The Sanitary Arts

Cleere, Eileen

Published by The Ohio State University Press


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One of the most striking features of Pater’s infamous conclusion to *The Renaissance* is that it begins not with the “inner world of thought and feeling,” but with what he terms our “physical life.” In any exquisite, isolated moment of bodily sensation, he asks, what is our physical life “if not a combination of those elements to which science gives their names?” Starting with the body, and with the minute elements, currents, and combinations isolated by science, Pater shifts easily into the more familiar passages of *The Renaissance*, where objects lose their realist solidity and become “unstable, flickering, inconsistent” impressions that give aesthetic pleasure in moments of fleeting ecstasy and quicken and multiply the consciousness (151). The perpetual mutability of the human body is, after all, a waxing scientific suspicion.

—Walter Pater, *The Renaissance* (1873)
by the 1870s: the discovery of the microbe and the invention of bacteriology, the rise of reductionist medicine and medical specialism, the development of antisepsis and anaesthesia, the regulation and regularization of experimental science, all shifted, if gradually, the cultural understanding of the human body from wholes to parts, from stasis to movement, and from a concept of disease as an external invader to be kept at bay through cleanliness and hygiene, to a concept of disease that was always endemic to the factionalized body itself. The increasing instability of the body in scientific discourse, in other words, paves the way for Pater's aesthetic Renaissance: if the perpetual decay and renewal of the human body's various organs and tissues is a physiological fact, if social and bodily perfectibility are biologically impossible, if the God-like status of man is a spiritual myth, then the shapelessness and lack of finish that characterized Pater's art of “impressions” was an enlightened mode of realism that could appeal to the evolutionary philosophy of human life by appealing to the effervescent senses of the fractured individual. “A counted number of pulses only is given to us of a variegated, dramatic life,” Pater mused. “How may we see in them all that is to be seen in them by the finest senses?” (152)

This is not to isolate Paterian aesthetics from the more general trend in Modernist philosophy that attempted to return physiological meaning to a word and to an experience that in the original Greek aisthesis was rooted in human sensation and perception. Eagleton, in fact, identifies Marx, Nietzsche and Freud as the dominant modern thinkers who returned the body to aesthetic theory, rescuing it from that disinterested Kantian intellectual experience that Bourdieu has called “a pleasure purified of pleasure.” But Pater's pleasure is especially important to the story I am trying to tell in this book because it was occasioned by, even authorized by, a scientific understanding of the body that directly clashed with the sanitary aesthetic. With the rise of pathological science through the 1870s and 1880s, an understanding of the human body as a potential site of dissection, anatomy, and surgical penetration threatened to overthrow a vitalist concept of the perfectible body defined by harmony, beauty and physical cleanliness. Always potentially sick, partially shadowed, locked in a perpetual cycle of decay and renewal, the human body that was reimagined by scientific discourse in the late nineteenth century underwrote the decadent body of Paterian aestheticism, the perverse pleasure of ridiculous villains like Broughton's Mr. Chaloner, who locates the highest form of beauty, we will remember, in the “passionate pulsations of pain.”

Allison Pease, remarking on the frequent images of death in The Renaissance, finds it difficult to imagine a genuine artistic rebirth amongst Pater's scattered corpses, graves, and caskets: the “profound negativity” at the heart of
Pater’s writing always manages to subvert his argument for a coming Renaissance. But on the other hand, corpses, graves, and caskets were increasingly linked with the secrets of life, health, and longevity under the new regime of pathological science. As Foucault argued, the advent of pathological anatomy in the nineteenth century marks an epistemic shift in the scientific understanding of life: the declining importance of vitalism and “humourism” in the scientific interpretation of the body meant that “life is to be distinguished from the inorganic only at a superficial level. . . . It is profoundly bound up with death, as to that which threatens to destroy its living force.” While the shift to anatomy and dissection in medicine was not as sudden as Foucault argues—such procedures had long been practiced by both doctors and scientists—nineteenth-century discoveries in chemistry and biology ensured that experimental surgeries could be, in Pater’s time, undertaken on living tissue, on humans and animals who were not dead, but who behaved as if they were dead, during longer, more leisurely operations. Indeed, what seems especially important to me about Pater, in his specifically physiological context, is that he recuperates the sensational, sensual pleasures of the flesh for aesthetic philosophy at the very moment a new scientific category of physical experience arises as the very opposite of *aisthesis*. Oliver Wendell Holmes had coined the term “anaesthesia” back in 1846 to underscore the more than material significance of the first successful dental surgery performed on a patient under the influence of ether by American doctor William Morton. In a letter to Morton, Holmes, writing as Professor of Anatomy and Physiology at Dartmouth College, heralded ether as a truly great scientific discovery, but also made it clear that the classification and understanding of surgical sleep was fundamentally intellectual, even philosophical. Holmes explained,

