

# Reading for Health

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**Medical Narratives and the  
Nineteenth-Century Novel**

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# Introduction

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## Becoming Patient Readers

In modern stories prepared for more refined or fastidious audiences than those of [Charles] Dickens, the funereal excitement is obtained, for the most part, not by the infliction of violent or—disgusting death; but in the suspense, the pathos, and the more or less by all felt, and recognized, phenomena of the sick-room. The temptation, to weak writers, of this order of subject is especially great, because the study of it from the living—or dying—model is so easy, and to many has been the most impressive part of their own personal experience.

—John Ruskin, “Fiction, Fair and Foul” (1880)

The pleasures of health are taken as a matter of course, and are only passively appreciated.

—Alexander Shand, “The Pleasures of Sickness” (1889)

Readers of Victorian novels will likely appreciate John Ruskin’s critique of “modern stories.” Disease and death are everywhere in nineteenth-century novels. Imagine Charles Dickens’s *Bleak House* (1853) without Esther Summerson’s delirium or the fetid atmosphere of Tom-All-Along’s, Charlotte Brontë’s *Jane Eyre* (1847) without a young Jane clutching a dead Helen Burns, or

an Elizabeth Gaskell novel without industrial illness—whether Mary Barton’s inanition or the fluff in little Bessy’s lungs. For many scholars, the Victorian novel would not be *Victorian* without illness.<sup>1</sup> As Miriam Bailin observes in *The Sickroom in Victorian Fiction: The Art of Being Ill*, “There is scarcely a Victorian fictional narrative without its ailing protagonist, its depiction of a sojourn in the sickroom.”<sup>2</sup> But for Ruskin, these “sojourns” are morally and aesthetically suspect—the mark of a lazy writer. Not only do such scenes cater to the reader’s baser instincts,<sup>3</sup> but they also, perhaps more damningly, take minimal effort and almost no talent to depict. “Few authors of second or third rate genius,” Ruskin argues, “can either record or invent a probable conversation in ordinary life; but few, on the other hand, are so destitute of observant faculty as to be unable to chronicle the broken syllables and languid movements of an invalid” (*Works*, 274).

Disappointed by what he saw as an unfortunate dependence on the morbid and the pathological in the fiction of his day, Ruskin called for a return to a healthier literature, one in which the death toll is kept at a minimum, the sickroom scene is understated or absent, and the characters are not so morally repugnant. Ruskin identifies the various deaths in Dickens’s *Bleak House* and the unredeemable characters in George Eliot’s *Mill on the Floss* (1860) as particularly objectionable. By way of contrast, Sir Walter Scott’s novels—which as Ruskin notes favor “character[s] of a highly virtuous and lofty stamp” (*Works*, 285), “landscape[s] [that are] rich” (378), intricately woven plots, and a laudable purpose, which is to “study the effects of true and false religion on conduct” (381)—exemplify the “healthy and helpful literature” (376) for which Ruskin was nostalgic. But even Scott was not completely immune to the allure of sickbeds. Ruskin cites *St. Ronan’s Well* (1824), *The Fair Maid of Perth* (1828), and *Castle Dangerous* (1832), which were written during the period of illness before Scott’s death,<sup>4</sup> as having sunk “into fellowship with the normal disease which festers throughout the whole body of our lower fictitious literature” (276). Disease, for Ruskin, was literal and metaphorical—the one often sliding into

the other. Although a writer need not be unhealthy to write sick literature, those who suffer from actual illnesses are presumably more likely to succumb to the reading public's prurient desire for "vice and gloom" (276) and to feature an array of diseased characters and insalubrious situations. "No good is ever done to society," Ruskin explains, "by the pictorial representation of its diseases" (376).

