

Consumptive death in Victorian literature: 1830 - 1880.

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Consumptive Death in Victorian Literature: 1830 – 1880

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PhD Thesis

September 2001



Abstract

Victorian medical men, writers, relatives of the dying and consumptive sufferers themselves seized on the narrative potential of representations of the disease in a variety of ways.

I argue that both medical and lay writers subscribed to a common set of beliefs about the disease and that medical knowledge, moreover, shared a common *narrative* way of knowing and understanding it. I analyse aspects of general clinical expository texts, including accompanying illustrations, showing how a narrative knowledge of death and the tubercular body was elaborated.

Furthermore, I show how documents used in the compilation of medical statistics on the cause of death were fundamentally narrative through their reliance on case narratives.

It is demonstrated that Dickens uses a seldom noticed consumptive death and decline to offset his heroine's development in Bleak House, in ways similar to those developed in Jane Eyre. Similarly, it is shown that Mrs Gaskell's use of a consumptive alcoholic 'fallen woman' unsettles her account of her heroine in Mary Barton. George Eliot's 'Janet's Repentance' is analysed, showing how the psychological struggle between an orientation towards life or death is played out across both alcoholism and consumption. I also examine how consumption presents a narrative opportunity whereby plots involving setbacks in love are resolved through women's consumptive deaths in popular fiction by Rhoda Broughton, Lady Georgiana Fullerton and others.

Through an examination of the Journal of Emily Shore and accounts of other actual deaths, I illustrate how experiences and accounts of consumptive deaths were structured and rendered intelligible through reliance on beliefs encountered in both fiction and medicine. In conclusion, the thesis alerts readers to the presence of signifiers of consumption in Victorian texts, showing how various narrative strategies are integral to any understanding of representations of its dying victims.

Acknowledgements

I would like to acknowledge the unfailing support, help, encouragement and forbearance of my supervisors, Professor Daniel Pick and Professor Morag Shiach. Thanks are also due to Dr John Whale. of the University of Leeds, for help in the initial stages of formulating the project. My thanks are also due to my wife, Sandra, for her support and especially for her assistance in ironing out my style. I also have a debt of gratitude to Queen Mary College for a Research Studentship, without which this project would have been impossible. I also wish to thank Dr Chris Lawrence, of the Wellcome Institute for the History of Medicine. for reading parts of the thesis. My thanks are also due to Dr Cathy Hadfield for help with my knowledge of the symptomatology of tuberculosis. I must also thank the academic unit at the Wellcome Institute for the History of Medicine for inviting me to present parts of the thesis to their 'Work in Progress' seminar. Similarly my thanks are due to the postgraduate research forum at Queen Mary College's School of English and Drama for comments on parts of the work. Thanks are also due to Ticehurst House for permission to use their records and to the staff of the Archive of Kings College and the Surrey Records Office.

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Introduction

While it is a commonplace of cultural studies of consumption and tuberculosis that both medical and lay writers subscribed to a common set of beliefs about the disease, I argue that they shared common *narrative* ways of knowing and understanding it. This is revealed by analysing aspects of general medical expository texts, including accompanying illustrations, showing how a narrative knowledge of death and the tubercular body was elaborated. This analysis includes a demonstration that documents used in the compilation of medical statistics on the cause of death were fundamentally narrative through their reliance on case narratives.

A further objective of this thesis is to show that consumption offered Victorian novelists and writers a host of artistic and narrative possibilities in their writing. Drawing on a little noticed consumptive decline and death in the work of Dickens, I show how the consumptive is used to offset his heroine's development in Bleak House (1852 – 1853), in ways similar to those developed in Jane Eyre (1847). Dickens exploits the idea of depression as a cause of consumption and integrates this with his view of a parasitic legal profession 'consuming' its clients. Charlotte Brontë's Helen Burns is deployed in a similar contrastive manner: her saintliness presents Jane with an alternative to her spontaneous, passionate response to life. This stance is carried over into Jane's potential mate, the preacher St. John Rivers, but Jane repudiates it in favour of marriage to Rochester. The consumptive ascetic life, as opposed to one which is emotionally and physically fulfilled, is offered as

one among a number of choices, with the narrative showing which one the heroine eventually chooses.

Similarly, Mrs Gaskell's use of a consumptive alcoholic 'fallen woman' unsettles her account of her heroine in Mary Barton (1848). Although Esther tells her own touching story, Gaskell's authorial comment leaves little room for sympathy for the consumptive. Gaskell shows a heroine in a predicament which, as the textual apparatus of allusion and references tells us, also threatens to reduce Mary to an outcast consumptive alcoholic prostitute.

George Eliot's short story 'Janet's Repentance' (1857) on the other hand, presents a respectable alcoholic woman who falls victim to an abusive alcoholic husband. I analyse how the psychological struggle between an orientation towards life or death is played out across an account of both alcoholism and consumption.

Alcoholism and consumption are presented as states of human suffering which Eliot suggests ought to bring us together in a morally positive way. Although the heroine is not consumptive, her relationship with a consumptive is predicated on a realisation of the universality of suffering and the consequent moral community which it makes possible.

I also examine how consumption presents a narrative opportunity whereby plots involving setbacks in love are resolved through women's deaths in popular fiction by Rhoda Broughton, Lady Georgiana Fullerton and others. In Broughton's Cometh Up as a Flower (1867), the heroine, Nell Le Strange, is tragically involved

in a love affair which is thwarted. She marries a man she does not love and learns that her old lover has died in foreign parts. The disappointment in love results in her falling into a consumption and dying. Here the path towards marriage is precisely a course which will end in death, since it is marriage to the wrong man. In the case of Broughton's "Good-bye, Sweetheart!" (1872), there is much the same pattern: the heroine, Lenore Herrick's perversity leads to a rift between herself and her lover. The rift widens and she takes up with a rival. On the verge of marriage to the rival, that is to say at the point at which she realises love for her original lover is hopeless, she falls into a consumption. In a sense, her death from consumption is also a death from unfulfilled love. In the case of Fullerton's Ellen Middleton (1844), something similar happens. A woman is blackmailed into going along with the attentions of a suitor despite being married. Her husband and the love of her life discovers her dealings with the rival, and husband and wife separate. The heroine falls into a consumptive decline and dies, albeit reconciled with her family and husband. These three popular novels show consumption being integrated into the plot to resolve it – the heroine's death is the outcome of her disappointment in love and ends the story.

Consumption was not, however, written about only by doctors and novelists. Given that approximately a quarter of all deaths in mid-century Victorian Britain could be attributed to tuberculosis, it was also a subject for those recording the lives of loved ones who died of the disease.¹ Attention is usually focussed, in the considerable literature on the history of tuberculosis, on American and continental sufferers and their accounts of their illnesses, often to indicate the degree of overlap

in medical and lay ideas about consumption. By examining the Journal of Emily Shore (1831 - 1839) and accounts of other actual deaths, I go a step further, illustrating how both experiences as well as accounts of consumptive deaths were structured and rendered intelligible through reliance on beliefs encountered both in fiction and medicine. This shows, for instance, that medical knowledge and biographical accounts rely on prolepsis in making sense of consumptive death – medicine, on the one hand, in its epistemological emphasis on the certainty of eventual death and the use of post mortem findings, and biography on the other hand using the proleptic revelation of consumptive death which awaits its subject. Besides revealing several ideas associated with the consumptive, and how lives were deeply affected by beliefs about the disease and by its physical effects, the biographies all show a tendency to make sense of an individual's death by relating the consumptive demise to events which the biographers view as having precipitated if not caused the fatal outcome. Practices, including overwork, sitting on wet grass, emotional shock, and over-exertion in bad weather are all presented as reasons for the consumptive deaths of loved ones. In addition, the biographic material reveals that narratives of consumptive deaths could also be shaped by patterns of intelligibility such as those surrounding the evangelical 'good death'. A variety of religious conventions surrounding the death of ardent evangelical Christians vie with those associated with the dying consumptive in some accounts.

Why restrict the investigation to consumptive death since Victorian studies show that the novels of the time are littered with death bed scenes and other demises?

The answers to this question are both conceptual and practical. On the conceptual

side, dying from consumption or tuberculosis usually takes considerable time – even so-called ‘galloping’ consumption takes time to hasten to its end, and there are precursors and signs of the impending collapse before it happens. It is therefore particularly suited to representation in fictional or other narratives. It is still necessary, despite the several good cultural histories of tuberculosis, to restore the disease and its signifiers to the modern critical consciousness.² On the practical side, there are so many diseases represented in Victorian fiction that their inclusion would have made this project unmanageable.

The temporal scope of the study has also been imposed by both practical and conceptual limitations. The history of medicine in the last thirty years has shown that serious cultural misconceptions often arise when assuming that a disease has always been known and thought of in the same way throughout human history. It is becoming clear that culture plays a vital role in medical knowledge, often determining what is discerned as disease and what is not, or deeply affecting the way diseases are delineated within medicine. Thus, although phthisis emerged within Western medicine from the mass of pulmonary diseases with which it was often confused, in March 1804 with the findings of René Théophile Hyacinthe Laënnec, the circumstances for the full practical adoption of these views were not in place in Britain until at least 1832. This is because the study of pathological anatomy required the availability of corpses and routine post mortem examination within hospital settings. In 1832, following serious popular unrest surrounding instances of grave robbing in the years preceding it, the Anatomy Act was passed, making the bodies of the unclaimed poor available for dissection for research and

teaching purposes.³ Also, Laënnec invented the monaural stethoscope in 1819, placing at medicine's disposal the most important technological tool in its dealings with phthisis.

The outer time limit for this study is roughly 1880 since it was in 1882 that the German, Robert Koch isolated mycobacterium tuberculosis, the bacterium largely responsible for the disease in man. It might be said that the disease had already been shown to be contagious by the Frenchman Jean-Antoine Villemin in 1865 in Paris. His findings were, however, officially rejected in Britain by Dr John Burdon-Sanderson, Medical Officer to the Privy Council, and his assistant, Dr John Simon, of the Local Government Board when they unsuccessfully repeated his experiments on rabbits. This despite William Budd's independent but published speculations in 1867 to the effect that there were strong reasons to suspect that tuberculosis was contagious.⁴ It would appear that their failure was due to poor experimental protocols. These experiments were only successfully repeated in Britain again in the early 1880s by William Watson Cheyne and Dawson Williams.⁵ The relevance of these developments lies in the fact that once phthisis or tuberculosis had been shown to be contagious it increasingly became associated with foreigners, the poor, and moral and social degeneration. In effect, the picture of the consumptive began to change in ways which gave rise to different possibilities for narrative.

In recent years, medicine's status as a culturally disinterested, 'scientific' endeavour has been challenged on many fronts. Most important here has been

Kathryn Montgomery Hunter's work showing contemporary medical practice's profound commitment to narrative.⁶ She demonstrates that the transmission of clinical medicine's knowledge in medical schools and in journals depends on a host of stories, ranging from the patient's account of his or her illness, through the 'case presentation' (including diagnosis) by medical interns through to case notes. It is even possible that diagnosis itself is a narrative operation if narrative is understood as a linking of three temporally distinct events by a concept of causation. In this Hunter would subscribe to the philosopher Arthur C. Danto's understanding of narrative. Working in the philosophy of history, he proposes that a narrative is any account in which some state of affairs exists at time one and then undergoes some specified processes of change at time two which cause the state of affairs at time one to change, a difference observable at time three.⁷ Besides involving the idea of cause to structure accounts of events, Danto and Hunter would agree that such an account would have 'a beginning, ... a middle, ... and an end' and so constitute a narrative.⁸ My account of the work of James Clark, Robert Carswell and Richard Bright all rely on this understanding of narrative.

There is a considerable literature devoted to the history of medicine's struggle against consumption/tuberculosis and much of it addresses the figure of the consumptive in literature, music and painting. René and Jean Dubos' The White Plague, Tuberculosis, Man, and Society is by far the most influential work in this field. The work, written by a sufferer and her husband, provides a brief survey of the historical prevalence of tuberculosis from ancient times until its publication in the early 1950s. They sketch the history of medicine's understanding of the

disease from the sixteenth century to the present. The work also goes into some detail on changes in therapeutic approaches and on the disease's epidemiology. In addition to providing an introductory account of the typical course of a case of tuberculosis, the book stands out as a thorough survey of prominent consumptives ranging from poets, artists, writers, philosophers, politicians, painters, to musicians and royalty. The work is particularly valuable as an introductory survey of continental and American literary representations of consumptives. It even offers the sketchiest of outlines of a series of ways in which the consumptive was deployed in Victorian fiction.⁹ Given that they only briefly cover Dickens and the Brontës, it was felt that this thesis's detailed attention to British nineteenth-century prose literature would supplement their work.

In the wake of the Dubos' seminal work others have elaborated expositions of the way in which the general social and cultural trends they discerned surrounding tuberculosis were played out in specific national contexts. One such example, Katherine Ott's Fevered Lives, Tuberculosis in American Culture Since 1870.¹⁰ Ott thoroughly examines the culture of tuberculosis mainly in the period between the isolation of the bacterium and the emergence of antibiotic drug cures in the 1950s. Her work clearly shows that the American cultural context included variables such as mass immigration, different epidemiological and legal circumstances, together with larger anti-tuberculosis campaigns than those found in Britain, all of which argues for further studies of the British social context in this and other periods.

Susan Sontag's Illness as Metaphor and Aids and Its Metaphors takes up where Renéand Jean Dubos left off, providing a useful general introduction to the mythology surrounding incurable and often fatal diseases, including tuberculosis and cancer.¹¹ Essentially Sontag is interested in the poetics of representations of various illnesses and in combating the negative consequences associated with various stereotypes. Her analysis reveals, for instance, the way in which both medical and lay representations of consumption valorised the lungs (as against any other organs often affected) and shows that the disease were surrounded by psychological myths, for example, euphoric states, increased sexual desire, increased appetite. She also notices how representations of the disease are embroiled in paradoxically deceptive symptoms such as upsurge of vitality from approaching death or rosy cheeks while feverish.¹² She further concludes that 'TB is a disease of time; it speeds up life, highlights it, spiritualises it', in so doing implying that consumption was particularly suited to narrative. Sontag compares the mythologies surrounding tuberculosis and cholera or spectacular epidemics, finding that tuberculosis was viewed as individuating or distinguishing the individual while epidemics homogenise the individual into the mass. In epidemics sufferers are all alike, while in the case of long illnesses which only affect some, there is the possibility that the sufferer is distinguished by the disease. This possibility is realised negatively once the disease becomes associated with contagion, foreignness, filth and poverty. In the period prior to 1882, however, tuberculosis was a disease of individuals, only later developing into the ailment of the masses.¹³

Sontag is keen on contrasting the often subtle or unnoticed metaphors associated with cancer, madness, syphilis and tuberculosis. Her analysis is useful insofar as it suggests an unconscious dimension to our thought and culture often associated with maltreatment of, or discrimination against, the ill. Her objective, however, is to raise awareness of the system of meanings surrounding diseases, so that sufferers are no longer viewed in a moral light. While Sontag's aim to 'neutralise metaphoric thinking about a reality', as Liam Kennedy puts it, is a necessary and laudable one, Sontag's findings make it doubtful whether there can be an absolutely morally neutral discourse about a disease. This is especially so, given the continued existence of contagious diseases (including drug resistant strains of tuberculosis). As the emergence of HIV/AIDS has shown, complexes of cultural and political anxieties will continue to form around illness.¹⁴

Following the work of René and Jean Dubos, two culturally orientated studies of tuberculosis have carried their hints and suggestions in productive directions. These are the work of Nan M^cMurray, 'And I? I am in a Consumption': The Tuberculosis Patient 1780 – 1930, and a thesis by Catherine Moloney, George Eliot, Henry James, and Consumption: A Shadow on the Lung of the Victorian Psyche.¹⁵ M^cMurray's work elaborates the Dubos' findings in greater detail, concentrating her examination of a wide range of sources primarily on American material, such as medical advice manuals, fashion and popular magazines and novels. Valuable as M^cMurray's work clearly is, it nonetheless raises questions about whether the picture of the consumptive in British literature agrees with her

findings. On an even more basic level, British Victorian literature lay outside the scope of M^cMurray's work.

The potential of the Dubos' work, however, is best illustrated by the recent work of Catherine Moloney. Concentrating on the work of George Eliot and Henry James, she analyses consumption's importance as a means for negotiating cultural anxieties surrounding sexuality and spirituality. In support of remarks by René and Jean Dubos, concerning the sexualisation and spiritualisation of Victorian consumptives, she argues that Eliot and James used the consumptive stereotype to contain impulses towards sexual transgression and the cultural anxieties surrounding them.

Working across the bacterial watershed represented by Robert Koch's isolation of the tuberculosis bacteria in 1882, Moloney sketches the cultural tensions surrounding consumption. Her analysis clearly shows how tuberculosis can be both a disease of degeneration and filth (contagion) and yet still offer possibilities of transcendence of a moral or religious kind. She places her analysis in a literary context of late-nineteenth and early twentieth-century fiction dealing with consumptives.¹⁶ Her work, however, largely concerns George Eliot's Daniel Deronda (1876) and James's The Wings of the Dove (1902). In her detailed analysis of Daniel Deronda she admirably shows how the problematic of the novel's two parts can be reconciled through resonances surrounding Gwendolen in the first portion and Mordecai in the second. Grounding her findings in readings of Victorian psychology and psychiatry, she demonstrates that sexual resonances as

well as degenerationist and anti-Semitic ideas involving Mordecai can be linked to Gwendolen. Moloney also offers remarks on Eliot's 'Janet's Repentance', to the effect that there is a substantial sexual element in the relation between the consumptive Reverend Tryan and the recovering alcoholic Janet Dempster. I disagree with this reading and will return to it at the appropriate points in my discussion of the story. She also offers a persuasive interpretation of James's The Wings of the Dove in terms of the sanctity/sexuality opposition surrounding the consumptive.

Another cultural study which owes much to Susan Sontag's analysis is Linda and Michael Hutcheon's Opera: Desire, Disease, Death.¹⁷ In a work devoted to operatic representations of disease, they also turn to tuberculosis in operas by Offenbach, Puccini and Verdi. Following Sontag's groundbreaking analysis, they examine E. T. A. Hoffmann's representation of a wasting young singer, Antonia, in his story, 'Rat Krespel,' and the subsequent adaptation of the story into a play, finding a sufficiently dense web of signs to merit construing the young woman's unspecified disease as consumption. They show that these signs were carried over into the unfinished 1881 opera, Les Contes d'Hoffmann (1881) by Jacques Offenbach and Jules Barbier. They analyse the rich, connotative resonances surrounding segments of the libretto of La Traviata (1853). They also closely analyse the libretto of Giacomo Puccini and Giuseppe Giacosa/Luigi Illica's La Boheme (1896) in terms of the changes that the consumptive stereotype had undergone after the discovery of the bacteria. They show how the stereotypical poverty, poor nutrition and inadequate housing of consumptives in this era are

embodied in the opera. They analyse the use of stereotype in the love aspect of the plot, with Mimi's beauty owing much to her illness.

Beyond the ambit of cultural studies of consumption, a host of works on the general field of relations between literature and illness has emerged. In particular, there are several psychoanalytically inspired readings of illness-related issues in fiction. Thus Miriam Bailin in her The Sickroom in Victorian Fiction: The Art of Being Ill focuses on the expression of tensions between the need for social cohesion and the individual's complex psychological needs in the fictional sickroom.¹⁸ She shows how characters' psychological conflicts or loss of social bearings are often resolved by a spell of illness and the sickroom's social recuperation. The self is unified and societal needs are accommodated. Given her psychoanalytic orientation, Bailin provides an analysis of the erotic possibilities surrounding the ill, much as Moloney attempts to do, but Bailin elaborates this in relations between nurse and patient. She remarks at one point that fictional sickbed scenes gain much from the proximity of death, however, examination of her analysis shows that these scenes gain much of their significance from the realistic prospect of recovery.¹⁹ I show, however, that with consumptives, on the other hand, death becomes the sick person's intimate companion, giving an altogether sombre tone to the characterisation of the consumptive and inflecting the characterisation of those around them accordingly.

Athena Vrettos also focuses on the relations between fiction and psychological medicine in her Somatic Fictions. Imagining Illness in Victorian Culture.

Focussing on issues surrounding ‘nervous sensibility’ in the post 1850 period, Vrettos examines the effects of language on physical well being and investigates the way the body emerged as a communicative vehicle.²⁰ She examines how transgressive narratives affect their readers’ understanding of feelings, pain and disease. Investigating how emotion was often viewed as contagious, she also shows how emotions produced in reading were seen as transferring to the body of the female reader.

While I have not adopted a psychoanalytic approach, my research nonetheless supports Vrettos’s view that, ‘to the extent that language has the power to shape and filter human experience and to invest individual practices with historically specific meanings,’ fictional narratives ‘chart the available categories through which people come to understand themselves’ both as readers and as writers.²¹

My research on popular fiction in Chapter six and memoirs in Chapter seven shows that she is correct in asserting that various ways of talking about illness are ‘forms of cultural fiction making, providing a set of collective stories middle-class Victorians told about their social and material relations.’²² Memoirs, fiction and clinical treatises concerned with consumption all exhibit dense patterns of cultural fantasy, belief and perception in relation to both death and disease. In ways that echo Vrettos’s findings concerning psychological illnesses, my research shows that there is not one coherent picture of the consumptive – rather the figure is pulled in various directions in Victorian fiction, medical narratives and memoirs.²³ There is a host of competing narrative uses of the sick and dying.

Because death is so prominent in the vast majority of representations and discussions concerning consumption prior to the introduction of anti-biotic drug therapies in the 1950s, this thesis focuses only on dying consumptives. It is useful, therefore, to situate my findings in the context of the vast literature on death in the West, among which there are a number of landmarks. One of the most comprehensive works on the history of death is Phillipe Aries' The Hour of Our Death, which analyses developments in funerary customs, and literary, scientific and social thought / practices from the late middle ages through to the very recent past.²⁴ His analysis is structured primarily through examining Western attitudes to death in relation to awareness of self and individuality. In Aries' view, death presents a threat to the individual and society and, historically, this had an impact on self awareness and assertions of individuality. He divides attitudes towards death into two stances: either it is threatening and 'wild' or it is the 'tame' death, one that has been subjugated and contained. In order to maintain its regularities of work, morality and social order, culture is ranged against nature's threats in the form of seasonal and environmental change, as well as those natural manifestations of the individual psyche, the sexual instincts and the fear of death. Aries also sees beliefs in an afterlife and evil as two constants necessary to distinguishing developments in the history of death. He distinguishes four phases in the history of death in the West: Medieval or late Medieval, the eleventh century, a long eighteenth century and Romantic/contemporary developments.

As Pat Jalland has noted, however, from the point of view of British, and especially Victorian developments, Aries' formidable work nonetheless has some

understandable limitations. His sources for British Victorian history are very limited. In addition to this, his model is primarily applicable to Catholic cultures, and so falls short of Protestant developments such as we find in the evangelical revival mentioned in the final Chapter of the present work.

For my purposes Aries' analysis is further limited by his views on the medical orientation towards death. For this reason, his findings are supplemented by those of Randal Albury who draws on both medicine and the life sciences in an attempt to outline the changes in the relation between life and death in medicine, mostly around the end of the eighteenth century.²⁵ His analysis is guided by the Aristotelian conception of opposites as falling into one of three categories: in terms of privative / positive, contraries or correlatives. In the case of correlatives, the definition of each term integrally involves the other and a science of any phenomenon so defined will necessarily cover both states of the object. It was precisely at the point at which phthisis or tuberculosis became distinguished as a specific disease, in the early nineteenth century, that medicine and biology's concepts of life and death ceased to be thought of in terms of privative/positive opposition and began to be thought of as logical correlates of one another. A scientific knowledge of any life form, including man, necessarily entailed knowledge of the precise ways in which it succumbed to death.

According to Michel Foucault's The Birth of the Clinic, a study which justifiably claims to be both 'about death' and about the birth of modern medicine, in the late eighteenth century France witnessed a series of institutional and epistemological

changes in medicine.²⁶ First, in the wake of the French Revolution, surgery and physic - old antagonists - were forced to re-orientate their respective positions and both become necessary components of medical education. Secondly, there was also a reorganisation of hospital medicine with the establishment of large civic hospitals in Paris. One consequence of the reorganisation of hospital medicine was the increasing availability of corpses for post mortem investigations. This is when the change in the medical form of the notions of life and death from a privative/positive opposition to correlatives was made. In the medicine elaborated at this time, including René Laënnec's modern description of tuberculosis, the processes of death became internalised into those of life. Chapter one, which investigates the role of narrative in the early Victorian understanding of consumption or phthisis, takes, as its starting point, expository clinical treatises by Sir James Clark and Sir Robert Carswell, showing not only that they advocated this form of medicine (having been influenced by developments in France), but also that they necessarily used narratives about death in doing so.

Pat Jalland's recent Death in the Victorian Family is perhaps the most comprehensive study of the Victorian way of death focussed solely on Britain, and makes good many of Aries' omissions.²⁷ Her study concentrates on the family as the central institutional context in which death was experienced for the middle and upper classes. She also focuses on the Evangelical movement since, as a domestic religion, it had a role in idealising the family and was influential in customs such as reading aloud around the fire, family prayers, religious education for children, and the strong moral earnestness of stricter religious homes. In particular, it revitalised

the idea of the 'good death' and supported the idea of heavenly family reunion noticed by Aries. Analysing over fifty families, Jalland's work impressively conveys a sense of the piety and spiritual commitment of most of the middle classes up until at least 1880. In this respect it provides solid background for works such as Moloney's discussion of the spiritualising and religious dimensions of representations of the consumptive. This study has used it extensively, both as a guide to sources and for its remarks on particular cases of consumptive death. My findings on the whole confirm Jalland's assertion that 'there were many Victorian ways of death, according to major variables such as age, disease, size and nature of the family, religious beliefs, wealth and class.'²⁸ There were also many ways of narrating events surrounding death, even within the parameters of a single disease, as the investigation of fictional and biographic sources undertaken here demonstrates.

Michael Wheeler's Death and the Future Life in Victorian Literature and Theology supplements Jalland's findings by concentrating closely on the theological and textual intricacies raised by the four categories of death, judgement, heaven and hell in Victorian Britain. It also supports Miriam Bailin's work in that it investigates the impact of these four theological topics analyses of death bed scenes in fiction, poetry and letters of the time. He admirably points up tensions, in these scenes, between the this-worldly and the other-worldly in the subtle ambiguities of language. He also examines how the theology of judgement is reflected in Trollope's The Warden, and The Last Chronicle of Barset. He contrasts Dickens's

use of the biblical language of judgement in Hard Times against Hardy's in Tess of the d'Ubervilles.

Wheeler points out that,

one of the main limitations of realist fiction in the nineteenth century was that, unlike the heavenly spectators in Evangelical epic poems, for example, narrators could not penetrate the veil which separates 'this side' from 'that side': even their so-called omniscience is restricted to time and space.²⁹

While, as Wheeler shows, key moments in realist fiction often show how the successive narration of temporal events is suspended in favour of catastrophic structures and the use of heightened language of sensation fiction or gothic novels, this ought not to prevent our reading narrative representations of consumption in terms of what Moloney and Kenneth Burke have called the 'life in death'. Part of the argument in Chapter 1 is precisely that Victorian medicine redistributed death through disease (especially consumption) and life, giving it a spatiotemporal existence in the fabric of the living body. My analysis of fiction also supports the view that the narrative deployment and effects of representing the dying consumptive are considerable enough to outweigh the impossibility of representing 'the other side'.

Two other works in the field of death and literature relate to my findings. Laurence Lerner's Angels and Absences. Child Deaths in the Nineteenth Century focuses on child deaths and admirably discusses the function of poetry in consolation, and the vexed question of sentimentality in Victorian fiction.³⁰ Its investigation of the uses of child deaths, from various causes, in fiction supplements my findings regarding consumption in particular. Lerner's comments on diagnosis in the cases

of real children's deaths he has studied, raises the issue of the 'diagnosis' of fictional cases. In this regard, I have used instances where symptoms are both consistent with the general stereotypical picture of the consumptive – especially where several key indicators, such as coughing up blood and bright eyes, are mentioned in a catalogue of symptoms – or where the disease is explicitly named. I have avoided using cases, like that in Henry James' The Wings of the Dove, because writers used specific diseases to dispatch their characters for particular purposes or effects. Where any doubt remains about the character's precise condition, such effects, for example, in relating contrasting characters, are also necessarily vague. As both Moloney and I have found in relation to fictional consumptives, there are significant indications that writers used some diseases or illnesses specifically for their connotations. Brain fever, for example, was invoked in cases where characters were subject to extreme emotional or mental stress, but did not inevitably result in death.³¹

Garrett Stewart's Death Sentences: Styles of Dying in British Fiction is concerned with stylistic questions surrounding death scenes, focussing particularly on the philosophical implications of language's limitations in representing or knowing death. He teases out the linguistic ambiguities, together with a range of special rhetorical or figural devices, used in the face of this problem.³² He focuses on a large variety of causes of deaths in the work of Dickens, Thackeray, Conrad, Hardy, Woolf, E. M. Forster and Beckett, but is primarily concerned with the individual subject's sense of 'metaphysical crisis' which his analysis reveals.³³

With the exception of Brontë's Helen Burns, about whom he briefly comments. his

analysis fails to take in the drawn-out deaths of consumptives and the potential this offers. Stewart's work does, however, acknowledge the importance of relations between the dying and those around them or who witness their deaths. In this respect my findings on the relations between dying consumptives and central characters who go on to survive, supplement the work of Stewart.

Chapter 1 considers early and mid-nineteenth-century clinical medicine's commitment to narrative and death. It also, however, examines the role of death in clinical narratives. In order to ascertain the general applicability of my views, I consider the published work of three English physicians: Sir James Clark, Sir Robert Carswell and Richard Bright. These three practitioners were selected because they do not seem to have had close professional, collaborative alliances, and yet all dealt with consumption in their publications. Because the nineteenth century witnesses the beginnings of truly medical, rather than anatomical, illustration, these play a key role in Bright's and Carswell's texts. Some attention is, therefore, also given to the question of narrative and its relation to medical illustration. The Chapter affords, in passing, a brief survey of the principal symptoms and course of consumption.

Chapter 2 examines the medical statements of cause of death written by doctors and used by the newly formed Registrar General of Births, Deaths and Marriages as the basis for entries in official registers. Building on the narrative conception of causality in Chapter 1, recourse is had to informal statements of the cause of death in order to show that, even when stating in extremely bald terms what an individual

died of, medicine necessarily produces tiny, compressed stories. Using case documentation from two mental asylums, Ticehurst Asylum and the Royal Bethlem Hospital in the period 1832 – 1880, it is shown that deaths, including consumptive deaths, were rendered intelligible both to medicine and to the nascent epidemiological and actuarial or demographic knowledges of the time through narrative.

Chapter 3 begins by setting out the general characteristics of the consumptive stereotype in the period. This general outline of aspects of the consumptive stereotype is followed by a close examination of the consumptive alcoholic prostitute, Esther, in Elizabeth Gaskell's Mary Barton. It shows how many of consumption's key indexes are attached to the outcast, but also explores the tension between the sympathy her illness would have engendered and the moral approbation attached to her 'fallenness', evident in narrative commentary. She is shown to be linked to the unemployed radical and fellow addict, John Barton, in ways which strengthened the reader's reluctance to fully sympathise with her. It is also suggested that a contrasting dynamic of situation and possibility links her to Mary herself, with Esther's betrayal and decline leading to degradation and death, while Mary narrowly escapes a similar fate, progressing towards matrimony and motherhood.

Chapter 4 reinstates the consumptive in readings of Dickens's Bleak House, suggesting that Richard Carstone's decline and death from tuberculosis forms a backdrop against which to view Esther Summerson's psychological struggles in the

wake of her episode of small pox. I also examine the depiction and function of the consumptive Helen Burns in Brontë's Jane Eyre, showing that the formation of Jane's personality involves a close identification with the dying girl and that issues first raised in the representation of Helen Burns continue to trouble Jane in her relations with the missionary St. John Rivers. Both the missionary and Helen Burns participate in a system of images and ideas from which Jane struggles to free herself, and from which she is finally liberated in the climactic scene where she hears Rochester's call and decides to return to him.

Chapter 5 examines George Eliot's 'Janet's Repentance' (1857), showing how her representation of consumption is integrated into the story's central, structuring series of conflicts and struggles. Besides the conflict over the Sunday evening lecture, Janet's struggle against the prospect of an alcoholic death is linked to reverend Tryan's struggle with consumption. It is shown that Eliot's moral message depends on her exploring individual suffering from the inside. Moreover, this strategy is supported by Eliot's focus on the 'fellowship of suffering' that exists between the dying consumptive and an alcoholic woman. The story hints that erotic causes are at the root of Tryan's consumption.

Chapter 6 focuses on three popular, romantic novels showing how the medically accepted idea that disappointment in love led to consumption was used to structure and resolve fictions. Rhoda Broughton's Cometh Up as a Flower and "Good-bye, Sweetheart!" and Georgiana Fullerton's Ellen Middleton all present heroines whose consumptive deaths are explicitly attributed to misfortunes in love. This

view of the sufferers themselves and their lovers is also borne out by the way the onset and progress of the heroine's consumption are presented. Two of the three novels, Ellen Middleton and Cometh Up as a Flower, are structured so that readers are aware of and anticipate the heroine's consumptive tragic ending in advance.

Chapter 7 surveys narratives of the lives and deaths of middle class consumptives written by either the sufferers themselves or by their close relatives. It focuses mainly on the journals, letters and memoirs of the young aspirant naturalist, Emily Shore, and two prominent physicians, James Hope and Andrew Combe.³⁴ It shows that the need for imposing structures which render experience of disease and death intelligible in fiction is also found in accounts of actual experience. In particular, the three substantial texts examined all reveal their subject's fate very early on in their accounts. These accounts also all rely on attributing the cause of the disease to dramatic, if not romantic, events. In addition, it shows that consumptive's deaths could be related and experienced in terms of conventions of dying, such as the 'good death', which were not specific to the disease. Furthermore, the impact of medical beliefs regarding the inheritability of the consumptive constitution on the relationships and lives of consumptives is shown.

In conclusion, while the thesis alerts modern readers to the presence of signifiers of consumption in Victorian texts, it also shows how various narrative strategies are integral to any understanding of clinical, fictional and biographical representations of its dying victims. If, as literary scholars have long held, *what* is said is intimately bound up with *the manner* of its telling, then the thesis shows that this is

true in both the fictional arena as well as in the deadly serious realm of our culture's relations with disease.

¹ See René and Jean Dubos' appendices in their The White Plague, Tuberculosis, Man, and Society (London: Rutgers University Press, 1987) pp. 229 – 231. They record that in England and Wales this equates to 300 deaths per 100 000 population annually.

² See Barbara Bates' Bargaining for Life: A Social History of Tuberculosis, 1876 – 1938, (Philadelphia: University of Pennsylvania Press, 1992) and Sheila Rothman's Living in the Shadow of Death, (New York: Basic Books, 1994) which both cover only American developments in their period. Also see Lynda Bryder's Below the Magic Mountain: A Social History of Tuberculosis in Twentieth-Century Britain, (Oxford: Oxford University Press, 1988).

³ See Ruth Richardson's discussion of the history of the Act in her Death, Dissection and the Destitute, (London: Penguin, 1989).

⁴ See William Budd's 'Memorandum on the Nature and the Mode of Propagation of Phthisis' in the Lancet, Oct. 12, 1867, p. 452.

⁵ See Thomas Dormandy's account of these developments in his The White Death, A History of Tuberculosis, (London: Hambledon Press, 1999), pp. 56 – 57.

⁶ See Kathryn Montgomery Hunter's Doctor's Stories: The Narrative Structure of Medical Knowledge, (Princeton: Princeton University Press, 1991), pp. 3 – 26, 51- 68, 83 – 106.

⁷ See Arthur C. Danto's Analytic Philosophy of History, (Cambridge: Cambridge University Press, 1965), p. 236.

⁸ *ibid.* p. 236.

⁹ See Dubos and Dubos, The White Plague, p. 48.

¹⁰ See her Fevered Lives, Tuberculosis in American Culture Since 1870, (London: Harvard University Press, 1996).

¹¹ See her Illness as Metaphor; and, Aids and Its Metaphors (Harmondsworth: Penguin, 1991).

¹² *ibid.* p. 13.

¹³ *ibid.* pp. 38 - 39.

¹⁴ See Sander L. Gilman's, Disease and Representation: Images of Illness from Madness to Aids, (Ithaca: Cornell University Press, 1988).

¹⁵ See Nan M^cMurray, 'And I? I am in a Consumption': The Tuberculosis Patient 1780 – 1930, (Ann Arbor, Mich.: Microforms International, 1986) and Catherine Therese Moloney's unpublished thesis, George Eliot, Henry James, and Consumption: A Shadow on the Lung of the Victorian Psyche Ph.D., University of London, 1999.

¹⁶ Thus she briefly comments on John Buchan's Sick Heart River (1941), a story by C. J. Cutcliffe Hyne, 'The Consumptive' which appeared in the Pall Mall Magazine, 17 (Jan – April 1899), Thomas Mann's The Magic Mountain, Guy de Maupassant's Bel-Ami (1885), and Edith Wharton's The House of Mirth (1905).

¹⁷ See Linda and Michael Hutcheon, Opera: Desire, Disease, Death (London: University of Nebraska Press, 1996.)

¹⁸ See Miriam Bailin's The Sickroom in Victorian Fiction: The Art of Being Ill, (Cambridge: Cambridge University Press, 1994).

¹⁹ *ibid.* p. 16.

²⁰ See Athena Vrettos' Somatic Fictions, Imagining Illness in Victorian Culture, (Stanford: University of Stanford Press, 1995).

²¹ *ibid.*, p. 3.

²² *ibid.* p. 3.

²³ *ibid.* p. 12.

²⁴ Aries, P The Hour of Our Death, trans. H. Weaver, (Harmondsworth: Penguin, 1983)

²⁵ Randal W. Albury, 'Ideas of Life and Death' in Companion Encyclopaedia of the History of Medicine, ed. by W. F. Bynum and Roy Porter, (London: Routledge, 1993).

²⁶ See Michel Foucault, The Birth of the Clinic, An Archaeology of Medical Perception, trans. by A. M. Sheridan, (London: Tavistock, 1973), p. ix.

²⁷ See Pat Jalland's Death in the Victorian Family, (Oxford: Oxford University Press, 1996).

²⁸ *ibid.* p. 11.

²⁹ Michael Wheeler Death and the Future Life in Victorian Literature and Theology, (Oxford: Oxford University Press, 1990) p. 113.

³⁰ See Laurence Lerner's Angels and Absences, Child Deaths in the Nineteenth Century, (London: Vanderbilt University Press, 1997). Also see Gillian Avery and Kimberley Reynolds' Representations of Childhood Death, (London: Macmillan, 2000) which contains three articles on Victorian representations of childhood death.

³¹ On brainfever see Audry C. Peterson's 'Brain Fever in Nineteenth Century Literature: Fact and Fiction', Victorian Studies, 19, 1976, pp. 445 – 464.

³² See Garrett Stewart's Death Sentences: Styles of Dying in British Fiction, (London: Harvard University Press, 1984), pp. 11 – 17.

³³ *ibid.* p. 8.

³⁴ George Combe's The Life and Correspondence of Andrew Combe, M.D., (London: Longman, 1850), Emily Shore's, Journal of Emily Shore, [written between 1831 and 1839] edited by Barbara Timm Gates, (London: University Press of Virginia, 1991) and Anne Hope's, Memoir of James Hope, M.D., ed. by Klein Grant, (London: J. Hatchard, 1844) are the main foci of my analysis.

Chapter 1

The Sense of an Ending: Narrative and Death in the Work of Sir James Clark, Sir

Robert Carswell and Richard Bright

It is my wish, in thus recording a number of Cases, to render the labours of a large Hospital more permanently useful, by bringing together such facts as seem to throw light upon each other; and it is more particularly my wish to preserve and explain by faithful Engravings the recent appearances of those morbid changes of structure which have been connected with the symptoms or have influenced the treatment of the disease. ¹

Than which not any. Time
Swings on the poles of death
And the latitude and the longitude of life
Are fixed by death, and the value
Of every organism, act and moment
Is, thanks to death, unique. ²

Kathryn Montgomery Hunter has convincingly argued that the practice of medicine and its transmission as a form of knowledge are profoundly narrative. ³ Hunter has found that the process of arriving at diagnoses, taking case notes, the presentation of cases by interns and the publication of cases or anecdotes in medical journals are all evidence of medicine's narrative rather than 'scientific' status. ⁴ On the other hand, Michel Foucault has also shown that death, most notably in the guise of post mortem examinations, was fundamental to the transformation of early nineteenth-century medical knowledge and remained important well into the nineteenth century. ⁵ Similarly, one commentator on A Treatise on Pulmonary Consumption

(1835), the most respected work by a British Victorian writer on phthisis, Sir James Clark, has remarked that it exhibits a fascination for ‘death in life’.⁶

Hunter’s work and that of others understandably focuses on the problems currently associated with misunderstanding medicine’s ‘scientific’ status, for example the long-standing neglect of trainee-doctors’ communication skills in their dealings with patients. The general case for medicine’s narrative commitment has implications, however, for the history of medicine, and particularly nineteenth century medicine. What role did narrative play during the nineteenth century, when nosological classifications became identifiably modern, when medical education became much like our own, when the interdependence of surgery and physic was institutionally recognised, and when many of the diseases which we now accept were first described? How far was early and mid-nineteenth-century pre-bacteriological medicine dependent on stories of the kind Montgomery Hunter has discerned and what was the role of death in these stories?

In answering these questions this Chapter will examine the work of three prominent British Victorian doctors, Victoria’s physician, Sir James Clark (1788 – 1870), King Leopold I’s physician Robert Carswell (1793 – 1857), and Richard Bright (1789 – 1858), a physician at Guy’s hospital. While this dissertation will focus on consumption and the way Victorian narratives engage with the disease and its sufferers and their deaths, the conclusions reached in addressing questions relevant to the history of medicine are pertinent to succeeding Chapters. In particular they provide a context showing how medical narratives surrounding consumption depend on and deploy death. More generally, the presentation of

Victorian medicine's understanding of consumption is shot through with ideas which I shall show were shared by sufferers, their surviving relatives/biographers and the writers of fiction. Some of these ideas have particular implications for the way fictional and biographical narratives dealing with consumption are structured.

Richard Bright (1787 - 1858) was one of the eminent 'men of Guy's' who is still remembered through the form of nephritis or kidney disease which bears his name. but he will feature here in what is perhaps an unusual guise: that of a 'scientific' story teller.⁷ If we examine the prefatory lines to his monumental work, Reports of Medical Cases, it becomes clear why this is so. He writes:

It is my wish, in thus recording a number of Cases, to render the labours of a large Hospital more permanently useful, by bringing together such facts as seem to throw light upon each other; and it is more particularly my wish to preserve and explain by faithful Engravings the recent appearances of those morbid changes of structure which have been connected with the symptoms or have influenced the treatment of the disease.

That a physician should want to document his cases in the hope that they will be of use to his profession is quite understandable; however, what proved useful, not least in his discovery of forms of nephritis, was the way in which 'recent appearances of those morbid changes of structure' and 'symptoms' or 'treatment' were brought together so as 'to throw light upon each other.' This way depends on narratives formulated on the basis of epistemologically determinate structures. The way was profoundly *narrative*: it related the appearances, *at death*, to signs and symptoms recorded in case documentation during the course of the patient's illness in the case narratives which constitute an essential part of his Reports of Medical Cases. Bright was able to make the advances he did *by telling stories* which depend on a certain use of autopsy findings, and involve a particular relation

between life and death itself, *relating* - both telling and logically conjoining - symptoms, physical signs and morbid appearances.

Bright's opening lines, however, also yield up a curious formulation. Not only does he wish to 'preserve' his narrative reports' findings, but also 'to explain by faithful Engravings the recent appearances of those morbid changes of structure which have been connected with symptoms....' How exactly do illustrations, no matter how faithful or accurate, gain the voice that is able to 'explain' anything? Bright, however, clearly felt that they *did* explain the 'connections' elsewhere established: almost as though his drawings and sketches had miraculously achieved the ability to speak. This raises questions regarding the relation between narrative and the perceptual or visual, and the relative status of both in early Victorian medicine. Some of these questions will be addressed here by showing that the narrative relating death as morbid appearances, symptoms and signs has its basic temporal and spatial constituents in the perceptual, captured in the illustrations of contemporary medical texts. Bright is not only an excellent story teller, he is also supported by a form of medicine which tells extremely precise stories about what is available to sensory perception.

British medical texts written in the first half of the last century, however, are not merely stories; they are written in deadly earnest about and *against* fatal diseases ravaging large parts of the European population. Because they are scientific texts conveying knowledge of the real world, it is also possible to examine them using Michel Foucault's findings concerning epistemic structures and regularities dependent on *death* in that narrative medicine.⁸ Even a cursory reading of The

Birth of the Clinic shows that the structures and regularities he identifies are not narratives by any stretch of the imagination. This Chapter will, therefore, briefly comment on the relation between these conceptual structures, integrally dependent on *death* as they are, and the stories supporting them – showing that narrative and epistemological structures are tightly interwoven.

Examination both of case reports and general expository texts shows that narrative dominates pre-bacteriological Victorian medicine. This medicine is involved in telling the story of the course of typical instances of disease in an expository fashion. Even the attribution of cause or aetiology within such accounts is narrative. Moreover these general accounts of the nature and causes of disease depend on narrative accounts of patient's illnesses in case and post-mortem reports. Post-mortem reports are integral to Victorian medicine because they invest its stories with a conceptually rigorous, scientific and *deadly* 'sense of an ending.' Despite being largely descriptive these post mortem reports are done in sufficient number and at sufficient points across the disease's development to constitute an implicit story of the body's progressive, invisible death during the patient's life.

General expository medical treatises of the early nineteenth century often purport to avoid 'theory' or 'speculation' in favour of more neutral descriptions of diseases - therefore, not appearing to be narratives of events in time at all. Medical histories and biographies of prominent doctors often blur questions of conceptual structure and epistemology into those of 'tradition' and 'influence,' or account for innovation in terms of personal acuity, 'genius', or even some form of 'spirit of the time'. Reading against such methods, I examine Clark's, Carswell's and Bright's

works and published cases as they appear to have had neither close contact nor shared common influences, to explore the role of narrative and death in early Victorian medicine.

Sir James Clark, unlike Bright, was not a groundbreaker.⁹ He holds only a minor place in history as court physician to Prince Leopold, later king of the Belgians and to the Duchess of Kent and the Princess, later Queen, Victoria.¹⁰ He is remembered as Keats' doctor in the final months leading up to his death in Rome. While opinions are divided on his treatment of the dying poet, all agree that his only care was for his patient's comfort.¹¹ Besides attending British, Belgian and French nobility in a professional capacity, he also was also consulted by the Nightingale family (treating Florence's sister Parthe), John Stuart Mill, Ruskin and his friend George Eliot.¹² He was influential and worked to support the founding of the Royal College of Chemistry (later Imperial College) and also the forerunner of the General Medical Council. He was knighted by the young Victoria in October 1837.

He first came to the attention of the public with the publication, in 1820, of Medical Notes on Climate, Diseases, Hospitals, and Medical Schools, in France, Italy, and Switzerland, whose subtitle is 'an inquiry into the effects of residence in the South of Europe, in cases of pulmonary consumption'. His interest in climate and consumption continued throughout his life and he brought out four editions of a similar book. He was also a close friend of the one of the first British psychiatrists, John Conolly, and wrote Conolly's biography in retirement at the age of 82. The Dictionary of National Biography unflatteringly dismisses Clark's major work, A Treatise on Pulmonary Consumption, as 'chiefly a compilation'

adding that he ‘made no addition to medical knowledge’ although it grudgingly recognises what it takes to be his one small contribution in the recognition that pregnancy forces complete remission in consumptive women.¹³ This, however, makes him all the more useful for our purposes since he is credited with having written the best contemporary English work on phthisis.¹⁴ Thus his claim upon the attention of his fellow physicians rests on the conservative hope, expressed in the introduction to his Treatise, that in laying out his opinions he makes ‘no pretensions to originality or peculiarity of doctrine,’ even admitting that much ‘that is contained in the following pages is already known to the more intelligent and experienced of the profession [...]’¹⁵

Although an explication of Bright’s and Carswell’s texts, condensed though they are, could yield up much of what is found in Clark’s work, there is an important difference. This consists in Clark’s essentially telling an explanatory story regarding the signs, symptoms, treatment and morbid appearances of the typical or common form of pulmonary consumption while also exploring the causes, duration and varieties of the disease. Clark’s text represents the fully articulated form of the knowledge of the disease necessary to make sense of Carswell’s and Bright’s two illustrated works of pathological anatomy.

Very early on in his Treatise Clark frankly declares medicine’s limitations in the face of pulmonary consumption when he says:

No physician, acquainted with the morbid anatomy of Tuberculous Consumption can for a moment indulge the hope that we shall ever be able to cure what is usually termed ‘confirmed consumption’, if we except that very small proportion of cases in which the tuberculous deposit is confined to a very limited portion of the lung. We might as reasonably expect to restore vision when the organization of the eye is destroyed, or the function of the brain when the substance of that organ is reduced by disease to a

pultaceous mass, as to cure a patient whose lungs are extensively disorganised by tuberculous disease.¹⁶

Clark's text, as is to be expected from a medical or scientific document, is impressively detached and controlled in both its emotion and language. In the course of strongly expressing his belief that many claims to having cured the disease were erroneous, however, his text anticipates its story's ending in death. Thought and consciousness are, even at this early stage in medical history, envisaged as dependent on the brain, one of the three supports of Xavier Bichat's vital tripod, and, by graphically invoking its destruction in a 'pultaceous mass', Clark's text not only forces the reader to recognise the impossibility of cure, but also confronts him or her with the condition's inescapable conclusion: death. This is reinforced by using a parallel - the destruction of the eye, that organ so dear to reflection itself. There is no hope, for either patient or physician, of medicine's being able to ward off death in cases of consumption. This 'ending' is presented as a foregone conclusion even before Clark's narrative has begun. This potentially dark shadow is, however, paradoxically involved in a great deal of illumination, as Clark's story unfolds.

The Treatise devotes its first Chapter to the patient, whom Clark sums up in a single adjective: cachectic. Although cachexia ranks beside 'intermittent', 'continuous', 'putrid' and 'hectic' as a now almost unintelligible conceptual construct, like phlogiston, in the eighteenth and early nineteenth-century knowledge of fevers, it has a precise meaning in Clark's exposition. He offers a definition:

By the term Tuberculous Cachexia, I designate that particular morbid condition of the system which gives rise to the deposition of tuberculous

matter, on the application of certain exciting causes, which have no such effect on a healthy system.¹⁷

In other words, a particular, unhealthy condition of the general system which, given certain 'exciting causes', results in tuberculous matter being laid down in the body, primarily the lungs. This condition can be either inherited or arise as the result of the child and adult's mode of life. As Clark states, this is not his invention or discovery, for he merely means what others term a 'scrofulous diathesis'. Issues surrounding the deposition of tuberculous matter will be addressed in relation to Clark's views on the disease's morbid appearances, where it is discussed in the greatest detail.

The cachectic type is identifiable simply in terms of his or her external appearance. Cachectic children's frames develop disproportionately, with head large, trunk small, abdomen 'tumid' and limbs unshapely, and there will be, says Clark, 'a want of symmetry in the whole'.¹⁸ These young children are also marked by a 'pale, pasty appearance', 'full' cheeks, and a 'tumid' upper lip and nose. The unfortunate individual may have either a dark or light complexion: in both cases there is some deviation from the norm. Darker, coarser skinned people will look 'sallow' and 'dingy', fairer skinned will have 'an unnatural white appearance, resembling blanchéd wax' with prominent veins. The characterisation also includes references to abnormally large eyes and long eye lashes. There is a painful irony in the appearance of those subject to disfiguring scrofulous and fatal pulmonary disease - they usually possess 'a placid expression' and 'often great beauty of countenance, especially in persons of fair, florid complexion.'¹⁹

These external appearances have their internal analogues. The circulation is 'generally feeble, as indicated by a weak pulse and cold extremities', for reasons which will become clearer when we discuss the formation of tuberculous matter. All the 'functions of organic life are more or less imperfectly formed, but those more immediately connected with nutrition, particularly the digestive function, are most evidently deranged.' Bowel, urinary, and cutaneous functions (perspiration) are all evidently 'deranged'. The key internal disorder to be found among those disposed towards consumption is 'strumous dyspepsia'. Its symptoms include bright red points on the tongue, fetid breath, sore throat, enlarged tonsils, bloody stools and expectorations.²⁰ They also include inflammations of the eyelid, cutaneous eruptions behind the ears and on the scalp. For Clark all scrofulous and tuberculous disease depends on this dyspepsia.

Cachectic persons are also defined by a set of mental characteristics, on which

Clark is unfortunately tantalisingly sketchy. He writes:

The state of the nervous system in Tuberculous Cachexia varies greatly in different individuals; it is generally morbidly sensitive and irritable: in persons naturally of a nervous temperament, more especially females, the nervous sensibility is greatly increased. The intellectual functions are often performed with a preternatural degree of activity, a premature development of mental faculties being a frequent accompaniment of the tuberculous habit.²¹

Here, sensitivity is brought into conjunction with illness and the physiological category of irritability is associated with 'nervous temperament'. Moreover, this heightened sensitivity is associated with a similarly increased functioning of a precocious intellect. Thus, to prevent or forestall the development of the cachexia into consumption itself, Clark cautions against intellectually overtaxing children once they are engaged in education, a danger all the greater since, the 'welfare of

the pupil demands the observance of this rule on the part of the master as well as the parents, more especially when the child belongs to that class of strumous children whose intellects are preternaturally acute.’²² He goes on to note how parents and teachers of such children often encourage this premature intellect for their own ends, with disastrous results. All possible measures are used ‘to stimulate the child to renewed exertions; and thus the health is enfeebled, *and even life is often sacrificed at a period of brilliant promise...*’ [italic added].²³ Here, in those liable to consumption, increased mental activity or development terminates in disease and death.²⁴

Yet the characterisation ‘varies greatly in different individuals’. This variance is itself contained within a typology: there are two kinds of mental constitution linked directly to physical appearance:

[...] the one, attended by a florid complexion, thin fair skin, and great sensibility to impressions, with a corresponding acuteness of mind; the other, characterised by a dark complexion and coarse skin, with a languid, torpid condition of the bodily functions, and a similar dullness of the mental faculties.²⁵

Besides these few explicit remarks concerning sufferers’ psychology, we can infer some limited ideas from remarks he makes elsewhere. The transition from cachexia to consumption is one potential sufferers either do not wish to make or, despite a heightened intellect, one which they remain blind to. Thus there is a class of patients often diagnosed as consumptive late in the disease’s progress, but who remain ignorant of their real condition even into the disease’s second ‘stage’.

Initially the patient, usually a ‘delicate’ young woman, experiences slight symptoms such as breathlessness, coughing, debility or a feeling of languor, nonetheless, this sufferer ‘scarcely considers herself ill. [...] Debility, being the

most prominent symptom, is often considered the cause of the others.’²⁶ Even when the disease has advanced to where bloody sputum is produced, patients remain unaware of their position. Clark’s text reveals a limited awareness of his culture’s view of cachectics and consumptives. He shows how both the patient and those around him or her treat the earliest manifestations of the disease, so as to render its ‘victims’,

[...] merely valetudinarians in their best state of health: their natural state is one of weakness, they are easily fatigued and even exhausted by exercise: [...] they have the lymphatic constitution of the child without the power and activity of the child’s circulating system, and yield to the ordinary causes of disease with remarkable facility.²⁷

Such victims are seen to regard themselves as naturally weak and susceptible.

Although likely to be immensely sensitive and intelligent, they are blind to their greatest threat. Ill health, in this self-conception, is normal.

Although Clark elaborates the individual’s psychological characterisation through the picture of cachexia, it nonetheless largely fails to form part of the narratives which describe consumption’s typical course. It is not used in the narrative or more rigorously explanatory parts of the text. Clark does not relate sensitivity, beauty, or other mental aspects of the diathesis to the physiology of digestion or excretion and the story of the tubercle. This individuating typology only resurfaces in odd remarks regarding the physician’s questioning of the patient, and in those where changes of consciousness function as both symptoms and signs of approaching death. These signs will be examined later.

It should now be clear that pre-bacteriological medicine is fully engaged in elaborating a complete picture of both the sick and the healthy. By blurring the boundaries between sickness and health, or at least extending that of sickness into

health, as does Clark's concept of cachexia, an indissociable ontology of mind and body is being elaborated. Those likely to become ill are already sick beings, both physically and mentally. This is borne out by the idea that cachexia is 'a morbid state of the constitution' or very make-up of the individual, and is perhaps one of the last medical vestiges of the individual being conceived of as inherently morally bad.²⁸ Negative uses of the word cachexia are reflected not so much in Clark's text as in the two examples cited in the Oxford English Dictionary in the years following Clark's work. These capture both the moral nuance and the physiological aspect which interested Clark. Cachexia is firstly defined as a 'depraved condition of the body, in which nutrition is everywhere defective', citing the Sydenham Society's Lexicon definition published between 1879 and 1899. Secondly, cachexia is cited as meaning 'a depraved habit of mind and feeling' in examples from 1843 and 1868. Clark's brief comments on mental sensitivity gesture towards this view while his more extensive physiological exposition shifts this conception to the level of the body. This may well account for what appears to be primarily a moral way of allowing for variation in the nature of the cachectic. Thus the typology of 'two opposite states of the mental as well as the physical condition' cited above generalises disease across social groups in morally resonant ways.²⁹ This typology also suggests that not only may the apparently healthy be ill, but that none fall outside the moral categories built into medical theory.

Although Clark presents narrative case histories and tells expository stories about the evolution of the disease's symptoms and their relation to physical signs, the Treatise largely narrates the history of the typical or commonest form of tuberculosis. Chapter II opens as follows:

In describing the course of tuberculous consumption, I shall endeavour to trace the relation between the symptoms and the physical signs, which attend and mark the progressive morbid changes in the lungs: as it is only by keeping this connection constantly in view that we are able to detect tuberculous disease in its commencement, follow it in its course, or distinguish it even in its more advanced stages, when latent, or obscured by the presence of other diseases.³⁰

The narrative of the ‘usual form and progress of consumption’, its events and duration, will, however, be dependent on relating symptoms to the physical signs.³¹ Although implicit in the above statement, this narrative depends on another linking these signs to the silent but lethal advance of disease within the body, which is finally laid bare at autopsy. This story articulates one of the epistemological links in pathological-anatomical medicine. Clark’s decision, ‘to adopt the usual mode of dividing the disease into stages, as it will enable me more easily to follow the progress of the pulmonary affection in connexion [sic] with its external manifestations’ shows this.³² By adopting these stages, Clark uses an older temporal framework for understanding progressive bodily destruction and death, with, however, significant conceptual differences. It is notable that the arrangement of three ‘stages’ adopted by Clark coincides with a common way of describing narratives as possessed of beginnings, middles and ends. Although this arrangement clearly predates Clark’s use of it, the formal distribution of stages precisely fits the minimal definition of narrative relied on here. The pervasiveness of narrative in medicine argued for by Montgomery Hunter and extended to include nineteenth-century medicine here would suggest that this innocuous division of a disease into stages in fact depends on medicine’s commitment to stories.

Increasing the importance of physical signs (related to morbid appearances) renders the time of the body’s dissolution pre-eminent. Despite considerable variation in each stage’s length, time is nonetheless integral to the body *and its death*. Changes

in both symptoms and signs, chart this time and medicine's narrative knowledge itself is dedicated to tracing their progress.

Clark's text articulates three stages in the disease's evolution, each of which, it seems, can roughly be divided into 'sub-stages' corresponding to the progression of symptoms within it. Despite the elaboration of a cachexia eroding the distinction between normal and pathological, Clark is still able to hold that coughing 'is generally the earliest symptom' indicating tuberculous lung disease.³³ Early non-productive coughing gradually gives way to a cough associated with a 'ropy' sputum and dyspnoea or breathlessness.³⁴ Productive coughing may be succeeded and supplemented by febrile symptoms such as the gradual onset of chill alternating, in the evenings and night, with fever and perspiration. Even the face begins to reveal symptomatic changes, becoming, for Clark, 'paler than usual' or changing colour frequently while beginning to be 'expressive of languor'.³⁵ All the while, the patient may be wasting. Although this is half the story which Clark uses to understand the disease, it is already an abstraction of histories of bodily actions and events - the course of symptoms in the first stage.

The action in, and the account of, this succession of events is dependent upon time. It is sufficient, when explaining the disease's general characteristics, for stages to succeed and logically follow each other for there to be a narrative. Thus it does not matter much that the duration and severity of each symptomatic phase varies enormously. The issue of time in this story will be returned to when considering Clark's pronouncements on morbid appearances, however, I will next discuss the physical signs which represent the story's other half.

Foucault very elegantly shows how eighteenth-century French clinical anatomical medicine was epistemologically committed to a semiotics and a symptomatology. In eighteenth-century medicine symptoms were a set of visible manifestations linked to diseases' essential natures and thus to their causes. Signs, such as the strength of the pulse, on the other hand, only obliquely touched on the nature of disease. They usually articulated a disease's temporal nature instead, allowing prognostication and indicating likely outcomes.³⁶ By the time Clark came to write his Treatise, however, medicine had changed profoundly. His understanding of signs is radically incompatible with this earlier medicine since signs had begun to determine the meaning of symptoms, through the medium of morbid appearances, by linking them to the time of the body's dissolution and progressive death. In nineteenth-century medicine signs are external signs of bodily destruction or change and so go to the heart of pathology. By 'signs' Clark and most of his contemporaries meant those physical signs mostly accessible by applying technologies and techniques for discerning the diseased state of internal organs, especially through mediat auscultation (hearing chest sounds) with the recently invented stethoscope and using percussion. The status of the pulse also changed. Clark, however, included signs dependent upon simple, unmediated examination of the body which indicates this knowledge's reliance on a relation between perception generally and the body's *depths*. Moreover, signs now spoke directly of disease itself.

Percussion of the chest and abdomen, a technique devised by the Viennese physician Leopold Auenbrugger and popularised by Jean Nicolas Corvisart, is

necessary to find one set of consumption's signs. Although in this first stage, signs are often elusive, still the 'sound' says Clark, 'elicited by percussion, when delicately performed, will often be found clearer under one clavicle than under the other.'³⁷ Obviously, the abnormal dullness is relative both to the sound of the corresponding lung in a perfectly healthy individual and to the sound in the patient's healthier lung.³⁸ Auscultation with the stethoscope reveals that the respiratory murmur 'will be less soft, and the resonance of the voice greater where the duller sound exists'.³⁹ Should doubt regarding the other two signs remain, Clark advocates observing whether both sides of the chest expand equally on inspiration. Almost invariably, 'and even at this early period, the motions of the upper parts of the chest [...] may often be remarked to be unequal,' the dull sounding side with a louder respiratory murmur expanding less than the other. These physical signs, especially those discerned by percussion and auscultation, can, Clark writes, 'afford the most unequivocal indications of the existence of pulmonary disease.'⁴⁰ Clark relies on an implicit narrative explanation of a single cause producing and accounting for all three signs or effects. Although he does not voice this narrative, his view depends, for its very truth, on this assumed explanation.

Clark is, however, adamant that the diagnosis, medicine's moment of truth, depends on the interrelation between these signs and the symptoms. He writes:

By careful inquiry into the state of the patient's health previously to the period now under consideration, and by attending to the various symptoms which have been enumerated, the physician who has been accustomed to trace the relations of symptoms to the morbid changes of the organs, will rarely fail to arrive at a correct opinion; and if he can avail himself of the evidence derived from the physical signs, he will have the positive assurance that his diagnosis is correct in a very large proportion of cases.⁴¹

The train of events leading to diagnosis is initiated by the patient's complaint and subsequent narration into which 'careful' inquiry is necessary. This, Clark informs us, should involve inquiring into 'the past health and occupations, the previous diseases,' and 'the family predisposition also (when possible), should be ascertained.' Access to this part of the evidence needed for diagnosis can be fraught with difficulties. Clark notes, in his discussion of breathlessness that,

[...] it is by no means uncommon to find the patient unwilling to admit the existence of dyspnoea until minutely questioned. Consumptive patients are often jealous of being interrogated respecting any symptom connected with pulmonary disease; and they occasionally conceal symptoms from the physician, who if he desires to arrive at the truth, must put his questions with great caution, and without appearing to attach much importance to them.⁴²

Because of the tremendous importance attached to symptomatic evidence, only accessible through the patient's account, and because patients are reluctant to reveal suspected dangerous indications of their condition, Clark advises very careful questioning to ensure this essential narrative component is available in practice.⁴³

The existence of instances of patients' reluctance to reveal symptoms also renders questionable those cases in which particularly intelligent valitudinarians and their friends appear to remain ignorant of the sufferer's real condition. In fact, as biographic and autobiographical material on consumptives' lives in Chapter 7 reveals, those around consumptives, including their doctors, were often reluctant to reveal the real state of affairs to sufferers. Moreover, there are also indications that consumptives did not wish to accept that they had the disease.



Although the role of ‘morbid appearances’ is still to be considered, Clark clearly believes it is vital to integrate them into the consideration of symptoms. This is partly due to the radical uncertainty and unreliability surrounding each particular symptom of the disease. It is possible, for example, for the onset of coughing to occur late in the course of the disease or for it to be so slight as to be overlooked. Similarly haemoptysis (the spitting of blood) may not appear at all, or perspiration and night chills may occur later in the disease’s course. There may also be little or no pain, and oedema may not occur at all. Symptoms are correlated against morbid appearances and signs to minimise this uncertainty. The relation between symptoms and morbid appearances is verified through physical signs which provide a certain kind of evidence. I shall consider how physical signs’ evidential status rests on the logical narrative connecting them to morbid appearances at a later point. Strictly speaking, the physician does not have access to his live patient’s morbid appearances. All the elements: patient’s reports, observed symptoms, physical signs and morbid appearances are integral and essential parts in the story, beginning with the predisposition’s description and ending with the patient’s death and dissection.

Clark’s tale, however, still has to progress through two further stages and an epilogue. The next event in the typical plot is the patient’s sputum changing from being ‘ropey’ to one containing a pale yellowish substance:

The colourless frothy fluid, which had hitherto been expectorated, is observed to contain, small specks of opaque curdly matter, of a pale yellowish colour ... specks or streaks of blood are also observed in the expectoration at this time.⁴⁴

This indicates ‘the transition from the first to the second stage of phthisis....’ What distinguishes this event, transforming it from merely another symptom to a crucial

transformation-marking stage, is the relation between this sputum and changes occurring within the body, which are only perceptible in two ways - through physical signs and morbid appearances. This is confirmed by Clark's indifference to the exact series of succession when describing the next set of symptoms characteristic of this stage. These are increased frequency of cough, increased severity of evening chills, febrile symptoms, definite constant, high pulse rate. more evident wasting and pallor. Chest pain may also occur at this stage.⁴⁵

The significance of morbid appearances within Clark's exposition is indicated by information on this point between his description of second stage symptoms and signs. He writes:

These symptoms are accompanied by a corresponding change in the morbid condition of the lungs. The tuberculous deposit has undergone that process which is often called softening, — [...] and the change in the character of the expectoration indicates at once the softening of the tuberculous matter and its passage into the bronchial tubes. While this process is taking place in the earlier tuberculous deposits, the pleura covering the diseased portion of the lung generally becomes adherent to the costal pleura.⁴⁶

While Clark states merely that the new symptoms are 'accompanied' by significant internal changes in the consistency of tubercles, evident in sputum alterations, he clearly means that the key symptom is *caused* by these changes. Substituting 'caused' for both formulations does not distort the meaning of the passage. A similar causal reading of changes in the pleura can also be made. An explanatory, conceptual structure determines or underpins the narrative of events concerning the patient. Significantly, when read together with information on pain localisation and physical signs, the remarks on pleural adhesions suggest that this narrative is involved in a thoroughly objective knowledge of the individual, confined, in this aspect at least, to the causally organised space and time of the diseased body.