> The state should, I think, be called anæsthesia. This signifies insensibility, more particularly (as used by Linnaus and Cullen) to objects of touch. The adjective will be anæsthetic. Thus we might say, the “state of anæsthesia,” or the “anæsthetic state.” The means employed would be properly called the “anti-anæsthetic agent.” Perhaps it might be allowable to say “anæsthetic agent”; but this admits of question.

While the cultural context and linguistic significance of the word “anaesthesia” has been largely forgotten through the twentieth and twenty-first centuries, it is worth recollecting here that Holmes’s word is forged in deliberate opposition to aesthetics: if “aesthesia” signifies a state of heightened sense perception, “anaesthesia” marks the repression of those senses, a state of the body characterized by indifference to physical pain or pleasure.
Of course, thirty years separated Holmes’s anaesthetic from Pater’s aesthetic, but as many historians of science have pointed out, the use of anaesthesia in Great Britain didn’t begin to be regularized or even regulated until the 1870s. In fact, Stewart Richards has argued that before 1870 the school of experimental physiology in Great Britain was fairly small, and only began to expand in the last decades of the nineteenth century. After the discovery of germs in the late 1860s and the isolation of anthrax in 1876, the potential results of medical experimentation on living tissue began to outweigh any lingering moral or ethical objections on the part of the scientific establishment. Anaesthesia made it possible for surgeons to undertake longer and more difficult operations in the absence of any personal fear about the pain or anxiety they were inflicting upon a senseless body on the table; in this sense, anaesthesia at least theoretically relieved the surgeon of the subjective burden of empathy and pity as fundamentally as it relieved the patient of consciousness. “A deliberate effort to desensitize oneself from the pain of another was no longer necessary,” Susan Buck-Morss explains. “Whereas surgeons earlier had to train themselves to repress empathetic identification with the suffering patient, now they had only to confront an inert, insensate mass that they could tinker with without emotional involvement.” While personal revulsion to laboratory medicine persisted, even amongst some doctors, through the end of the nineteenth century and beyond, anaesthesia also dulled the public sense of outrage about the practice of live vivisection considerably, especially after the successful passage of The Cruelty to Animals Act in 1876. Even many opponents of animal experimentation concluded that if there was no pain there could be no cruelty, and thus no moral objection to a form of experimentation that promised so much for the future health and vitality of the human race.

This chapter isn’t meant to be an examination of the rise of anaesthesia in medicine, nor a record of the scientific discoveries that made surgery an unremarkable component of mainstream medicine by the dawn of the twentieth century. But anaesthesia, I will argue, helped to reorganize the moral understanding of pleasure and pain, beauty and ugliness, sympathy and apathy that had authorized and underwritten so much of the traditional aesthetic philosophy I’ve discussed in previous chapters. The particular threat that anaesthetics posed to traditional aesthetics was no doubt unintended by Oliver Wendell Holmes. But if the distinctions between pleasure and pain, beauty and ugliness, were decided by physiological “pulse” rather than intellectual taste, and could be altered, reversed, confused or manipulated by medical science, the aesthetic and the anaesthetic were hardly oppositional forces at all. In fact, the “pure,” disinterested, moral form of aes-
thetic pleasure so valued by Shaftesbury, Kant, Burke and other eighteenth-century thinkers, the pleasure that repressed the more suspicious feelings of the body in favor of lofty intellectual experience, as Eagleton suggests, might itself “be more accurately described as an anaesthetic” (196). Accordingly, this chapter will explore the so-called revolution in medicine that occurred in the last decades of the nineteenth century as a more protracted cultural controversy about *aisthesis*, an intellectual dispute about the human body that pitted the proponents of sanitary science, or prevention, against the rising forces of laboratory science, or cure.