Ruskin was not the only critic who thought about literature this way. As Bruce Haley points out in his seminal study *The Healthy Body and Victorian Culture*, "The Victorian critic believed that he should diagnose a work, looking for signs of disease or soundness, then looking further for causes of the disclosed condition."<sup>5</sup> For example, when Thomas Carlyle writes about Rousseau in 1841, he claims that Rousseau's "books[,] like himself, are what I call unhealthy; not the good sort of Book."<sup>6</sup> In his 1858 analysis of Scott's *Waverley* novels, Walter Bagehot implies—as Ruskin would much later—that the author's experience with literal health was somehow integral to literary form, particularly when it comes to depicting monstrous or "anomalous" characters. Bagehot lauds Scott's superior skills of characterization, claiming, "A writer must have sympathy with health before he can show us how and where and to what extent that which is unhealthy deviates from it."<sup>7</sup>

Literary criticism that aligns the author's mental, physical, and moral health with the metaphorical soundness of his text—though common enough during the nineteenth century—represents a type of evaluative and biographical analysis that has largely fallen out of favor. Twentieth- and twenty-first-century scholars are much less inclined to make claims about the role that an author's health plays in the value of his or her work.<sup>8</sup> But in turning away from such health claims, we have, I suggest, lost a chance to see the subtle ways in which health—particularly physical health—operates in these works: the challenges it poses and the reading practices it engenders.

Ruskin suggests in the above epigraph that illness is "impressive"—that one's experience with illness makes an impression on her life in a way that the experience of health cannot. Narratively

speaking, health functions as little more than an addendum to the story of illness; it becomes simply a charming (or annoying) resolution, an innocuous character trait, or a pernicious metaphor for all that is right and good. In “Pathologizing the Victorians,” Kirstie Blair comments on the scholarly interest in disease at the 2000 Victorian Institute Conference on Victorian illness, health, and medicine, observing, “Almost every speaker focuse[d] on illness rather than health” and “Pathology has been the focus of Victorian criticism for some time.”<sup>9</sup> Medical historian Roger Cooter makes a similar point in a 2003 review for *Victorian Studies*: “Corporeality and pathology have become obligatory points of passage in the study of Victorian society and culture.”<sup>10</sup> Over a decade later, this preoccupation is still largely the case,<sup>11</sup> for although we may be somewhat less interested than the Victorians in judging a novel based on how the writer felt as she wrote, we continue to ask why sickness is so pervasive and what exactly disease means in Victorian novels and to the Victorians themselves.<sup>12</sup>

My reading of the Victorian novel draws from these two critical modes: first, the current scholarly interest in disease, and second, the nineteenth-century call for “healthy literature.” I am sympathetic to our persistent fascination in Victorian studies with the pathological, and I am inspired by the methods recent scholars have used to articulate the social, political, and narrative implications of illness. But I am equally intrigued by Ruskin’s frustration with the ample material Victorian writers left us. I do not aim, as Ruskin did, to condemn the Victorian writers’ gratuitous use of illness, nor do I want to use sickness as a barometer for evaluating their characters. I do, however, want to ask, “Why always disease?” In asking this question, I want to suggest that health is an epistemological problem and that nineteenth-century narratives register, through both their form and their content, the difficulty of knowing what health is, how to preserve it, and whose is best.<sup>13</sup> These questions are made explicit in the periodical press, in government pamphlets, and in memoirs, and are implicit as well as explicit in novels.<sup>14</sup>

One reason for the critical interest in disease, of course, is that disease and illness are medically and narratively more interesting than health. To use Ruskin's term, illness is "impressive," whereas health is, as Alexander Shand notes in the second epigraph to this introduction, a "matter of course," only "passively appreciated." Health is, in other words, a nonstory. Like Athena Vrettos, who points out in *Somatic Fictions* (1995) that "[t]o be ill is to produce narrative,"<sup>15</sup> John Wiltshire surmises in his work on Jane Austen, "If the healthy body is largely passive, unconscious of itself, then the unhealthy body, as a site of anxious self-concentration, is the source of events, of narrative energies."<sup>16</sup> For the doctor, illness is a problem *to solve*; it must be diagnosed, treated, and cured. For the patient, illness is an obstacle *to overcome* or perhaps a punishment for sin. Indeed, illness forces us to take notice of our bodies and behaviors, to experience compassion, to purge, to repent. In contrast, health signifies the absence of all of this; if anything, it functions merely as the end of the action, the prized reward. It provides the requisite closure or the inaugurating condition that incites narrative, but it is certainly not what keeps the story going.