During inspiration at this stage the chest is usually less freely raised than in health. *Both* lungs produce dull resonances on percussion. Furthermore, ‘on applying the stethoscope to the chest a slight but peculiar cracking sound (crepitant rhonchus) is heard. The voice is most resonant, amounting generally to bronchophony (sound emanating from the bronchi), and distinct pectiloquy is often heard in one or more points of the clavicular or scapular regions.’⁴⁷ Clark uses the French doctor René Laennec’s terms, which in their etymology suggest that the bronchi and pectoral regions speak; however, these distinctive sounds are only resonances of the patient’s own voice during examination. Death’s significance in this form of medicine is revealed by the peculiar history of one of these arcane terms. Laennec had first wanted to designate the ‘rhonchus’ a ‘rhale’ or rattle, but was dissuaded by the connotations of death rattle which would distress his patients. His original prompting, however, is truer to both the conceptual links between crepitant rhonchus and death and between the sign and the disease’s usual fatal outcome.

Clark also discusses stage two’s duration in relation to the possibility of imminent death and the slim chance of spontaneous cure and normal life. He writes that,

In some cases a few weeks suffice to lead [the patient] to the brink of the grave, while in [other cases] many months, or even years, may pass without any remarkable increase or diminution of the symptoms, or, there is reason to believe, of the pulmonary affection. In a small proportion of cases a curative process is established, by which the tuberculous disease is partially or entirely obliterated.⁴⁸

The language referring to dramatic dissolution is aptly forceful and calls for no scientific precision: one is led to the very brink of the abyss in weeks. The first alternative, remission, with its intermediate duration suspending both reader and patient uncertainly between life and death, is referred to rationality and its

application to knowledge of precise states of organs. The chance of life and cure, however, is 'small'. Moreover, the shadow of death is still not entirely expunged: note the cautious words 'partially or entirely'. This caution is necessary, as suggested by the absence of stated 'reasons' within Clark's and Carswell's texts. As we shall see, cure remains only a promising story for sufferers. Carswell can only offer one symptomatic correlate for the alterations in morbid tissue which support his and Clark's view of spontaneous cure.⁴⁹

Stage three is marked at both extremities: it is distinguished at onset in Clark's text by the conferring of a name and at its termination by the patient's almost inevitable decline and death. Its finality is also marked by its being the last of Clark's designated stages of consumption, but only the penultimate stage of the patient's medical encounter. The final stage, Clark informs us, 'has been termed the colli-quative stage, from the copious perspirations, the frequent attacks of diarrhoea, and the abundant expectoration by which it is usually attended.'⁵⁰ Its name reflects the increasingly severe fluid discharge from the patient's body, however the technical term also conveys the meaning of wasting or melting away, in other words, death through liquefaction. As is to be expected from the name's conjured image and its rationale, the majority of the symptoms are not new. Thus the cough usually increases, breathing becomes extremely difficult, and chest pain is more severe and frequent in those patients who suffer from this symptom. New symptoms, however, also emerge: diarrhoea was absent in the previous two stages, but its severity links it to the others noted above, therefore excluding the possibility, for Clark, of its being promoted to the status of a privileged defining symptom despite it contributing greatly to the increased debility and suffering. In

addition, early morning oedema or swelling of the legs and, occasionally, in the arms and face may set in. ‘In general [...] [oedema] is a sure prognostic that the disease is approaching its termination.’⁵¹ The other new symptom is the appearance of aphthae or mouth ulcers. Clark writes,

An apthous state of the mouth is commonly the last in a long catalogue of maladies which affect the consumptive patient. It occurs generally a week or two before death, [...] varies greatly in degree, [...] and is sometimes [...] attended with so much irritation and tenderness of the mouth and throat as to prove a source of considerable suffering.⁵²

Oedema and aphthae, while being symptoms, also appear to indicate the system’s dissolution as a whole (as are increased severity of bodily discharges): Bichat and his colleagues found that there are signs, such as these, announcing the approach of death. Accordingly the diarrhoea gains significance, resulting in a picture of shocking emaciation: ‘The diarrhoea being once established, the process of wasting advances more rapidly, affecting the whole of the soft parts; and frequently before death there remains little more than the integuments and the bony skeleton.’⁵³

Dissolution affects the patient’s mind. Disintegration encounters consciousness both as an object of that consciousness as well as determining its form and ultimately its very limit. Clark writes:

With the loss of physical strength, the energy of the mind generally undergoes a corresponding diminution; the reasoning faculty remains, but its powers are greatly enfeebled. Although inwardly conscious of his decay, the patient seldom excludes the possibility of recovery, until at last he becomes indifferent to his own state and to what is passing around him, notwithstanding he had been hitherto remarkably alive to every symptom.⁵⁴

We cannot expect a physician, in an age when the mind is only beginning to become part of the territory of the newly scientific medicine, to elaborate a full-blown psychology of consumption. The patient’s interest in his own health,

however, comes into conflict with his objective knowledge of his own state - he or she cannot but be conscious of their physical decline and impending death. The desire to be well, which prompted the patient to seek help initially, has persisted although it doubtless increases or lessens as the case may be, but in the final stage it is revealed for what it is - rather than a desire to be well it is a desire to escape death: the patient 'seldom excludes the possibility of recovery' almost until the very loss of consciousness itself. The same desire, it seems, was implicated in the physician's need to question the patient extremely cautiously, to overcome the reluctance to admit the existence of symptoms which the patient feared were dangerously significant.

Despite Clark's relatively sporadic attention to the patient's mental condition, the confrontation between desire and death is not limited to any specific consumptive 'stage'. Having remarked on the terminal signs of apthae and oedema, he writes:

The condition of the nervous system undergoes a considerable change:— the patient becomes nervous, both mentally and physically, even in the early period of the disease: he is timid and apprehensive of the least circumstance which can increase his complaint: his hand shakes and he often becomes peevish and irritable. These nervous affections generally keep pace with the increasing debility. The intellect, however, for the most part remains clear till, when slight delirium [...] occasionally supervenes.⁵⁵

What is interesting here is the way this passage consolidates and affirms the grounding of the mental in the physical as in the picture of the cachectic outlined above. There appears to be a gap between the cachexic and the confirmed consumptive's nervous state. The picture of the extreme intelligence, sensitivity and creativity is not sustained in the sketch of the disease's progress, almost as though resorting to a common 'condition of the nervous system' rendered the reconciliation of such paradoxes and gaps unnecessary. The story of the mind's

and the body's dissolution is, however, not necessarily coterminous. Here consciousness is dependent on a physical support (another expression of the mind, within this medicine, being grounded on and in the body). The patient only 'occasionally' slips into delirium in the disease's final stage.

The final stage's physical signs are appropriately dramatic. That gaze which in earlier stages was cross checked and rectified by two other forms of signs is now able to articulate its truth unequivocally:

The chest at this advanced period of the disease is found to be remarkably changed in its form; it is flat instead of being round and prominent; the shoulders are raised and brought forward and the clavicles are usually prominent, leaving a deep hollow space between them and the upper ribs.⁵⁶

The chest also hardly expands visibly on inspiration. The perception which reads the lung's destruction as anatomical abnormality, nonetheless, still has recourse to the other signs. Percussion at this stage in the region of both the lungs' summits usually discerns a less dull sound than that detected in the earlier stages, and Clark's explanation of this point is almost forced to introduce the morbid appearances which link the two: '[...] the caverns which partially occupy this part of the lungs and the emaciated state of the parietes, may render the sound less dull'.

There is a paradoxical proliferation of signs found by auscultation as the body disintegrates:

[...] the respiration is obscure and in some places inaudible, while in others it is particularly clear, but has the character of bronchial, or tracheal, or even the cavernous respiration of Laennec. There is a mucous rhonchus; coughing gives rise to a gurgling sound (gargouillement), and pectriquiry is generally more or less distinct.⁵⁷

In addition to the extremes of 'inaudible' and 'particularly clear' there are now six distinct perceptible sounds. Moreover, this disintegration is comprehended almost as a displacement or disorganisation of bodily regions - the murmur of normal

respiration within the pulmonary parenchyma has become like that of the bronchi and trachea - death and dissolution cause physical signs to displace across the space of the body. The 'abundant expectoration' also has its correlative in an audible index of that symptom - the gurgling sound technologically and precisely supports this stage's name, the 'colli-quative'.

In general, the patient's view and experience of disease seems to have become marginalised with the rise of increasingly specialised hospital medicine between the end of the eighteenth century and the bacteriologically orientated medicine initiated in the 1880s. Moreover, the later form of medicine appears to have extinguished the patient's voice through technologies for examination and testing. Nevertheless, the patient's voice and the story it conveys have a key role in the diagnostic process: he initiates the dialogue and supplies vital information at important points. The numerous guidebooks on the procedures for taking a history, written for interns during Clark's lifetime, show that it was a vital part of medical practice. Some even stress that the patient's own words ought to be recorded.

Clark's Treatise is a generalisation based on particular narratives in real cases and contains paraphrases or reports of patients' stories together with the processes of rational deduction performed upon them in the light of the physician's current knowledge. As a generalisation it cannot carry the voices of real patients within it, so it may well appear to support the case for the disappearance of the patient's voice from medicine. The particular cases I will examine will, however, dispel any such appearances. For the moment suffice it to quote, at some length, an extremely powerful passage in which Clark voices his awareness of his patients' experiences

to dispel erroneous popular ideas concerning consumption's mild and painless character:

They must have witnessed but little of the disease who could give this as its general character. The miserable sensations produced by the frequent chills during the day, and by the more distressing and death-like chills which follow the copious perspirations in the night and morning; the harassing cough and expectoration; the pains of the chest, the frequent dyspnoea, amounting often to a threatening of suffocation; the distressing sense of sinking produced by the diarrhoea, — all increasing as the strength of the unfortunate patient fails; — and, more than these that ‘contention de l’esprit,’ that inward struggle between hope and fear, which whether avowed or not, is generally felt by the patient in the later stages, — constitute a degree of suffering which, considering the protracted period of its duration, is seldom surpassed in any other disease.⁵⁸

Consumptive dissolution and death, are eminently dramatic for the patient: the struggle between life and the death which is slowly corroding their bodies is paralleled by a pain-wracked struggle between incipient terror and the very desire to live.

Given that for Clark death has become a *process* of temporally progressive destruction of bodily space (apparent for example in ideas concerning the distribution of early and later forms of tubercle in the lung) it is easy to see why he is extremely brief concerning the moment of death. He writes simply that for some, ‘sufferings give place to a state of tranquillity and ease during the last few days of life’ and that in ‘other cases the struggle continues to the last.’⁵⁹ While death is a commonplace experience for medical practitioners and one to which they necessarily become less sensitive, the brevity of this statement also reflects the epistemology which has redistributed death through life, as disease, as well as through health, as we have seen in the idea of the cachexia.

Death is the end of the patient's story and marks the end of his or her ability to tell a story, but it is, nonetheless, not the end of medicine's story about that patient.

The fourth Chapter in Clark's Treatise, devoted to post mortem 'Morbid Appearances', follows his general description of the disease. I have already alluded to an unacknowledged fourth stage in his exposition of the course of the disease since it continues the story of the typical course of the disease by supplying the essential links binding symptoms to physical signs. The section on morbid appearances is both epistemologically and dramatically vital for Victorian medicine to make the fullest possible sense of the disease. In addition, the Chapter contains material which allows us some insight into the conception of life and death at the very limits of pathological anatomical medicine.

The fourth stage, like the preceding three, has a documentary counterpart not in the clinical case notes, but in autopsy reports. As such, like the previous three stages, it represents a general description abstracted, as it were, from countless actual cases. If it is a stage in the story it is marked as such by the patient's demise, its actual condition of possibility. Contrary to expectations, Clark's Chapter opens *not* with an account of the gross pathology of organs such as we find in Morgagni, although it depends on similar dissections and observation, but begins instead with a consideration of the 'seat' of the tubercle itself:

Minute and careful anatomical researches, often repeated, have led Dr Carswell to the conclusion that the surface of the mucous and serous tissues, and the blood, form the exclusive seat of tuberculous matter. [...] The free surface of mucous membranes forms the chief seat of tuberculous deposits. 'There, as in a great emunctory of the system, it appears to be separated from the blood and becomes visible to us under a variety of forms.'⁶⁰

If, as Louis MacNeice suggests, ‘the latitude and longitude of life / are fixed by death,’ then these co-ordinates have their material supports in tissue surfaces within pathological anatomical medicine. The fundamental spatial strata of the body are tissues for Clark and Carswell and such contemporaries as Thomas Hodgkin, and it is here that disease is discernible within the space of the body (composed of 21 types of tissue according to Bichat). I shall return to the language of Clark’s quotation from Carswell in due course.

We have already seen the notion of deposition at work elsewhere, Clark explains it here:

‘As a morbid constituent of the blood’ Dr Carswell observes, ‘we can take no cognizance than through the medium of the secretions, or until that fluid has ceased to circulate; then the tuberculous matter is seen to separate from the serum, fibrin, and colouring matter, and is distinguished from them by its peculiar physical characters.’⁶¹

This illness, in a period when microscopic verification was still impossible, is attributed jointly to the blood and membranes - one’s blood can be sick. Yet the explanation proposes a process - a series of events in time - through which deposition occurs: first the blood ceases flowing, ‘then’ its constituents ‘separate’ leaving tuberculous matter and the other constituents of this blood behind. It is really a story about the origins of tuberculous deposit, dependent on time (of unspecified duration), place (membrane) and perhaps even linked to obscure causes which impede the circulation of the blood and certainly implicate the patient and his forebears as distantly responsible for this pathology.⁶² It would not be wrong to suggest that there is a link here between ‘blood’ as the means for the transmission of heredity on the one hand, and circulatory physiology and histology on the other.

The story of deposition is mapped onto symptoms, connecting them to morbid appearances. In discussing acute phthisis, otherwise known as ‘galloping consumption’, Clark notes that,

When subjects already labouring under consumption, or who are in a state of tuberculous cachexia, are exposed to violent irritations of the lungs, these [tuberculous] granulations are deposited so rapidly and in such numbers throughout the lungs, as to give rise to the most alarming dyspnoea.⁶³

The story concerning the speed of deposition allows for a causal explanation in the account of patients’ symptoms.

The history of tuberculous granulations goes beyond their deposition. Although the spread of tubercles in bodily space is not confined to a single tissue functioning as the spatial link between bodily regions, nonetheless the story of tubercle development is linked to the tale of their progressive invasion of the lung, and by implication, the remainder of the body. Clark writes that,

During the process of softening and ulceration, tuberculous matter continues to be deposited in other portions of the lung, the progress being generally from above downwards; so that we often find excavations at the summit, crude or softened tubercles below these, and granulations, with no trace of opaque matter in the lowest part.⁶⁴

At death, for Clark, the lungs reveal archaeological strata supporting the story of tubercle development in the lung. It is especially important for the largely temporal narrative of the tubercle’s development to be articulated onto the three dimensional pulmonary space, and in doing this the above section also voices a view of the principle of spread of the disease. Although application of this principle, in conjunction with the concept of tissue, could be used to generalise the disease throughout the body, Clark does not do so.

An embryonic picture of such proliferating disease is to be found in his discussions of complications of the pulmonary form of the disease. His ideas concerning ulceration of the epiglottis fit into this pattern. The first section of his Chapter on ‘Complications’ begins as follows:

The mucous membrane of the air passages is generally diseased, in the course of pulmonary consumption, to a greater or lesser extent.

Ulceration of the epiglottis. — This generally occurs late in the disease. [...] in general the larynx is affected at the same time and in the same manner [...]

Not only are the lesions of the epiglottis generally a late development, but they are also spatially determined: Clark explains that the upper or lingual surface of this tiny flap is only rarely ulcerated, the lesions occurring generally on its underside. Similarly ulceration of the intestines is also spatially determined, a point which will be particularly relevant to our examination of Carswell’s and Bright’s texts. Clark writes:

Ulcers of the intestines, when first formed, are always small; they occur most frequently in the lower portion of the ileum, and chiefly in that part opposite its attachment to the mesentery, where the glandulae agminatae are chiefly situated. These glands form their primary seat. In the large intestines the ulcerations occur irregularly. When the ulcerative process is once established, it often extends to the surrounding tissues; the neighbouring ulcers coalesce, and the mucous membrane is undermined or destroyed to a great extent.⁶⁵

The last sentence of the above passage contains a tiny *story* about the spatial extension, and destruction resulting from the establishment of tuberculous lesions in the intestines. Moreover it contains the idea of the development of single ulcers which were precisely situated in the preceding sentence. Although I shall not explicate the example in any detail, Clark presents a medically interesting case illustrating another principle in the spatial proliferation of disease.

In the course of discussing affections of the pleura in relation to pulmonary lesions, Clark tells the tale of one of his cases. He explains that the pulmonary pleura secretes 'a quantity of coagulable lymph' on its surface and that this is then involved in its 'adhesion to the pleura costalis'; the extent of this process is determined by 'that of the tuberculous disease'. He is very direct in holding that this story, together, with statistical evidence relating to these adhesions gleaned from the work of Louis, is causally structured: 'These facts, show in the clearest and most satisfactory manner, the intimate relation of tubercles and adhesions as cause and effect.'⁶⁶

This view of the spatial extension of death in the body ultimately structures his understanding of perforation of the pleura, 'which generally takes place over a [pulmonary] tuberculous abscess or cavern of considerable extent,' in which air and 'purulent matter' escape from the lung into the sac formed by the pleura rendering breathing difficult.⁶⁷ The story constituting this particular case concerns a patient with advanced tubercular disease in the right lung. The patient experienced severe pain on the left side of the chest and had all the indications of a pleural infection. Some few days later he experienced a coughing fit accompanied by very difficult breathing. Inspection found that the left side of the chest was distended with air. An incision was then made between two ribs on that side, resulting in an escape of air and restoring some comfort to the patient. The patient, however died within twelve hours. Upon autopsy the pleura was found to be torn at one of the points of adhesion, 'over a very small [pulmonary] tuberculous cavity'. Clark also appends an ingenious explanation of the mechanics of the adhesion, its tensions, stresses and the process which led to the tear. What is interesting, however, is how the

advanced pulmonary affection, involving cavernous lesions, is bound into the story of pleural adhesion by a principle of penetration.⁶⁸ More interesting still is the way that these stories form part of the case history of a given individual ending in death. In effect Clark's diagnosis was confirmed by his findings at autopsy.⁶⁹

We have seen how the narrative about processes of deposition described the emergence of tuberculous matter from the blood and membranous surfaces. The question of life and death is, however, raised in a further development on the story of deposition: Clark's text relates a story in which the transition from inanimate or dead to animate and living is made as well as marred. In his Chapter on the pathology of phthisis Clark subscribes to a view, advanced by one 'Dr Todd,' of the secretion and organisation of lymph 'into organized tissue' which involves processes of nutrition. Where, however, a morbid cachectic constitution exists 'this nutritive matrix, either from deficient vitality or some other condition may be formed of a nature below the standard of organization,' and this allows him to see 'how in this state the nutritive molecules may, instead of tissue, be converted into tubercles.'⁷⁰ Poor nutritive substance, deficient in 'vital force' leads to production of deadly substances in the place of healthy, living tissue. Clark's remarks in the course of discussing the causes of tuberculous cachexia in those *not* predisposed to the condition through heredity, ought to be understood in the light of this account. Clark again produces a little account of the physiology of respiration and nutrition.

He writes:

[...] Next to improper or deficient diet, I would rank an imperfect supply of pure air. The assimilation of the chyle, or nutritious element of our food, is completed during its circulation through the lungs, and by being brought into contact with the atmospheric air in the process of respiration.⁷¹

By ‘assimilation’ he clearly means that process which transforms inert nutritive substances into constituent parts of living tissues. We must agree with Clark’s view that, despite the obvious gaps in this account and in that of circulatory ‘abdominal plethora’ impeding nutrition and so contributing to cachexia, he has offered a story: ‘But although we cannot perceive every link of the chain, we have, I am persuaded a good notion of the chain itself.’⁷²

These accounts, support the immense stress laid on nutrition and the measures necessary for rectification of the cachectic ‘dyspepsia’. So cachexia may be induced in new-born infants through their being nursed by ‘a woman whose milk is inadequate in quantity or quality to afford proper nourishment; (it may be too rich and too exciting; it may not be sufficiently nutritious)...’⁷³ The cachectic constitution may also be passed from parent to child in mothers’ milk. Clark rarely adopts a dictatorial tone, preferring instead to persuade, but on this point he writes,

I would therefore lay it down as a rule [...] that the child of a consumptive mother, or of one in whom the strumous constitution is strongly marked, should be suckled by another woman, and that the period of nursing should generally extend from twelve to eighteen months, or even longer [...] to enable the infant to pass over the period of teething with greater safety.⁷⁴

Although variously coloured and shaped, tuberculous matter also exists at the very limit of both what can be seen and known about this disease for Clark and his contemporaries. At that limit, however, death informs its language in remarkable ways. The consistence of tuberculous matter is initially - and thus fundamentally - ‘fluid’, as we saw in the account of deposition.⁷⁵ As such it is essentially formless, and Clark, following Carswell, devotes considerable space to defending the view that the tubercle necessarily derives its various forms from its situation in various solid tissues.⁷⁶ Thus he argues that its granular and round shape in the lungs and

in the brain derives from the pressures and shapes which surrounding tissues lend to the developing tubercle. It would seem that there is an implication here regarding the living status of tuberculous matter. It should be recalled that life itself, for Cuvier, is defined in terms of structure, form and function in this period, in which case formlessness is an index of death.⁷⁷ This is borne out by the antagonistic relations between this ‘matter’ and its surrounding tissues.

Tuberculous matter is not only formless, but cannot spontaneously produce its own forms. Clark writes ‘[...] it is to be regarded as a morbid inorganizable product, and consequently insusceptible of any change that is not effected by the living tissue in which it is deposited.’⁷⁸ Clark only here refers to tissues as ‘living’ indicating that the life-death distinction is in play. Although it would seem that only a living matrix may structure and form this ‘matter’ into recognisable shapes and consistencies, it still has effects on these living tissues. Unsurprisingly these are particularly deadly. Despite noting that tubercles can be found in perfectly healthy tissue, Clark is keen to stress that,

The changes induced by the presence of tubercles are, serous and sanguinous congestion, inflammation, induration, or softening, ulceration, mortification, atrophy, and the formation of accidental tissues of a fibrous or cartilaginous nature.⁷⁹

In a text as concerned with change and effects as Clark’s is, this catalogue surely outweighs the gesture towards Carswell and others. It is clear evidence of the detrimental and deadly effects of tubercles on surrounding tissues; as the concept of ‘mortification’ makes clear, tubercles are progressively ‘deposited’ by the sick body in ways which result in both the death of its basic parts and in that of the patient as a whole. The tubercle has a dangerous ‘life of its own’ which can be told in narrative form, while it is essentially dead. It would take Pasteur’s and then

Robert Koch's discoveries to redescribe this 'life' in ways which apportioned these deadly effects to a new form of life.

What then of cause in this medicine, since it has been suggested that anatomical pathological medicine is unable to confront the question of cause? ⁸⁰ The full title of Clark's Treatise, however, purports to present an '...Inquiry into the *Causes*, Nature, Prevention and Treatment ...'[italics added] of tuberculous disease. We have already seen Clark's ideas on tuberculous cachexia and its influence in the disease. Yet the system of causes in the work is still more refined. Opening the Chapter devoted entirely to the question of cause, Clark writes:

The causes of tuberculous disease are referable to two distinct heads, the remote and exciting, — those which induce the morbid state of the constitution, — tuberculous cachexia, — and those which determine the local deposition of tuberculous matter. The one class operates by modifying the whole system, the other by determining in a system so modified the particular morbid action of which tuberculous matter is the product. ⁸¹

Clark and Carswell, whose views Clark quotes extensively, are embroiled in the tensions originating in debates surrounding the distinctions between local (characterised by distinctive lesions and appearances) and general diseases (leaving only few or slight morbid appearances). With the work of Broussais the latter class, mostly the 'essential fevers', were articulated onto the concept of inflammation, which is a *general* physiological process occurring throughout the body. Although this enabled the subsequent development of a concept of disease as functional disorder, since inflammation is actually an index of immunological function, it also opened the way towards a conception of the agent and cause of inflammation. ⁸²

Clark subscribes to the view that consumption is ‘a disease sui generis’. Moreover, he supports Carswell’s view that because tuberculous matter is formed in different organs under a variety of ‘morbid agency, to which these organs may have been subjected, [...] we cannot admit its formation to be the necessary consequence of any of those local causes to which it has been ascribed.’⁸³ For Clark then, inflammation does not cause the deposition of tuberculous matter, nor does it have any role in that process. In support of this view he brings forward instances where inflammation occurs without any subsequent deposition of tuberculous matter. He confidently declares that, ‘on the contrary, the formation of tuberculous matter is found to take place in organs, the functions of which were never observed to have been deranged, and in which, after death, none of those lesions could be detected which are known to follow inflammation.’⁸⁴

This leaves Clark free to elaborate a complex of remote causes including deficiencies and irregularities in nutrition, ‘impure air’, exposure to dust and particulate materials in various industries, lack of exercise, poor clothing and exposure to the elements. Yet of all the remote causes, the ones which are most significant here are those centring on the transmission of parental diseases or ‘diseased’ constitutions. While a parent’s cachectic constitution is the most prominent in Clark’s account, leading him to statements such as ‘A parent labouring under tuberculous cachexia entails on his offspring a disposition to the same affection, proportioned in general to the degree of disease under which he labours’, it seems *any* disease can have the same effect. Clark writes that the predisposition in children may be brought about by a

[...] disordered state of the digestive organs, gout, cutaneous diseases, the injurious influence of mercury on the system, debility from disease, age,

etc.; — in short a deteriorated state of health in the parent from any cause, to a degree sufficient to produce a state of cachexia, may give rise to the scrofulous constitution in the offspring.⁸⁵

Clark is convinced that this view is supported by observation, that he has seen scrofulous children of healthy parents, but has never encountered healthy children of scrofulous parents. In this view disease itself is almost bound to replicate itself as though it were an independent life form within sick individuals who naturally reproduce - diseases cause each other across generations. This may have some bearing on views of the sexual aetiology and effects of consumption, ideas which Clark only touches on in a remark about the possible role of irregularities of parental genitalia. He notes that an 'imperfect development or a feeble state of the organs of generation has long been considered a cause of scrofula in the offspring;' and that such affects may arise from '— any thing which interferes with the act of conception ...'⁸⁶ Although his comments are very brief, there is material, scattered throughout works on consumption in this period, for an examination of the relation between the concepts of life under the aspect of sexual reproduction, death and disease.⁸⁷

Robert Carswell (1793 - 1857), like his friend Clark, will not be remembered as a great innovator, or for that matter for having made any significant contribution to medical science. If he is remembered at all it will be as artist and as physician at the Belgian court.⁸⁸ None the less he shares a common commitment to narrative in his work. Carswell's text is an illustrated treatise on pathological anatomy and one might be led to think that his text marks the limits, *because* it is illustrated, beyond which narrative and language fall silent. Paradoxically, and despite the illustrations' elegance, his pictures rather constitute a site for the triumph of

narrative while at the same time embodying the failure of the form of medical perception which they represent.

We have already seen the rich, sensuous language which Clark and his contemporaries used to define and grasp the nature of the tubercle in all its stages. This language is deployed in stories and explanations through which speech was able to colonise Hamlet's unutterable 'bourn'. This language, however, also embodied the limitations with which Victorian medicine could articulate with perception, since it was committed to structures which determined what *could* be seen. It was not simply the commitment to a certain form of language which brought pathological anatomy to a halt; it was, for example, those structures which resulted in its privileging surfaces within the body. So although Xavier Bichat's resolution of the body into twenty one tissue types was enormously fruitful in unifying the paths of disease in the body and founding histology, this also meant that tissues were fundamental constituents - there could, conceptually, be no space between the surfaces of a membrane.

Jacalyn Duffin has lately convincingly argued that strictly *medical*, as opposed to anatomical, illustration is a relatively recent historical development. She shows that this development follows from epistemological changes which made the epistemological 'space' of disease coincide with bodily space in the emergence of pathological anatomy.⁸⁹ Once the manner in which disease was conceptualised allowed for its spatio-temporal existence, it could be represented pictorially as well as nosologically categorised. Carswell's text allows us to see how medical narratives articulate or link with perception and its spaces, since he reveals, at key

points, how stories can be laid out in line, colour and form to produce pictures in which time and its developments have been distributed in two dimensions. Bichat and his French contemporaries had found the necessary conceptual and practical means for allowing death to articulate, analyse or redistribute the body. Carswell captures this 'dissection by disease' in the fine texture of his illustrations, binding them to narratives in which they gain whatever value they may have for knowledge. On the simplest level all the forms, proportions, shades, colours, tints and hues described in Clark's text are there in Carswell's illustrations.⁹⁰

Carswell illustrates his Chapter on tubercles with pictures of many parts of the affected anatomy, ranging from cerebral manifestations through various pulmonary forms, the pancreas and even stretching to include a lung from an infected cow and the liver of a rabbit. Most of these illustrations are superb, but the picture of a diseased portion of intestine with attached lymph glands in Plate III in the Chapter on tubercle is the clearest and the one most worth examining here.⁹¹ Like all textual illustrations, this one has explanatory notes attached to it, but these notes are extensive enough to contain the following:

The tuberculous matter is shown occupying the mucous follicles and enlarged aggregated gland, A. It is also seen projecting from the orifices of the solitary glands of follicles, B. At C, these follicles are represented in a less advanced stage, their central orifices just beginning to be visible, from the distension occasioned by the tuberculous matter collected within their cavities. The first stage of this diseased state of these follicles is seen on various points of the surface of the mucous membrane, and is indicated by the presence of a small, round, somewhat conical, elevation of a light grey or pale straw colour. Ulceration of the glandulae aggregatae and solitariae, and of the mucous, cellular, and muscular coats of the intestine, is represented at D, E, F, as the consequence of the presence of tuberculous matter in these tissues. D, three small oval ulcers, with sharp smooth, pale borders, formed in the mucous membrane, in the situation of the isolated follicles, their bottoms consisting of the submucous cellular tissue. Ulceration of the aggregated follicles, mucous, sub-mucous, muscular, and sub-peritoneal tissues is represented at E and F. E, the muscular coat laid

bare and ulcerated, and containing tuberculous matter in its inter-cellular tissue.⁹²

The point here is that the formation of tubercles is captured in *stages* distributed over the surface of the intestine. The enlargement of follicles is successively captured by the points C, B, D and then the ulcerative process is seen to begin in D and progress through to the large ulcer at E and F which has progressively eroded layers of tissue, each visible as a coloured ring, to reveal the destructive process going on at the very base of the ulcer. Essentially Carswell has illustrated, in visible perspectival space, a temporal process, which he describes and understands in narrative, causal terms. It is extremely difficult to imagine how this picture would be interpreted without the narrative support embodied in Clark's and Carswell's general accounts, and in the notes attached to the figures.⁹³

Something of the narrative link between morbid appearances and symptoms touched on in the survey of Clark's work is seen in the explanation of the plates as well. This is particularly clear in the notes to figure 3, Plate IV. Unfortunately, although the grosser aspects of bleeding into the bronchi, the subject of the plate, are clearly visible in the illustration, the finer points of the account are not.

However, that a clearer representation was possible is shown by the illustration of the diseased intestine just discussed. The notes explain that the figure shows 'Vesicular deposition of grey, demi-transparent tuberculous matter [...] in all the air-cells of a number of contiguous lobules'. Unfortunately all that can be discerned in the copy I consulted was what looked like an inflamed area with tiny bloody specks on its periphery. It also claims to show how pulmonary veins were obstructed and destroyed by dense tubercle formation, 'followed by effusion of blood into the bronchi,' (the bloody bronchi are very clear), but it goes on noting

that the case was associated with symptomatic ‘frequent expectoration of this fluid.’ The links between the illustration and the narratives connecting symptoms, signs and appearances are explicit when it adds, ‘we regard this case as explanatory of the nature and origin of haemoptysis which so frequently announces the existence of pulmonary phthisis....’

The full integration of narrative modes in early nineteenth-century medicine is perhaps most evident in Bright’s Reports. Right from the outset, as my epigraph, taken from its Preface shows, the Reports are conceived along these lines. Their declared objective is to record ‘such facts’ in a way that ‘bring[s] together’ these facts, enabling them to ‘throw light upon each other’. Moreover, they aim to accomplish this pictorially, illuminating death’s bodily manifestations by connecting them with symptoms displayed during life. Symptoms, however, are most directly captured in the case history, as the brief mention of one of Clark’s case histories showed. Bright’s Reports differ from Carswell and Clark’s work, while nonetheless conceptually according with them in bringing all four elements - the generally accepted view of disease, the case history, the autopsy report, and medical illustration, together explicitly. His text is composed of very succinct descriptions of the disease, added to which are case histories, autopsy reports and illustration.

It will be useful to consider Bright’s discussion of a case similar to that relating to the one illustrated in Carswell’s magnificent plate. In discussing complications involving the intestines in advanced consumption, Bright writes that,

affection of this membrane is one of the most important features in a majority of the cases in phthisis: it shows itself by unequivocal symptoms during life, and is traced in two different forms after death;

Either a diffused irritation along the *whole* membrane from the pylorus to the termination of the rectum,

[...] evinced by increased vascularity or by the appearance of innumerable minute black specks, which give a general grey colour to all the parts where they are most frequent (Plate XII, Fig. 2) and sometimes affording evidence of a more severe affection, by the formation of numerous ulcers which are found ... These ulcers, as found in the small intestines, are usually in the first place very small and circular, and appear to originate from round opaque white bodies about the size of half a sweet-pea; but whether these are altogether morbid tubercular deposits, or are only enlarged mucous glands, it is no easy matter to decide[...] These ulcers often extend to the size of a shilling, and sometimes still further in a lengthened form.⁹⁴

Not only is this description concerned to tie symptoms to morbid appearances, but an epistemological need leads to the invocation of the *visible*, in the reference to the plate and figure. It turns out that the figure in question pictures a portion of diseased intestine removed from a patient whose case history Bright goes on to report. There is a close relation between the mutually supporting general scientific description of a disease and the case history which encapsulates it as a knowledge of the individual.

The case history in question is, in itself, unexceptional.⁹⁵ It records the illness of a man in his twenties who died of consumption. It is obviously based on case notes taken by attending medical staff during the patient's illness, but in published form Bright bears sole responsibility for it as a document.⁹⁶ Its status as a narrative document is signalled in its very first sentence: 'James Norton, aet. 29, who had been a servant at a public-house, was admitted into the hospital January 18th, 1827.' This is like the opening of a very conventional novel: it tells us who the leading character is, something of his age, sex and occupation (and class) and sets

the action in train by noting an event - his admission to Guy's hospital on a winter day in 1827. This opening is then integrated into a structured account of events. The case contains some information concerning the events leading to the patient's admission including their duration and temporal relation to one another. The history moves on to an account of his condition on admission, including his emaciation, his dyspnoea, and pulse rate. It is not quite clear whether the account of the state of his expectorations, feverish symptoms, and bowels, in the penultimate sentence of the report relates to his state at admission or sometime later. Since he was in hospital for nearly a month, these symptoms obviously occurred between admission and death. It should be noted that, even for someone barely acquainted with medicine, the reading of this account is strongly narrative. Thus, although the mention of exertion may or may not be registered by the reader as physiologically causing the expectoration of copious quantities of blood, its description in the context of his admission to hospital allows an interpretation of the haemoptysis as serious enough to at least contribute to the reasons for that admission. Similarly, the remainder of the account at least enables a reader of average experience to conclude that Mr Norton was seriously ill and that this led to his hospitalisation.

The case history's language, although characterised by typical economy is nonetheless narrative: ' [...] his breathing rapid and difficult; and his pulse seldom under 120 ...' it goes on to tell us all about the patient's experience including his perspiration (which would have occurred at definite periods during the day) and is careful to record how many stools the poor man passed in a day. This narrative also records the changes in, and circumstances surrounding, these evacuations: '[...] his

bowels were generally more open than natural, passing about two stools in the day; and although within a day or two of his death they became relaxed, yet it was without any pain.' Mr Norton's medical story ends in his death on a specific day. The final event of the case narrative does not, however, constitute a 'surprise ending' since it is, at this time, almost a foregone conclusion that consumptive patients are bound to die.

Although Mr Norton's story ends in death, medicine's story about him does not. The second large part of the account is the autopsy report or 'Sectio Cadaveris', an event that occurred the day after his death. The proximity of these two dates is significant both epistemologically and in terms of narrative. It should be remembered that a high degree of certainty attends the dissection of the body soon after death. Through doing the autopsy soon after death the morbid appearances will be found to be those of the disease, minimising any confusion between the phenomena of decomposition and those of disease.

There is a suggestion, in the elliptical style of the autopsy report, that time and words are not to be wasted. Although the meaning of the sentence, 'Body greatly emaciated' may be stated as 'The body *was* greatly emaciated', the absence of the verb and its tense conveys the fact that this observation was recorded during the autopsy itself. As the body is opened, however, facts are described so as to set a narrative in train: the statement on emaciation is immediately followed by one recording the absence of fat in the abdomen's cellular membrane. The implication being that the body appeared emaciated, *because* there was little fatty matter in this membrane. The autopsy report, however, is also a narrative of the pathologist's

actions: it notes what was observed ‘on raising the sternum’ and what was seen on ‘cutting into’ the intestine, etc. We have already seen that the case of a torn peritoneum recorded by Clark includes an account of the physician’s intervention. This domain of action is not explicitly articulated in the material examined here, despite its importance for medicine’s status as a science. The objectivity of medicine’s cause-and-effect narratives is amenable to the test of intervention, although in the period under discussion intervention or treatment was notoriously flawed.

Something of the relation between physical signs and morbid appearances can clearly be seen in the description of the left and right lungs. He begins by discussing the left lung, a large proportion of which,

[...] was excavated into one large cavity lined by a rough tuberculous membrane and traversed by bands of hardened tuberculous matter. The remaining part of that lobe was a mass of miliary tubercles formed into clusters. The inferior lobe of this lung was nearly in the same state, though less advanced. The right lung had its upper lobe in precisely the same condition, except that the cavities were less, and the general state of solidity more complete[...] ⁹⁷

The possibilities for auscultation, with different levels of pectriquiry and distinct forms of respiratory murmur associated with it are obvious.

The narration of findings at autopsy also contains, however, a reference to the illustrations. Bright writes:

The intestines externally did not show marks of inflammation, but on cutting into them, the whole colon was ulcerated in large spreading patches of an oval form in the transverse direction of the intestine, with slightly elevated edges (Plate XII. Fig. 3.) The ilium and jejunum were also ulcerated from place to place along the whole tract, and even in the duodenum within half an inch of the pylorus an ulcer was situated. The internal lining of the intestine was thickly speckled over with minute black spots, scarcely larger than the prick of a pin (Plate XII. Fig. 2). ⁹⁸

Of course it would be naive to assume that what the figure presents to the reader is what Bright *saw*, a fact made clear by the difference between Carswell's delicate and Bright's rather more clumsy renditions of similar specimens. Nonetheless, the illustration shows this medicine's intensely visual (and generally sensory) orientation to its objects. The narrative of morbid appearances is telling a story about the ways death can be seen to have left its diseased traces distributed across the spaces which dissection reveals.

The notes to Plate XII, figure 2, when read in isolation (as of course, such notes never are) seem to tell no story at all, and appear to be a description. So it is composed of statements like, 'The whole mucous membrane is rendered grey by numerous dark points of carbonaceous matter;' or '...the ulcer is seen with edges puckered and thickened into tubercles, ...'. These statements, however, are supported by explanations - stories relating things - which parallel those advanced by Carswell and Clark. So it comes as no surprise that a note is inserted between the account of the 'Sectio Cadaveris' and the plates and explanatory notes. In this little note Bright discusses whether the grey appearance he is so keen to notice in the illustration, is the 'product' of inflammatory processes or whether it is a distinct state of that condition. He finds that 'it is a carbonaceous matter deposited at the termination of a *process* of inflammation which has subsided'. He then goes on to speculate about possible involvement of processes of extravasion and when exactly in the course of events this deposit is laid down. It requires little imagination to see the parallels between the narrative of deposition in Clark and that attached to Bright's Plate. Bright's and Carswell's illustrations capture something of the way

narratives of death invest the visual and inform the relation between what can be said and what seen.

In summary, I have shown that narratives are central to early nineteenth-century medicine's exposition of the nature of disease. They tell the story of a patient's symptoms, the signs of disease he exhibits and also the morbid appearances discerned at autopsy. These stories are, however, bound together by epistemological structures which weave them into the fabric of knowledge. This unified narrative also depends on certain epistemological structures involving the relation between *life and death*, without which the narrative of morbid appearances could not be integrated.⁹⁹ This general account is dependent on *all* forms of perception. Narrative is important because it permeates or structures what may be seen, an example of which is to be found in medical illustration. Moreover, the formal exposition of medicine's knowledge of particular conditions is underpinned and supported by the physician's narrative application of this knowledge in the encounter with individual patients. The narrative generated in such situations includes the patient's own account of an experience of disease, the deductive narrative relating signs and symptoms, concluding in the diagnosis/prognosis, the account or record of treatment and its effects, and, in fatal cases, the correlation of this story with a 'description' of the morbid appearances visible within and upon the patient's body at autopsy. In conclusion, I have shown that death is an integral conceptual part of the narratives which form early nineteenth-century British medicine.

During the nineteenth century medicine can rightly have laid claim to having become a science, if by that it is meant that its knowledge and description of

diseases turn out to be a peculiar, objective knowledge of the individual, whose suffering it aim to minimise. Its claims were justified in that it led ultimately to effective interventions and treatments which achieved its objectives of minimising individuals' suffering. It also played a key role in public health movements, helping to institute social changes which diminished suffering on a larger scale. To do so, however, medicine needed a means of transmitting its narrative knowledge in a form which was amenable to the requirements of the nascent epidemiology of the time. It should be recalled that a parallel development in medicine involved the introduction of quantification and statistical methods into medicine itself. The French doctor Pierre Louis, produced very elaborate statistical information on the cases in his hospital. Yet the medicine described here was by no means statistical. How then did narrative medicine articulate with an actuarial knowledge of society and its demands for accurate statistical mortality or morbidity tables? To answer this question we must turn to the introduction of cause of death certificates in England.

¹ Richard Bright, Reports of Medical Cases, Selected with a View of Illustrating the Symptoms and Cure of Diseases by a Reference to Morbid Anatomy, 2 vols (London: Longman, Rees, Orme Brown and Green, 1827), vol. 1, Preface.

² Louis MacNeice, Part IV of 'Trolls', see his Collected Poems, (London: Faber and Faber, 1966), p. 198.

³ J. Wesley Boyd, 'Narrative Aspects of a Doctor-Patient Encounter', Journal of Medical Humanities, 17 (1996), 5 – 15. Boyd cites E. J. Cassell's idea that not only is the history of an illness a story, but that because a disease is a series of events in time it too merits a narrative. Boyd however, stresses the need for careful attention to fully detailed and well tailored stories in the doctor-patient encounter. See also William J. Donnelly, 'Righting the Medical Record: Transforming Chronicle Into Story', Soundings: An Interdisciplinary Journal, 72 (1989), 127 – 36. Donnelly makes a case for the explicit use of patients' own experience of their illnesses in case documentation. In this account, the bare chronological succession of events in the section of case documentation devoted to the history of the present illness is insufficiently narrative and fails to capture the texture of patients' own experience. Some of the consequences of doctors' failure to attend to patients, needs is clearly illustrated by cases presented by Linda C. Garro in her 'Chronic Illness and the Construction of Narratives', in Pain as Human Experience: An Anthropological Perspective ed. Mary-Jo Del Vecchio Good, Paul E. Brodwin, Byron J. Good, Arthur Kleinmann, (Oxford: University of California Press, 1992). She compares the narratives of a series of patients with particularly painful temporomandibular joint problems locating a series of common themes and

narrative structures. Her work illustrates the place narrative holds in patients' attempts to make sense of their excruciating condition and difficulties with treatment.

⁴ Kathryn Montgomery Hunter's Doctor's Stories: The Narrative Structure of Medical Knowledge, (Princeton: Princeton University Press, 1991), pp. 3 – 26, 51- 68, 83 –106.

⁵ See Foucault's The Birth of the Clinic: An Archaeology of Medical Perception, trans. by A. M. Sheridan, (London: Tavistock, 1973), pp. 140 – 47.

⁶ See Catherine Moloney, George Eliot, Henry James, and Consumption: A Shadow on the Lung of the Victorian Psyche, unpublished Ph.D thesis, University of London, 1999, p. 92.

⁷ See biographies by D. Berry and C. Mackenzie, Richard Bright 1787 - 1858: Physician in an Age of Revolution and Reform, (London: Royal Society of Medicine, 1992), and Bright, P., Richard Bright 1789- 1858, (London: Bodley Head, 1983).

⁸ Foucault, The Birth of the Clinic, pp. 140 - 147.

⁹ Bright is also keen to dissociate himself from any suggestion of his trying to 'lay before [his] readers a succession of striking novelties.' Bright, p. viii.

¹⁰ See Dictionary of National Biography, ed. L. Stephen, (London: Smith, Elder, 1908) and the title page of Bright's Treatise.

¹¹ George Whitfield, in his unpublished manuscript, 'Beloved Sir James', The Life of Sir James Clark, Bart, Physician to Queen Victoria, 1788 – 1870, unpublished manuscript, held at the British Library, pp. 32 – 37 covers the case. See also Robert Gittings' John Keats, (London: Heinemann, 1968), pp. 421 – 33.

¹² See Whitfield's 'Beloved Sir James', p. 145 for his treatment of Parthe Nightingale. He discusses Clark's treatment of Mill pp. 148 – 50 and his treatment of Ruskin pp. 150 – 51.

¹³ Dictionary of National Biography, vol. iv, p. 402.

¹⁴ This is Robert Keers' opinion of Clark. See his Pulmonary Tuberculosis: A Journey Down the Centuries, (London: Bailliere-Tindall, 1978), p. 49. Clark is distinguished from other authors on tuberculosis in adopting a conservative view especially on cure. Writers such as Alfred Beaumont Maddock, Francis H. Ramadge and John Epps were among the dozens in Britain alone who turned out publications on consumption. They seem to have believed that they could cure the disease in their various ways and devoted considerable portions of their texts to demonstrating this rather than to setting forth a thorough exposition of current knowledge of the illness. See John Epps, Consumption: (Phthisis) Its Nature and Treatment, (London: Sanderson, 1859); Francis H. Ramadge, Consumption Curable, 3rd edn (London: Longman, Rees, Orme etc. 1838); Alfred Beaumont Maddock, Pulmonary Consumption, Bronchitis, Asthma, Chronic Cough and Various Other Diseases of the Chest Successfully Treated by Medical Inhalations, 7th edn, (London: Simpkin, Marshall, 1859).

¹⁵ James Clark, A Treatise on Pulmonary Consumption Comprehending an Inquiry into the Causes, Nature, Prevention and Treatment of Tuberculous and Scrofulous Diseases in General, (London: Sherwood, Gilbert and Piper), 1835 p. xii.

¹⁶ Clark, p. 6.

¹⁷ Clark, p. 12.

¹⁸ Clark, p. 14.

¹⁹ Clark, p. 13.

²⁰ Clark, pp. 18 – 19.

²¹ Clark, p. 20.

²² Clark, p. 288.

²³ Clark, p. 289.

²⁴ While a fatal outcome of mental overexertion is associated with boys' schooling, girls were also seen as subjected to potentially fatal educational rigors. Chapter 7 will examine the effects of such beliefs on the life of one of Clark's young female patients. Clark writes passionately about detrimental educational regimens and inadequate heating in girls' schools, causing consumption.

²⁵ Clark, p. 20.

²⁶ Clark, p. 40.

²⁷ Clark, p. 41.

²⁸ Clark, pp. 5 – 6.

²⁹ Clark, p. 20.

³⁰ Clark, p. 22.

³¹ Clark, p. 23.

³² Clark, p. 23.

³³ Clark, p. 23. Some indication of the modernity of this medicine can be seen in the differential reading of a patient's cough. In his detailed exposition on consumptive coughing, it is distinguished from four other types of cough: catarrhal, gastric, abdominal and nervous. The consumptive's cough is specified by the periods in the day when it occurs, its relation to exertion, its production of specific forms of sputum, its association with particular forms of pain and sensations of being suffocated. The other forms of cough similarly are either 'deep' and produced with all the respiratory muscles, or alternatively are louder and characterised by paroxysm or their association with different forms of pain etc. Each of the particular coughs is itself dependent on integration into a story which reconciles all the evidence in a rationally coherent way, ultimately issuing in a diagnostic moment which sums up its truth. For a detailed differential exposition of the cough, see Clark, pp. 71 - 81. For a reading of similar differential situations in case conferences in terms of narrative see Hunter Doctor's Stories, pp. 107 - 110.

³⁴ It is quite possible, on the basis of detailed observation and distinctions in Clark's text, to elaborate a reading of the semiotics of consumptive sputum, although, for reasons of length, it is not possible to elaborate this here. Suffice it to notice that Clark discriminates between at least five kinds of tubercular sputum, clearly viewing the distinctions between them as comprehensible as external signs of the progress of pulmonary and bronchial destruction. See the section headed 'Expectoration' in his detailed exposition of signs and symptoms for his elaboration of textures, colour, odours, quantity and composition of sputum. Clark, pp. 84 - 90.

³⁵ Clark, p. 25.

³⁶ See Foucault, pp. 91 - 93.

³⁷ Clark, p. 27.

³⁸ This cross checking excludes any anomaly that may arise from the slight difference in structure of left and right lungs.

³⁹ Clark, p. 27.

⁴⁰ Clark, p. 27.

⁴¹ Clark, p. 28.

⁴² Clark, pp. 82 - 83.

⁴³ The patient's narrative will probably be the only source of information concerning early forms of expectorated sputum, dyspnoea, chills and perspiration, languor, condition on exertion, cough, diarrhoea and especially pain. Many little guides devoted specifically to aiding young doctors in interrogating patients and taking case histories were published in the period under consideration here. See Aberdeen Royal Infirmary, Hints and Directions for the Use of Clinical Clerks and Students of Clinical Medicine, (Aberdeen: Arthur King, 1866), A. Wood Smith (?), Plan for Examining and Reporting Medical Cases, to be Followed in Dr Wood Smith's Wards of the Glasgow Royal Infirmary, (Glasgow: Aird and Coghill, 1876). Also see Westminster Hospital, Hints for Clinical Clerks in Medical Cases, (London: Saville and Edwards, c.1863) and Francis Warner's The Student's Guide to Clinical Medicine and Case Taking, 2nd edn, (London: J. & A. Churchill, 1881). There is an interesting tension involving whether to question the patient before or after examination, but all of these little manuals insist on closely questioning patients nonetheless.

⁴⁴ Clark, p. 29.

⁴⁵ Clark, p. 29. As in the case of differential reading of various forms of cough, noted above, and the discussion of various signs, Clark carefully localises and distinguishes between pain felt just below the clavicles and that felt in the epigastric region at the back. Catarrhal pain, on the other hand, is experienced as burning beneath the sternum. Pain is itself cross checked against the physical signs and used to verify them: it is, writes Clark, 'most severe on that side in which tubercular disease is most extensive' (an extension with consequences for percussion and the sounds detected with the aid of the stethoscope).

⁴⁶ Clark, p. 30.

⁴⁷ Clark, p. 31.

⁴⁸ Clark, p. 32.

⁴⁹ See Robert Carswell, Pathological Anatomy: Illustrations of the Elementary Forms of Disease, (London: Longman, Orme, Brown, Green and Longman, 1838), unpaginated, Section headed 'Tubercle'. There is some discussion of 'cure' in the text itself, but Carswell refers the reader to Plate IV figures 5 and 6 and the explanatory notes attached to this plate.

⁵⁰ Clark, p. 33.

⁵¹ Clark, p. 106.

⁵² Clark, p. 107.

⁵³ Clark, p. 77.

⁵⁴ Clark, p. 34.

⁵⁵ Clark, p. 107.

⁵⁶ Clark, p. 33.

⁵⁷ Clark, p. 34.

⁵⁸ Clark, pp. 35 – 36.

⁵⁹ Clark, p. 36.

⁶⁰ Clark, p. 121.

⁶¹ Clark, p. 121. Clark citing Robert Carswell's article on 'Tubercle' in the Cyclopedia of Practical Medicine, eds. John Forbes, Alexander Tweedie and John Connolly, (London: Sherwood, Gilbert and Piper and Baldwin and Cradock, 1833) IV, pp. 253 - 68. Carswell's Pathological Anatomy also contains this idea of tubercle as being a product of an irregularity of secretion. He writes 'On the surface of serous membranes, whether natural or accidental, it may have either a globular or lamellated form, as the secretion in which it originates may have taken place in distinct points, or from a continuous surface [...]'.
⁶² Carswell elaborates a similar story regarding secretions on the surfaces of the alveoli in the lung. Thus his little narrative depends on temporal links such as '[...] which after a certain time is separated [...]'. For him the process whereby tubercles emerge on the peritoneum can be divided into three distinct stages all of which are visible, sometimes simultaneously, on the surfaces related to the membrane. See the section on 'Consistence and Colour of Tuberculous Matter' in Carswell's Pathological Anatomy. He and Clark also argue against Laennec's views regarding softening. Laennec saw the tubercle as a living being and saw softening as a process involved in this being's development. What is interesting, rather than the veracity of either party, is perhaps the way in which both could be shown to rely on narratives in their accounts.

⁶³ Clark, p. 124.

⁶⁴ Clark, p. 128.

⁶⁵ Clark, p. 159.

⁶⁶ Clark, pp. 150 – 51.

⁶⁷ Clark, p. 153.

⁶⁸ See Foucault's The Birth of the Clinic on penetration as a principle of disease elaboration within bodily space. p. 150.

⁶⁹ In Chapter 2 we shall see that those responsible for the initiation of national mortality statistics in England and Wales saw the connection between diagnosis and its confirmation on performing the post mortem examination as essential for statistical or epidemiological purposes.

⁷⁰ Clark, p. 259.

⁷¹ Clark, p. 232.

⁷² Clark, p. 261.

⁷³ Clark, p. 228.

⁷⁴ Clark, pp. 276 – 77.

⁷⁵ Clark, p. 121.

⁷⁶ Clark writes 'The form of tuberculous matter Dr Carswell considers as entirely dependent on the structure of the organ in which it is deposited. Its granulous appearance in the lungs is owing to its accumulation in a small number of contiguous air cells; and the lobular arrangement, which it sometimes presents in the same organ, is produced by its being deposited in the air cells of a number of lobules, the intervening pulmonary tissue being unaffected.' *ibid.* p. 122.

⁷⁷ See Foucault's The Order of Things: An Archaeology of the Human Sciences, (London: Tavistock, 1973), pp. 263 – 80.

⁷⁸ Clark, p. 122. At one point Carswell reveals the connection between this matter's inability to organise itself and its 'consequent' implication in illness or morbidity. He says tubercles are 'not susceptible of organisation, and consequently give rise to a morbid compound, capable [...] of undergoing no change that is not induced in it by the influence of external agents.' See his section on 'Composition of Tuberculous Matter'.

⁷⁹ Clark, p. 13. Carswell says much the same thing in the section of his work covering 'Progress and Termination of Tuberculous Matter'.

⁸⁰ Foucault has suggested that the epistemological structures relating pre-bacteriological medical discourse to its objects precluded a thoroughly physiological medicine such as Bernard was to go on to found, in addition to preventing early nineteenth-century medicine from advocating the use of microscopy and thus precluding access to bacterial agents. See Foucault's statements in The Birth of the Clinic, p. 188, as well as similar remarks by Erwin H. Ackerknecht, Medicine at the Paris Hospital 1794 – 1848, (Baltimore: Johns Hopkins University Press, 1967), p. 122.

⁸¹ Clark, p. 21.

⁸¹ Clark, p. 9.

⁸² See Foucault, The Birth of the Clinic, p. 188.

⁸³ Clark, pp. 244 - 45 citing Carswell.

⁸⁴ Clark, p. 245.

⁸⁵ Clark, p. 222.

⁸⁶ Clark, p. 224.

⁸⁷ Clark also invokes incest and ideas of the degeneration of the family considered as a race. He strongly advocates that individuals in scrofulous families 'should avoid the all too common practice of intermarrying among their own immediate relatives, — a practice at once a fertile source of scrofula, a sure mode of deteriorating the intellect and physical powers, and eventually extinguishing a degenerate race'. p. 270.

⁸⁸ See his entry in DNB, in which he stands out as an excellent artist and pathologist.

⁸⁹ Jacalyn Duffin, 'Imaging Disease: The Illustration and Non-illustration of Medical Texts, 1650 – 1850', in Muse and Reason, The Relation of Arts and Sciences 1650 – 1850: A Royal Society Symposium, ed. by B. Castel, J. A. Leith and A. W. Riley, (Ottawa: Royal Society of Canada, 1994). pp. 79 – 108. (pp. 89 – 102).

⁹⁰ I suspect that the scale of his text even allows the size of the specimens described to be approximated visually. The scale would seem to be life-size. It is interesting that the smallest illustration in the plates concerned with tubercles is the tubercle itself, illustrated in a 'cell' or compartment of the pancreas; were it drawn any smaller it would disappear below the threshold of visibility.

⁹¹ See Appendix 1.

⁹² Carswell, Notes to Plate III, figure 1, in the section on 'Tubercle'.

⁹³ Carswell also produces a picture. (figure 5 of Plate III), in which the deposition process itself is illustrated. The account of the stages in the deposition process, from the secretion of the matrix, through the separation of its various parts, culminating in the formation of the tubercle itself is similarly spatially represented. Unfortunately this figure is not as clear as that illustrating the destruction of the intestine because of the size of the illustration (approximately one inch by two inches). See the explanatory notes to that figure.

⁹⁴ Bright's Reports of Medical Cases, p. 151.

⁹⁵ See Appendix 2.

⁹⁶ The process of writing up a Victorian medical case for publication can be seen in W. B. M^cDaniel's reading of the progressive changes introduced into the case documents relating to the American, nineteenth century physician William Beaumont's discoveries regarding gastric juices and the physiology of digestion, finally published in 1833 as 'Experiments and Observations on the Gastric Juice, and the Physiology of Digestion'. See W. B. Daniel's 'Literary Qualities of some American Medical Classics', Bulletin of the Medical Library Association, 32 (1944), 57 – 72.

⁹⁷ Bright, Reports of Medical Cases, p. 170.

⁹⁸ Bright, p. 170.

⁹⁹ I am referring here to the general physiological concepts such as the tripod of life and the idea that the body dies slowly rather than instantaneously. The tripod of life is the system of dependencies between brain, respiratory system and heart, whereby the death of the animal is induced in definite forms depending on which of the three elements fails. It was necessary to distinguish between the effects of disease and those of death, observable most clearly in chronic illnesses, before morbid anatomy could focus on the effects of disease alone. See Foucault's The Birth of the Clinic, pp. 134 – 36 and 143 - 46.

Chapter 2

Certificates, Stories and Statistics - Death In The Discursive Margins

The registration of births, deaths and marriages is usually discussed in the context of the history of demography and has only recently begun to be examined for the role it played in politically inspired, public health or sanitary movements in the mid-nineteenth century.¹ To supplement such valuable work, this essay will address medical discourse's nature and status at the interface with demographic statistics. I wish to interrogate the function, place and nature of certificates written by doctors as part of the registration process since the use made of the data gathered in death registration has been addressed by others. In fact, I will be concerned not with death certificates themselves, but with the certificates of the cause of death issued by doctors in an effort to assist the officers of the Registrar General in compiling mortality statistics prior to the Registrar General's introduction of formal, officially designed and printed certificates of cause of death. I will show that these apparently simple statements of the cause of death are *narratives* of the most compressed and reduced kind and that they both depend on, and substitute for a segment of larger medical narratives in the form of case documentation.

The introduction of a uniform national system for the registration of births, deaths and marriages in England and Wales was, at the time, unique in western Europe and America. Thus although the United States Census Bureau was established as early as 1790, its function was largely political and economic. It had been

established as part of the apparatus necessary to ensure parity between regional populations and the number of congressmen representing them, functioning to gather census data through the succeeding century. The information it amassed, however, was of little value epidemiologically since it did not include cause of death. The current authority with responsibility for registering births, deaths and marriages has noted that, throughout the nineteenth century, 'statistics on birth and death were based primarily on census figures and were for the most part untrustworthy, especially in respect to the recording of the cause of death.'² It was only in 1900 that there were moves to standardise the method of registering deaths across all states through harmonising practices and laws, and the introduction of a standard certificate of death. Even this took many years since it was only in 1933 that all the States in the union achieved this aim. The position in France was similar in that although the *Statistique Général de la France* started operations in 1833, recording vital information for census purposes, it failed to record the cause of death nationally until 1885. Only at this date were all large towns compelled to register the cause of death along with vital information.³

Prior to the establishment of the General Register Office or GRO in 1837, there had, however, been systems for registering vital information in the form of parochial registration and even an elementary statistical service in certain cities. Parish registers were begun in 1538 to record baptisms, marriages and burials, and registration was made compulsory during Elizabeth's reign in 1597. In terms of this system parish registers had to be maintained by the clergy and copies of these records ought to have been centrally held by each bishopric. In practice, however, this was seldom done and records were haphazardly maintained and poorly

stored.⁴ The only other source of statistics that could have been used for actuarial purposes were the Bills of Mortality begun when plague struck London in the 1590s. These statistics were gathered by casually employed, untrained women working for the Company of Parish Clerks who published Bills of Mortality regularly during the plague. These Bills of Mortality did, however, include information on cause of death. Publication ceased once the epidemic was over, only to resume again with a new outbreak in 1603. Bills of Mortality continued to be published regularly thereafter. For statistical purposes, both epidemiological and actuarial, however, these varied in their reliability and were too restricted to be of use for national purposes.⁵ The epidemiological shortcomings of the information contained in the Bills of Mortality did not go unnoticed since William Black, a physician, proposed in 1781 that a public office, staffed by medically-trained men, be set up to collect mortality statistics for London. Similarly, the Company of Parish Clerks, who produced the Bills, lobbied Parliament to reform registration so that births and deaths instead of baptismal and burial ceremonies were recorded along with marriages. However, nothing came of these moves.

Matters reached a head, however, in 1833 when a Select Committee was set up to examine parochial registration. The political force behind the re-examination of parochial registration came from Dissenters' dissatisfaction with the cessation of official recognition, for a short period, of their marriages and baptisms. The evidence, however, presented to the committee came from actuaries, antiquarians, barristers and the medical profession. The latter were not amongst the most effective witnesses. The London physician George Mann Burrows' evidence placed more stress on the moral, as opposed to medical, benefits of a new system of

registration. He only noted that a more correct form of parochial registration 'might point out and elucidate many important and dubious medical points essential to the preventative and curative arts.'⁶ Although the profession seems not to have fielded a witness to articulate its concerns, it did present written evidence to the committee in the form of a letter sent following a resolution adopted by the Provincial Medical and Surgical Association. In addition to expressing their satisfaction at the Committee's consideration of their statistical needs, they also urged, 'that great benefit might be expected to accrue to medical science, and consequently to the community at large, if arrangements were made for recording the causes of death in the local registers of mortality.'⁷

On the suggestion of the Select Committee, an act was drafted and passed in 1836 which formally gave the General Registrar Office the responsibility for registering births, deaths and marriages. This provided for the establishment of a network of registrars and superintendent registrars in registration districts based on the Poor Law unions' administrative areas. All births, deaths and marriages had now to be recorded by a registrar, although the Act allowed the clergy to continue their records. Fees were to be paid to registrars in each area according to the number of entries made in their registers. They also had, quarterly, to forward copies of their registers to the local superintendent registrar for verification before they were sent on to be centrally recorded and indexed at the offices of the GRO. The Act also allowed for penalties for those who failed to register deaths.

The new law obliged four groups to register a death: any person attending the deceased in the final illness, anyone present at the death, the 'occupier' of the

house, and should the occupier of the house die, then any other inhabitant.⁸ In practice, however, reporting the death to the registrar fell to the person burying the body, since burial could only take place once the registrar had issued a certificate authorising interment. The person reporting the death was obliged to provide information regarding the dead person's name, age, sex, rank or profession and to say when he or she had died. He was also bound to offer information on what caused the death. He also had to give and sign his name, with a cross if necessary, against the entry in the register once the information had been taken down.

It is interesting that despite the submission from the Provincial Medical and Surgical Association, urging that cause of death be included in the information registered, no provision for this was made in the draft bill of the Act. It was only when the Bill got to the Lords that Lord Ellenborough had the clause providing for recording the cause of death inserted. The historian John Eyler has concluded that it was upon the urging of Edwin Chadwick that it was included, and it has been proposed that he did so in order to placate the medical profession who, at the time, were dissatisfied with the Poor Law medical services.⁹ Although the inclusion of information on the cause of death for every demise in England and Wales was of enormous benefit for demography, epidemiology and for actuarial work, the provisions for supplying that information were somewhat lax. The registrar was bound to accept the opinion of the person reporting the death regarding its cause despite the informant's potential ignorance of its real cause. The column in the register for the cause of death could also contain second-hand medical information or, where inquests were held, the equally inaccurate verdict of a medically ignorant jury.

