakthrough for general practitioners, who “will no longer be regarded in families as plunderers, whose interested object it is to convert the stomachs of their patients into drug-shops, but they will now be looked upon as men of experience and skill” (“January 16, 1830” 538). The ability to charge for attendance was a crucial element in the rise of the general practitioner, and the fact Lydgate is aware of the “recent legal decision” (which may actually have taken place after he began practicing in Middlemarch) and able to set up his practice to take advantage of it is another example of Eliot using her later knowledge to place her medical protagonist on the leading edge of the medical profession.

In a provincial town like Middlemarch, the legal validity of Lydgate's new method would be of little consequence to the medical men and their patients who had spent their entire lives operating within a clear system in which physicians are given (it would be ungentlemanly to charge) their fees for attendance and general practitioners charge for the drugs they dispense. The unanimous judgment against Lydgate from the medical establishment was that he, “by not dispensing drugs, intended to cast imputations on his equals, and also to obscure the limit between his own rank as a general practitioner and that of the physicians” (Eliot, *Middlemarch* 182). While the charge that his methods are a deliberate attack on his fellow practitioners is unjust, it is true that Lydgate's conception of

professional reform entails not merely obscuring but completely breaking down the rigid hierarchy of the field. In “Medical Reform in *Middlemarch*,” Lillian Furst points out the advanced nature of such a position: “[Lydgate] is as avant-garde in his defiance of rigid compartmentalization as in his recourse to new instruments and treatments” (“Struggling for Reform” 345). Lydgate does not hesitate to transgress against the hierarchy of the profession when he believes that it will help his patients or advance the cause of reform, such as when he steps above his station by correcting a misdiagnosis by one of the towns' physicians. The zeal with which Lydgate pursues reforms that disrupt the medical establishment in Middlemarch is also strengthened by his social blindness, which prevents him from seeing the consequences he will face for disrupting a status quo that both the medical men and the townspeople were quite happy with before he arrived.

The difficulties caused by Lydgate's reformed method of prescribing drugs are not limited to conflict with his professional rivals, but also come from that same public who associates medical practice with “giving a great many drugs” (Eliot, *Middlemarch* 146). After Lydgate gives a “hasty popular explanation of his reasons” to the grocer Mr. Mawmsey (444), the rumor mill of the town is soon buzzing with the idea that the new medical man has declared that there is “no use in taking medicine” (446). Lydgate's treatment of Mr. Turnbull would have further confused the issue of his stance on the utility of drugs, and the fact that it had been successful in that case would have been of little significance to people like Mr. Mawmsey who “enjoyed the pleasure of forming an acute judgment as to [the drugs'] immediate effects” (445). The provincial townspeople of Middlemarch are automatically inclined to be suspicious of change, particularly when the justification for it comes from foreign medical theories, and Lydgate's practice shrinks because he is unwilling or unable to

recognize that the people of Middlemarch are by and large quite satisfied with the medical status quo and see no reason for any radical upheavals. It is Lydgate's blindness to the social responses to what he believes are perfectly reasonable actions that leads to his financial difficulties, and his shrinking practice makes it impossible for him to pursue his goals of scientific research and professional reform.

Much like Dr. Thorne, Lydgate is aided in his conflict with the medical establishment of the provincial town by the fact that his knowledge and skill are superior to those of his rivals, although the narrator sees that advantage more clearly than most of the townspeople do. In a meeting with Lydgate not long after his arrival in Middlemarch, the banker Mr. Bulstrode provides a harsh but accurate assessment of the town's medical men: "The standard of that profession is low in Middlemarch... I mean in knowledge and skill; not in social status... I have consulted eminent men in the metropolis, and I am painfully aware of the backwardness under which medical treatment labours in our provincial districts" (125). The banker is quick to acknowledge Lydgate's superiority over the rest of the medical men because he recognizes that the new medical practitioner's zeal for professional reform can be made to serve Bulstrode's own zealous pursuits. Middlemarch's chief banker is an Evangelical who uses his money and influence to push the town to adopt moral standards more in line with his own, and Bulstrode's "close attention was not agreeable to the publicans and sinners in Middlemarch" (124). Because of his active meddling in the affairs of his neighbors, especially those who owe him money, the banker is a polarizing figure in the town, and a new arrival like Lydgate would have to align himself with one camp or the other. Bulstrode's flattery in his meeting with the new surgeon is motivated by the fact that Bulstrode wants to secure his vote on the issue of appointing a new chaplain for the

infirmary. Bulstrode knows that the medical board, of which Lydgate is now a member, is evenly divided between those loyal to him and an opposition party united in favor of the Reverend Farebrother. Lydgate is quite honest about the fact that he has no opinion on the subject, but he refuses to recognize that the only way to remain neutral would be to avoid any and all entanglements with the town, which would mean giving up his desire to create a new fever hospital. As a skillful manipulator, Bulstrode presents Lydgate with the opportunity to become the medical director of the New Hospital that he is setting up. There is no explicit *quid pro quo*, but once Lydgate is hooked by the prospect of having the freedom to enact his medical theories in the New Hospital without interference from the town's other medical men, he becomes unavoidably linked to Bulstrode, a link that is especially dangerous because Lydgate tells himself that he is still a free agent who is only siding with Bulstrode for rational reasons. By failing to recognize that his decisions have placed him in the Bulstrode camp, Lydgate cannot anticipate the social consequences of that alliance, an error that costs him the business of those patients who object to Bulstrode's moral meddling and threatens to drag the young doctor into ruin when Bulstrode's questionable past returns to haunt him.

In much the same way that Eliot sets Lydgate up as an innovator in his techniques of treatment and diagnosis, she carefully constructs the setting of the novel and introduces the other medical characters to allow the heroic medical reformer ample opportunity to combat all the worst elements of provincial medical practice. Lydgate's most direct rivals are the surgeons Wrench, Toller, and Gambit, who are ostensibly his peers, though they are his inferiors in both social standing (because of his background and family connections) and medical expertise (because of his superior education). The most successful of them is Toller, who “belonged to an old Middlemarch family” and was “a well-bred, quietly facetious man,

who kept a good house” (447), but his professional work displays all the worst excesses of the day. Toller understood that showy acts of “heroic treatment” were an effective way both to impress patients and justify larger bills, and his “bleeding and blistering and starving his patients” only led them to observe that “his treatment was as active as you could desire: – no man, said they, carried more seriousness into his profession: he was a little slow in coming, but when he came he *did* something” (447). The standard of care provided by Mr. Wrench is even lower, and he dismisses Fred Vincy's illness as a “slight derangement” before Lydgate steps in and correctly identifies it as a potentially deadly case of typhoid fever. The third of them, Mr. Gambit, is considered by most of the townspeople to be slightly inferior to Toller and Wrench, and although he possesses a “satisfactory practice,” he endures “professional contempt” for having so little education that he “call[s] the breathing apparatus 'longs” (447). It should come as no surprise that Lydgate's medical expertise and status as a gentleman would lead his supposed peers to fear that “a man who without calling himself a London-made M.D. dared to ask for pay except as a charge on drugs” might disrupt their stable practices and cause their patients to expect a higher level of treatment without the excessive fees of a physician (444).

