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INTRODUCTION

The tragedy that befell the Cathcart family was repeated in countless households during the eighteenth and nineteenth centuries. A mother, father, son, and two daughters struck down by tuberculosis—but it was the poignant death of the second daughter, Mary, that encompassed the full tubercular repertoire. A beautiful, delicate, kind, intelligent woman beloved by her family, and most especially by her husband, quietly slipped away in 1792 despite every effort to forestall her end. Mary Graham (1757–1792) was the daughter of the ninth Baron Cathcart and the wife of Thomas Graham of Balgowan, whom she married on December 26, 1774. Mrs. Graham evidently captured the attention of Thomas Gainsborough, whose rendering of the recently married eighteen-year-old Hugh Belsey argues “is one of the finest portraits he ever painted.”¹ (See Plate 1.)

The couple was devoted to one another and Thomas went to enormous lengths to shore up his wife’s health. Although his estate was in Scotland, they spent a great deal of time in the milder climate of England to avoid stressing her delicate constitution. Thomas and Mary also attended a number of heath resorts, undertaking a regimen of sea-bathing at Brighton and visiting Clifton, a popular option for consumptives.² When this proved inadequate, they traveled abroad multiple times for Mary’s health, visiting a spa in Belgium and going to Portugal in 1780. In 1781, during this trip, Thomas Graham gave the following account of Mary’s condition, stating:

I think it is most probable that we shall not pass next winter at home, though Mrs. Graham continues pretty well, and has borne these fatigues surprisingly. I hope it will not be necessary for her to go abroad again but it may be prudent to put it easily in our power by being in some place in the southernmost part of England, which will likewise be a milder climate than any other in Britain.³

They returned to England and rented a home in Leicestershire in an attempt to avoid another sojourn abroad.⁴

Mary’s health continued to degenerate and in 1791 the desperate couple made their way to France, in spite of the revolutionary turbulence, hoping the milder climate would prove beneficial. After spending some time in Paris, they settled in Poil just outside of Nice on the advice of Mary’s physician Dr. Webster who was traveling with them. Here they remained, until May of 1792, hoping to gain benefit from the sea air.⁵ Mary’s health continued to decline, and by the summer of 1792, she recognized the inevitability of her death. Choosing to keep her thoughts from her husband, fearing she would cause him even greater distress, she instead spoke to her friend Mrs. Nugent of his “affectionate conduct to me” stating that “a Mr. Graham is not easily found,” and expressing concern over “how he suffers” and “how he tries to conceal it from me.”⁶

Her physician prescribed a sea voyage and the Grahams set out from Nice on June 19. Nine days before they left, Mary wrote a letter to her husband to be given to him after her death. This note demonstrated her resignation and concern for those she would leave behind. To her beloved Thomas she wrote “Let your comfort be that I could never have lived without you, and am happy to go first.”⁷ Although she had given up hope of recovery, Thomas’s journal provides glimpses of a woman enjoying her time dining on deck, reading *Don Quixote* and even proving a good sailor. He wrote “She was not at all sick & did not mind this gale at all but was rather entertained with the confusion & the awkwardness of those who try’d to get the things put in

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order.”⁸ Despite his tender devotion, Thomas was not present when Mary passed away. He had been assured the end was not close by her physician, and on June 26, 1792 went ashore at Hyères to seek lodging, when he returned Mary was gone. Thomas lamented “It is impossible to say how much I regret being absent when this angel breathed her last.”⁹

The trials did not end with Mary’s death as Thomas ran into trouble trying to get her home from Revolutionary France. On July 14, just outside of Toulouse, the boat was stopped by National Guard and Volunteer soldiers. What followed filled Thomas with abject horror and rage, he wrote that a “riotous mob of half-drunk rascals . . . armed with muskets . . . insisted on seeing the Box that was sealed.” Although he had the permission of the town’s municipal officer to pass unmolested and despite his attempts to stop them: “With savage violence they broke open everything.” They were so brutal the grieving widower found it necessary to have Mary’s body examined by Dr. Webster and was deeply relieved to hear “that there was no injury done,” however, he wrote “there was a necessity for a new lead coffin.”¹⁰