The GRO consequently launched a campaign to encourage the medical profession to participate fully in registering deaths to ensure that the resulting statistics were accurate. The first Registrar General, encouraged by his assistant and later chief compiler of statistics, William Farr, himself a doctor, enlisted the support of the presidents and secretaries of the Royal Colleges of Surgeons and Physicians and the Society of Apothecaries.¹⁰ With their support he urged all medical practitioners to provide written statements of the cause of death to be left with the person who was to report to the registrar.¹¹ These statements should, the Registrar General urged,

be very short, the column in the Register Book in which it is to be inserted being not more than sufficient for the insertion of about ten words of moderate length. It should therefore contain only the name of the disease which was considered to be the cause of death, and not a detailed account either of antecedent symptoms or of the appearances which may have presented themselves after death.¹²

Farr also wrote to the leading medical journals in his efforts to make the profession aware of the problems medical statisticians encountered in having to work with inaccurate information. Here he gave quite detailed suggestions, including information on reporting the duration of the fatal disease and asking that information should also be provided regarding any *post mortem* examinations performed on the body.¹³

It appears the campaign was not totally successful for a number of reasons, one of which was the variable quality of written statements which practitioners composed. It would also seem that although the rates of return of these informal statements to registrars was good, by 1845 the Registrar General, George Graham, decided, in the interests of accuracy and uniformity of the returns, to issue blank certificates of

cause of death to all registered medical practitioners in England and Wales.¹⁴ The form copied in Appendix 3 is the published example illustrating how the Registrar General wished these certificates to be filled in. It will be seen that the form provided for primary, secondary and tertiary causes as well as the duration of each to be noted. It also instructed practitioners to note down where diagnoses had been verified using *post mortem* examination, by entering the letters 'P. M.' next to the entry.¹⁵ After the introduction of these forms, deaths registered without their use were entered in the registers as 'not certified' in the column for the cause of death, and should there have been no medical involvement in the illness and death this fact was also entered in the column. This detail in the Registrar's official form attest to their acceptance that post mortem findings were integral to diagnosis. Unfortunately it was the policy of registrars to retain these certificates (received from informants) for a limited period only and then destroy them, and today medical certificates are still kept for ten years and then destroyed. By 1870 the Registrar was reporting that the cause of death in 92% of cases in England were being reported with these or sufficiently good versions of this form.¹⁶

William Farr, the GRO's Compiler of abstracts, had other problems. Clearly statistics on the cause of death would only be useful if all practitioners supplying the data were using the same system of terms to refer to the diseases responsible for deaths. At the time, and for the remainder of the century, there was no universally accepted nosology in western Europe for reporting the cause of death, so Farr set about producing a compromise, 'statistical' nosology on the basis of his impressive grasp of the nosological authorities of the day. Dividing diseases into classes and families, however, also inevitably commits the classifier to implicit theories of the

nature of disease, often determined by the view of shared or similar causes for any one particular group of ailments. In distinguishing endemic diseases (which occur in definite localities only), from epidemic/contagious diseases (which can occur in any locality and be spread by contact) and sporadic diseases (occurring without spreading), Farr unfortunately adopted a classification which was disapproved of by factions in the medical establishment and was forced to revise it to meet their objections. Despite this, Farr's nosology was acceptable to many practitioners since he adhered to theories, such as the 'miasmatic' theory, current at the time. Even tuberculosis was not accepted as a unified disease in his Statistical Nosology until the 1855 revision.¹⁷

The system of registering deaths was, however, open to criticism on several fronts. Although informants were required to give their names for entry in the register, the use of a cross as the informant's mark beside his name allowed the informant to conceal his identity and so possibly to evade suspicion of involvement in murder. Also the Act did not require still-births to be registered and so infanticide could escape notice. There was still no legal obligation for doctors to certify the cause of death in all cases and when they did, it could still be done without the practitioner actually having seen the patient. As Farr's friend, Henry W. Rumsey noted, doctors could also be prevailed upon to substitute more acceptable causes which, for instance, would not shame or disgrace the dead person's family since the cause of death only became confidential information in England in 1926. This was especially the case with tuberculosis which was believed to be an inheritable disease.¹⁸ For the purposes of epidemiology or public health statistics, the error of mistaking mortality for morbidity statistics did not seem to have occurred to the

staff of the GRO since Farr himself thought the one could be inferred from the other, although it is surprising, given his eagerness to quantify, that he did not work out the regularities or offer values.¹⁹ This conflation of mortality and morbidity indicates the strength of the conceptual bond between death and disease.

Disputes concerning nosological classifications used in statements of the cause of death and the contemporary criticisms of shortcomings in the system of death registration, however, distract attention from the status of these medical statements. Is it sufficient to say that these medical statements are merely the 'raw data' needed by statisticians or is there more to them than this? Following the work of Kathryn Montgomery Hunter, Chapter 1 has shown that clinical diagnosis of tuberculosis on the basis of signs and symptoms was narrative and that it formed part of a larger narrative complex in Victorian medicine.²⁰ Hunter notices, however, that a patient's death features in the patient's 'chart' or case notes amongst those events which receive the most concisely narrated notes. Like chronic illnesses and conditions whose aetiology is well understood, death is merely given the simplest of labels. Death, in these circumstances, is not an important medical event, especially where the patient dies after a long illness. Montgomery Hunter notes, following Tolstoy, that 'Narrative requires difference, atypicality and (like happy families) broken arms, appendicitis or dying patients are all alike.'²¹ It would seem, for both medicine and for a literary scholar concerned with the place of stories in contemporary practice, that patients' deaths are not worthy of scrutiny in terms of the narratives they give rise to.

Montgomery Hunter also briefly touches on the way in which medical causality is restricted to linear, materialist conceptions which exclude contributory factors such as violence, bereavement, poverty and inadequate health care from featuring in the aetiology of disease.²² One such place in which she sees this as most evident is in current American death certificates.²³ Here the primary cause of death is usually reported as heart, lung or cerebral failure, while secondary cause will usually cover the localised cause of that failure, for example myocardial infarction in certain cases of heart disease. Only the tertiary cause of death resembles the diagnosis, for example pneumonia in the case of lung failure.²⁴ In stressing medicine's disinclination to become entrapped in ideas of overdetermination, Montgomery Hunter misses the chance to raise the question of the narrative status of certificates containing information on the cause of death. Could it not be that despite being the most concise statements, certificates of the cause of death are nonetheless narratives? Despite their being reports of bald 'facts' which carry information in a form amenable to statistical calculation and tabulation, are these certificates not stories? If they are narrative how, then, do they articulate with the rest of medicine's narrative discourse? What place do these compressed stories occupy within the tales told about illness and about patients? These are questions, however, the answers to which are only hinted at by Montgomery Hunter, concerned as she is with the overall form of present knowledge. It is to the recent historical past, such as the first forty years of the General Registrar's Office, that we may turn to answer some of these questions.

There are indications in the documents produced by the General Register Office that suggest that early Victorian medicine was indeed profoundly narrative. We

have already noticed that the Registrar General urged that written statements of the cause of death,

be very short, the column in the Register Book in which it is to be inserted being not more than sufficient for the insertion of about ten words of moderate length. It should therefore contain only the name of the disease which was considered to be the cause of death, and not a detailed account either of antecedent symptoms or of the appearances which may have presented themselves after death.

The Registrar seems, from these directives, to have been aware that doctors of the time conceived of their diagnoses as inseparable from the symptomatic evidence which allowed them to form them. He also seems afraid that they would have endeavoured to do each case justice by stating, *fully* and at length, what caused their patients' deaths. Although it has not proved possible to trace copies of these informal manuscript statements, material from a Victorian private mental asylum shows that physicians did write narratives about the deaths of some patients.

This narrative content was bound up with the notion of cause at the heart of these statements and, when certificates were introduced, they allowed this story to be articulated in terms of primary, secondary and tertiary causes of death. The certificates allowed the cause of death to be complex in that they provided for the primary disease giving rise to complications, the whole ensemble of which eventually caused the patient's death. Not only is the causally related series of events narrated, but the temporal relation between these events was seen as significant by the Registrar General. It was seen as important that doctors state the duration of each successive illness relative to its onset before death. The Registrar, probably under Farr's guidance, even encouraged doctors to keep detailed case notes charting the progress of each case since it was felt that the details entered in

the newly introduced certificates of cause of death would be more accurate and reliable where practitioners had kept such records.²⁵

The notes and observations attached to the Statistical Nosology include an example of the case records which the Registrar recommended. In this tabular example what appears to be a hypothetical young male patient contracts measles on the 5th of March and pneumonia a week later. The example also adds that the patient was first seen by the medical attendant on the 9th, at which stage the disease's dermal eruptions were visible, having been reported as occurring the previous day. By the 12th the young patient exhibits the characteristic symptoms of the secondary disease. These become more and more severe and the doctor's 'private register' reports that he saw the patient on the day before he died - on the 20th of March. The example also notes that a post mortem revealed that a lung had hepatized and its pleura become adherent. Despite its status as hypothetical example, this is clearly a story and, in fact, the table would be incomprehensible without being understood in narrative terms.²⁶

We have seen how the Registrar General's request for doctors' written statements met with some success, and that despite this it was necessary to issue nosological guidelines as well as to formalise these statements in 1845. Due to the Registrar's policy of destroying these certificates after a period of years, it has not been possible to trace copies of these completed documents. Fortunately the case notes and patient files compiled in Ticehurst lunatic asylum have been preserved (including the asylum's own formal certificates of cause of death), and it is to these that we will turn for an idea of the way doctors viewed and used the certificates and

statements they drew up to fulfil their obligations under the Births, Deaths and Marriages Act. Before turning to a detailed examination of one particular asylum's records it should be noted that the conclusions reached are broadly typical of the institutions I have examined. I have sampled the records of Royal Bethlem Hospital between 1840 and 1865. Although the Royal Bethlem Hospital case books do not contain drafts and copies of certificates sent to the Registrar, there are duplicate copies of forms sent to the Coroner at Southwark amongst the records.²⁷ Also, the Register of Discharges and Deaths begun in 1853 contains, on its fly leaf, a set of instructions drafted by the clerk as memoranda on the then new set of procedures in asylums. There are notes reminding the clerk to inform the Commissioners in Lunacy, the undertakers (when the body was buried by the hospital) and a Home Office official where the deceased was a criminal patient. There is also a note stating that the 'Reg[istrar]' should be informed of the patient's 'date of death, disease, age, profession, origin' etc., so it can be safely assumed that something like the certificates of cause of death which were sent to the Coroner also reached the Registrar. The case records at Royal Bethlem, however, do not include the drafts or exact copies of documents sent to the registrar, so I will discuss only those from Ticehurst Asylum in any detail.

The case documents from Royal Bethlem are interesting in that they regularly contain records of *post mortem* examinations appended to case notes. It is difficult from the case documents alone, however, to say whether any attempts were being made to 'localise' the mental conditions which caused the patient's deaths since the records themselves are rigorously descriptive, eschewing interpretation. Without surveying the many hundreds of cases thoroughly and going into the issue of the

way mental disease was related to other diseases, it is also very difficult to say whether the conception of mental diseases involved special or characteristic ideas of death. It may well be that this is the case since the Bethlem records I consulted were divided according to whether the cases were viewed as 'Uncurable' [sic] or 'Curable'. Even a cursory glance at the records reveals that the incurable patients were the ones most likely to die in the institution.

Ticehurst Asylum, later called Ticehurst House, was set up in the 1790s to cater for the needs of psychiatric patients drawn from the upper classes, although a few non-paying patients were accepted.²⁸ Here patients lived much as they would have at home with considerable freedom, but subject to constant supervision and the 'moral' therapies fashionable at the time. Many patients spent decades in the institution due to the intractable nature of their conditions, but some patients did recover and leave the asylum. Many inmates died, however, before they could be discharged. It is to the records of these deaths that we now turn.

The case files vary considerably and contain a host of different documents. Most contain the orders committing the patients to the Asylum or records of their moving to Ticehurst from other establishments. There are letters relating to patients and even the odd undertaker's bill or record of burial.²⁹ Many, however, contain the Asylum's own cause of death certificates, which it seems continued to be used long after the Registrar introduced his certificates in 1845, as well as manuscript drafts of statements of death. The files selected for examination here all have either draft or final versions of the certificate of cause of death and were selected because they could be cross referenced with corresponding patients' notes in the

Case Books. Also, as will be seen, the examples vary from being astonishingly brief to extraordinarily detailed, dealing with patients with a range of conditions. Whether a file has a corresponding entry in the Case Books seems entirely arbitrary. For the purposes of gaining some insight into the nature of certificates of the cause of death it was felt that those with corresponding notes in the Case Books yielded the fullest picture. It should be noted that the files examined here represent deaths due to both 'mental' and physical diseases since they were not treated differently for purposes of case documentation and seem to have been reported to the Registrar in the same way. The inclusion of patients who died of straightforward physical diseases allows us some idea of how cases in non-asylum contexts would have been documented and reported. Unfortunately it proved impossible to locate documentary statements of the cause of death for the few cases of terminal consumption found in the asylum records. This gap in hospital records, however, is not peculiar to consumption since there are numerous other terminal cases where the causes of death are diseases other than consumption and where no document has been retained. From the documents examined for Chapter 1, however, it is likely that such records could well have been drawn up where the cause of death *was* consumption. Let us then turn to the files of those whose ends were particularly well documented in hospital files.

One such file relates to a Mr William Petar and consists of the certificate and just such a manuscript draft of a statement of death.³⁰ The single page draft is marked 'Statement of Death for entry into Case Book'. The manuscript draft contains alterations relating to the issue of cause, as do many of these drafts. Besides stating that the patient died at a precise time on New Year's Eve in 1854, the draft reads

‘The cause of his death was pulmonary apoplexy. This patient had been subject to haemophthisis for some years past which terminated in pulmonary apoplexy as above mentioned.’ It has been revised to read ‘The cause of his death was pulmonary apoplexy occasioned by the rupture of a blood vessel in the lung’ and the clause relating to the haemophthisis has been removed. The change transfers the narrative, i.e. causal, weight to the description of vascular rupture which brought about the haemorrhage, but does not do away with it completely, despite dropping the reference to haemophthisis. The certificate notifying the local registrar (*et al.*) of Mr Petar’s death is in all essentials the same as the draft statement, with the additional mention of the attendant present at the patient’s death. The draft statements, however, routinely end with a declaration to the effect that they are correct copies of the contents of the Case Book maintained by the medical proprietors of the Asylum.

Examination of the Case Book entries for Mr Petar reveal that this statement of cause features as the final entry in his notes and, as such, is the end of the story of Mr Petar’s years in the Asylum. The story is exceptionally brief, filling only one page in order to cover his admission ‘in good bodily health’ while suffering from ‘delusions’. His notes only mention a slight attack of colic and an attack of bronchitis from which he recovers in the year preceding his death. His mental state is carefully monitored but is so uniform as to elicit repeated remarks such as ‘much as usual’ or ‘continues the same’. The story does however, include a reference to pulmonary symptoms associated with the fatal rupture of a blood vessel.³¹ The note preceding the entry of the drafted statement in the Case Book mentions that Mr Petar’s ‘breathing is sometimes difficult and he feels change of weather.’ This

penultimate note, despite its brevity, provides a narrative context, in the case, in which to locate the final medical event captured in the certificate - it tells the beginning of the mortal tale concluded in the certificate of the cause of death. It is clear, from the agreement between the draft and both the Case Book entry and the certificate, that the statement was used both to end the story in the Case Book and to *compress* that story to its narrative minimum, acceptable to the registrar and useful in statistical terms, in the death certificate proper. The certificate of the cause of death then functions at the interface between a narrative knowledge of disease and death on the one hand and a calculus of public health and mortality associated with political attempts to defend the population against disease and death.

While the documents charting Mr Petar's stay at the asylum are perhaps remarkable for the way in which his mental state appears to remain the same throughout the 15 years of his stay, there are others which are even more brief and yet attest to the strength of medicine's necessary recourse to narrative. Not all patients' admission documents are tied into the Case Books, since there are many files not supported by entries in the Case Books or whose entries are not cross referenced to admission or patient numbers. Yet even one of the briefest of cases supports the view that narrative is used by the physician in an attempt to make medical sense of what otherwise might appear as an unexpected death. One such case is that of Mr Woodus Cramp for whom the files contain an amended draft statement of the cause of death and a completed certificate.³²

Unlike Mr Petar's file, the only amendment to the draft statement is the deletion of the formulaic clause certifying that it 'is a correct copy of the statement entered in the Case Book [...]'. This seems to have been deleted since the statement that he died in the evening of the 14th October 1856 from peritonitis has been supplemented, when entered in the Case Book, by the addition of some details which make the records of his hospitalisation into a case and allow some sense to be made of the record of death. Having noted that he died of peritonitis and that this diagnosis was confirmed by a post mortem examination, the notes continue,

The above gentleman had become very feeble about six months since + [sic] had suffered during that time occasional attacks of constipation. Mr Cramp had been in the establishment thirty one years.³³

A careful search of the Case Books until the date of Mr Cramp's death yielded no entries other than this one. Death, as the example of this narrative shows, can only be understood in a context which allows the writer to make medical sense of it. The death of a patient only becomes meaningful or intelligible once sufficient details of events preceding that death are available and are assimilated into a narrative. Even in those circumstances where an autopsy is necessary for forensic purposes, medical sense is only made by inferring events before death from the traces it leaves within and upon the body. It is interesting that despite Victorian medicine's stress on the importance of post mortem findings (because they represent the precise ways in which disease and death have modified the body) these are insufficient to make *full* medical sense of the death.³⁴

Some idea of the nature of the informal statements used by physicians prior to the introduction of certificates of cause of death by the Registrar can be had by examining one last patient file from Ticehurst. The Case Books report the

admission and subsequent events in the case of a 16 year old youth, George Frederick Heathcote, admitted with what was diagnosed as epilepsy and who spent nearly a year and a half in the asylum before his death following one of his frequent seizures.³⁵ The physician and proprietor C. H. Newington seems to have been keenly interested in epilepsy since this case is closely followed and comprehensively documented in these notes. What is unusual, however, about this patient's file is the absence, for reasons which remain unclear, of the usual certificate used by the hospital. Instead, there are two manuscript drafts of statements of death (one drawn up and signed by Dr Newington and another headed 'To the Registrar of Deaths' drawn up and signed by another hand, but initialled by Newington) and a carefully structured chronological account of the events surrounding Heathcote's death. The detailed chronological account seems to have been drawn up in an effort to establish exactly when George Heathcote died, since he suffered a seizure in the evening of his death and then was seen apparently sleeping soundly by several attendants. When his servant went to wake him the following morning it was clear that he had been dead some time.

Of the two draft versions of the statement of death the one signed and drafted by Newington is concise and contains some revisions, none of which is notable. The other statement is more interesting in that it initially adheres to the wording of the printed forms notifying the Registrar and provides the standard information as to name, dates of admission and death, who was with the patient when he died and the cause of death. It adds, however, 'This patient had been subject to frequent Epileptic seizures of a severe character during the whole time he was in the asylum, having had from the day of his admission to the day of his death 214 fits.' This

detail adds to George Heathcote's story, relying on the existence of the chronological case notes containing records of each fit, although it may also have been inserted to meet the requirements of the Registrar's Statistical Nosology which asks that note be made, on the certificates, of 'whether the fits were the first &c. experienced; or, at any rate, how long the patient had been subject to epilepsy.'³⁶

When we look at the two accounts in the Case Book, we are presented with two versions of the same events, one which closely adheres to the short draft of the statement of death by Newington and another, also in his hand, which contains more detail and is thus able to retell the same events as a smoother, fuller narrative.

The longer account reads:

May 7th [1857]. Last evening Mr Heathcote has [sic] a fit about 10 o'clock from which he rallied as usual. It appears in the morning when [?] his servant left him he seemed to be in a comfortable sleep at 7. 30 when the servant entered the room he seemed to be still sleeping - he then left him to attend to another patient thinking it a pity to disturb him, at eight o'clock the servant returned to and went to rouse him when he found him dead having died in his sleep - he lay most peacefully and appeared to have died without a movement as neither his limbs nor bed clothes were in the least displaced - During the time he has been in the Asylum he has had 214 fits. The following notice was sent to the Commissioners in Lunacy, the clerk to the Visitors [...]³⁷

Although some of the details in this account are derived from the chronologically structured account (which uses the page's right hand margin to mark the times at which events occurred), others are not. It seems, from the chronological account, that Dr Newington was called immediately the body was discovered and so could have personally seen the peaceful attitude noted in the account. It is difficult to see why the standard short statement, drafted and copied into the Casebook after the account reproduced above, was felt to be insufficient. It is almost as though the

long 'story' represented by the extensive and detailed case notes required a fitting narrative ending, one that went beyond the bare details necessary for officialdom, while still accommodating its need for information.

The three examples examined here, whether the very bald statements or the fuller versions of events, are none the less narratives which terminate larger tales.

Victorian certificates of the cause of death are tales in that they relate events which befall patients between admission and death and also ascribe a cause to that death, besides providing other information relating to the circumstances of the demise.

The narrative heart of the story is the attribution of cause, and it makes the tale a medical one since it takes the form of a diagnosis.³⁸ These ascriptions of cause bind events - a death and a bodily malfunction or collapse - over time in ways which make medical sense. Yet examination of the function and place which certificates of the cause of death occupy in medical discourse allows one to see that, almost like the endings of Victorian fiction, they represent a summary statement of the main character and events (the patient and his mortal disease) which, because of the nature of the event, must terminate the story.

The certificate also functions, however, as the basis of an entry in a register of deaths. Here it is the raw information, a grasp of the fact of disease or a true, 'scientific' statement about an individual's disease and death which is then assimilated into a larger statistical picture of disease and death within the nation.

The narrative science of the individual, dependant as it is on death, began, our examples show, to yield true and accurate raw data in such a compressed form as to make it useful to a numerical or mathematical system which its creators saw as

establishing laws of life and death itself.³⁹ The certificate of the cause of death allowed the narrative operations of medicine (in diagnosis, case notes and presentations, and autopsy reports, together with the practices which sustained these discourses) to be compressed or pared down to a form amenable to the demands of epidemiologists, actuaries and reforming politicians. One might even say that the calculus of human mortality had never before reached the sophistication which it gained with the establishment of the Registrar General and the introduction of a column for the cause of death in his registers.

Death through consumption and other diseases was not, however, the exclusive domain of medicine despite the extensive medicalisation of British and Western culture generally in the period covered here. Over and above the conceptualisation of death in medicine and nascent epidemiological and demographic knowledges, death also featured prominently in the imaginative literature of the time. British culture addressed itself *en masse*, because of the broad popularity of fiction, to issues surrounding death and the individual in a domain free of the constraints of the real world and its necessity for combating disease. Freed of such restrictions, fiction provided a domain in which to think through, develop and use ideas surrounding the sick, subject only to the demands of literature. If medicine shared a host of broadly cultural ideas concerning consumption with society at large, what were these ideas and how were they developed, deployed and integrated into narrative fiction? It is to questions such as these which we now turn.

¹ Simon Szreter's 'The GRO and the Historians', *Social History of Medicine*, 4 (1991) 401 - 414, a special issue devoted to the history of the General Register Office (now the Office of Population Censuses and Surveys).

² See the United States National Office of Vital Statistics' *First and Last Things: The Story of Birth and Death Certificates*, (Washington: US Department of Health, Education, Welfare and Public Health Service, National Office of Vital Statistics, 1960), p. 23.

³ Simon Szreter, 'The GRO and the Historians', p. 91.

⁴ John M. Eyler summarises this aspect of records of death in his Victorian Social Medicine: The Ideas and Methods of William Farr, (London: Johns Hopkins University Press, 1979), p. 38. See also Muriel Nissel's People Count: A History of the General Register Office, (London: Office of Population Censuses and Surveys, 1987), p. 6.

⁵ Nissel, p. 99.

⁶ Appendix 'K' of the Register General's Regulations For The Duties of Superintendent Registrars (London: Register General of Births, Deaths and Marriages, 1838), pp. 57 – 58.

⁷ Appendix 'K' of the Register General's Regulations For The Duties of Superintendent Registrars, p. 75.

⁸ United Kingdom, Register General of Births, Deaths and Marriages, Regulations For The Duties of Superintendent Registrars, (London: Register General of Births, Deaths and Marriages, 1838), p. 44. See also the statute, Cap. 86, 'An Act for Registering Births, Deaths and Marriages in England', A Collection of the Public General Statutes Passed in the Sixth and Seventh Year of the Reign of His Majesty King William the Fourth 1836 (London: Eyre and Spottiswoode, 1836), paragraph XXV, p. 774.

⁹ Eyler Victorian Social Medicine, p. 45.

¹⁰ Farr was helped in getting the post of compiler of abstracts by Sir James Clark, who also treated Farr's wife for tuberculosis, and Farr later repaid him by helping with the second edition of his Treatise on Pulmonary Consumption. See George Whitfield's unpublished manuscript, 'Beloved Sir James', The Life of Sir James Clark, Bart, Physician to Queen Victoria, 1788 – 1870, (held at the British Library) p. 57.

¹¹ Appendix 'M', First Annual Report of the Registrar General of Births, Deaths and Marriages in England (London: Register General of Births, Deaths and Marriages, 1839), p. 58.

¹² Appendix 'M', First Annual Report of the Registrar General, (1839), p. 59.

¹³ William Farr's letter to the editor, 'Notice Relative to Returns of Cause of Death', in London Medical Gazette (n.s.), 2, (1842 – 1843), p. 52.

¹⁴ Appendix to the Seventh Annual Report of the Registrar General of Births Deaths and Marriages in England (1846).

¹⁵ See the 'Circulars' appended to the Seventh Annual Report of the Registrar General of Births, Deaths and Marriages In England, (London: Register General of Births, Deaths and Marriages, 1846).

¹⁶ Eyler, Victorian Social Medicine, p. 52 - 53.

¹⁷ The 1845 Statistical Nosology still classified phthisis among diseases of the 'Respiratory Organs' and notes that 'it is not universally admitted that it belongs to the same genus as scrofula.'

¹⁸ Eyler, Victorian Social Medicine: The Ideas and Methods of William Farr, p. 60.

¹⁹ Farr writes that there 'is a relation between death and sickness; and to every death from any cause there is an average number of attacks from sickness, and a specific number of persons incapacitated for work.' See the selection from the 'Supplement to the 35th Annual Report of the Registrar General' relating to the constitution and significance of death rates as tests of health and progress in Vital Statistics: A Memorial Volume of Selections from the Reports and Writings of William Farr, (London: Sanitary Institute, 1885), p. 117.

²⁰ J. Wesley Boyd, 'Narrative Aspects of a Doctor-Patient Encounter', Journal of Medical Humanities, 17 (1996), 5 –15. Boyd cites E. J. Cassell's idea that not only is the history of an illness a story, but that because a disease is a series of events in time it too merits a narrative. Boyd however, stresses the need for careful attention to fully detailed and well tailored stories in the doctor-patient encounter. See also William J. Donnelly, 'Righting the Medical Record: Transforming Chronicle Into Story', Soundings: An Interdisciplinary Journal, 72 (1989), 127 – 36. Donnelly makes a case for the explicit use of patients' own experience of their illnesses in case documentation. In this account, the bare chronological succession of events in the section of case documentation devoted to the history of the present illness is insufficiently narrative and fails to capture the texture of patients' own experience.

²¹ See Kathryn Montgomery Hunter's Doctor's Stories: The Narrative Structure of Medical Knowledge, (Princeton: Princeton University Press, 1991), p. 91.

²² Hunter, p. 102. Lindsay Prior has codified a series of five rules which structure explanations in these cause of death certificates. According to this schema death is always the result of one or

another form of pathology or disease. It is always a physical event with a cause whose traces are theoretically discernible in the body. The notion of cause is, as Hunter has found, always linear and temporal. The cause is also always present at the moment of death and is not remote. This seems also to be the underlying structure for the Victorian certificates I examined. See Lindsay Prior 'Actuarial Visions of Death: Life, Death and Chance in the Modern World' in The Changing Face of Death: Historical Accounts of Death and Disposal ed. by P. C. Jupp and G. Howarth, (London: Macmillan, 1997), p. 188.

²³ For an example see First Things and Last, p. 4.

²⁴ Hunter, Doctor's Stories, p. 102.

²⁵ A Statistical Nosology for the Use of Those Who Return the Cause of Death Under 6 & 7 Will. iv., c 86 (London: Office of the Registrar General, 1845), p. 13.

²⁶ William Farr, Statistical Nosology, p. 13.

²⁷ Unfortunately the material held in the Royal Bethlem Hospital Archives is not catalogued. For example, see case 73 in 'Case Book, Males 1877' where a copy of a certificate of cause of death of a 32-year-old man who died of 'epileptiform seizures and general paralysis' is to be found. All the cases consulted have the same general structure as those found at Ticehurst: a case history, day to day records of the course of the patient's illness and a record of the death, the copy of a certificate of cause of death and post mortem report. They thus support the conclusions regarding narrative which I reach on the basis of Ticehurst's documents.

²⁸ Charlotte MacKenzie, Psychiatry For The Rich: A History of Ticehurst Private Asylum 1792 – 1917, (London: Routledge, 1992).

²⁹ Wellcome Institute for the History of Medicine Library, Western Manuscripts Collection, Ticehurst House Hospital Records, 1787 – 1980. See also a guide to the collection entitled List of the Ticehurst House Hospital Records 1787 - 1980, Deposited in the Wellcome Institute for the History of Medicine drawn up by R. Palmer and K. Moore for the library in 1991. Patient files are housed in box no 6326 and numbered by admission 1 - 199. Further reference to items in this collection will take the form 'WIHM, Western Mss Collection, Ticehurst House Hospital Records' followed by box or volume number and, where applicable, by item or page numbers.

³⁰ WIHM, Western Mss Collection, Ticehurst House Hospital Records, box 6326: item 43.

³¹ WIHM, Western Mss Collection, Ticehurst House Hospital Records, box 6361 p. 60.

³² WIHM, Western Mss Collection, Ticehurst House Hospital Records, box 6326 item 17.

³³ WIHM, Western Mss Collection, Ticehurst House Hospital Records, box 6363 p. 62.

³⁴ Farr, it is assumed, since he was the only medical expert employed at the GRO, stressed that careful note should be made in the deaths register where attributions of cause of death had been verified by post mortem. Despite nineteenth-century pre-bacteriological medicine's heavy dependence on gross pathology and post mortem findings there are signs, in the Statistical Nosology, of the rational appreciation of post mortem examination being clouded by an emotional ambivalence towards the practice. See the remarks in Willam Farr's Statistical Nosology, p. 13.

³⁵ WIHM, Western Mss Collection, Ticehurst House Hospital Records, box 6363, pp. 105 – 36.

³⁶ Farr, p. 28.

³⁷ WIHM, Western Mss Collection, Ticehurst House Hospital Records, 6363, pp. 122 and 136.

³⁸ This is almost the obverse of present American death certificates since there the primary cause of death is not of the order of a diagnosis, or if it is it is so only by virtue of a synecdochic substitution.

³⁹ Farr's chief tool here was the life table, illustrating the regular way in which generations succeed each other. With these tables it was possible to predict the number or proportion of a population which would have survived at any given point on the journey between birth and death, given certain constant conditions. He also believed that rational medicine depended on the existence of laws governing the phenomena of life and death. He nevertheless was careful to limit the usefulness of statistical regularities to the probabilities (not the prediction) of events in relation to individuals. See Eyer, Victorian Social Medicin, pp. 32 and 34.

Chapter 3

'... The Life-In-Death ...': The Figure of the Consumptive in Gaskell's Mary

Barton

There was a low knock at the door! A strange feeling crept over Mary's heart as if something spiritual were near: as if the dead, so lately present in her dreams, were yet gliding and hovering around her, with their dim dread forms. And yet why dread? Had they not loved her? - and who loved her now? Was she not lonely enough to welcome the spirits of the dead, who had loved her while here? ¹

... I must have my dram. Oh! you don't know the awful nights I have had in prison for want of it,' said she, shuddering, and glaring round with terrified eyes, as if dreading to see some spiritual creature, with dim form, near her.

'It is so frightful to see them,' whispering in tones of wildness, although so low spoken. 'There they go round and round my bed the whole night through. My mother, carrying little Annie (I wonder how they got together) and Mary - and all looking at me with their sad stony eyes....' ²

Thus far I have argued that Victorian medicine's understanding of death and disease, especially consumption, is profoundly narrative. Clinical interaction with patients, the case histories and other documents which arise out of it, expository text books expounding the generally accepted view of the nature of consumption and even autopsy reports and medical statements of the cause of death have all been shown to be committed to narrative. It has also been shown that death is a central conceptual pillar in these narratives. Yet death and disease feature in imaginative narratives simply because death is both culturally and psychologically important. Because one of Victorian fiction's main aims is to reflect and represent reality it was almost inevitable that mortality and morbidity became so prominent in fiction. This Chapter aims to set out some of the main ideas associated with

consumption and the Victorian consumptive. Having outlined this general area, it goes on to examine Mrs Gaskell's use of these ideas in Mary Barton.

Pulmonary Consumption, phthisis or, as we now know it, tuberculosis has - at least in Western Europe - been a spectre largely laid to rest since the therapeutic successes of the 1960s, and has only recently resurfaced in the popular media due to the emergence of strains of bacteria which are resistant to available drug treatments. Since some of what follows touches on clinical points relating to the nature and symptoms of the disease, it is necessary to offer brief preliminaries on these matters before examining Victorian ideas about consumption.

Tuberculosis is chiefly contracted by inhaling a small amount of one of a number of *mycobacterium tuberculosis* species.³ This evades the upper respiratory tract's mechanisms for excluding larger particles such as dust etc. and settles in an alveolus of the lung. Because the location is rich in oxygen and other prerequisites for its survival, the bacterium lives and begins to multiply there. In patients previously unexposed to the bacteria, the body's immune system does not recognise them as a danger and the white blood cells responsible for defence merely ingest it without destroying them - due to the bacteria's possession of a thick waxy outer coating. Contained within a white blood cell, they then may travel unrecognised to many parts of the body, in some of which it is easily destroyed, however, they may also infect and progressively destroy the ends of the longbones, kidneys and genito-urinary tract, brain, pericardium, stomach, and intestines. Typically the ingested bacteria are transported to lymph nodes in the neck and lodge there within the macrophages, continuing as viable living entities. At this stage the bacteria multiply freely wherever they are found.

Approximately four to eight weeks after infection, however, the immune system becomes hypersensitive to the pathogen and begins to react more vigorously to the bacteria; treating them as a danger, white blood cells surround the bacteria, encapsulating them in microscopic conglomerates of defensive cells. This period of hypersensitive reaction is marked only by very mild sensations of malaise and very slight fever which may go unnoticed by patients. The bacterium is then essentially contained, imprisoned but unharmed, surviving as a viable but dormant entity. This situation may last for months or even years, with the patient experiencing protracted periods of remission.

When these imprisoning white blood cells eventually die, however, the tiny formations - microscopic 'tubercles' - become cheesy or calcified and may liquefy and disintegrate, liberating the bacteria which reproduce, infecting other previously unaffected areas, usually of the lung. In this way the lung is progressively destroyed by lesions which increase in size due to the spread of bacteria and the body's attempts to contain and eradicate them. Tubercles range in size from microscopic specks in pulmonary tissue to caseated deposits involving the whole lung. During this progressive destruction process some tubercles may rupture into the lung's larger air ducts (or bronchi), giving rise to irritation and coughing. Once one of these structures has drained, it leaves a cavity which then becomes an excellent breeding ground for more bacteria. The cavities enlarge, some reaching the size of a man's fist. When the small pulmonary veins inevitably erode, the patient coughs up the telltale bloody sputum and eventually even dangerously large amounts of frothy, bright red blood itself.

Besides coughing and its characteristic products, there are other associated symptoms. The patient registers progressive impairment of lung function as breathlessness and difficulty in breathing. Subjects experience a regular fever which rises in the afternoon and subsides in the evening. They suffer feverish night-sweats. The precise reasons for febrile reaction to infection with the bacteria are still uncertain. Sufferers also exhibit progressive, alarming weight loss due to loss of appetite and reduced food intake.⁴ If destruction is extensive the pleura and peritoneum may also be affected, causing adhesions; the patient then experiences characteristic chest pains. Patients gradually weaken as the disease progresses, eventually dying of inanition or asphyxiating when their lungs fill with body fluids. In cases of widespread or milliary tubercule formation involving other vital organs, failure of one of these may result in death.

A host of terms describe the forms of tuberculosis: phthisis, consumption, graveyard cough, scrofula, king's evil, not to mention many more devised by medical experts. All these terms were used, along with their associated medical knowledges and therapies, to know, contain and ultimately to control, what we now understand as the consequences of infection by a variety of bacteria. This range of words - from the lay conception in 'graveyard cough' to the more ancient, but nonetheless precise 'consumption' - suggests that conceptions of disease are as multifaceted as the language used to represent them.⁵ Moreover, this proliferation of a disease's names suggests the possibility that language or discourse can accommodate various clusters of competing, reciprocal and supplementary ideas about that disease. Cultural ideas about consumption have historically gathered

and formed themselves into what, to the modern and even an early nineteenth-century scientific medical observer are, and were, popular mythologies. Alongside, and as we shall see, interpenetrating the scientific discourses of the past, these mythologies also represent part of the cultural response to death.

Although there is an almost universal tendency among English-speaking medical historians to treat the history of disease and medicine's confrontation it as though it were a monolithic story of progressive illumination, there are reasons to proceed more cautiously. This despite the fact that infection and its consequences are certainly as old as the species involved. Tuberculosis, for instance, was only fully described within a recognisably modern knowledge in the nineteenth century.

Prior to that time what is known is not 'tuberculosis', but a collection of symptoms, named and classified according to a very different conception of the body and illness. It is not merely a matter of eighteenth-century physicians not being aware of the precise nature (e.g. bacteriological or histological) of medical phenomena, but of their apprehending in a different way symptoms, diseases and the nature of the creature who became diseased. Viewed in this way, the history of tuberculosis is not monolithic - it becomes one of fractures and changes. One of these periods lies between the early nineteenth century and the discovery of microscopic pathogens eighty years later - roughly after tuberculosis was reconceptualised by RenéLaennec and before the French physician Jean Villemin proved its contagious nature in 1865 and Koch discovered the bacterium in 1882.⁶ Corresponding to, and perhaps resting on, this fairly stable unit of medical knowledge, there is a mythology surrounding the consumptive. After the 1880s, there are shifts in this mythology which are bound up with new treatment regimes and ideas of its

treatability in sanatoria, such the consumptive's increasingly being seen as morally responsible, through ignorance or willful neglect, for the decline in his or her own health.

Foucault suggests that the cultural prominence of the stereotypical consumptive in this part of the nineteenth century is bound up with fundamental changes in the philosophical and medical conceptualisation of life and death. Morbidity or illness, he maintains, both in pathological anatomical medicine and in the wider cultural conception, allows us to see most precisely what distinguishes life and the living/dying individual. Thus arises, suggests Foucault, the Victorian cultural 'privilege of the consumptive': 'in becoming tubercular' the sufferer 'fulfills his incommunicable secret'.⁷

Victorian medical knowledge of consumption, while being noticeably modern, is nonetheless shot through with what to us appears as this mythology of the consumptive.⁸ Alongside consumption's complex aetiology, early nineteenth century medicine elaborated a picture of the 'constitution,' identifiable by body build, general health, and mental or emotional characteristics, likely to lead to the disease. In this, nineteenth-century medical writers adhered to doctrines prevalent in the previous century. The eighteenth-century physician and Edinburgh medical professor William Cullen believed that slender people with long necks, narrow chests and prominent shoulders were likely to develop consumption.⁹ The Victorian London physician Francis Hopkins Ramadge noted that persons with a rosy, but 'delicate' appearance, bright eyes, narrow waist, sharply protruding scapulae and fine bones were more likely to become consumptives.¹⁰ Some

mention prominent white teeth, thick lips, prominent veins and fair skin as indicative of a consumptive ‘diathesis’ or predisposing constitution. One doctor held that the tubercle itself was only secondary even at the tissular level. Edward Smith, one of those who attempted to promote a belief in consumption’s curability, noted that the ‘tubercle itself is a foreign but passive agent;’ and that the destructive changes which follow the development of tubercles in the lungs were ‘not due to any distinguishing action in the tubercular element, but in the tissues which contain it.’¹¹ He believed, it seems, that the lung in those afflicted with the disposition was responsible for consuming or destroying its own substance.

Others also believed that mental or emotional characteristics such as a sanguine temperament and acute intellect rendered their possessors liable to consumption. They were also usually seen as sensitive. In 1815 an American physician and naturalist Thomas Young observed that,

the enthusiasm of genius, as well as of passion, and the delicate sensibility which leads to a successful cultivation of the fine arts, have never been developed in greater perfection than where the constitution has been decidedly marked by that character ... which is often evidently observable in the victims of pulmonary consumption.¹²

Sixty years later, despite tuberculosis’ contagious nature being proven, the British writer, John Francis Churchill, still adhered to similar ideas. In words widely echoed through the texts on phthisis in the intervening years, he writes,

Excessive delicacy of feeling, ardour of affection, vivacity of imagination, precociousness of intellect, all these are, but too frequently signs or forerunners of phthisis. Those whom Heaven seems to have endowed with the seeds of all that is most noble and elevated in the head or in the heart of men, are the most likely to fall victims to this fell disease.¹³

Possessing only one of these characteristics was insufficient - the whole ensemble of qualities thought relevant was necessary in order to qualify an individual as

stereotypically consumptive. Heredity was used to explain why some individuals and not others were disposed to consumption. Thus, because hereditary, the diathesis or disposition was thought to be part of one's mental and physical being - the very fabric and composition of certain healthy minds and bodies orientated both towards the most distinguishing characteristics as well as towards the death that would eliminate them at the height of their powers. What made this group of potential sufferers examples of humanity at the height of its distinctive powers also meant that their deaths were imminent - death and distinction were indissociable in this view.

In addition, pre-bacteriological nineteenth-century medicine also recognised immediate causes. A range of environmental and mental shocks were offered as precipitating consumption; cold and damp, cold air, too much time spent in close heated rooms, and humoral disorders. It continued to be believed that excretory function failures lead to concentrations of irritating poisons in the lungs ultimately causing tubercules and cavitation. Similarly, although medical epistemology was turning away from older conceptions of diseases transforming into one another and towards disease specificity, the belief that febrile and respiratory illnesses (such as smallpox, yellow fever, pneumonia or bronchitis) could 'become' consumption still persisted. The American, Samuel K. Jennings still held that a neglected cold could induce pulmonary irritations issuing in consumption.¹⁴

In line with psychological characteristics, similar psychological states and events were believed to cause consumption in predisposed individuals. This applied to any thoughts or feelings disrupting the equanimity of normal existence for

extended periods, even the intellectual passions involved in study. Clerics were viewed as pale, thin and dyspeptic. Reading novels could also over-excite the sensibilities and cause diseases. Laennec, whose work was promoted by John Forbes in London, focussed on the depressing passions, writing that

Among the occasional causes of phthisis, I know of none more assured operation than the depressing passions, particularly if strong and of long continuance.¹⁵

Victoria's physician and specialist Sir James Clark, similarly held that

Disappointment of long cherished hopes, slighted affections, loss of dear relations, and a reverse of fortune, often exert a powerful influence on persons predisposed to consumption, more particularly in the female sex.¹⁶

Again, such explanations could be rationalised and reconciled on the physical level since they were intended as explanations of bodily disease. Francis H. Ramadge claimed these psychological shocks involved shallow breathing which exercised the lungs insufficiently. Consumption was held likely to develop in such underused organs.¹⁷ Any zealously and passionately pursued occupation - such as excessive intellectual or religious fervour - was also held to cause the disease, without the precise mechanisms involved being specified.

Events and desires centred on erotic passion, like Laennec's 'slighted affections' feature prominently among the immediate causes and figure among the effects of the disease. Excessive sexual activity was thought to cause consumption since the body was seen as possessing a limited amount of 'vital energy' which was spent either in sexual gratification or in fighting off the disease. Those already diagnosed as consumptive were urged to conserve this energy, especially, as we will see, since they were held to be prey to desires stronger than those experienced by healthy individuals.

Victorian and current medicine recognise similar clinical symptoms. Victorian doctors diagnosed consumption from the signs and symptoms of gross pathology rather than on the basis of positive tuberculin tests or laboratory cultures of the bacteria from patients' sputum. As we have seen in Clark's Treatise, doctors recognised the patient's coughing up of bloody sputum, breathing difficulties, 'high' pulse, weakness, wasting physique and flushed countenance as symptoms of consumption and usually diagnosed accordingly. Relying solely on such symptoms often led to the inclusion of symptoms we would now recognise as those of other respiratory diseases. Surprisingly their medical treatises pay scant attention to patient's chest-pain and discomfort, either because it is occasionally possible for some to suffer little or no pain or because popular ideas about the disease almost preclude acknowledgement of its existence.

More importantly, however, all these symptoms occur late in the development of the disease. In effect, doctors were only able to offer positive diagnosis at a late stage. Even Laennec's newly discovered stethoscope only allowed the physician to detect and distinguish between the various sounds of the already deteriorated lung. Nonetheless, because the disease progresses relatively slowly, with patients often surviving for years, physicians did divide the disease's progress into stages such as 'incipient', 'progressing', and 'final'. What distinguishes nearly all this period's medical writers is their belief in consumption as fatal. Being diagnosed as such was essentially a death sentence.

The problem, compounded by elaborating a diathesis, was that it was extremely difficult to say exactly when the patient crossed the line between health and illness.

Clark even distinguished latent or occult phthisis:

The patient is weak, languid, chilly but scarcely considers himself ill ... this is a most insidious form of consumption ... as it is liable to be overlooked, both on account of the obscure character of the local symptoms, and the little importance attached to them by the patient's friends. ... In such persons the transitions from their usual health to a state of tuberculous chachexia, and from this to actual tuberculous disease of the lungs, are easy and imperceptible. ¹⁸

There were many diagnostic obstacles: no one symptom was sufficient, added to which they were the basis on which at least the physical aspects of the diathesis were elaborated - the category of disease extended to those who merely resembled the sick. This, of course, does not wholly explain the diathesis or the need for one, however it begins to suggest parallels in the relevant aspects of medicine.

Formulating a theory of a disposition towards consumption can be seen as shifting attention away from the fruitless pursuit of cure and treatment towards predicting who was likely to become ill, thereby making it possible to forestall the patient's gradual decline into disease. Although this is logical, it is just as likely that a medicine which supported the view of a diathesis was involved in psychologistic individuation such as that practised in Lavater's physiognomy. Medicine gave the individual a scientific reality or existence by allowing a space and time unique to the body's (as opposed to the disease's) progressive death in illness.

For the purposes of exposition, I have distinguished between medical and non-medical ideas concerning the disease - what in the bacteriological age seem like myths - however, this distinction is largely false. Nineteenth-century medical

literature incorporates elements of the representation of the consumptive which we would dismiss as inaccurate. Similarly, journals, autobiography, novels and short stories, poetry and operatic libretti, allow a fuller exploration and artistic use of mythic ideas while also facing up to the reality of appalling suffering. Nonetheless, we need to appreciate the essential coherence or, at the least, relation between popular representation and the medical view of the consumptive and his or her disease. While we understand Susan Sontag's emphasising the need to counter the possible detrimental effects of continuing to adhere to tuberculosis, cancer and Aids mythologies, both medical and literary historians should explain the precise form of the relation between medical knowledge and its attendant social practice, including the circulation of representations of illness and health.¹⁹

We have already noticed that the consumptive diathesis included beauty amongst its features and that psychological turmoil of an erotic or amorous nature was held to induce consumption. This focus on sexuality surfaces in popular myths where the typical (admittedly female) consumptive is alternatively pale and flushed. Although a few medical treatises note pallor as a symptom or sign, it is more important in relation to beauty. M^cMurray shows that the contemporary ideal form of female beauty - the so-called 'steel-engraving lady' - included being pale, fair-skinned, frail and possessing sloping shoulders.²⁰ Moreover, commentators on feminine beauty both in the early nineteenth century as well as after the discovery of the bacteria noticed the similarity between ideals of beauty and typical signs of illness.

Most important is the recognition of an attractive, erotic element in those regarded as ill, whether in fiction or reality. There is often a reluctance to admit openly the erotic nature of the attraction and thus there are numerous instances in which desire is couched in the veiled terms of floral imagery. Young women are often compared to blossom burnt by late frost or to flowers lain in the grave. Ramadge himself says:

No sight is more painfully interesting than that of a female on the verge of womanhood yielding unconsciously to the fatal decree, and like a drooping flower, nipped untimely in the bud, graceful and lovely to the last breath.²¹

Dying of consumption was thought not only to befall the beautiful but to enhance the beauty of those liable to the disease in the first place.²² While the young tubercular naturalist Emily Shore was in Funchal, she visited the English cemetery where many consumptives were buried. Herself a consumptive, she nonetheless saw those buried there as ‘so many early blossoms, nipped by a colder climate’ as she looked at the graves which would, she felt, soon surround her own.²³

Similarly, medical writers perceived that the proximity to death seemed to arouse the sufferer’s desires. Ramadge writes how there was a particular danger of the diathesis being passed on to the next generation:

When we are the prey of other disorders, the desires are deadened, and lie comparatively dormant; but even in the last stage of consumption the love of the sex seems to increase with the decay of the strength, and the disease while it kills, is still propagated in the future life of an unborn being. The same holds true, though in less degree, with respect to the gentler part of the creation.²⁴

There are also instances of patients being earnestly advised to abstain sexually in order to impede the disease’s progress.²⁵

Febrile symptoms were also not clearly distinguished from the physiological and emotional states associated with passionate love. Thus when a predisposed person felt ill or feverish it was not immediately clear whether he or she was suffering from emotional turmoil associated with love or from the early stages of consumption. American periodicals in this period abound in stories of young women who part from their lovers, pine away forelornly and then imperceptibly 'fall into' consumption.²⁶ In the early nineteenth century the medicine of fevers and neuroses were the two areas where localisation of lesions was impossible - where physical traces of disease on the body and its tissues were invisible. This explains why Sontag includes burning up or being consumed by some form of internal fire in her exposition of the myths surrounding consumption.²⁷ In some instances, there is no direct association with love, but the victim is instead 'passionately' spiritual, anticipating the afterlife.

The popular image of the consumptive also includes a fatalistic, anticipatory spirituality or 'unworldly wisdom' noticed by those around the victim. M^cMurray comments on short stories in nineteenth-century American magazines in which consumptive children are endowed with precocious wisdom. She cites the example of an orphaned consumptive child, observed by mothers who have lost their offspring, who discern a '...bloom too unearthly' and an 'eye too spiritual to last'.²⁸ In another, a young jilted heiress contracts the disease but, in reply to a question about her future 'pointed upwards' replying that 'My futurity lies there', calmly accepting her fate. It is at this moment that the narrator notices that the hand pointing heavenward is thin and the speaker's eye 'glittering and

consumptive.’²⁹ One of the British examples I shall examine illustrates this aspect of the consumptive’s image.

One element of the popular picture represented in the texts to be examined in detail here, is the belief that consumptives gained in intellectual and creative power as their conditions worsened. Andrew Duncan, an early nineteenth-century Scottish medical writer, noted that consumption did not produce anxiety or depressing effects like other fevers, but instead led to a ‘peculiar flow of spirits, and uncommon quickness of genius.’³⁰ Charlotte Brontë adhered to the belief that the disease caused rapid intellectual advance when she wrote of her sister Emily that ‘... while physically she perished, mentally, she grew stronger than we had yet known her.’³¹ Something of this conception, as we shall show, is present in her depiction of consumption in Jane Eyre.

No example of consumptive death in fiction resembles another precisely. Also stereotypes do not mean that all instantiations of that type will conform exactly to the hypothetical model. Thus neither Dickens’s Bleak House nor Brontë’s Jane Eyre explicitly includes the languor found elsewhere and one of them omits the cough.³² They both, however, illustrate the feverish activity and hacking cough which ultimately produces the telltale bloody sputum and eventually blood itself, which Sontag mentions, but *not* in the same individual.³³

The popular word ‘consumption,’ captured the patient’s wasting away and made him prey to a disease that, by definition, ‘ate’ his flesh. While dietary measures were advocated as useful, by doctors claiming that consumption was curable, there

is little contemporary medical evidence indicating that the consumptive was seen as excessively hungry, although it would accord well with the patient's slender frame.

³⁴ The literary possibilities of a 'consuming' disease would prove very interesting in relation to our findings regarding an instance in Dickens, as we shall see.

Although the disease can affect many parts of the body, the typical consumptive of popular representations is affected with disease of the lung rather than any other part of the anatomy, as we will see in examining some examples more closely. ³⁵

Most importantly here, especially for the function of minor characters in Victorian English fiction, is the popular view of consumption as fatal. As close analysis will show, the circumstances and relationships surrounding consumptive deaths either articulate with the heroine's identity or are the outcome of the threat to that identity.

The inevitable death was popularly held to be an easy, painless separation from life. ³⁶ Although the associated distress could be considerable and the pain extreme, the widespread belief that consumption was a painless condition prompted Clarke to write that,

they must have witnessed little of the disease who could give this as its general character. The miserable sensations produced by the frequent chills during the day... pains in the chest, ... frequent dyspnoea, ... threatening of suffocation ... constitute a degree of suffering which, considering the protracted period of its duration, is seldom surpassed in any other disease. ³⁷

Our examples show just how entrenched the view was. Fiction, although 'realist', made demands which militated against representing the pain and suffering observable in real consumptives. Since fictional deaths must be true to character, most will avoid representing ghastly realities except in cases where a character 'deserves' a gruesome death. The text examined here adheres to the convention.

If consumption, as Sontag suggests, was imagined as a disease of distortions of time, in the popular imagination sufferers always fall into a gradual decline. In Jane Eyre, consumption results in a lingering, if quiet death.³⁸ The phenomenon of *spes phthisica* is more interesting. According to this belief, sufferers in the final stages of their illness continue to experience delusive hopes of recovery right up to the moment of death.³⁹ Despite the attribution of strengthened mental abilities, wrote George Gregory in 1829,

On the prospect of his own recovery, the judgement of the phthisical patient is nearly always erroneous. The most obvious indications of danger are overlooked; and, full of hope, he is busied only in the anticipation of approaching convalescence.⁴⁰

Alfred B. Maddock, a Victorian physician and specialist, also noted that ‘the poor patient gradually and imperceptibly sinks into eternity, oftentimes anticipating to the last moment a recovery.’⁴¹ The picture of the disease promoted by popular literature seems peculiarly torn between life and death. Sufferers were seen both as inevitably doomed and yet simultaneously as imbued with vigorous, enhanced life forces such as sexual drives and mental capacities. Similarly they were seen as unable to recognise death although their physical condition could barely support life. Nonetheless, despite the tensions in the image of the consumptive, on the whole consumption in the nineteenth century represents a condition in which already distinguished individuals are destined to become even more remarkable - the beautiful become ‘radiant’, their innate intelligence often briefly flames into genius and their superior moral power is often transformed into spiritual sanctity. Small wonder that consumption, in the age of the sanatorium, was what one commentator has called the ‘badge of refinement’.⁴²

Thus far we have seen that a number of ideas about the consumptive circulated both in medical texts and in the culture of the time. The consumptive was viewed as possessed of particular distinguishing physical features, for example a specific form of beauty, and then, when he or she went on to develop the disease, was seen as typically suffering from specific symptoms. It was held that they generally remained ill for some time before an inevitable death. Their disease was attributed to a host of causes ranging from heightened intellect, through spirituality and even involving the vicissitudes of love. When death did eventually come, it was held to be a painless and quiet exit. Yet questions remain regarding the way specific novels deploy this stereotypical figure and his or her disease. Which symptoms feature more than others in fiction? Do particular kinds of character get the disease? Are they, for example, typically members of one or another profession or men rather than women, children rather than adults? What elements, if any, of contemporary medical knowledge are suppressed and why? Most importantly, if Victorian medicine, as we have seen, is committed to comprehending disease in narrative terms, do any of the ideas surrounding consumption have implications for fictional narratives which deal with it? Do consumptive characters get to tell their stories, or are they spoken about in fiction? In answering such questions I aim to show that various artists bring to these ideas their own artistic, social and moral concerns and in so doing inflect the consumptive stereotype in ways which often escape the modern reader. What follows is offered as a contribution to the effort to restore aspects of the Victorian consciousness of disease and illness to readings of Victorian texts.

Mary Barton is deservedly classed among the ‘Condition of England’ novels since it deals in harrowing detail with conditions witnessed by Elizabeth Gaskell in Manchester in the 1830s and 1840s. Besides the trials and suffering attendant upon unemployment, it also covers the associated social evils of poor housing and sanitation together with the disease and death that accompany them. We encounter at least 24 deaths in the novel from various causes, including eight forms of disease. Chief among these is typhus,⁴³ but there is mention of its characters suffering the ravages of smallpox,⁴⁴ stroke,⁴⁵ scarlet fever,⁴⁶ diseases of malnutrition,⁴⁷ addictions to alcohol and opium, and tuberculosis. Gaskell also invokes mental illness, although consumption will form the focus of what follows.

Death impinges on the novel, however, not merely as its subject matter. Before the narrative proper opens, the reader is confronted with an epigraph in which a dead speaker begs Charon to accept ‘a triple fare’ as he or she feels it to be the ferryman’s due since the passenger is accompanied by two spirits.⁴⁸ This may be due to the fact that Gaskell wrote the work in the depths of mourning for her son William, who, like John Barton’s son, succumbed to scarlet fever.⁴⁹ This would have alerted contemporary readers to the importance of death when reading the work.

Among this plethora of mortality critics have, however, detected more than a simple exploration of the author’s mourning. John Lucas discerned an aspect in Gaskell’s work which works against her liberal, pious complacency and constitutes an ‘endlessly rewarding unofficial side’, ‘revealing different patterns of inevitability, of antagonisms, misunderstandings, hatred’, a point subscribed to by

Elaine Jordan, in her examination of the political uses of Gothic elements in the novel.⁵⁰ Jenny Uglow has also noticed evidence of an interest in humanity's darker side. She sees Will's account of the mermaid as a little story of the battle between science and myth but also as figuring female desire in the mermaid herself. She also remarks on how John Barton is both a monster and the gentle creature who returns a stray child to its mother while on his way to commit a murder. Uglow traces these and other aspects of the novel to Gaskell's deep prejudices and fears regarding sexuality, violence and political unrest.⁵¹ W. L. James even concludes that the 'overkill' in the novel ultimately represents a statement of the futility of society's bulwarks, be they familial, economic or religious against death. This despite its author's obvious wish to recall contemporary society to Christian attitudes and values and so to a Christian acceptance of death.⁵² I wish to supplement these views and scattered remarks by focusing on one dying character, Esther since her diseased status has been eclipsed by critics' concern with the political and economic circumstances surrounding the action.

W. A. Craik, considering major characters such as John Barton and the mill owner Mr Carson, noticed that Gaskell assessed her characters on the basis of each one's 'whole life and ideas, not for a single act'.⁵³ I hope also to show that this applies to minor characters as well, while indicating something of the involvement of stories in that assessment. Central to Gaskell's view of Esther, and independent of whether she relies on stereotypes, is the story the prostitute tells about herself - it is only through that story of her past, present and implicit gloomy future, that she emerges as an engaging individual who may be assessed at all.

I want to argue against the view that Esther is one of the instances in which Gaskell's control of her material slips into presenting conventional moral utterances or in which she 'presents situations not fully realized or apprehended.'⁵⁴ Esther's story, as she tells it to Jem, shows Gaskell remarkably sympathetic to her motivations and situation, while nonetheless clinging to the rhetoric of 'fallenness' and suffusing it with consumptive metaphors. Unfortunately Alison Williams, the one commentator who addresses the question of disease in Gaskell, restricts her work to the relation between notions of illness and infection on the one hand the morality entailed in the rhetoric of brotherhood and class on the other.⁵⁵ Thus she focuses on the biblical story of Lazarus and Dives, alluded to in Mary Barton, and traces the allusion to Esther's sin as 'the leper-sin' in order to investigate Esther's outcast status. Unfortunately she overlooks Esther's actual disease although she comments on Gaskell's presentation of another consumptive in North and South.⁵⁶

I wish to place Esther in the critical spotlight, showing the extent to which Gaskell's depiction of her is indebted to the stereotypical view of the consumptive in the period. Moreover it will be seen that the implications of this stereotype allow Esther to act as a focus for many of the novel's analyses of the 'darker side' of life: in representing her progressive disease, her addiction, in raising questions of her sanity and her sexuality. Although considerations of space prevent the detailed exposition of the matter here, it can be shown that Esther is complemented at many points in her depiction by John Barton. It can also be shown that Esther occupies a very important position as a backdrop to Mary's growth or development - limited as that may be: both John Barton and Esther herself are afraid that the

heroine will turn out like her ‘fallen’ aunt.⁵⁷ Moreover, the figure of Esther also hangs over the novel’s closing pages whereas John Barton, who was to have been an eponymous hero, has been buried two full Chapters before the end.

Early reviewers of Mary Barton were particularly aware of Esther, although, of course some omitted to mention her at all in the flurry of controversy inspired by the novel’s political resonances. An unsigned review in the Inquirer in November 1848 placed Esther among those characters ‘exquisitely drawn’ and admiringly commented on ‘the heart-breaking misery and inextinguishable love of the poor outcast Esther.’⁵⁸ John Forster also remarked that ‘We have rarely been more affected than by ... the death of Esther, by the interview in which the poor gaudy outcast (a pitiable piece of truth which will force reflection on the most thoughtless) pretends to be what she is not that her services may not be rejected...’⁵⁹

The reader encounters Esther herself on four occasions: when she returns to accost John Barton, when she leaves prison and successfully accosts Jem, when she meets Mary in disguise and finally when she returns to her old home to die. Her troubling presence is felt, however, right from the opening of the novel: at the heart of the idyllic outing to Green Heys Fields lies a disruptive anxiety concerning sexuality and death. This anxiety surfaces again in the second Chapter despite efforts to maintain a semblance of normality at the Bartons, impromptu tea party.⁶⁰ The very first verbal exchange between characters concerns her: after politely greeting John, Wilson asks ‘in a lowered voice’, ‘“Any news of Esther yet?”’⁶¹ It transpires that Mrs Barton’s sobs have been occasioned by her fears that her sister

has ‘drowned herself’ despite John’s view that she would not have chosen her best dress to do it in. We also learn that John’s fears that she has ‘gone off with somebody’ are linked, in his mind, with her beauty and vanity. It is significant, for later developments, that John picks out Esther’s facial appearance for comment in these early pages. He says:

You’ll not see among the Manchester wenches such fresh rosy cheeks, or such black lashes to grey eyes (making them look like black), as my wife and Esther had.⁶²

Her eyes, and facial aspect will feature prominently in the episodes that follow.

Barton explicitly links Esther’s appearance and vanity to her disappearance by recalling, for his friend Wilson, an admonition which he had given his young sister-in-law. He recalls telling her that he had predicted her fate:

Esther, I see what you’ll end at with your artificials, and your fly-away veils, and stopping out when honest women are in their beds; you’ll be a street-walker, Esther, and then don’t you go to think I’ll have you darken my door, though my wife is your sister.⁶³

John Barton, is concerned both for his wife’s vulnerability regarding her sister and for the aunt’s influence over his daughter. Moreover, John’s concern is not misplaced. In an episode in which it is clear that Mary has been swayed by the rich mill owner’s son Harry Carson, Gaskell couches this influence in terms of a metaphor from baking when she notes that, the ‘old leaven, infused years ago by her aunt Esther, fermented in the little bosom, and perhaps all the more for her father’s aversion to the rich and gentle.’⁶⁴ Yet the link between aunt and niece goes beyond mere influence and her putting ‘nonsense’ into the young Mary’s mind - it extends to the *physical* resemblance between the two. Wilson remarks to John, almost in passing, that young Mary too is developing ‘into as fine a lass as one can see on a summer day; more of her mother’s stock than thine,’ inadvertently

hinting that Mary will later be tempted by similar ideas of a dangerous alliance beyond her station.⁶⁵

Esther makes her first appearance in the novel in suitably ominous circumstances. John Barton, a Chartist delegate, has returned from London with his hopes dashed, blacklisted by the mill owners and thus unemployed and starving. In his depression he has resorted to opium, further deepening his already black mood. Moreover, on the night she meets him he is on his way home from a trade union meeting at which ‘desperate plans’ have been debated at a meeting pervaded by ‘fierce gloom.’⁶⁶ It is raining and Barton is stopped by Esther’s light touch from behind upon his arm: ‘He turned, and saw, by the darkness visible of that badly-lighted street, that the woman who stood by him was of no doubtful profession.’⁶⁷ The dark overtones of the situation are suggested by an allusion to Paradise Lost in the paradoxical ‘darkness visible.’⁶⁸ This allusion suggests that Gaskell places both Esther and John among the damned, before the reader has had an opportunity to hear from Esther herself. This suggestion of metaphysical ‘darkness’ is, however, made painfully real in the form of Esther’s ‘faded finery’: her formerly pink bonnet is now only ‘dirty white’ and her dress is bedraggled and ‘wet up to the knees’ and the woman it clothes is shivering from the cold.

Esther, perhaps not wishing to draw attention to the meeting, whispers to John that she needs to speak to him, but is rebuffed with an oath as he sees only a whore accosting him. She persists however, rather revealingly:

Don’t send me away. I’m so out of breath, I cannot say what I would all at once.’ She put her hand to her side, and caught her breath with evident pain.⁶⁹

This is the first indication of Esther's physical condition - while she may be breathless from pacing about in the street waiting for Barton to come out of his meeting, the pain in her side quickly becomes evidence of ill health. This symptom is built on in a way which relies on and harks back to the initial descriptions of Esther in the opening pages. Suspecting it to be Esther, Barton recognises her voice and drags her by the arm to the nearest lamp post so that he may have a better look at her features:

He pushed the bonnet back, and roughly held the face she would fain have averted, to the light, and in her large, unnaturally bright grey eyes, her lovely mouth, half open, as if imploring the forbearance she could not ask for in words, he saw at once the long-lost Esther; she who had caused his wife's death.⁷⁰

The lovely grey eyes which initially characterised her are now 'large' and 'unnaturally bright', a brightness whose unhealthy aspect can only be read as the conventional signifier of consumption.⁷¹ This aspect of the stereotype occurs in both medical and other depictions of the consumptive in this period and we can confidently say that contemporary readers, unlike more recent commentators, would have been aware of the significance of such fleeting details. This is confirmed in John's apprehension of Esther as somehow different from her former self: 'Much like the gay creature of former years; but the glaring paint, the *sharp features*, the changed expression of the whole!' [italic added] While Esther's painted face is an index of her profession, her 'sharp features' are not - she already has the gaunt visage of the wasting consumptive and it is this, as much as the 'fallen' aspect, that gives rise to the 'changed expression of the whole'. Although physicians and doctors were extremely cautious in diagnosing the disease, with even those within the work itself being shown to be very indecisive regarding other illnesses, such caution need not apply in this case. There is sufficient material here

for the reader to see Esther as a consumptive who would have been recognised as such by contemporary readers. According to the consumptive stereotype, it should be remembered, Esther is thus already *marked for an early grave*.

Close on the heels of Thanatos, however, follows Eros, and so it is with the representation of this consumptive. The sexual element in the conventional picture of the consumptive is, however, inflected with violence in this episode.

Traditionally consumption was viewed as caused, amongst other things, by disappointment in love in those predisposed to the disease, and was also viewed as attacking the beautiful, rendering them even more fascinating. It is possible that contemporary readers would have viewed Esther's consumption as caused by her abandonment. This certainly accords well with my findings regarding romantic fiction thirty years later.⁷² Because Esther is not the central character, however, and thus cannot be represented in enough detail to settle the question, it is only possible to say that her story may represent, in miniature, the emplotment of a deserted romantic heroine's consumptive death.

Esther, as we have seen, has been characterised as beautiful even before we learn anything of her illness, however, this erotic element is given a darker hue in this passage. The long sentence quoted above follows one describing how John grabs Esther physically and forces her into the light. The violence is made all the more shocking in that it is linked (by being contained in the same sentence) to Esther's beauty, signalled in the mention of her 'lovely mouth'. There is a suggestion that the violence is bound up with Esther's diseased sexuality, imparting a suggestion of rape to John Barton's 'passion', the 'fire' which Esther inadvertently further

inflames.⁷³ The violence is certainly present verbally in his biting sarcasm.