The town's physicians feel their status to be threatened by the innovative newcomer as well, particularly because his good breeding enabled him to interact with the gentry of the county in a way that most general practitioners never could, regardless of how effective their skills might be. Of course, among the patients in Middlemarch, “ [n]obody's imagination had gone so far as to conjecture that Mr Lydgate could know as much as Dr Sprague and Dr Minchin, the two physicians, who alone could offer any hope when danger was extreme, and when the smallest hope was worth a guinea” (142). Dr. Sprague and Dr. Minchin are

described as being esteemed for their “weight” and “penetration” respectively, but the narrator's quotation marks around those words suggest that the townspeople's perception of those qualities is not reliable. In the case of Dr. Sprague, the basis for his reputation is a thirty-year-old treatise on meningitis, and his initial dislike for Lydgate is a reaction against “a disposition to unsettle what had been settled and forgotten by his elders” (157). The evidence of Dr. Minchin's medical ignorance is even stronger, as he misidentifies Nancy Nash's cramp as a tumor, thus allowing Lydgate to earn the dubious accolade of having cured her cancer when he makes the correct diagnosis and she recovers naturally. The physicians do have some cause to feel threatened, as Lydgate's skill wins over several of the county's foremost families, such as the Casaubons, the Chettams, the Brookes, and the Vincys. The rival physicians' concern about Lydgate poaching from the limited supply of patients from the county's wealthiest families would be particularly acute because the “surprising thing about the two physicians is that, with membership in the Royal College totalling 146 in 1795 and 213 in 1809 — to give a range of dates when they might have qualified — both should have settled in the same provincial town” (Cline 278). Lydgate's single-minded pursuit of medical reform and scientific advancement may cause him problems with his professional rivals and in his social interactions with potential patients, but in his medical practice he displays extraordinary sensitivity: “he was an emotional creature, with a flesh-and-blood sense of fellowship which withstood all the abstractions of special study. He cared not only for 'cases', but for John and Elizabeth, especially Elizabeth” (Eliot, *Middlemarch* 145). It is part of the tragedy of Lydgate's story that being an ideal doctor is not enough to preserve his worthwhile ambitions from his social flaws, a poorly-considered marriage, and the opposition of the provincial community.

For a doctor who has studied in the cosmopolitan cities of London, Edinburgh, and Paris, it might seem odd that Lydgate establishes himself in Middlemarch, but part of his scientific ambition is to “settle in some provincial town as a general practitioner [and] keep away from the range of London intrigues, jealousies, and social truckling, and win celebrity, however slowly... by the independent value of his work” (145). The irony is that Lydgate fails to comprehend that a provincial town has more than enough intrigues, jealousies, and social truckling to derail his plan to be “a good Middlemarch doctor, and by that very means keep himself in the track of far-reaching investigation” (147). The defeat of his efforts for reform and scientific investigation is so complete that at the end of the novel he has “an excellent practice, alternating, according to the season, between London and a Continental bathing-place; having written a treatise on Gout, a disease which has a good deal of wealth on its side... he always regarded himself as a failure; he had not done what he once meant to do” (834-835). Lydgate's great flaw is that his excellent observational skills are narrowly limited to his scientific research; he is not only blind with respect to social relationships, but having grown up as an aristocrat in the home of his uncle, a baronet, leads Lydgate to believe in his faulty social perceptions with absolute confidence at the beginning of the novel. His decision to settle in Middlemarch out of admiration for the provincial work of one of his medical heroes without seriously considering what his role would be in the community is a perfect example of his poor social judgment.

Lydgate also fails to recognize that his French training in the Paris School, which was inspired by the work of anatomists like Bichat who dissected human corpses, would be associated by townspeople like Mrs. Dollop with the London papers' coverage of the recent sensational case of Burke and Hare committing murder and selling the bodies for medical

research. Anything foreign is cause of suspicion among the provincial Middlemarchers, and the fact that Bulstrode grants Lydgate exclusive control over the medical operations of the New Hospital makes it easy for rumors to spread unchecked about Lydgate killing off patients in order to supply corpses for the medical research he is so passionate about. He underestimates the opposition to his plans for the hospital by thinking of it as merely personal opposition to the hospital's chief supporter Bulstrode. Furthermore, many of the townspeople are genuinely opposed to Bulstrode as a result of his meddling in people's personal lives and his deliberate decision not to seek funding for the New Hospital from the rest of the community so that he could be in sole administrative control. Lydgate happily overlooked that unusual situation because Bulstrode's complete control of the hospital gave Lydgate the freedom to enact all of his medical theories as medical director without having to compromise with any of the rest of the town's medical practitioners.

Before the 1850s, general practitioners in provincial settings had to deal with social marginalization as members of a still-emerging professional class and as independent individuals in a provincial society that still relied heavily on class hierarchies to control social interactions. In “Marginal Men: Aspects of the Social Role of the Medical Community in Sheffield 1790-1850,” Ian Inkster uses that town's surviving records to examine how medical men with no direct ties to their area of practice were seen as “‘new men’ in the provinces [who] were marginal to established English society if only because they were demonstrably mobile” (128). In the years before the 1858 Medical Act, a medical practitioner could work without being subject to any real authority if he was far enough removed from the sphere of influence of the Colleges of Physicians and Surgeons and the Society of Apothecaries, and in many cases simply being outside of London was far enough. Lydgate

was not entirely incorrect in thinking that a medical man working in the provinces outside of the reach of the London colleges might face fewer institutional obstacles to reform and research. What he failed to recognize was that the opportunities created by working in the provinces were offset by marginalization because “the medical practitioner did not on the whole gain the sanction of the community simply because the layman could not immediately identify the status of any one medical man” (131). The most successful of the marginalized medical 'new men' in Inkster's analysis of the Sheffield medical community were those who worked on “the development of medical facilities and institutions... and this at once brought them into close contact with the industrial middle class” (140). Lydgate engages in a similar activity when he becomes involved with Bulstrode's New Hospital, but he misses out on the possibility for community approval that it might have presented because both he and Bulstrode deliberately exclude the rest of the town in order to monopolize control. Lydgate sees the New Hospital as an opportunity to carry out his vision of proper medical practice, but he is blind to the fact that Bulstrode's jealous control over the New Hospital excludes the community that Lydgate needs to win over. When the New Hospital is seen as the exclusive domain of Bulstrode, it marginalizes the institution that might otherwise have allowed a larger portion of the town to understand Lydgate's medical theories because he would have been forced to compete with the other medical practitioners to win over a board of directors rather than simply being granted complete medical control over the hospital as Bulstrode's subordinate.