This cultural debate is vividly illustrated in the sanitary hostility to the incursion of germ theory into debates about illness and epidemic disease, and in the frustration and impatience conversely expressed by contagionists at the continued public focus on miasmatic conditions and environmental fever-nests. In fiction, it is a controversy that is shepherded into an offshoot of what I have been describing as the sanitary narrative; more properly defined as medical fictions, these late-Victorian texts collectively indulge a cultural fantasy about medical perversion within the context of Paterian aestheticism and its decadent obsession with “exquisite” physical and emotional sensation. This brand of medical fiction is less interested in moral reconciliation than the straightforward sanitary narrative; medical fiction instead exposes and exploits moral confusion about the rise of pathology, revealing the shared territory of aesthetics and human health to be not the utopian, evolutionary platform of sanitary perfectibility, but the dystopian, degenerate nightmare of surgical intervention. Prevention is better than cure, in much of this fiction, because it preserves the moral authority of well-regulated public health, the social, even “socialized” medicine of sanitary authorities from Chadwick to B. W. Richardson. But prevention, as we will continue to see, is also about aesthetics, and about the vital, sensible, harmoniously constructed and functioning human body that underwrites those aesthetics. The amoral forces of fragmentation and dismemberment threatened the sanitary beauty of the body, certainly, but they also threatened to inscribe a set of decadent pleasures and pains at the very heart of *aisthesis*.

I. The Anaesthetics of Aesthetics

As I argued in the second chapter, the sanitary narrative provides an ideological clarity that makes the marriage plot morally legible: art is bad, health is good. A heroine like Gillian Lattimer in Broughton’s *Second Thoughts* can embrace an entire sanitary philosophy by choosing to marry a cleanly hospi-
tal doctor instead of a filthy painter from the Paterian school of aestheticism. But to examine the marriage plot from the perspective of some late-Victorian medical fiction is to encounter a love triangle similar to Broughton’s without the happy positivism that manufactures sanitary desire over a convalescent child in King’s Hospital. True, Etheleen Stuart, the likely heroine of Roy Tellet’s *A Draught of Lethe: The Romance of an Artist* (1891), must choose between a painter and a doctor, but the interests of both men is identically deformed by the late-century rapture over aesthetic decay. Our first glimpse of fair Etheleen is through the eyes of rising British painter, Fitzalan Lindley, who is traveling through southern Germany when he decides to visit a “dead house” in a cemetery. There, on a slab, is the beautiful corpse of a young girl dressed entirely in white, an English girl, who has already served as an attraction for another traveling Englishman that very morning. Fitz is clearly moved and even excited by the senseless body: “If this was death,” he marvels, “it was death shorn of all its revolting details—it seemed rather the transfiguration of life by which all material grossness was purged away and an ideal glory was given to the tabernacle of flesh” (Tellet 10). Etheleen, as she is called, has a rope attached to a bell twisted around her right hand, in keeping with the superstitious fear that the seemingly dead body could awaken suddenly and require a different kind of attention; shockingly, the bell begins to ring as Fitz is departing the cemetery, and he rushes back inside to sit with the lifeless body while the doctor is summoned. When Dr. Falck arrives to check the status of the girl, however, he assures Fitz that she is, indeed, actually dead.

We should be alerted to the fact that there is something wrong with Dr. Falck because he arrives in the dead house “lit up in a Rembrandt-like manner” (22). But even if we miss this Ruskinian revulsion, we are impressed almost immediately by his apparently faulty medical training: just as Fitz and Falck are about to screw the lid down on the girl’s coffin, her frantic eyes pop open and the love triangle is disturbingly established. In fact, when Fitz realizes later in the novel that he is actually in love with Etheleen, he will realize also that “it was love at first sight; strangest, perhaps of all, it had been love with one to all appearance dead” (121). Elisabeth Bronfen has argued persuasively that images of dead female bodies in fiction and the visual arts are powerful vehicles of sensual aesthetic experience because they articulate “stillness, wholeness, perfection” while presaging “the dissolution of precisely those attributes of beauty.”

This image of a feminine corpse presents a concept of beauty which places the work of death into the service of the aesthetic process, for this form of
beauty is contingent on the translation of an animate body into a deanimated one. Beauty fascinates not only because it is unnatural, but because it is precarious. . . . It is not just the translation of the inanimate that defines the relationship between beauty and death, but also the fact that this form of beauty, even as it signifies an immaculate, immobile form, potentially contains its own destruction, its division into parts.  