Although John does not harm Esther he does invoke her death by talk of his determination to see her accused, by her sister if not by himself, on judgement day.

Esther is then thrown against the lamp post where she collapses and lies 'in her weakness, unable to rise.' The end of the encounter is witnessed by a policeman who takes her into custody having concluded that she is intoxicated. Contrary to the constable's and the gaol superintendent's conclusions to the effect that Esther is drunk, it would seem, in the light of the evidence cited above, that Gaskell means her readers to perceive an injustice being committed: Esther's 'half-delirious wails and moanings' are rooted both in despair *and* in illness - they are half delirious and half sensible.⁷⁴ This is borne out by the Chapter's penultimate paragraph reporting that her only concern in those 'moanings' is that Mary's fate not come to resemble her own. Nonetheless, Esther is imprisoned for a month's hard labour for vagrancy and disorderly conduct.

Although Esther is imprisoned for a month she nonetheless continues to influence developments in the Barton household. Having cursed Esther and thrown her violently aside, John experiences an anguishing remorse and is plagued by dreams of the outcast and his injustice towards her. On the following nights he returns to her haunts seeking her in vain. The 'bodily likeness' of Esther and Mary momentarily raises the possibility of Mary's being in a similarly perilous position to her aunt in John's mind, and he is prompted to upbraid her for not encouraging Jem, since this would, to Barton's mind, have removed her from danger.

Unfortunately the friction between father and daughter only precipitates a lengthy estrangement between Jem and Mary.

The Chapter headed 'Jem's Interview With Poor Esther' opens with a paragraph which highlights the way in which a month – the length of Esther's term of imprisonment - could have been filled with either pleasure or the darkest of pain, suffering and mourning and in so doing it gestures towards the tensions between the joyous and the dark sides of the novel. While it is indicated that Esther has been a model prisoner picking her allotted quantity of oakum and 'civil and decorous in her language', the passages preceding her meeting with Jem also intimate that her chief concern in prison has been the project which landed her there in the first place - 'saving' Mary Barton. As with the larger ambiguities surrounding the novel's presentation of Gaskell's political attitudes, the sympathy for Esther is similarly ambivalent. Thus the text notes that 'One thought had haunted her both by night and by day,' but this intimation of a positive concern for her niece is qualified and undercut when the sentence continues: 'with monomaniacal incessancy;' ⁷⁵ Esther is thus nudged into the company of John Barton who is also described as deranged by 'monomania'. ⁷⁶ In the episode in which Esther visits the scene of the murder before going on to see Mary, she is again described in terms of mental illness or madness. There her very 'nature' has been 'rendered *morbid* by the course of life she led' and her thoughts are used to categorise her as having a 'Poor, diseased mind' [*italics added*]. ⁷⁷

Esther is determined to 'tell her tale' to someone close to her niece in an effort to save her and she finally hits upon the idea of Jem, Mary's old playfellow, as a most

reasonable alternative to John Barton. She waylays him on his way home from work one night and is nearly shaken off when Jem recognises her profession from her dress. Unwilling, however, to be cast aside again, she tells him she insists on being heard for Mary's sake and reveals her own identity as Jem's long lost friend. Jem, in his joy at meeting his boyhood friend again momentarily forgets her outcast status and asks her where she has been all these years. She forcefully replies:

Why do you torment me with questions like these? Can you not guess? But the story of my life is wanted to give force to my speech, afterwards I will tell it you. Nay! Don't change your fickle mind now, and say you don't want to hear it. You must hear it and I must tell it; and then see after Mary, and take care she does not become like me.⁷⁸

She begins to tell her life (and death) tale and reaches its most distressing part, prompting Jem to interrupt her in an effort to spare her the mental pain the narrative is evidently causing her, but she retorts: "What you're tired already, are you? but I will tell you; as you've asked for it, you shall hear it. I won't recall the agony of the past for nothing. I will have the relief of telling it.' The story is, of course a fairly conventional one of love and desertion, involving Esther's falling in love with a soldier with whom she has a daughter. The soldier is posted abroad and Esther and her child are abandoned with little money. She attempts to open a haberdashery, but this fails due to her daughter's illness and, to raise money for her sick child, Esther is forced into prostitution. Her daughter dies, leaving Esther shattered. She returns to Manchester and observes her old friends from a distance, too ashamed to contact them again. In this manner she discovers Mary's perilous situation and determines to attempt to intervene.

There is, however, a curious twist in the course of her observation of Mary. She tells how she observed Mary becoming infatuated with Carson's attentions and had begun to become concerned for her niece when,

... I was laid up for a long time with spitting of blood; and could do nothing. I'm sure it made me worse, thinking about what might be happening to Mary. And when I came out, all was going on as before, only she seemed fonder of him than ever ...⁷⁹

Given the graphic detail of other episodes of illness in the novel, for example Davenport's typhus, the modern reader may well overlook the significance of this piece of the picture of the consumptive. This is, nonetheless decisive evidence for Esther's status as consumptive and, even for contemporary medicine, marked the point at which the diagnosis (as well as its implied terminal prognosis) was made.⁸⁰ This makes it painfully ironic when Esther declares that 'I suppose that it would be murder to kill her, but it would be better for her to die than to live *to lead such a life* as I do.' [italics added]⁸¹ The chilling fact is that Esther is already within the jaws of death and that her life consists of dying very, very slowly. The irony is hammered home by Jem's reply, coming out of his own disappointment in love as it does, that 'It would be better. Better we were all dead.' In the light of the connections between mortality and sexuality, it is interesting that an episode of severe consumptive haemophthysis should occur in the novel in a way which favours the development of Mary's and Carson's dangerous relationship.

Esther concludes her story when Jem, moved by what he has heard thus far, attempts to persuade the outcast to return home with him and lead a virtuous life, cared for and helped by his mother. She is forced to refuse his help recognising that she cannot be changed merely by his assistance: she is addicted to alcohol and is thus irremediably committed to her shadowy life. If the likes of her, she

observes, 'did not drink, we could not stand the memory of what we have been, and the thought of what we are, for a day', drink is 'the only thing to keep us from suicide.'

Over and above being bound towards death by consumption, Esther is drawn within the ambit of the dead by her addiction - she is truly an example of what one reviewer called 'the life-in-death'.⁸² The epigraph of this paper is drawn from her response to Jem's insistence that she accompany him to his home and resume her previous life. She says 'I could not lead a virtuous life if I would' and continues,

... I must have my dram. Oh! you don't know the awful nights I have had in prison for want of it,' said she, shuddering, and glaring round with terrified eyes, as if dreading to see some spiritual creature, with dim form, near her. 'It is so frightful to see them,' whispering in tones of wildness, although so low spoken. 'There they go round and round my bed the whole night through. My mother, carrying little Annie (I wonder how they got together) and Mary - and all looking at me with their sad stony eyes....

Esther is not, however, plagued by random hallucinations in the depths of withdrawal, she is haunted by the dead, although she does not realise it when she says she does not understand how her mother (dead since Mary senior was like a mother to her) and her dead daughter have met up. Already dying herself, her hallucinations too are filled with the 'stony eyes' of the dead. This association of Esther with and among the dead is reinforced by the second quotation in my epigraph from the moment at which she visits Mary:

There was a low knock at the door! A strange feeling crept over Mary's heart as if something spiritual were near: as if the dead, so lately present in her dreams, were yet gliding and hovering around her, with their dim dread forms. And yet why dread? Had they not loved her? - and who loved her now? Was she not lonely enough to welcome the spirits of the dead, who had loved her while here?

Here Esther, for the reader and for Mary, is eerily ranked among the dead: she is felt to be 'something spiritual' and perceived 'as if' dead.⁸³ This can be

understood as a function of Mary's distraught mind, but it must surely echo Esther's deathly existence due to her consumption and alcoholism. Like the dead, Esther could indeed be said to love Mary though ambiguously 'alive'.

In the meeting between Esther and Mary there are further signs and symptoms of illness. Mary only vaguely recognises the much-changed Esther and Mary re-examines the face before her: ' "Are you Aunt Hetty?" asked Mary faintly, still looking at the face which was so different from the old recollections of her aunt's fresh dazzling beauty.' Realism here allows age and perhaps the disease to be presented in these terms, but it leaves the question of age *or* disease open and the reader may well construe this as an index of both. There is a similar ambiguity surrounding the text's presentation of Esther's declining Mary's offer of food, when it is noted how painful the refusal is: 'And Esther! How scanty had been her food for days and weeks, her thinly covered bones and pale lips might tell, but her words should never reveal!' This could be both the result of Esther's 'wasting' disease and her starvation.

There can be no ambiguity about the text's comments when it registers Esther's physical difficulties as she tells Mary about her visit to the scene of the murder and the scrap of paper she found there:

The very action of speaking was painful to her, and so interrupted by he hard, raking little cough, which had been her constant annoyance for months, that she was too much engrossed by the physical difficulty of utterance, to be a very close observer.⁸⁴

It would seem that Elizabeth Gaskell had a very good knowledge of the symptoms and progress of consumption, since pain on speaking is one of the symptoms of laryngeal complications of the disease.⁸⁵ The cough, however, is carefully

characterised as having dogged Esther 'for months' again clearly signalling the progressive hold the disease has upon her. It is unusual for consumptives' pain to be registered in literary renditions at this period and its appearance here may be put down to Gaskell's evident concern to capture as many details of the sufferings of the Manchester poor as possible.

Esther makes her final entrance, in the Chapter appropriately and prophetically headed 'Conclusion', only to fulfil the promise of death that has haunted her through every earlier appearance. While Jem and Mary await the day when they are to depart for Canada to begin their new life, Jem discovers that Mary remains unaware of Esther's real status. When, with some difficulty, he enlightens her, in a gesture which reciprocates her aunt's overwhelming earlier concern for Mary, she immediately insists that Esther be found and 'saved'. Jem eventually enlists the help of the police who direct him to one of her haunts. There he meets the landlady who reveals that Esther is conscious of her impending death:

'I know the Butterfly was here,' said she, looking round. 'She came in, the night before last, and said she had not a penny to get a place for shelter; and that if she was far away in the country she could steal aside and die in a copse, or a clough, like the wild animals; but here the police would let no one alone in the streets, and she wanted a spot to die in, in peace.'

Moreover she is now, according to the landlady, 'nought but skin and bone, with a cough to tear her in two.'⁸⁶ Unfortunately for Jem she has disappeared since 'in the restlessness of approaching death, she had longed to be once more in the open air, and had gone forth'.

Jem leaves directions that if Esther is found he is to be contacted and returns to Mary's house where they talk over their plans, having concluded that Esther is lost.

While they sit together in the gathering gloom Jem gives a start and turns his face towards the window. Mary follows his gaze and sees, 'a *white face* pressed against the pane on the outside, gazing intently into the dusky chamber' [italics added] - a vision which parallels that of the shadowy trades union men who visited her father.⁸⁷ Yet the passage continues,

While they watched, as if fascinated by the appearance, and unable to think or stir, a film came over the bright, feverish, glittering eyes outside, and the form sank down to the ground without a struggle of instinctive resistance.⁸⁸

These are the typical eyes of the consumptive, since it is often noted in the contemporary medical literature on consumption, that they are abnormally 'bright', and 'glittering'. This reading is confirmed by the interpolation of the adjective 'feverish' among the others. When the lovers rush out to find Esther the text momentarily suggests that she has finally been totally consumed, leaving only the metonymic heap of faded clothing:

... fallen into what appeared simply a heap of white or light coloured clothes, fainting or dead, lay the poor crushed Butterfly - the once innocent Esther.⁸⁹

Esther's nickname is only used twice, nonetheless it suggests the beauty and finery which has been associated with her all through the novel, as well as something of the brevity which characterises its holder's life. The nickname is also deeply ironic since Esther has been transformed not into a beautiful attractive woman, but a bedraggled dying outcast. Her hold on life is so tenuous that it takes a scientifically knowledgeable Job Legh to find her pulse, detecting a final fluttering in her frail frame.

Having been carried upstairs and laid in a bed Esther rallies once more before she expires, and with her rallying, death becomes the arbitrator as she seeks to

distinguish delirious dream from anguishing reality. She sits upright in bed in a convulsive motion and enquires of her awful life:

‘Has it been a dream, then?’ asked she wildly. Then with a habit, which came like an instinct even in that awful dying hour, her hand sought for a locket which hung concealed in her bosom, and, finding that, she knew all was true which had befallen her since last she lay an innocent girl on that bed.

She fell back, and spoke word never more. She held the locket containing her child’s hair still in her hand, and once or twice she kissed it with a long soft kiss. She cried feebly and sadly as long as she had any strength to cry, and then she died.⁹⁰

Esther, consumed by disease, is haunted by the dead, and dies mourning for her long dead daughter. Garret Stewart has suggested that the mode of death in Victorian fiction often encapsulates and represents the life preceding it and this seems to be borne out by Esther’s death.⁹¹ She has lived a wasting, haunted existence and, finally consumed by guilt and disease, dies mourning the dead.

There is a curious tension between Gaskell’s characters’ views and her narrator’s, most easily discerned where political subjects are at stake. That tension also extends to Esther’s understanding of her own life and experience, captured in her account of her life to Jem. It would seem that the narrator allows Esther to tell an extremely convincing story and to be seen acting in ways which engage the reader’s sympathy while nonetheless deploying alienating Gothic elements and stereotypes of disease and fallenness in the presentation of Esther’s character.

Thus there is a tension between Esther’s view of her illnesses and life and the wider narrative’s perspective on the subject, for example the negative overtones in the allusion to the ‘darkness visible’ of the street in her meeting with John Barton. In fact the touchstone of truth, the locket which distinguishes delirious dream from reality in the sentimental passage above, seems to be involved in an attempt to

paper over these differences by conferring truth on the larger narrative as well as on Esther's motives and experience. This seems borne out by the amount of sentiment which this death-bed scene calls into play. A reader with tear-filled eyes is unlikely to focus clearly on the texts' elision of its negative views of the fallen woman.

Esther's burial is the final element in a long series of associations, which depend on ghostly connotations, addiction and suggestions of madness, linking her to John Barton. Just before the action finally moves to Canada in an attempt to regain the relative innocence of the pastoral opening pages, the burial is reported as follows:

They laid her in one grave with John Barton. And there they lie without name, initial, or date. Only this verse is inscribed upon the stone which covers the remains of these two wanderers:
Psalm ciii. v. 9. - 'For He will not always chide, neither will He keep His anger for ever.'

Rose Busto, perhaps with some thought of the burial of suicides in unmarked graves, has suggested that the absence of Esther's name on the tombstone, together with the replacement of her name by 'Butterfly' implies an obliteration of her identity.⁹² This, however, is too simplistic since the fact of the shared grave, together with the long series of links, consigns Barton and Esther to a shared (and thus exorcised) guilt for all the darker forces in the novel, be they sexual, violent, moral or bound up in disease. It would also seem that the novel cannot contain the forces of Thanatos liberated by its genesis and embodied in Esther and John Barton, simply by containing and interpreting their stories of disease: these forces escape through the cracks of Gaskell's containing narrative and leave the attentive reader profoundly unsettled. The novel's attempt to draw these two deaths into the ambit of a palliative religious morality and simultaneously to contain these forces

fails because the power of these murky domains cannot be expunged by the incantation inscribed on the tombstone. In a similar way the political tensions in the novel cannot finally be resolved by the heroine and hero's leaving them for the New World.

Although Mary Barton has been seen as confronting the full social consequences of *laissez faire* capitalism, the function of the stereotypical consumptive, I have shown, has been overlooked by commentators. In fact there is an intricate system of connections between the depiction of *this* disease, and such areas as the wider matter of Victorian discourses on sexuality (in the form of the 'fallen' women) and an alienating deployment of Gothic conventions in the novel. Although it has not been possible to focus on the matter here, questions surrounding Gaskell's presentation of Mary's experience (especially internally), development or growth must address the issue of disease in the novel. The physical resemblances and parallel predicaments of Mary and Esther in their relations with men both direct the reader to compare the two, in effect to read decline, disease and death as the obverse of growth, health/happiness and life.⁹³ Mary Barton, on the one hand, and her father John and the prostitute Esther on the other, form the two sides of a development/decline opposition and cannot be read separately, although it has been necessary to highlight the example of Esther here.⁹⁴ Indeed, the view that the two sides of the development/decline or death opposition are indissociable is supported by Gaskell's original intention that the work bear John Barton's name rather than Mary's as its title.⁹⁵ It is to be hoped that in future commentators will attend more carefully to the issue of disease in the novel.

Gaskell's Mary Barton shows not only how some of the signifiers of consumption, such as bright glittering eyes, hacking cough, pallor and spitting of blood distinguishing Esther were used, but also provides some indication of other possibilities opened up by the stereotype. We have seen that consumption is brought into relation with 'fallenness', although no sexual or erotic cause for the condition is proposed. This gives rise to tensions in the work: on the one hand Esther's illness and account of her sufferings engender the reader's sympathies, but on the other hand her status as outcast and the associated moral condemnation present in the narrator's comments would have caused the majority of Gaskell's contemporary readers to hesitate to sympathise completely. Through the text's development of a series of physical and situational comparisons between Esther and Mary, the dynamics of the relation between Esther's decline and death are pointedly contrasted with Mary's progress towards success as wife and mother. In this way consumptive decline is used to contrast with and perhaps even to darken the positive moral message offered by the novel. There are yet other ways in which the potential afforded by the dying consumptive and his or her disease can be exploited in fiction, but for this we must turn to two other minor characters, one in Dickens's Bleak House, and the other in Brontë's Jane Eyre.

¹ Elizabeth Gaskell, Mary Barton, A Tale of Manchester Life, ed. M. Daly, (Harmondsworth: Penguin, 1995), p. 231. All further references will take the form 'Gaskell, MB' followed by page number only.

² Gaskell, MB, p. 164.

³ There are at least eight mycobacteria species responsible for pulmonary infections in man: *Mycobacterium tuberculosis*, *Mycobacterium bovis*, *Mycobacterium kansasii*, *Mycobacterium avium*, *Mycobacterium intercellulare*, *Mycobacterium scrofulaceum*, *Mycobacterium malmoeense* and *Mycobacterium xenopi*. The commonest are the first two. See, Clinical Tuberculosis ed. P. D. O. Davies, (London: Chapman and Hall, 1994), pp. 33 - 8. My summary of the clinical picture is drawn from Principles and Practice of Infectious Diseases, ed. C. L. Mandell and others, 3rd edn (London: Churchill Livingstone, 1990), p. 1884 - 1887. Also, Harrison's Principles of Internal

Medicine, ed. K. J. Isselbacher and others, (London: McGraw-Hill, 1994), pp. 710 - 12. See also Mark Caldwell's lucid summary in the 'Introduction' to his The Last Crusade: the War on Consumption 1862 – 1854, (N.Y.: Ateneum, 1988).

⁴ I am indebted to Dr. Cathy Hadfield for clarification, in personal communication, on points regarding the physiological basis for consumptive's febrile symptoms and weight loss.

⁵ The Oxford English Dictionary dates the earliest citation of consumption, meaning 'a wasting of the body by disease; a wasting disease; now applied specifically to pulmonary consumption or phthisis' at 1398. This clearly applied to *any* wasting disease when viewed from a modern perspective, although by 1620 the wasting was associated with the lungs and a citation is given specifically mentioning 'consumption of the lungs.' More interesting perhaps, are the earliest adjectival uses describing persons i.e. 'consumptional', 'consumptionary', 'consumptionish', 'consumptuous' which mostly date from the mid 17th century. These then are much younger. Most interestingly, the substantive, 'consumptive', attached to sufferers also has its earliest date set at 1666 with a citation noting 'The Spring is bad for Consumptives.' Unsurprisingly, given my investigation of figures in Victorian fiction, the only other citation for this form is dated 1880. The earliest use given by the Oxford English Dictionary for 'tuberculosis' as 'any disease characterised by the formation of tubercles' is only in 1860, following the introduction of the term by the Swiss medical professor, J. L. Schonlein in 1839. Moreover, the substantive use of 'tubercular' meaning a person having tuberculosis seems rare, with the dictionary only citing a 1950 American newspaper's use and one again by Malcolm Muggeridge in 1980. In the citations for these two dates the references are specifically to infected persons attending hospitals for respiratory diseases. The reader needs to bear in mind that, although the conceptual structures able to accommodate a bacteriological knowledge were in place in the early nineteenth century, the mythology and the medical apprehension were nonetheless different from our advanced chemical and genetic distinctions regarding the diseases.

⁶ Mark Caldwell has noted that after the discovery of the contagious nature of consumption, American medicine's efforts focused on eradicating or containing the spread of the disease by improving the provision of light and air through building measures and improving drainage to remove the then unknown contaminant. He notes that through the late 1860s and 70s this approach gradually displaced the mythology we will be investigating, in favour of urban planning and domestic science which brought, in its turn, new preconceptions relating to poverty and ignorance in tuberculosis sufferers especially in the wake of the increasing belief that the disease was curable. See Mark Caldwell, The Last Crusade: the War on Consumption 1862 – 1854, p. 29.

⁷ See, Foucault, M. The Birth of the Clinic: An Archaeology of Medical Perception, trans. A. M. Sheridan, (London: Tavistock, 1973), pp. 170 – 71.

⁸ The mythology associated with 'consumption' in the 1830's is different from that associated with the bacteriologically defined affliction associated with vigorous anti-tuberculosis campaigns and the regimes of sanatoria. Vera Pohland locates the shift in Germany in the late nineteenth century following Koch's discovery of the bacillus and its integration into Villemin's proof of its contagious nature. In the context of a system of surveillance and control in sanatoriums, investigations that posit a psychopathology of tuberculosis that tend to criminalise sufferers, and ideas which link it to theories of cultural degeneration, the disease became a negatively stigmatised between 1880 and 1940. See Vera Pohland 'From Positive-Stigma to Negative Stigma. A Shift of the Literary and Medical Representation of Consumption in German Culture' in Disease and Medicine in Modern German Cultures, eds. Rudolf Kaser and Vera Pohland, (Ithaca, N.Y.: Cornell University Press, 1990). p. 152 – 53.

⁹ See William Cullen's First Lines of the Practice of Physic, (Philadelphia: Steiner and Cist, 1781), p. 313.

¹⁰ F. H. Ramadge Consumption Curable, (London: Longman, Rees, Orme, Brown, Green and Longman, 1836), p. 18 cited in Nan M^cMurray, 'And I? I am in a Consumption': The Tuberculosis Patient 1780 – 1930, (Ann Arbor, Mich.: Microforms International, 1986) p. 18.

¹¹ See Edward Smith Consumption: Its Early and Remediable Stages, (Philadelphia: Blanchard and Lea, 1865), p. 20, cited in Nan M^cMurray, 'And I? I am in a Consumption', p. 16.

¹² Thomas Young, A Practical and Historical Treatise on Consumptive Diseases, (London: B.R. Howlett, 1815) p. 43 – 44, cited in M^cMurray p. 29.

¹³ John F. Churchill, Consumption and Tuberculosis, (London: Longman, Green and Co. 1875), p. 262, cited in M^cMurray p. 30.

¹⁴ See S. K. Jennings' A Compendium of Medical Science, (Tuskaloosa, Alabama: Marmaduke, J. Slade, 1847) p. 379, cited in M^cMurray, p. 66.

- ¹⁵ See R. Laennec, A Treatise on Diseases of the Chest, trans. J. Forbes, from the 3rd London Edition (New York: Wood, Collins and Hennay, 1830), p. 333, cited p. 70 in M^cMurray.
- ¹⁶ See James Clarke's A Treatise on Pulmonary Consumption, (London: Sherwood, Gilbert and Piper, 1835), p. 236 – 37.
- ¹⁷ See Ramadge, p. 12.
- ¹⁸ Clarke, p. 40 – 1, cited in M^cMurray p. 52 – 3.
- ¹⁹ See Susan Sontag's Illness as Metaphor and Aids and Its Metaphors, (Harmondsworth: Penguin, 1991), a work aimed at combating the negative effects of illness stereotypes.
- ²⁰ See M^cMurray, p. 55 ff.
- ²¹ Ramadge, p. 15.
- ²² This point is also made by Caldwell who notices the 'radiant' quality associated with dying consumptives. Sontag makes a similar point, which M^cMurray elaborates on, by noting the prevalence of floral imagery. See Caldwell, p. 17, Sontag p. 13, M^cMurray p. 90 – 2.
- ²³ Emily Shore, Journal of Emily Shore, ed. Barbara Timm Gates, (London: University Press of Virginia, 1991), p. 300.
- ²⁴ Ramadge, cited in M^cMurray p. 79.
- ²⁵ M^cMurray cites American examples, see p. 79.
- ²⁶ Chapter 6 will examine British parallels for these American stories.
- ²⁷ M^cMurray p. 14.
- ²⁸ M^cMurray, p 103 citing a story entitled 'The White Lamb' in The Home Circle vol. 6, May 1852.
- ²⁹ See M^cMurray, p. 103.
- ³⁰ See Andrew Duncan, Observations on the Distinguishing Symptoms of the Different Species of Pulmonary Consumption, 2nd Edition, (London: Longman, Hurst, Rees, Orme and Brown, 1816) p. 33.
- ³¹ See Bronte's 'Biographical Notice of Ellis and Acton Bell' in Wuthering Heights, ed. David Daiches, (Harmondsworth: Penguin, 1965), p. 34 – 5.
- ³² See the diaries of Marie Bashkirtseff, The Journal of a Young Artist, trans. M. J. Serrano, (N.Y.: Dutton, 1926) which record her awareness of the langourous beauty and the distinction it confers. Referred to in René and Jean Dubos' The White Plague: Tuberculosis, Man and Society (London: Gollancz, 1953) p. 243.
- ³³ See Susan Sontag's brief summary of the characteristics of the stereotypical consumptive in her Illness as Metaphor and Aids and Its Metaphors, (Harmondsworth: Penguin, 1991), p. 12 – 31.
- ³⁴ *ibid.* p. 15.
- ³⁵ *ibid.* p. 16.
- ³⁶ *ibid.* p. 16.
- ³⁷ Clarke, A Treatise on Pulmonary Consumption, p. 35 – 6.
- ³⁸ *ibid.* p. 14.
- ³⁹ See, René and Jean Dubos, The White Plague, pp. 59 – 61.
- ⁴⁰ See George Gregory, Elements in the Theory and Practice of Medicine, (Philadelphia: Towar and Hogan, 1829), I, p. 430, after the 3rd London edn, cited in M^cMurray, *ibid.* p. 141.
- ⁴¹ Alfred B. Maddock, Pulmonary Consumption, Bronchitis, Asthma and Various Diseases of the Chest Successfully Treated by Medicated Inhalations (Philadelphia: C.W. van Horn, 1855), p. 30 cited in M^cMurray p. 142.
- ⁴² Mark Caldwell, The Last Crusade, p. 19.
- ⁴³ Most notably in the instance of Davenport's death in MB, Ch. 6, pp. 56 - 73. We learn that it is typhus, when Barton goes to a druggist who '... concluded it was typhus fever, prevalent in that neighbourhood...' and then sells Barton an utterly useless concoction for the dying man. See p. 63.
- ⁴⁴ Jem is said to be 'marked by the small-pox' See Gaskell, MB, p. 29.
- ⁴⁵ In the case of Alice.
- ⁴⁶ Barton's son Tom '... fell ill of the scarlet fever...', Gaskell, MB, p. 25.
- ⁴⁷ John Barton himself is described as follows: 'He was below the middle size and slightly made; there was almost a stunted look about him; and his wan, colourless face, gave you the idea, that in his childhood he had suffered from the scanty living consequent upon bad times and improvident habits.' He clearly bears the signs of the bad nutrition which features so prominently in the novel. See Gaskell, MB, p. 7.
- ⁴⁸ Gaskell, MB, p. 395. The epigraph is a quotation from 'Auf der Überfahrt' by Ludwig Uhland.
- ⁴⁹ See Jenny Uglow's Elizabeth Gaskell: A Habit of Stories, (London: Faber and Faber, 1993), pp. 152 – 53, for an account of the bereavement and the genesis of the novel.

⁵⁰ See Elaine Jordan's 'Spectres and Scorpions: Allusion and Confusion in Mary Barton', Literature and History, 7 no. 1, (1981), p. 48. Also John Lucas 'Mrs Gaskell and the Nature of Social Change', Literature and History, 1, (1975), p. 12.

⁵¹ See Uglow, p. 204.

⁵² See W. L. G. James' 'The Portrayal of Death and 'Substance of Life' Aspects of the Modern Reader's Response to 'Victorianism'' in Reading the Victorian Novel: Detail into Form, ed. by Ian Gregor, (N.Y.: Barnes and Noble, 1980), pp. 226 – 42.

⁵³ Craik gives a brief but excellent discussion of the significance of deaths in Mary Barton, noticing how death is integrated into the fabric of life for its characters rather than being an extraneous event. In his view the characters live with and are effected by death, thus making a death such as Alice's seem natural and acceptable. He says Gaskell 'shows herself able to see not only life but death steadily and see it whole, as few English writers before or since have done.' See W. A. Craik's Elizabeth Gaskell and the English Provincial Novel, (London: Methuen, 1975), pp. 21 - 4. For his discussion of her judgement of characters see p. 12.

⁵⁴ See Craik, p. 40.

⁵⁵ See Alison. S. Williams, Disease and Brotherhood in Carlyle, Kingsley, Dickens and Gaskell, (PhD thesis, University of London, 1980). Its final Chapter is devoted to Gaskell.

⁵⁶ Gaskell, MB, p. 159 for the reference to the 'leper-sin'. See Gaskell's presentation of Betty as consumptive in North and South. The ex-factory girl is visited by Margaret and is, for instance described as 'feverish'. See Elizabeth Gaskell, North and South, ed. M. Dodsworth, (Harmondsworth: Penguin, 1970), p. 202.

⁵⁷ In this regard the progressively worsening Esther functions much like Richard Carstone in Dickens's Bleak House, providing the reader with an example of decline towards death while the heroine progresses towards marriage and children.

⁵⁸ See Elizabeth Gaskell: The Critical Heritage, ed. Angus Eason, (London: Routledge, 1991), p. 75.

⁵⁹ Eason, p. 69.

⁶⁰ The party is brought to a dismal close, it will be recalled, by Alice's inadvertently formulating a toast which calls Ester's disappearance to mind, in this case Mrs Barton's already perturbed and anxious mind. She bursts into tears, putting a damper on what should be a convivial gathering.

⁶¹ Gaskell, MB, p. 8.

⁶² Gaskell, MB, p. 9.

⁶³ Gaskell, MB, p. 9. This is one of several deadly plays on the meaning of 'end' as death in the novel; Esther does in fact die as a consequence of homelessness and drink, with the debility that these occasion leading to her contracting tuberculosis. In another instance Jane Wilson seizes on the word 'end' as suggesting death where it was not intended to convey this meaning at all.

⁶⁴ Gaskell, MB, p. 81.

⁶⁵ Rose Mary Busto has pursued the contemporary currency of ideas relating to poor women's marrying for money and the dangers entailed therein, but glosses over Esther as 'a victim of capitalism comparable to the Davenports, when she does not hold out for the highest prize...' See Rose Mary Busto, Prose and Passion: Mrs Gaskell's Presentation of Sexual Relationships Within the Context of Nineteenth-Century Literature and Society, (Unpublished PhD thesis, University of London, 1987), p. 28.

⁶⁶ Gaskell, MB, p. 123.

⁶⁷ Gaskell, MB, p. 123.

⁶⁸ See Milton's Paradise Lost (1674 edition), Book 1, l. 63.

⁶⁹ Gaskell, MB, p. 123.

⁷⁰ Gaskell, MB, p. 124.

⁷¹ The Victorian London physician Francis Hopkins Ramadge noted that persons with a rosy, 'delicate' appearance, *bright eyes*, narrow waist and sharply protruding scapulae and fine bones were more likely to become consumptives. See F. H. Ramadge, Consumption Curable, (London: Longman, Rees, Orme, Brown, Green and Longman, 1836), p. 18.

⁷² See Chapter 6 for my analysis of how this potential is realised in popular romantic fiction by Georgiana Fullerton and Rhoda Broughton.

⁷³ There are other surprising instances of close and startling connections being made between death and sexuality in the novel. In a scene following the death of the Wilson twins Mary touches Jem in a bid to console him on the loss of his brothers. However, Mary's touch is reported as having 'thrilled through his frame' and this sexual passion prompts him to declare his love. In his declaration he explicitly admits that he 'would not give up this minute, when my brothers lie dead,

and father and mother are in such trouble, for all my life that's past and gone. And Mary... you know what makes me feel so blessed.' See Gaskell, MB, p. 79. Jenny Uglow has noted how Harry Carson's sisters chatter about his amorous adventures at the very moment at which his corpse is being carried into a different part of the house. See Uglow, *ibid.* p. 207.

⁷⁴ Gaskell, MB, p. 125.

⁷⁵ Gaskell, MB, p. 158.

⁷⁶ John Barton's depressed concern for his class, for the difference between 'rich and poor', is medicalised when Gaskell writes, 'The same state of feeling which John Barton entertained, if belonging to one who had leisure to think of such things, and physicians to give names to them, would have been called monomania; so haunting, so incessant were the thoughts that pressed upon him.' The text then introduces a metaphor borrowed from William Mumford's The Iron Shroud, which treats these thoughts as destined to cause his death - the metaphor of the Italian punishment whereby a prisoner's cell walls gradually move towards him, closing in and eventually crushing the occupant to death. The passage concludes 'And so day by day, nearer and nearer, came the *diseased* thoughts of John Barton. ... They were preparing his death.' [italics added], p. 169. See H. P. Sucksmith 'Mrs Gaskell's Mary Barton and William Mumford's The Iron Shroud', Nineteenth Century Fiction, 29, (1974 - 75), pp. 460 - 63.

⁷⁷ Gaskell, MB, p. 235, [italics added]. The link between Mary and Esther also includes this aspect of Esther's characterisation since Jem fears that Mary may be reduced to a 'gibbering maniac' in the period in which Mary suffers both mental and physical collapse after Jem's trial. See Gaskell, MB, p. 338.

⁷⁸ Gaskell, MB, p. 160.

⁷⁹ Gaskell, MB, p. 163.

⁸⁰ For an example of contemporary medicine's view on this see Robert Carswell's and Sir James Clark's work. See Robert Carswell, Pathological Anatomy: Illustrations of the Elementary Forms of Disease (London: Longman, Orme, Brown, Green and Longman. 1838,), [unpaginated]. See the Section on 'Tubercle', especially the explanatory notes attached to Figure 3, Plate IV concerning haemophthysis.

⁸¹ Gaskell, MB, p. 163.

⁸² John Barton's addiction to opium draws him into the ambit of death in a different way, through intensifying his depression and being implicated in his murder of Harry Carson. Addiction is, however, viewed in similar terms in both cases. Gaskell goes a long way towards understanding the use of opium as an 'anaesthetic' which blots out the pangs of hunger and despair. She also clearly understands similar motives behind Esther's gin drinking. See Gaskell, MB, p. 169 for her deliberations on opium addiction. Kathleen Tillotson cites this phrase from Charles Kingsley's unsigned review, which appeared in Fraser's Magazine, April 1849, pp. 429 - 33, in her Novels of the Eighteen-Forties, (Oxford: Oxford University Press, 1954), p. 207. The review is reproduced in Eason, *ibid.* p. 152 - 55, where it is attributed to Kingsley.

⁸³ In the course of a series of dreadfully painful ironies centring on Esther's outcast status, and her abandonment by Captain Fergusson, she concocts for herself an ironical address at 'Angel's Meadow' when Mary asks her where she lives. This serves to reinforce her status as fallen angel, but also resonates with her fatal disease: she is soon to be 'with the angels.' See Gaskell, MB, p. 241.

⁸⁴ Gaskell, MB, p. 239.

⁸⁵ Williams notes that, as a girl in Knutsford, Elizabeth Gaskell accompanied her uncle, Dr Peter Holland on his rounds. See W. Gerin's Elizabeth Gaskell: A Biography (Oxford: Oxford University Press, 1976), pp. 10 - 11. It would also seem that she may have had occasion to observe consumptives at first hand in the course of her voluntary work for the Manchester and Salford Provident Society during the Cotton Famine. See Williams, *ibid.* p. 214 and 216.

⁸⁶ Gaskell, MB, p. 391.

⁸⁷ See Gaskell, MB, p. 118, 'Strange faces of pale men, with dark glaring eyes, peered into the inner darkness, and seemed desirous to ascertain if her father was at home.' Elaine Jordan has noted the use of Gothic conventions here, and elsewhere in the novel, to alienate the reader from the trades unions and their seditious desires. See Elaine Jordan, p. 50.

⁸⁸ Gaskell, MB, p. 391.

⁸⁹ Gaskell, MB, p. 392.

⁹⁰ Gaskell, MB, p. 392.

⁹¹ See Ch. 1 of Garrett Stewart's Death Sentences: Styles of Dying in British Fiction, (Cambridge, Mass.: Harvard University Press. 1984). See also Karl S. Guthke's analysis of the western cultural

tradition of last words summing up a life in his Last Words, Variations on a Theme in Cultural History, (Princeton: Princeton University Press), 1992. pp. 48 – 67.

⁹² Busto, p. 90.

⁹³ This is a structural parallel to that found in Dickens's Bleak House. There, as I show elsewhere, the heroine Esther Summerson's progress in the world is contrasted with Richard Carstone's consumptive decline as he becomes ensnared by the Chancery system.

⁹⁴ Which is not to disagree with the critical commonplace which decries the schism between the 'condition of England' plot in the first half and the melodramatic murder story in the second part; rather our findings here ought to suggest something of the positive reasons for this difference.

⁹⁵ See Macdonald Daly's note on the text in Gaskell, MB, p. xxxi.

Chapter 4

All-Consuming Passions: Consumption, Death and Identity in *Jane Eyre* and *Bleak*

House

On many such loungers have the speckled shadows of those trees often fallen; on the like bent head, the bitten nail, the lowering eye, the lingering step, the purposeless and dreamy air, the good consuming and consumed, the life turned sour. This lounge is not shabby yet, but that may come. ¹

... it was such a pleasant evening, so serene, so warm; the still glowing west promised so fairly another fine day on the morrow ... I was noting these things and enjoying them as a child might, when it entered my mind as it had never done before:- ‘How sad to be lying now in a sickbed, and to be in danger of dying! This world is pleasant—it would be dreary to be called from it, and to have to go who knows where?’ ²

This Chapter will further explore the relation between elements in the mythology of the dying consumptive and mid-Victorian fiction, focussing on the fictional role of the individuated or distinguished sufferer. My point of departure will be a consideration of a case in Bleak House which contrasts with the heroine’s growth and apparent recovery from smallpox, although this contrast cannot be analysed here. The instance in Bleak House will be used as a basis for comparison with Jane Eyre. As I have argued above, the contemporary Victorian reader was very likely to have been familiar with cases of tuberculosis and would have readily recognised associated stereotypical ideas in fiction. Given the decline of tuberculosis following the development of antibiotic drugs and the consequent erosion of the stereotype in modern readers’ minds, it is hoped that this Chapter

will alert the reader to the existence and functions of this cluster of ideas and offer new readings of those parts of the texts selected for examination.

Some commentators on Richard Carstone's decline and death, merely include it in lists of the various diseases manifested in the work.³ Few critics even notice his symptoms or trouble themselves with his physical condition, despite the heroine's interest in his health recorded in her part of the novel. Yet it is possible to argue that death is integral to the formation of Esther Summerson's identity in Bleak House, and to show how her 'progress', including her recovery from a smallpox infection, is the inverse of Richard Carstone's decline.⁴ At one point the text metaphorically links the effects of disease on Richard and Esther. In her account of a visit to Richard and Ada, Esther's narrative explicitly likens her occasional, slight resemblance to her former pretty self to the increasingly rare flash of Richard's 'old light-hearted manner' once he begins to sink and sicken under the weight of the Suit.⁵

This Chapter will therefore also present a detailed examination of all the indications of consumption in relation to Richard in an effort to redress the balance, together with some thoughts on Dickens's particular use of that stereotype.⁶

Dickens's use of the stereotype will be compared with Charlotte Brontë's deployment of the consumptive, showing that the dynamics of Jane's development crucially involve questions of life and death. Because these questions of life and death are initially formulated in relation to the consumptive Helen Burns, her spectre, as it were, haunts Jane throughout her difficulties in the later parts of the novel.

When the reader first encounters Richard there is little to suggest that he is in any way distinctive. He is an orphan like Ada and, apparently, Esther herself, and all three have had the good fortune to become the object of John Jarndyce's benevolence. There are, however, early signs of his darker destiny. Within the first few days of their acquaintance with Chancery, Richard unwittingly jokes about the fate of those caught up in the trammels of litigation. As he, Ada and Esther are guided through the dingy interior of Krook's rag and bone shop, arrayed with the debris of the legal profession - worn out gowns, wigs and ink bottles - he notices a heap of salvaged bones and light-heartedly quips to Ada and Esther that one 'had only to fancy ... that yonder bones in a corner, piled together and picked very clean, were the bones of clients, to make the picture complete.'⁷ The dreadful irony is that Richard will also end up in a state very nearly like this as a result of the disease and worry associated with Chancery.

When Richard and Ada begin to form closer emotional ties, they are observed unawares by Jarndyce and Esther, who describes what she sees. They are simultaneously watched by the fanciful Skimpole, who feels Ada looks more like a 'child of the universe' whose path in life should be strewn with roses and lie 'through bowers.' Esther's perspective on Richard and Ada as they enjoy this quiet musical interval in the next room is less rosy, and markedly ambivalent:

Ada sat at the piano; Richard stood beside her, bending down. Upon the wall, their shadows blended together surrounded by strange forms, not without a ghostly motion caught from the unsteady fire, though reflected from motionless objects. Ada touched the notes so softly, and sung so low, that the wind, sighing away to the distant hills, was as audible as the music. The mystery of the future, and the little clue afforded to it by the voice of the present, seemed expressed in the whole picture.⁸

The ambivalence lies in the picture's comprising a number of richly connotative elements. Ada's and Richard's future is precisely what is being hinted at here. They do, as the subsequent paragraph reveals Jarndyce hopes, fall in love and marry, as the shadows 'blended together' suggest they will. Yet it also suggests, in these shadows being surrounded by strange 'ghostly' forms, that a darker fate awaits the pair. This hint of an ominous fate is heightened by the allusion to Ada's music contending with the elemental sound of the wind, suggesting a struggle between the harmonious cultural realm and the indifferent universe which Jarndyce, moments before, had invoked.

As far as aetiology is concerned, it matters little in the nineteenth century whether Richard's psychological constitution causes his disease or whether the disease engenders his frame of mind. The novel shows both aspects affected in illness, seemingly unconcerned to attribute any predisposition to the young man. It is clear, however, that Dickens aimed to show how a corrupt and archaic judicial system - a 'diseased' institution - led to the young hopeful's death.

The first information concerning the larger world which Jarndyce conveys to a recuperating Esther after her bout of smallpox significantly concerns Richard's growing fascination with the Suit and its effects on his relations with his guardian. Esther naively declines to believe that the Cause has 'warped him out of himself' feeling it is almost impossible that Richard could suspect someone so beneficent as John Jarndyce. Jarndyce assures her that

... it is the subtle poison of such abuses to breed such diseases. His blood is infected and objects lose their natural aspects in his sight.

Also, that Richard has ‘been induced to trust in that rotten reed’ which ‘communicates some of its rottenness to everything around him.’⁹ The abuse represented by Chancery is here characterised in ways drawing on the language of disease which resonates with the Chancery system’s deadly and morbid consequences in odious places such as Tom-All-Along’s. The fascinations of Chancery have bred the disease that ‘infects’ the wellsprings of Richard’s life. This metaphor later becomes horrifyingly literal through Richard’s steady but gradual decline into tuberculosis.

This was not, however, incompatible with the distinction between predisposing and initial causes in the contemporary view of consumption. Richard suffers from a weak will and lack of purpose - witness his indecisiveness with regard to the choice of a career. Also, none of his choices seems to satisfy him and he ends up either indifferent to each or so melancholic that this may have brought on his disease, as Sontag following Laennec suggests, but any aetiology is not clearly rendered.¹⁰

Having tried various professions, Richard decides he should enter Kenge and Carboy’s office as a clerk both to acquire useful professional skills and more closely to monitor the suit in which he, like so many, is enmeshed. He returns regularly to Bleak House to see Ada. In the course of these visits, Esther recognises his fascination with the Cause:

... I was not easy in my mind about him. It appeared to me that his industry was all misdirected. I could not find that it led to anything but the formation of delusive hopes in connexion [sic] with the suit already the pernicious cause of so much sorrow and ruin. He had got at the core of that mystery now, he told us; and nothing could be plainer than that the will under which he and Ada were to take, I don’t know how many thousands of

pounds, must be finally established, if there were any sense of justice in the Court of Chancery—but O what a great *if* that sounded in my ears—and that this happy conclusion could not be much longer delayed. He proved this to himself by all the weary arguments on that side he had read, and every one of them sunk him deeper in the infatuation. He had even begun to haunt the court.

At the court he regularly sees Miss Flite, as he informs Esther, who remarks:

... But he never thought— never, my poor, dear, *sanguine* Richard, capable of so much happiness then, and with such better things before him!—what a fatal link was riveting between his fresh youth and her faded age; between his free hopes and her caged birds, and her hungry garret, and her wandering mind. [italics added] ¹¹

Richard causes Esther unease by giving way to the temptation of ‘delusive hopes’, here pointedly emphasised by the conditional, ‘if’, and Esther’s less sanguine recognition of the unlikelihood of their ever being fulfilled. Her detachment from his delusion is also registered by her noting that he proved the likelihood of a successful outcome to ‘himself’ only. His relation to the suit is characterised as an ‘infatuation’ - a term which signals the sexual undertones of this fascination. Richard, the text suggests, is not merely deluded but commits himself to a course of action which will determine his fate and perhaps lead to his death.

Ambiguity is used to signal Richard’s truncated future, in order to maintain the necessary suspense. The text suggests that he and Miss Flite will share a similar fate through their fascination with Chancery in the ‘fatal link ... riveting between his fresh youth and her faded age’. Through the use of the adjective ‘fatal’, foreshadowings of Richard’s destined *fatality* are also summoned up - his particular destiny will be death. The ‘link’ between him and Miss Flite strengthens, not because he is able to pity her, but because he is himself becoming as dangerously fascinated as she is with the Cause.

Gridley's death provides another occasion for Esther to meditate on Richard's destiny. Esther and Richard accompany Miss Flite when Gridley, finally 'worn out' by his struggle against the Chancery system, summons her to be with him in his final hour at George's Shooting Gallery.¹² Gridley reminds Jarndyce, Richard and Esther of his earlier prediction that if he ever surrendered the struggle for true justice, he would either go mad or ensure that he died in the very Court of Chancery, thereby forcing its officers to witness the consequences of their complicity in its evils. He says, with his visitors looking on and Miss Flite holding his hand to comfort him,

This ends it. Of all my old associations, of all my old pursuits and hopes, of all the living and the dead world, this one poor soul alone comes natural to me, and I am fit for. There is a tie of many suffering years between us two, and it is the only tie I ever had on earth that Chancery has not broken.

Gridley's final speech is an admission of his physical defeat: '... I am worn out. How long I have been wearing out, I don't know; I seemed to break down in an hour.' He continues hoping that the Chancery officials never get to hear of his defeat. Despite Bucket's best efforts to rouse his old opponent's fiery animosity and therewith the waning man, Gridley slumps back, dead in his chair. Esther comments :

The sun was down, the light had gradually stolen from the roof, and the shadow had crept upward. But, to me, the shadow of that pair, one living and one dead, fell heavier on Richard's departure, than the darkness of the heaviest night. And through Richard's farewell words I heard it echoed:

Of all my old associations, of all my old pursuits and hopes, of all the living and the dead world, this one poor soul alone comes natural to me, and I am fit for. There is a tie of many suffering years between us two, and it is the only tie I ever had that Chancery has not broken!¹³

The light imagery deployed when Ada sings to Richard, with darkness coming up from below to obscure the scene, parallels the shadows which creep up and obscure

Lady Dedlock's picture at Chesney Wold - a symbolic link exists between her being overwhelmed by dark forces and Gridley being overwhelmed by Chancery. It is curious that Gridley invokes both the living '*and the dead world,*' since Miss Flite is lively enough in her own deluded way. She also, however, inhabits the margins of physical obliteration: on her visit after the smallpox episode, she exhibits her horribly thin arm to the recuperating Esther. Gridley's invocation of both living and dead merges the distinction, suggesting that Miss Flite is tinged with death. Elsewhere in the text, life and death are not radically different things - social neglect ensures that the cemetery where Nemo's body lies is a domain where life is close on death and death corrupts life.

It is important here that, in Esther's estimation, Richard is drawn into this symbolic complex - his fate is signalled by Gridley's and Miss Flite's shadows falling across his departure. Gridley's words echo in Richard's farewell words because he has embarked on a course which Esther senses will end in a similar way. In the Chapter entitled 'Beginning the World', Richard's final departure unites him with many individuals, but the tie that will ultimately be stressed will be one that manifestly resists destruction by Chancery - the tie binding him to Ada.

Although Miss Flite is mad, like the seer Tiresias she is permitted some insight - she concedes that it would be wiser not to attend to Chancery as it is 'so very wearing to be in expectation of what never comes... wearing ... to the bone'.¹⁴ Moreover, her painful familiarity with the destructive consequences of Chancery makes her opinion a valuable one. She tells the convalescing Esther how she became involved in, and entranced by Chancery, explaining how all her family

were drawn into Chancery proceedings and eventually to their destruction. She even pinpoints the court's symbols as the source of a mystical attraction capable of drawing the sense, peace, good looks and 'all the good qualities' out of the litigants.

Miss Flite claims that her intimate knowledge of Chancery's attractions makes her the best judge of their operation in others:

"... I know far better than they do, when the attraction has begun. I know the signs, my dear. I saw them begin in Gridley. And I saw them end. Fitz-Jarndyce, my love," speaking low again, "I saw them beginning in our friend the Ward in Jarndyce. Let someone hold him back. Or he'll be drawn to ruin."¹⁵

Her experience of Chancery is extensive enough to include the entire fascination from beginning to mortal end in Gridley's case - and she clearly believes that Richard will come to the same end.

Having fallen under Chancery's spell, in direct opposition to Jarndyce's entreaties, Richard arranges to meet Esther at a public house in the village near Chesney Wold. He arrives in cheerful spirits, but Esther notices the change that has come over him:

So young and handsome, and in all respects so perfectly the opposite of Miss Flite! And yet, in the clouded, eager, seeking look that passed over him, so dreadfully like her!¹⁶

Esther later takes the opportunity to encourage Richard to rest instead of pursuing his part in the Chancery suit. In anticipation of the *spes phthisica* at his death, he responds that were she,

".. living in an unfinished house, liable to have the roof put on or taken off—to be from top to bottom pulled down or built up—tomorrow, next day, next week, next year—you would find it hard to rest or settle. So do I. Now? There's no now for us suitors."

I could almost have believed in the attraction on which my poor little wandering friend had expatiated, when I saw again the darkened look of last night. Terrible to think, it had in it also a shade of that unfortunate man who had died.¹⁷

Spes phthisica is the characteristic psychological denial of the imminence of death, usually manifest in the patient's hopeless planning for the future. Esther senses Richard's deadly resemblance to Gridley. When she upbraids Richard for having lost some of his perspective in accusing Jarndyce of only taking care of his own interests in Jarndyce and Jarndyce, she does so by reminding him how much he has changed. The language of Richard's reply ranks the negative moral influence of Law alongside the array of physically corrupting agents in the novel:

If I have the misfortune to be under that influence, so has he. ... it taints everybody. You know it taints everybody. You have heard him say so fifty times¹⁸

Ester sees Richard's expression of his determination to attempt the impossible in bringing the suit to an end as sadly reminiscent of Gridley: ' "[the suit] can't last forever," returned Richard, with a fierceness kindling in him which again presented to me that last sad reminder...' ¹⁹ Richard resolves to 'make it the object of my life.' Losing the case, however, means forfeiting his very life.

He does realise, in a way which foreshadows his end, that he may have lost all perspective on the matter, going so far as to promise to make reparation to Jarndyce once he is clear of the case, should Esther have been proven right.²⁰ Esther's formulation of Richard's condition, that '...Richard was losing himself, and scattering his whole life to the winds', captures his physical and psychological dissolution.

Closer examination of the professional and financial relations between Richard and his solicitor, Mr Vholes, provides insight into the young litigant's medical condition. In particular, the many allusions to the lawyer's cannibalism represent not only his sapping Richard's meagre wealth, but also his *visibly* embodying what otherwise remains active but buried within the obscure depths of Richard's body.²¹ It is then particularly fitting that Vholes dresses like an undertaker and rides off with Richard in a carriage drawn by a horse resembling that of the Apocalypse.

When Esther is introduced to Vholes she immediately notices how cold and deathly he is:

a sallow man with pinched lips that looked as if they were cold, a red eruption here and there upon his face, tall and thin, about fifty years of age, high shouldered, and stooping. Dressed in black, black gloved, and buttoned up to the chin, there was nothing so remarkable in him as *a lifeless manner*, and a slow fixed way he had of looking at Richard. [emphasis added]²²

In a text featuring a devastating skin disease such as Esther's, Vholes's skin condition distinguishes his evil. Elsewhere Vholes is described as secretly picking 'at one of the red pimples on his *yellow* face with his black glove.'²³ If the legal profession is indeed morally diseased, as the possible wordplay on the name of the case 'Jarndyce and Jarndyce' and the word 'jaundice' suggests, Vholes is the only lawyer who exhibits these physical signs in his yellow appearance. Vholes is not so much an instance of diseased life, however, as a diseased zombie - the face that Vholes picks at is 'cold' with more than Lady Dedlock's emotional repression. His sombre attire, lifeless manner and almost hypnotic gaze all mark the solicitor as associated with death.²⁴ This symbolism assumes mythical overtones when he and Richard finally leave the inn together:

Richard's high spirits carrying everything before them, we all went out together to the top of the hill above the village, where he had ordered a gig to wait; and where he found a man with a lantern standing at the head of the gaunt pale horse that had been harnessed to it.

This 'gaunt pale horse' is an allusion to the passage, 'And I looked, and beheld a pale horse: and his name that sat on him was Death' at Revelations 6. 8.

Esther's acute observation of lawyer and client catches the contrast between living and dead, prey and predator:

I shall never forget those two seated side by side in the lantern's light; Richard all flush and fire and laughter, *with the reins in his hand*; Mr. Vholes, quite still, black-gloved, and buttoned up, looking at him as if he were looking at his prey and charming it. I have before me the whole picture of the warm dark night, the summer lightening, the dusty track of the road closed in by hedgerows and high trees, the gaunt pale horse with his ears pricked up, and the driving away at speed to Jarndyce and Jarndyce. [emphasis added]²⁵

Besides Richard's assuming the ominous role of driver, there is an emphasis on Richard's high spirits - a stress on the 'flush and fire' - which brings him within the ambit of the mythology of consumption. He has the feverish exuberance characteristic of the consumptive patient. The threat, however, inherent in this is embodied or represented by the lawyer. Vholes preys upon his client, leading us to suspect that he functions both to embody the parasitic nature of his profession and to objectify the disease which finally *consumes* Richard. Thus Vholes surveys Richard, 'as if he were making a meal of him with his eyes as well as with his professional appetite.'²⁶ Elsewhere Vholes regards his host 'immovable in attitude and never winking his hungry eyes.'²⁷ Vholes also addresses Richard as 'Mr. C.'²⁸ Although the resonances of the names Dickens uses are legendary, this curious, abbreviated form of address is unprecedented in this novel.²⁹ I suggest

that it lexically represents the lawyer's devouring his client through eroding his name, and obliquely signals Richard's illness - he is Mr Consumption.

While sarcastically attacking Vholes's hypocritical 'respectability,' the text again considers his 'impaired', but nonetheless highly 'respectable' digestion, appending a curiously forced amalgam of biblical and proverbial allusions to this observation: noting '*And he is making hay of the grass which is flesh, for his three daughters.*' [emphasis added].³⁰ The combined allusions alongside the erroneous, ungrammatical 'And' suggest some connection between Vholes' digestion and the use of his client's flesh as a resource for his own betterment. Moreover, he is of a class of lawyers who would be ruined should the legal system be reformed. The impact of legal reform is presented in a way that allows for the conventional reading of lawyers in the story as money-grubbing parasites, but also accommodates a metaphoric reference to cannibalism:

As though, Mr. Vholes and his relations being minor cannibal chiefs, and it being proposed to abolish cannibalism, indignant champions were to put the case thus: Make man-eating unlawful, and you starve the Vholes!³¹

This metaphor, of unusual uses of flesh, is extended when Vholes, removing his gloves, is described 'as if he were skinning his hands,' and doffing his hat as though 'he were scalping himself.' Vholes's 'cannibalism' relates to his disturbed digestion. Vholes himself associates this problem with his acting for his declining client: 'My digestive functions, as you may have heard me mention, are not in a good state, and rest might improve them; but I shall not rest, sir, while I am your representative.'³² He also unaccountably declines lunch after his journey to St Albans.³³ When Richard finally leaves the end-of-term interview with his representative, Vholes balances his accounts by squaring the debts incurred on

Richard's behalf against the remittance his client has scraped together, in his accustomed predatory manner, as

... might an industrious fox, or bear, make up his account of chickens or stray travellers with an eye to his cubs; not to disparage by that word the three raw-visaged, lank, and buttoned-up maidens, who dwell with the parent Vholes in an earthy cottage situated in a damp garden at Kennington.³⁴

It's little wonder that Miss Flite suggests to Esther that she should dislike Vholes, calling him a 'Dan-gerous man.'³⁵

The interview itself resonates with death: Vholes taps on his desk, declaring it to be the rock upon which Richard has built his part in the Cause. The 'rock,' sounds 'as hollow as a coffin. Not to Richard, though. There is encouragement in the sound to him.'³⁶ Later, Vholes again refers metaphorically to his services as the 'rock' which Richard's hopes are founded on. This time, however, the allusion echoes that describing Symonds Inn as 'like a large dust-bin of two compartments and a sifter.'³⁷ So when Vholes stresses the solidity of his services by again tapping on the desk: '... rapping the hollow desk, with a sound as if ashes were falling on ashes, and dust on dust, a rock', although Richard cannot recognise the sounds as physical echoes of the burial ceremony that awaits him, the reader cannot fail to notice the allusion. Richard becomes hopeful and, fired up by Vholes, inveighs against John Jarndyce. In his fervour he also emphasises his words by similarly tapping on the 'rock of trust.'³⁸

Richard's change is marked as a rapid 'depreciation,' the text contrasting his first and most recent visits to the Inns and noting how his heart becomes 'heavy with corroding care, suspense, distrust, and doubt'. A darker overtone emerges when

his obsessive opposition to Jarndyce in the Cause is said to be ‘*resolving his existence into itself*’ [emphasis added] - Richard’s very existence is being dissolved, in ways beyond the merely spiritual or mental. Even his exit has an ominous ring: he crosses the square brooding and biting his nails finally to be ‘*swallowed up by the shadow of the southern gateway.*’³⁹

Richard, distracted, fails to notice Mr Guppy and his friend Weevle whom he passes as he leaves. Guppy, accustomed to seeing care-worn litigants, notices him, however, and remarks to Weevle, that ‘there’s combustion going on there! It’s not a case of Spontaneous, but its smouldering combustion it is.’⁴⁰ This conjures up Consumption’s feverous component as well as his obvious mental fulmination. Richard is also subject to periods of euphoric optimism and desire to win the Case. Although lacking the markers of sexual desire, it could, nonetheless, be said that his passion for the Cause is a misdirected form of sexual passion. Richard’s ardour for the Cause is certainly sufficiently powerful to offer a reason for his being ‘consumed’ by it.⁴¹ At one point Ester hopes that Richard will, ‘exhaust his ardour in the Chancery suit by being in so very earnest in it.’ Perhaps this is Dickens’s veiled way of gesturing towards the sexual part of the myth.⁴² Richard also clearly recognises that he is possessed by a profound fascination: ‘... I am afraid I have wanted an object; But I have an object now—or it has me—and it is too late to discuss it.’⁴³ This is, however, as close as Dickens comes to the sexual side of the stereotype.

The idea of consumption, of being consumed, is in fact used in relation to Richard's state of body and mind, although the disease remains unnamed. The passage used as the epigraph to this Chapter says of the pensive litigant:

On many such loungers have the speckled shadows of those trees often fallen; on the like bent head, the bitten nail, the lowering eye, the lingering step, the purposeless and dreamy air, the good consuming and consumed, the life turned sour. This lounge is not shabby yet, but that may come.⁴⁴

His mental state is metonymically described through the bodily indicators of dejection, but the shadows also fall on the cares that these betray, cares which, like the disease Richard has, eat into his spiritual merits and finally physically destroy his soured life altogether.

When Vholes, as a parting gesture, touches Esther's hand with his 'dead glove,' she observes that it 'scarcely seemed to have a hand in it.' His long, thin, menacing shadow leaves Esther thinking of its effects as he travels back to London, 'on the outside of the coach, passing over all the sunny landscape between us and London, chilling the seed in the ground as it glided along.'⁴⁵ It seems Vholes has only to cast his shadow over any form of incipient life to bring it within death's ambit.

Esther finds Richard worn depressed, dishevelled and on the verge of resigning his commission when she visits in an attempt to help him out of his difficulties. Yet he is not prematurely old - there is something paradoxical about Richard's appearance (as there is in ideas associated with living death), since he is 'worn and haggard, ... even in the fullness of his handsome youth.'⁴⁶ His final attempt to establish himself in a profession has failed because he has 'no care, no mind, no heart, no soul, but for one thing.' His pursuit of the Cause is, he realises, so intense and

passionate that he admits it could be called madness. She hands him Ada's letter and he is so overwhelmed by its offer of her small fortune to help keep him in his profession, that he breaks down, crying 'I—I wish I was dead!' ⁴⁷

When Esther and Woodcourt meet Richard she asks of the doctor whether he has seen any change in him. He replies:

It is not ... his being so much younger or older, or thinner or fatter, or paler or ruddier, as there being upon his face such a singular expression. I never saw so remarkable a look in a young person. One cannot say that it is all anxiety, or all weariness; yet it is both and like ungrown despair.

When Esther enquires whether he thinks Richard ill, he says 'No. He looked robust in body' merely noting that he appeared physically healthy, but hinting that there appears to be some medical reason for concern regarding his mental state. ⁴⁸

When Woodcourt calls, he comes upon Richard in a daydream, finding him as dishevelled as he was in Deal. Richard jokes about Woodcourt's appearing like a ghost from that daydream, but Woodcourt's playful response is to inquire how the 'mortal world' goes - unintentionally suggesting Richard's peculiar association with death.

Besides the often commented upon infectious miasmas, there are other ways in which death is in the air in this novel. Esther and Ada go to visit Richard in his new London apartment, and on the way Esther notices that she 'thought there were more funerals passing along the dismal pavements, than I had seen before.' ⁴⁹

When they reach Richard's apartment they find his 'name in great white letters on a hearse-like panel.' ⁵⁰ Esther notices 'how *sunken* and *how large his eyes appeared*. how dry his lips were and how his finger-nails were all bitten away'. Large eyes were a prominent feature among the characteristics associated with the

consumptive at this time. This appearance prompts Esther to enquire whether Richard would not fare better away from these sullen legal precincts. Richard, with dreadful irony, responds by saying that his departure from Symonds Inn ‘... can only come about in one of two ways... Either the suit must be ended, Esther, or the suitor,’ optimistically predicting that it will be the suit. Yet this is scarcely likely, surrounded as he is by the likes of Vholes and ensconced in an apartment whose door resembles a hearse’s panels. The reader remembers that there are other, metaphoric references to the grave in terms of houses and lodgings elsewhere in the novel, for example, Tulkinghorn’s grave and Nemo’s final abode.

Richard’s mental condition, as Esther sees it, marks his body. She remarks on his fiercely hungry, yet unsustainable, ‘hopefulness’ and how it pained her to observe the signs of this anxiety. Moreover, these changes have become irreversible and the language used to suggest this also invokes death:

... the commentary upon it now indelibly written on his handsome face, made it far more distressing than it used to be. I say indelibly; for I felt persuaded that if the fatal cause could have been for ever terminated, according to his brightest visions, in that same hour, the traces of the premature anxiety, self-reproach, and disappointment it had occasioned him, would have remained upon his features to the hour of his death.⁵¹

Richard’s despondency and disappointment blight his physical appearance as surely as smallpox does Esther’s features and identity. The invocation of death here, coming as it does in a series of allusions to mortality - is more than a mere manner of speaking. It is interesting that Esther regularly remarks on his ‘handsome’ appearance, perhaps a signifier of the beauty of the dying consumptive.

Having been surprised by the unexpected announcement of Ada and Richard’s marriage, Esther reluctantly leaves her dear friend with Richard in Symonds Inn,

but secretly returns some hours later with Charley. They walk up and down outside the apartment, and Esther finally goes up the dark stairs to the apartment's front door where she quietly listens to the voices within:

... in the musty rotting silence of the house, [I] believed that I could hear the murmur of their young voices. I put my lips to the hearse-like panel of the door, as a kiss for my dear, and came quietly down again....⁵²

While the gesture is clearly a farewell to the confidant Esther has had since her arrival in London, the reference to the deathly quality of the door and house relates to the room's occupants. Esther's kiss resembles the impassioned kissing of coffins noted by Philippe Aries, leaving the reader fearing that Ada has crossed into the region of the dead behind this hearse-like door.⁵³

Even once wed, Richard's health continues to cause concern. Esther is afraid that the hours Woodcourt spends with Richard indicate a deterioration in the young litigant's delicate health. Woodcourt offers his professional opinion in an equivocal manner designed to set her mind at ease, but leaves the final verdict open:

No, no, believe me; not ill but not quite well. He was *depressed and faint*—you know he gets so worried and so worn sometimes—and Ada sent to me of course, and when I came home I found her note, and came straight here. Well, Richard revived....[italics added]⁵⁴

Richard inhabits the uncertain mental and physical ground between health and illness occupied by the stereotypical consumptive, neither ill nor quite well, mentally fatigued and physically exhausted. It seems Woodcourt knows more than he reveals or that he wishes to spare Esther unnecessary worry. I will return to the question of Richard's condition and the probable diagnosis, however, the disease is never named, which is common in the fiction of the period. Still, there is no noticeable shift from Richard being 'not quite well' to Woodcourt's declaring that

he has no bodily illness later.⁵⁵ Thus Jarndyce equivocally assures Esther in Chapter LX that Woodcourt's verdict on Richard is unchanged: 'He knows of no *direct* bodily illness that he has; on the contrary, he believes that he has none. Yet he is not easy about him; who *can* be?'⁵⁶ The word 'direct,' signals Woodcourt's continuing uncertainty and apprehension despite Richard's apparent health - which is commensurate with the conventional picture of the consumptive.