The doubly marginal status of provincial general practitioners both within the profession and within the community offers a kind of freedom, but the economic reality of having to compete against other medical men and win over patients to earn a living meant

that forging a new role in provincial society for doctors as scientists and reformers was a slow process full of many compromises. So much of Lydgate's failure as a reformer can be traced to his unwillingness to humor his professional peers and his potential patients. His philosophy that it is better to “make your value felt, so that people must put up with you whether you flatter them or not” is quite insufficient against a community and a medical establishment that are not receptive to major changes in the status quo (Eliot, *Middlemarch* 174). Lydgate's involvement with Bulstrode is based on the doctor's desire to make his value felt by having unchallenged medical authority to run the New Hospital according to his theories, which are quite sound. Even when Lydgate is poised on the brink of professional ruin, it is because of his unwise social connections and not because of any error in his medical practice.

Being aligned with Bulstrode causes problems enough for Lydgate when the banker is only sparking opposition from those who object to his heavy-handed religious meddling, but that ill-advised connection threatens to destroy Lydgate's reputation when Bulstrode's past starts coming back to haunt him. Bulstrode had moved to Middlemarch as an adult and the townspeople knew little about his earlier life, so when the hard-drinking Mr. Raffles arrives in Middlemarch and seems to have Bulstrode under his thumb, the rumor-mill goes to work. The debts Lydgate accumulates because of his shrinking practice and Rosamond's unwillingness to economize force him to seek a loan from Bulstrode, which the banker initially refuses to grant. When Bulstrode's attempt to pay Raffles to go away and spare his good name fails and the man returns in a state of alcohol-induced delirium, it is only natural that Lydgate is called in. Eliot does not reveal the secret that Raffles is able to hold over Bulstrode's head, but it is serious enough that Caleb Garth breaks off a potentially lucrative

business arrangement after Raffles reveals it in the throes of his illness. The danger for Lydgate comes from the great relief that Raffle's death would be for Bulstrode. Lydgate does not for a moment contemplate violating his medical principles, and the case is another example of his advanced medical knowledge, as he relies on new research from America that made what now seems like the obvious argument that the traditional treatment of opium and more alcohol for severe alcohol poisoning is completely wrong. It is at this point that Bulstrode changes his mind and decides to lend Lydgate the money he needs after all, and Lydgate is so blind as to how the town might perceive such a loan that he accepts it without hesitation. That evening Bulstrode gives in to temptation and supplies Raffles with brandy, and by the next morning he is dead. The death of Raffles while under Lydgate's care draws the suspicion of the town upon him, but the patient actually died because the new treatment Lydgate prescribed for delirium tremens was disobeyed without his knowledge. It is ironic that Lydgate did the right thing by defying the conventional wisdom in the case of Raffles, but he also manages to avoid some criticism from town's medical community because they only hear that the patient had been given opium and brandy, which was their standard treatment for delirium tremens, without mention of the fact that it was in violation of Lydgate's orders. At every stage of the novel it is never Lydgate's medical value that is found wanting, but rather it is his unwillingness to devote his attention to his social relationships that strands him in a disastrous marriage and drives him to the brink of bankruptcy.

In spite of Lydgate's superior knowledge and excellent professional conduct, what saves him from ruin in the novel's climax is his social connection to the novel's other protagonist, Dorothea. Lydgate and Dorothea follow parallel paths through the novel, both marrying spouses they mistakenly believe will support their aspirations. One of the many

tragedies of the prejudices that mar Lydgate's social perception is that when he first meets Dorothea, exactly the sort of intelligent, idealistic woman who would understand and support his efforts to reform the profession and advance the state of medical knowledge, he concludes based on a single conversation that "her interest in matters socially useful" makes it "troublesome to talk to such women. They are always wanting reasons, yet they are too ignorant to understand the merits of any question and usually fall back on their moral sense to settle things" (93). Dorothea marries Casaubon because she actively desires a husband who can provide her with precisely that sort of instruction, which Casaubon unfortunately is unable to do, highlighting the error that Lydgate commits in dismissing her because she does not "look at things from the proper feminine angle," which he imagines to be "a paradise with sweet laughs for bird-notes, and blue eyes for a heaven" (95). When Raffles' death seems poised to destroy his good name, his salvation comes not from his professional brilliance or Rosamond's blue eyes, but from the moral sense of Dorothea, who refuses to believe that Lydgate could have accepted the money as a bribe from Bulstrode. Not only does she seek Lydgate out and prompt him to tell her the truth of the whole affair so that she might convince others of his innocence, but she uses her money to relieve his obligation to Bulstrode and take over as the chief supporter of the New Hospital. Most importantly, she is able to speak to Rosamond when Lydgate could not, thus redeeming his good name and saving his marriage. Throughout the novel, Lydgate imagines himself as a great discoverer, triumphing over ignorance by virtue of his superior knowledge and powers of observation, but in the end it is the superior quality of Dorothea's social perception that saves his professional merit from being ruined by his inability to see the social consequences of his actions.

It is the sharp contrast between his professional brilliance and his social blindness that makes Lydgate such an interesting character with respect to the evolving image of the medical professional. Much has been made of the “spots of commonness” that eventually undermine his grand ambitions, but “if he has spots of commonness in his character, they do not impinge on him professionally” (Furst, “Struggling for Reform” 346). The narrator highlights the divide between his professional and social identities by introducing him as “not altogether a common country doctor” and “rather more uncommon than any general practitioner in Middlemarch” (Eliot, *Middlemarch* 142), while his “spots of commonness lay in the complexion of his prejudices [and] that distinction of mind which belonged to his intellectual ardour, did not penetrate his feeling and judgment about furniture, or women, or the desirability of its being known (without his telling) that he was better born than other country surgeons” (150). Even Lydgate's choice of professional heroes reflects his inability to recognize the unavoidably social component to life. In a conversation with Rosamond, Lydgate compares himself to the sixteenth century founder of modern anatomy, Vesalius, who had to dig up bodies from graveyards in order to make his discoveries about anatomy and who was attacked by his peers because his discoveries contradicted the traditional knowledge passed down from the ancient Greek physician Galen. Lydgate conceives of himself as a modern Vesalius fighting against “the medical fogies in Middlemarch,” and when Rosamond asks what happened to Vesalius, Lydgate completely fails to understand why his reply of “He died rather miserably” makes her wish that he had not chosen to be a medical man (458). He wants to be a medical hero, and he is unwilling or unable to see what Rosamond easily recognizes, that a life of conflict with one's peers followed by a miserable death is the price to be paid for declaring war against tradition.