Robert James's definition of health in his three-volume *A Medicinal Dictionary* (1743–45)<sup>17</sup> attests to the unconsciousness that attends health: the body is in a "sound state," he explains, when "nothing is wanting" (lxvi). James depicts health as a negation or an absence ("nothing is wanting") rather than an affirmation or presence (that is, "every need is met"). Borrowing from D. A. Miller, whose work has greatly influenced this book, we might describe health as the nonnarratable state of "quiescence assumed by a novel before the beginning and supposedly *recovered* by it at the end."<sup>18</sup> But even here, we can see just how pervasive the disease narrative is, for the very form of the traditional novel and the language we use to theorize it rely on a reading of crisis and recovery that imagines health as the end or beginning, as absence of action. After all, since its rise in the eighteenth century, the novel has persistently trained its readers to expect conflict and resolution, mysteries and

solutions, a beginning that moves (but not too quickly) toward an end. The endings of eighteenth-century texts, such as Charlotte Lennox's *Female Quixote* (1752) and Tobias Smollett's *The Expedition of Humphrey Clinker* (1771), for example, spectacularly showcase cure from illness as the desired and achievable goal.

In this book, I consider the effort (and, as the medical advice warns, it takes effort) that goes into reading for health. I identify a model of reading that interprets health as more than a point of entry or of departure—as more than something to be “passively appreciated.” The novels of Jane Austen, Charlotte Brontë, Harriet Martineau, Charles Dickens, and Elizabeth Gaskell—novels that prominently feature invalids and their doctors, contagions and fevers, sicknesses and cures—provide lessons not only in how to be healthy but also in how to read for health. Whereas a study such as Haley's offers insight into the former, this book seeks to broaden our understanding of the latter by exploring the difficulty of replacing the familiar narrative arc of prelude, crisis, and cure (which I refer to as *therapeutic*) with one centered on more-static models of maintenance and prevention (what I am calling *hygienic*). The novelists and medical advisers featured in the following chapters demonstrate that health has a narrative of its own, one that complements even as it complicates the linearity of the disease-cure model. Through cautionary tales and secondary narratives and characters, the writers I study provide strategies for reading others and the environment for hygienic purposes. Reading for health's narrative challenges our sense of order and temporality, setting and metaphor, point of view and voice. It means reading for what has largely remained unread.

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Physicians have long registered their concern about society's passive appreciation of health. In *The Code of Health and Longevity* (1807), Sir John Sinclair laments, “People seldom attend to their health till it be too late. They scarcely ever think of it till they are seriously impaired.”<sup>19</sup> The year before, Thomas Beddoes supposed

in his *Manual of Health* (1806) that “could you but once lead the public to suspect that health may be SOMEWHAT OF AN ACCOMPLISHMENT, they would then, I think, cultivate it uninterruptedly without grudging, and not dismiss it as shortly as they can, like an importunate creditor.”<sup>20</sup> By the end of the century, James Hinton was still warning readers in *Thoughts on Health* (1871), “The time for unconscious fulfillment of the laws of health has practically past. We must either know or suffer.”<sup>21</sup> These criticisms recur in numerous medical and nonmedical texts throughout the eighteenth and nineteenth centuries, a time during which handbooks such as these rose in popularity and accessibility. The prevalence of so many guides, pamphlets, and memoirs that warn readers about their ignorance and their inability to attend properly to health attests to a cultural desire—compulsion, even—to read and write about, and to imagine, health.<sup>22</sup> The mass of material during this period also registers an epistemological anxiety about the possibility of ever truly knowing health. Victorian surgeon John Milner Fothergill captures this concern when he exclaims in the introduction to *The Maintenance of Health* (1874), “Health! What is it? And how is it maintained?”<sup>23</sup> Health is both something we can assert emphatically (“Health!”) and something that remains a mystery (“What is it?”).

An entire industry was dedicated (and still is) to answering Fothergill’s questions and to helping readers solve the mystery of health, which was often imagined in vague yet alluring terms. Fothergill claims that health is the “balance betwixt the various parts of the organism” (1), whereas Hinton declares that it involves being in “harmony with the ceaseless activities of nature” (*Thoughts*, 333). Such a view of health explains why it is easy to ignore and why it seems to fail as a model for narrative. Health is or should be unremarkable: “[N]o man is truly healthy,” Hinton claims, “who is thinking about his health” (332). We might think here of Aristotle’s conception of tragedy; his emphasis on catastrophe and the consequent catharsis (purification) as offering an early articulation of this critical investment in crisis and cure. But even Hinton’s

definition of health's congruence signifies its narrative potential: health "exists in ceaseless adaptation to all the infinite variety of nature—ever the same, yet ever new. . . . Health knows no *monotony*" (333, emphasis added). Such claims allow us to interpret health as largely a process, a movement, or an act of loss or gain—in short, as narrative.