Richard's unrelenting obsession with the Cause leads Miss Flite to appoint him as executor in her will in the event of her being 'worn out.' She informs Esther that she had intended 'to nominate, constitute, and appoint poor Gridley', whose pursuit of the case was as assiduous as Richard's turned out to be, but who 'wore out', ominously prompting Richard to be 'appointed his successor.'⁵⁷ He literally takes the man from Shropshire's place.

Vholes expresses a curious interest in his client's health on the occasion that he and Esther converse in Richard's apartment. Esther tells him that Richard 'looks very ill. Dreadfully anxious.' She also observes that Vholes is:

So slow, so eager, so bloodless and gaunt, I felt as if Richard were *wasting away* beneath the eyes of this adviser, and there were something of the Vampire in him. [italics added]⁵⁸

By this stage Richard has become shabby,

thin and languid, slovenly in his dress, abstracted in his manner, forcing his spirits now and then, and *at other intervals relapsing into a dull thoughtfulness*. About his *large bright eyes* that used to be so merry, *there was a wanness and a restlessness* that changed them altogether. I cannot use the expression that he looked old. There is a ruin of youth which is not like age; and into such a ruin Richard's youth and youthful beauty had all fallen away.⁵⁹ [emphasis added]

This passage contains most of consumption's stereotypical signs: characteristic bright eyes, wasting, languor and the characteristic pallor. These symptoms suggest, without a doubt, that Richard is consumptive. Also, his appetite is disturbed - he eats little and then without interest. Although Vholes has dinner with them, no mention is made of what he consumes.

Esther initially believes 'his old light-hearted manner' has finally deserted him, but then notices that 'it shone out of him sometimes, as I had occasionally known little momentary glimpses of my own old face to look out upon me from the glass.'⁶⁰ The presentation of Richard's decline functions as a dark backdrop for the equally chilling complexities of Esther's psychological evolution, as I have discussed elsewhere. If Esther's identity is a psychologically complex, spiralling evolution, with death at its centre (through the effects of smallpox on her appearance and her resemblance to her living and later dead mother), then Richard constitutes a variant on that mortal theme. In his case, however, the reader only has access to Esther's necessarily external representation of his diseased decline following his 'infection' with the fascinations of the Cause.

The months pass and Richard continues his fatal course, gradually wearing his life away as he allows his diminishing vitality to be sapped by the hopeless pursuit.⁶¹ By this time only Woodcourt's caring benevolence can rouse him from his absorption 'in his fixed idea,' especially, as Esther notes, 'when he sunk into *a lethargy of mind and body that alarmed us greatly*, and the returns of which became more frequent as the months went on.' Once his and Ada's fortunes are joined together in marriage, he is inspired to even greater fervour in his involvement in the suit.⁶²

The discovery of a will which entirely changes the complexion of the Cause precipitates Richard into a ‘burst of business and agitation that buoyed him up for a little time;’ another characteristic of the consumptive. The very language characterising this energetic activity resonates with disease. Esther notes that he ‘had lost the elasticity even of hope now, and seemed ... to retain only its *feverish anxieties*.’⁶³

When the suit eventually gets to court, Richard is ‘extremely agitated, and *was so weak and low*, though his illness was still of the mind’ [emphasis added], clearly showing the physical weakness that is associated with his disorder.⁶⁴ When Richard and Woodcourt learn that the whole estate has been ‘absorbed in costs’, the doctor’s first thought is for the effect this will have on his patient’s delicate health. Esther also immediately concludes that the shock may well come as the fatal stroke of his protracted decline:

... I too had seen so much of his gradual decay, that what my dear girl had said to me in the fullness of her foreboding love, sounded like a knell in my ears.

Perhaps appropriately, Wholes’ final act in the novel is to tell Esther and Woodcourt where he has abandoned his now useless client as he gives Esther,

that slowly devouring look of his, while twisting up the strings of his bag ... he gave one gasp as if he had swallowed the last morsel of his client, and his black buttoned-up unwholesome figure glided away...⁶⁵

The narrative discreetly avoids directly presenting the spectacle of Richard as Woodcourt finds him in the court and, instead, Esther learns from Ada that,

Allan had found him sitting in a corner of the court, ... like a stone figure. On being roused, he had broken away, and made as if he would have

spoken in a fierce voice to the judge. He was stopped by his mouth being full of blood, and Allan had brought him home.⁶⁶

His momentary fury resembles Gridley's, and like the fierce 'man from Shropshire' only his illness prevents him voicing his opposition to Chancery's deep injustice.

When Esther at last sees him, he appears, '*quite destitute of colour*, and now that I saw him without his seeing me I fully saw, for the first time, how worn away he was. But he looked *handsomer* than I had seen him look for many a day.'

[emphasis added]. Despite the pallor and haggard look, Richard is at his most attractive, echoing the belief that the consumptive was intensely beautiful.

True to the stereotype, Richard's death is pleasant, apparently painless and characterised by *spes phthisica*.⁶⁷ He is cheerful and quietly happy at Esther's prospective marriage. Moreover, he finally gains some insight into his misjudgement of Jarndyce, transcending, as is typical for the consumptive death, his personal limitations on his deathbed. He resolves, despite his very weak condition, to make a fresh start once again, to 'begin the world,' on a new footing, another popular medical and non-medical representation of the consumptive. In the contemporary view, dying consumptives became convinced they would recover, even planning for the future in the face of certain, inevitable death, as Richard does. *Spes phthisica*, however, is given another dimension by being integrated into the novel. Given the evidence in Dickens's text and the wide use of the stereotype, we can conclude that the contemporary reader would have recognised or suspected Richard's consumptive status and anticipated his final delusion regarding his health. If, as both popular opinion and the medicine of the time believed, consumption transformed the sufferer's life into a protracted experience of dying, then, in one sense, Richard's portrayal in the novel is one of a protracted *spes*

phthisica. Begging Ada's forgiveness, and with a confused view that he can still 'begin the world,' Richard dies quietly and painlessly in Ada's arms.

We are offered two perspectives on Richard's death. Esther optimistically feels that Richard begins the world by entering into the afterlife, beginning the 'world that sets this right.' Opposing this religious interpretation of *spes phthisica*, is Miss Flite's puzzling, although also optimistic, view. The little madwoman, inhabiting her own delusional world says that she has 'given her birds', including a pair dubbed 'the Wards in Jarndyce,' 'their liberty,' which she had promised only to do once she had received a Judgement. The reader is left, as with the moral dilemma of the whole novel, to choose either Miss Flite's darker, insane and only partially comprehensible picture on the one hand, or Esther's ultimately unconvincing religious interpretation on the other. These negative resonances accord with the psychological disquiet which remains apparent due to Esther's scarred complexion in the closing pages of Bleak House.

A more positive example of the intimate relation between a central character and a consumptive is to be found in Jane Eyre, a novel of growth and development.

Jane Eyre is, as its subtitle makes explicit, the narrative of its heroine's *life*. As such, the reader would not expect death to occupy a prominent place in it. The Brontë industry has insisted, however, that there is a close relation between Charlotte's life and work, and since her sisters Maria, Elizabeth, Anne, Emily, and brother Branwell all succumbed to tuberculous infections, this raises the question of consumption's role in Jane Eyre.⁶⁸

Deaths from consumption, and death in general, are more important in this novel than might at first appear. Many deaths occur within the work: many unnamed girls die of typhus at Lowood, Helen Burns, Mrs Reed, John Reed and Bertha Rochester all die, and St John Rivers is dying as the novel ends. Also, Jane's parents' early deaths render her an orphan, although this is not strictly an event in the novel. Many allusions and passing references to death are made: Jane dreams of falling to her death along with an unspecified infant, life at Thornfield Hall has become a 'living death' for Rochester because he feels chained to its insane inhabitant and is nearly driven to suicide as a result. He threatens suicide to prevent Jane from leaving and fears she lies dead in a ditch once she has fled. This could be attributed to the Gothic inheritance active in the novel, but is also compatible with Robert Keefe's psychoanalytic investigations, in which these references are attributed to the author's and heroine's unconscious guilt regarding the deaths in the real and represented worlds. Both these views, however, neglect the place of consumption in the novel.⁶⁹

Following on from my view that Dickens's Richard Carstone functions as a dark backdrop for problems involving death and disease in Esther Summerson's identity, I shall pursue a similar direction of inquiry regarding Jane Eyre's 'progress', especially since the work presents itself as the narrative of a *life*. Questions of death from the perspective of the myth of the dying consumptive easily follow, since both novels contain consumptives.

Within the opening pages of Jane Eyre it is established that the little heroine's sense of being set apart is bound up with her macabre fascinations. Forced into

seclusion by the cold wintry weather and the emotional severity of the Reed family home, Jane takes up a favourite book and is understandably drawn to illustrations of solitary and deserted places and ‘melancholy isles’. She is intrigued by a catalogue of icy northern zones, not merely because they are cold and desolate: Jane perceives their danger for she explains that, while generally uninteresting, the text contained fascinating, evocative allusions to frozen ‘death-white realms’. She not only goes on to interpret the illustrations that follow, but is also deeply impressed by a series of representations of deathly scenes: a ‘quite solitary churchyard, with its inscribed headstone,’ two becalmed ships which are ‘marine phantoms’ and a scene of ‘a black, horned thing, seated on a rock, surveying a distant crowd surrounding a gallows.’⁷⁰ Despite her admittedly imperfect understanding of, or feelings about, the pictures and text, as readers we must conclude that Jane is ‘profoundly’ interested in things deathly from the outset.

When Mrs Reed imprisons Jane in ‘the red-room’ as a punishment for defending herself against John Reed, Jane uses the solitude to examine her appearance in a mirror rather than her conscience:

All looked colder and darker in that visionary hollow than in reality: and the strange little figure there gazing at me, with a white face and arms specking the gloom, and glittering eyes of fear moving where all else was still, had the effect of a real spirit: I thought it like one of the tiny phantoms, half fairy, half imp, Bessie’s evening stories represented as coming out of lone, ferny dells in moors, and appearing before the eyes of belated travellers.⁷¹

Although an imaginary ‘spirit’ drives Jane into an hysterical fit of fear when a patch of light penetrates the room and hovers above her on the ceiling, there is further evidence of Jane’s fascination with death before this outburst. As her passion abates, Jane’s thoughts turn to her guilt and her reactions to the injustice

she suffers. She had, she recalls, felt so persecuted as a result of being 'imprisoned' that she contemplated absconding or letting herself starve to death should the former 'expedient' for escaping these injustices prove impossible.⁷² When calmer, she realises that this thought 'was certainly a crime' but continues rather curiously, 'and was I fit to die? Or was the vault under the chancel of Gateshead Church an inviting bourne?'⁷³ Jane evidently imagines herself on the gallows which she's seen pictured earlier as her punishment. The uncertainty in the initial question regarding her fitness for death continues into the succeeding question beginning 'Or...', suggesting that Jane is also unsure of the prospect she imagines she deserves. There is, however, a definite sense that she is *attracted* to the tomb since she feels death a just punishment.

As a consequence of the events culminating in her imprisonment and fit, Mrs Reed decides to have Jane sent to Lowood school. This gives Jane further opportunity to meditate on death following Mr Brocklehurst's austere questioning on the spiritual destiny of little miscreants. In response to the question 'Do you know where the wicked go after death?' she not surprisingly sketches a vivid account of Hell as a 'pit full of fire', but avoids giving Mrs Reed and Lowood's manager the satisfaction of saying she ought to behave properly in order to avoid its tortures. Jane realises her reply that she should 'keep in good health and not die' was 'obnoxious', but is spirited enough on this occasion to overcome both her opponents as well as the temptation of death. Her struggles against the tide of death will, however, not always be as easy.

The Lowood regime, sadistically instituted by the Vholes-like Reverend Brocklehurst, together with the climate when Jane arrives there, are austere and rigorous enough to suggest death in the general way noticed by Kenneth Burke.⁷⁴ The near starvation, physical deprivation and emotionally chilling circumstances, which have shocked most commentators, come to a head in the description of the garden where Jane and the other girls are forced to exercise:

... now, at the latter end of January, all was wintry blight and brown decay. I shuddered as I stood and looked around me: it was an inclement day for outdoor exercise; not positively rainy, but darkened by a drizzling yellow fog; all underfoot was still soaking wet with the floods of yesterday. The stronger among the girls ran about and engaged in active games, but sundry pale and thin ones herded together for shelter and warmth on the veranda; and amongst these, as the dense mist penetrated to the shivering frames, I heard frequently the sound of a hollow cough.⁷⁵

The semantic force of the freezing, darkening day, blighted and decaying vegetation and dense yellow fog bear down on the bodies of the less robust girls and together suggest some responsibility for their pallor, emaciation and the first sign of illness at Lowood: a distinctive, 'hollow' cough.

Coughing, 'close behind me' first alerts Jane to Helen Burns's existence. Noticing that Helen is reading, (Jane's recourse in the unfriendly context of Gateshead), she is drawn to strike up a conversation, despite her natural reticence. She overcomes her accustomed solitude because Helen's 'occupation touched a chord of sympathy somewhere'.⁷⁶ This empathy with the consumptive, while establishing Jane's fascination with mortality in the forging of her identity, also forms the basis for tensions and antipathies that this quest for identity gives rise to. This is also an important element in the narrative of Jane's development.

Having broken off an earlier conversation with Helen Burns at the crucial point at which Helen avoids saying whether she is ‘happy here’, Jane realises just how different her new friend is when she sees her dismissed from a history lesson and punished by being forced to stand conspicuously alone in the middle of the room.

Jane writes:

I expected she would show signs of great distress and shame; but to my surprise she neither wept nor blushed: composed, though grave, she stood, the central mark of all eyes. ‘How can she bear it so quietly—so firmly?’ I asked myself. ‘Were I in her place, it seemed to me I should wish the earth to open and swallow me up. She looks as if she were thinking of something beyond her punishment—beyond her situation: of something not round her nor before her. I have heard of day-dreams—is she in a day-dream now? Her eyes are fixed on the floor, but I am sure they do not see it—her sight seems turned in, gone down into her heart: she is looking at what she can remember, I believe; not at what is really present. I wonder what sort of girl she is—whether good or naughty?’⁷⁷

Jane compares herself to Helen, building on her initial perception of sympathy.

Here she finds even greater reason to empathise with a girl being humiliated.

Helen’s composure and gravity mystify and surprise Jane, and she is puzzled by

Helen’s peculiar detachment from the agonies Jane feels *she* would undergo were

she in a similar position. The passage stresses Helen’s detachment, through the

repeated use of ‘beyond’ and her focus on ‘something not round her’, which Jane

believes must be a reflection on some past happiness rather than a day-dream. This

detachment from the pains of the present, however, indicates a concern not with the

past, but with the future rewards for enduring the wrongs inflicted on her. Jane

does not consciously recognise the other-worldliness characteristic of the myth of

the consumptive, which, nonetheless, fascinates her.

The next day, Jane observes another scene of humiliation during Helen’s history

lesson, and learns more about her friend. Helen, as Jane observes, is singled out by

Miss Scatterd for a string of petty offences and harried almost interminably, suffering all with forbearance. The history lesson centres on Charles I and the girls are expected to memorise details concerning his reign from attending to a reading. The girls are then asked difficult questions concerning quantities, tonnages and 'ship-money' during Charles' reign, but none except Helen is able to recall such details. Jane is astonished that Helen seems to have 'retained the substance of the whole lesson,' and is 'ready with answers on every point.'⁷⁸ This phenomenal, precocious intellect is yet another sign, unrecognised by Jane, of the consumptive.

Jane again has occasion to witness Helen's suffering some minutes later when she sees her friend ordered to fetch a bundle of twigs and receive 'a dozen strokes' on the back of her bare neck. Jane is unable to continue her needlework 'because my fingers quivered at this spectacle with a sentiment of unavailing and impotent anger', but Helen's composure remains unruffled; the sentence continues 'not a single feature of her pensive face altered its ordinary expression.'⁷⁹ Jane's identification with Helen is presented through comparisons between the two, at the same time as Jane distinguishes herself *from* Helen. Casual reading, however, of passages containing crucial details attached to the sufferer cause them to be overlooked. For example, on this occasion, Jane sees Helen emerging from the book storage room hurriedly pocketing her handkerchief and observes that 'the trace of a tear glistened on her thin cheek.' This shows that Helen is clearly sensible of the physical pain, but more importantly, notices her 'thin cheek', which is yet another marker of the consumptive with whom Jane has begun to identify.⁸⁰

When Jane has an opportunity to speak to Helen that evening, she discovers something of the motives for her endurance. A verbal slip which Jane makes, leads

the reader to believe that she knows that Helen will never return to her father in the Scottish borders: she asks Helen whether she will ‘*ever* go back’. Jane’s growing empathy is articulated when she observes how she would react were she treated as badly by Miss Scatcherd, ‘... if I was in your place I should dislike her; I should resist her; if she struck me with that rod, I should get it from her hand; I should break it under her nose.’ Helen, however, advocates endurance for the sake of those, besides the victim, who might bear the consequences of a passionate revolt, advocating returning ‘good for evil.’ While unable to understand the doctrine of tolerance, Jane is mesmerised by Helen’s superhuman aspect:

I heard her with wonder: I could not comprehend ... and still less could I understand or sympathise with the forbearance she expressed for her chastiser. Still I felt that Helen Burns considered things by a light invisible to my eyes. I suspected she might be right and I wrong; but I would not ponder the matter deeply: like Felix, I put it off to a more convenient season.⁸¹

The allusion to St Paul here sanctifies Helen: her turn-the-other-cheek philosophy is divinely inspired. Jane begins to be won round from her fiery, spontaneous response.

Having strenuously attempted to convince Helen of her error in responding to evil with good instead of violence, and been encouraged to read the New Testament for her efforts, Jane finally tells Helen of her suffering at the hands of the Reeds. Yet in attempting to understand Jane, Helen reveals a longing to die which holds risks she cannot comprehend for her younger listener:

Would you not be happier if you tried to forget her severity, together with the passionate emotions it excited? Life appears to me too short to be spent in nursing animosity, or in registering wrongs. We are and must be, one and all, burdened with faults in this world: but the time will soon come when, I trust, we shall put them off in putting off our corruptible bodies; when debasement and sin will fall from us with this cumbrous frame of flesh, ...⁸²

Jane is, as yet, unaware of the reason for the perspective from which ‘life appears ... too short’ or why the time is ‘soon’ to come when this particular representative of humanity will abandon her ‘cumbrous frame of flesh.’ The operation of the consumptive myth, however, alerts the reader to the gruesome literalness resonating within these statements. Jane now learns that it is possible to distinguish the criminal from the crime and that her friend inhabits a serenity associated with ‘looking to the end.’⁸³

Helen’s example is not lost on Jane. When the Reverend Brocklehurst makes his regular school inspection visit, Jane tries vainly to avoid his notice since he had promised, on the basis of Mrs Reed’s evidence, to warn the staff of Jane’s intractability and so disgrace her. She drops her slate and its noisy shattering attracts the dreaded attention; Brocklehurst orders her to stand on a high stool exposed to the entire school’s inspection, and begins an oration branding Jane an ‘interloper’, ‘alien’ and a ‘liar’. Moments before she is lifted onto the stool for this harangue, Jane is seized by ‘an impulse of fury against Reed, Brocklehurst, and Co.’ at the prospect of the anticipated injustice. She is fiercely conscious that, as she says, she ‘was no Helen Burns’ yet when, at the end of the ordeal, she remains in disgrace before everyone’s eyes, a radical change occurs:

There I was, then, mounted aloft: I, who said I could not bear the shame of standing on my natural feet in the middle of the room, was now exposed to general view on a pedestal of infamy. What my sensations were, no language can describe: but just as they all rose, stifling my breath and constricting my throat, a girl came up and passed me: in passing she lifted her eyes. What a strange light inspired them! What an extraordinary sensation that ray sent through me! How the new feeling bore me up! It was as if a martyr, a hero, had passed a slave or victim, and imparted strength in the transit. I mastered the rising hysteria, lifted up my head, and took a firm stand on the stool.⁸⁴

The strange, consumptive glitter in Helen Burns's eyes has the capacity to inspire Jane with a miraculous fortitude. Even Jane herself is surprised by the transformation brought about by the gaze of her 'hero' and 'martyr' (who suffers in incurring Miss Scatcherd's wrath for concocting a trivial question as an excuse to pass near Jane). The text conveys the source of Helen's power as she smiles and returns to her place:

What a smile! I remember it now, and I know that it was the effluence of a fine intellect, of true courage; it lit up her marked lineaments, her thin face, her sunken grey eye, like a reflection from the aspect of an angel.⁸⁵

The smile may well have been the product of courage and wisdom, but the deed and fortitude it inspires have their origins in her disease, signalled here by the 'thin face' and the 'sunken grey eye'. If it is the 'reflection' from 'the aspect of an angel', Jane should remember that angels have to dispense with the source of the passionate warmth which animates her. Viewed in this light, Helen Burns's denial of things physical is disquieting: at the very moment she supports her friend she wears a badge of disgrace upon her arm and is to have a 'dinner of bread and water on the morrow' for her misdemeanour.⁸⁶ Helen, already ill, embarks on a dangerous course which can only hasten her death.

Jane's transformation is, however, unsustainable without its source of inspiration. She falls into despair when Helen disappears to get her meagre tea with the other girls leaving her to complete her punishment alone. Believing her fall from grace to be so profound that she will never rise in anyone's estimation again, Jane writes that she 'ardently wished to die.' Nevertheless, Helen later comes and attempts to console her by pointing out that no one in the school is likely to put much store by the inspector's views, and that, even if they did, Jane would still have her

conscience to support her in a friendless world. Jane is so deeply convinced that she cannot survive without others' regard and affection, that she would prefer death to social exile: 'if others don't love me, I would rather die than live—I cannot bear to be solitary and hated, Helen.' The depth of Jane's feeling of her need for love is expressed in a willingness to suffer broken bones, being thrown by a bull and even be stood before a kicking horse and 'let it dash its hoof at my chest'.⁸⁷ Helen responds by telling Jane of the angels who 'see and recognise our innocence' and of 'God' who 'waits only the separation of spirit from the flesh to crown us with a full reward.' Moreover, she says Jane ought not to be overwhelmed by her misfortunes since 'life is so soon over, and death is so certain an entrance to happiness....' With this advocacy of the afterlife as the innocent's reward ringing in her ears, Jane becomes aware of something disquieting about Helen:

Helen had calmed me; but in the tranquillity she imparted there was an alloy of inexpressible sadness. I felt the impression of woe as she spoke, but I could not tell whence it came; and when, having done speaking, she breathed a little fast and coughed a short cough, I momentarily forgot my own sorrows to yield to a vague concern for her.⁸⁸

Helen's woe is bound up with both her torment by others and her other affliction, here causing her shortness of breath and her cough: still, Jane is not yet fully cognisant of her friend's plight.

She only once witnesses the full, individuating force which the nineteenth century accorded to consumption, when she and Helen meet privately with Miss Temple. Jane having given a satisfactory account of the facts surrounding the Reverend Brocklehurst's imputations, Miss Temple's attention turns to Helen, immediately focusing on her health:

‘How are you to-night, Helen? Have you coughed much to-day?’

‘Not quite so much, I think, ma’am.’

‘And the pain in your chest?’

‘It is a little better.’

Miss Temple got up, took her hand and examined her pulse; then she returned to her own seat: as she resumed it, I heard her sigh low. She was pensive a few minutes, ...⁸⁹

The concentrated concern for the various symptoms of pulmonary consumption take on a medical meaning with Miss Temple’s attention to Helen’s pulse.

Although no explicit pronouncement follows, the text signals the dismal lack of any progress through Miss Temple’s sigh and thoughtfulness - the nineteenth-century reader could have been in no doubt as to the nature of Helen’s disease and its prospects, even though Jane remains unconscious of its stark implications.

Jane stands in marked awe of Miss Temple, ‘the serenity in her air,’ the stateliness in her bearing and the ‘refined propriety in her language’. A comparison between Helen and Miss Temple is made, however, such that Miss Temple is far outshone by the consumptive:

... but as to Helen Burns, I was struck with wonder.

The refreshing meal, the brilliant fire, the presence and kindness of her beloved instructress, or, perhaps more than all these, something in her own unique mind, had roused her powers within her. They woke, they kindled: first they glowed in the bright tint of her cheek, which till this hour I had never seen but pale and bloodless; then they shone in the liquid lustre of her eyes, which had suddenly acquired a beauty more singular than that of Miss Temple’s—a beauty neither of fine colour nor long eyelash, nor pencilled brow, but of meaning, of movement, of radiance. Then her soul sat on her lips, and language flowed, from what source I cannot tell: has a girl of fourteen a heart large enough, vigorous enough, to hold the swelling spring of pure, full, fervid eloquence? Such was the characteristic of Helen’s discourse on that, to me, memorable evening; her spirit seemed hastening to live within a very brief span as much as many live during a protracted existence.⁹⁰

Besides Jane’s powerful regard for Helen, the passage integrates the language of fire, which David Lodge justifiably associates with Jane’s passionate vehemence,

with the consumptive.⁹¹ Although Jane attributes Helen's glowing cheek to the meal, the warm room and Miss Temple's benevolence, it is equally possible for it simply to be the way a mild feverish bout is registered in contrast to the habitual consumptive pallor. Also remarkable here is the single reference to Helen as beautiful, at the moment at which she evinces all the classic traits of the consumptive. Her usually saintly eyes assume the 'radiance' remarked on by Nan McMurray, in a way which stresses this appearance's dependence on some inherent, individuating character (rather than being artificial).⁹² In its final sentence the passage obliquely suggests the source of this distinction - her personality appears to compress a lifetime of experience within the brief length of a congenial conversation. In an allusion to the novel's pervasive physiognomy, which perhaps accords with the myth of the consumptive by crudely functioning to distinguish individuals on the basis of the body, it is understandable why Jane's 'organ of Veneration' reacts to Helen by 'expanding at every line' of Virgil which she translates for Miss Temple.

The circumstances surrounding Helen's death are critical for Jane's development. They give us insight into the dynamics of Jane's relation to death and present a peculiar, but revealing twist in the stereotypical presentation of the consumptive's death. The contrast between life and death is heightened through a typhus epidemic's striking Lowood in Spring, and an entire paragraph elaborates this.⁹³ At this time the rigorous daily routine is disrupted on medical advice necessitating extra exercise for the few pupils who remain healthy, and Jane and her friends spend it roaming the surrounding countryside in exquisite freedom. Helen, however, is not among them since she has been confined indoors. Jane learns that

her friend is housed not with the ‘fever patients; for her complaint was consumption, not typhus: and by consumption I, in my ignorance, understood something mild, which time and care would be sure to alleviate.’ Although it was not effectively recognised in northern Europe that tuberculosis was contagious, typhus was believed to be, so Helen is sequestered in Miss Temple’s room, too ill to be seen by Jane. The interesting thing, is *Jane’s* belief in her friend’s prospects of recovery:

I was confirmed in this idea by the fact of her once or twice coming downstairs on very warm sunny afternoons, and being taken by Miss Temple into the garden: but on these occasions I was not allowed to go and speak to her...⁹⁴

Here Jane can be forgiven her misunderstanding the fatal nature of the disease simply because she has not been told.

Some time in the summer, however, Jane intuitively grasps the presence of death in the midst of life as she realises how unpleasant it would be to be summoned, at that glorious summer moment, from life. The text builds on the paragraph contrasting the simultaneous presence of death and summer’s luxuriance (itself perhaps a variation on the theme of ‘*Et in Arcadia ego*’,)⁹⁵ as Jane attempts to reconcile herself to it through Christian eschatology:

... it was such a pleasant evening, so serene, so warm; the still glowing west promised so fairly another fine day on the morrow ... I was noting these things and enjoying them as a child might, when it entered my mind as it had never done before:-

‘How sad to be lying now in a sickbed, and to be in danger of dying! This world is pleasant—it would be dreary to be called from it, and to have to go who knows where?’

And then my mind made its first effort to comprehend what had been infused into it concerning heaven and hell: and for the first time it recoiled, baffled; and for the first time glancing behind, on each side, and before it, it saw all round an unfathomed gulf: it felt the one point where it stood—the

present; all the rest was formless cloud and vacant depth: and it shuddered at the thought of tottering, and plunging amid the chaos.⁹⁶

Jane's grasp of the sensual warmth of the season draws her back from the prospect of death; while unable to grasp the significance of heaven and hell, her mind is certain of the sensual present. At this very moment Jane has an opportunity to learn more of Helen's condition from her nurse. The nurse responds to Jane's enquiries, telling her the doctor 'says she'll not be here long.'⁹⁷ Jane now has sufficient grasp of consumption and the ubiquity of death to realise that her friend is dying:

This phrase, uttered in my hearing yesterday, would have only conveyed the notion that she was about to be removed to Northumberland, to her own home. I should not have suspected that it meant she was dying; but I knew it now: it opened clear on my comprehension that Helen Burns was numbering her last days in this world, and that she was going to be taken to the region of the spirits, if such a region there were.⁹⁸

Helen Burns is dying, Jane realises, and dying at the height of both her powers and that of the seasonal flux.

Jane steals through the school in the dead of night to bid her friend farewell, but fears, desperate as she is to see Helen, that she will encounter a corpse. She whispers through the curtain surrounding Helen's bed to establish whether Helen is still alive, surprising her friend, who draws back the curtain revealing a pale and wasted face. Jane concludes that Helen is not going to die:

'Oh! I thought, 'she is not going to die: they are mistaken: she could not speak and look so calmly if she were.'

I got on to the crib and kissed her: her forehead was cold, and her cheek both cold and thin, and so were her hand and wrist; but she smiled as of old.⁹⁹

Of course, Jane does not wish to lose her friend and understandably seizes on any sign, however slim, that she will recover. The strong identification that naturally

binds Jane to Helen also means that, contrary to the usual consumptive death scene, *Jane* takes on the denial of death's inevitability characteristic of *spes phthisica*. It is Jane who anticipates Helen's departure for Northumberland, when she asks Helen 'Are you going somewhere, Helen? Are you going home?' Helen, in characteristically saintly manner, instead anticipates her eternal home and, in her last words, attempts to convince Jane of death as an escape from suffering and heaven as the place where they will be reunited. With Jane having joined Helen under the quilt they bid each other good night:

'Are you warm darling?'

'Yes.'

'Good-night, Jane.'

'Good-night, Helen.'

She kissed me, and I her: and we both soon slumbered. ¹⁰⁰

The calm of this conventional consumptive death is typical and duplicates that of Richard Carstone in Bleak House. Garrett Stewart has noted how the formulation of the last sentence above suggests, in the elliptical 'and I her', a profound, even erotic, identification between Jane and Helen at the moment of Helen's death. ¹⁰¹

Jane clearly thinks that she and Helen fall asleep simultaneously, but Helen is dead and, in a macabre scene, Jane is discovered asleep the following morning clutching her friend's corpse.

Helen features only once more in the text, when Jane recalls her at Mrs Reed's deathbed. Obeying her aunt's dying wish to see her niece, and surrounded by her self-absorbed cousins, Georgiana and Eliza, and an indifferent hired nurse, Jane goes up to Mrs Reed and finds the nurse absent: 'the patient lay still, and seemingly lethargic; her livid face sunk in the pillows: the fire was dying in the grate. I

renewed the fuel, re-arranged the bedclothes,' and then Jane goes to gaze out of the window:

The rain beat strongly against the panes, the wind blew tempestuously: 'One lies there,' I thought, 'who will soon be beyond the war of earthly elements. Wither will that spirit ... flit when at length released?'

In pondering the great mystery I thought of Helen Burns, recalled her dying words—her faith—her doctrine of equality of disembodied souls. I was still listening in thought to her well-remembered tones—still picturing her pale and spiritual aspect, her wasted face and sublime gaze, as she lay on her placid deathbed, and whispered her longing to be restored to her divine Father's bosom—when a feeble voice murmured from the couch behind: 'Who is that?'

I knew Mrs. Reed had not spoken for days: was she reviving? I went up to her. 'It is I, aunt Reed.'

'Who—I?' was her answer. 'Who are you' ... 'You are quite a stranger to me ...'¹⁰²

There is a dynamic of symbolic association and perhaps wordplay here concerning Jane's identity, which is still unresolved as well as troubled by the pull of her old attraction to Helen Burns. The dying fire in the grate clearly parallels Mrs. Reed's fast ebbing life and Jane brings her own warmth as well as that of the renewed fuel to the dying woman. The larger picture, however, is one of elemental contention - rain, wind or even life and death - which causes Jane to recall her friend's placid, welcoming exit. Matters of identity immediately arise, under the guise of the stroke-victim's imperfect memory, which the text emphasises as a central issue through the dying woman repeating her failure to recognise the young woman before her. Despite Jane's assuring Mrs Reed that it is her, she learns, however, that her aunt had written to her only remaining uncle, informing him that 'Jane Eyre was dead: she had died of typhus fever at Lowood.'¹⁰³

There are many scattered references to Jane as a consort of the dead, or to her as an 'unearthly creature'.¹⁰⁴ For instance, the song which Rochester sings her, is used

to intimate that she has promised to live and die with him.¹⁰⁵ A series of references to death centred in Jane's paroxysm of despair and self-doubt following the aborted marriage further links her to death.¹⁰⁶ In addition to this extensive set of allusions, however, death continues to exert a claim on Jane's identity. The relationship between Jane and St. John Rivers continues many of the themes dealt with in the introduction of the consumptive Helen Burns.

Before St. John explains his offer to help the destitute governess secure a suitable post, he is at pains to disillusion her as to his status:

Rivers is an old name; of the three sole descendants of the race, two earn the dependant's crust among strangers, and the third considers himself an alien from his native country—not only for life, but in death. Yes, and deems and is bound to deem, himself honoured by the lot, and aspires but after the day when the cross of separation from fleshly ties shall be lain on his shoulders, and when the Head of that church-militant, of whose humblest members he is one, shall give word, "Rise, and follow Me!"¹⁰⁷

Subtle theological differences aside (in a novel where Christianity sits somewhat uncomfortably), St. John and Helen have similar, other-worldly perspectives on life. Like Helen, he lives only for the afterlife. The very words he longs to hear echo the line inscribed on Helen's tombstone, 'Resurgam' - I shall rise again.¹⁰⁸

Jane's and St John's experiences of temptation are also similar, but their reactions to it are profoundly different. When St. John visits Jane she has been sketching Miss Oliver, with whom St. John is in love. Having noticed his barely controlled reactions to the heiress when he meets her at Jane's school, Jane is emboldened to say how much Miss Oliver likes him. St. John is so pleased at the news that he cannot resist indulging the subject further, taking out his watch and exhorting Jane

to continue her observations for precisely a quarter of an hour. Revealingly, Jane says very little and St. John permits his fired imagination free reign:

I see myself stretched on an ottoman in the drawing-room of Vale Hall, at my bride Rosamond Oliver's feet: she is talking to me in her sweet voice—gazing down on me with those eyes your skilful hand has copied so well—smiling at me with these coral lips. She is mine—I am hers—this present life and passing world suffice to me. Hush! say nothing—my heart is full of delight—my senses are entranced ... ¹⁰⁹

This passage parallels Jane's temptation in relation to Rochester, in which 'conscience, turned tyrant held passion by the throat'. Temporarily, however, the effects of St. John's repression of passion are corrosive, betraying his similarity to Helen Burns. Having heard St. John's fervent, steadfast refusal to relinquish his divine ambition for the delights of marriage, Jane remarks that the suppression of his passion in favour of Miss Oliver's numerous other suitors is delivered, 'coolly enough,' but, says Jane, 'you suffer in the conflict. You are wasting away.' St John's attempt to minimise these effects only emphasises the similarity: 'No. If I get a little *thin*, it is with anxiety about my prospects, yet unsettled' [italics added] - St. John's passions corrode his body where Helen's disease destroyed hers. No other reference is made to St John's health - he seems extraordinarily strong, visiting his parishioners in all weathers, nevertheless his 'health' will be important when considering the novel's conclusion.

Jane falls under St. John's deathly influence just as she did with Helen in Miss Temple's room, losing her own identity in the process. She notes that he slowly 'acquired a certain influence over me that took away my liberty of mind...'. Her inherent vivacity is repressed to the extent that she falls 'under a freezing spell', and reluctantly becomes his obedient servant. The full implications of

identification with a dangerously ‘cold’ St. John are only articulated, however, in the scene in which he proposes to her.

St. John’s proposal itself is cast in an ascetic mould; almost compelling her to marry him, he tells her she ‘must’ be a missionary’s wife and claims her, as he says ‘not for my pleasure, but for my Sovereign’s service.’¹¹⁰ Jane resists his claim, explaining that she lacks the vocation involved, and he offers his view of her in an effort to convince her:

In the resolute readiness with which you cut your wealth into four shares, keeping but one to yourself, and relinquishing the three others to the claim of abstract justice, I recognised a soul that revelled in the flame and excitement of sacrifice.¹¹¹

To this mis-recognition of the nature of Jane’s ‘fire’ St John does add a tolerably accurate picture of Jane’s merits, but it is her merits which recommend her rather than any warmth of feeling on St. John’s part. Jane instantly recognises the deadly consequences of such an alliance when she writes, ‘my *iron shroud* contracted around me...’ [emphasis added] despite her realising that she is suited to the life of a missionary.

Her thoughts, as she meditates the full implications of such a marriage, centre curiously on death. She is persuaded, by St. John’s insight into her character, that she could acquit herself very well as a missionary worker in India, as she says, but the thought of death immediately associates itself, albeit vaguely with that possibility:

... That is, if life be spared me. But I feel mine is not the existence to be long protracted under an Indian sun.—What then? He does not care for that: when my time came to die he would resign me, in all serenity and sanctity, to the God who gave me.¹¹²

Jane, in obliquely recognising the psychological emptiness and frigidity with which St. John would meet her death, recognises the absence of love. Moreover, she is painfully aware that, although all prospect of returning to Rochester is hopeless, her business 'is *to live* without him now', and that she must find another interest 'in *life*' to replace this attachment. Although drawn to the idea of contributing to her fellow creatures' betterment through St. John's project, something chilling continues to deter Jane:

—and yet I shudder. Alas! If I join St. John, I abandon half myself: if I go to India, I go to a premature death. And how will the interval between leaving England for India, and India for the grave be filled?

The concentration on death, entailing much more than the loss of 'half' of her self, is emphasised by a resonance here of Jane's formulation, in the second Chapter of the novel. There the transition to the grave was seen as a journey to another country, the 'bourne' which had previously attracted her.¹¹³ The journey still holds some attractions for her, but Jane is at least able to resist their pull because it depends on her sacrificing any hope of love 'on the altar' of St. John's asceticism.

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As the missionary's assistant Jane feels she could still retain her identity: 'I should still have my unblighted self to turn to: my natural unenslaved feelings with which to communicate in moments of loneliness. There would be recesses in my mind which would be only mine....' The consequences of marriage to St. John, however, are couched in language which betrays the necessity of her taking up a self-corroding position similar to that which we saw St. John adopt in relation to Miss Oliver:

... as his wife—at his side always, and always restrained, and always checked—forced to keep the fire of my nature continually low, to compel it

to burn inwardly and never utter a cry, though the imprisoned flame consumed vital after vital—*this* would be unendurable.¹¹⁵

If the words ‘If I were to marry you, you would kill me. You are killing me now.’ are, as St. John intimates, ‘untrue’, her later vehement rebuttal of death in an alliance with him is not.¹¹⁶

The critical moment when Jane verges, for one last time, on the brink of the abyss occurs in Chapter thirty five, and is, appropriately, couched in language redolent of death. On the night before St John’s departure, Jane has sat through his final domestic Bible reading before retiring for bed and then listens to his direct exhortations to her to remember ‘the fate of Dives, who had the good things in this life.’ At this point Jane totters on the very brink:

I felt veneration for St. John—veneration so strong that its impetus thrust me at once to the point I had so long shunned. I was tempted to cease struggling with him—to rush down the torrent of his will into the gulf of his existence, and there to lose my own.¹¹⁷

Jane recognises that she will be overwhelmed and annihilated by St. John’s icy, unbending will: her identity will be lost, and there is every indication that she will succumb. In a moment couched in the language of exhilarated Christian enthusiasm, the deadly implications of her next step are almost lost upon Jane, but there is one point which recalls Helen Burns’ attitude to eternity:

All was changing utterly, with a sudden sweep. Religion called—angels beckoned—God commanded—life rolled together like a scroll—death’s gates opening, showed eternity beyond: it seemed, that for safety and bliss there, all here might be sacrificed in a second. The dim room was full of visions.¹¹⁸

The delights of summer and the life it implies have become as unappealing as a roll of parchment, and death beckons. Helen had said ‘... and God awaits only the separation of spirit from the flesh to crown us with a full reward. ... and death is so

certain an entrance to happiness—to glory’, her ideas closely paralleling Jane’s at this critical moment when she has lost the will to resist the temptation to self immolation. As Jane balances on this knife edge of eternity crying out for guidance, her life and senses are roused from St. John’s deadly hypnotic spell and she is ‘forced to wake’ by Rochester’s call. Her kinship with Rochester has remained alive, however hopeless, and is reanimated in dramatic fashion to finally rescue her from the chilling end offered by St. John and earlier by Helen Burns.

The endings of Bleak House and Jane Eyre adopt the same general strategy: a marriage occurs and the female narrator presents a brief summary of the later fates of the characters. The appearance of all being well with Jane is borne out by an event which, strictly speaking, ought to be recorded in the conclusion since it occurs after her marriage to Rochester, and that is the erection of the tombstone on Helen’s grave in Brocklebridge churchyard. The final sentence of Chapter IX notes only that, ‘for fifteen years after her death [the grave] was only covered by a grassy mound; but now a grey marble tablet marks the spot, inscribed with her name, and the word ‘Resurgam.’”¹¹⁹ Helen’s father’s poverty precludes his responsibility for its appearance. Thus it seems that the recently wealthy Jane has arranged for its erection as a tribute to the friend whom she can finally lay to rest, perhaps burying a dark part of herself. Bleak House, however, closes on an inconclusive and troubled note, registering continuing tensions, surrounding death and disfiguring disease, in Esther’s identity.

The tensions involved in the final paragraphs of Jane Eyre, however, concern St. John and his fate. The penultimate paragraph, clearly aiming at a positive ending,

is laden with praise for St. John's character and efforts in India: he is 'Firm, faithful, and devoted', and 'full of energy, and zeal, and truth' in his efforts. Yet he remains unmarried and Jane is convinced, 'he never will marry now', not because his self-sufficiency sustains him, but because Jane is convinced he is dying:

... the toil draws near its close: his glorious sun hastens to its setting. The last letter I received from him drew from my eyes human tears, he anticipated his sure reward, his incorruptible crown. I know that a stranger's hand will write to me next, to say that the good and faithful servant has been called at length into the joy of his Lord.¹²⁰

Jane seems to have no evidence for his dying of any particular physical ailment although there are similarities between the way Jane envisages his death and the quiet demise of Helen Burns: 'No fear of death will darken St. John's last hour: his mind will be unclouded; his heart will be undaunted; his hope will be sure; his faith steadfast.' This welcoming of death and deliverance is almost identical to that which Jane experiences at first hand as a child. This repetition, and its prominence at the very end of the novel, suggest that although Jane has escaped death in marriage to Rochester, the drift of the novel as a whole is towards affirming the hold of death on the self and on life, it exists as a determining parameter towards which the narrating self tends, but which it cannot fully embrace if narration is to continue.

In a comparative exercise such as this it is has not been possible to thoroughly explore the 'lively' side of Jane's character and so to throw into even starker relief the case for her struggle between life and death and the intricate dynamics of death in the formation of her identity. Much of that work has, however, been done by Keefe and others, and my concern here has been to explore the interplay between the stereotypical picture of the consumptive and particular formations of identity in

Jane Eyre. The analysis of Jane Eyre shows that the individuating or distinguishing force of death active in the stereotype is central in the formation of Jane's identity. In Bleak House there are hints in this direction, but Dickens is more concerned to turn the potential represented by the consumptive stereotype to use in his polemic against Chancery. Some of the parallels between the two works examined could well be attributed to Dickens's having been impressed by the public success of Jane Eyre, and perhaps having read the work itself. The appeal, however, of both works to a public experiencing the horrors of the height of a centuries-long, tuberculosis mortality cycle, and imbued with the myths which surrounded it, must rest on the reality, in the contemporary reading public's consciousness, of that stereotype.

I have suggested that Dickens contrasted Esther Summerson's contraction of smallpox and subsequent recovery with Richard Carstone's consumption and death. George Eliot was also aware of the possibilities of linking representations of consumption with alcoholism, which at the time of her Scenes of Clerical Life, was beginning to be thought of as a disease. Where Mrs Gaskell had portrayed a consumptive, alcoholic prostitute haunting a healthy young heroine, George Eliot brought her moral sensibilities to the narrative possibilities of representing the struggles and psychological agonies of a recovering alcoholic woman and a dying consumptive. Let us then turn to a closer examination of Eliot's 'Janet's Repentance'.

¹ Charles Dickens, Bleak House, ed. George Ford and Sylvere Monod, (London: Norton, 1977), ll. 7–12, p. 489. All further references will take the form of the abbreviation 'BH' followed by the relevant line and page references.

² Charlotte Brontë, Jane Eyre, ed. Richard J. Dunn, 2nd edn, (London: Norton, 1987), Ch. IX, p. 68–9. All further references to Jane Eyre will take the form of the abbreviation JE followed by the Chapter number and page number, as here JE, Ch. IX, p. 68–9.

³ See F. S. Schwartzbach, 'The Fever of Bleak House', *English Language Notes*, 20, (1983), no. 3/4, p. 21. Also Graham Benton, "'And dying thus around us every day": Pathology, Ontology and the Discourse of the Diseased Body. A Study of Illness and Contagion in *Bleak House*' *Dickens Quarterly*, 11, (1994), no. 2, 69 – 80, p. 70.

⁴ I have argued this in an unpublished paper entitled 'Narrative, Contagion and Death in *Bleak House*.' I also show, especially with reference to Esther's self doubts at the close of the novel, that the psychological scars left after the episode of smallpox blight Ester's self conception as much as her face.

⁵ *BH* ll. 8 – 21, p. 722.

⁶ Dickens had personal familiarity with the disease since his sister Fanny died of tuberculosis before he embarked on *Bleak House*. In her discussion of Richard Carstone, Emilie Babcox points out that he had already presented an idealistic picture of the consumptive in Smike before this experience. See Emilie Babcox's *Health, Illness and Medical Theory in the Novels of Jane Austen, Charles Dickens and Charlotte Brontë*, (Ann Arbor, Mich.: University Microforms International, 1998), p.117 – 123. For this episode in Dickens's life see Fred Kaplan's *Dickens: A Biography* (London: Hodder and Stoughton, 1988), p. 237 – 239. It is even suggested that Dickens may have had the renal form of tuberculosis himself. See Carol Mcleod 'Dickens's Maladies Re-evaluated', *The Dickensian*, 1991, no. 424, vol. 87, part 2. p. 77. Besides using consumption in the case of Smike, Dickens had also used it in depicting Oliver's little companions in *Oliver Twist*. Little Dick has characteristic palor and 'large and bright' eyes. See *Oliver Twist*, ed. Peter Fairclough, (Harmondsworth: Penguin, 1985), p. 96 and p. 172.

⁷ *BH*, ll. 20 – 23, p. 49.

⁸ *BH*, l. 40, p. 68 – l. 4, p. 69.

⁹ *BH*, ll. 11 – 18, p. 435.

¹⁰ Richard 'rests his aching head upon his hand, and looks the portrait of Young Dispair' when he dejectedly seats himself for his final consultation with Vholes before the summer vacation and this is how Dickens had him represented in the illustration for this Chapter.

¹¹ *BH*, l. 36, p. 286 – l. 10, p. 287.

¹² Regarding Gridley's decline and its relation to Richard, we recall that one of the less specialised meanings of 'consume' is 'to wear out and decay.'

¹³ *BH*, ll. 15 – 24, p. 315.

¹⁴ *BH*, ll. 10 – 12, p. 440. The links between this metaphoric reference to the body ("to the bone") and her actual emaciated condition are painfully ironic.

¹⁵ *BH*, ll. 17 – 22, p. 441.

¹⁶ *BH*, ll. 15 – 17, p. 459.

¹⁷ *BH*, ll. 6 – 14, p. 462.

¹⁸ *BH*, ll. 2 – 7, p. 463.

¹⁹ *BH*, ll. 24 – 25, p. 464.

²⁰ See *BH*, ll. 39 – 42, p. 464.

²¹ Thomas J. Galvin makes a related point, in maintaining that Vholes 'has become the external representation of the state of Richard's spirit.' See his 'Mr. Vholes of Symond's Inn', *Dickensian*, 64 (1968), pp. 22 – 7, (p. 25).

²² *BH*, ll. 40 – 45, p. 469. The look is emphasised at ll. 29 – 30, p. 484, "... and fixedly and slowly looking at his client,..."

²³ *BH*, ll. 27 – 28, p. 541.

²⁴ Vholes wears "funeral gloves", at one point, which he ineffectually attempts to warm at the fire. See: *BH*, l. 32, p. 542. The 'lifeless manner' is stressed at l. 10 p. 471 as well. See: "It required some attention to hear him, on account of his inward speaking and his lifeless manner." His office is housed, moreover, in a building constructed of materials so dilapidated that they look as if they "took kindly to the dry rot ... and *all things decaying* and dismal." [italics added] l. 1 – 2, p. 482. See Thomas J. Galvin's 'Mr Vholes of Symond's Inn', *Dickensian*, 64 (1968), pp. 22 – 27, for a comprehensive analysis of Vholes as representing the corruption of the Chancery system.

²⁵ *BH*, ll. 28 – 40, p. 471.

²⁶ *BH*, ll. 1-3, p. 485.

²⁷ *BH*, ll. 16 – 17, p. 487.

²⁸ *BH*, l. 36, p. 484.

²⁹ Even Ada, Jarndyce and Esther refer only to "Rick."

³⁰ *BH*, ll. 33 – 34, p. 482.

³¹ *BH*, ll. 40 – 43, p. 483.

- ³² BH, ll. 42 – 45, p. 487.
- ³³ See BH, ll. 39, p. 542 - l. 2, p. 543.
- ³⁴ BH, l. 45, p. 488 - l. 3, p. 489.
- ³⁵ BH, l. 38, p. 718.
- ³⁶ BH, ll. 43, p. 485 - l. 1, p. 486.
- ³⁷ BH, ll. 30 – 34, p. 481.
- ³⁸ BH, l. 15, p. 486.
- ³⁹ BH, ll. 38 – 39, p. 489 [emphasis added.]
- ⁴⁰ BH, ll. 43 – 45, p. 489.
- ⁴¹ *ibid.* p. 21.
- ⁴² BH, ll. 31 – 32, p. 540.
- ⁴³ BH, ll. 43 – 44, p. 609.
- ⁴⁴ BH, ll. 7 – 12, p. 489.
- ⁴⁵ BH, ll. 21 – 23, p. 543.
- ⁴⁶ BH, ll. 19 – 20, p. 545.
- ⁴⁷ BH, l. 36, p. 546.
- ⁴⁸ BH, ll. 21 – 27, p. 550.
- ⁴⁹ BH, ll. 19 – 21, p. 611.
- ⁵⁰ BH, ll. 34 – 35, p. 611.
- ⁵¹ BH, ll. 38 – 44, p. 612.
- ⁵² BH, ll. 40 – 44, p. 615.
- ⁵³ See Phillipe Aries' description of Alexandrine La Ferronay's mourning for her husband Albert in The Hour of Our Death, trans. H. Weaver, (Harmondsworth: Penguin, 1981), pp. 421 – 22.
- ⁵⁴ BH, ll. 39 – 42, p. 705.
- ⁵⁵ Esther also has a period of unspecified "illness" following her mother's death - but the reader must assume that it is due to the mental and physical consequences of the chase and its conclusion. See, "I had an illness, but it was not a long one; and I would avoid even this mention of it, if I could quite keep down the recollection of their sympathy." BH, ll. 9 – 11, p. 714.
- ⁵⁶ BH, ll. 3 - 5 p. 715 [emphasis added].
- ⁵⁷ BH, ll. 11 – 14, p. 719.
- ⁵⁸ BH, ll. 24 – 26, p. 720.
- ⁵⁹ BH, ll. 8 – 15, p. 722.
- ⁶⁰ BH, ll. 8 – 21, p. 722.
- ⁶¹ See, "Richard, more worn and haggard, haunted the court day after day; listlessly sat there the whole day long, when he knew there was no remote chance of the suit being mentioned; and became one of the stock sights of the place." BH, ll. 5 – 8, p. 730.
- ⁶² See Esther's remark "I have no doubt that his desire to retrieve what he had lost, was rendered the more intense by his grief for his young wife, and became like the madness of a gamester." BH, ll. 19 – 21, p. 730.
- ⁶³ BH, ll. 4 – 7, p. 749.
- ⁶⁴ BH, ll. 28 – 30, p. 757.
- ⁶⁵ BH, ll. 27 – 33, p. 760.
- ⁶⁶ BH, ll. 6 – 10, p. 761.
- ⁶⁷ See Sontag, p. 18.
- ⁶⁸ See Elizabeth Gaskell's Life of Charlotte Brontë, (Harmondsworth: Penguin, 1975), p. 104 and p. 108.
- ⁶⁹ See Robert Keefe's Charlotte Brontë's World of Death, (London: University of Texas Press, 1979) and Robert B. Heilman's 'Charlotte Brontë's "New" Gothic', in From Jane Austen to Joseph Conrad, eds. R. Rathburn and M. Steinman Jr., pp. 118 – 32, (Minneapolis: University of Minnesota Press), 1958.
- ⁷⁰ JE, Ch. I, p. 6.
- ⁷¹ JE, Ch. II, p. 11.
- ⁷² JE, Ch. II, p. 12.
- ⁷³ JE, Ch. II, p. 13,
- ⁷⁴ See Kenneth Burke's analysis of the poetics whereby cause of death becomes an index of death. 'Thanatopsis for Critics: A Brief Thesaurus of Deaths and Dying', Essays in Criticism, 2, no. 4, (1952), pp. 369 – 75.
- ⁷⁵ JE, Ch. V, p. 41 – 2.
- ⁷⁶ JE, Ch. V, p. 42.

⁷⁷ JE, Ch. VI, p. 44 – 5.

⁷⁸ JE, Ch. VI, p. 46.

⁷⁹ JE, Ch. VI, p. 46.

⁸⁰ JE, Ch. VI, p. 47.

⁸¹ JE, Ch. VI, p. 48.

⁸² JE, Ch. VI, p. 50 – 1.

⁸³ JE, Ch. VI, p. 51.

⁸⁴ JE, Ch. VII, p. 58.

⁸⁵ JE, Ch. VII, p. 59

⁸⁶ This novel contains a host of ideas concerning food and its consumption. One of the clearest textual formulations of the vicissitudes of desire in the text occurs very early on, when Jane is recovering from the “nervous shock” of her experience in the red-room. Bessie allows the convalescent child to eat from a much desired, but previously withheld, decoratively illustrated china plate, but Jane is unable to eat the tart offered upon it. Similarly the most impressive and harrowing episodes, the spell at Lowood and the three days spent in near starvation in Malton village years later, centre upon food and the consequences of its deprivation. Aside from the ‘reality effect’ to be derived by representing the deprivations experienced at Lowood so graphically, a psychoanalytic link to Charlotte Brontë’s life may exist here. Keefe suggests that Charlotte Brontë had a hand in her death through depriving herself of food, as she had done when younger, in the final weeks of her life. See Keefe’s Charlotte Brontë’s World of Death, (London: University of Texas Press, 1979), pp. 43 – 4.

⁸⁷ JE, Ch. VIII, p. 60.

⁸⁸ JE, Ch. VIII, p. 61.

⁸⁹ JE, Ch. VIII, p. 61.

⁹⁰ JE, Ch. VIII, p. 63 – 4.

⁹¹ See David Lodge’s Language of Fiction: Essays in Criticism and Verbal Analysis of the English Novel, (London: Routledge & Kegan Paul, 1984) pp. 119 – 42. Both Richard and Helen are consumed or destroyed by the same fire, while Janes’s passion takes a less exalted form and so enables her to survive. See BH, ll. 28 – 40, p. 471.

⁹² Nan M^cMurray, “And I? I am in a Consumption”: The Tuberculosis Patient 1780 – 1930, (Ann Arbor, Mich.: Microforms International, 1986) p. 18.

⁹³ See, “While disease has thus become an inhabitant of Lowood, and death its frequent visitor ... bright May shone unclouded over the bold hills and beautiful woodlands out of doors.” The paragraph goes on to note how the flowers from the girl’s gardens finally serve only as wreaths placed in the dead girls’ coffins. JE, Ch. IX, p. 67.

⁹⁴ JE, Ch. IX, p. 68.

⁹⁵ See Erwin Panofsky’s ‘Et in Arcadia Ego’ in Philosophy and History: Essays Presented to Ernst Cassirer, ed. R. Klibansky and H.J. Paton (Oxford: Oxford University Press, 1936) pp. 223 – 254.

⁹⁶ JE, Ch. IX, p. 68 – 69.

⁹⁷ Compare Jane’s peculiar question earlier regarding how long Helen thinks she will spend at Lowood: “Will you *ever* go back?” [italics added] JE, Ch. VI, p. 47.

⁹⁸ JE, Ch. IX, p. 69.

⁹⁹ JE, Ch. IX, p. 70.

¹⁰⁰ JE Ch. IX, p. 71.

¹⁰¹ See Garrett Stewart’s Death Sentences: Styles of Dying in British Fiction, (London: Harvard University Press, 1984) p. 103.

¹⁰² JE, Ch. XXI, p. 208 – 209.

¹⁰³ JE Ch. XXI, p. 210.

¹⁰⁴ See JE, Ch. XXII, p. 214. Rochester jokingly takes up her statement that she has “...been with my aunt, sir, who is dead.” construing it literally and feigning horror at one “from the abode of the people who are dead”. Even the critical moment of Rochester’s first proposal contains a reference to her as an “almost unearthly thing”. See, JE, Ch. XXXIII, p. 224.

¹⁰⁵ See the lines, “My love has sworn, with sealing kiss,/ With me to live—to die” to which Jane offers a defiant response, determined as she is to resist his advances until they are married. JE, Ch. XXIV, p. 240.

¹⁰⁶ She sees her blighted hopes expressed in “hay-field and corn-field” covered in a “frozen *shroud*” and her hopes are now “all *dead*” and her wishes are “stark, *chill, livid corpses*”. See JE, Ch. XXVI, p. 260.

¹⁰⁷ JE, Ch. XXX, p. 311.

¹⁰⁸ JE, Ch. IX, p. 72.

¹⁰⁹ JE, Ch. XXXII, p. 328.

¹¹⁰ JE, Ch. XXXIV, p. 354.

¹¹¹ JE, Ch. XXXIV, p. 355.

¹¹² JE, Ch. XXIV, p. 356.

¹¹³ Cf. JE, Ch. II, p. 13.

¹¹⁴ See, for example, St. John's open admission that "it is not the insignificant private individual—the mere man, with the man's selfish senses—I wish to mate: it is the missionary." JE, Ch. XXXIV, p. 357.

¹¹⁵ JE, Ch. XXXIV, p. 359 Cf. JE Ch. XXXII, p. 329.

¹¹⁶ JE, Ch. XXXV, p. 363.

¹¹⁷ JE, Ch. XXXV, p. 368.

¹¹⁸ JE, Ch. XXXV, p. 368.

¹¹⁹ JE, Ch. IX, p. 72.

¹²⁰ JE, Ch. XXXVII, p. 398.

Chapter 5

Deadly Struggles: Disease, Drink and Death in George Eliot's 'Janet's Repentance'

But I am not poised at that lofty height. I am on the level and in the press with him, as he struggles his way along the stony road, through the crowd of unloving fellow men. He is stumbling, perhaps; his heart now beats fast with dread, now heavily with anguish; his eyes are sometimes dim with tears, which he makes haste to dash away; he pushes manfully on, with fluctuating faith and courage, *with a sensitive failing body; at last he falls, the struggle is ended*, and the crowd closes over the place he has left.¹

Having established the centrality of the consumptive in Bleak House and Jane Eyre, I now turn to George Eliot's representation of disease and its relation to her concentration on the suffering, struggling individual. I shall focus first on the question of death in 'Janet's Repentance', relating it to concepts of disease and conflict in a close reading of George Eliot's depiction of consumption and alcoholism.² This will show that conceptions of tuberculosis and alcoholism are integrally bound up with notions of death in the story. This conclusion is supported by the physician and critic Dr J. W. Bennett's praise for Eliot's accurate and convincing presentation of symptoms associated with alcoholics' withdrawal symptoms.³ Secondly, it will also be shown that the story's dynamic force depends on a series of conflicts, primarily that over the Sunday evening lecture, but also a series of contrasting struggles against death and disease, forming the main narrative and ethical armature of the tale.⁴ Thirdly it is also necessary to restore the image of the consumptive to readings of the story as Eliot uses human sympathy for the ill or dying to relate characters like Janet and Tryan as well as to engage her readers' sympathy, thereby offering her own moral message.

Little attention has been paid to the awareness, expressed in this early fiction, of the body and particularly the suffering, diseased, conflict-embroiled body.⁵ Only recently have a physician and a theologian provided useful insights into the role and place of disease in 'Janet's Repentance'. Besides the work of Dr J. W.

Bennett mentioned above, the theologian J. Clinton McCann, Jr. demonstrates that Eliot was 'heavily influenced by Scripture in the role she assigns to disease'.⁶

Other critics are aware of the importance of death in the early works, but fail to treat death as a physical event, with minute bodily details registered in her texts.

The story is underpinned by changes in the structure of medical knowledge, centring on the place of death, which allowed consumption to be distinguished from the confused mass of conditions covered by the term phthisis before 1819. Also, the stereotypical image of the consumptive gained in cultural resonance in the context of a medicine deeply dependant on death and in which, as we saw in Chapter 1, mortality permeated medicine's understanding of consumption. It will be shown that, in George Eliot's hands, the figure of the consumptive presents more than the 'easy metaphors' dismissed by Bennett.⁷ I hope to demonstrate that Eliot structures the relations between her characters on the basis of their diseases and imminent deaths, while going beyond the stock images of the consumptive or of the alcoholic as she does so. This is especially important if we are properly to grasp the tensions between ideas of curability and incurability as opposed to repentance and 'restoration' within the story, as J. Clinton McCann Jr. attempts to do.⁸ Although alcoholism (chronic or acute) was initially conceived of in moral rather than pathological terms in the early part of the nineteenth century, it appears

that, as the century wore on, death became more important in its conception, so drawing it into the orbit of clinical medicine.⁹

The earliest critic to read 'Janet's Repentance', George Eliot's editor John Blackwood, in whose Blackwood's Magazine the story was first serialised, was appalled that the heroine and her brutal husband should both be alcoholics. This prudish attitude to depicting woman drinkers has continued to distract modern critical attention from the importance of death in relation to this aspect of the story. Both Sheila Shaw and J. W. Bennett have found George Eliot's representation of the disease to be invested with immense descriptive and observational power, Bennett, a doctor, even preferring the novelistic representation of delirium tremens to the abstract clinical descriptions of the condition in medical textbooks.¹⁰ Shaw especially shows how faithfully George Eliot presents the various stages through which a recovering alcoholic such as Janet Dempster passes. Despite, however, Robert Dempster's enforced and harrowing delirium tremens and his death from a mortifying broken leg, complicating an alcohol-related meningeal disease, Bennett does not follow up his observation that medicine believes that chronic alcoholism 'has only two ultimate outcomes: sobriety or death.'¹¹

Critics' failure to see death as integral to alcoholism is bound up with chronic alcoholism's ambiguous moral and medical status for a large portion of the nineteenth century. It is the contention here, however, that the history of medical thought on alcoholism in the nineteenth century is in accord with Eliot's suggestion that it was a disease, and like all diseases at the time, crucially depended on the notion of death. William Bynum notes that at the beginning of the 1800s,

excessive drinking had been regarded as a vice and there was no morally neutral medical term describing habitual drunkenness, or alcoholism as we would now refer to it. Habitual drunkenness had been described by the English doctor Thomas Trotter as a disease in 1804, but it was still seen as morally bad.¹² This moralistic view of alcohol and the alcoholic were fostered by the enormous rise in temperance movements in the period. These moral attitudes to alcoholism continued until just a few years after the publication of 'Janet's Repentance' when, Brian Harrison notes, the word *alcoholism* was used to mean 'the diseased condition produced by alcohol'.¹³

The first half of the nineteenth century did see considerable progress in the medical understanding of chronic alcoholism. As early as 1819, the German, von Brühl-Cramer, wrote a treatise on the disease in which it was not treated as a vice. He allowed that alcoholism could lead to immoral acts but distinguished this from the disease itself being a vice. In his view alcoholism, or dipsomania, as he called it, was the abnormal involuntary craving for alcohol. This craving was related to a changed condition of the nervous system and was preceded by physical presentiments (e.g., involuntary eye movements). That the disease was a physical and not a moral condition was further supported by his view that the sufferer could be supported through to abstinence by largely physical means. He also related alcoholism to death, distinguishing three different ways in which the chronic alcoholic's death might be hastened. Amongst these is the case in which a body weakened and damaged by alcohol was vulnerable to other potentially fatal affections. These findings were supplemented by Karl Rösch's work in the 1830s which, in an epistemological gesture towards death, added comprehensive *post*

mortem findings to the description of the disease. He also allowed that there could be both internal, psychological as well as external causes, such as social factors or economic conditions contributing to chronic alcoholism. A work was published by the Swede, Magnus Huss, in 1851, however, which downgraded these findings. It elevated the neurological and psychological symptomatology of the chronic alcoholic to the core of the disease because these symptoms could not uniformly be correlated with organic changes, of the sort discernible at autopsy, in the nervous system and elsewhere.¹⁴ Thus nineteenth-century medicine had already adopted notions of alcoholism in which death played a considerable conceptual role.

The question then is how this new notion of alcoholism, dependant on the concept of death, is registered in fiction. If Janet's physical withdrawal symptoms are downplayed, as Bennett observes, it is precisely because George Eliot is concerned to present the subjective, individualised psychological struggle Janet experiences in the face of physical craving and suffering. Eliot opts to present the struggle against alcoholic disease and death from the inside. Concentrating on the individual's experience of anguish and pain is central to both George Eliot's narrative method and moral objectives – she aims to engender a sympathy between the reader and character which parallels that which she advocates between individuals outside of fiction. She presents the individual, with whom the reader can sympathise and identify, rather than the type – the alcoholic or the consumptive – entering into characters' intimate fears and sufferings when, for example,

his heart now beats fast with dread, now heavily with anguish; his eyes are sometimes dim with tears, which he makes haste to dash away; he pushes manfully on, with fluctuating faith and courage, *with a sensitive failing body;* until *'at last he falls, the struggle is ended,* and the crowd closes over the place he has left.' [italics added]

As the epigraph to this Chapter shows, it is the suffering individual, the *patient*, in the Greek sense of the word, caught up in a drama of life and death upon whom Eliot focuses. As Victorian writers from Dickens to Rhoda Broughton realised, it was when characters were on the verge of death that their creators could be certain of engaging their readers' sympathy and interest.