The fact that Lydgate's professional virtue can act as a convincing counterweight for the flaws in his character is a strong indication of the improved status of the field of medicine in the years after the 1858 Medical Act. In the case of Dr. Thorne, his flaw of stubbornness affects both his social life (in rejecting his wealthy cousins) and his professional life (in his fights with Dr. Fillgrave), but likewise the same qualities that make him a good doctor also make him a good person. In presenting Lydgate as an uncommon doctor in spite of the spots of commonness in his personal life, Eliot taps into the emerging sense of medical work as being worthy of admiration independent of the personal qualities of the individual who performs it. This emerging personal/professional divide is one of the signs of the transition of medicine towards becoming a modern profession, which is characterized by “full-time practice, the high degree of skill or expertise of the member, explicit and fairly uniform educational and training programmes, recognised and consistent examinations leading to readily identified qualifications, legal recognition and autonomy of regulation” (Inkster 130). All of these criteria are important for the medical profession to create a new social role for general practitioners who are at the top of the developing middle class and have a built-in measure of social prestige because they advance the state of scientific knowledge and support the public good by promoting health and fighting disease.

Because the evolution of the medical profession in Victorian England was actually composed of myriad efforts by medical men to achieve the best results for themselves and (in most cases) their patients, the social role of the doctor remained full of uncertainty at every stage of the profession's development. Nonetheless, the years leading up to the 1858 Medical Act did see the emergence of new social roles for medical practitioners outside of the three-class hierarchy of the London colleges, and novelists like Trollope and Eliot took advantage

of those new perspectives. The rise of the general practitioner and the professionalization of medicine presented the opportunity for novelists to create ambiguous characters like Lydgate who are personally flawed but professionally heroic. It is easy to recognize the appeal of the work of life and death as a subject for a story, and as relations between doctors and their patients shifted towards a balance of power with the patient in the secondary role, centering a novel on the professional life of a doctor was no longer quite so absurd. The concept of the professionally brilliant but personally flawed doctor embodied by Lydgate was quickly adopted by other writers in such works as Robert Louis Stevenson's *Dr. Jekyll and Mr. Hyde*, Emile Zola's *Dr. Pascal*, Sinclair Lewis' *Arrowsmith*, A. J. Cronin's *The Citadel*, the stories of Sir Arthur Conan Doyle, and many others, and that conception of the doctor remains an important element of modern fiction. The process of medical reform and professionalization leading up to the 1858 Medical Act provides a compelling insight into the origins of the medical protagonists that pervade modern fiction.

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Appendix

THE MEDICAL PRACTITIONERS BILL,
TO BE INTITULED,
AN ACT TO REGULATE THE QUALIFICATIONS OF PRACTITIONERS IN MEDICINE
AND SURGERY.

[THE following is a copy of the Bill, as it has passed the Houses of Lords and Commons, and now (Thursday, July 29th) only requires the Royal Assent to make it an ACT OF PARLIAMENT]

WHEREAS it is expedient that persons requiring medical aid should be enabled to distinguish qualified from unqualified practitioners : Be it therefore enacted by the Queen's most excellent Majesty, by and with the advice and consent of the Lords Spiritual and Temporal, and Commons, in this present Parliament assembled, and by the authority of the same, as follows : --

I. *Short title.* -This Act may for all purposes be cited as "The Medical Act."

II. *Commencement of Act.*-This Act shall commence and take effect from the 1st day of October, 1858.

III. *Medical Council.*-A Council, which shall be styled "The General Council of Medical Education and Registration of the United Kingdom," hereinafter referred to as the General Council, shall be established, and branch Councils for England, Scotland, and Ireland respectively formed thereout as hereinafter mentioned.

IV. *Members of Council.*-The General Council shall consist I of one person chosen from time to time by each of the following bodies-that is to say, the Royal College of Physicians,

the Royal College of Surgeons of England, the Apothecaries' Society of London, the University of Oxford, the University of Cambridge, the University of Durham, the University of London, the College of Physicians of Edinburgh, the College of Surgeons of Edinburgh, the Faculty of Physicians and Surgeons of Glasgow. One person chosen from time to time by the University of Edinburgh and the two Universities of Aberdeen collectively. One person chosen from time to time by the University of Glasgow and the University of St. Andrews collectively. One person chosen from time to time by each of the following bodies :-The King and Queen's College of Physicians in Ireland, the Royal College of Surgeons in Ireland, the Apothecaries' Hall of Ireland, the University of Dublin, the Queen's University in Ireland; and six persons to be nominated by Her Majesty, with the advice of Her Privy Council, four of whom shall be appointed for England, one for Scotland, and one for Ireland; and of a President, to be elected by the General Council.

V. Providing for appointment, if Universities of Glasgow, Aberdeen, and St. Andrews disagree.-If the said Universities of Edinburgh and Aberdeen, of Glasgow and St. Andrews respectively, shall not be able to agree upon some one person to represent them in the Council, it shall be lawful for each one of the said Universities to select one person; and thereupon it shall be lawful for her Majesty, with the advice of her Privy Council, to appoint one of the persons so selected to be a member of the said Council for the said Universities.

VI. Branches of the Council for England, Scotland, and Ireland.- The members chosen by the Medical Corporations and Universities of England, Scotland, and Ireland respectively, and the members nominated by her Majesty, with the advice of her Privy Council, for such parts respectively of the United Kingdom, shall be the branch Councils for such parts respectively of the United Kingdom, to which branch Councils shall be delegated such of the

powers and duties vested in the Council, as the Council may see fit other than the power to make representations to her Majesty in Council as hereinafter mentioned. The President shall be a member of all the branch Councils.

VII. *Qualification.* -Members of the General Council representing the Medical Corporations must be qualified to be registered under this Act.

VIII. *Resignation or death of member of General Council.*- The members of the General Council shall be chosen and nominated for a term not exceeding five years, and shall be capable of reappointment, and any member may at any time resign his appointment by letter addressed to the President of the said Council, and upon the death or resignation of any member of the said Council, some other person shall be constituted a member of the said Council in his place in manner herein before provided; but it shall be lawful for the Council during such vacancy to exercise the powers hereinafter mentioned.

IX. *Time and place of meeting of the General Council.*-The General Council shall hold their first meeting within three months from the commencement of this Act, in such place and at such time as one of her Majesty's principal Secretaries of State shall appoint, and shall make such rules and regulations as to the times and places of the meetings of the General Council, and the mode of summoning the same, as to them shall seem expedient, which rules and regulations shall remain in force until altered at any subsequent meeting; and in the absence of any rule or regulation as to the summoning a meeting of the General Council, it shall be lawful for the President to summon a meeting at such time and place as to him shall seem expedient, by letter addressed to each member; and at every meeting, in the absence of the President, some other member to be chosen from the members present shall act as President; and all Acts of the General Council shall be decided by the votes of the majority of

the members present at any meeting, the whole number present not being less than eight, and at all such meetings the President for the time being shall, in addition to his vote as a member of the Council, have a casting vote, in case of an equality of votes; and the General Council shall have power to appoint an executive committee out of their own body, of which the quorum shall not be less than three, and to delegate to such committee such of the powers and duties vested in the Council as the Council may see fit, other than the power of making representations to her Majesty in Council as hereinafter mentioned.