The desire to foreground health's narratability—to make it legible—has been central to medical advice since antiquity. As Greek physician and philosopher Galen explains, health is part one of a two-part story: "Since, both in importance and in time, health precedes disease, so we ought to consider first how health may be preserved, and then how one may best cure disease."<sup>24</sup> P. N. Singer notes in the introduction to his translation of *Galen: Selected Works* that doctors, such as Galen, were part of the Roman elites' "daily entourage" and that health was, since at least "Hippocratic times[,] . . . something which involve[d] certain types of constant, daily practice for its maintenance."<sup>25</sup> The advice Galen and subsequent medical writers offer distinguishes between health and disease, between the "daily practice" and the temporary treatment. "Whereas the science concerned with the human body is one," Galen notes, "its foremost and largest subdivisions are two: one of these is called hygiene, the other therapeutics, differing in their respective functions, the former being concerned to maintain, the latter to modify, the condition of the body."<sup>26</sup>

Galen's demarcation between hygiene and therapeutics, as well as the format of his medical advice, persisted with surprisingly little alteration—given the changes in medical knowledge—well into the nineteenth century. The concern that medical writers express about their readers' inability to recognize health did not originate in the nineteenth century, and it certainly did not end there; but the availability of written material on the subject, the developments in medicine, and the vastness of the reading public converged during the nineteenth century to make it a period of intense debate about health, particularly in terms of the two categories of

medicine—hygiene and therapeutics—that Galen identified. For although these categories are interrelated, advice books by medical professionals and laypersons alike often emphasize one over the other. William Strange, for example, wrote predominantly on the restoration of health,<sup>27</sup> or therapeutics, whereas Sinclair focused on hygiene, organizing the sixth edition of his *Code of Health and Longevity* (1844) “under three general heads:—on the means, 1. Of preserving health, 2. Of prolonging life, and 3. Of curing or alleviating disease” (3). The first two headings (preserving and prolonging) fall under the umbrella term of maintenance (hygiene), while the third is dedicated to therapeutics. Sinclair employs this formula in part because he was not an expert on cure. But more than that, he (like many other writers) was aware of or concerned about the notion that readers think too much about cure. The reading public, among whom Sinclair includes medical professionals, needs to attend more to the story of health than to that of disease. Thus, while I am interested in the narrative structures that make health legible—a text to be read and followed—I want to demonstrate how these structures and how reading “hygienically” function as a form of resistance to dominant modes of thought, particularly the curative or “therapeutic” ethos, which seeks closure and a definitive end.

I attend to these issues not to suggest that disease and closure are unimportant or that the ability to find solutions for them is unworthy of our attention. Getting sick is terrifying, and it was particularly so during the period before germ theory was fully accepted, when a simple cut could lead to a life-threatening infection or a drink of water could unleash a deadly epidemic. But wherever possible, avoiding illness in the first place is safer than relying on treatment. Sinclair was not a medical man, but his work offers a plan for health based on his extensive reading (it summarizes several popular medical guides) and his own experience. Influenced by Galenic theories of medicine that tout the importance of moderation in diet and exercise, he counsels readers, “The foundation should be laid early; the plan or system should begin in youth,

and ought afterwards resolutely to be persevered in" (1844 *Code*, 10), while acknowledging that the perseverance (or narrative "drive") perhaps more than the plan (or "plot") is what readers seem to resist. He criticizes those who "represent hygeian rules as troublesome; and account all persons as miserable, who live according to any regular system," promising instead that "pleasure," or what we might call narrative fulfillment, comes from developing "habits" of health (14).