Bronfen’s ideas are interesting here because they call attention to an aesthetic discourse of wholeness and perfection challenged, at a most intimate moment, by the medical desire to fragment, penetrate, and disrupt the vitality of the human body. But when Bronfen suggests that the beautiful female corpse “places the work of death into the service of the aesthetic process,” she also isolates and describes a particularly resonant translation of the medicalized human body into the decadent aesthetic. The Rembrandtesque Dr. Falck, it seems, has invented the perfect anaesthetic: it is a drug called Worliform that renders the body passive and ready for the pain of surgery, while allowing the mind to stay active and alert. Dr. Falck was preparing Ettheleen for his own experimental purposes when Fitz accidentally intervened. Now that she is fully awake, Falck believes his crime will remain undetected because Worliform has also somehow rendered Ettheleen an amnesiac.

Anaesthesia, in other words, becomes the perfect vehicle for aesthesia in Tellet’s novel, an impression reflected by the testimonies of many surgical patients in the Victorian era that reported extremely pleasurable sensations and even “beautiful dreams” during surgical sleep. Ether, in particular, powerfully “embellished and disguised an operation,” stimulating pleasurable feelings while repressing negative sensations; through anaesthesia, “the agonies of surgery were reconfigured ‘into poetry,’ and all without pain.” This anaesthesia provided by anaesthesia gains even more importance in A Draught of Lethe when Falck attempts to neutralize his rival by appealing to the decadent sensibilities that made the artist fall in love with Ettheleen in the dead house. When Fitz visits the doctor in an attempt to learn the truth about Ettheleen’s amnesia, Falck begins to rhapsodize about Worliform’s ability to intensify feelings and cause profound mental stimulation while paralyzing the flesh. Worliform is essentially Lethe, Falck explains; the mind is active but the body is pacified for surgery, the sensations of the Lotus-eaters steal over the patient causing sublime hallucinations and powerful feelings of pleasure. Fitz ends up begging the nefarious doctor for a dose: he is so happy in his love for Ettheleen that the chance “to intensify my own feelings” is too tempting for the artist to resist (196). Of course, once Fitz inhales the drug, Falck drops his mask and begins to prepare his surgical materials. The painter is
saved only at the last minute by a fellow artist who followed Fitz to the doctor’s office, and the marriage of an aesthetically chastened Fitz to a living Etheleen closes Tellet’s remarkable story.

Rather than ether, Dr. Falck’s Worliform actually resembles curare, another anaesthetic that was very controversial at mid-century precisely because it worked to divide the immobile (but still sensitive) body from the alert mind, and therefore challenged the notion that all seemingly painless experimental surgery was actually as humane and as moral as its supporters maintained. Decried by vocal opponents of physiological experimentation, or “vivisection,” like Mark Twain and Frances Power Cobbe, curare was described by the surgeons who used it on animals as a drug that paralyzed the body but had no effect on the sensory nerves. As the eminent French physiologist Claude Bernard infamously revealed in 1864:

In this motionless body, behind that glazing eye, and with all the appearance of death, sensitiveness and intelligence persist in their entirety. The corpse before us hears and distinguishes all that is done around it. It suffers when pinched or irritated; in a word, it still has consciousness and volition, but it has lost the instruments which serve to manifest them.¹⁴