Thomas Graham never recovered from Mary’s death, and could not bear to look upon her countenance—packing up the Gainsborough portrait of her and placing it in storage.¹¹ He did, however, keep mementos of Mary including his wedding ring, which he wore throughout his fifty-year widowhood and a more tangible reminder of her final days—a dress worn during her last illness. (See Plate 2.) This gown illustrates the wreckage consumption wrought on its emaciated victim, revealing Mary’s very slight frame at the end of her illness.¹² It stands as a tangible remnant of a life cut short and as an attempt to memorialize the last days of a lovely young woman sinking under tuberculosis. Rather than just serving as the material evidence of the illness, dress and tuberculous would become connected in a number of active and meaningful ways.

Constructing Tuberculosis

During the late eighteenth and early nineteenth century cultural ideas about beauty intertwined with the disease process of tuberculosis, allowing the ravages of the illness to be presented in an aesthetically pleasing light. How is it possible that a disease characterized by coughing, emaciation, relentless diarrhea, fever, and the expectoration of phlegm and blood became not only a sign of beauty, but also a fashionable disease? The practical application of this rhetoric and the ways in which consumption became both idealized and feminized are the overarching concerns of this inquiry.

Depictions of tuberculosis diverged from those proffered for other diseases like smallpox, cholera, and typhoid; these differences were due in part to the way the illness manifested itself in the body and its social distribution. Although it altered its sufferer physically, it was not disfiguring in the same way that smallpox or cholera was. Instead, as a disease characterized by wasting and pallor, consumption seemed to enhance its victim by amplifying those qualities already established as attractive. Tuberculosis was further distanced from other illnesses in its chronic nature and constant presence. Unlike sudden, acute maladies that manifested in sweeping epidemics, tuberculosis was always present, in all classes at all times. However, beginning at the end of the eighteenth century, mortality from tuberculosis was on the rise, at its peak causing 25 percent of all deaths in Europe, and then after 1850 it gradually declined.¹³ This epidemic curve corresponds with the relatively gentle representation of the illness, which shifts by the mid-century.

Between 1780 and 1850 there was a growing correspondence between tuberculosis and rapidly changing concepts of beauty and fashion. The symptoms were not only compatible with popular ideals of beauty, but the dominant presentation of tuberculosis was that of a disease characterized by attractive aesthetics. This was made possible, in part, by a congruence of factors including disease mortality, advances in the approach to illness, and the influence of the key social movements of the era. The cultural expectations that developed for

tuberculosis, as a result of these broader changes, were articulated in medical treatises, literature, poetry, and the works that sought to define fashion and the female role. All of these provided examples that connected the hallmarks of beauty with the symptoms of tuberculosis, and as such, reveal a shared consciousness that the disease was aesthetically pleasing.

The Social Context

Illness is not only a subjective experience but also one defined by its cultural location, both geographically and historically. The intricate relationship between society and illness provides a way in which the value-laden concepts of health and disease can function both within and outside the framework of established medical knowledge and biological evidence. Echoing Susan Sontag, Claudine Herzlich and Janine Pierret argue “that in all societies there is a correspondence between the biological and social order.”¹⁴ It is through this interaction that “the language of the sick thus takes shape within the language expressing the relations between the individual and society.”¹⁵ A large part of this process is determined by changing definitions of the body and its corresponding relationship to health and disease. Susan Sontag’s investigation into the role of metaphor in the disease experience—particularly her contrast between the positive Romantic representation of tuberculosis and the stigmatization of certain illnesses (including cancer and AIDS)—was an important step in explicating the ways in which illnesses are culturally created.¹⁶ Social and historical theorists like Michel Foucault have argued that illness is an invention of ideology, society, and economics.¹⁷ Illness, therefore, reflects the intricate mix of circumstances that define life and social value, as well as its own significance in a given time. The varying terminology employed in describing tuberculosis over the centuries reflects the power of linguistic representations in crafting metaphorical descriptions of an illness. These terms also mirror the dominant understandings of the disease and illustrate the persistent confusion over the cause, course, and meaning of tuberculosis. Tuberculosis infections have been classified using a number of idiosyncratic designations and these alterations in language demonstrate one way in which a dialogue evolves to reflect new information and attitudes towards an illness.¹⁸

