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CONCLUDING THE FASHION

One of the primary concerns of medical investigation has been to supply acceptable explanations to the public for the various diseases with which it is afflicted, while creating inclusive unitary theories of illness that encompass all possible aspects of the disease process. Over the course of the nineteenth and twentieth centuries, as researchers identified a definitive, single cause for each infectious disease, as a result of the advances that accompanied germ theory and microbiology, multi-causal approaches waned in popularity. In the antibiotic age, the model simplified: a bacterium, virus, etc., causes an illness, a chemotherapeutic agent was administered, and the patient was subsequently cured. A single cause, once addressed and eradicated, effectively removed the disease. This simplicity is no longer a defining feature of twenty-first century medicine however, for the proliferation of chronic and systemic illnesses as well as new investigations into infectious disease, has once again made unfashionable the notion that a complicated illness could have a simple cause. Today's medicine has once more established a role for external causative explanations in the case of those illnesses that cannot be easily eliminated by medication. Echoing earlier theories of illness, there is once more a role for the influence of an individual's lifestyle and environment in the case of illnesses like Type II diabetes, heart disease, or cancer. Once again, notions of illness cross the boundaries between medicine and society, as they did in the eighteenth and nineteenth centuries when the association between tuberculosis, society, and the sick individual was a fluid relationship, whose terms were constantly being renegotiated, changing, and adapting to new social conventions and emerging medical information.

Social analysis of the causes and course of a number of diseases became an important component of the public health movement during the nineteenth century, and the interpretation of health along class lines remained a prominent theme in the discourse of disease. In the first part of the nineteenth century, consumption in the working class was seen as the product of the deleterious influence of a range of vices, including fornication and alcoholism; however, in the middle and upper classes it was presented as the product of delicate sensibilities and social refinement. These class distinctions were not just a result of material and social disparity. They were seemingly confirmed by the perception of physiological divergence, with members of the upper classes being touted as possessing a more refined nervous system than those of the lower classes. Middle- and upper-class women in particular were presented as being more likely to develop pulmonary consumption because of their weakened and innately fragile constitutions. This was an idea that also fit well with hereditary notions of the disease, since the refinement which characterized both the illness and the nervous constitution of the upper orders could be passed on to the children. In the late eighteenth and early nineteenth centuries, the hereditary constitution, the environment, and any other strains provided by lifestyle, continued as prominent themes in the working knowledge of tuberculosis. There was an acceptance by physicians, and society alike, of an association between the illness and the sophisticated lifestyle pursued by members of the middle and upper classes. Notions about disease were shaped by social definitions of those illnesses believed to be products of "civilization."

These ideas were critically important in intertwining consumption with beauty and fashion from 1780–1850. Evangelicalism and Romanticism also proved influential in creating positive representations of tuberculosis. Romantic ideology helped strengthen the connections between consumption and the best and

brighest members of society, those intelligent, delicate individuals who seemed so prominent in the ranks of its victims. As a consequence, there developed a prototype for the consumptive disease process and death, one that encompassed evangelical notions of resignation and submission to Divine will with a Romantic ideology that saw the victims of tuberculosis as unable to withstand the buffeting of the wider world due to nervous debility and creative genius.

The cultural construction of the disease was refashioned in the 1830s and 1840s under the influence of sentimentalism, when it was increasingly interpreted as a function of the weakness and delicacy of the female victim, and meaning was assigned to the disease experience based upon gender. The separate spheres ideology mingled with a growing medical literature that saw tuberculosis as linked to women through the actions of the increased quantity of nervous sensibility accorded them in contemporary biological theory. By the early Victorian period sensibility and, by virtue of its association with that quality, tuberculosis, had become explicitly feminine. The harsh reality of the consumptive disease process did not fit neatly into the altered reality promoted by Romanticism and sentimentalism. As a result, the illness was rationalized in an effort to cope with its devastating effects. The Romanticized notions and sentimental rhetoric applied to the disease, provided a way of imposing order on an aspect of their lives that middle- and upper-class English people had little other control over. Increasingly, women were the focus of a discourse that not only set acceptable behaviors but also reinforced and legitimated these functions through the medical and physiological sciences. Observed biological differences were extended into social expectations and saw femininity, in part, as a function of excess sensibility. These biological ideas were then transformed into a code of propriety, sensibility, and physical delicacy, all of which presented women as balanced on the edge of disease, and, by implication, tuberculosis. These concepts were employed to construct persistent representations of consumption as a disease that was not only denoted by beauty but was also one that could confer that quality upon its victim.