Novelists such as Austen, Brontë, Martineau, Dickens, and Gaskell not only thematize and satirize the details of these "plans" (recall Mr. Woodhouse's concern about wedding cake in *Emma*) but also incorporate the notion of perseverance and daily practice into the very form of their narratives. Jane Austen's *Sense and Sensibility* and Charlotte Brontë's *Jane Eyre*, for example, may feature therapeutics as integral to the advancement of their heroines' plots and seem almost wholly organized around the crisis (or multiple crises) they must endure, but these plots are governed equally, if not so obviously, by a hygienic model of narrative. They reflect a desire to maintain rather than simply treat, to prevent rather than cure. In these narratives, the ostensibly dilatory state of health intersects with and subsumes the teleological impulse of disease. These novels teach us an alternative rhythm of reading, one that operates outside the comfort of cure and the allure of disease and invites readers to revise their expectations about character development (*bildungsroman*), the narrator's authority (omniscience and reliability), narrative closure (essential to marriage plots), and the metaphorical language associated with these structural elements, which align with the critical investment in illness.

Although determining what people knew about health and whether or not they were accurate in that knowledge is of interest in this book,<sup>28</sup> I am more concerned with identifying the ways authors write about such topics—the narrative strategies used by novelists and medical writers when trying to preserve, promote, and define health and the reading practices these strategies invite or impose.<sup>29</sup> *Reading for Health's* focus on the narrative of health has

been shaped, as the title implies, by Peter Brooks's *Reading for the Plot* (1984) and D. A. Miller's *Narrative and its Discontents* (1989), as both critics examine the reader's and the narrative's relationship to beginnings and ends and to the traditional narrative of crisis and recovery.<sup>30</sup> Brooks challenges "the static models" of narrative developed by formalists, because they fail to account for "reading narrative as a dynamic operation." He uses metaphors such as "motor" and "engine" to explain the type of movement that occurs in narrative, and he couples this model with a Freudian understanding of psychic mobility, suggesting that desire for the end (the death instinct) initiates the narrative and drives the plot. As he explains it, "Narrative desire is ultimately, inexorably, desire *for* the end."<sup>31</sup> But even as Brooks asserts the death drive as narrative's primary force, he calls on the language of medicine to describe this narrative event. In his examination of *Great Expectations* (1860–61), for example, he argues, "At the end [of the novel] we have the impression of a life that has outlived plot, renounced plot, been *cured* of it: life that is left over." "Plot," he suggests, "comes to resemble a diseased, fevered state of the organism."<sup>32</sup> Medical rhetoric, particularly the language associated with crisis and recovery, seeps naturally into theories of narrative action.

For Miller, "narratability" is "the instance of disequilibrium, suspense, and general insufficiency from which a given narrative appears to arise."<sup>33</sup> Miller offers Mary and Henry Crawford from Austen's *Mansfield Park* (1814) as examples, noting that both characters defer textual closure—Henry through his flirtatious behavior and refusal to commit to marriage and Mary through discourse, her "perpetual promise and deferral of knowledge and right nomination." Miller highlights these two characters because, for Austen, narratability "coincides with what the novelist strongly disapproves of (waywardness, flirtation) and . . . closure is associated with her most important official values (settlement, moral insight, and judgment)." These nonnarratable, or "healthy," behaviors are, for Miller and others, what the novel (and the novel reader) seeks to achieve.

In another example, Miller explains that we know Emma Woodhouse has been “cured” when she begins to think of herself in terms of her “blindness” and “blunders,” when her language shifts from self-absorbed to self-aware.<sup>34</sup> Both Miller and Brooks call on the language of health (cure and recovery) to construct their theories.<sup>35</sup> In doing so, they highlight the notion that traditional narratives are marked by the drive toward cure, toward expelling that which is undesirable or diseased.

But just as a story in which everyone is healthy and happy is no story at all, neither is one in which all the characters are constantly sick. We need, as Brooks might argue, the detours that move us between these two states and keep us slightly off-balance. Miriam Bailin challenges the traditional view that health and cure are fiction’s desired and necessary end, arguing in her study on the Victorian sickroom that “[t]he conventional pattern of ordeal and recovery takes on its particularly Victorian emphasis in the location of the desired condition of restored order and stability not in regained health but in a sustained condition of disability and quarantine.”<sup>36</sup> Referring to Charlotte Brontë and Charles Dickens in particular, she goes on to argue that the “narrative cure for disorder is more often than not illness itself and the therapeutic situation constructed around it.”<sup>37</sup> If, as Bailin proposes, the Victorian novel transforms illness into cure (narratively speaking), then I would like to suggest that it transforms health into action, into a kind of narrative crisis in itself. For, even as novels in the nineteenth century rely on the illness-cure model, another model, I argue, undergirds this traditional structure—one determined by the vagaries to be found within plots of health. Health is a precarious and subjective condition marked by uncertain chronologies, invented plots, and hopeful, vigilant characters. It insists on the simultaneous application of hindsight and foresight and provides writers narrative possibility rather than simply an ending, an ongoing drama rather than the absence or end of action.<sup>38</sup>