X. Appointment of registrars and other officers. -The General Council shall appoint a registrar, who shall act as secretary of the General Council, and who may also act as treasurer, unless the Council shall appoint another person or other person as treasurer or treasurers; and the person or persons so appointed shall likewise act as registrar for England, and as secretary and treasurer or treasurers, as the case may be, for the branch Council for England; the General Council and branch Council for England shall also appoint so many clerks and servants as shall be necessary for the purposes of this Act; and every person so appointed by any Council shall be removable at the pleasure of that Council, and shall be paid such salary as the Council by which he was appointed shall think fit.

XI. Appointment of registrars and other officers by branch Councils. -The branch Councils for Scotland and Ireland shall each respectively in like manner appoint a registrar and other officers and clerks, who shall be paid such salaries as such branch Councils respectively shall think fit, and be removable at the pleasure of the Council by which they were appointed; and the person appointed registrar shall also act as secretary to the branch Council, and may also act as treasurer, unless the Council shall appoint some other person or persons as treasurer or treasurers.

XII. *Fees for attendance at Councils.*-There shall be paid to the members of the Councils such fees for attendance, and such reasonable travelling expenses, as shall from time to time be allowed by the General Council, and approved by the Commissioners of her Majesty's Treasury.

XIII. *Expenses of the Councils.*-All monies payable to the respective Councils shall be paid to the treasurers of such Councils respectively, and shall be applied to defray the expenses of carrying this Act into execution in manner following :- that is to say, separate accounts shall be kept of the expenses of the General Council, and of those of the branch Councils; and the expenses of the General Council, including those of keeping, printing, and publishing the Register for the United Kingdom, shall be defrayed, under the direction of the General Council, by means of an equal percentage rate upon all moneys received by the several branch Councils; returns shall be made by the treasurers of the respective branch Councils, at such times as the General Council shall direct, of all monies received by them; and the necessary percentage having been computed by the General Council, the respective contributions shall be paid by the treasurers of such branch Councils to the treasurer or treasurers of the General Council ; and the expenses of the branch Councils shall be defrayed, under the direction of those Councils respectively out of the residue of the monies so received as aforesaid.

XIV. *Duty of registrar to keep the register correct.* -It shall be the duty of the registrars to keep their respective registers correct in accordance with the provisions of this Act, and the orders and regulations of the General Council, and to erase the names of all registered persons who shall have died, and shall from time to time make the necessary alterations in the addresses or qualifications of the persons registered under this Act; and to enable the

respective registrars duly to fulfil the duties imposed upon them it shall be lawful for the registrar to write a letter to any registered person, addressed to him according to his address on the register, to inquire whether he has ceased to practise, or has changed his residence, and if no answer shall be returned to such letter within the period of six months from the sending of the letter it shall be lawful to erase the name of such person from the register; provided always, that the same may be restored by direction of the Council should they think fit to make an order to that effect.

XV. Registration of persons now qualified, and persons hereafter qualified.-Every person now possessed, and (subject to the provisions herein-after contained) every person hereafter becoming possessed, of any one or more of the qualifications described in the Schedule (A) to this Act, shall, on payment of a fee, not exceeding £2, in respect to qualifications obtained before the 1st day of January, 1859, and not exceeding £5 in respect to qualifications obtained on or after that date, be entitled to be registered on producing to the registrar of the branch Council for England, Scotland, or Ireland, the document conferring or evidencing the qualification or each of the qualifications in respect whereof he seeks to be so registered, or upon transmitting by post to such registrar information of his name and address, and evidence of the qualification or qualifications in respect whereof he seeks to be registered, and of the time or times at which the same was or were respectively obtained: provided always, that it shall be lawful for the several colleges and other bodies mentioned in the said Schedule (A) to transmit from time to time to the said registrar lists certified under their respective seals of the several persons who, in respect of qualifications granted by such colleges and bodies respectively, are for the time being entitled to be registered under this Act, stating the respective qualifications and places of residence of such persons; and it shall

be lawful for the registrar thereupon, and upon payment of such fee as aforesaid in respect of each person to be registered, to enter in the register the persons mentioned in such lists, with their qualifications and places of residence as therein dated, without other application in relation thereto.

XVI. *Regulation of registers.*-The General Council shall, with all convenient speed after the passing of this Act, and from time to time as occasion may require, make orders for regulating the registers to be kept under this Act, as nearly as conveniently may be in accordance with the Form set forth in Schedule (D) to this Act, or to the like effect.

XVII. *Persons practising in England before August 1st, 1815, entitled to be registered.*- Any person who was actually practising medicine in England before the 1st day of August, 1815, shall, on payment of a fee to be fixed by the General Council, be entitled to be registered on producing to the registrar of the branch Council for England, Scotland, or Ireland, a declaration according to the Form in Schedule (B) to this Act, signed by him, or upon transmitting to such registrar information of his name and address, and enclosing such declaration as aforesaid.

XVIII. *Council may require information as to course of study, &c., required for obtaining qualifications.*-The several colleges and bodies in the United Kingdom mentioned in Schedule (A) to this Act, shall from time to time, when required by the General Council, furnish such Council with such information as they may require as to the courses of study and examinations to be gone through in order to obtain the respective qualifications mentioned in Schedule (A) to this Act, and the ages at which such courses of study and examination are required to be gone through, and such qualifications are conferred, and generally as to the requisites for obtaining such qualifications; and any member or members

of the General Council, or any person or persons deputed for this purpose by such Council, or by any branch Council, may attend and be present at any such examinations.

XIX. Colleges may unite in conducting examinations.- Any two or more of the colleges and bodies in the United Kingdom mentioned in Schedule (A) to this Act, may, with the sanction and under the direction of the General Council, unite or cooperate in conducting the examinations required for qualifications to be registered under this Act.

XX. Defects in the course of study or examinations may be represented by the General Council to her Majesty's Privy Council.- In case it appear to the General Council that the course of study and examinations to be gone through in order to obtain any such qualification from any such college or body are not such as to secure the possession by persons obtaining such qualification of the requisite knowledge and skill for the efficient practice of their profession, it shall be lawful for such General Council to represent the same to her Majesty's most honourable Privy Council.