Much as Peter Fenves has noted in the case of Rev. Tryan, Janet stands out from the crowd of drinkers on the basis of her struggle against a deadly disease. That throng, it will be recalled, is made up of her husband's companions and the constituents of Milby society, 'who', like Janet, 'often found it impossible to keep up their spirits without a very abundant supply of stimulants'.¹⁵ Death, moreover, is prominent in Eliot's presentation of two crises in Janet's life. J. Clinton McCann has noted the presence of death imagery surrounding Janet's ejection from her home. Furthermore, Janet chooses the cell-like seclusion of Dempster's grave as the site in which to overcome her critical struggle against the temptation to drink.¹⁶ These little textual details act to foreground Janet's relation to death and allow the reader to become aware of its importance in the central concern of her life, her battle with alcohol.

Thus while Bennett is correct regarding Eliot's use of the consumptive because this figure offered a series of established, stereotypical characteristics to the contemporary writer, it will be shown that she moved beyond static cliché, contextualising the consumptive's imminent death within the dynamics of conflict which drive her fiction. The consumptive not only offers possibilities for pathos and poignant death scenes, but, because death is usually slow and gradual, presents

the chance to explore the implications of life fundamentally directed towards death *from the inside*. George Eliot is concerned with the ethical rather than the metaphysical consequences of this idea. Death is conceived, in ‘Janet’s Repentance’, not only through disease but also through the struggle of the living against death. Conflict itself is often seen as the attempt to impose death on the living.¹⁷ Carol Martin and J. Clinton McCann Jr. have both commented on the religious interpretation of conflict in the work. Martin shows that the first serialised part of the story included three key conflicts – that between Dempster and the Rev. Tryan, between Janet and her husband Dempster, and Janet’s struggle with her addiction to alcohol.¹⁸ If George Eliot is deeply interested in the organic notion of change as growth or decay, as Carroll notes, then the dynamics of this change depend on crises in which death and injury of one form or another are real possibilities.¹⁹

The story’s action is structured by the conflict surrounding the Sunday evening lecture. Tryan temporarily loses the battle, but ultimately triumphs when the Bishop overrules the local decision against the meeting. Once this final victory is complete, Dempster’s fortunes go into permanent decline, leading to his death. Throughout this struggle Dempster steadily drinks his way towards severe ill health, while Rev. Tryan gradually succumbs to consumption. Janet’s struggle with her husband matches his fortunes in the wider world, with the proviso that there is no respite in his mounting cruelty even in the brief period of his minor victory. The need for Janet to take a stance in relation to her alcoholism gradually becomes more and more imperative, reaching a climax once Dempster has thrown her out. While sustained in her efforts by Rev. Tryan’s help, her battle with

alcohol reaches crisis point when she discovers her dead husband's secreted decanter of brandy and is tempted to drink again.

Yet such schematic trends within the narrative are also subject to the strictures of the code of secrets described by Roland Barthes.²⁰ In terms of this code, elaborated in Barthes's analysis of a nineteenth-century short story, the reader is allowed limited access to secret knowledge and is kept reading by his or her desire to learn the truth. 'Janet's Repentance' is no exception to this code and thus the resolution of the plot necessarily remains unclear until very near the end. It is unclear, from the story's title, for example, whether Janet's 'repentance' will be successful or not. On the other hand, Dempster's name contains his fate – as the one who pronounces doom it is soon clear that he will meet a sticky end involving drink. Edgar Tryan's fate is only gradually revealed. It is uncertain whether he is ill with a minor or major malady as his symptoms emerge – until, that is, his fate is sealed when the text reveals sufficient information for the reader to conclude that he is consumptive. These plot trajectories also depend on death since, as Kenneth Burke noticed, they are manifestations of the way in which characters' modes of life often determine their way of death.²¹ George Eliot's focus on mortal struggles, the struggles of individuals and their gradual decline and death also has implications for moral closure at the end of the story.

II

Given that modern readers have lost sight of the importance of signifiers of consumption due to changes in medicine, it is useful to explicate these fully before showing that illness forms the crucial connection between Janet and Tryan. Once the textual details of Tryan's consumption have been presented, I will show that death is prominent at crucial moments in Janet's struggle with her own condition and in the presentation of Dempster's alcoholism.

The reader first discovers that Reverend Tryan's health is in danger when Mrs Pettifer voices her fear that Tryan's concern to be near his poor parishioners has overridden considerations of health. By living in 'close rooms' among 'dirty cottages', she says, 'I'm afraid he hurts his health by it; he looks to me far from strong.' As the story progresses we learn a great deal, particularly about Tryan's own orientation to his disease, however, this is better considered with reference to some details of Janet's struggle with alcohol. Mr Tryan is first presented in a paragraph which contains the classic signs of the literary consumptive. Although his having been refused permission to hold the contentious Sunday evening lecture could be construed as causing him to have lost some of his equipoise, he carries the signs of consumption right from the outset since his 'grey eyes too shine with unwonted brilliancy'. The text is also at pains to impress Tryan's difference from any 'ordinary whiskerless blond' upon the reader, for it further notes that,

Except ... that the complexion was rather pallid, giving the idea of imperfect health, Mr Tryan's face in repose was that of that of an ordinary whiskerless blond, and it seemed difficult to refer a certain air of distinction about him to anything in particular, unless it were his delicate hands and well-shapen feet.²²

Tryan's delicate body, his blond hair and his pallor are all accommodated in the picture, elaborated by contemporary medicine, of the phthisical diathesis.

Janet's friend and neighbour, Mrs Pettifer, is not the only one to notice Edgar Tryan's disregard for his health. His friend, Mr Jerome, eventually resolves to discuss the priest's health with him seriously, riding out from Milby to Paddiford to see Tryan. Mr Jerome raises the matter in a way which brings home to both the reader and the young priest that death has become a very real possibility. He notes that one of the doctors in the town, Mr Pratt,

... tells me as your constitution's dillicate, as anybody may see, for the matter o' that, wi' out bein' a doctor. An' this is the light I look at it in, Mr Tryan ... The more care you take o' yourself, the longer you'll live, belike, God willing, to do good to your fellow-creatures.

Tryan's response is typically fatalistic, revealing that his perspective on his own health is somewhat skew:

'Why, my dear Mr Jerome, I think I should not be a long-lived man in any case; and if I were to take more care of myself under the pretext of doing more good, I should very likely die and leave nothing done after all.'²³

There are others with a more selfish interest in Edgar Tryan's health. Eliza Pratt, the doctor's daughter, has had occasion to overhear her father declare that Mr Tryan, 'was consumptive, and if he didn't take more care of himself, his life would not be worth a year's purchase'.²⁴ News of Tryan's impending death causes three changes of heart: Eliza Pratt feels guilty about her recent selfish speculations on whether Tryan is romantically involved, the two Miss Linnets abandon their own similar interests in Mr Tryan, and Mrs Pettifer discounts any prospect of marriage given his condition.

Contrary to situations in which consumptive young women are rendered desirable by their illness, here romantic interest falls off sharply once the illness becomes known. At a tea party Mary Linnet asks Mrs Pettifer whether she noticed ‘that short dry cough of Mr Tryan’s yesterday’, continuing, ‘I think he looks worse and worse every week’. Death precludes any prospect of marriage in Mrs Pettifer’s view as she regrets that ‘he could have taken some nice woman as would have made a comfortable home for him. I used to think he might take to Eliza Pratt; she’s a good girl, and very pretty; but I see no likelihood of it now’.²⁵ Although the vague air of delicacy seems to encourage Edgar Tryan’s young female parishioners, the ironic note in much of the depiction of these silly young women gives way to a critical presentation of the manner in which they react to the certainty of Tryan’s imminent death. Criticism aside, however, Tryan’s life from this point is led and read within the shadow of death.

George Eliot traces the smallest of changes in the progress of Tryan’s disease. In so doing she adds the weight of medical exactitude to any verisimilitude produced by invoking the traditional literary signs of consumption. This provides a contrasting backdrop of decline against which to view Janet’s increasing separation from disease and death as she overcomes alcoholism. So Mrs Pettifer notices that as well as ‘getting thinner and thinner’, Tryan is also ‘quite short o’ breath sometimes’ at the time when she and Janet plan to persuade him to move to a healthier location. The disease’s progress is confirmed by a second opinion, supported by the technologically advanced stethoscope. Through these means, Janet comes to know ‘the worst.’ In the novella’s penultimate Chapter we learn that ‘the cough had changed its character’ and that the emaciation has advanced so

far as to have rendered Tryan's hand 'transparent'. All of which extends the drama of verisimilar detail which Josephine McDonagh has remarked upon in Scenes of Clerical Life and the other early fiction.²⁶

Bennett's suggestion that 'throughout, George Eliot's medical allusions to tuberculosis are merely confirmatory of a known diagnosis, providing easy metaphors for her moral message', and its implication that the work indulges in a rather superficial use of disease indicators to make a moral point, is too dismissive.²⁷ George Eliot enters into her characters' psychological struggles, through indirect internal speech, so as to have a technical finger on that pulse which 'now beats fast with dread, now heavily with anguish' and to trace the subjective fluctuations of 'faith and courage' noted in the epigraph to this Chapter. Consumption, for George Eliot, provides a textual opportunity to avoid the superficial, exterior presentation of the disease which, for example, Dickens's Richard Carstone in Bleak House represents. Instead of offering the clichéd picture of a pain-free affliction, 'Janet's Repentance' inflects the cliché by adding subjective depth to it.

Janet takes a morsel of pudding round to the consumptive Sally Martin only to hear an unfamiliar voice in Sally's sickroom. Reluctant to leave with her little benevolent mission incomplete, Janet stands in the next room, her presence as yet undetected, and overhears what passes. The voice, which she takes to be Tryan's,

was interrupted by one of the invalid's violent fits of coughing.
 'It is very hard to bear, is it not?' he said when she was still again. 'Yet God seems to support you under it wonderfully. Pray for me Sally, that I may have strength too when the hour of great suffering comes. It is one of my worst weaknesses to shrink from bodily pain, and I think the time is perhaps not far off when I shall have to bear what you are bearing. ...'²⁸

Tryan clearly knows that he will soon have to suffer the physical ravages of tuberculosis and fears them sufficiently to ask for Sally's prayers. Janet, in the opposite, anti-Evangelical camp in the dispute over the Sunday evening lecture, is surprised not only that Tryan is not the expected self-satisfied, unctuous and exhorting preacher, but that what she hears is,

a simple appeal for help, a confession of weakness. Mr Tryan had his deeply-felt troubles, then. Mr Tryan, too, like herself, knew what it was to tremble at a foreseen trial – to shudder at an impending burthen, heavier than she felt able to bear?

Janet's growing sympathy is precisely predicated on their both being prey to deadly diseases. The narrative continues, emphasising both the radical change in Janet's attitude towards Tryan and the function his disease plays in this change:

The most brilliant deed of virtue could not have inclined Janet's good-will towards Mr Tryan so much as this fellowship of suffering, and the softening thought was in her eyes when he appeared in the doorway, pale, weary and depressed.²⁹

The key literary signifier of consumption, pallor, occurs in the sentence registering the beginning of their intimacy. Catherine Moloney, exploring the sexual overtones associated with consumptives, argues that Janet's pathologisation as an alcoholic endows her presentation, 'with a certain electricity, and erotic momentum which is the medium of Janet's encounters with Tryan,'³⁰ Moloney fails to show, however, that there is anything more than the profound friendship founded on mutual human suffering.

It is Janet's memory of this brief recognition, a moment in which Janet and Tryan exchanged no words, that comes to her in her darkest hour. Having been ejected from her home into a cold winter's night in the small hours of the morning wearing only a night-dress, Janet seeks shelter with her friend, Mrs Pettifer. She is thrown

into a profound despair, realising that a critical moment has come both in her relations with her husband Robert and in her related, habitual use of alcohol. She then recalls Tryan's personal experience of suffering and the hope of being understood which that holds out for her. She pours out her heart to Tryan and he is so moved by the depth of her passion that he barely hesitates before he relates his own 'deep and hard experience' in a bid to convince her that she may yet find comfort and hope.³¹ I shall return to Janet's confession when discussing alcoholism and death, however, the conclusion of their interview also involves Tryan's consumption in a way which develops the subjective experience of the disease and impending death. Janet takes Tryan's hand, assuring him she will trust in God's beneficence and that she will follow Tryan's suggestions. The text carefully describes the final wordless moments of the interview:

Janet's dark grand face, still fatigued, had become quite calm, and looked up, as she sat, with a humble childlike expression at the thin blond face and slightly sunken grey eyes which now shone with a hectic brightness. She might have been taken for an image of passionate strength beaten and worn with conflict; and he for an image of the self-renouncing faith which has soothed that conflict into rest. As he looked at the sweet submissive face, he remembered its look of despairing anguish, and his heart was very full as he turned away from her. 'Let me only live to see this work confirmed, and then ...'³²

Tryan's consumptive state is stressed through the presentation, above, of three literary and, medical signifiers: the thinning face, sunken eyes and the feverish, 'hectic' brilliance which characterise them. The quoted thought which ends the passage, however, shows how Tryan reluctantly recognises that his disease and his desire to help Janet through the necessarily protracted struggle to free herself of her alcohol dependence are at odds; Tryan, for the first time wishes his death to be deferred and the text mirrors this desire by suppressing, through ellipsis, any mention of mortality. So although, as some commentators have indicated, there is

an allusion to Christ in Tryan's presentation, it is counterbalanced by secular longings such as the ones he experiences here.³³ Similar secular attachments underlie Tryan's unwillingness to consider a change of climate in the hope that it may defer his death. Tryan evades a direct reply to Miss Linnet's enquiries as to why he will not avail himself of a change of climate, 'I don't see any good end that is to be served by going to die in Nice, instead of dying amongst one's friends and one's work. I cannot leave Milby...' Tryan not only wants to prolong his life, but the reason *why* he wishes to do so also means that he needs to prolong it in close proximity to his 'friends'.³⁴

Alcoholism and tuberculosis are both chronic diseases with an associated high risk of death. Both are integral to the plot and psychological dynamics in 'Janet's Repentance'. As was seen above, what draws Janet, already addicted and increasingly brutalised by Dempster, to Tryan is the recognition of his status as a fearful and anxious consumptive: there is a 'fellowship of suffering' between them. The conversation, held as the ladies of Paddiford parish cover the Evangelical pastor's lending library stock in black canvas, which introduces the subject of Tryan's ill health into the novel also introduces Janet's alcoholism.³⁵ Unlike consumption, however, alcoholism was a morally charged condition and the ladies hedge around its precise nature with dark suggestions of her 'leading such a life', 'looking so strange' and her occasionally appearing in the town's streets in a state in which 'she wasn't fit to be out.'³⁶ Mrs Pettifer, however, defends her friend, citing her loyalty, and goes on to suggest that Janet ought to be excused her 'failing' because

When a woman can't think of her husband coming home without trembling, it's enough to make her drink something to blunt her feelings – and no

children either, to keep her from it. You and me might do the same, if we were in her place.³⁷

Although Janet drinks enough to ‘blunt her feelings’ of fear, the reader can only infer her addiction from the strength of the moral opprobrium which surrounds Janet.

The ladies gather to work on the library books the day after Mr Prendergast refuses to allow the Sunday evening lecture and the protracted celebrations which follow. As a result of these celebrations Dempster leaves the local inn thoroughly drunk. In a fit of drunken anger he knocks loudly on his front door, fruitlessly trying to rouse Janet to open it for him, despite his having a latch key. He angrily enters the house calling for his wife and cursing her as a ‘creeping idiot’ when he perceives her shuffling on the stairs. As with Tryan, the initial description of Janet notes her attractiveness, as well as the way her suffering has left traces on her body:

Her grandly-cut features, pale with the natural paleness of a brunette, had premature lines about them, telling that the years had been lengthened by sorrow, and the delicately-curved nostril, which seemed made to quiver with the proud consciousness of power and beauty, must have quivered to the heart piercing griefs which had given that worn look to the corners of the mouth. Her wide open black eyes had a strangely fixed, sightless gaze, as she paused at the turning, and stood silent before her husband.³⁸

The reason for the ‘sightless’ quality of her gaze is immediately seized upon by her drunk husband as he threatens to ‘teach’ her ‘to keep me waiting in the dark, you pale staring fool!’ He realises that she has been drinking again and, in a painfully ironic line, says ‘What, you’ve been drinking again, have you? I’ll beat you into your senses.’ He pushes her into the dining room where he proceeds to beat Janet, despite her being so intoxicated that she does not even tremble, instead,

standing stupidly unmoved in her great beauty, while the heavy arm is lifted to strike her. The blow falls – another – and another....³⁹

as she begs in vain for pity. This presentation of domestic violence vividly verifies Mrs Pettifer's view that Janet finds herself in circumstances which easily result in recourse to alcohol's anaesthetic effects.

Janet's deepening alcoholism is signalled by Milby gossip in the closing paragraphs of Chapter 13, which focuses on the various 'symptoms that things were getting worse with the Dempsters.' Everyone remarks on Janet's increasingly obvious misery and her friend, Mrs Crew, admits that Janet is 'not like herself lately.' She also observes how Janet is 'out of health' and plagued by severe 'headaches'. Mrs Phipps notices how Janet is now 'often "so strange"', 'and then never taking care of her clothes, always wearing the same things week-day or Sunday.'⁴⁰ Janet reaches the lowest point of her downward spiral into alcohol and despair seated on the cold doorstep when Dempster throws her out, beginning, then, to gain some insight into her pathological condition. The narrative invokes the motif of the drowning person's instantaneous review of their past life, common to many Victorian death scenes, to suggest a death-like crisis, but also succeeds in objectifying the form of her life for her. Her despair, however, forces her to conclude that all the promise of her beauty, love and youthful hopefulness has only served to deepen her sense of misery and despair as these illusions have been destroyed. In contrast to her mother's view of suffering as a way of drawing her nearer to God, she concludes that,

*Her troubles had been sinking her lower and lower from year to year, pressing upon her like heavy fever-laden vapours, and perverting the very plenitude of her nature into a deeper source of disease. Her wretchedness had been a perpetually tightening instrument of torture, which had gradually absorbed all the other sensibilities of her nature into the sense of pain and the maddened craving for relief.*⁴¹

The use of miasmatic ideas of disease, in the ‘fever-laden vapours’ corrupting Janet’s very nature, convey Janet’s oblique consciousness of her pathological condition.

Also the erosion of sensibilities leaves only the elements pinpointed by Mrs Pettifer, a sense of pain and an insane desire for what the same paragraph terms ‘oblivion’, whatever its source.

Despite these early hints of the pathological course Janet has embarked on, she sees her predicament in the moral and religious terms which reflect one part of contemporaneous thought on alcoholism. Janet realises, however, that the heart of the problem is that she has become trapped in an ‘evil habit, which she loathes in retrospect and yet is powerless to resist.’⁴² Eliot presents a very enlightened view of alcoholism in showing Janet to be prey to irresistible urges rather than merely indulging a vice. When Edgar Tryan comes to her aid she immediately says she needs to share her unhappiness with someone, but sees it in terms of ‘how weak and *wicked*’ she is. Janet’s confession of how she began drinking is saturated with moral language:

I had never been used to drink anything but water. I hated wine and spirits because Robert drank them so; but one day I was very wretched, and the wine was standing on the table, I suddenly I can hardly remember how I came to do it I poured some wine into a large glass and drank it. It blunted my feelings, and made me more indifferent. After that the temptation was always coming, and it got stronger and stronger. I was ashamed, and I hated what I did; but almost while the thought was passing through my mind that I would never do it again, I did it. It seemed as if there was a demon in me always making me rush to do what I longed not to do.⁴³

She continues, saying ‘I shall always be doing wrong and hating myself after – sinking lower and lower, and knowing that I am sinking.’ Tryan not only reveals the extent to which he can empathise with her despair through telling his own story, but also offers practical advice. He advises her to confide in her mother and Mrs

Pettifer and to ask ‘them to help you in guarding yourself from the least approach of the sin you most dread. Deprive yourself as far as possible of every means and opportunity of committing it.’⁴⁴ This advice is understandably couched in moral terms since it comes from a clergyman, but it does echo Janet’s own recognition of the involuntary component of alcoholic craving.

The day after this interview, Janet begins to suffer mild withdrawal symptoms. Having changed her views on the Reverend Tryan, she accompanies Mrs Pettifer to church to hear him preach and is warmly welcomed by Tryan’s flock. Mrs Pettifer sees that Janet is emotionally and physically taxed and hurries her home; the text carefully registering Janet’s state:

When they reached home, a violent fit of weeping, followed by continuous lassitude, showed that the emotions of the morning had overstrained her nerves. She was suffering, too, from the absence of the long-accustomed stimulus which she had promised Mr Tryan not to touch again. The poor thing was conscious of this, and dreaded her own weakness, as the victim of intermittent insanity dreads the oncoming of the old illusion.

There is a suggestion that Janet’s mental grasp of reality falters as a result of the withdrawal of her ‘long-accustomed stimulus’ since,

as evening approached Janet’s morning heroism all forsook her: her imagination, influenced by physical depression as well as by mental habits, was haunted by the vision of her husband’s return home, and she began to shudder with the yesterday’s dread. She heard him calling her, saw him going to her mother’s to look for her, she felt sure he would find her out, and burst in upon her.⁴⁵

The horrifying implications behind these mild symptoms are brought home through George Eliot’s skilful handling of the two plot lines. For while Dempster has been brutalising Janet, his fortunes have simultaneously been declining and his legal practice has lost several clients due to his involvement in the Sunday evening lecture conflict. Consequently, he has been drinking even more heavily than usual,

and has beaten his horse so savagely that it threw him from his cart on the second night Janet spent with Mrs Pettifer. Thus the Chapter which registers the rigors of undergoing mild withdrawal ends with the recovery of 'Dempster's body' and skilfully notes that 'No one knew whether he was alive or dead.'⁴⁶

Yet, from the opening paragraphs of the story one can discern suggestions, of the sort which interested Frank Kermode, of a deadly fate awaiting Dempster.⁴⁷ The first words he utters, contain an idiomatic reference to his death: he defiantly says 'as long as my Maker grants me power of voice and power of intellect, I will take every legal means to resist the introduction of demoralising, methodistical doctrine into this parish'. It also becomes clear why Dempster speaks in 'a loud, rasping ... tone': he is 'seated mixing his third glass of brandy-and-water.'⁴⁸ The first Chapter significantly closes with his friend Mr Tomlinson remarking 'Why, he's drunk the best part of a bottle o' brandy since here we've been sitting'. It is unlikely that George Eliot expected her readers to believe Mr Tomlinson's assertion that Dempster could tolerate drink so well that 'his head'll be as clear as mine' very shortly.⁴⁹ Thus, when his fortunes worsen, it comes as no surprise that he begins drinking 'more than ever', driving even more furiously and indulging his taste for sadistic cruelty by beating Janet.

There are other direct forebodings and predictions of the pathological effects being wrought in Dempster's body, amongst the 'symptoms' which provide Milby with subjects for gossip about the Dempsters' fortunes. Mr Pratt remarks to Mr Pilgrim, Dempster's doctor, that Dempster has finally seen sense and hired a driver for his client meetings and that he now 'won't end with a broken neck after all. You'll

have a case of meningitis and delirium tremens instead.' Mr Pilgrim agrees that Dempster's body 'can hardly stand it much longer at the rate he's going on,' but feels that his practice can afford to lose a few clients. Pratt retorts 'His business will outlast him, that's pretty clear,' but adds, in what appears to be an innocuous afterthought, that Dempster will 'run down like a watch with a broken spring one of these days.'⁵⁰

After the Sunday service Mr Landor, one of Tryan's friends, brings him the news that Dempster has been involved in an accident, informing him, and the reader, that the lawyer has been seen by Mr Pilgrim suffering from a leg broken in two places, but that 'It's likely to be a terrible case, with the state of his body.'⁵¹ When Tryan, concerned that news of the situation should reach Janet should Dempster be dying, rushes to the lawyer's house, he is informed by Mr Pilgrim:

Well, you know there's no telling in these cases you know. I don't apprehend a speedy death, and it is not absolutely impossible that we may bring him round again. At present he's in a state of apoplectic stupor; but if that subsides, delirium is sure to supervene, and we shall have some painful scenes. It's one of those complicated cases in which delirium is likely to be of the worst kind – meningitis and delirium together – and we may have a good deal of trouble with him.⁵²

Although Dempster's alcoholism has not killed him at this point, he is certainly seriously ill as a result of it. Mr Pratt's prediction has been fully realised.

The ravages of alcohol are, however, simultaneously wracking Janet's body and mind, and the reader is meant to see Janet's condition – repentant as she is – in the light of her husband's more dangerous and advanced case. When Tryan reaches Mrs Pettifer's to see Janet, he is determined to keep the news of Dempster's accident from her and so spare her the shock which, in her present delicate state of

withdrawal, might undo the progress she has made. Mrs Pettifer confirms that Janet is ‘not fit to hear any bad news;’ since she is ‘very low this evening – worn out with feeling; and she’s not had anything to keep her up as she’s used to. She seems frightened at the thought of being tempted to take it.’⁵³

Janet comes face to face with the horrifying bodily consequences of alcoholism when she follows Mr Pilgrim into her home, having seen him hurriedly entering, and surmises that something is amiss. Dempster is in the grip of delirium tremens and requires the force of ‘two strong nurses’ to restrain him. While his face, ‘purple and swollen, his eyes dilated,’ is shocking enough, it is the terrifying hallucinations which attract George Eliot’s detailed attention. He seems to see Janet as alternately dead and then alive, come to revenge herself upon him. He utters confused fears that he is being pursued for financial malpractice, and bursts into threats against religious people. He even sees flying toads with fiery tongues. Throughout these visions he remains deaf to Janet’s anguished entreaties and finally breaks loose from the nurses, collapsing in a convulsive fit. Despite his past cruelty to her, the ‘fellowship of suffering’ also extends to include Dempster and she is determined to nurse him, spending the following few days with him as his condition worsens.

The delirium lessens and Dempster spends longer and longer spells unconscious, but Janet avoids confirming her growing fears. Eventually Mr Pilgrim feels compelled to prepare her for the worst; he tells her,

Mr Dempster’s state is now such that I fear we must consider recovery impossible. The affection of the brain might not have been hopeless, but, you see, there is a terrible complication; and I am grieved to say the broken limb is mortifying.⁵⁴

Death now explicitly and literally has taken hold in Dempster's body. Four days later, having ironically been sustained by the doctor's administering 'stimulants', Dempster lies on the verge of death. The reader is not allowed to forget Mr Pratt's retort to his colleague about how Dempster will meet his end, since Janet is presented as sitting in the profound silence of the house hearing 'no sound but her husband's breathing *and* the ticking of the watch on the mantelpiece.'⁵⁵ At the key moment, when the text itself is signalling the imminence of death, the reader is reminded that Janet too is an alcoholic, albeit recovering:

There was a smell of brandy in the room; it was given to her husband from time to time; but this smell, which at first had produced in her a faint shuddering sensation, was now becoming indifferent to her: she did not even perceive it; she was too unconscious of herself to feel either temptations or accusations.⁵⁶

Although the drama of Dempster's final illness takes precedence over Janet's symptoms, this detail is inserted to remind one of the opposing directions the two characters are moving in on the life-death continuum. This distinction is emphasised since it is now Dempster who figuratively drowns as he moves further and further away from her, the text continues: 'She only felt that the husband of her youth was dying; far, far out of her reach, as if she were standing helpless on the shore, while he was sinking in the black storm-waves'.

An eerie elision of the boundaries between life and death, not unlike that hinted at in the case of Tryan's consumption, characterises both the Chapter's and Dempster's end. This is suggested by the way daylight paradoxically fails to bring a positive note to the scene when it is noted that 'the new light thrown on her husband's face seemed to reveal the still work that death had been doing through

the night'. The uncanny slippage continues when Dempster is given brandy by Mr Pilgrim in an attempt to rouse him, and the patient rallies:

Suddenly a slight movement, like the passing away of a shadow, was visible in his face, and he opened his eyes full on Janet.

It was almost like meeting him again on the resurrection morning, after the night of the grave.

'Robert, do you know me?'

He kept his eyes fixed on her, and there was a faintly perceptible motion of the lips, as if he wanted to speak.

But the moment of speech was for ever gone – the moment for asking pardon of her, if he wanted to ask it. Could he read the full forgiveness that was in her eyes? She never knew; for, as she was bending to kiss him, the thick veil of death fell between them, and her lips touched a corpse.⁵⁷

The 'passing away of a shadow' is strongly suggestive of the moment of death, despite Dempster's looking at Janet. This note is emphasised in the comparison which invokes 'the resurrection morning' and suggests that Dempster is perhaps both physically and morally dead already. Although there is a degree of historically accurate sentiment in Janet's kissing a corpse, there is something deeply troubling, perhaps dependent on the ambiguity surrounding veils (they hide, but typically reveal as well), in the relation established between Janet and the 'corpse' in the close of the Chapter. This leads to the conclusion that Janet has not fully escaped from the ambit of death, and is still in its embrace.

Although it is suggested, as was seen above, that Janet has progressed in her struggle to overcome alcohol, it is not certain, at Dempster's death, that she is entirely free of its hold. It was noted above how the text is strongly informed by moral attitudes to alcohol prevalent at the time, but an exception to this overall picture occurs early in the Chapter following Dempster's death. George Eliot presents the opinions which make up Milby gossip as an additional backdrop against which to view Janet. One of these exchanges reveals something of even

English medicine's willingness to regard alcoholism as a disease in the 1850s (despite the story being set in the early 1830s).⁵⁸ Mr Pilgrim, the Dempsters' physician, is an acute enough medical observer to have deduced Janet's struggle from his close association with her during Dempster's final days. Thus in response to Mrs Lowme's hasty critical remark that Janet ought to 'cure herself' of 'her habits' before adopting the high moral position entailed in Evangelicalism, Pilgrim remarks:

Well, I think she means to cure herself, do you know. ... I feel sure she has not taken any stimulants all through her husband's illness; and she has been constantly in the way of them. I can see she sometimes suffers a good deal of depression for want of them – it shows all the more resolution in her. Those cures are rare; but I've known them to happen sometimes with people of strong will.⁵⁹

Although currently some factions are of the opinion that talk of 'cure' in relation to alcoholism distracts from alcoholics' difficulties even when detoxified, the term does allow a more neutral moral approach to the disease. Despite overcoming the temptation to drink while her husband lies ill, Janet is still not in the clear.

The critical point in Janet's struggle with her deadly condition is foreshadowed by a deepening of the emotional turmoil which she experienced on her first visit to Mr Tryan's service. All is going fairly well when her mother is suddenly called away to attend to a relative's final illness and Janet goes to seek companionship and support from her friends Mrs Pettifer and Mrs Crewe, only to find that both are not at home. This is the first time she has been left alone since being ejected from the house and a feeling of 'undefined fear' seizes her. On returning home she bursts into tears and the narrator comments that it 'is such vague undefinable states of susceptibility as this – states of excitement or depression, half mental, half physical – that determine many a tragedy in women's lives.' This formulation echoes the

description of an earlier experience of withdrawal symptoms, where it was noted that her ‘imagination, *influenced by physical depression as well as by mental habits,*’ was plagued by visions centring on Robert’s cruelty.⁶⁰

The critical moment, however, is reached when Janet is searching through Dempster’s writing desk for a letter relating to his legal practice and comes upon a decanter of brandy secreted in his writing desk. She sees the bottle and is seized by an irresistible desire which shudders through her frame:

it seemed to master her with the inevitable force of strong fumes that flood our senses before we are aware. Her hand was on the decanter; pale and excited, she was lifting it out of its niche, when, with a start and a shudder, she dashed it to the ground, and the room was filled with the odour of the spirit.⁶¹

Janet rushes from the house and the text signals the life-and-death nature of Janet’s struggle in her choice of Dempster’s recently closed grave as the place where she feels the ‘demon’ of nearly overwhelming desire can be frightened off. In a passage reminiscent of the moment of conversion in many spiritual autobiographies, Janet sits down in cell-like confinement beside the grave with the intention of recalling the agonies and horrors of addiction so as to strengthen her commitment to her new-found source of Christian strength. Yet even her invocations of the past are shot through with references to disease as, ‘She tried to recall those first bitter moments of shame, which were like the shuddering discovery of the leper that the dire taint is upon him; the deeper and deeper lapse; the oncoming of settled despair’.⁶² To reinforce this impetus towards abstention, Janet reminds herself of Tryan’s succour, but she is still despondent about the prospects of withstanding such overwhelming desire again.

Only once she has sought out the ailing priest is she finally able to complete the break alluded to in the story's title and, perhaps because her disease is incurable, this break is reported in suitably Christian terms. She walks home from the brief interview with Tryan through the fields between Paddiford and Milby and the text consolidates its confessional pattern by noting,

That walk in the dewy starlight remained for ever in Janet's memory as one of those baptismal epochs, when the soul, dipped in the sacred waters of joy and peace, rises from them with new energies, with more unalterable longings.⁶³

Janet has replaced the 'impetuous' pathological desire of her temptation with the decanter with healthier, moral, 'longings'. The story's close is, however, ambiguous: Janet appears to have totally overcome alcoholism, escaping the death it held in store for her, but it leaves her a painfully reduced character. The final paragraph alludes to a now aged Janet surrounded by children (of an adopted daughter), a woman 'rescued from self-despair, strengthened with divine hopes, looking back on years of purity and helpful labour.'⁶⁴

If, as Diana Reisen has shown, Eliot's major novels give prominence to struggles or conflicts between characters orientated either towards life or towards death, it can also be shown that life and death conflicts permeate the story. Besides Janet's struggle against an eventual alcoholic death, other individuals' struggles are also presented.⁶⁵ The individual's struggle to survive also encompasses the diseased Edgar Tryan.

When Tryan is first introduced, it is noted that his eyes shine with the 'unwonted brilliancy' characteristic of the consumptive. The text adds that this brilliancy is also linked with tensions in his character:

They were not remarkable eyes, but they accorded completely in their changing light with the changing expression of his person, which indicated the paradoxical character often observable in a large-limbed sanguine blond; at once mild and irritable, gentle and overbearing, indolent and resolute, self-conscious and dreamy. Except that the well-filled lips had something of the artificially compressed look which is often the sign of a struggle to keep the dragon undermost, ... Mr Tryan's face in repose was that of an ordinary whiskerless blond, ...⁶⁶

The narrative understandably focuses on Janet's struggle to free herself from her addiction, but it also contrasts this with an account of the sexual and psychological aetiology of Tryan's disease. Tryan, describing his own past sufferings to Janet during her first crisis, reveals that the distress he suffered following his discovery that his lover, Lucy, had gone off with another, together with the dissipated life he had led, led to 'an illness which left my health delicate, and made all dissipation distasteful to me.'⁶⁷ What sort of 'dissipation' this has been is unclear, but Tryan's guilt centres on his responsibility for sexually corrupting Lucy and, ultimately causing her death. Tryan's consumption is a painful consequence of psychological suffering and dissipation: it is a penalty.

The conflict between Tryan and Dempster is also linked directly to Tryan's eventual death. In the first half of the story, Dempster is determined to drive Tryan from the town even though he cannot stop the Sunday evening lecture. To achieve his aim he orchestrates a demonstration of anti-Tryanite feeling, including satirical posters and catcalling, around the church entrance. Tryan, characteristically pale, and his supporters band together and march resolutely through the jeering crowd towards the church. The narrative provides a perspective on individual suffering, noting how outwardly, 'Mr Tryan was composed, but inwardly he was suffering acutely' from the jeering 'tones of hatred and scorn'. It continues,

... his conscience was in repose, but his sensibility was bruised.

Once more only did the Evangelical curate pass up Orchard street followed by a train of friends; That second time, Janet Dempster was not looking on in scorn and merriment; her eyes were worn with grief and watching, and she was following her beloved friend and pastor to the grave. ⁶⁸

Here the prolepsis makes it very clear that Dempster and his supporters are partially responsible for Tryan's death.

I have shown that it is possible to read 'Janet's Repentance' as a tale of illness involving life and death struggles. George Eliot penetrates the intimate psychological lives of her characters, tracing therein the dynamics of their struggles with death. She frames the account of Dempster's horrific, acute alcoholic illness and death within the story of Janet's battle with alcohol, forcing the reader to perceive the deadly danger at the heart of Janet's predicament. Dempster's conflict with Tryan and its outcome is integrated with an exploration of Tryan's wish to live or die. Eliot also forges moral links between Janet and Tryan on the basis of their both inhabiting the world of deadly disease and sharing 'a fellowship of suffering'. Through the use of disease in 'Janet's Repentance', death comes to be both *within* and *opposed to* life. Ultimately, however, George Eliot settles for life. This is seen both in the story's conclusion and in the two kisses which, in the one case, resolves a conflict, and, in the other, seals a poignant change of orientation to life. In addition to signalling Janet's continuing existence within the shadow of alcoholic pathology, kissing Dempster's corpse is also her gesture of forgiveness towards him. Her final kissing of Tryan, on the other hand, is a small symbol of Tryan's paradoxical resumption of a positive, erotic orientation towards life at its very end. If death and sexuality had been linked in Janet's kissing Dempster's corpse in a troubling, perhaps disgusting way, this second conjoining of Eros and Thanatos affirms Janet's new *life* in her relation with Tryan. Tryan, after all,

proposes that they ‘kiss each other’ and the narrative continues, ‘She lifted up her face to his, and the full, *life-breathing lips* met the wasted dying ones in a sacred kiss of promise’ [italics added].

¹ George Eliot, ‘Janet’s Repentance’ in Scenes of Clerical Life, ed. Graham Handley, (London: Dent, 1994), Ch. 10, p. 266 [italics added]. Further references to this edition of the story will take the form ‘GE’ followed by the Chapter and page number, as here GE. Ch. 10 p. 266.

² In her study of the major novels Diana Reisen, for example, addresses questions of death through considering the operation of death wishes. Reisen discusses the way in which concepts of life and death become moralised. Characters who may be said to be dead in life itself, and as a consequence suffocate or stifle others, are negatively viewed. Survivors, such as Dorothea, in Middlemarch, are positively viewed. See Diana M. C. Reisen’s Pilgrims of Mortality: The Quest for Identity in the Novels of George Eliot, (Ann Arbor, Mich.: Dissertation Abstracts International, 1975). p 257 ff. Similarly, David Carroll touches on the relevance of death and decay to the organic metaphor in his discussion of the way this metaphor is formally embodied in Eliot’s fiction. See David Carroll, “‘Janet’s Repentance’ and the Myth of the Organic”, Nineteenth Century Fiction, 35, no. 3, 1980. Peter Fenves discusses the tension between ‘encyclopaedic’ and ‘historical’ deployments or control of language as they relate to individuality, touching on the question of death and methods of reading. See his ‘Exiling the Encyclopedia: the Individual in ‘Janet’s Repentance’ in Nineteenth-Century Literature, 41, no. 4, 1987.

³ See J. W. Bennett ‘The Apprenticeship of George Eliot: Characterisation as Case Study in ‘Janet’s Repentance’ in Literature and Medicine, 9, 1990. p. 50 – 1.

⁴ Peter Fenves considers the issue of struggle and conflict in the story, but pursues an interpretation of dialectics of interpersonal struggle in his discussion of modes of linguistic comprehension and dominance in ‘Janet’s Repentance’. See his ‘Exiling the Encyclopedia’.

⁵ So although Sally Shuttleworth attends to the repercussions of metaphors of the organic and the life sciences from which they spring, she concentrates on the later fiction in her George Eliot and Nineteenth Century Science: The Make Believe of a Beginning, (London: Cambridge University Press, 1984).

⁶ See his ‘Disease and Cure in ‘Janet’s Repentance’: George Eliot’s Change of Mind’ in Literature and Medicine, 9, 1990.

⁷ See Bennett, ‘The Apprenticeship of George Eliot: Characterisation as Case Study in ‘Janet’s Repentance’ p. 58.

⁸ J. Clinton McCann Jr. has focussed on the religious dimensions of cure and recovery, pursuing the allusions to Rev. Tryan as a Christ figure. See his ‘Disease and Cure in ‘Janet’s Repentance’: George Eliot’s Change of Mind’ p. 71.

⁹ The differences between the role of death in the knowledge of alcoholism and tuberculosis will be discussed below.

¹⁰ See Sheila Shaw’s ‘The Female Alcoholic in Victorian Fiction: George Eliot’s Unpoetic Heroine’, in Nineteenth Century Women Writers of the English-Speaking World, ed. Rhoda B. Nathan, (London: Greenwood Press, 1986), pp. 173 – 77.

¹¹ Bennett, *ibid.* p. 60.

¹² See William F. Bynum ‘Chronic Alcoholism in the First Half of the 19th Century’, Bulletin of the History of Medicine, 42, 1968, pp. 163 – 64.

¹³ See Brian Harrison’s Drink and the Victorians: the Temperance Question in England 1815 – 1872, (Keel: Keel University Press, 1994), p. 23.

¹⁴ See Bynum, pp. 170 – 174 and 180 – 184.

¹⁵ See Fenves, p. 427 and GE, Ch. 2, p. 202. It is curious that psychiatry began to accommodate alcoholics among the mad in the early Victorian period with Jean. E. D. Esquirol’s Mental Maladies originally published in 1838 in Paris as Des Maladies Mentales, (New York: Hafner, 1965) since he placed them among the instinctive monomaniacs with diseases of the will resulting in actions which neither reason, affection nor science could restrain. For a summary of Esquirol’s contribution to psychiatric knowledge of alcoholism see Bynum, p. 164.

- ¹⁶ See, GE, Ch. 25, p. 335. David Carroll has noticed how Janet's sense of a self stable across time is challenged when she drifts towards metaphoric death seated alone on the cold doorstep after ejection from her home. See Carroll, p. 345.
- ¹⁷ See Diana M. C. Reisen's Pilgrims of Mortality: The Quest for Identity in the Novels of George Eliot, p. 3 and p. 257 ff. for a discussion of this point.
- ¹⁸ See Carol A. Martin George Eliot's Serial Fiction, (Columbus: Ohio State University Press, 1994), p. 78.
- ¹⁹ See David Carroll, p. 333.
- ²⁰ See Roland Barthes' 'Voice of Truth' or hermeneutic code. See his S/Z, (Oxford: Blackwell, 1990), p. 21 and the scattered comments on its operation summarised on p. 262.
- ²¹ See Kenneth Burke's 'Thanatopsis for Critics: a Brief Thesaurus of Deaths and Dyings' in Essays in Criticism, 2, no. 4, 1952, p. 370.
- ²² GE, Ch. 3, p. 222. Bennett also mentions these physical aspects of Tryan's presentation.
- ²³ GE, Ch. 11, p. 270.
- ²⁴ This prediction or prognosis is alluded to in Ch. 26 when Tryan's condition has worsened and plans are afoot to have him move to a more comfortable, salubrious house. See '... it was felt that the fulfilment of Mr Pratt's prediction could not long be deferred ...' GE, Ch 26, p. 342 – 43.
- ²⁵ GE, Ch. 11, p. 272.
- ²⁶ See the first Chapter, 'Vague Dreams: Realism and the Drama of Details', of Josephine McDonagh's George Eliot, (Plymouth: Northcote House, 1997).
- ²⁷ See Bennett, p. 58.
- ²⁸ GE, Ch. 12, p. 274.
- ²⁹ GE, Ch. 12, p. 275.
- ³⁰ Catherine Moloney' unpublished thesis, George Eliot, Henry James, and Consumption: A Shadow on the Lung of the Victorian Psyche, p. 144.
- ³¹ GE, Ch. 18, p. 300.
- ³² GE, Ch. 19, p. 306.
- ³³ In the paragraph just preceding the one quoted, there is mention of ideas 'made flesh' in the narrator's suggestion that ideas of human fellowship are more effectual when acted upon than in any other guise. See J. Clinton McCann, p. 71.
- ³⁴ GE, Ch.26, p. 343.
- ³⁵ Although George Eliot modelled Janet on Mrs Nancy Wallington Buchanan, her fictional counterpart's alcoholism seems not to have been there in the original. It is thus unclear whether George Eliot's knowledge of alcoholism stemmed from direct observation. On the parallels in the story with persons and events from George Eliot's childhood see Gordon Haight's George Eliot's Originals and Other Contemporaries: Essays in Victorian Literary History and Biography, ed. H. Witemeyer, (London: Macmillan, 1992), pp. 5 – 7.
- ³⁶ GE, Ch. 3, p. 220.
- ³⁷ GE, Ch. 3, p. 221.
- ³⁸ GE, Ch. 4, p. 230.
- ³⁹ GE, Ch. 4, p. 231.
- ⁴⁰ GE, Ch. 13, p. 279 – 280.
- ⁴¹ GE, Ch. 15, p. 287. It is significant that the darkest moment in the book lies half way, in Chapter 15, suggesting the centrality of place with which George Eliot viewed tragedy and despair.
- ⁴² GE, Ch. 16, p. 292.
- ⁴³ GE, Ch. 18, p. 299. There is a parallel between this treatment of Janet's resort to drink and that of Esther in Mrs Gaskell's Mary Barton, since both women explain how they need the numbing effects of alcohol in order to withstand the brutalities in their lives. It is unclear whether George Eliot had already read Mary Barton because, although she mentions Mrs Gaskell in 'Silly Novels by Lady Novelists', and this antedated Scenes of Clerical Life, there is no specific mention of Gaskell's text. Gordon Haight notes, however, that it was only while in Germany in 1858 after the publication of 'Janet's Repentance' that she and Lewes read Mrs Gaskell's novel to one another. See Gordon S. Haight's George Eliot: a Biography, (London: Oxford University Press, 1968), pp. 209 and 258 and Elizabeth Gaskell's Mary Barton, ed. M. Daly (Harmondsworth: Penguin, 1996). Ch. 14, p. 164.
- ⁴⁴ GE, Ch. 19, p. 305.
- ⁴⁵ GE, Ch. 21, p. 313.
- ⁴⁶ GE, Ch. 21, p. 314.

⁴⁷ While Kermode does not deal with representations of death, his The Sense of an Ending does address patterns of expectation set up in fiction. Thus the opening paragraph of 'Janet's Repentance' hints at the death to come. See The Sense of an Ending: Studies in the Theory of Fiction (London: Oxford University Press, 1966), p. 17 ff.

⁴⁸ GE, Ch. 1, p. 195.

⁴⁹ GE, Ch. 1, p. 200.

⁵⁰ GE, Ch. 13, p. 280.

⁵¹ GE, Ch. 22, p. 316.

⁵² GE, Ch. 22, p. 318.

⁵³ *ibid.*

⁵⁴ GE, Ch. 24, p. 326.

⁵⁵ GE, Ch. 24, p. 328 emphasis added.

⁵⁶ *ibid.*

⁵⁷ GE, Ch. 24, p. 328 - 329.

⁵⁸ Chapter 2 notes that more 'than a quarter of a century has slipped by' since the events in the opening of the story. See GE, Ch. 2, p. 200.

⁵⁹ GE, Ch. 25, p. 330.

⁶⁰ GE, Ch. 21, p. 313, [*italics added*].

⁶¹ GE, Ch. 25, p. 335.

⁶² GE, Ch. 25, p. 337.

⁶³ GE, Ch. 25, p. 338.

⁶⁴ GE, Ch. 28, p. 351.

⁶⁵ See Diana M. C. Reisen's Pilgrims of Mortality, p. 3 ff.

⁶⁶ GE, Ch. 3, p. 222.

⁶⁷ GE, Ch. 18, p. 301. There is an interesting reversal of genders here since my analysis of heroines in the popular romantic fiction of the time shows that deserted, love-lorn women were usually the ones who 'fell into a consumption'.

⁶⁸ GE, Ch. 9, p. 260.

Chapter 6

Till Death Us Do Part: The Consumptive Heroine in Popular Romantic Fiction

All the love and aspirations I had to bestow had been squandered on that intense earthly passion which seemed to be eating up body and soul ¹

I meant really to have married you on Tuesday — you cannot doubt that? Had I not my wedding dress on? But see how ill the thought has made me. Give me six months. In six months I shall get used to the idea; ... ²

... I am in the full possession of my senses; and if I could, or dared, thank God for anything, it would be for this interval of reason, which allows me to declare, with all the force of a death-bed assertion, that the woman you have turned out of your house as my mistress, is as pure as she was on the fatal day when we both first saw her; and loves you with a passion which has made the misery of my life, which has baffled every effort I made to destroy her virtue, and which she dies of at last, blessing you and hating me as a woman; ... ³

It is a commonplace that Victorian fiction abounds in death-bed scenes, so it should not be surprising that consumption, which accounted for a quarter of all actual deaths in Britain in this period, should be represented in a host of popular fictional cases. It occurs, for example, in Mary Sherwood's The Fairchild Family, ⁴ Edmund Yates's The Forlorn Hope, ⁵ F. G. Trafford's George Geith of Fen Court ⁶ and in at least five novels by Charlotte Yonge ⁷. These however, are instances in which the affected person is either a child, a man or a subsidiary character. There are, however, other examples which all fall into the class of popular romantic fiction and in which a central character is presented as succumbing to the disease.

Susan Sontag has noticed that thwarted desire was held to lead to TB in the nineteenth century. She writes,

According to the mythology of TB, there is generally some passionate feeling which provokes, which expresses itself in, a bout of TB. But the passion must be thwarted, the hopes blighted. And the passion, although usually love, could be a political or moral passion.⁸

Catherine Molney also holds a similar view when, in her analysis of the relations between Gwendolen and Mordecai in George Eliot's Daniel Deronda, she observes that the 'Ophelia stereotype of female instability' which so fascinated the Victorians, 'has much in common with the fetishised nineteenth-century woman wasting away from consumption...' ⁹ Following Sontag's suggestion, Nan Marie M^cMurray mentions three short stories published in nineteenth-century American magazines in which young women fall into a consumptive decline and die when deserted or disappointed in love. She cites Washington Irving's 'The Pride of the Village' (1819 – 1820), a story in which a girl falls in love with a soldier who is subsequently posted away and who suggests that she run away with him. She refuses such a disgraceful suggestion, falls into hysterics and dies of consumption some time later. The lover returns just in time to see her die.¹⁰

M^cMurray also mentions 'The Old Oaken Chair' 1838 from the American The Ladies' Companion in which a the narrator discovers a manuscript dated 1660.

The writer of the manuscript says she is dying in the embrace of a 'monster' while her friends whisper that consumption is preying on her. She writes 'My friends whisper in soft accents that Consumption is fast preying upon me, and so it is, but it is consumption of the heart, and not of the body. Who can live when his heart is decayed?? And is mine not wasting away by degrees?' ¹¹ M^cMurray also cites the case of Emily, the heroine in 'Henry Oswald' in Holden's Dollar Magazine of

1848, in which the heroine sickens – prey to a ‘hopeless consumption’ when parted from her true love.¹²

M^cMurray cites, as following this trend, some examples found in popular nineteenth-century British penny magazines. She cites Ada Trevanion’s ‘A Lover’s Quarrel’ in The Home Circle 1849.¹³ A conventional love story in which a penniless young woman, Edith Lascelles, falls in love with the most intelligent and accomplished young man in the village, Cyril Eyre. Although Cyril is the preferred suitor, there are others. As the romance develops, so does Cyril’s jealousy for one of them in particular, Frank Stewart. Not wishing to seem too ardent, Edith also continues to see Frank, despite being in love with Cyril. An incident in which she accepts a much-sought-after rare plant from Frank is misconstrued by Cyril. They meet the following day, quarrel and part on bad terms.

The parting leaves Edith distraught. She is pale, nervous, confused and suffers sleepless nights as a consequence. She rallies sufficiently to go walking with Frank, but, by chance, encounters Cyril. The shock of seeing him overwhelms her and she faints and is carried home senseless. Cyril and Edith meet at a village dance, but both Cyril’s and Edith’s pride prevent a reconciliation and she is again inconsolable. Cyril leaves for London. Edith’s Aunt Hanna worries that the upset will cause Edith to fall into a ‘decline’ as she begins to lose her looks. Edith’s friend Mrs Myrvin visits and, by chance, has met a ‘Mr C. Eyre’ in London. She has learned that he is to wed Miss Curzon, the daughter of a rich banker, on the very day on which she tells Edith. The news comes as a physical shock to Edith.

She wanders the fields around her home for hours, dazed and confused, and is finally caught up in a storm and drenched. She is initially confined to bed, senseless for three days, slowly recovering after some weeks sufficiently to sit outdoors. She shows all the signs of consumption – cough, pallor, night sweats, wasting - having fallen into the ‘decline’ feared by her aunt:

She always said she felt better, and should soon be quite well, but her thin hand grew daily more tremulous and transparent, and she had a short frequent cough and pain in her side, which rendered her days tedious, and her nights full of pain.¹⁴

Cyril returns to learn that his beloved is ill and rushes to her side. He reveals that the ‘C. Eyre’ who has recently married was in fact his cousin, Caleb Eyre, not himself. He and Edith are reconciled. Edith makes a miraculous recovery owing to ‘happiness - that most skilful and unerring of physicians’ although her health is never the same. They marry.

The story lacks the key element of a *dying* consumptive heroine and the often associated rhetoric of death. Although aunt Hanna’s fearing that Edith will ‘fall into a decline’ raises this possibility before it is realised in subsequent events, the story also lacks the associated pattern of foreknowledge found in other fictional and non-fictional narratives of consumption. Edith is interesting, however, in that she falls into a consumption as a consequence of difficulties in love. The potential of this motif is, however, fully explored in three Victorian popular novels written by women: Rhoda Broughton’s Cometh Up As A Flower (1867), “Good-bye, Sweetheart!” (1872), Georgiana Fullerton’s Ellen Middleton (1844). These texts can be grouped together not only because the consumptive heroine offers the writer greater scope for the artistic use of the disease and its associated mythology in affecting death scenes, but because they all exemplify this common way of

exploiting the consumptive stereotype. Not only are many of the common signifiers of consumption deployed, but these works adopt the same, medically recognised cause of consumption, integrating it into their central romantic plots, and basing the resolution of those plots on its outcome: the heroine's death. This Chapter will, therefore, explore the works of Broughton and Fullerton in order to examine the uses made of this motif.

Before examining the texts it will be useful to briefly restate the mythology surrounding the consumptive already set out in the early parts of Chapter 3. It will be recalled that, in the absence of a definitive and specific cause for the disease, Victorian medicine elaborated a picture of those individuals most likely to develop the disease: the so called hereditary, tuberculous or consumptive 'diathesis'.¹⁵ According to this idea, those possessed of a long neck, prominent shoulders or shoulder blades, bright eyes, narrow waist and fair skin were likely to develop the disease. Mentally such individuals would also be of a sanguine temperament, highly intelligent, sensitive, passionate and artistic or imaginative. Such ideas were subscribed to by doctors and by the wider public. Again, because no specific, single cause was held to lie behind the disease, a number of precipitating causes would be seen as triggering the disease in those with the diathesis. Thus cold or damp air, close heated rooms, fevers of various sorts and respiratory illnesses were all held to trigger the disease. On the psychological or mental front there was a similarly long list of precipitating causes: emotional shocks, protracted or excessive study, long spells of depression, disappointment in love or slighted affections, the loss of a loved one and excessive sexual activity were all held to be immediate causes.

The mythology of consumption registered coughing and especially coughing up blood as a telltale sign. Wasting, feverish flushing and difficulties breathing were also commonly held to be part of the disease. Finally, consumptives were also held to have increased pulse and to suffer from general weakness. The chest pain recognised by doctors as a significant part of the consumptive's experience seems, however, often to have been repressed in the popular consciousness as few artistic presentations of the consumptive feature this symptom. Popular opinion also generally regarded consumption as a slow disease, downplaying medicine's recognition of forms of the disease which would rapidly overwhelm the sufferer. As the disease progressed, sufferers were held to often become more other-worldly. Also they were sometimes viewed as becoming both more spirited as well as experiencing heightened intellectual capacities. They were also believed to suffer a specific unwillingness to recognise the gravity of their situation in that they were held, by both medical and popular opinion, to deny that death was imminent. This was known as 'spes phthisica'. Death, when it finally came, was viewed as uniformly painless and quiet.

The three novels by Broughton and Fullerton are in some respects quite different – for example, Ellen Middleton is essentially an exploration of the agonies of psychological and religious guilt played out through a plot which turns on love and blackmail. The two works by Broughton, on the other hand, are fairly conventional romances. The decision to have the heroines die of consumption however, precludes the happy ending and gives the works an altogether darker tone. This is achieved, as I will show, through structuring the works much as dramatic tragedies,

such as Oedipus Rex, in which the audience knows the outcome at the outset, are structured. Both Broughton's Cometh Up and Fullerton's Ellen Middleton are presented as autobiographies written by the dying heroines themselves. Also, I will show how the mythology of the consumptive is used, in ways which a contemporary audience would have recognised, to signal the heroine's ultimate fate and fatality. Finally, I demonstrate that the three romantic novels have the onset of disease precipitated by setbacks in their heroine's romantic fortunes. Whereas Gaskell and George Eliot only hint at an erotic aetiology behind their characters' consumption, as we have seen in Chapters three and five, Broughton and Middleton seize on the narrative possibilities in medicine's attribution of consumption to romantic misfortunes and use this motif in ways which are vital to their plots. Broughton and Middleton adopt the tiny narrative kernel of medicine's erotic causal accounts of consumption, dramatising this in ways which also affect the meaning of events within the story.

Rhoda Broughton (1840 – 1920) was a clergyman's daughter raised in the ancestral home, Broughton Hall, in Staffordshire. She was educated at home and began writing soon after the death of her father and her departure to live with aunts and uncles. Her initial efforts were encouraged and supported by her uncle, Sheridan Le Fanu, but the association was a brief one. She thereafter found it necessary to support herself by writing and wrote 28 novels and numerous short stories in the years until her death. Early in her career she commanded considerable fees for the triple-decker novels then in vogue with the circulating libraries. Her work sold very well and went through numerous editions, being translated into French,

German, Swedish, Spanish, Italian, Danish and Dutch. She lived in Ruthin, Oxford and London, dying in Oxford in 1920. ¹⁶

Cometh Up as A Flower concerns the romantic adventures of the young, vibrant and prepossessing Nell Le Strange who falls in love with a penniless Major, Dick M^cGregor. Nell's father is an impoverished nobleman with hopes that his youngest daughter Nell will marry a wealthy landowner, Sir Hugh Lancaster, and so restore the family fortunes. Nell's sister, Dolly, also feels it would be unfitting for Nell to wed M^cGregor. The cold-hearted, materialistic Dolly forges a letter by Nell to M^cGregor, jilting him. With this avenue closed to her, and her dying father's wish to see her married to Sir Hugh, Nell sacrifices personal happiness and marries Hugh only days before her father dies. M^cGregor surreptitiously turns up at Nell's home in the hope of one final meeting with the now Lady Lancaster and together they discover the deception. Nell is distraught and begs M^cGregor to take her with him to India despite her marriage. He refuses to participate in so immoral an act and leaves. Some months later Nell hears of his death from fever in the tropics, falls into a consumptive decline and dies, having just managed to pen the final lines of her autobiography, i.e. the novel.

The novel met with mixed reviews, but was a nonetheless a best seller, managing to sell nearly three thousand copies in the first year and continuing to be reprinted and translated until 1920. ¹⁷ It was reviewed in The Times, which praised the

‘vigorous manner of its telling’ and Nell's commentaries, ‘sometimes quaintly humorous, sometimes cynically bitter, sometimes plaintive and melancholy....’ ¹⁸

Mrs Oliphant praised the work for its ‘sprightly, prepossessing, and lifelike’

heroine, who ‘is not by any means so disagreeable, so vulgar, so mannish, as at the first beginning she makes herself out to be....’ Perhaps it is not surprising, given the gulf between mid-nineteenth-century and later myths surrounding tuberculosis, that a novel in which a terrible disease is presented as essentially romantic was also praised for its truth to nature. Mrs Oliphant notes a ‘touch of nature’ in Nell, praising the work ‘as a sample of the kind of expression given by modern fiction to modern sentiments from the women’s point of view.’¹⁹ Mrs Oliphant, however, was also extremely critical of the novel’s lax morals and Nell’s socially challenging suggestion that she leave Sir Hugh to live with Dick in India.

The novel’s success, however, was not entirely due to the relatively frank treatment of youthfully forthright physical love, in the form of a few embraces and kisses, and Nell’s hopes that heaven will continue the joys she experiences in her lover’s arms. Instead I suggest that readers enjoy, even if at an unconscious level, the *prospect*, presented as they read, of a heroine dying for love. If, as Pamela Gilbert has noted, Broughton’s first two romances fail to offer a Victorian equivalent of today’s Harlequin romances, complete with happy ending, Cometh Up As A Flower and “Good-bye, Sweetheart!” nonetheless allow readers to witness and identify with a love so intense that its disappointment leads to the heroine’s physical and mental destruction.²⁰ There are a number of ways in which the novel invokes death so as to bring about this tragic vision.

The title, Cometh Up As A Flower, is the first signal to the reader that the novel is to be an examination of love from the sombre perspective of death since it is an allusion to the Book of Job. The actual text is, ‘Man that is born of woman is of

few days, and full of trouble. He cometh forth like a flower, and is cut down: he fleeth also as a shadow, and continueth not.’²¹ The echoes of mortality lie in the suppressed, ‘and is cut down’. It must be supposed that the novel’s first readers were well enough versed in scripture to recognise the allusion. Once alerted by the title to the novel’s commitment to death, the reader is probably not surprised that the text itself opens with Nell’s idle, youthful speculations on her own death, since the opening sentence is ‘When I die, I’ll be buried under that big old ash tree yonder — the one that Dolly and I cut our names on with my jagged old penknife nine, ten years ago now.’²² Right from this opening paragraph, however, it is apparent that Nell’s tone is one of youthful exuberance — she goes on to ‘utterly reject and abdicate’ her ‘reserved seat in the family mausoleum’, preferring to be interred in a spot of beauty surrounded by flowers.

Having, in the first Chapter, gone on to clamber over the churchyard wall and encounter the tall, handsome M^cGregor among the tombstones, the second Chapter ends on a sombre note that fulfils something of the title’s and opening Chapters’ deadly promise. Having drifted into thoughts on how unpleasant her older sister is by not reassuring her about the sensitive question of her beauty, and consequently how much she enjoys having Dolly away from home visiting friends, Nell wonders whether she would even be able to mourn her sister in the event of an untimely death. Nell then reveals, at the strategically important close of a Chapter, that she need not have been disquieted regarding her responses to a sister’s death since,

As I write, myself tottering on the verge of that last bed I so tiredly long for, Dolly is in the heyday of health and prosperity. Dolly will have that tear difficulty to contend with in my case; not I in hers. She will vanquish it, and will weep plentifully over this poor thin carcass, which indeed is ugly now.²³

Not only do we discover that Nell anticipates an early death, but, it is established at this early and prominent point that her former youthful beauty has been destroyed and that she inhabits a *wasting* body which the language tells us is that of an already dead creature. By the end of the second Chapter Broughton has established that her narrator writes on the verge of the grave.

There is a dense interweaving of matters of love and death in Cometh Up As A Flower. This begins with the lovers' first encounter in the graveyard and runs through numerous other references to death in the context of love. We shall see this connection reach its height when considering the way the mythology surrounding the consumptive is used. The tragic note is, however, an undertone to many of Nell's experiences of love before she becomes ill. For example, when Nell receives news that M^cGregor's leave is at an end, and that her only chance of meeting him before his departure for his regiment will be at a ball held on Sir Hugh's estate, Wentworth. On receipt of the invitation, Nell asks Dolly whether they shall go, all the while trying to contain her pleasure at the prospect of meeting her lover. Nell takes the opportunity, given by her sister's hesitation over whether they ought to attend, to insert a little meditation on the diminishing of man's pleasures as he ages. This digression almost naturally terminates in the thought that death is the final stage of the journey through life and Nell's confession that she perforce must be ignorant of its pleasures or pains. Nell uses this as an opportunity to remind the reader of her current situation:

My hand is on the thick black curtain, whose warp is darkness, and whose woof is grief; when next the hedges, burgeoning now, are putting forth their sprouting green, I shall have raised the curtain, and have found out what there is behind it.²⁴

Which is not to say that death suffuses Nell's consciousness before she falls ill. On the contrary, it is the levity and vibrant, youthful wit and energy which Broughton's contemporary readers found so attractive. The meditation, whose end is quoted above, rather reflects the perspective of a wiser, if suffering, Nell.

Frank Kermode, in his The Sense of an Ending comments on St. Paul's and St. John's use of the concept of 'crisis' and the attendant stress on the period between the present moment and one's death. With these developments, says Kermode, eschatology is neutralised and the weight of the End of history is felt in every moment.²⁵ Reaching a similar conclusion, one might say that death in the three novel's under consideration here is both *imminent* and *immanent*. This means that it is both anticipated and foreseen *as an event* by the reader and experienced as suffusing metaphors, meditations and even the depiction of minor characters at many points throughout the narrative. While it is impossible to present the whole complex of such resonant points in Cometh Up As A Flower, it is useful to examine some examples.

It turns out that Dolly had the misfortune to have been on the brink of a marriage to a 'pink-eyed young man of immense property' but that he 'died of consumption a week before his intended wedding-day'.²⁶ A more interesting reference occurs during one of Nell and Dick's secret trysts. They arrange to meet in an alder grove near her home. The meeting is brought to a close by the knell of a church clock which reminds Nell that she will be locked out if she does not leave soon. Nell writes that the clock strikes ten and that its knell, 'tells the dead people that they are an hour nearer their release...' introducing a sombre note into the proceedings.²⁷

Again in the same week as that of the same tryst, Nell's beloved father, Sir Adrian Le Strange, has had to go away on business, leaving Dolly and Nell with the servants. Nell finds the resulting quiet in the house oppressive, longing for the birdsong and ploughboys' whistling to be brought indoors to enliven 'the silence as of a house where a shrouded body lies confined, a tenantless rigid clay image.'²⁸ Similarly gloomy references abound. When Nell faints following her and Sir Hugh's being thrown from a dogcart, the landlady of an inn where Nell is carried mistakes her for a corpse.²⁹ Also one of the guests at the house party Nell was so keen to attend is a short gentleman 'who wore death's-head studs and made jokes.' Coincidentally, Nell finds that 'Fate' assigns her to this very 'gentleman with the death's-head studs,' whose name turns out to be Mortimer De Laney, 'Morty' for short.³⁰

The section of narrative dealing with the course of Nell's clinical consumption is not very remarkable since it relies on the usual mythic signifiers of the disease. In the final Chapter Nell writes that she has had cause to believe that 'never should grey hairs and I make acquaintance....' She writes that,

I looked very well certainly — Hugh's men friends complimented him (so he told me) on his wife's beauty; such rosy cheeks I had too; I, who used to be pale to a proverb; and my rosy cheeks did not come out of the rouge pot,

But surely, surely I was getting oddly, unaccountably thin: my rings took to slipping off my fingers, and rolling into remote corners, and all 'me frocks,' like Glorvina's, of lovelorn memory, 'had to be took in.' Also I somehow stopped very often, and leant against the carved banisters; as I went up the shallow broad oak steps of the grand staircase.³¹

Unlike Thackeray's Glorvina O'Dowd, Nell's condition is chillingly real rather than merely imaginatively anticipated.³² Having detected 'hectic' rosy cheeks,

begun wasting and become short of breath, Nell tentatively tests her worst suspicions in conversation with her mother-in-law, Lady Lancaster:

‘Mother,’ I said (Hugh liked me to call her mother), ‘don’t you think I’m getting to look very like Jane Stevens, that died of consumption at the West Lodge, last year?’