During the first half of the nineteenth century, the disease not only infused popular ideals of beauty, but the belief that tuberculosis was a disease characterized by attractive aesthetics became a dominant theme. Beauty was thought to be one of the noteworthy symptoms of the hereditary predisposition to tuberculosis; moreover, once the disease was established, the symptoms were also believed to increase the attractiveness of its victim as its effects became visible in the complexion, eyes, and even the smile. This beauty was denoted by thin frames, long swan-like necks, large dilated eyes, luxurious eyelashes, white teeth, and pale complexions accented by blue veins and rosy cheeks. As the notions of sentimentalism gained purchase, beauty was taken to be the reflection of the internal character of a woman. As a result, tuberculosis also came to confirm the character of the sufferer through its ability to confer beauty. Increasingly, the acquisition of beauty was believed to occur through the cultivation of those qualities believed to be desirable in women (modesty, innocence, goodness, nurturance, delicacy) rather than in the cheap imitation found in cosmetic aids. Under the influence of sentimental rhetoric, the use of make-up became more furtive and once cosmetic aid was eschewed, tuberculosis's role in creating beauty naturally increased the links between that condition and positive aesthetics. The cultural expectations that surrounded consumption were articulated in literature, medical treatises, and those works concerned with defining fashion and the female role, all of which overflowed with examples that connected the disease to beauty and reveal a shared consciousness that tuberculosis was indeed attractive.

The relationship between tuberculosis and attractiveness also played out in the rhetoric and practice surrounding the fashions of the day. Not only did these ideas reflect attitudes about beauty, health, and the female role, but clothing actually played an active role in defining contemporary notions about the relationships between beauty and disease. Clothing was not only assigned a reflective function but it also was given an active role in both the emulation of the illness and in creating consumption. From 1780 to 1850, consumption appeared repeatedly in the contemporary discourses surrounding fashion, and the focus of the discussions of

clothing and the disease tended to accord female fashions agency in creating the illness. As the clothing moved from the willowy neoclassical to the ornamented Romantic and eventually to the subdued sentimental style of dress, the role of fashion as a cause of consumption also altered. The insubstantial nature of the neoclassical fashions were thought unequal to the task of protecting their wearers from the English climate. The environment, in the form of damp, cold, and even dust, interacted with neoclassical clothing to cause consumption. The concern over climate and fashion persisted even after the style waned. With the move toward Romantic styles, the corset became the main link between fashion and the disease, an association that continued to intensify as corsets tightened with the move toward sentimental styles.

The connections between tuberculosis and dress moved beyond the ability to cause the disease and also encompassed an imitation of some of the physical signs of the illness. The clothing, to a varying degree depending on the style, either highlighted certain symptoms of tuberculosis (like the wing-back present in neoclassical fashion) or actively imitated certain manifestations of the illness (like the stoop shoulder seen in sentimental dress). In the 1850s the power of consumptive beauty and fashion began to wane. The interpretation of the disease in women altered due to the influence of sanitary reform and the changing rhetoric of the disease in literature, which had shifted toward a model of fallen womanhood.

During the second half of the nineteenth century, the notions that dominated the lower-class interpretation of the disease—the ones that saw tuberculosis as the result of moral and hygienic shortcomings, complicated by filthy and crowded living and working conditions—gained purchase and were increasingly applied at all levels of society. This approach to tuberculosis gradually became the dominant image of the illness, particularly with the growing focus on public health in the middle of the nineteenth century. The introduction and eventual acceptance of the germ theory of disease would make this hygienic model, with its moral undertones, the sole explanation for tuberculosis, and so would impart an unsavory element to the illness. Health was now privileged as a desirable goal in the face of mounting social concerns and fears over biological degeneracy.