I turn briefly here to the great medical novel *Middlemarch*,<sup>39</sup> for although it is not central to my study, it was written by a novelist

who, by 1872, had thoroughly absorbed the lessons of health that I identify in each of my chapters. Two moments from George Eliot's text exemplify how we might become more conscious of what it means to "read for health." At first, the scenes are so steeped in the language and metaphors of illness and therapeutics that it is difficult (more so than in the other texts I study) to read them "hygienically." Each episode involves the doctor-hero Tertius Lydgate, but neither features the doctor engaged in typical medical practice or relies on the clinical and scientific verisimilitude that is generally associated with Eliot's realism.<sup>40</sup> In the first, Eliot stages the scene of Nicholas Bulstrode's climactic expulsion from Middlemarch at a town meeting—significantly—about sanitary reform. The town's literal and figurative health is at stake, as the scandal surrounding the wealthy banker has the potential to infect all with whom he comes into contact. Mr. Hawley refuses to let Bulstrode comment on the town's sanitary concerns if Bulstrode is not himself free of taint, of scandal. Bulstrode cannot refute the allegation that he "was for many years engaged in nefarious practices, and that he won his fortune by dishonest procedures," and his body reveals as much—he becomes too weak to walk unassisted. Lydgate, though he realizes that any association with Bulstrode will harm his reputation, cannot refuse to see Bulstrode as his patient and must help: "What could he do?" (450). The narrator explains that Lydgate's "movement of resentful hatred was checked by his instinct of the Healer which thinks first of bringing rescue or relief to the sufferer" (449). At this point, the scene satisfies the requirements of the conventional crisis-cure narrative, underscored by the narrator's reference to Lydgate as "the Healer" (that is, one who cures). Bulstrode's narrative is in crisis, he becomes sick, and the doctor offers relief.

The action of this scene comes largely from the publicity of Bulstrode's misdeeds, but this moment also invokes a preventative impulse, inviting the reader to think of the past and future simultaneously. As any good physician knows, the doctor's job is not only to diagnose and cure but also to teach patients to avoid illness in the

first place. In fact, if more of the latter occurred, less of the former would be needed. Bulstrode's illness and potential cure become a cautionary tale about the dangerous effects of past acts, while Lydgate's act of sympathy sets in motion his own tragic future. Had it not been for the doctor's instinct to offer the weak man his arm and lead him from the meeting, Lydgate would have been absorbed, at least temporarily, into the status quo. As a result of his sympathy, we begin to anticipate, along with Lydgate, the potential dangers of his actions—we begin, that is, to think “hygienically” in terms of prevention and preservation, becoming aware of that moment when Lydgate could have avoided future “dis-ease,” and did not. The townsmen are similarly poised between a crisis-cure model, as they seek to exorcize their diseased part, and a hygienic one, enacting a quarantine to prevent further and future damage. Lydgate helps to remove Bulstrode, but “curing” Bulstrode's hypochondriasis or saving the town does not motivate his actions or drive the narrative. In fact, this type of “therapeutic” language, though not wrong in this case, is inadequate. The town and the narrative require Lydgate's sympathy, as “bitter” as it might be, more than they require any type of medical cure. And although this model of sympathy ultimately does not prevail, the impulse of health—of preservation and prevention—emerges momentarily as it pushes questions of moral and medical disease aside.