The term “tuberculosis” did not come into widespread use until the latter half of the nineteenth century; instead, the disease was identified by a number of other names, including phthisis, consumption, and scrofula (which referred to a non-pulmonary form of the disease). Other terms used include: tabes, inflammation of the lungs, bronchitis, asthenia, lupus, graveyard cough, and hectic fever, to name a few. In 1725 Richard Blackmore expressed the difficulty in categorizing the affliction that accompanied this diverse nomenclature, emphasizing the dominance of ancient medicine in the understanding of disease, by addressing the Greek roots of phthisis. The term was already in common use in the sixteenth century and translates into a wasting away, perishing, or decaying of the body and its use was, in part, an indication of the sweats and emaciation that were characteristic symptoms of the malady’s final stages.

Though the term “phthisis” remained in common use well into the nineteenth century, it was increasingly supplanted by “consumption,” which was in use by 1660 to denote phthisical decline.¹⁹ This term spoke to the fact that the disease seemed to consume its victim from the inside out, leaving a withered husk and gaunt devastation. Although evocative, the term was neither precise nor exclusive, as it was used to identify a plurality of wasting conditions. In 1847 Henry Deshon complained of the indiscriminate use of the label, stating “The term ‘Consumption,’ as generally applied to denote disease of pulmonic origin, is employed in too vague and indiscriminate a manner . . . ‘Pulmonary consumption,’ or ‘phthisis pulmonalis,’ more correctly applies to the general failure of health dependent upon the formation of tubercle.”²⁰ This curious intermingling of terms and their use as essentially interchangeable entities was indicative of the ongoing confusion over identifying and

quantifying the illness; however, the role of the tubercle would become increasingly important in discussions of the illness. (See Plate 3.)

The term “tuberculosis” first appeared in print in 1839, when J. L. Schonlein, a professor of medicine in Zurich, proposed the word as a generic sobriquet for all manifestations of the disease. The root word “tubercle” was, by this point, commonly understood to be the fundamental unit of pathology. The word derived from the Latin term *tuberculum*, which translated into “lump.”²¹ The term reflected the growing influence of pathological anatomy as medical investigators searched for the exact role the tubercle played in the disease’s causation, course, and consequences. In 1852 Henry Ansell laid out the appropriate usage for all associated tubercular definitions.

The term “Tuberculosis” being employed to designate the constitutional origin of all the local manifestations of Consumption and Scrofula, and “Tubercle” to designate a special morbid element, the word “Tubercular” is generally used where the presence of tubercle is intended to be implied, and the word “Tuberculous” where it is not; but owing to the indefinite employment of these terms by preceding writers, it has been found impracticable to adhere rigidly to any rule.²²

Nonetheless, the term tuberculosis would not supplant consumption or even phthisis until the turn of the twentieth century.²³ Robert Koch’s identification of the *Mycobacterium tuberculosis* bacillus in 1882 proved a crucial step in the acceptance of the germ theory of disease and would eventually ease the way for the term tuberculosis.