While the above passage was cited frequently in British and American anti-vivisection materials through the turn of the century, the fact of Curare’s existence was enough to strengthen the widespread cultural suspicion that experimental surgery could only be carried out by cruel, detached, callous individuals, doctors who had themselves become numb to the suffering of their patients. Twain’s 1899 letter to the Anti-Vivisection Society of London cites Bernard’s description of Curare in order to disprove the argument that vivisectors do not “perpetuate cruelty,” even in the years since the Cruelty to Animals Act had forbidden animal surgeries without anaesthesia.¹⁵ Cobbe was likewise outraged by Bernard’s continued use of curare as an anaesthetic long after his own discovery of the drug’s limitations, but more generally incensed by the callousness to pain and suffering Bernard demonstrates in his also infamous Introduction to the Study of Experimental Medicine. A surgeon or an experimental scientist, Bernard insists here, is an extraordinary man who “no longer hears the cry of animals, he no longer sees the blood that flows, he sees only his idea and perceives only organisms concealing problems which he intends to solve.”¹⁶ Even before anaesthesia gave surgeons the ability to repress the sensationalized body of the patient during surgery, the truly masterful surgeon, according to Bernard, had already learned to ignore his own
The surgical gaze, in other words, has the power to convert even filth into value, and is capable of transforming the most pestilent and insanitary scenes of disease and disaster—“soot, morasses, cesspools”—into something much less revolting, and even, on some levels, agreeable. Furthermore, vision was not the only form of sense perception that could be scientifically recalibrated to recognize value in what was formerly waste. Even the most highly respected natural arbiter of the fair and the foul, our sense of smell, could be anaesthe-
tized against the discomfort of any odor deemed scientifically productive or progressive: “A foul odor is very disgusting, and makes us decidedly hostile to whatever it comes from,” Holmes-Forbes explains patiently, but “let the same odour, however, be generated by chemicals in a laboratory, for the purposes of some important experiments, and our disgust is almost annihilated, and the odour becomes much more tolerable” (162).

The hospital, the laboratory and the operating theater were, for late Victorians, crucial sensory switch points; places where the difference between pain and pleasure could be neutralized or reversed, where the moral and social definition of ugliness became transitory, associative, contextual, impressionistic. Indeed, the suspicion that the experimental hospital was a place of aesthetic perversion was well circulated in a variety of late-nineteenth-century anti-vivisection material, including many of those medical fictions I mentioned at the outset of this chapter. Grant Allen, prolific Victorian novelist and science writer, published *Hilda Wade* in 1900, a novel that features a cruel physiologist, Professor Sebastien, at St. Nathaniel’s Hospital in London, and his professional nemesis, the intuitive Nurse Wade. Sebastien is perfecting a new anaesthetic called lethodyne that could eventually replace chloroform, and testing it on rabbits and raccoons, sheep and hawks, cats and weasels. When the rabbits, sheep and cats all die, Hilda Wade suggests that lethodyne is poisonous to all “phlegmatic” patients. Only “imaginative, vivid temperaments” will be able to withstand the new anaesthesia, and under this working hypothesis Hilda volunteers to be the first human patient (Allen, *Hilda Wade* 12). She has a tooth successfully extracted under lethodyne, but when Cumberledge, Sebastien’s assistant, praises the surgeon’s coolness during the procedure, Hilda objects that it isn’t coolness, but cruelty; scientists simply want to know the whole truth about the human body, without regard to humanity or philanthropy (14).

He is a man of high ideals, but without principle. In that respect, he reminds one of the great spirits of the Italian Renaissance—Benvenuto Cellini and so forth—men who could pour for hours with conscientious artistic care over the detail of a hem in a sculptured robe, yet could steal out in the midst of their disinterested toil, to plunge a knife in the back of a rival. (131)

The “disinterested toil” of the artist is certainly on display when Sebastien greenlights further human testing for lethodyne. For example, when a pretty tobacco trimmer is brought in for the removal of a tumor, Sebastien is thrilled: “It is a beautiful case! Beautiful, beautiful! I never saw one so deadly or malig-
nant before. We are indeed in luck’s way” (16). The surgical team predicts the patient will die, but proceeds with the operation anyway. Indeed, the outcome of any surgery has nothing to do with the success or failure of any procedure measured in effects: in fact, one surgeon explains his own disinterested toil by asking “How could I preserve my precision and accuracy of hand if I were always bothered by sentimental considerations of the patient’s safety?” (16).

_Aisthesis_, in its original meaning, describes an intensification of our sensory experience. But as Neill Leach argues in _The Anaesthetics of Architecture_, “this flooding of the senses in one domain blots out the reception of impulses in another. The raising of one’s consciousness of sensory matters—smell, taste, touch, sound, and appearance—allows a corresponding indifference to descend like a blanket over all else. The process generates its own womb-like sensory cocoon around the individual, a semi-permeable membrane that ensures a state of constant gratification by filtering out all that is undesirable.”

Heightened aesthetic sensitivity, in other words, is always a form of insensitivity, a suspicion that was wide awake at mid-century when Ruskin, when Dickens, when Eliot criticized the low picturesque as a brutal repres-sion of “harsh social relations.” The anaesthetic, in Allen’s novel, thus underscores the contradictory force of aesthetic pleasure untethered from morality, utility, or sympathy. Indeed, anaesthesia, in much late-Victorian medical fiction, signals the pure gaze of artistic objectification and empathetic detachment, enabling disease, decay, and, indeed, organ meat, to provide Paterian pleasure because they remind us of our tenuous and unstable physical life.