XXI. Privy Council may, by order, suspend the right of registration in respect of qualifications granted by college or body in default. Provision for revocation.- It shall be lawful for the Privy Council, upon any such representation as aforesaid, if it see fit, to order that any qualification granted by such college or body, after such time as may be mentioned in the order, shall not confer any right to be registered under this Act: provided always, that it shall be lawful for her Majesty, with the advice of her Privy Council, when it is made to appear to her, upon further representation from the General Council or otherwise, that such college or body has made effectual provision, to the satisfaction of such General Council, for the improvement of such course of study or examinations, or the mode of conducting such examinations, to revoke any such order.

XXII. *Persons not to be registered in respect of qualifications granted by the college of body before the revocation of the order.*- After the time mentioned in this behalf in any such order in Council no person shall be entitled to be registered under this Act in respect of any such qualification as in such order mentioned, granted by the college or body to which such order relates, after the time therein mentioned, and the revocation of any such order shall not entitle any person to be registered in respect of any qualification granted before such revocation.

XXIII. *Making and authentication of orders, &c.* - All powers vested in the Privy Council by this Act may be exercised by any three or more of the lords and others of the Privy Council, the vice-president of the committee of the said Privy Council on Education being one of them; and all orders and acts of the Privy Council under this Act shall be sufficiently made and signified by a written or printed document, signed by one of the clerks of the Privy Council, or such officer as may be appointed by the Privy Council in this behalf; and all orders and acts made or signified by any written or printed document purporting to be so signed shall be deemed to have been duly made, issued, and done by the Privy Council; and every such document shall be received in evidence in all courts, and before all justices and others, without proof of the authority or signature of such clerk or other officer or other proof whatsoever, until it be shown that such document was not duly signed by the authority of the Privy Council.

XXIV. *As to registration by branch registrars.*-Where any person entitled to be registered under this Act applies to the registrar of any of the said branch Councils for that purpose, such registrar shall forthwith enter in a local register in the form set forth in Schedule (D) to this Act, or to the like effect, to be kept by him for that purpose, the name and place of

residence, and the qualification or several qualifications in respect of which the person is so entitled, and the date of the registration, and shall, in the case of the registrar of the Branch Council for Scotland or Ireland, with all convenient speed send to the registrar of the General Council a copy, certified under the hand of the registrar, of the entry so made, and the registrar of the General Council shall forthwith cause the same to be entered in the general register; and such registrar shall also forthwith cause all entries made in the local register for England to be entered in the general register; and the entry on the general register shall bear date from the local register.

XXV. Evidence of qualification to be given before registration.- No qualification shall be entered on the register, either on the first registration or by way of addition to a registered name, unless the registrar be satisfied by the proper evidence that the person claiming is entitled to it; and any appeal from the decision of the registrar may be decided by the General Council, or by the Council for England, Scotland, or Ireland (as the case may be); and any entry which shall be proved to the satisfaction of such General Council or Branch Council to have been fraudulently or incorrectly made may be erased from the register by order in writing of such General Council or Branch Council.

XXVI. Register to be published.-The registrar of the General Council shall in every year cause to be printed, published, and sold, under the direction of such Council, a correct register of the names in alphabetical order according to the surnames, with the respective residences, in the form set forth in Schedule (D) to this Act, or to the like effect, and medical titles, diplomas, and qualifications conferred by any corporation or university, or by doctorate of the archbishop of Canterbury, with the dates thereof, of all persons appearing on the General register as existing on the 1st day of January in every year; and such register shall be

called "The Medical Register;" and a copy of the Medical Register for the time being, purporting to be so printed and published as aforesaid, shall be evidence in all courts and before all justices of the peace and others that the persons therein specified are registered according to the provisions of this Act; and the absence of the name of any person from such copy shall be evidence, until the contrary be made to appear, that such person is not registered according to the provisions of this Act: provided always, that in the case of any person whose name does not appear in such copy, a certified copy, under the hand of the registrar of the General Council or of any branch Council, of the entry of the name of such person on the general or local register shall be evidence that such person is registered under the provisions of this Act.

XXVII. *Names struck off from list of college or body.*-If any of the said colleges or the said bodies at any time exercise any power they possess by law of striking off from the list of such college or body the name of any one of their members, such college or body shall signify to the General Council the name of the member so struck off ; and the General Council may, if they see fit, direct the registrar to erase forthwith from the register the qualification derived from such college or body in respect of which such member was registered, and the registrar shall note the same therein: provided always, that the name of no person shall be erased from the register on the ground of his having adopted any theory of medicine or surgery.

XXVIII. *Medical practitioners convicted of felony may be struck off the register.*-If any registered medical practitioner shall be convicted in England or Ireland of any felony or misdemeanour, or in Scotland of any crime or offence, or shall after due inquiry be judged by the General Council to have been guilty of infamous conduct in any professional respect, the

General Council may, if they see fit, direct the registrar to erase the name of such medical practitioner from the register.

XXIX. Registered persons may have subsequent qualifications inserted in the register.-

Every person registered under this Act who may have obtained any higher degree or any qualification other than the qualification in respect of which he may have been registered, shall be entitled to have such higher degree or additional qualification inserted in the register in substitution for or in addition to the qualification previously registered, on payment of such fee as the Council may appoint.

*XXX. Privileges of registered persons.-*Every person registered under this Act shall be entitled according to his qualification or qualifications to practise medicine or surgery, or medicine and surgery, as the case may be, in any part of her Majesty's dominions, and to demand and recover in any court of law, with full costs of suit, reasonable charges for professional aid, advice, and visits, and the cost of any medicines or other medical or surgical appliances rendered or supplied by him to his patients: provided always, that it shall be lawful for any College of Physicians to pass a bye-law to the effect that no one of their fellows or members shall be entitled to sue in manner aforesaid in any court of law, and thereupon such bye-law may be pleaded in bar to any action for the purposes aforesaid commenced by any fellow or member of such college.

XXXI. None but registered persons to recover charges.- After the 1st day of January, 1859, no person shall be entitled to recover any charge in any court of law for any medical or surgical advice, attendance, or for the performance of any operation, or for any medicine which he shall have both prescribed or supplied, unless he shall prove upon the trial that he is registered under this Act.

XXXII. *Poor-law medical officers not disqualified if registered within six months of passing of Act.*-Provided also, that no person who on the 1st of October, 1858, shall be acting as medical officer under an order of the Poor-law Commissioners or Poor-law Board shall be disqualified to hold such office by reason of his not being registered as herein required, unless he shall have failed to be registered within six months from the passing of this Act.

XXXIII. *Meaning of legally qualified medical practitioner.*- After the 1st day of January, 1859, the word "legally qualified medical practitioner" or "duly qualified medical practitioner," or any words importing a person recognised by law as a medical practitioner or member of the medical profession, when used in any Act of Parliament, shall be construed to mean a person registered under this Act.