As the above example demonstrates, the shift I am tracing can be fleeting. As soon as it arises, it is subsumed by the prevailing discourse and metaphors of disease. We see this in a parallel moment when Dorothea posits a more intricate relationship between character transformation and health. Enlisting the kindly Reverend Camden Farebrother into a diagnostic assessment of Lydgate's condition, Dorothea tries to convince him that Lydgate is innocent of killing or purposely mistreating Raffles, the man who has exposed Bulstrode as a fraud. She asks Farebrother to consider Lydgate's character, to which he responds, “But my dear Mrs Casaubon . . . character is not cut in marble—it is not something solid and unalterable. It is

something living and changing, and *may become* diseased as our bodies do” (454, emphasis added). Appropriating the language of medicine, interweaving therapeutics and hygiene, as Farebrother does, Dorothea responds in kind: “Then [character] *may be* rescued and healed” (454, emphasis added). Health, in this exchange, appears to be an end point, the result of sequestering Lydgate in a metaphorical sickroom and treating his illness—he will be healed. On the one hand, then, this scene seems to be (more so than the first example) a moment of crisis in need of cure. And to some extent it is, but we can see, too, that health and the actions one takes to preserve it are not simply about cures and ends. “The Healer” must think hygienically as well as therapeutically, and Dorothea’s project, which does not work as she had hoped, registers a desire to do both: to institute a preventive model, something from which her own love plot may have benefited, and to hint at the possibility (“may become,” “may be”) of preservation rather than only of immediate cure. Health is a persistent, if often overlooked, force within narrative, a continuous and dynamic operation and, ultimately, a form of sustained compassion. As in the first episode, Eliot provides readers a model of social action that does not depend on the sickroom scene, so that thinking novelistically means turning to health rather than disease; it means opening our thinking to a wider range of possibilities and temporalities.

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Reading for health involves, as medical advisers routinely assert, knowing what health is. Just as in the therapeutic model, wherein one must be sick to get cured, so too in the hygienic model one must recognize good health to maintain it. But as the novelists discussed in the following chapters demonstrate, and as the organization of this book suggests, defining health and maintaining it are interdependent narrative acts. One’s ability to know what health is does not always precede one’s attempts to maintain it. In fact, it is through the maintenance of health, particularly through acts of prevention, that we can know health, that it becomes a legible text

that we become proficient in reading. We define our health, in other words, by the ways we interpret and modify our body's responses to, for example, the environment in which we live, the food we eat, the physical activity we exert, and the mental and physical hardships we endure.<sup>41</sup>

While the following chapters reflect an evolution of fictional form and medical practice during the nineteenth century, they do not aim to tell a linear or progressive history of either field. In fact, reading linearly and chronologically is, in part, what this book proposes to resist. I have organized the chapters into three parts to highlight the recursivity of health's narrative. Our attempts to manage health shape our definition of it, and the terms we use to define it govern how we manage it. Part 1 examines domestic health and personal conduct, whereas part 2 focuses on texts and characters that represent an unconventional view of health. Both parts alternate between chapters on prevention and chapters that seek to define health through maintenance. Part 3 departs from this model by turning to the realm of the professional (the physician and the physician's stand-in), who must become adept at reading for health. Such narrative competence is an essential instrument of medical practice and medical education.

Chapter 1 identifies prevention as the primary marker of the hygienic plot in Jane Austen's fiction; it competes with and overrides the more traditional therapeutic one. As I argue in this chapter, health, for Austen, has little to do with the pursuit or even the rejection of cure and everything to do with the absence of crisis. Although most novels ask us to invite risk, experience disease, and recover slowly, her fictions (*Sense and Sensibility* and *Mansfield Park*, in particular) move relentlessly to preempt disaster. "Recovery," then, is the work of ceaseless and anxious prevention. It means looking ahead to what might happen and looking back at what has been in order to manage current, healthful behavior. Austen's novels and the domestic medical guides discussed in this chapter—William Buchan's *Domestic Medicine* (1769) and Thomas Beddoes's *Hygeia*

(1802)—are equally intent on teaching their readers to think and to read as preventionists.

Jane Eyre, perhaps the best “reader” in this book, is a heroine whose preventionist instinct shapes her plot and, more importantly, her sense of self. Jane’s autobiographical narration not only illustrates how to avoid the fates of other women in the novel (Helen Burns, Bertha Mason, and the would-be Mrs. St. John Rivers) but also depends on an active and aggressive assertion of what health means and her acute awareness that she must maintain it. She is not the “picture of health,” as is Emma Woodhouse, but her narrative probes what it might mean to be the one who draws that picture. Chapter 2, therefore, focuses more directly on the strategies medical writers used to define the contours of health and on the narration and narrative desire that emerge around the twin objectives of identifying and preserving it. Health, as the medical dictionaries of the period suggest, is a recognizable condition as well as a range of conditions; it is capacious, rare, and always relative, unique to the individual but also generalizable to the community. *Jane Eyre*’s point of view and the “improvement” (marriage) plot to which it gives rise rely on the power and narrative authority that come from narrating one’s health.