Scholarly Construction of Tuberculosis

The scholarly engagement with tuberculosis has itself been a reflection of specific social and cultural concerns—in particular, concerns about class, poverty, and the role of the state. Thus, while scholars have long been interested in the study of the “white plague” they have primarily concerned themselves with explaining its mortality decline, or with analysing the ways in which campaigns to mitigate its effects took place in various countries.²⁴ The return of tuberculosis as a public health threat in the 1980s, with its tendency to co-infect those with the human immunodeficiency virus (HIV), led to a resurgence of interest and in the 1990s there were a number of works published on tuberculosis in American society.²⁵

The threat has not diminished and tuberculosis has once again become an enormous global public health problem. In 2007 there were approximately 1.7 million deaths from tuberculosis and 9.27 million new cases, even more shockingly one-third of the human population is thought to be infected with the *Mycobacterium tuberculosis*.²⁶ (See Plate 4.) Global efforts at tuberculosis (TB) eradication have been complicated by the growing incidences of MDR-TB (multi-drug resistant TB), the advent of XDR-TB (extensively-drug resistant TB),²⁷ and by the reliance on decades-old drug therapies.²⁸ This combination of factors “threatens to return TB treatment to the pre-antibiotic era, when 50% of patients with TB died of the disease.”²⁹ Current therapies for MDR-TB include a combination of between eight to ten different medications and the course of the therapy ranges on average from 18–24 months. Despite these aggressive tactics the treatment regime fails in nearly 30 percent of those cases of XDR-TB.³⁰

The continuing concern over tuberculosis is reflected in a number of new scientific works on the subject as well as new histories of the illness.³¹ There remains, however, a dearth of works on tuberculosis that concentrate exclusively on Britain, and those that do, like Linda Bryder’s *Below the Magic Mountain: A Social History of Tuberculosis in Twentieth-Century Britain* (1988), focus on the late nineteenth or twentieth centuries. In

Figure I.1 Left: X-ray of chest showing tuberculosis. Right: Photograph of the lungs of a patient after death from tuberculosis. Francis Henry Williams, *Roentgen Rays in Medicine and Surgery as an aid in diagnosis and as a therapeutic agent* (New York, London: Macmillan, 1903). Wellcome Library, London. Copyrighted work available under Creative Commons Attribution only licence CC BY 4.0 <http://creativecommons.org/licenses/by/4.0/>

general, works on tuberculosis in the nineteenth century have either looked at the concepts surrounding the illness at the beginning of the century, focusing exclusively on the working classes, or are devoted to assessing the illness in the latter half of the century. These works often acknowledge the existence of the Romantic myth in literature, but this subject was not adequately explored until Clark Lawlor's *Consumption and Literature: the Making of the Romantic Disease* (2006). Lawlor's work addresses the disparity between biological reality and literary interpretation and remains the only work that delves deeply into the "aesthetics" of consumption. However, his focus is primarily literary and fails to adequately delve into the popular applications of that rhetoric or on its correspondence with contemporary beauty ideals. Even the newest works on the subject, for instance, Katherine Byrne's *Tuberculosis and the Victorian Literary Imagination* (2011) and Helen Bynum's *Spitting Blood: A History of Tuberculosis* (2012), only briefly mention the aesthetics of the illness.

There was a definite relationship between female roles, fashion, and beauty that both illustrated and aided the construction of a changing social view of tuberculosis. The nature of consumption's reciprocal impact during the late eighteenth and first half of the nineteenth centuries on upper- and middle-class women, both as individuals and as part of the social body, is the focus of this inquiry. There was a persistent and influential idea during the period that consumption, in its middle- and upper-class incarnations, was a disease that was not only identified by the existence of beauty in women, but one that also conferred beauty upon its sufferer. Thus, tuberculosis was rationalized as a positive affliction for women, one to be emulated in beauty ideals and fashions. Yet there was also a contradiction, since fashions and the way of life of fashionable society were

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thought to “excite” the disease in upper- and middle-class women who possessed a predisposition to consumption and whose inherent feminine character rendered them more susceptible to the activation of that predisposition. The positive associations with consumption and its “look,” permitted the widespread flouting of admonitions against the clothing and fashionable practices believed to cause the disease. Tuberculosis, despite evidence to the contrary, was portrayed as an easy or beautiful way to die. How did these poignant representations of consumption reconcile with its horrific reality? Moreover, why was the illness interpreted aesthetically not only as a sign of strong emotions such as passion and love, or as a mark of genius and spirituality, but also as a marker for physical beauty?