By the time _Hilda Wade_ was published, Grant Allen had been asserting the physiological origin of all aesthetic pleasure for decades, most notably in his 1877 text _Physiological Aesthetics_. Here, just a few years after the publication of Pater’s _The Renaissance_, Allen extends the argument for the centrality of the physical life to the appreciation of beauty: rather than celebrating the aesthetic feelings as “something noble or elevated,” we must recognize that the senses are a matter of “organ function,” and taste a matter of “discrimination in the nerves” (Allen, _Physiological Aesthetics_ 39, 48). Allen is no particular lover of fine art, he admits, but that makes him better able to evaluate every aspect of what he calls the more commonplace “aesthetic emotions,” and not just the most “fastidious” or intellectual. “It is the business of Art,” he thus reasons, “to combine as many as possible of their pleasurable sensations, and to exclude, so far as lies in its power, all their painful ones; thus producing that synthetic result which we know as the aesthetic thrill” (Allen, _Physiological Aesthetics_ 36). For Allen, art must
necessarily include and exclude, must indulge and repress, must stimulate the pleasurable material feelings while anaesthetizing the body against weariness, depression, sleeplessness, debility, and, of course, outright physical pain. The body that returns to aesthetic philosophy, at least in this particularly Paterian strand of physiological pleasure, is a fragmented, factionalized organism, a mechanism that must be atomized to be synthesized, and anatomized to be healed.

II. Prevention Is Better Than Cure

In the most obvious, most material of ways, the body, during and after the slow dissemination of germ theory, was increasingly permeable. Microbiology and cellular pathology made the vital human body a set of organs to be separated and tissues to be flayed. But it is especially important here to put this discourse of science-as-fragmentation back into conversation with the discourse of sanitation-as-wholeness, and to locate these oppositional concepts themselves within nineteenth-century aesthetic controversies. First, I'd like to return for a moment to B. W. Richardson's utopian paradise, Salutland, where people are happy, powerful and beautiful because everybody knows basic sanitary laws and understands cleanliness to be the first principle of good health. Among the most interesting features of this future community is that it employs no members of any of the “destroying professions”; in other words, Salutland contains no lawyers, no soldiers, and most importantly, no doctors. Any healer who was concerned only with the symptoms of disease, with the administration of drugs and surgeries, with cure rather than prevention, would be cast out of the “legitimate followers of Aesculapius,” and shunned by the community (Richardson, “Salutland” 32).

Salutland's workforce is important to my argument because it demonstrates a split between preventive medicine and curative medicine that divided the medical profession, and helped to prolong the rise and acceptance of germ theories through the end of the nineteenth century. Indeed, Lister proved the existence of microbes in 1865, Koch isolated anthrax bacillus in 1876, and Pasteur discovered the anthrax vaccine in 1881. But through the 1880s and 90s, sanitarians still circulated a mission statement that prevention is better than cure, and insisted that the fundamental laws of diet, exercise and hygiene represented a higher, more evolved form of medical care than surgical and pharmacological interventions. Dr. F. de Chaumont made this line of argument abundantly clear in his speech to the Sanitary Institute in 1880, when he explained that “the highest medicine is that which obviates the
use of drugs—the highest surgery that which saves the limb, not that which lops it off. The Greek for Physician . . . signifies ‘to avert,’ to ‘ward off.’ It is in this sense that we employ the term medicine, and public or preventive medicine is thus the science that wards off diseases from the community.”

In sanitary logic, surgery and other curative programs are clearly lower on the evolutionary scale, their continued practice a sign of atavism and cultural degeneration brought on, paradoxically, by the onslaught of industrial civilization. Ten years later, at the Hastings and St.-Leonard’s-on-the-Sea Health Congress where Richardson was the presiding officer, Frederick Bagshawe, M.D., stepped up the evolutionary rhetoric of sanitary philosophy: “When we were primitive like quadrupeds, we didn’t know much about fevers or ailments . . . and may have stood in need of a surgeon.” With the rapid growth of towns and cities under industrialization, Bagshawe explains, “the necessity first for curative medicine, was soon recognized. Still later, for preventive medicine, which has only been fully acknowledged at this late stage of the world’s course, and when misery and suffering have taught their lesson.”