XXXIV. *Registered persons exempted from serving on juries, &c.*- Every person who shall be registered under the provisions of this Act shall be exempt, if he shall so desire, from serving on all juries and inquests whatsoever, and from serving all corporate, parochial, ward, hundred, and township offices, and from serving in the militia, and the name of such person shall not be returned in any list of persons liable to serve in the militia, or in any such office as aforesaid.

XXXV. *Unregistered persons not to hold certain appointments.*- After the 1st day of January, 1859, no person shall hold any appointment as a physician, surgeon, or other medical officer either in the military or naval service, or in emigrant or other vessels, or in any hospital, infirmary, dispensary, or lying-in hospital, not supported wholly by voluntary contributions, or in any lunatic asylum, gaol, penitentiary, house of correction, house of industry, parochial or union workhouse or poorhouse, parish union, or other public establishment, body, or institution, or to any friendly or other society for affording mutual

relief in sickness, infirmity, or old age, or as a medical officer of health, unless he be registered under this Act : provided always, that nothing in this Act contained shall extend to repeal or alter any of the provisions of the Passengers Act, 1855.

XXXVI. *No certificate to be valid unless person signing be registered.*-After the 1st day of January, 1859, no certificate required by any Act now in force, or that may hereafter be passed from any physician, surgeon, licentiate in medicine and surgery, or other medical practitioner, shall be valid unless the person signing the same be registered under this Act.

XXXVII. *Wilful falsification of register.*-Any registrar who shall wilfully make, or cause to be made, any falsification in any matters relating to the register, shall be deemed guilty of a misdemeanor in England or Ireland, and in Scotland of a crime or offence punishable by fine or imprisonment, and shall, on conviction thereof, be imprisoned for any term not exceeding twelve months.

XXXVIII. *Penalty for obtaining registration by false representations.*- If any person shall wilfully procure or attempt to procure himself to be registered under this act, by making or producing or causing to be made or produced any false or fraudulent representation or declaration, either verbally or in writing, every such person so offending, and every person aiding and assisting him therein, shall be deemed guilty of a misdemeanour in England and Ireland, and in Scotland of a crime or offence punishable by fine or imprisonment, and shall, on conviction thereof, be sentenced to be imprisoned for any term not exceeding twelve months.

XXXIX. *Penalty for falsely pretending to be a registered person.*- Any person who shall wilfully and falsely pretend to be or take or use the name or title of a physician, doctor of medicine, licentiate in medicine and surgery, bachelor of medicine, surgeon, general

practitioner, or apothecary, or any name, title, addition, or description implying that he is registered under this Act, or that he is recognised by law as a physician, or surgeon, or licentiate in medicine and surgery, or a practitioner in medicine, or an apothecary, shall, upon a summary conviction for any such offence, pay a sum not exceeding £20.

XL. Recovery of penalties.-Any penalty to which under this Act any person is liable on summary conviction of any offence, may be recovered as follows: that is to say, in England, in manner directed by the Act of the session holden in the eleventh and twelfth years of her Majesty, chapter 43, and in Ireland in manner directed by " the Petty Sessions (Ireland) Act, 1851," or any other Act for the time being in force in England and Ireland respectively for the like purposes; and any such penalty may in Scotland be recovered by the procurator fiscal of the county, or by any other person before the sheriff or two justices, who may proceed in a summary way and grant warrant for bringing the party complained against before him or them, or issue an order requiring such party to appear on a day and at a time and place to be named in such order, and every such order shall be served on the party by delivering to him in person, or by leaving at his usual place of abode, a copy of such order and of the complaint whereupon the same has proceeded, and upon the appearance or default to appear of the party, it shall be lawful for the sheriff or justices to proceed to the hearing of the complaint, and upon proof on oath or confession of the offence, the sheriff or justices shall, without any written pleadings or record of evidence, commit the offender, and decern him to pay the penalty named, as well as such expenses as the sheriff or justices shall think fit, and failing payment, shall grant warrant for recovery thereof by poinding and imprisonment, such imprisonment to be for such period as the discretion of the sheriff or justices may direct, not exceeding three calendar months, and to cease on payment of the penalty and expenses.

XLII. *Application of penalties.*- ANY sum or sums of money arising from conviction and recovery of penalties as aforesaid shall be paid to the treasurer of the General Council.

XLIII. *Application of monies received by treasurer.*-All monies received by any treasurer arising from fees to be paid on registration, from the sale of registers, from penalties, or otherwise, shall be applied for expenses of registration and of the execution of this Act.

XLIV. *Accounts to be Published.*-The treasurers of the General and Branch Councils shall enter in books to be kept for that purpose a true account of all sums of money by them received and paid, and such accounts shall be submitted by them to the respective General Council and Branch Councils at such times as the Councils shall require; and the said accounts shall be published annually, and such accounts shall be laid before both Houses in the month of March in every year, if Parliament be sitting, or if Parliament be not sitting, then within one month after the next meeting of Parliament.

XLV. *Notice of death of medical practitioners to be given by registrars.*-Every registrar of deaths in the United Kingdom, on receiving notice of the death of any medical practitioner, shall forthwith transmit by post to the registrar of the General Council and to the registrar of the Branch Council a certificate under his own hand of such death, with the particulars of time and place of such death, and may charge the cost of such certificate and transmission as an expense of his office; and on the receipt of such certificate the medical registrar shall erase the name of such deceased medical practitioner from the register.

XLVI. *Provision for persons practising in the colonies and elsewhere and for students.*-It shall be lawful for the General Council by special orders to dispense with such provisions of this Act, or with such part of any regulations made by its authority, as to them shall seem fit, in favour of persons now practising medicine or surgery in any part of her Majesty's

dominions other than Great Britain and Ireland, by virtue of any of the qualifications described in Schedule (A); and also in favour of persons practising medicine or surgery within the United Kingdom on foreign or colonial diplomas or degrees before the passing of this Act ; and also in favour of any persons who have held appointments as surgeons or assistant surgeons in the army, navy, or militia, or in the service of the East India Company, or are acting as surgeons in the public service, or in the service of any charitable institutions, and also, so far as to the Council shall seem expedient, in favour of medical students who shall have commenced their professional studies before the passing of this Act.

XLVI. New Charter may be granted to the College of Physicians of London.-It shall be lawful for Her Majesty to grant to the corporation of the Royal College of Physicians of London a New Charter, and thereby to give to such corporation the name of "The Royal College of Physicians of England," and to make such alterations in the constitution of the same corporation as to Her Majesty may seem expedient; and it shall be lawful for the said corporation to accept such charter under their common seal, and such acceptance shall operate as a surrender of all charters heretofore granted to the said corporation, except the charter granted by King Henry VIII., and shall also operate as a surrender of such charter and of any rights, powers, or privileges conferred by or enjoyed under an act of the session holden in the fourteenth and fifteenth years of King Henry VIII., chapter 5, confirming the same as far as such charter and act respectively may be inconsistent with such new charter : provided, nevertheless, that within twelve months after the granting of such charter to the College of Physicians of London, any fellow, member, or licentiate of the Royal College of Physicians of Edinburgh, or of the Queen's College of Physicians of Ireland, who may be in practice as a physician in any part of the United Kingdom called England, and who may be

desirous of becoming a member of such College of Physicians of England, shall be at liberty to do so, and be entitled to receive the diploma of the said college, and to be admitted to all the rights and privileges thereunto appertain on the payment of a registration fee of £2 to the said college.