‘Nonsense! my dear,’ answered the old lady, very hastily, ‘you should not get fanciful; young people of your age often look delicate in such cold weather; don’t imagine anything so silly!’

But she was very much flurried as she spoke, her old nose got red, and two big tears dropped on to her eternal knitting. I asked no more questions; I said no more on the subject, but from that day, I knew that my fate was sealed. So I was going to die; ...³³

The only other indication of Nell’s condition comes on the penultimate page when we learn that she is so weak, she finds it difficult to hold the pencil with which she struggles to write the last words of her narrative.

More interesting than the way in which Nell’s narrative uses the more clinical aspects of the consumptive mythology, is the way psychological or erotic crisis precipitates her end. Nell’s first admission of her love for Dick M^cGregor contains a veiled reference to her fate. Nell is walking home along the river when she notices M^cGregor emerge from the alder grove that they later use as their trysting place. She immediately registers how handsome he is through one of her innumerable allusions, since, she writes:

... and most assuredly I thought so on that day, when
‘I lifted up mine eyes,
and loved him with the love that was my doom;’
 for love him I did, though I have not said much about it, ...³⁴

By this point in the narrative it has long been obvious to the reader that Nell has fallen ‘neck and crop’ in love with Dick, but the suggestion that her love is to be the cause of her ‘doom’ is the first indication that her physical fate will depend on the outcome of the romance.

There are two critical moments in Nell's adventures, both of which are addressed through the heroine's body. Nell's sister, Dolly, forges a letter to Dick in which Nell jilts him, which stops him writing to Nell. Dolly also intercepts all Nell's letters to him. In the context of Sir Adrian's declining health, Nell realises that a piece of good news, such as the announcement of her marriage to Sir Hugh, would give her father reason to live. She reluctantly decides to accept Sir Hugh although she does not love him. Having decided to go through with a loveless marriage, she goes to encounter Sir Hugh in the drawing room, seating herself on a sofa. She feels,

as if I were going to have an a leg or an arm cut off, and as if Hugh were the operator, and I wish he would make haste and begin. Oh, if I could but take a whiff of chloroform, and awake to find the limb amputated, the process over, the wooing accomplished.

Hugh then unwittingly fulfils his role of 'surgeon' by observing her body and remarking,

'you've grown very thin since last I was here.' That is how it begins. The surgeon is taking off his coat, and rolling up his shirt sleeves.

Nell, then lies that her diminished size is the result of financial worry, rather than admit that it has been caused by Dick's neglect. Hugh offers to share her burden and Nell uses this offer, in effect to ask Hugh to marry her. Just before Nell responds to his assertion that he does indeed wish to marry her, by accepting him, Nell's thoughts are of Dick. When she finally does manage to speak it is by reducing her acceptance of Hugh to a transaction:

I will — do as you wish, if — if — you will — lend me — give me — some money — a great deal; oh dear ... !

Dull and prosaic as Hugh is, he nonetheless sees that she ought to be marrying him for love and disappointedly tries to impress this upon Nell. She links her view of

the marriage as a transaction to the slightly shocking metaphor of the proposal as an amputation when she writes that,

It seemed to me the most matter-of-fact piece of barter in the world; so much young flesh and blood for so much current coin of the realm.³⁵

The full impact of Nell's abandonment of all her hopes regarding Dick in this acceptance scene is signalled in the way she feels when she gives her father the good news. Realising she faces perhaps sixty years with Hugh and without her beloved father, Nell wishes herself dead:

Oh, why could not I die of consumption, like that girl I took the jelly to yesterday? Why could not I cough myself out of the world, as she was doing so fast? 'On the — th instant, at Le Strange Hall, Eleanor, younger daughter of Sir Adrian Le Strange, of rapid decline, aged nineteen.' And Dick would see it in the Times, and be compunctious ... and he would rush away to the wars — ... and die, covered in wounds, and kissing my photograph.³⁶

Nell's wishing herself dead is not, however, unusual since she has previously casually wished to die or light-heartedly said she would die of disgust were she to marry Hugh.³⁷ This is the first time she has wished to die in any particular way, and it is no accident that she wishes to die of consumption given the crisis prompted by the proposal and her acceptance.

Mrs Oliphant rightly identified the scene in which Nell, now Lady Lancaster, and Dick meet for the last time as one of the dramatic highpoints of the book. The drama of Dick and Nell's discovery of the forgery behind their separation and Dick's refusal to accede to her scandalous demand that they run away to India together, dooming her to a life with Sir Hugh, reaches its zenith appropriately with a kiss and Nell fainting away:

as he so kisses and clasps me, a great blackness comes over my eyes, and I swoon away in his arms.³⁸

Such a bodily collapse in the face of such overwhelming emotional upheaval is not, of course, surprising in a novel of this kind, but Broughton does not leave this moment there. Dolly accepts a proposal from the stupendously wealthy Lord Stockport and Nell's mother-in-law insists that the Lancasters host the wedding celebrations. Dolly is persuaded to marry in summer, a fact which Nell registers as 'And so there comes a sultry day in early June — a day when my sister's life began to open, and mine, I think, to close.'³⁹

If Nell recognises the onset of her disease much later, she nonetheless fixes the beginning of the end of her life, which is the same thing, at her sister's wedding day. The reason for this is indicated by the text itself. At the marriage celebrations, Lord Capel remarks how the entire company previously gathered at the house party at Wentworth is reassembled for the wedding, 'with one exception.' Morty De Laney begs to know why it is that he has referred to the absent Dick as 'poor M^cGregor,' forcing a reluctant Lord Capel to reveal the 'melancholy' fact of Dick's death to the whole company, including Nell.

Immediately the news is broken, Dolly realises the shock will be too much for Nell and rushes to her, whispering to her not to reveal her attachment to Dick in her reaction. Nonetheless, Nell writes that she hears,

her whispering very eagerly, and then there sounds a loud buzzing in my ears; a deadly sickness comes over me, and I faint away, as I fainted away five months ago, in those strong arms that will never more embrace any bride but corruption.⁴⁰

The text links the two critical moments – Dick's final parting with Nell and her fainting on that occasion on the one hand, and her collapse on hearing of his death on the other. Moreover, it signals a pathological change once again, since here it is 'a deadly sickness', not merely an ordinary fainting collapse, that afflicts Nell. In

this way the text indicates that Nell's consumption is to be understood as having been caused by what Sir James Clarke called 'disappointment of long cherished hopes' and 'slighted affections', despite Nell not seeming to be predisposed to the disease.⁴¹ Thwarted love gives rise to deadly disease, as Nell recognises in the final pages of her autobiography, since, having developed the classic phthisical symptoms she concludes that,

All the love and aspirations I had to bestow had been squandered on that intense earthly passion which seemed to be eating up body and soul.⁴²

Broughton's 'Good-bye, Sweetheart!' was separated from her second work by five years and two further novels. Despite being a more mature work and meeting with greater critical acclaim, its sales nonetheless fell below the twelve thousand copies which its predecessor, Red As a Rose Is She, sold in seven years.⁴³ It is a romance concerning two sisters, Jemima and Lenore Herrick, with Jemima sharing the role of narrator with 'the Author.' The romance centres on the vivacious, independent-minded, petulant Lenore's successful if eccentric pursuit of Paul Le Mesurier, an impoverished gentleman whom they meet while holidaying in France. Given Lenore's trying temperament and Le Mesurier's conventional outlook, their relationship is stormy, but does result in their becoming engaged. The engagement is broken off by Paul, however, when in a fit of jealousy, Lenore's independence of mind leads her to insist on continuing her flirtation with another suitor, the wealthy Charles Scrope. Le Mesurier concludes that he and Lenore are incompatible and spurns her efforts to heal the rift.

Lenore then takes up with Charles in earnest to spite Le Mesurier. They are very quickly engaged and matters get as far as the wedding morning when Lenore, about

to leave for the church, collapses and faints, lying ill in bed for three days. Lenore begs her fiancé to postpone the wedding, but, increasingly aware of Lenore's lack of real affection for him, he presents her with the ultimatum of no further postponements or the engagement will be ended. Lenore breaks it off. The Miss Herricks and their vulgar sister leave England for the cooler climate of Switzerland's Engadin valley for the good of Lenore's worsening health. There Lenore meets Paul by chance and discovers he is to be married to his cousin. Charles Scrope appears, having come to join his relatives who happen to be touring in Switzerland as well. Lenore's health worsens, and she realises she is in a terminal consumption. Sinking fast, Lenore sends Scrope to summon Le Mesurier. Scrope returns with the news that he could not bring Le Mesurier and Lenore dies.

Broughton's initial suggestion for the title of the novel was 'Morning, Noon and Night' but when her publisher, Bentley, objected to this choice, she suggested 'Life's Little Day.' Although she found her friends ridiculing 'Goodbye Sweetheart, Goodbye' (despite its being the name of a song), she still offered it as a possible title to Bentley. Her publisher, to her chagrin, settled on the truncated title under which the book appeared. Broughton's conception of the structure of the novel was in terms of 'life's little day' since she heads its sections 'Morning,' 'Noon' and 'Night'. 'Morning' ends with Paul's injunction against Lenore's flirting with Scrope while her first fiancé is away in England. 'Noon' contains the break with Le Mesurier and her brief relationship and engagement to Scrope, ending with her rejection of his ultimatum. 'Night' ends with Lenore's death. From this it can be seen that Broughton conceived the novel as charting the heroine's temporal passage towards death. Although this is lost in the title which

she finally accepted, that title still resonates with several events in the novel - Lenore's sarcastic parting from one of her suitors in the novel, the two breaks with successive fiancés and with her death from consumption, since that would, perhaps, have been the most poignant parting for the contemporary reader.⁴⁴

By the time Broughton came to write 'Good-bye, Sweetheart!', she had evidently matured as a writer, since her treatment of the tragic element inherent in a consumptive death is far more subtle than in the similar case in Cometh Up As A Flower. In particular, the use of the prosaic Jemima as narrator and the third person authorial voice for the remaining sections precludes the retrospective awareness of impending death that informs Cometh Up As A Flower. Her use of the consumptive stereotype is also more sophisticated in that she comes very close to exploiting the consumptive diathesis. Lenore, Jemima and Le Mesurier end up rowing up the Rance at Dinan in a very unstable small boat which Lenore discovers can capsize easily. Le Mesurier, who is rowing, points out to her that he would only be capable of rescuing one of the sisters in such an event. Lenore, having set her mind to winning the cynical and 'misogynist' Le Mesurier's regard and affections, immediately seizes on the opportunity of finding out which of the two sisters he holds in higher regard by purposely rocking the vessel. Le Mesurier's hand is forced and he deposits a terrified Jemima on the bank. On resuming their course upriver, Paul gives Lenore leave to upset the boat as she pleases since he could then save her. Lenore declines the offer by explaining that once given leave to do a thing she immediately loses the inclination, although she has got into the habit of not waiting to be permitted to act because,

Once, long ago, when I was little, I was very, *very* ill—I'm not over-strong now, though you would not think it to look at me — and the doctor said I

was to have whatever I asked for, for fear of bringing on a fit of coughing if I screamed; and the consequence was that if ever I wanted anything I always threatened to break a blood-vessel, and straightway got it.

Paul remarks, looking at her full 'womanly' figure, her plump hand and her beautiful 'cream-white' throat, that such threats must surely have long since lost their effect. Lenore assures him that this is not the case, since 'the prestige of my delicacy still remains, though the fact no longer exists, and I of course am careful to keep up a tradition which tends so much in my interest....'⁴⁵ Lenore is clearly a healthy, fit young woman, but she nonetheless inhabits and exploits the realm of the delicate young woman. It might even be said that illness has determined her character.

For all Lenore's physical robustness, great play is made of her bodily responses (in common with the other heroines we are examining here,) perhaps to highlight the pathological changes when they do occur. Thus every blush or flush she experiences is registered and the beauty of her figure or eyes is often remarked upon. When dancing with Paul on the fateful night when they argue, she is flushed with exertion, remarking '... I am never long-winded; doctors often say that I ought not to dance.'⁴⁶ Having had a row with Paul, and called their engagement off, she is discovered by Jemima and Sylvia the following morning locked in her room. Jemima eventually gains admission, whereupon she solicitously takes her 'hot reluctant hand' in her own, enquiring what the matter is. Lenore is clearly very disturbed by Paul's break with her since she states that she found herself battering her head against the floor. As she explains, this she places her 'burning hand' on Jemima's arm, saying that she was even momentarily tempted to 'put an end' to herself, but could not find the means to achieve this.⁴⁷ Jemima manages to coax

Lenore into writing to Paul in an attempt to effect a reconciliation, and the text registers the effect of the upheaval in pathological terms. Lenore writes the letter and seals it, while the text continues,

‘Jemima,’ she says, clasping my arms with her two hot slender hands, while her great solemn eyes fix themselves, feverish and miserably excited, on mine, ‘the responsibility of this lies with you. I do not know whether it is affectionate or not; I cannot judge—I hardly know what is in it; but if it fail, the shame of it will *kill* me.’⁴⁸

Any hint of illness here is dismissed by Jemima, despite the rhetoric of death that surrounds Lenore’s hysteria when Paul replies, coldly rejecting her.⁴⁹

The developments following Lenore’s confirmation of her acceptance of Scrope and on the wedding day itself, however, are not so easily dismissed. Jemima and Sylvia hear of the wedding so soon after the break with Paul that Jemima rushes up to Lenore’s room to have the news confirmed. In the face of Jemima’s disbelief, Lenore reminds her that she disapproved of Paul, while Scrope is far more handsome, describing him with a detachment more appropriate to a perfect piece of goods. Jemima is on the verge of leaving the room in disgust and is prevented by Lenore’s holding her hand and an injunction to examine her face. Jemima writes:

I look at her, as she tells me — look with uncomfortable misgivings at the bright beauty that has prospered her so little: her cheeks are crimson, and the hand which holds mine, *burns*.⁵⁰

Jemima’s emphasis is unmistakable. So when Lenore asserts that Scrope is more ‘suitable’ to her, and, ‘laughing feverishly,’ that she did not really care for Paul after all, the reader and Jemima conclude that Lenore is ill. This is confirmed when, as the exchange turns to the size of the wedding feast, Jemima notices that Lenore’s eyes ‘are sparkling like diamonds at night,’ and that ‘the splendid carnation that fever gives paints her cheeks.’⁵¹ These signs persist until the night

before the wedding when a dinner is given at Sylvia's home for all the wedding guests. The 'Author' writes that,

The hot red roses have to-night left Lenore's cheeks; she is very white — *deadly* white, one would say; only that it is a dishonour to the warm, milk whiteness of *living* loveliness, to liken it to the hue that is our foe's ensign. She is pale, but her eyes outblaze the star that quivers and lightens in Mrs Scrope's grey head. ⁵²

The 'Author's' edging around the word 'deadly' only serves to emphasise the seriousness of Lenore's condition. These clues, together with Lenore's breathlessness while dancing and the loss of weight which her fiancé notices, mean that the events on her wedding morning are no surprise for the reader. ⁵³

The part of the text in which Jemima relates the events of the morning of the wedding day is suffused with the rhetoric of death, and it is at this time that Lenore is first incapacitated by consumption. ⁵⁴ Having helped Lenore put her veil on, Jemima's attention strays to the window through which she sees the attire of the wedding guests as they depart for the church in the drive below. When she turns back to Lenore, however, things take a startling turn:

... as soon as I catch a glimpse of her face my mirth dies, and I utter a horrified ejaculation. It is lividly white, and she is gasping.
 'Open it wide!' she says, almost inaudibly. 'I — I — I am stifling!'
 'Good heavens!' cry I, apprehensively and dissuasively, with my usual practical grasp of the subject. 'You are not going to faint? Do not! — not till I get you a chair.' ...
 As I speak I am struggling with the hasp of the window ...
 'Quick! quick!' she says, faintly, panting 'wider!' wider!'
 But it is too late. ⁵⁵

This is the first clinical sign of Lenore's consumption, and there is no mistaking it for merely another nervous faint.

Although there is insufficient space here to go into the full details of Lenore's illness, it is notable that Broughton does not ignore the less pleasant symptoms of the disease. Whereas the heroine of Cometh Up As A Flower merely hinted at the symptoms sufficiently to establish a contrast with her former beauty and indicated some signs of coughing and emaciation, the presentation of Lenore's case does not shy away from unpleasant symptoms. In particular, Lenore's characteristic ruse of childishly 'threatening to break a blood-vessel' in the face of any prohibition becomes a gruesome, involuntary reality during the trip to Switzerland. Lenore overhears a guest at the hotel they are staying at remark that she is 'not long for this world' and takes the news badly. The upset brings on a fit of coughing, leading to her breaking a pulmonary blood vessel.⁵⁶ Also, in the very final stages of her illness, Lenore admits to needing her former fiancé, Scrope, near her because she needs 'some good patient person to be near me, and look sorry when I am out of breath and in tiresome pain.'⁵⁷ Another instance is when she is explaining to Scrope how she has been anxiously scouring the papers for news of Le Mesurier's wedding: a 'long and painful fit of coughing intervenes' in their conversation.⁵⁸ She is also presented as experiencing 'spes phtisica', the characteristic delusion experienced by consumptives in the final stages of the disease, that she will recover. Having faced the fact of her inevitable death from consumption, nevertheless, writes Jemima, Lenore sometimes,

forgets it for a moment; sometime the conquered spirit of youth reasserts itself; sometimes she talks gaily of what she will do next year; sometimes she rives our hearts by making plans for the winter, whose snows she will never feel, for the new distant spring, whose flowers will open on her grave. But it is only for a little while that the beautiful illusion lives; always it vanishes ...⁵⁹

Together with Lenore's showing the first disabling signs of consumption moments after putting on her wedding veil, there is another, key way in which "Good-bye, Sweetheart!" signals the fact that thwarted love is at the heart of Lenore's condition.

Having sent Scrope off to find and bring Le Mesurier back with him, Lenore puts all her remaining strength into staying alive until her old lover comes. She is suddenly determined to eat, and conserve her strength for his return, and has her sick room cleared of all the paraphernalia of illness on the day of his expected arrival. She even requests that she be allowed have her hair plaited and to dress in anticipation, choosing the 'old blue gown' in which Le Mesurier rescued her from the waters of a French river, because 'it is the only one among my clothes that he ever praised.'⁶⁰ A long agonising wait ensues as the day wears on and the two men do not arrive, but eventually a carriage arrives and feet are heard climbing the stairs to Lenore's room:

The door opens, and Charlie enters, haggard, travel-stained, and alone. She does not even look at him; her eyes are staring with an awful eager intentness at the door behind him; but no one follows, nor does he leave it open, as if expecting to be followed. On the contrary, he closes it ...

Scrope rushes past the horrified Jemima to kneel beside Lenore, taking her up in his arms and explaining that he could not bring Le Mesurier because, when he reached him, he discovered that it was his wedding day and that he was in the midst of the celebrations. Holding Lenore in his arms, he implores her to speak to him:

... 'Oh, beloved, speak to me! Say you forgive me — you are not going without *one* word — speak — speak!'

But Lenore will never speak to him any more: her head has sunk back, with all its pretty careful plaits, on his shoulder, Lenore has

*"Gone thro' the straight and dreadful pass of death."*⁶¹

Thus the closing pages and these, the closing lines of the novel, make it very clear that disappointment in love, can, for the Victorian romantic heroine, prove fatal.

Lady Georgiana Fullerton (1812 – 1885) is remembered chiefly for her benevolence and religious work in Sussex where she spent the latter part of her life, rather than as a novelist. Her career was not typical of popular novelists of the time. She was born into an aristocratic family, the youngest daughter of the first Earl Granville, who was for much of Georgiana's life, the ambassador in Paris. At the age of twenty two she married George Fullerton, an officer in the guards, leaving Paris in 1841. Thereafter she lived in Rome and Cannes and published her first novel, Ellen Middleton, in 1844. She converted to Catholicism in 1846 and, after the death of her son in 1854, devoted her life to charitable work and philanthropy. She and her husband eventually settled in Sussex, where she died in 1885. Besides her first novel, she penned five other novels including romantic and historical fiction.⁶²

Ellen Middleton, which won wide critical acclaim and even attracted the approval of Gladstone in the English Review, is far more than the 'study of piety in the upper classes.' It is a highly wrought exploration of guilt and conscience in the context of blackmail and love. It is the story of Ellen Middleton, an orphan, taken in by her uncle and reared by him and his wife. Young Ellen's adoptive parents have a daughter, Julia, but Ellen displaces her in her mother's affections. The petulant young Julia becomes spoilt following a spell of illness in which doctors advise that she be given her own way. With the consequent friction between the two girls, Ellen's uncle and aunt discuss sending Ellen away to school. Julia taunts

Ellen, who has overheard the discussion, with this prospect and the older girl lashes out in a moment of anger, striking Julia. Unfortunately Julia is at that moment perched precariously at the head of a steep flight of stairs which leads down to a raging mountain stream into which she tumbles. Julia is swept away and later found drowned. The incident is secretly witnessed by Mary Middleton's brother, Henry Lovell, and his odious old nurse who is using his gambling debts to force him to marry her daughter, Alice. Both Lovell, who subsequently falls in love with Ellen, and Mrs Tracy, the former nurse, are involved in intrigues using their knowledge against the young woman, who believes she has committed a crime or at least ruined her adoptive parents' lives by killing their daughter. She is also set to inherit the Middleton fortune on the basis of the death.

Ellen is briefly infatuated with Lovell, thus putting off Edward Middleton, Mr Middleton's nephew. She subsequently discovers she loves Edward, but the development of their romance is impeded by Lovell's blackmail. Lovell, however, is forced to marry the innocent and naive Alice Tracy, while still remaining in love with Ellen. Ellen accidentally makes her feelings known to Edward and it is assumed by everyone that they will marry. They do marry, but the marriage is destroyed by Mrs Tracy's revealing Ellen's secret to an old suitor of Alice's. Old Mr Middleton dies. On the day of Edward's victory in a parliamentary by-election, he learns of the relations between his wife and Lovell and turns Ellen out of the house. Ellen goes away to a distant town where she develops consumption. There she writes her account of her life and confesses the secret that has blighted her life to a priest. Through the agency of the priest, all is revealed to Ellen's adoptive

mother, her estranged husband, Alice and Mrs Tracy. The consumptive Ellen is carried back home where she dies reconciled with all.

There are numerous episodes of illness and bodily incapacity in the novel. Not only does Ellen's consumption feature prominently in both framed and framing narratives, but there are also key instances of other illnesses as well. Ellen falls ill with an unspecified fever at the psychologically critical, first confrontation with Edward and Lovell after Julia's death, due perhaps to anxiety surrounding possible detection of her 'crime'.⁶³ Similarly, she suffers a possible attack of 'brain fever' when Mrs Tracy threatens to halt proceedings at her wedding, thrusting a note, reading, 'Your sin shall find you out', into Ellen's hand as she leaves the church.⁶⁴ She suffers a relapse days later at a rally celebrating her husband's victory in a parliamentary by-election, during which Alice's disgruntled old suitor denounces Ellen as a murderer from among the crowd.⁶⁵ Other characters suffer too, Henry Lovell succumbs to the same disease - his final act is to write to Edward, confessing his own guilt and declaring Ellen's innocence.⁶⁶ Alice suffers from an unspecified illness for a period, but recovers. Her child dies shortly after it is born. Old Mr Middleton retreats to the warmer part of France for his health, where he dies.

The use of a narrative frame containing Ellen's own story in Ellen Middleton allows the novel to exploit the same dark, tragic atmosphere seen in Cometh Up As A Flower. The difference is, however, that the earlier text has a framing story told by an anonymous narrator, through which we learn enough to guess Ellen's ultimate fate before her own narrative is presented. By establishing that Ellen is

tubercular in the framing narrative, the reader is deliberately left to discern the cause of her condition in the events which are subsequently presented.

We first hear of Ellen from Mrs Denley, the woman with whom the banished Ellen has taken lodgings. She is concerned for her new lodger and takes her concerns to the local priest, Mr Lacy. From Ellen's appearance, Mrs Denley judges that she is 'dying by inches — of something — the Lord only knows what — for Dr. Reid doesn't' as the young woman refuses to see him. Mrs Denley's opinion is confirmed some time later when she has occasion to put flowers in her new lodger's room and, as she stands chatting to her, tries to kill an insect which ran out from among the leaves,

but she caught my hand and stopped me; and *her* hand, sir! — why it was more like one of those bits of hot coal there, than the little white soft thing it looked like, and when I looked at her face, there was a bright fever spot on each cheek, and her lips were as white as could be.

'You are very ill ma'am,' says I to her; 'your hand is burning hot.' She put it to her forehead and 'it does not feel hot to me,' says she, and walks away to the window and opens it, for all that it was almost as cold and raw as tonight. But now ... she has taken to her bed, and is in a very bad way indeed, I take it.' ⁶⁷

Ellen is clearly in the grip of very advanced consumption, indicated by the hectic spots and her fever. Moreover, unlike Lenore, she knows it and faces her fate bravely since she tells Mrs Denley and the nurse who has been procured for her that doctors 'can do me no good.'

Mr Lacy calls round to enquire after Ellen, but is told by the nurse that although she declines to receive him, she has rallied temporarily and feels much better,

and so strong that she's been a getting up and walking about her room; but I take it, her strength is fever strength, for her cheeks are red as crimson, and she seems as if she could not sit still. ⁶⁸

The brief remission lasts until the following Sunday, allowing Ellen to attend Mr Lacy's service. Ellen, who had been characterised only by the 'slightness of her figure' on her first visit to the church, is now a 'shrunken form' and this, together with her 'flushed cheeks', reveals

the fatal progress of a disease which betrays its victims all the more surely, by imparting to them, at certain stages of its course, a false strength, that lures them to exertions only serving to accelerate its fearful termination.⁶⁹

Given the seriousness of her condition, Ellen relents and agrees to see Mr Lacy.

When he goes to pray with her the text presents another sign of her condition. She extends 'her thin transparent hand' to him in greeting.

In a novel featuring so many episodes of mild illness, fainting and 'feverish' emotion or anxiety it is difficult to be absolutely certain of the precise cause of Ellen's consumption, but there is a strong indication that it lies, as it does in Broughton's two novels, in matters of love. The first indication of Ellen's consumption, in terms of the novel's sequence of events, comes when Edward has just forbidden her to see or communicate with Lovell on any account. Prostrate with worry lest Edward discovers her 'secret' she goes to see Alice, Lovell's wife. Ellen writes that,

As I arrived at her door and walked up-stairs to her, *for the first time* I felt a sensation of bodily weakness, which gave me a sudden apprehension that my physical strength was giving way under such protracted mental suffering.⁷⁰ [italics added]

The indication in this passage that Ellen feels differently from, for example, the way she felt during episodes of 'brain fever' is important in signalling the beginnings of a new disease.

Lovell, despite Ellen's entreaties to stay away from her, forces his way into her home only to have Edward return just as Ellen lies at Lovell's feet begging him to end their association. Ellen writes of the moment at which she becomes aware of his presence in the room by invoking her own mortality:

Was it the angel of death? — was it the vision of judgement that passed before me? Was it Edward I saw? — and did I live over that hour? I must have seen him — for never since that day, in dreams or in thought, have I beheld him without that dreadful expression which haunts and pursues me. It deprived me of my senses then — it has been killing me ever since.⁷¹

When Ellen comes to, Edward and Henry have left, but a letter from Edward arrives in which her husband vows, 'I shall not return to my house till you have left it. I will never see you again, or hear your name pronounced, as long as I live.'⁷²

In an agony of despair Ellen goes to the saintly Alice for comfort, but when she reaches the house she is prevented from seeing her by a servant who informs her that Alice's baby has died. As she leaves the house feeling dizzy, she is prevented from falling by Robert Hardy, Alice's disappointed former suitor. Ellen asks him whether he thinks Alice too will die, he replies, 'God only knows that,' but observes that Ellen also seems 'like to die....'⁷³

Ellen returns home to a loving letter from her aunt which only deepens her despair since it dramatically highlights all that she has lost. She momentarily contemplates drowning herself, but is too afraid. Instead, her rejection by Edward leads her to resolve to leave home for an anonymous seclusion in which to die:

Edward had forbidden my name to be uttered before him. Never again should it be uttered as the name of a living creature. I would take another, and bury myself in a seclusion where I might linger through the increasing symptoms of that illness which, during the last few days, I had detected, and recognised by the hectic spots on my cheeks, by a racking cough, and nightly sweats. There I should live alone, suffer alone, and die alone; ...⁷⁴

The reader knows that, in terms of realist conventions, Ellen is dying of consumption. For Ellen, however, the vision of Edward as he stumbles upon her and Lovell together, is what is ‘killing’ her. In the passage above, her abandonment by Edward is linked, textually, with her full consciousness of her fatal disease. The dissolution of the bonds of love is, in this novel, closely bound up with the dissolution of life. For Ellen, life without Edward is insupportable: as she packs to leave she welcomes death:

My cough was dreadful, and shook me to pieces; but I listened to its hollow sound with terrible joy; and as I counted the bank notes in my pocket-book, I wrote with a pencil on the back of the last — ‘For my burial.’⁷⁵

Fullerton attempts to give her story a positive conclusion by having Ellen reconciled with Edward and her family. The main weight of these efforts falls on Ellen’s speech to her relatives gathered around her sickbed. In the course of her ‘confession’ of her part in Julia’s death she says that this is what has brought her to her present state:

Mrs Middleton, you had a child, and you lost her; my hand, unwittingly, unknowingly (so help me God! as I speak the truth) — *my* hand was the instrument of her death; it was lifted up in anger but not in malice, and that anger has been visited upon me by a fearful punishment, which, like the mark which was set on Cain’s brow, has followed me all my days since, and has brought me to an early grave.⁷⁶

As we have seen, however, this is outweighed by the text’s adherence to the same pattern found in Broughton’s works — the pattern in which disappointment in love leads to a consumptive death. Henry Lovell’s dying words in his letter to Edward also seem to bear this out. Suffering from what proves to be a fatal brain fever, in a moment of lucidity he writes,

‘... I am in the full possession of my senses; and if I could, or dared, thank God for anything, it would be for this interval of reason, which allows me to declare, with all the force of a death-bed assertion, that the woman you have turned out of your house as my mistress, is as pure as she was on the fatal day when we both first saw her; and loves you with a passion which

has made the misery of my life, which has baffled every effort I made to destroy her virtue, and which she dies of at last, blessing you and hating me as a woman; ...'⁷⁷

Ellen Middleton, Lenore Herrick and Nell Le Strange are all, it would seem, afflicted by a fatal passion. Moreover, they inhabit narratives which are structured, in various ways, by a convention, well understood by their contemporary readers, concerning the bodily outcomes of misfortunes in love. Athena Vrettos's investigations of hysteria and fiction lead her to conclude, that in

both medical-advice literature and Victorian novels, illnesses frequently appear as indirect expressions of emotional meaning. They constitute an immediately recognisable and conventional language that was subject to a complex set of interpretative codes. These codes were shaped, at least in part, by medical assumptions about women's nervous susceptibility.⁷⁸

While it remains possible to integrate my findings regarding the three novels examined here with Vrettos's ideas on nervous sensibility, it remains clear that the case for nervous sensibility must allow for codes of intelligibility surrounding the development of consumption following setbacks in love.

¹ Rhoda Broughton, *Cometh Up As A Flower*, (Leipzig: Bernhard Tauchnitz, 1867) p. 387.

² Rhoda Broughton, "Good-bye, Sweetheart!", (London: Richard Bentley, 1872) vol. 2, p. 115 – 16. All further page references to this three volume work will be in the form of volume and page references, thus here 2: p. 115 – 16.

³ Georgiana Fullerton, *Ellen Middleton*, (London: Edward Moxon, 1844) vol. 3, p. 219 – 220. All further page references to this three volume work will be in the form of volume and page references, thus here 3: p. 219 – 220.

⁴ The novel was first published in parts between 1818 and 1842 and finally as a whole in 1847.

⁵ First published in 1867.

⁶ First published in 1864.

⁷ See her *The Daisy Chain* (serialised 1853 –55 and issued separately 1856), *The Pillars of the House, or Under Wode Under Rode* (1873), *The Castle Builders* (serialised 1851 – 1852 and issued separately in 1854), *Hopes and Fears* (1860) and *The Trial* (1863). See Annis Gillie's discussion of the appropriateness of Yonge's attribution of symptoms to the diagnosis of consumption in her 'Serious and Fatal Illness in the Contemporary Novels' in *A Chaplet for Charlotte Yonge*, ed. Georgina Battiscombe and Marghanita Laski (London: Cresset Press, 1965).

⁸ See Susan Sontag, *Illness as Metaphor and Aids and Its Metaphors*, (Harmondsworth: Penguin, 1991) p. 23.

⁹ See Catherine Moloney's unpublished thesis, *George Eliot, Henry James, and Consumption: A Shadow on the Lung of the Victorian Psyche*, (Ph.D., University of London, 1999), p. 184. See also Helen Small's *Love's Madness, Medicine, the Novel, and Female Insanity 1800 – 1865*, (Oxford: Oxford University Press, 1996), for an analysis of the declining role of the figure of the love-mad woman in Victorian psychiatry. On the basis of Small's work and my findings here, it can be

argued that misfortunes in love offered literary, social and medical writers a series of pathologised plots which rendered the fates of jilted women intelligible.

¹⁰ Nan M^cMurray, 'And I? I am in a Consumption': The Tuberculosis Patient 1780 – 1930, (Ann Arbor, Mich.: Microforms International, 1986) p. 74.

¹¹ M^cMurray, p. 75.

¹² M^cMurray, p. 70.

¹³ M^cMurray, p. 75 – 76. See Ada Trevanion 'The Lovers' Quarrel' in The Home Circle, vol. 1, 1849, pp 281 – 93.

¹⁴ Ada Trevanion 'The Lovers' Quarrel' in The Home Circle, vol. 1, 1849, p. 292.

¹⁵ For a full discussion of how this picture changed in response to scientific and social developments from the beginning of the nineteenth century to the first two decades of the twentieth century see Charles E Rosenberg's 'The Bitter Fruit: Heredity, Disease and Social Thought in Nineteenth-Century America' in Barbara Gutmann Rosenkrantz ed. From Consumption To Tuberculosis, A Documentary History, (London: Garland, 1994) pp. 154 – 194.

¹⁶ My summary of her life is culled from Marilyn Wood's Rhoda Broughton (1840 – 1920), Profile of a Novelist, (Stamford, Lincolnshire: Paul Watkins, 1993).

¹⁷ Wood, p. 25 and pp. 176 – 78.

¹⁸ Cited in Wood, p. 25.

¹⁹ See the unattributed review section, 'Novels' in Blackwood's Edinburgh Magazine vol. 102. Sep. 1867 pp. 265 – 68. Pamela K. Gilbert attributes this review to Mrs Oliphant in her discussion of Broughton's Not Wisely But Too Well. See Pamela K. Gilbert's Disease, Desire And The Body in Victorian Women's Popular Novels (Cambridge: Cambridge University Press, 1997) p. 90 and pp. 194 – 95.

²⁰ Gilbert p. 88 – 9. Miriam Bailin suggests that there is a related drive, on the part of the writer of sickroom scenes, to bring the dead back to life and that the sickroom scene fulfils this wish, while allowing the reader to fulfil similar drives vicariously. See Bailin's The Sickroom in Victorian Fiction, p.17.

²¹ Job, XIV, 1 – 2.

²² Broughton, Cometh Up As A Flower p. 7.

²³ Broughton, Cometh Up As A Flower p. 26.

²⁴ Broughton, Cometh Up As A Flower p. 174.

²⁵ See Frank Kermode's The Sense of an Edging: Studies in the Theory of Fiction, (Oxford: Oxford University Press, 1966), p. 25.

²⁶ Broughton, Cometh Up As A Flower p. 107.

²⁷ Broughton, Cometh Up As A Flower p. 60.

²⁸ Broughton, Cometh Up As A Flower p. 163.

²⁹ Broughton, Cometh Up As A Flower p. 205.

³⁰ Broughton, Cometh Up As A Flower p.176, 231 and 275.

³¹ Broughton, Cometh Up As A Flower p. 384 – 85.

³² See W. M. Thackeray, Vanity Fair, (London: Everyman, 1991), Ch. 43, p. 552. Glorvina, unlike Nell, recovers from her romantic setbacks and, by the end of the novel has become Mrs Glorvina Posky.

³³ Broughton, Cometh Up As A Flower p. 385.

³⁴ Broughton, Cometh Up As A Flower p. 65.

³⁵ Broughton, Cometh Up As A Flower p. 289 – 91.

³⁶ Broughton, Cometh Up As A Flower p. 296.

³⁷ Broughton, Cometh Up As A Flower p. 252. At the house party at Wentworth when Nell meets Dick she is so happy she declares 'I wish to God I could die now.' Similarly when Dolly tries to persuade Nell of the financial merits of marrying Hugh, Nell bursts out 'Ugh! married to Hugh! I should be dead of disgust in a week!' p. 221.

³⁸ Broughton, Cometh Up As A Flower p. 345.

³⁹ Broughton, Cometh Up As A Flower p. 378 – 79.

⁴⁰ Broughton, Cometh Up As A Flower p. 383.

⁴¹ See James Clarke A Treatise on Pulmonary Consumption (London: Sherwood, Gilbert and Piper, 1835) p. 236 – 37.

⁴² Broughton, Cometh Up As A Flower p. 387.

⁴³ Wood, p. 30 – 33.

⁴⁴ Broughton, "Good-bye, Sweetheart!" 1: p. 16 is the point at which the title features, in the dialogue, Lenore belittling the clergyman's obvious infatuation with her.

- ⁴⁵ Broughton, "Good-bye, Sweetheart!" 1: p. 83 – 84. When Paul, having fallen in love with Lenore, recklessly capsizes the same boat, Lenore loses her shoes and contemplates a walk home on her delicate unshod feet. Paul offers to carry her and she reveals that she weighs 'nine stone eight' and could well carry him. See 1 : 146.
- ⁴⁶ Broughton, "Good-bye, Sweetheart!" 2 : p. 176.
- ⁴⁷ Broughton, "Good-bye, Sweetheart!" 2 : p. 240.
- ⁴⁸ Broughton, "Good-bye, Sweetheart!" 2 : p. 249 – 50.
- ⁴⁹ Lenore throws herself on the floor burying her face in the carpet 'while her hands dig themselves into it, like those of a man in the death-agony. After all, why should the soul's death be accompanied by those less bitter than the body's?' Lenore further remarks on how measured and controlled the script of the reply is saying 'See how straight the lines run— how firmly the letters are formed— it might be a thesis instead of a death warrant!' Broughton, "Good-bye, Sweetheart!" 2 : p. 260.
- ⁵⁰ Broughton, "Good-bye, Sweetheart!" 3 : p. 18.
- ⁵¹ Broughton, "Good-bye, Sweetheart!" 3 : p. 22.
- ⁵² Broughton, "Good-bye, Sweetheart!" 3 : p. 39.
- ⁵³ Lenore remarks that the dancing 'takes my breath away' and Scrope remarks to her that 'you are much thinner than you were.' See Broughton, "Good-bye, Sweetheart!" 3 : p. 44 and 3 : p. 46.
- ⁵⁴ Jemima goes in to see Lenore once she is already dressed: 'She is fully dressed, with the exception of the wreath and veil; — all dead white— dead white, like the doll at the top of a twelfth-night cake; only that the doll usually compensates for the colourlessness of her attire by cheeks that outshine the peony, and *Lenore's* cheeks are dead white too.' When Jemima tries to rouse an understandably subdued and unresponsive Lenore she does so by an unfortunate choice of words: ' "Will you be good enough," continue I, ironically, "to look round and convince yourself that this is not a funeral?"' Getting no response, Jemima continues ' "Lenore ... are you dead? are you dumb? are you cataleptic?" ' See Broughton, "Good-bye, Sweetheart!" 3 : pp. 71 – 2.
- ⁵⁵ Broughton, "Good-bye, Sweetheart!" 3 : pp. 75 – 6.
- ⁵⁶ Broughton, "Good-bye, Sweetheart!" 3 : pp. 254 – 60.
- ⁵⁷ Broughton, "Good-bye, Sweetheart!" 3 : p. 220.
- ⁵⁸ Broughton, "Good-bye, Sweetheart!" 3 : p. 294.
- ⁵⁹ Broughton, "Good-bye, Sweetheart!" 3 : p. 286.
- ⁶⁰ Broughton, "Good-bye, Sweetheart!" 3 : p. 304.
- ⁶¹ Broughton, "Good-bye, Sweetheart!" 3 : p. 310.
- ⁶² See her entry in the Dictionary of National Bibliography, ed. L. Stephen (Oxford: Oxford University Press, 1917) and the entry in John Sutherland's Longman Companion To Victorian Fiction, (London: Longman, 1989). Elisabeth Dornseifer's Lady Georgiana Fullerton 1812 – 1885, A Critical Approach, (Koln: Josef Gouder, 1967) is the only critical work on Fullerton. It fails to deal with the function of Fullerton's use of the consumptive stereotype, concentrating, instead on providing an overview of her fiction instead.
- ⁶³ Fullerton, Ellen Middleton 1 : p. 101.
- ⁶⁴ Fullerton, Ellen Middleton 2: pp. 284 – 87. There is no indication that this brain fever is a precipitating cause of Ellen's eventual consumption.
- ⁶⁵ Fullerton, Ellen Middleton 3: p. 21 – 4.
- ⁶⁶ Fullerton, Ellen Middleton 3: 'Conclusion' p. 181ff.
- ⁶⁷ Fullerton, Ellen Middleton 1: p. 17 – 18.
- ⁶⁸ Fullerton, Ellen Middleton 1: p. 26.
- ⁶⁹ Fullerton, Ellen Middleton 1: p. 29.
- ⁷⁰ Fullerton, Ellen Middleton 1 : p. 7.
- ⁷¹ Fullerton, Ellen Middleton 3 : p. 59.
- ⁷² Fullerton, Ellen Middleton 3 : p. 160.
- ⁷³ Fullerton, Ellen Middleton 3 : p. 167.
- ⁷⁴ Fullerton, Ellen Middleton 3 : p. 172 – 73.
- ⁷⁵ Fullerton, Ellen Middleton 3 : p. 174.
- ⁷⁶ Fullerton, Ellen Middleton 3 : p. 240.
- ⁷⁷ Fullerton, Ellen Middleton 3 : p. 219 – 20.
- ⁷⁸ See Athena Vrettos' Somatic Fictions, Imagining Illness in Victorian Culture, (Stanford: University of Stanford Press, 1995), p. 15.

Chapter 7

Life 'in a Consumption' : Journals, Biographies and Other Accounts of Victorian Consumptives

Thus far we have examined medical, statistical and fictional accounts of the pre-bacteriological Victorian consumptive and his or her disease. In particular, the various ways in which narratives concerned with consumption represent the disease and those who are afflicted with it, have been investigated. Medical treatises, case notes and certificates of the cause of death, however, offer only indirect access to the sufferer's own experience. Besides this, they also provide their own, mediated perspective. Similarly, fictional accounts have been shown to respond to aesthetic demands, whether through proffering diseased contrasts to central characters or in developing particular ideas associated with the consumptive where central characters 'fall into a decline'. It therefore proves useful to contrast these narratives with biographic material and journals, written either by consumptives or by their close relatives. Such texts, however, do not permit the reader anything like an unmediated or pure experience of the disease: on the contrary, we shall show that both sufferers and the close relatives who wrote accounts of their lives were deeply imbued with what we now see as stereotypical ideas concerning the consumptive. We shall see that several of these ideas deeply influenced some of the most private and profound aspects of the lives of individual sufferers.

The list of familiar figures whose lives were touched and changed by consumption includes John Stuart Mill (1806 - 1873), Margaret Oliphant (1828 – 1897),

Anthony Trollope (1815 - 1882), Edward Bouverie Pusey (1800 -1882) as well as minor figures such as the poet and writer John Sterling (1806 – 1844), the painter Andrew Geddes (1873 – 1844), the essayist John Forster, the novelists Richard Jefferies (1848 – 1887), George Macdonald (1824 - 1925), Mrs Yorick Smythies (1813 – 1883), and the artist and poet David Gibson (1827 – 1856). There were also those, however, who documented their lives or whose lives were documented in some detail by their relatives. Four of these, Margaret Emily Shore, Dr. Andrew Combe, Dr. James Hope and Sophia Leakey will be examined here.

I particularly wish to examine the way in which these middle-class writers and their subjects viewed the predisposing and precipitating causes of consumption. Also, I shall add further insight into the physical and mental effects of tuberculosis on sufferers through recourse to letters and journals, where possible citing their own words. Given that many of the examples encountered in this work showed profound religious commitments on the part of both the writers and their subjects, a consideration of religious ideas will also be presented. The sources show that the few who could afford the time and expense involved, travelled to warmer climates to improve their chances of survival. This aspect of consumptives' lives is often neglected in considerations of consumption in this period, so this will also be commented on.

Shore's Journal, and the biographies of Hope and Combe clearly show that what is here referred to as the consumptive stereotype is in some respects a simplification: in reality there is a densely interwoven and inseparable cluster of ideas, accounts, knowledges and practices concerning the pre-bacteriological, Victorian

tuberculosis sufferer. Ideas encountered in fiction, opera and medicine had the power to affect and change sufferers' lives and conduct. We, with our germ theory of disease, antibiotic treatment regimes and resultant heroic conceptions of medicine, are often mistaken in the belief that we inhabit a world of clarity, illumination and truth unsullied by metaphor, imprecision and 'irrational' cultural preconception, having left such mythological forms behind. Close examination of biographies and journals offers some insight into the ways in which experience of disease is *always* mediated and structured by often unexamined cultural conceptions.

The published accounts of consumptives cannot, of course, be transparent or absolutely comprehensive records of sufferers' experiences because there is always some degree of selection which excludes some material. The impossibility of transparency, or access to the sufferer's 'real' experience, is most clear in the case of Emily and Caroline Leakey's accounts of their sister Sophia's last days. In the account published in the Sunday at Home, Caroline felt it necessary to change the names of the persons involved – probably to protect their grief. Almost paradoxically, she opted to present the graphic details of her sister's physical suffering. The paradox is especially intriguing since consumptives were often thought to die painlessly. The reasons for this anomaly are bound up with her presentation of the case as an example of an Evangelical 'good death', the religious emphasis on the afterlife being increased where it contrasts with physical, earthly suffering.¹

We shall see that Sophia's deathbed experiences are rendered intelligible through recourse to religious conventions of action and expectation, patterns which compete with ideas of the typical consumptive death. These and similar patterns make access to the 'pure', subjective experience of consumption impossible.

Sophia Leakey herself viewed her suffering as insignificant, because it was 'worldly', yet also felt religiously inspired guilt regarding her natural avoidance of this suffering. Emily Shore, on the other hand, showed signs of ambivalence on account of her view that her passion for study and learning may have caused her condition and could, if further indulged, have worsened it. Her consumption meant that as she sat weakened by disease, struggling to hold the book she was reading she must simultaneously have struggled with the idea that her passion for study was also hastening her death. The impossibility of transparency, of getting at a 'pure' experience of disease, arises because ideas and patterns of intelligibility not only affect the way sufferers felt and acted, but also the way both they and their relatives made sense of, and thus experienced, their diseases.

In relatives' accounts, other determinants structure the way they understood and presented their loved-ones' lives and diseases. The accounts provided by three of our subjects' surviving relatives all show, either directly through narrative or through interpolated editorial remark, that they comprehended their relatives' consumption through ideas of dramatic crisis or a critical event. In Combe's case overexertion and exposure, in Hope's case a struggle for a professional position, and in Shore's case an apparently harmless summer picnic all fulfil this function. Just as Broughton's and Fullerton's stories show their heroines' misfortunes in love

determining their consumptive deaths, so too did the writers and editors of these three works find critical moments which determine their relatives' fate.

While the biographies written by the doctors' relatives do not show the degree of detail found in Caroline Leakey's account of her sister, they nonetheless do contain a wealth of relevant material since their subjects' profession involves a high degree of awareness of the body. George Combe had to consider the suggestion, by a reader of his manuscript, that he not go into such great detail concerning his brother's illness since his reader felt that all illnesses end either in 'recovery or death'.² He defended his approach on the grounds that the insight into both the causes of the disease and the means he used to combat its progress would be valuable to the general public.

Emily Shore was the daughter of a dissenting clergyman who, refusing to subscribe to the thirty nine articles on the basis of conscience, supported his wife and three daughters by taking in pupils. Her mother was the daughter of a churchman. All three daughters were educated at home by their father and possessed literary abilities. Louisa and Arabella Shore brought out volumes of poetry between 1855 and 1890, Louisa Shore contributing the main work in them. As well as editing the work of both her sisters, Arabella Shore published articles in the Westminster Review on the rights of women. Emily Shore was born on Christmas day 1819 and died of consumption at the age of nineteen in Madeira in 1839. She was an enthusiastic student and naturalist, publishing three articles in The Penny Magazine.³ From the age of eight she kept a voluminous journal which covered nearly 2000 octavo pages by the time of her death. Only two volumes of the

manuscript, including the last, survive.⁴ She also kept a more private intimate journal in parallel with the one eventually published, of which three volumes had been written by 1839, but which were not published and have been lost. The surviving Journal is a record of a lively, intelligent, vibrant, ambitious and sensitive young woman. In it she records her studies, her investigations in botany and natural history, her travels, as well as her experiences of a more domestic and social kind. There are hints of romantic attachments, friendships and a portrait of her family life. As well as being an acute observer of the natural world and a keen student of history, geography and literature, Emily Shore used her journal as an opportunity to practice her writing skills, an exercise in which she gained the self-conscious sophistication of many an older journal-writer as she progressed. Her journal also shows that she herself became the object of her keen analytical intellect as she became a young woman.

Of the texts examined here, Emily Shore's Journal is the most tantalising since it offers hints concerning material of interest to the investigation of consumption, but fails to fulfil these promises because it is so heavily edited. Thus, all the medical detail as well as the account of her final days of her life have been suppressed, both in the process of editing and by an unknown hand responsible for cutting pages from the final volume of the manuscript of the Journal.⁵ Similarly, the editor remarks that elements of Emily's Journal relating to her romance with Henry Warren, as well as a passionate attachment to a mysterious 'friend' have been suppressed.⁶ It is possible that these sections had some bearing on conceptions of consumption involving love.

In contrast to Emily Shore's Journal, the memoirs of doctors James Hope and Andrew Combe are distinguished by their wealth of information on the two subjects' consumption. The Memoir of the Late James Hope, by his widow Anne Hope, simply tells the story of the childhood, education and career of a doctor who rose to occupy the eminent position of physician to London's St. George's Hospital. Born in 1801, he was the son of a Lancashire merchant and manufacturer whose respect for science and the arts encouraged James in the direction of medicine. As a classmate of Andrew Combe, he studied medicine in Edinburgh, distinguishing himself to become house-physician at the Royal Edinburgh Infirmary before he had passed his final medical examinations. While an undergraduate, he became interested in morbid anatomy and the functioning and diseases of the heart, already collecting material for a work on the former. He then moved to London where he took the diploma of the Royal College of Surgeons before going to Paris to study under M. Chomel at La Charité for a year. In Paris his work as Chomel's clerk involved preparing illustrations of morbid anatomy for the distinguished surgeon. He then returned to London and became a member of the Royal College of Physicians, establishing a practice in the city in 1828. He continued his research on the heart and on morbid anatomy as a student at St. George's. In this period he wrote articles on the physiology of the heart and had some claim to offering the first experimentally based explanation of the heart's sounds discerned using the stethoscope. In 1831 he was elected physician to the Marylebone Infirmary and gave private lectures on diseases of the chest. At the end of 1831 he published his major work, A Treatise on the Diseases of the Heart and Great Vessels, which went through three editions in his brief lifetime.

Having completed the first edition of his work on the heart, he turned his attention to the illustrated work on morbid anatomy, Principles and Illustrations of Morbid Anatomy, which came out in parts in 1833 and 1834. In early November 1834 he took the post of assistant physician at St. George's. While there he championed the use of the stethoscope to diagnose valvular diseases of the heart, challenging opponents of the relatively new technique to contests in diagnosis. He also established a student prize for skill in using the stethoscope and enthusiastically promoted its use by his students.⁷ He occupied the post of assistant physician until 1839 when the full physicianship became vacant and he was appointed. Shortly after he accepted the role, his health declined dramatically and he finally gave up his work at the hospital in February 1841. He died in Hampstead in May of that year.

A picture of an extremely dedicated and committed physician emerges from his wife's biography. While an undergraduate at Edinburgh he experienced deep revulsion on performing the mandatory anatomical dissections on a cadaver, a response which persisted for at least six years. Despite this disgust he nonetheless recognised the importance of morbid anatomy to the progress of medicine and undertook the task of producing and gathering the illustrations that were to result in his Illustrations of Morbid Anatomy. He was also ready to forego the pleasures of light reading whenever his work or lecturing required his full attention over many weeks. He was a man of deep religious conviction, having applied his considerable intellect to theology before he became a committed Christian, even declining a chair in medicine at University College London because it conflicted with his religious beliefs. He had one son.

Born in 1797, Andrew Combe was the seventh son among an Edinburgh brewer's fifteen children. He attended Edinburgh High School and Edinburgh University and seems not to have enjoyed these experiences. In 1812 he was apprenticed to a surgeon in Edinburgh and took his surgeon's diploma in 1817. During this time he lived with his brother George, gaining a deal of intellectual confidence thereby. At around this time his brother and biographer, George, became interested in phrenology and met and became a friend of Dr. J. G. Spurzheim, a keen populariser of the doctrine. Living in his house and naturally respecting the views of his older brother, Andrew also became interested in phrenology. Like many young doctors at the time, Combe went to Paris for a year to improve his medical knowledge. He attended the surgeons on rounds at the Hôtel Dieu and La Pitié and learned French. On Spurzheim's suggestion he also attended Esquirol's lectures on mental derangement at the Salpêtrière. At the completion of the year's work he returned to Edinburgh where he showed signs of consumption in March 1820. Medical advice sent him to Livorno where he found it necessary to retire during the following winter. He recovered sufficiently to begin practising as a surgeon in Edinburgh in 1823. In the same year he was involved in founding the Phrenological Journal and defended phrenology in an address to a hostile audience of the Royal Medical Society of Edinburgh. He graduated M.D. in Edinburgh in 1825 with a dissertation on the seat of hypochondriasis. In 1831 he published Observations on Mental Derangement, an application of phrenology to insanity. The first edition soon sold out, but his health prevented Combe from preparing a second edition.

He spent the winter of 1831 – 1832 in Paris and Rome, returning to Scotland in the summer. From this point on he was accompanied and cared for on all his travels by his niece, Marion Cox, who also lived with him when at home.⁸ He spent the winter of 1832 - 1833 in Edinburgh. He was not, however, sufficiently recovered to resume the rigors of general practice and began writing Physiology Applied to Health and Education. This was completed by March 1834 and sold exceedingly well. Although he returned to general practice as his health gradually improved, he was unable to make night calls and avoided strenuous exertion. He temporarily abandoned general practice in 1835. Despite his health he accepted the position of physician to King Leopold I of Belgium, for which Dr. James Clark, whose work I examined in Chapter 1, had recommended him. Unfortunately his health again failed after only months in the post and he returned to Scotland late in 1836. Despite ill health and the disruptions of his aborted sojourn in Brussels, Combe managed to complete The Physiology of Digestion in 1836 which also met with considerable success.

He returned to practising in Edinburgh and was well enough to overwinter in Scotland in 1837 – 1838. In March 1838 he was appointed a physician extraordinary to the Queen in Scotland, a position he obtained on the basis of Sir James Clark's recommendation.⁹ He was well enough to travel to Brussels where he called on Leopold and treated Prince Albert, then in the city, before travelling to Germany. He completed his next work, The Physiological and Moral Management of Infancy in 1839, but it was not as successful as his previous work. In 1840 he resigned as one of the managers of the Lunatic Asylum at Morningside as he felt his ill health prevented him from personally fulfilling his responsibilities towards

his patients. Despite Combe's generally taking great care of himself, his health gradually worsened over the next two years.

In the summer of 1842 Sir James Clark and his own doctor advised him to overwinter in Madeira. He was forced to spend the following winter there as well. In the winter of 1844 he remained in Scotland and attempted a trip to Germany in the following summer, only to have to abandon it due to his health. The winter of 1845 – 1846 was spent in Scotland and in the summer of 1846 he sailed from London to Dublin, Liverpool and Glasgow for his health. He remained in Scotland during the winter of 1845 – 1846, but his health gradually deteriorated. Despite his condition he undertook a visit to one of his brothers in America from April to June, but, having seen his brother, he cut short the trip and returned to Scotland due to his health. In August of 1846, already in poor condition, he suffered a severe attack of diarrhoea, quickly becoming very weak, and died at the age of 50 on the 9th of August.

Having sketched our three consumptives' biographies we can move on to the way they were written about and viewed themselves and their condition. Neither Emily Shore herself nor her sisters Louisa and Arabella, one at least of whom must have edited her Journal, express an opinion on the predisposing cause of her condition. The journal-writer herself, however, subscribed to stereotypical ideas surrounding consumptives, including those regarding the susceptibility of genius to the disease. On the 5th of August 1837 she records the visit of her cousin, the MP and minor poet, Winthrop Praed, to the family at Exeter, describing his ill appearance:

He is a very clever and agreeable man ... about thirty-five years old, as thin as a lath, and almost ghastly in countenance; his pallid forehead, haggard

features, and the quick glances of his bright blue eyes are all indications, I fear, of fatal disease. He seems, alas! sinking into a consumption ... if indeed he is not already in one. ¹⁰

She also had the opportunity of attending the celebrations following Praed's election to the House of Commons and closely observed her cousin that night. She watched him while toasts and speeches were made, recording how

he had been sitting silent, grave, and thoughtful; to my eyes there was even a shade of melancholy across his pale and interesting countenance, as if he had secret forebodings of the result of the unseen malady within him, that malady which is so often the accompaniment of fine genius and deep feeling. ¹¹

Clearly, Emily felt herself to be only 'delicate' or threatened with consumption and so seems not to have seen any similarity to her own situation in the newly elected MP.

Both doctors' biographies, however, contain evidence indicating that either their biographers or the subjects themselves believed consumption to be due to an inherent predisposition to the disease. In the first few pages of James Hope's Memoir, Anne Hope is at pains to trace the origins of her husband's illness. She remarks how James was one of 12 children, four surviving at the time of writing, noticing how 11 grew to maturity characterised by every appearance of health. This promise, was, however illusory since five died under the age of twenty five and two others died at the age of forty, including James, 'and the four surviving members of the family are of a remarkably delicate constitution.' She writes that James came to the professional opinion that the

causes of so great a degeneracy in the descendants of so long-lived a family ... could be ascribed ... in a great measure, to the very injudicious mode of clothing and feeding children, which was then prevalent, and which was adopted by his mother, under the directions of a surgeon of great eminence in the town of Manchester. ¹²

Doctor Hope in fact believed that 'exposure to cold and inadequate nutrition in childhood, sowed the seeds of the disease which was developed in later years.'

James, writes Ann, based his opinion on his own medical experience and on the observation of physiological experiments 'in which tubercular disease may be produced by a similar mode of treatment.' While we may wonder at this apparent firm basis of belief in experimental verification, there can be no disputing the fact that five of the twelve children 'died of tubercular disease'.

George Combe writes of the family's move to the brewery at Livingston's Yards where Andrew was born:

The local situation of Livingston's Yards was low, damp, and, in winter, much shaded from the sun; and the dwelling-house was insufficient to afford comfortable accommodation to the large family which inhabited it. These circumstances affected injuriously the physical health of the children.¹³

In response to his brother's suggestion, at a time when he is already ill, that ignorance caused the family a great deal of suffering, Andrew Combe himself writes:

The statement you give of the vitiated air in which our parents and the younger members of the family passed the night, and the neglect of ventilation of clothes and bedding, to which may be added the neglect of general ablution or bathing where warm water was constantly at hand, sufficiently account for the appearance of scrofulous disease and impaired constitutions in us.¹⁴

The biography mentions the death from consumption of Abram Combe, Andrew's oldest brother, but only notes that 'several of the more advanced members of the family were cut off in the bloom of youth or early manhood'. Exactly how many is unclear.¹⁵ Such a view may be regarded as a quaint oddity today, but the biography reveals that acceptance of the doctrine had far reaching personal consequences for Andrew Combe.

The reader of the biography learns that, while in Paris before falling ill, Andrew was jokingly linked to an unnamed young Frenchwoman and at least foresaw romance, even if only on his return to Edinburgh, as fairly inevitable. He writes that despite his supposed ardour for the unnamed young Frenchwoman having had time to cool in the long intervals between their meetings, ‘...Jean will find some ‘Beauty’ for me to fall in love with in Edinburgh when I come back; and I am quite convinced that the Edinburgh ‘Beauties’ are the best in every respect.’¹⁶ Yet he returns to Edinburgh and the biography remains remarkably silent on the subject of Edinburgh ‘Beauties’. So while George’s marriage is recorded in the Life, the reader might begin to wonder at the conspicuous gap in the account when, in relating the events of Andrew’s trip abroad in 1831, George writes that Andrew’s health forced him to overwinter in Italy and that he wrote to his niece, Marion Cox, from Paris asking her to accompany him to Livorno. George deals with this development by noting ‘From that time to the day of his death, she never ceased to be his constant, devoted, and most useful companion, and, in seasons of sickness, his nurse.’¹⁷

The mystery is resolved in a letter written in response to George’s exhortation that Andrew should write a series of letters setting out a narrative of his life and in which he could mention any subjects not previously discussed in his works, but which had engaged his thoughts. Thus on the 16th of November 1841, at the end of a letter concerning his motives for writing his works and the place of his religious beliefs in his conduct, he writes:

There is one part of my conduct which I rejoice at having adhered to, and which cost me some sacrifice of feeling, viz., not having married. If there

is one circumstance which demonstrates more clearly than another a practical unbelief, if not real ignorance, among my brethren, of the importance of physiology as a guide to the improvement and happiness of the race, it is the culpable recklessness with which medical men often marry, in flagrant opposition to the clearest evidence of constitutional infirmity or actual disease in themselves or their offspring. How very few see any harm or immorality in this! From the natural affections which I possess, I have always felt that man's highest happiness here must be based upon the gratification of his affections in the domestic circle; and in my individual case, I believe few things could have added so much to my enjoyment as having a good wife and children. But one of the evils of my impaired health, was its having rendered these 'forbidden fruits' to me; and although I felt the deprivation, it is now a comfort to me to reflect that no one is involved in my fate except myself. ¹⁸

The full extent of the enjoyment which Andrew denied himself is clear from one of his death notices, appended at the end of the biography. In it his nephew, Dr.

Robert Cox, touchingly writes how Andrew

was fond of children: and some who read these pages will remember the heartiness with which, in their early youth, they used to shout with merriment at the 'funny faces' he made for their amusement; and the storms of glee that arose when, feigning unconsciousness, he allowed a regiment of his little friends to carry him in procession through the room, on the floor of which they would deposit their somnolent burden, celebrating their achievement by dancing and shouting around it. ¹⁹

Andrew Combe's adherence to the current medical theory on the nature of his disease, together with his deep sense of morality, forced him to sacrifice personal fulfilment and happiness.

Besides ideas of predisposing causes of consumption, the Victorians also subscribed to a range of precipitating causes. The three substantial works examined here clearly show that the idea of precipitating cause presented the writers with a dramatic structure through which they could render their subjects' lives intelligible, just as similar ideas were used by popular romantic novelists in conceiving of love-lorn heroines' fates. ²⁰ The reader of Hope's biography is guided, by the remarks mentioned above on his constitutional susceptibility to the

disease, towards regarding the onset of his consumption as occurring in May 1836. In February 1836 he decided to take out life insurance and his lungs were carefully examined because of the prevalence of consumption in his family. He was declared fit. In the May of that year, however, 'he had a slight cough and pain in his side, which yielded to a blister' and he regarded himself as completely well once more. In the spring of 1837 he had an attack of influenza, affecting his chest, and from this period he was never free from a slight, hacking cough.²¹ Given his family history, Anne Hope clearly dates the onset of his decline from this period. Two points, however, in the early stages in the progress of his disease, are given prominence in the biography: James' workload at St. George's Hospital, and the mental and physical stresses surrounding his election to the position of physician to the hospital. Before considering Hope's workload, it will be instructive to consider it in the context of a fictional parallel.

In the course of discussing changes surrounding the consumptive stereotype in the late nineteenth century, Nan Marie M^cMurray cites the case of fictional seamstresses presented as dying from consumption due to overwork in British short stories. One such occurs in Anna Maria Seargeant's story, 'The Ball Dresses' in The Home Circle.²² On the verge of coming out, the young Lady Arabella Harcourt visits a dressmaker, Mrs Wharton, and insists that two ball gowns be made for her despite Mrs Wharton's protests that her seamstresses are too busy to fulfill an urgent order. The dressmaker informs Lady Harcourt that one of her best employees is ill with overwork and has just left to go home. As they discuss the possibility of delivering the dresses in time for the ball, the seamstress, nineteen year old Fanny Elwin, is glimpsed in the passage on her way out. Mrs Wharton

calls her back. She looks so ill that 'her haggard and worn out appearance' startles her employer who insists she cannot ask Fanny to undertake to complete the dresses.²³ Arabella offers Fanny a gift of a guinea if she can complete the dresses. Fanny accepts since it will mean that she can now afford to have a physician visit her ailing father.

Fanny, already ill, sits up all night to complete the task, delivering the dresses at the appointed hour. Arabella, however, is unhappy with the fit of one of them and insists that it be altered. Despite severe exhaustion Fanny quickly alters the dress. While Arabella turns to get the promised reward, Fanny collapses, 'apparently lifeless on the couch on which she had been sitting'.²⁴ In the ensuing bustle, Arabella is persuaded to pay Fanny later and agrees, knowing that the money was needed for the physician.

Fanny is taken home by a kind relative of Arabella who takes her own family physician to see the seamstress the next day. The doctor is of the opinion that further work will be impossible for Fanny. Fanny's suitor, the apprentice William Morris, is heart broken when it is revealed to him that the young woman he had intended marrying is dying, '... the victim - or should we say one of the numerous victims - of close sedentary habits and over toil.'²⁵ Fanny accepts death once she knows that Morris will care for her father.

The story closes with Arabella examining a hat at Mrs Wharton's as Fanny's funeral procession, led by her father and William passes by. She recognises William and so concludes that it is Fanny's funeral. Mrs Wharton declares that Fanny, 'was too delicate for our business. I fear she fell a victim to her close

application.’²⁶ In response Arabella asks Mrs Wharton why she allows young women to work so hard. Mrs Wharton informs her that wages are so low and demand for work so high that customers too need to bear some responsibility for the deaths of young workers.

The story, and others like it, clearly attribute the seamstresses’ deaths to overwork, and in ‘The Balldresses’ the situation was presented to the public clearly in order to raise awareness of the evil consequences of poor pay and bad working conditions.

The idea is also reflected in Hope’s biography, where it is presented in suitably dramatic circumstances. James Hope clearly knew that he had consumption and that his workload at the hospital was crucial to any possible remission or recovery.