Part 2 is the rebellious sibling of part 1. While the two chapters in this section similarly disrupt the crisis-cure model of narrative, they also push back against the Austenian sense of prevention and complicate the Brontëan version of the healthy heroine. By first focusing on preventionist discourse of public health in the novels of Charles Dickens (chapter 3) and then on the definitional strategies that the invalid Harriet Martineau uses in her novel and memoir (chapter 4), I suggest that these novelists reflect a more combative relationship to the dominant health discourse of the period than do the novelists in part 1. Whereas Austen’s novels advance and even refine the advice offered by preventionists who are concerned with domestic medicine, Dickens’s *Little Dorrit* virtually rejects public health experts’ opinions about the best policy for preventing

epidemic disease. The sanitary reforms Dickens advocated in his speeches, his essays, and many of his novels (such as *Bleak House*) fade into the background in *Little Dorrit*, in which he features a competing and, for Dickens's occasional public health adviser Thomas Southwood Smith, dubious approach to the preservation of public health: quarantine. Rather than promote the kind of curative and preemptive action that is characteristic of the "sanitary method" and Austen's preventionist cautionary tales, Dickens turns to a more static and isolationist model of prevention that appears to court—even as it promises to obstruct—disease. Health depends on the risk associated with touch and on an almost willful refusal to look ahead to what might be or to learn from what has been.

If, as in the works of Dickens, we can achieve health through counterintuitive means, then the very definition of health is equally disputable. The chapters in this book represent health as a story we tell about ourselves within community and isolated from it. This story occasionally contradicts prevailing modes of thought about sanitary reform or, as in chapter 4, able-bodiedness. The figure of the invalid tests the limits of what health means. Is invalidism merely the opposite of health, or does it represent ideal health? I suggest that the works of Harriet Martineau and others redefine invalidism as a narrative stance rather than a social or physical condition exclusively marked as debility. The culture's interest in fitting invalidism into the larger discourse of health intersects with the invalid's desire to stake her claim in society. And it is through their privileged perspective *on* the health of others—a perspective figured as a form of health—that they assert their cultural and narrative authority. Like Charlotte Brontë's heroine, the invalids in this chapter resist a curative ethos in favor of a hygienic one; but instead of turning to prevention (avoidance), these characters embody a preservationist stance by claiming the fictional authority associated with omniscience. They are, in effect, health's narrators.

Chapter 5 and the afterword conclude this study by applying the lessons of hygienic reading explored in the first two parts to

fictional and contemporary medical education. Here, I focus more particularly on the figure of the doctor as the one who most needs to learn from this alternative way of reading. For unlike the impatient readers Beddoes and others lament, the doctor stands out as lacking the requisite reading skills. In *Wives and Daughters* (1865), for example, Elizabeth Gaskell reimagines medical practice and the role of the “healer” as a version of domestic management that requires not only the management of families but also the management of their stories. She neither defies the doctor’s professional privilege nor adopts it. Instead, she depicts the doctor’s authority and his expertise as contingent on narrative competence—the ability, as Rita Charon and others define it in relationship to medical practice, to listen to, interpret, and ethically act on the stories of others.<sup>42</sup> This, Gaskell, tells us, is best taught and learned in the home and from the novel. I offer an extended close reading of *Wives and Daughters*, drawing together the various lessons of the previous chapters about domestic health, quarantines, healthy heroines, and invalidism. As I discuss in my afterword, this type of narrative competence is essential to medical education as a way of bridging the traditional divide between patients and their doctors. Contemporary work in the field of narrative medicine assumes, like Gaskell’s novel, an integral relationship between storytelling and medical advice. By becoming attentive to the multiple ways that stories work—not only as symptoms of illness but also as strategies for sustaining health—doctors and patients can experience more humane and effective medical encounters. I am suggesting that such an approach to health and medicine is part of the legacy that medical advice and the nineteenth-century novel have left to their readers.