XLVII. Her Majesty may grant power to College of Surgeons to institute examinations as to fitness of persons to act as dentists.- It shall, notwithstanding anything herein contained, be lawful for her Majesty, by charter, to grant to the Royal College of Surgeons of England power to institute and hold examinations for the purpose of testing the fitness of persons to practise as dentists who may be desirous of being so examined, and to grant certificates of such fitness.

XLVIII. New charter may be granted to College of Physicians of Edinburgh.-It shall be lawful for her Majesty to grant to the corporation of the Royal College of Physicians of Edinburgh a new charter, and thereby to give to the said College of Physicians the name of "The Royal College of Physicians of Scotland," and it shall be lawful for the said Royal College of Physicians, under their common seal, to accept such new charter, and such acceptance shall operate as a surrender of all charters heretofore granted to the said corporation.

XLIX. The Faculty at Glasgow may be amalgamated.-If at any future period the Royal College of Surgeons of Edinburgh and Faculty of Physicians and Surgeons of Glasgow agree to amalgamate, so as to form one united corporation, under the name of "The Royal College of Surgeons of Scotland," it shall be lawful for her Majesty to grant, and for such College and Faculty, under their respective common seals, to accept, such new charter or charters as may be necessary for effecting such union, and such acceptance shall operate as a surrender of all

charters heretofore granted to such College and Faculty; and in the event of such union it shall be competent for the said College and Faculty to make such arrangements as to the time and place of their examinations as they may agree upon, these arrangements being in conformity with the provisions of this Act, and subject to the approval of the General Council.

L. New charter may be granted to the King and Queen's College of Physicians in Ireland.-It shall be lawful for her Majesty to grant to the corporation of the King and Queen's College of Physicians in Ireland a new charter, and thereby to give to such corporation the name of " The Royal College of Physicians of Ireland," and to make such alterations in the constitution of the said corporation as to her Majesty may seem expedient ; and it shall be lawful for the said corporation to accept such charter under their common seal, and such acceptance shall operate as a surrender of the charter granted by King William and Queen Mary, so far as it may be inconsistent with such new charter.

LI. Charters not to contain new restrictions in the practice of medicine or surgery.- Provided always, that nothing herein contained shall extend to authorize her Majesty to create any restriction in the practice of medicine or surgery, or to grant to any of the said corporations any powers or privileges contrary to the common law of the land or to the provisions of this Act, and that no such new charter shall in anywise prejudice, affect, or annul any of the existing statutes or bye laws of the corporations to which the same shall be granted further than shall be necessary for giving full effect to the alterations which shall be intended to be effected by such new charters and by this Act in the constitution of such corporation.

LII. Provisions of 17 & 18 VICT. c. 114, as to University of London to continue in force.-

The enactments and provisions of the University of London Medical Graduates Act, 1854, shall be deemed and construed to have applied and shall apply to the University of London for the time being, notwithstanding the surrender or determination of the therein-recited Charter, and the granting or acceptance of the now existing Charter of the University of London, or the future determination of the present or any future Charter of the said University, and the granting of any new Charter to the said University; and that every bachelor of Medicine and Doctor of Medicine of the University of London for the time being shall be deemed to have been and to be entitled and shall be entitled to the privileges conferred by the said Act, in the same manner and to the same extent as if the Charter recited in the said Act remained in force, subject nevertheless to the provisions of this Act.

LIII. *Pharmacopoeia*.—The General Council shall cause to be published under their direction a book containing a list of medicines and compounds, and the manner of preparing them, together with the true weights and measures by which they are to be prepared and mixed, and containing such other matter and things relating thereto as the General Council shall think fit, to be called "British Pharmacopoeia;" and the General Council shall cause to be altered, amended, and republished such Pharmacopoeia as often as they shall deem it necessary.

LIV. *Chemists, &c., not to be affected*.—Nothing in this Act contained shall extend or be construed to extend to prejudice or in any way to affect the lawful occupation, trade, or business of chemists and druggists and dentists, or the rights, privileges, or employment of duly licensed Apothecaries in Ireland, so far as the same extend to selling, compounding or dispensing medicines.

SCHEDULE (A.)

1. Fellow, Licentiate, or Extra Licentiate of the Royal College of Physicians of London.
2. Fellow or Licentiate of the Royal College of Physicians of Edinburgh.
3. Fellow or Licentiate of the King's and Queen's College of Physicians of Ireland.
4. Fellow or Member or Licentiate in Midwifery of the Royal College of Surgeons of England.
5. Fellow or Licentiate of the Royal College of Surgeons of Edinburgh.
6. Fellow or Licentiate of the Faculty of Physicians and Surgeons of Glasgow.
7. Fellow or Licentiate of the Royal College of Surgeons in Ireland.
8. Licentiate of the Society of Apothecaries, London.
9. Licentiate of the Apothecaries' Hall, Dublin.
10. Doctor, or Bachelor, or Licentiate of Medicine, or Master in Surgery of any University of the United Kingdom; or Doctor of Medicine by Doctorate granted prior to passing of this Act by the Archbishop of Canterbury.
11. Doctor of Medicine of any Foreign or Colonial University or College, practising as a Physician in the United Kingdom before the 1st day of October, 1858, who shall produce certificates to the satisfaction of the Council of his having taken his Degree of Doctor of Medicine after regular examination, or who shall satisfy the Council, under Section Forty-five of this Act, that there is sufficient reason for admitting him to be registered.

SCHEDULE (B.)

DECLARATION required of a person who claims to be registered as a Medical Practitioner, upon the ground that he was in practice as a Medical Practitioner in England or Wales before the 1st day of August, 1815:

To the Registrar of the Medical Council.

I, _____ residing at _____ in the County of _____ hereby declare that I was practising as a Medical Practitioner at _____ in the County of _____ before the 1st day of August, 1815.

(Signed) [Name.]

Dated this _____ Day of _____ 185 .

SCHEDULE (D.)

Name	Residence	Qualification
A.B.	London . .	Fellow of the Royal College of Physicians of _____
C.D.	Manchester	Fellow and Member of the Royal College of Surgeons of England
E.F.	Dublin . .	Graduate of Medicine of University of Dublin
G.H.	Bristol . .	Licentiate of the Society of Apothecaries
I.K.	London . .	Member of the College of Surgeons or Licentiate of the Society of Apothecaries