While his symptoms decreased on vacation in the Scottish Highlands, they increased sufficiently for his family to press him to see Sir James Clark on his return to London. Clark, having examined his lungs with the stethoscope, formed ‘an unfavourable opinion’ and advised him to go abroad. James Hope was then insufficiently wealthy to leave his post at St. George’s and was forced to decline, although he recognised that something would have to be done to address his heavy workload should his condition not improve. Accordingly, he began gathering material to substantiate the case he felt he would have to make to the hospital’s Board. Anne Hope presents the document that eventually resulted, showing that he was responsible for approximately 400 outpatients at any one time, having to see between 100 and 160 patients daily. He was also responsible for taking case notes and updating these as he saw patients. The hospital’s secretary’s office found that in five years he had seen nearly 30 000 patients. He occasionally had some help, but often had to undertake the task single-handedly, despite being ill himself. He

also gave lectures to the hospital's medical students at the time.²⁷ Hope's meticulous and comprehensive document, presented to the hospital's Medical Committee (made up of its physicians and surgeons), presents a picture of a workload which would prove overwhelming for a healthy individual, but which must, he and his wife felt, have contributed considerably to his deterioration.

Six days after James Hope presented his case for assistance in the performance of his duties, his superior, the hospital's chief physician, resigned due to ill health, opening the prospect of James succeeding him. Usually the assistant physician would, as a matter of course, succeed to the physician's post. On this occasion, however, the medical committee decided not to automatically endorse James Hope and left the decision open to each of its members when the final vote came. To make matters worse, James found himself competing against Dr C. J. B. Williams, with whom he had had a disagreement on the publication of some of his experimental work on sounds of the heart.²⁸

Enlisting the help of his family and aided by many of his students, James Hope immediately set about canvassing support for his election. Anne writes:

He had too much discernment not to perceive, that, while to Dr. Williams a defeat would be only the loss of an election, to him it would be the loss of character, of fortune, of fame — of all that he prized, and had worked so hard to attain. The shock was too much for his already enfeebled frame. He was immediately attacked with a spitting of blood, and, while his family sat up through the night, occupied with preparations for the election, he himself was obliged to go to bed.²⁹

Despite the haemoptysis, James worked day and night for five days before his opponent withdrew from the contest and he was elected Physician. The full significance of the dramatic moment for his biographer is, however, stated in terms

of life and death. While his friends congratulated and his opponents envied him,

Anne Hope pondered the cost to James:

But what was the price that he had paid — it cost him no less than life. The spitting of blood with which he had been attacked on the night of the 19th of June, the agitation and excitement of the ensuing week, the fatigue of the election ... were what he never could recover. From this time he dated the final breaking up of his health, which, thenceforth, progressively and rapidly declined.³⁰

Where Broughton's and Fullerton's heroines had died of love, James Hope seems to have died of work, and yet they all died of consumption.

While Emily Shore's Journal does not raise the issue of predisposition, her editor intervenes in the work to comment on the precipitating events behind her consumption. Having noted that Emily was largely self-taught in Nature's classroom, her editor writes,

Her passion for Natural History will appear in the earlier journals; it was, indeed, in a great degree to her wanderings at dawn of day in the dewy woods, and her late watchings at open windows with a telescope, collecting plants and studying the habits of birds and insects, that she owed the attack of lung-disease which terminated so fatally and so soon.³¹

It is indeed curious that so well educated and informed a pair of women as Louisa and Arabella Shore, who together were responsible for the first edition of the Journal, should, in 1891, attribute Emily's disease to 'dewy woods' and draughty windows when tuberculosis bacteria had been shown to be the causative agent in the early 1880s. It should also be remembered that experimentation had proven the contagious nature of tuberculosis in the late 1860s. The editors are even more specific in that they date the beginning of the disease to a summer picnic which Emily went on in Devon. They write,

On June 7 took place a picnic excursion to Bradley Woods, a merry young party who boated, scrambled, sketched and sang, recited poetry, and read aloud, and dreamed happy young dreams by the sunset and moonlight. But

that summer day, intensely as she enjoyed it, set the seal on the malady she was apparently recovering from. She caught cold, and from that time may be said never really to have rallied, though no one was aware of the fatal harm that had been done.

The Journal from this date until the 4th of July fails to mention either her cold or her health, but by the 4th she was very debilitated. The editors clearly felt a need to distinguish general ill health from a terminal disease, and felt confident enough to attribute her decline to conditions on the day of the picnic. They seem to have been aided in making this distinction by the secrecy which surrounded Clark's real view of Emily's condition. Despite lacking the dramatic power of a critical event such as Hope's realisation that the longed for and expected position could be snatched away, Shore's editors' comments mark the downward trajectory of Emily's life.

Ideas about another possible, precipitating cause of consumption are also registered by Emily herself. It will be recalled, from James Clark's Treatise on Pulmonary Consumption for example, that excessive study was held to bring on the condition. Thus, it is not surprising that the seventeen-year-old Emily writes in September 1837 that,

In looking back on the beginning of my illness, I feel sure that one of the principal causes of it was overworking my mind with too hard study, which is no uncommon cause of consumption. For many months before I was actually ill, I tasked my intellectual powers to the utmost. My mind never relaxed, never unbent; even in those hours meant for relaxation, I was still engaged in acquiring knowledge and storing my memory. While dressing, I learned by heart Chapters of the Bible, and repeated them when I walked out, and when I lay in bed; I read Gibbon when I curled my hair at night; at meals ... my mind turned to arithmetic, history, and geography. This system I pursued voluntarily with the most unwearied assiduity, disregarding the increasing delicacy of my health, and the symptoms that it was giving way.³²

This idea engendered both an emotional conflict for Emily herself, and anxieties for her loved ones. Several of Shore's readers remark on what some take to be her intellectual precocity, and an impressive range of studies clearly formed one of her greatest joys.³³ Only weeks after recording the above observation, we thus find Emily writing that she has again embarked on a rigorous, self-devised course of reading and studies, not unlike the one she thought might have caused her condition. She writes:

I do not know whether I shall be strong enough to pursue this system of study very long, particularly as my health seems getting worse. Mamma is afraid of my overworking my mind again; still, I cannot bear the idea of living, even in sickness, without systematically acquiring knowledge.³⁴

Study had become so integral to Emily's identity that she was prepared to tolerate a degree of illness as the price of learning. A month later her journal records that while she finds reading 'lives' fatiguing she cannot give up the delights of study, despite her parents' fears that she is 'overtasking [her] brain again.'³⁵

Recently some doubt has been expressed as to whether Andrew Combe suffered from pulmonary tuberculosis. Discussing Andrew Combe's life, including the whereabouts of his cranium, which was prepared for phrenological examination after his death, Walker, Shaw and Kaufman touch on the post-mortem findings recorded at Combe's death. Through consideration of the state of the left and right lungs, as described in the post-mortem report, they conclude that the evidence 'strongly suggests that Combe suffered from bronchiectasis, or a widening of the bronchi (congenital or infection-related), rather than from pulmonary tuberculosis, which was suspected at the time.'³⁶ Combe, however, clearly felt he had tuberculosis, even coughing up a 'distinct tubercle' during his stay in Brussels.³⁷

The events surrounding the onset of Andrew Combe's consumption are only touched upon by his biographer, although they involve similar environmental and intellectual agents. Just prior to returning from Paris late in 1819, Combe and his friend, Alexander Collie, undertook a walking tour in Switzerland and northern Italy, a course of action his biographer feels was ill advised as Andrew should have been 'seeking temporary relaxation to recruit his diminished energies.'³⁸ George Combe also feels the two companions exhibited a disregard for the 'laws of health' in trudging through rain and snow to cross the Simplon in late August, covering 42 miles in the day of the crossing without a proper meal.³⁹ He further attributes Andrew's sense of sadness on returning to London after his tour, to 'cerebral exhaustion consequent on excessive excitement and exertion'.⁴⁰ The biographer, however, declines to directly attribute his brother's consumption to these causes.

The relation between 'excessive physical and mental exertion' and consumption is clearer in the case of Abram Combe, Andrew's elder brother, if only because the exposition of his case in the Life is briefer. George Combe tells how Abram was inspired by Robert Owen's philanthropic community at New Lanark and set about establishing a similar community at Orbiston in Lanarkshire. He invested all his own financial resources and encouraged other similarly philanthropic individuals to do the same, establishing a community of three hundred people. He also, however, felt compelled to set a good example for the labouring poor involved in the scheme.

George Combe writes that Abram:

by way of setting an example of industry, took to digging with the spade, and actually wrought for fourteen days at that occupation, although previously unaccustomed to labour. This produced haemoptysis, or spitting of blood.⁴¹

When this occurred he took to directing the efforts of the 250 strong workforce and ‘*spoke the whole day, the effusion of blood from his lungs continuing.*’⁴² This forced Abram to seek Andrew’s medical advice in May 1826. He was advised against overtaxing his strength, but returned to his community only to suffer ‘inflammation of the lungs’ from ‘imprudent exertion’. This was successfully treated, but George writes that ‘the malady ended in pulmonary consumption,’ of which Abram died in August 1827.⁴³ The little narrative concerning Abram Combe’s consumption seems to explicitly articulate what remains only hinted at in Andrew Combe’s case.

The Journal, biographies and personal accounts all provide mediated access to sufferers’ experience of their disease, both mentally and physically. As is to be expected from the fairly comprehensive medical accounts of consumption, such as that of Sir James Clark in his Treatise, the mental and physical effects of the disease exceed what one may have been led to expect by artistic representations of consumption. The examples investigated reveal a richly complex web of physical and mental suffering. They also provide some indication of the psychological strategies for dealing with uncertainty and the prospect of death, adopted by both sufferers and those who cared for them. It is to these experiences that we now turn.

The most pervasive, and often very distressing symptom reported, is coughing. In early 1837 the seventeen-year-old Emily Shore was surprised to find her almost uninterrupted round of rambles in the woods, plant collecting, reading and writing annoyingly interrupted: ‘I have been confined to the house, and partly to my bed, by a cough — a thing which I have not for many years had, except for my last fever.

...unless I get out very soon, I am afraid that I shall miss the first singing birds of passage.’⁴⁴ Similarly, in early 1820, Andrew Combe, the twenty-two year old who had walked forty miles a day months before, suffered a cold and wrote to his walking companion, ‘for some days I have suffered from a terrible cold, and, in consequence, am inactive and ill at ease.’ His uneasiness it seems was well founded, since we find him writing again 26 days later that,

my cold continues unabated; for ten days my brother has been uneasy about me, although he does not know the worst. During some days I have had pains in the left side of the chest, extending from between the ribs to the sternum, which give me a good deal of uneasiness in the mornings. I cough, but not a great deal. On going to bed I feel myself cold perhaps for two hours, and in the morning I have considerable perspirations, etc. I have taken a variety of medicines without effect; my digestive organs do not perform their duty, and I believe that that is at the bottom of my ailments.⁴⁵

Just over a month later he reports to his friend that he is no better, and, as his brother George writes, ‘now haemoptysis is added to the other symptoms’ forcing Andrew to move to his sister’s home at Gorgie Mill ‘for change of air’. The distress of coughing could be compounded by the mental distress which the expectoration of blood or even tubercles themselves could occasion. There can be little doubt about the ailment when the sufferer coughs up ‘a distinct tubercle’, as Andrew Combe later did while in Brussels.⁴⁶ Andrew’s first episode of haemoptysis, however, is not treated dramatically, as James Hope’s was by his biographer, but there were times, when the disease had advanced, when he regarded it as serious – perhaps as he was aware that a severe episode could lead to death.⁴⁷ George Combe also records that in late January 1841, Andrew was seized with ‘an alarming attack of haemoptysis’ while out walking in Edinburgh’s George Street.⁴⁸ Having been ill for over two years and been forced to leave for Madeira ostensibly for her father’s health, the nineteen-year-old Emily Shore finally conceded that she was ‘in a consumption’ after a severe episode of haemoptysis.

She writes, 'On the 4th of April I broke a blood-vessel, and am now dying of consumption, in great suffering, and may not live many weeks. God be merciful to me a sinner.'⁴⁹

Perhaps the most disabling symptom reported by sufferers is the weakness and fatigue attendant upon weight loss and diminished lung function. Having almost daily botanised and gone bird-watching before her illness, Emily Shore writes:

My constant fatigue and weakness are quite distressing to me. About bedtime I generally feel brisker, but during the rest of the day the slightest thing is a painful exertion to me; I dread walking up-stairs. Both my mind and my body feel worn out and exhausted; my hands can with difficulty hold a book; and actually I am content on these beautiful summer mornings to sit quietly and stupidly at my needle, alone for any length of time, silent and scarcely thinking, unwilling even to repeat poetry.⁵⁰

In this condition not only was her reading hampered, but she was forced to limit her entries in her Journal as well. In late November 1837 she read Romeo and Juliet aloud to three young children, writing how they enjoyed it, but adding that she cannot expatiate fully on her own response to the play as 'I am always obliged for health's sake, to limit myself in the use of my pen.'⁵¹ It should be recalled, however, that Shore, Combe and Hope suffered from a condition which usually included periods of remission, so that the disabling fatigue and weakness would abate markedly. All three experienced marked remissions in warmer periods and climates.

Within weeks of reaching the warmth of Funchal, Shore recorded that 'in the afternoon, being stronger than usual, I took a walk with mamma and L., longer than any since I have been in Madeira, and almost a country walk.' She was so taken by the novel, semi-tropical scenery that, despite being 'very weary' and being urged

by her mother to stop, she was 'tempted on' to explore further.⁵² While Andrew Combe was unable to walk the ward rounds with the consultants or attend classes at the Paris hospitals in June 1821, because he found his 'strength still unequal to the task of standing two or three hours at bed-sides', he improved sufficiently later in the summer to walk and ride in Scotland.⁵³

Pain also features among the symptoms that trouble consumptives. Thus the poet and novelist Caroline Leakey's 1858 account of her sister Sophia's character and final days, 'Holy Living: Happy Dying', published in Sunday at Home, is remarkably frank and graphic regarding her symptoms, especially pain. This is anomalous, however, in the light of Dickens's and Brontë's artistic representations of the disease. Leakey's published account includes graphic detail because this would help persuade the reader of the spiritual comfort offered by her message. It would seem, however, that the pain was sufficiently severe to induce Sophia to fear that death itself would necessarily involve considerable agony. Because, as we have seen, Sophia subscribed to the Evangelical ideal of the 'good death', she was weighed down by guilt at not wishing to encounter death fully conscious and asked her sister, 'Do you think it would be wrong to pray I may die in my sleep?'

Caroline, one suspects, given her raptures over her sister's eventual wakeful end, failed to confirm the acceptability of such a wish in responding: 'God knows the wish of your heart; leave it to Him; better not let it pass into prayer.'⁵⁴ Similarly when Emily Shore consulted Sir James Clark in July 1836 and was subjected to percussion of the chest during the examination, she experienced some pain.⁵⁵ By December of that year she was writing that, 'I cannot read or write without a headache, and writing also gives me a pain in my chest, which I have not, indeed,

been free from for some days.’⁵⁶ Anne Hope records how, a few days before James Hope died, he affirmed to his doctor that,

... he should choose his own complaint, except perhaps in a few aggravated forms, quite distinct from what he suffered. And this, too, at a time, when, in addition to his previous ailments, he had been unable for several weeks to speak above a whisper, or to swallow any thing without extreme difficulty, in consequence of an inflammation of the larynx.⁵⁷

It should be assumed that in these final days all the sufferers mentioned here would have had recourse to laudanum, mentioned by Mrs Hope, and which her husband used to allay the agony of coughing with an ulcerated larynx.⁵⁸

Consumption derives its name from the effects of the disease on sufferers’ weight – at times it appears they are wasting away. Yet sufferers regarded or dealt with this mentally distressing symptom in different ways. Andrew Combe was a physically imposing man, his brother recording that he was over six feet tall. In the five months he spent in Belgium as physician to King Leopold I, his weight dropped so considerably that even his employer remarked on how thin he had become by his departure in August 1836. During a visit to a weaving factory he and some friends weighed themselves on one of its scales and Andrew weighed only 9 stone 4 lb.⁵⁹ Andrew’s response to his weight loss is not recorded. Sophia Leakey, however, could make light of her wasting by downplaying the value of her body, concentrating her energies and attention on the afterlife instead. Caroline Leakey’s account of Sophia’s consumption includes a remark by herself, in the guise of ‘Charlotte’, on how thin the invalid, ‘Selina’, has become. ‘Selina’, or Sophia, cheerfully responds that she can entrust her ‘poor worn body to Jesus,’ since ‘he who has so richly provided for my soul can surely take care of these bones.’⁶⁰

James Hope exhibited perhaps the most dispassionate and disinterested approach to

the wasting effects of his disease. Certain that he would die within months, throughout the final stages of his consumption he kept a strip of paper which he used to measure his leg, 'and as it diminished inch by inch, he used to smile, and to speculate on the probability of his going before or after July, the time which he had first named', as the time of his demise.⁶¹

Symptoms of the disease grow more and more severe as it progresses, and despite a reluctance to present some of the most disturbing symptoms in published accounts, occasionally writers do mention these. While on his second voyage to Madeira in November 1843, Andrew Combe was by far the most medically qualified passenger on the *Duncan Ritchie* and attended a dying young American also bound for Funchal due to his consumption, but travelling alone. Unfortunately he was in the final stages of the disease and was so unwell that he was unable to leave his cabin. A letter Andrew Combe wrote from Madeira reports that,

when I saw him the day before his death, he told me with a smile of joy, that his brother and sister and some other friend, had arrived to take care of him, and what a pleasure it was; and under this happy delusion he died.⁶²

Caroline Leakey gives a harrowing account of the night of Sophia's death. She writes that Sophia's 'peculiar unstrung manner' and 'shivering coldness' so alarmed the family that the doctor was summoned, only to declare that there was no immediate danger. Once he had left, however, 'at midnight she had a severe convulsion' and her attending relatives could only pray for her relief.⁶³

Paradoxically, such shocking symptoms in the final stages of consumption do not form part of the dramatic structures which we saw used to render consumptives' lives intelligible in relatives' accounts.

Relatives' personal accounts of their loved ones' lives are, unlike the often clinically dispassionate medical narratives, able to present the details of sufferers' psychological vicissitudes on the long road to the grave. We have already seen how Sophia Leakey felt reluctant to admit to her fear of dying in the context of a family who subscribed strongly to the Evangelical ideal of the 'good death'. Fear, however, is also registered in Emily Shore's account of her illness. She describes how the prospect of consulting doctor James Clark in early July 1836 raised her to an agonising pitch of anxiety, fearful of his verdict on her health. She writes that before he had even examined her, she 'trembled all over', continuing 'my heart throbbed, my pulse quickened, and the perspiration broke out from every pore.' While he delivered his verdict to the patient's mother in private, keeping his views from Emily herself, she was 'left in a state of anxiety amounting almost to agony,' fearing that her death sentence was about to be pronounced, and anticipating that she was to be told that 'the pulmonary disease had already begun.' In the event Clark tells her, that although delicate and at risk, she is as yet free of consumption.⁶⁴

Emily Shore's case raises the issue of whether the diagnosis of fatal disease was withheld from patients, perhaps to minimise their distress and fear. It is clear, from letters included in Andrew Combe's biography, that his doctors felt it advisable not to inform him of the full severity of his case at various points, a rather short-sighted strategy since Combe was himself both a trained surgeon and physician. Writing from Rome, where he had gone to avoid the Scottish winter, on the 25th of February 1832, he praises the friendliness and efficiency of his two doctors, Dr Hirschfeld and Dr Jenks. A footnote added by George, however, notes that the

letter also reports Dr Jenks' statement that Andrew's present illness had nothing to do with the presence of tubercles in his lower lung. Andrew also reports that 'neither [Jenks] nor Dr Hirschfeld was very willing to say that tubercles were not formed in the upper part of the lung, and I could not press them farther. The expectoration seems to me almost characteristic of them, so far as one symptom can be so.'⁶⁵ George Combe adds that the real state of the lungs at post-mortem revealed that Andrew's suspicion, that he had tubercles in his lung, was correct, and suggests that his doctors did not wish to alarm him.

Another, more clear-cut instance of this sort occurred in August of 1841. Andrew was in London and went to consult Sir James Clark for what appears to have been an expert second opinion, having already seen his own nephew, Dr. Cox, in early July. He reports to his brother George, on 29th August, that Sir James', 'account of the lung agreed with that given by James Cox.' Andrew's biographer, however, prints a letter sent by Sir James to George, and received on 28th September, which casts a different light on the same consultation. Whereas Andrew had written that his nephew had found his lungs mending and that Sir James agreed, Sir James's letter to George is more grave:

I intended, indeed, to have written you on the subject before this time; it was a painful task, and I shrank from it from day to day. The painful truth is, and you should know it, I found your brother much worse than I expected when he was in London. He did not feel ill, and, except greater weakness, one could not detect in his appearance that he was in a worse state of health than when he was last in London. But upon examining his chest, I was grieved indeed to find that the lungs, on one side, were affected to a considerable extent.

... My examination of your brother gave me great distress, more than I ever suffered from the examination of a patient; because it gave me the painful conviction, that my dear friend's life could not, in all human probability, be long preserved.⁶⁶

Andrew was experienced enough, however, to ask for Clark and his nephew's candid and honest opinion directly, and one of them, it seems, revealed the truth.

Thus Andrew again writes to George on 1 October that,

I have now obtained what I long sought for in vain, the explicit opinion of Sir James Clark and of James Cox on my own state and prospects, and find that Sir James was anxious to make you fully aware that I might die before the end of the winter, and could not be expected to go on much beyond it, that you might arrange accordingly. A kind motive kept them from telling me earlier; but injudiciously.⁶⁷

One suspects that it was this bad news that prompted George to ask his dying brother to provide the account of his life, to which Andrew responded in a letter of November of that year, containing the revelation that he never married for fear of passing his impaired constitution on to his offspring. It may be wondered, in the context of Combe's speculations about his consumption, and given the modern flexible bi-aural stethoscope, whether it was not possible for doctors such as Hope and Combe to have examined themselves and so gained first-hand evidence of their condition. Flexible monaural stethoscopes had been developed by the time Combe and Hope became ill, but were not in widespread use. With these, suggests P. J. Bishop, 'auto-mediate auscultation' was possible.⁶⁸ There is no record in the biographies, however, that either Combe or Hope used such instruments on themselves despite Hope's keen medical interest in the progress of his own case.

Emily Shore, on the other hand, seems to have been unwilling, for a time at least, to face the fact of her consumption. An anomaly emerges, for instance, between her account of her second visit to the then doctor James Clark in early September 1836 and her comments on that visit in 1837. Thus she writes that, on the second visit, Clark 'pronounces' her, 'much better in every respect,' and he says he finds her 'health more improved than he had expected.' Despite this 'good' news, he

advises her to seek the comparative warmth of south Devon for the winter ⁶⁹ Yet on the 26th February 1837, expressing how relieved and astonished she is to have escaped the influenza epidemic that struck Britain that winter, she writes that she is surprisingly well despite her doctor's misgivings, since 'when I left him he considered me to have tubercles in my lungs'. ⁷⁰ It should be remembered that Shore had been used to visiting and reading to a local girl who had died of consumption when at Woodbury, and that Emily's cousin and fellow consumptive, the MP Winthrop Praed, had visited while she was there. In the light of this it hardly seems possible that Shore could not have known that she had been positively diagnosed as having tuberculosis. Still, she did eventually face reality, even if she adopted an ironic intellectual guise, in her Journal. In mid-July 1838, having gone south to the New Forest, she writes,

Here is a query, which I shall be able to answer decidedly at the end of this volume, most likely before. What is indicated by all these symptoms — this constant shortness of breath, this most harassing hard cough, this perpetual expectoration, now tinged with blood, this quick pulse, this painfully craving appetite, which a very little satisfies even to disgust, these restless, feverish nights, continual palpitations of the heart, and deep, circumscribed flushes? Is it consumption really come at last, after so many threatenings? I am not taken by surprise, for I have had it steadily, almost daily, in view for two years, and have always known that my lungs were delicate. ... It must be my business to prepare for another world; may God give me grace to do so! ⁷¹

Despite this realisation, like all the examples cited here, Shore remained defiant, continuing to walk in the country when she could and to embark on ambitious courses of self-improvement.

Doctors Combe and Hope offer similar examples of dedication to medicine and personal strength in their insistence on carrying on their medical investigations even on their death beds. Having crossed the Atlantic in an emigrant ship on his

visit to his brother in Jersey City, Combe became aware of the appalling conditions which Irish immigrants faced aboard ship. He began investigating the situation, writing to a Liverpool corn merchant for information to assist his 'doing something about the matter' only a week before his death.⁷² When he realised that he was close to death, he asked his doctor and nephew to see the piece through to publication. Similarly, while James Hope was in the very final stages of his consumption, himself suffering from ulceration of the larynx and in considerable pain, he worked on a paper on laryngitis.

While Emily Shore's Journal is too heavily edited to offer any insights into the precise details of her final days, the examples of doctors Combe and Hope and Miss Sophia Leakey show that, in different ways, all three accepted or even welcomed death when it finally came. Combe's companion, Marion Cox, writes in her letter to absent family members that Andrew 'said that although nature would cling still to life, it was, in the eye of reason, better for him to die, seeing that his powers had become so much enfeebled.'⁷³

Doomed sufferers such as Andrew Combe could also come to terms with their disease, and so their fate, through humour. Combe's letters often reflect an admirable degree of humorous detachment. Having had to abandon an excursion in the Scottish Highlands in 1831 because of his health, he writes that instead of being a help to his companions,

I have been unfit for everything; three steps of a walk made me pant as if I had left my lungs at home. Nine parts out of ten of them seemed in vacation, for work they would not. My stomach, seeing them restive, also rebelled and refused to digest; and then my brain thought it might strike work too; so that on leaving Perth on Saturday morning, I resolved ... to go home.⁷⁴

Similarly, having gone to Rome in 1832 to avoid the Scottish winter, he writes to George that his health has improved very little,

I am nearly as long and lean as I was five months ago, and sometimes think that my amendment resembles a little that of our royal personages, who, according to the official bulletins of their health, are “better” and “easier” every day, till we suddenly hear that they are removed to “a better world,” where, certainly, they *are* “far better” than here. However I shall be very well pleased, if, in my case, the parallel shall fail.⁷⁵

All of the cases examined here show that Christian consolation played an important part in sufferers’ acceptance of death. Besides entrusting her fate to God once she had accepted the inevitability of imminent death, Emily Shore’s feelings regarding her illness itself were expressed in religious form. As Barbara Timm Gates notes, Emily Shore often used the end of a volume of her journal or the end of each year of her life as a point for pausing and reviewing her situation.⁷⁶ Thus we find a now seventeen-year-old Emily looking back, on Christmas day 1836, at the year in which she first became ill. She writes,

I remember that last year I had no outward impediments to happiness. All was prosperous around me, I could pursue unchecked all my favourite studies and amusements, and I grew more and more attached to the world and estranged from heaven. In this state I felt no danger. I felt as if no ordinary call would awaken me from my dream of happiness; I almost wished and prayed for affliction, if there were no other means of correction. And has not God answered this half-indulged wish? Has He not chastised me by withdrawing me from those things which chiefly formed the delight of my life? It is a striking, and impressive circumstance, in which I cannot fail to see His fatherly hand.⁷⁷

Neither Andrew Combe nor James Hope were troubled by guilt in this religious form although both men were deeply religious. While Christian consolation was almost as important as the comfort the dying James Hope receives from the presence of his wife at his side, in the case of Sophia Leakey this consolation is transformed into an physically restorative, ecstatic religious experience on her deathbed.

We saw earlier, in relation to Sophia's severe symptoms, how ravaged she was on the night of her death. Caroline and another sister who were nursing her had occasion to leave her bedside to effect some arrangement for her comfort, but they returned to find her transformed:

We reached the door, and there stood amazed. There were none of the lineaments of suffering by which we were sadly wont to trace her beloved features. Her face was as it had been the face of an angel; and awe-struck we gazed on the lovely sight that dying pillow revealed. She who before had been too weak to move without assistance had now raised herself to a sitting posture. Surprise and rapture were in that upturned face, whilst her eyes, always large and beautiful, were so widely opened that they seemed doubly large, and they glistened beyond description. Her lips were parted in a most lovely smile, and her whole countenance shone with a light that I can only compare to a transparency.⁷⁸

Yet Sophia's rapturous exclamations which follow, welcoming 'Jesus come to fetch me', are suddenly broken off:

She stopped. The light faded, and a cold grey hue overspread her face; a look of unutterable horror clenched her dear lips into an expression of anguish, her brow contracted, and her eyes half closed and glanced quiveringly sidewise, as though dreading though obliged to meet some terrible object behind her. Thank God, the distortion lasted but an instant. Turning her head slowly, with a dignified expression, she said, in a voice imperial in its firmness, regal in its triumph, 'Get—thee—behind me—Satan.' Then vanished every cloud, and out shone the radiance more brilliant than ever, ...⁷⁹

Her sisters come to her aid, reciting scripture, but the critical moment has passed and Sophia is able to die with restored equanimity, remembering her friends and family. This account exemplifies all the conventions of the 'good death' – dying at home, farewells to family, the dying person's mental and physical capacity to complete spiritual business and their bearing of suffering with fortitude. This example shows how the conventions of the Evangelical 'good death' could outweigh ideas commonly associated with consumptive death. Although Sophia dies peacefully, the symptoms she is said to have suffered were uncharacteristic of

non-medical accounts of consumptives. As was suggested above, the inclusion of convulsions in the description may be accounted for by this severe symptom's stark contrast with the spiritual rapture which shows Sophia's readiness for death.

Besides adhering to the conventions of the 'good death', Caroline Leakey's account is also clearly rhetorically structured by an experienced writer and published novelist. Despite her claim that 'What you are now going to read is no fiction, no romantic creation, no dream of a gifted spirit; it is a truth, or I had not dared to write it', she is very aware of the rhetorical power death has over her readers. She admits that her division of her piece into two parts – one presenting the deathbed scene, and the other a brief sketch of the life of the saintly consumptive – enables her to captivate the reader, presenting the sketch of the 'Holy Living' of the title, *after* the reader has 'become interested in her by reading of her death.'⁸⁰

An awareness of the interest death had for Victorian readers also contributes to the other three accounts of consumptives' lives considered here. Although Emily Shore could not possibly have known in advance that she would become consumptive, the fact of her consumptive death is proleptically introduced into her sisters' 'Introduction' to the Journal, in the reference to the cause of Emily's consumption discussed above. Thus the reader of the published Journal knows Emily's fate from the start. Both James Hope's and Andrew Combe's biographers similarly resort to prolepsis, alerting the reader very early on to their subjects' ends. Although George Combe is at pains to point to the public usefulness of presenting the details of his brother's illness, the introduction of the 'ending' into the early

pages of his biography has a similar effect to that intended by Caroline Leakey. It draws readers in, leading us to interpret particular events within the life which follows, in the light of the subjects' eventual consumptive death. As was noted above, this structure is shared by fictional accounts of thwarted or disastrous love in the popular fiction of Broughton and Fullerton. In these instances of both fictional and true accounts of consumption, the disease is bound up with a device for structuring narrative.

Both fictional and non-fictional works examined here adopt the strategy of alerting their readers to 'the ending' very near the beginning of their accounts. Moreover, the accounts also interpret particular events within the body of the narrative in ways which allow their readers to see that the 'beginning of the end' has been reached both in their subjects' lives and in their tales. Clark, Carswell and Bright are also doing a similar thing, seeing the 'end in the beginning' through basing their understanding of consumption's signs and symptoms on post mortem findings. Similarly, their use of the language of 'crisis' and 'critical stage' in the progress of the disease also relies on discerning the beginning of the foregone end.⁸¹ It would seem that narratives ending in a subject's death, whether medical, biographical or fictional, consequently lapse into prolepsis.

In the age being investigated in this study, consumption also compelled wealthier sufferers to become tourists. The flight from death involved leaving one's loved ones and even one's country in the often vain attempt to ward off death while in warmer climates. As we have seen in the example of Andrew Combe's childhood home, it was thought that certain environments within even relatively small areas

could be more or less detrimental to the constitution. So, paradoxically, while sufferers were often incapable of walking any distance, they might have to undergo sea voyages or travel considerable distances by coach and later rail. Readers of Emily Shore's Journal, as a consequence, find her depressed not only at her condition, but at being forced to live away from her beloved childhood home and family. Initially she moved from Woodbury to Devon in the winter of 1836 – 1837, after which the family moved south to the New Forest, largely on her account. This too eventually proved insalubrious and Emily and some of her family again moved, this time to Madeira. As an early death became ever more inevitable, Emily's annoyance at removal gave way to resignation to never seeing her friends again.⁸² She became so depressed in Madeira that she felt it useless writing to friends she knew she would never see again.⁸³ It should be noted, however, that sufferers such as Combe and Shore did experience temporary relief from their condition while in warmer climates, with Combe walking and riding while in Madeira and Emily able to resume limited walking on the island.

Since Madeira and Livorno were popular resorts for consumptives they also brought our subjects into contact with other sufferers. Mediterranean resorts were so popular with consumptives that one commentator, Dr T. H. Burgess, wrote that Rome and Milan in the 1850s boasted numerous 'spectacles of human misery', 'in the advanced stages of phthisis, with pallida mors visibly stamped upon their countenances, cawling along the street, or dragged in invalid chairs, to see the sights perhaps the last they will witness.'⁸⁴ In a long letter to The Scotsman from Madeira, Andrew Combe estimated that of the nearly 400 English visitors to the island during the winter 1842 – 1843, 127 were invalids, the remainder being their

companions.⁸⁵ While there in early 1839, Emily Shore's family took the unaccompanied fifteen-year-old Charles Park under their wing. He too suffered from consumption and Emily was interested enough in his situation to record that

He is ... in very melancholy circumstances.... His brothers and sisters have been dropping off in consumption one after the other; he himself anticipates the same fate. His father is dead, and his mother, who is in very narrow circumstances, is only just able to send him out to Madeira, where he is all alone, in delicate health, and suffering great depression of spirits. ... He is a shy, modest boy, very gentle in his manners, and looks pale and sickly.⁸⁶

She also became a close friend of the Freemans, a brother and sister who visited Madeira due to Mr Freeman's consumption.⁸⁷ Andrew Combe also had occasion to meet other consumptives on his journeys to Livorno, and on successive years, sees the circle of his acquaintance diminish as many of them die.⁸⁸ Combe and Shore were aware that the middle-class experience of consumption was not universal. In April 1865, Andrew was travelling in Ross-shire, visiting friend and fellow doctor, Sir George S. Mackenzie, and accompanied him on his rounds of the poor. These included consumptive patients whom he describes in the following terms:

Fancy to yourself a poor consumptive creature, with irritable lungs, living in an atmosphere of thick smoke, with wind blowing in at every chink, the floor and bed dirty, the face and limbs unwashed, and add to this the clandestine administrations of whisky, and a wretched diet; and then say what could Esculapius himself do for them if he were here? Three out of four I could touch only with gloves on, from the itch.⁸⁹

Combe felt that the task was a hopeless burden on any doctor, although he admired Sir George's efforts. It is almost certain that James Hope, as assistant physician seeing hundreds of out-patients daily at St. George's hospital, would have encountered the consumptive poor, perhaps even contracting his disease from them.

In conclusion, it has clearly emerged that there were both tensions and intersections between the consumptive stereotype and sufferers' and their relatives' accounts of their experiences. The far reaching effects of beliefs regarding consumptive's impaired constitutions are exemplified by Andrew Combe's self imposed bachelorhood. It has also been shown that consumptives themselves could and did adhere to ideas concerning the susceptibility of genius to the disease. Moreover, the sources show that ideas concerning consumptive death vied with other conventions and beliefs surrounding the end of life.

We also demonstrate that narrative structures commonly found in fictional accounts of dying, love-lorn heroines also operate in narratives of the lives of real sufferers. The texts examined here show that consumptives' experiences varied considerably and suggest that no typical experience will be encountered in accounts of consumptives' lives. Moreover, these accounts are all from the middle classes, leading to the suspicion that the experience of the consumptive poor and their associated forms of intelligibility - of coming to terms with and understanding the disease - may have been different. To begin with, they would have been the patients seen by physicians such as James Hope and would have been admitted into hospitals such as St. George's, rather than being treated at home. The examination of how the poor viewed and experienced their consumption, however, must be undertaken elsewhere.

¹ See Pat Jalland's Chapter 'The Evangelical Ideal of the "Good Death"', in Death in the Victorian Family, (Oxford: Oxford University Press, 1996), pp. 17 – 38, and pp. 22 – 3 for discussion of the case of Sophia Leakey.

² George Combe, The Life and Correspondence of Andrew Combe, M.D., (London: Longman, 1850), p. vi.

³ Emily Shore, *Journal of Emily Shore*, ed. Barbara Timm Gates, (London: University Press of Virginia, 1991), p. 231. All further references will be in the form 'Shore, *Journal*,' with appropriate page references.

⁴ These are now held in the University of Delaware's Library.

⁵ Barbara Timm Gates' 'Introductory' to the *Journal*, pp. xxvii – xxix.

⁶ Gates' 'Introductory' to the *Journal*, p. xix and the editor's remarks on a long period of melancholia associated with the return of the mysterious 'friend', p. 265 - 6.

⁷ See Edward I. Bluth 'James Hope and the Acceptance of Auscultation' in *Journal of the History of Medicine*, 25, (1970), 202 – 10.

⁸ See Charles Gibbon's *The Life of George Combe, Author of The Constitution of Man*, (London: Macmillan, 1878), p. 249.

⁹ See George Whitfield's unpublished manuscript biography of Clark, 'Beloved Sir James', *The Life of Sir James Clark, Bart, Physician to Queen Victoria, 1788 – 1870*, p. 75.

¹⁰ Shore, *Journal*, p. 210.

¹¹ Shore, *Journal*, p. 212.

¹² Anne Hope, *Memoir of James Hope, M.D.*, ed. Klein Grant, (London: J. Hatchard, 1844), p. 4.

¹³ Combe, *Life*, p. 9.

¹⁴ Combe, *Life*, p. 32.

¹⁵ Combe, *Life*, p. 145.

¹⁶ Combe, *Life*, p. 54.

¹⁷ Combe, *Life*, pp. 206 – 7.

¹⁸ Combe, *Life*, p. 402.

¹⁹ Combe, *Life*, p. 533.

²⁰ See Chapter 6 in which I show how the onset of consumption was precisely attributed to romantic setbacks. Broughton's consumptive heroine, Nell, writes 'All the love and aspirations I had to bestow had been squandered on that intense earthly passion which seemed to be eating up body and soul.' Similarly, Fullerton has her heroine's rejected lover declare 'the woman you have turned out of your house as my mistress, is as pure as she was on the fatal day when we both first saw her; and loves you with a passion which has made the misery of my life, ... and which she dies of at last, blessing you and hating me... .' See *Cometh Up As A Flower*, (Leipzig: Bernhard Tauchnitz, 1867), p. 387 and *Ellen Middleton*, (London: Edward Moxon, 1844), vol. 3, p. 219 – 20.

²¹ Hope, *Memoir*, p. 208.

²² See *The Home Circle*, 2, (1850), pp. 88 – 91.

²³ *The Home Circle*, (1850), p. 88.

²⁴ *The Home Circle*, (1850), p. 90.

²⁵ *The Home Circle*, (1850), p. 90.

²⁶ *The Home Circle*, (1850), p. 91.

²⁷ Hope, *Memoir*, pp. 211 – 21.

²⁸ Hope, *Memoir*, pp. 155 – 62.

²⁹ Hope, *Memoir*, pp. 223 – 4.

³⁰ Hope, *Memoir*, p. 226.

³¹ Shore, *Journal*, Introduction, p. vi.

³² Shore, *Journal*, p. 219.

³³ See, for example, Arthur Ponsonby, *More English Diaries*, (London: Methuen, 1927), p. 204.

³⁴ Shore, *Journal*, p. 221.

³⁵ Shore, *Journal*, p. 225.

³⁶ E. M. Walker, J.P. Shaw, M.H. Kaufman, 'Andrew Combe (1797 – 1847): Edinburgh Physician and Phrenologist', *Proceedings of the Royal College of Physicians of Edinburgh*, 25, (1995), 652 – 662, p. 659.

³⁷ Combe, *Life*, pp. 93 – 4.

³⁸ Combe, *Life*, p. 84.

³⁹ Combe, *Life*, p. 86 – 7. See Combe's *Physiology Applied to Health and Education*, Ch. vi, p. 177, 13th edition, which George Combe offers as a forceful exposition of the dangers of such neglect of the laws of health.

⁴⁰ Combe, *Life*, p. 88.

⁴¹ George Combe, *The Constitution of Man Considered in Relation to External Objects*, 8th edn., (Edinburgh: Maclachlan, Stewart and co., 1847), pp. 168 – 9.

⁴² *ibid.* p. 169.

⁴³ Combe, *Life*, pp. 142 – 5.

- ⁴⁴ Shore, Journal, p. 137.
- ⁴⁵ Combe, Life, pp. 93 – 4.
- ⁴⁶ Combe, Life, p. 262.
- ⁴⁷ See Andrew's fears when the symptom recurs or threatens to, causing him to travel by sea and to summon his niece's assistance in another case. Combe, Life, p. 98, pp. 260 – 261.
- ⁴⁸ Combe, Life, p. 387.
- ⁴⁹ Shore, Journal, p. 350.
- ⁵⁰ Shore, Journal, p. 205.
- ⁵¹ Shore, Journal, p. 226.
- ⁵² Shore, Journal, pp. 309 – 10.
- ⁵³ Combe, Life, p. 111.
- ⁵⁴ Emily Leakey, Clear Shining Light: A Memoir of Caroline W. Leakey, (London: John F. Shaw, c. 1883), p. 56.
- ⁵⁵ Shore, Journal, p. 142.
- ⁵⁶ Shore, Journal, p. 170.
- ⁵⁷ Hope, Memoir, p. 271.
- ⁵⁸ See Hope, Memoir, p. 287 and Marion Cox's letter describing Andrew Combe's final hours. See Combe, Life, p. 528.
- ⁵⁹ Combe, Life, p. 265.
- ⁶⁰ Caroline W. Leakey, 'Holy Living: Happy Dying', Sunday at Home, part 80, December 1860, no. 345, pp. 773 – 775, part I, and no. 346, pp. 795 – 798, part II. p. 774.
- ⁶¹ Hope, Memoir, p. 265.
- ⁶² Combe, Life, p. 466.
- ⁶³ Caroline W. Leakey, 'Holy Living: Happy Dying', p. 774.
- ⁶⁴ Shore, Journal, p. 142.
- ⁶⁵ Combe, Life, p. 213.
- ⁶⁶ Combe, Life, p. 394.
- ⁶⁷ Combe, Life, p. 395.
- ⁶⁸ See P. J. Bishop's 'Evolution of the Stethoscope', Journal of the Royal Society of Medicine, 37, (June 1980), (p. 452 – 3) pp. 448 – 56.
- ⁶⁹ Shore, Journal, p. 149.
- ⁷⁰ Shore, Journal, p. 183.
- ⁷¹ Shore, Journal, pp. 263 – 4.
- ⁷² Combe, Life, p. 525.
- ⁷³ Combe, Life, p. 528.
- ⁷⁴ Combe, Life, p. 202.
- ⁷⁵ Combe, Life, pp. 212 – 13.
- ⁷⁶ See Gates, 'Introductory' to the Journal, p. xvii.
- ⁷⁷ Shore, Journal, pp. 174 – 5.
- ⁷⁸ Caroline W. Leakey, 'Holy Living: Happy Dying', p. 774.
- ⁷⁹ *ibid.* pp. 774 – 5.
- ⁸⁰ *ibid.* p. 773. This structure is absent from Emily Leakey's account of Caroline Leakey's life, which relies heavily on Caroline's published account of the deathbed scene, but lacks the didactic purpose. See Emily Leakey, Clear Shining Light, pp. 54 – 60.
- ⁸¹ One could well extend Frank Kermode's ideas on the relation of the notion of 'crisis' to one's death and other significant ends to include medicine's invocation of critical points and stages in the progress of diseases. See Kermode's The Sense of an Ending, Studies in the Theory of Fiction, (London: Oxford University Press, 1966), p. 25 – 8.
- ⁸² Shore, Journal, p. 281.
- ⁸³ Shore, Journal, pp. 345 – 6.
- ⁸⁴ Dr T. H. Burgess' Climate of Italy in Relation to Pulmonary Consumption, (1852), p. 135 cited in John Pemble's The Mediterranean Passion, Victorians and Edwardians in the South, (Oxford: Oxford University Press), p. 243 – 4.
- ⁸⁵ Combe, Life, p. 442.
- ⁸⁶ Shore, Journal, p. 330.
- ⁸⁷ Shore, Journal, p. 314.
- ⁸⁸ Combe, Life, p. 120.
- ⁸⁹ Combe, Life, pp. 250 – 1.

Conclusion

Consumption was seen as a chronic, terminal disease and was thus inherently suited to narrative representation. Narratives, as I have shown, offer society a host of representational possibilities. They allow and facilitate depiction of the changes sufferers experience as their condition worsens, and crucially bring concepts of causality to bear on these alterations. Moral changes can also be temporally represented, change can be from good to evil or evil to good, and often moral change is mapped onto bodily change. The aim of this thesis has been to indicate how Victorian clinical medicine deployed ideas of death within the fabric of life, using narrative to understand the processes of bodily destruction. Clinical medicine's highly compressed narrative statements on the cause of death formed the cornerstone of epidemiological mortality statistics. Several canonical Victorian texts use the narrative representation of consumptive decline and death as a dark background against which to enact their heroine's progressive growth, marriage and motherhood. Also, one of medicine's causal explanations of consumption constituted the germ or matrix for an entire series of popular fictions about the almost inevitable fatality which awaited the 'love sick' women. Medically sanctioned causative ideas relating to consumption were held by middle-class biographers and fiction writers, often even deeply affecting their loved one's lives. The thesis also suggests that proleptic narrative structures, that is, those which reveal events long before their appropriate chronological place in stories, underlying biographic accounts of consumptive deaths, are paralleled by medicine's narrative use of concepts of death-in-life itself.

A number of issues, however, need further investigation. This study has focused mainly on representations of, and by, middle-class consumptives, their relatives and doctors, rather than the representation of the lower social class sufferer. While Sir James Clark's, Sir Robert Carswell's and Richard Bright's patients were often working-class, and indeed, feature as the subjects of their published clinical cases and illustrations, these patients' class seems not to figure largely in these representations. There are hints, however, in the representation of the working class-prostitute Esther, in Mary Barton, and in William Acton's mention of a consumptive prostitute in his Prostitution Considered in Its Moral, Social, and Sanitary Aspects in London and Other Large Cities (1857), which suggest that ideas of vice and class were associated with the consumptive, perhaps in moral if not clearly 'contagionist' ways.¹ These indications may well yield material applicable to Samuel Warren's moralistic representation of the consumptive poor in his popular tales published as Passages From the Diary of a Late Physician in the 1840s.² All of the above raises the question of the means which the vast majority of consumptives, that is, the workers and the poor, used to make sense of the disease and the textual forms which they may or may not have used. The answers to such questions not only lie beyond the scope of this work, but also depend on the availability of source documentation such as ballads or workers' letters, diaries and journals.³

The potential for thorough comparative investigations, even within the confines of prose and fiction, of the similarities between narrative representations of tuberculosis/consumption and other terminal diseases such as cancer, has already been indicated by Susan Sontag. These investigations still largely remain to be done. As

Sontag's work on both tuberculosis and HIV/AIDS indicates, there are benefits arising from such work, especially for contemporary representations of the sick in a range of media, be it in printed advertising, publicity or even soap opera. Greater awareness of moral prejudices attached to the ill will necessarily lessen the potential for discrimination against them. It is my belief that the current, justifiably heavy, emphasis placed on rigorous scientific training in many branches of the medical profession stands in need of complementary training in the communicative arts, one of which is story telling. Patients continue to die daily of terminal diseases and, given the resultant psychological devastation suffered by patients and relatives, stand in need of physicians, surgeons and other medical staff with an excellent grasp of the function of narrative in their profession.

The question of the representation of the consumptive pauper or worker is particularly relevant to investigations of narrative uses of the causal matrices, such as we have found in the work of Rhoda Broughton, Georgiana Fullerton and others. Were the narratives produced, perhaps as part of anti-tuberculosis campaigns in the late 1800s and early 1900s, due to shifts in the consumptive stereotype, influenced by the germ theory of disease? If so, how? Given that narrative, cinematic representations of the dying tuberculosis sufferer continue to be made even after the introduction of very effective drug therapies, what, it might be asked, does the potential for alternative 'endings' to bouts of tuberculosis mean for these representations. ⁴

Stories continue to be told about the dying and their bodies. Moreover, such stories are still not the province of one discipline rather than another; the findings of this

thesis and others which it supports, suggest that writers, film makers, scientists and doctors are all storytellers, each with a particular sense of an ending.

¹ See his Prostitution Considered in its Moral, Social, and Sanitary Aspects in London and Other Large Cities; With Proposals for the Mitigation and Prevention of Its Attendant Evils, (London: Churchill: 1870) p. 19 and p. 26. Cited in Moloney, George Eliot, Henry James, and Consumption: A Shadow on the Lung of the Victorian Psyche, p. 122. Mary Barton itself constitutes material for an investigation of class issues, albeit as a middle class view of working class experience.

² See both the first and second series of Passages From the Diary of a Late Physician, (Leipzig: Bernhard Tauchnitz, 1844)

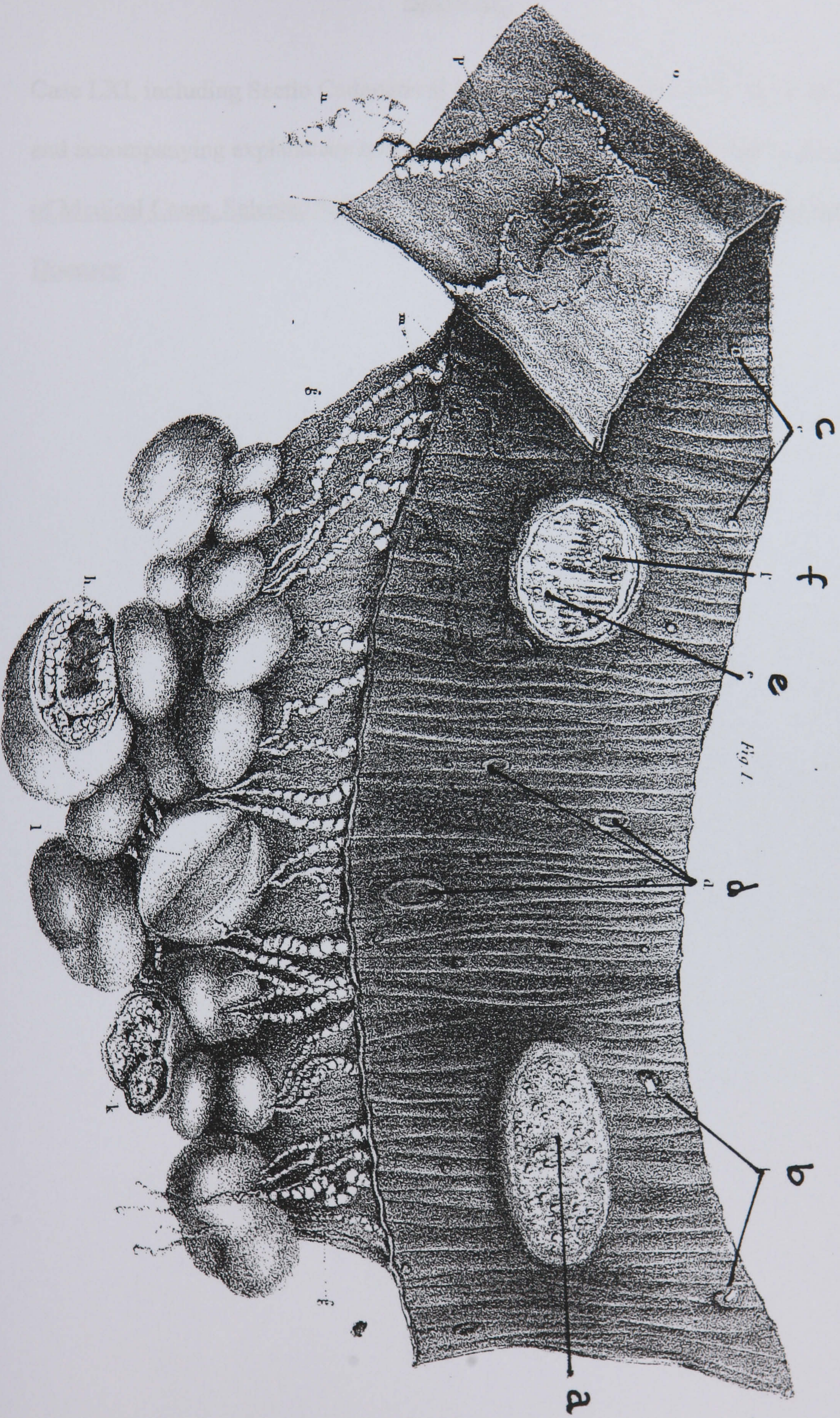
³ See such a task might begin with the sources indicated in Cynthia Huff's British Woman's Diaries, A Descriptive Bibliography of Selected Nineteenth Century Manuscripts, (New York: AMS, 1985) as well as taking in the wealth of sources available for the experiences of the Victorian working class.

⁴ See for instance John Schlesinger's *Midnight Cowboy* (United Artists, 1969).

Appendix 1

Plate III from section on 'Tubercle' in Robert Carswell's Pathological Anatomy, Illustrations of the Elementary Forms of Disease

Plate III.



Appendix 2

Case LXI, including Sectio Cadaveris and 'note' on p 168, Plate XII fig. 2 and 3 and accompanying explanatory notes to Plate XII. From Richard Bright's Reports of Medical Cases, Selected With a View of Illustrating the Symptoms and Cure of Diseases

CASE LXI.

JAMES NORTON, æt. 29, who had been a servant at a public-house, was admitted into the Clinical ward, January 18th, 1827. While walking about seven months before, without any particular exertion he spit up nearly half a pint of blood; and this recurred several times at intervals of three or four days. About three weeks afterwards cough came on, and the expectoration (which was mucus mixed with blood in small

quantities) continued to the time of his admission, when he was much reduced; his breathing rapid and difficult; and his pulse seldom under 120. His expectoration was decidedly puriform; his perspiration often profuse; his bowels were generally more open than natural, passing about two stools in the day; and although within a day or two of his death they became relaxed, yet it was without any pain.—He gradually sunk and died on the 14th of February.

SECTIO CADAVERIS.—Feb. 15th, 1827.

Complexion and hair inclined to be sandy. Body greatly emaciated. The cellular membrane of the abdomen almost devoid of every vestige of fatty matter. On raising the sternum the glands along the inside were enlarged, white, solid and cheesy, as were some which rested on the diaphragm in the anterior mediastinum. The left lung adhered to the ribs over a considerable extent; the greater part of the upper lobe was excavated into one large cavity lined by a rough tuberculous membrane, and traversed by bands of hardened tuberculous matter. The remaining part of that lobe was a mass of miliary tubercles formed into clusters. The inferior lobe of this lung was nearly in the same state, though less advanced. The right lung had its upper lobe in precisely the same condition, except that the cavities were less, and the general state of solidity more complete. The lower lobes were more pervious to air, and the line of demarcation formed by the separation of the lobes was very well defined: the disease, however, was not limited to the upper lobe, but did not appear to have extended by contiguity. The intestines externally did not show marks of inflammation; but on cutting into them, the whole colon was ulcerated in large spreading patches of an oval form in the transverse direction of the intestine, with slightly elevated edges (Plate XII. Fig. 3.). The ilium and jejunum were also ulcerated from place to place along the whole tract, and even in the duodenum within half an inch of the pylorus an ulcer was situated. The internal lining of the intestine was thickly speckled over with minute black spots, scarcely larger than the prick of a pin (Plate XII. Fig. 2.). The whole mass of the mesenteric glands was enlarged, and hardened into a substance of a cheesy consistence; and in several instances the lacteals originating near the ulcers were seen choked up and distended with a white substance till they entered the enlarged glands (Plate XII. Fig. 2.). The kidneys were flaccid, but in no way disorganized. The liver was slightly granulated, but neither hardened nor enlarged.

It is not improper here to remark, that the peculiar gray appearance occasionally observed in the intestines after death, appears to be a product of inflammation or congestion in the vessels. Some of the French writers have considered it a sign of the existence of a subordinate degree of inflammation; but from what I have myself observed, I am much more inclined to adopt the opinion of my friend Dr. Hodgkin, that it is carbonaceous matter deposited at the termination of a process of inflammation which has subsided, indicating therefore the subsidence of inflammatory action; and most probably not a state of actual inflammation, even at the time the deposit took place: for I suspect that the matter has been left by some process of extravasation during a state of venous congestion, whether such have been the sequel of inflammation, or have existed without any previous inflammatory action. It must no doubt require some peculiar condition of the vessels not always occurring in inflammation, or we should find it more frequently than we do; and that condition, be it what it may, is not peculiar to the vessels of mucous membranes, for we sometimes, though more rarely, find it after inflammation of the peritoneum. An instance of this occurrence external to the intestine will be found in Case XXVIII. page 100 of this volume; and I have among others the following observations in a case of death from Carcinoma which I saw examined in 1825. "The peritoneal covering of the mesentery, and in some parts that of the intestine, was sprinkled with a number of black spots, not raised nor of any assignable thickness, but like stains on the peritoneum from sooty matter deposited from the atmosphere; they had no defined margins, were many of them rather gray than black, not unlike the dark gray matter sometimes expectorated, and they were most numerous on the surface of the fatty matter of the mesentery." It is not improbable that previous to the gray deposit, the internal lining of the intestines may have been in a state analogous to that of WHITE, in the case which I shall next relate, covered with an uniform deep red where vessels are no longer discoverable. The three following cases, of which that of HAMILTON alone was phthisis, will serve at least to show the immediate connection between the gray deposit in the intestines, and symptoms of abdominal irritation.

PLATE XII.

ULCERATION OF THE CÆCUM, COLON AND ILLIUM, IN PHTHISIS PULMONALIS.

FIG. 1. Represents the cæcum and the processus vermiformis (Case LV.). *a, a*, are the two corresponding points of the vermiform process, which has been cut open longitudinally in the direction *a, c*, showing the remarkable thickness which it has acquired, and the ulceration which it has undergone. *d*, is the orifice of the iliac valve, much contracted by the ulceration and thickening of the surrounding parts. One large ulcer is seen to occupy nearly the whole cæcum, while another, opposite to *c*, is situated more completely in the ascending colon. Part of the mucous membrane, as at *d* and *c*, still remains entire, but is vascular and unhealthy. It is to be observed that the ulcers are irregular in form, bearing a sluggish character, and that their surface has an uneven tubercular appearance.

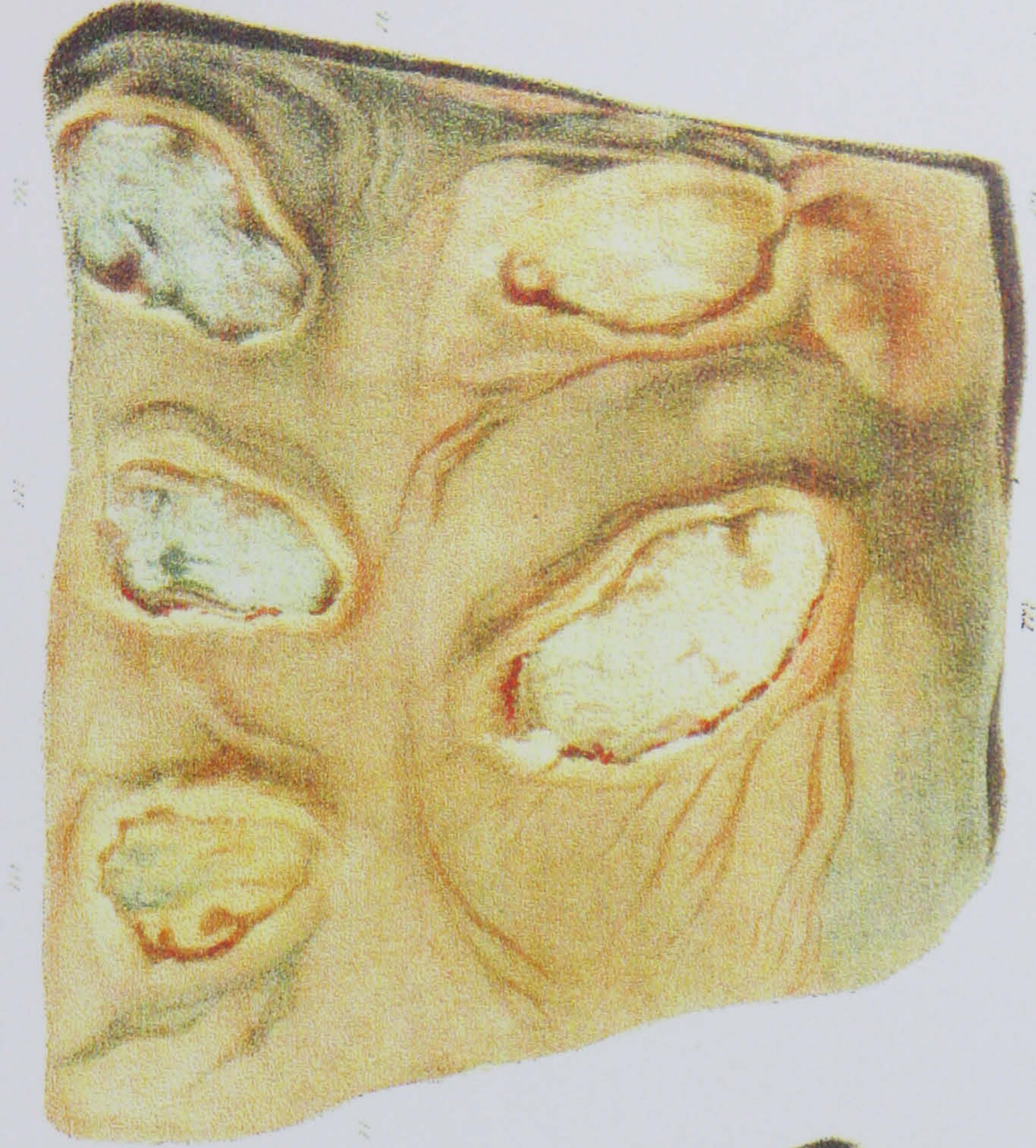
FIG. 2. Represents a portion of the small intestines (Case LXI.) laid open to display an ulcer. The whole mucous membrane is rendered gray by numerous dark points of carbonaceous matter; and the ulcer is seen with its edges puckered and thickened into tubercles, where it divides the valvulæ conniventes: *k, l*, represent mesenteric glands much enlarged; and at *h*, two branches of the lacteals filled with chyle are seen crossing the mesentery; they appear to unite, but again divide and enter the gland *k* separately.

FIG. 3. A portion of the colon (Case LXI.) showing some of the oval ulcers *m, m, m*, with edges somewhat elevated, running transversely to the intestine on each side of the longitudinal band *n, n*.



FIG. 2.

Drawn by F. H. Sney.



Engraved by H. May,
 5, Mark Lane Street.

London, Published Jan'y 1835, by Longman, Ross, Green & Utton.

Appendix 3

Registrar General's 'Example of the mode of filling up the Medical Certificate of Cause of Death'

EXAMPLE of the mode of filling up the

MEDICAL CERTIFICATE OF THE CAUSE OF DEATH.

Name John StevensAged 7 Yearslast Birthday;—was attended by me, andDied on the 26th day of April, 1845.

| | Cause of Death. | Duration of Diseases. |
|--------------------------|---|-----------------------|
| Primary Disease (°) . | Measles | 21 days* |
| Secondary Diseases (b) . | Pneumonia | 7 days |
| (if any) (c) . | [If any other diseases supervene, write them against (c) and (d) in the order of their appearance.] | |
| (d) . | | |

Have the goodness to state the primary and only the important secondary Diseases, with the time between the attacks and the death in hours, days, or years: Example—Measles 21 days, Pneumonia 7 days. Use, if convenient, the names in the first column of the Statistical Nosology. Add P. M. when a Post Mortem inspection has taken place. If this Form should, by accident fall into the hands of any unqualified practitioner, he is recommended not to fill it up.

S.B.—Qualified practitioners who have not yet been supplied with a Copy of the Nosology may obtain it on application per post to the Registrar-General.

Professional Titles.

Signed William Carter,

M.D.

* By this it is to be understood, that the first evident symptoms of Measles appeared 21 days before death—the first evident symptoms of Pneumonia 7 days before death. The duration of other diseases is to be reckoned in the same way.

Registrars are requested to forward to the Registrar-General the names, addresses, and medical titles of every person who may take up his residence and commence practice in their districts, in order that those qualified to practise may be duly supplied with books.

III.—“A LETTER addressed to CORONERS, with OBSERVATIONS on the REGISTRATION of the CAUSES of VIOLENT DEATHS.

“ (CIRCULAR.)

“ SIR,

General Register Office, 10th August, 1845.

“ I HAVE the pleasure of transmitting to you a copy of my Sixth Annual Report, and I beg to direct your attention to pp. 210-266,* in which I have given an abstract of the causes of the violent deaths in England, chiefly derived from the ‘informations’ which you and other coroners have given under the Registration Act.

“ In order that the results of the ‘informations’ may be compared, and become really useful to the public, in pointing out the causes of violent deaths (which appear to be of much more frequent occurrence in this kingdom than in the rest of Europe), the nature of the fatal cases inquired into by juries must be returned somewhat more in detail than is done at present. In many ‘informations’ all the facts that can be useful are stated; and it is only required that the practice, already partially existing, should be extended and made uniform, to place the whole upon a satisfactory footing.

“ You will observe, by referring to the Abstracts, pp. 234-6, that, exclusive of suicides, executions, some doubtful cases omitted, and 971 imperfectly returned in one year, 3305 persons were killed by mechanical injuries of various kinds—by falls, falls of stone, &c., machinery, railways, waggons, carriages, horses, and other agencies—fracturing their bones or crushing their bodies: 1950 lives were lost by water (drowning); 3057 by fire (148 by explosions, 2577 by burns, 332 by scalds); 188 persons were accidentally poisoned; 65 were murdered in ways not stated in the ‘informations;’ and there were 83 cases of manslaughter.

“ It is believed that, although deaths by personal violence have diminished, poisoning, the violence called accidental, and the resulting dangers, have increased within the present century;—which may be ascribed to the number of deadly poisons now so accessible in every chemist’s shop, the introduction of the new force of steam, the redoubled activity of traffic, travelling, navigation, agriculture, manufactures, and mining operations. Science itself creates new instruments of death. But if these instruments be brought to light by your inquests, described accurately, and placed fully before the public, science will find no difficulty in discovering remedies, or rendering less harmful the new and striking, as well as the old and obscure, causes of violent death, which have made little noise, but have been in operation from time immemorial in every county of the kingdom.

“ It is to discover the dangers attendant on the occupations, pursuits, and various circumstances in which the population is placed, that I request your aid, in the hope that, if the

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box 6326: item 43

box 6361

box 6326

box 6363

box 6363

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