Sexologist and founding member of the Fabian Society, Havelock Ellis, was similarly disenchanted by “the picture of the world presented to us by the bacteriologist,” describing it in 1892 as “undoubtedly somewhat awful, resembling the conception of the medieval Christian. We are surrounded by legions of invisible foes, always ready to take advantage of a false step, the least crevice in our armor,” protected only by the medically prescribed act of “swathing ourselves—either literally or metaphorically—in antiseptic cotton wool.” For progressives like Ellis, the “discovery” of the germ made disease, once again, a kind of primitive, supernatural belief in the invisible sources of human illness; diseases could not be avoided or prevented under this interpretation, but might mysteriously be removed by “some art, or conjuration, or divination” invented by the new biological science. New discoveries by the bacteriologists would only succeed in making people more hypochondriacal, he argued, more superstitious, and above all, more fearful. While members of the Fabian Society were not, strictly speaking, sanitarians, the Society was an 1884 political offshoot of The Fellowship of the New Life, a group that had united members including Ellis and Edward Carpenter under the ambitious ameliorist goal of “The cultivation of a perfect character in each and all.” The Fabian commitment to causes like vegetarianism, pacifism, and universal health care produced a late-Victorian social philosophy that resembled and re-enforced the sanitary philosophy of physicians like B. W. Richardson: harmony, unity and proportion was the very definition of a healthy society for Fabian socialists, while the knife of the surgeon and the drugs of the pharmacist inflicted only disruption, disease and chaos. “To pursue knowledge in this way is to
cover ourselves with darkness,” exclaimed Carpenter in an anti-vivisection
lecture he delivered in 1904. “It is to blind ourselves to the greatest and most
health-giving of all knowledge—the sense of our common life and unity with
all creatures.”

In fact, Carpenter’s address to an 1896 meeting of the Humanitarian
League of London, specifically warned against the encroachment of reduc-
tionist medicine into the human experience of bodies and environments.
Everyday life will be at best uncomfortable under the new bacteriology, he
surmises, but at worst, daily life will be passed in “a kind of nightmare . . . in
the discovery that the air around us is full of billions of microbes; in a terrified
study of these messengers of disease, and in a frantic effort to ward them off
by inoculations, vaccinations, vivisections, and so forth, without end.” Like
so many other Victorian crusaders against experimental medicine, the Fabi-
ans tapped into a growing cultural prejudice against modern voodoo science,
and against those witch doctors who raised ancient, unholy specters of disease
in order to test their occult theories and remedies. This return to medical bar-
barism was cited by a range of sanitarians and socialists as further evidence of
late-Victorian cultural degeneration and physical decline: by passively accept-
ing Darwinian ideas of evolution, mankind had abandoned its godlike status
in the animal kingdom and voluntarily retreated to superstitious ignorance
and simian darkness. “Primitive men attributed disease to magic, spirits of
dead men,” lamented anti-vivisectionist Dr. Edward Berdoe. And, at the end
of the nineteenth century, this “disease demon reappeared in the form of a
germ.”

Under this assessment of scientific progress, civilization itself was a wast-
ing disease that would eventually enervate the individual and social body. In
some of the most dire, devolutionary predictions, human beings would cease
to use their muscles and limbs, gradually becoming, according to Carpenter,
bald, toothless and even toeless. While this particular claim seems exag-
gerated, even hysterical, and invites the kind of fear and paranoia to which
sanitarians ostensibly objected, it underscores what David Wootton has iden-
tified as a long gap, or “delay” between the much-heralded discovery of the
germ and the development of most successful medical therapies or cures.
He writes, “any history of medicine that focuses on what works immediately
brings to the fore these uncomfortable questions about delay, resistance, hos-
tility, and (if we use the word metaphorically) malpractice.” In Civilisation:
Its Cause and Cure, Carpenter asks questions from the midst of that long
delay about the swelling ranks of physiologists, bacteriologists, pathologists,
and vivisectionists at a moment when disease seemed not in abeyance, but on
the increase.
Medical science makes a fetish of disease, and dances round it. It is (as a rule) only seen where disease is; it writes enormous tomes on disease; it induces disease in animals (and even men) for the purpose of studying it; it knows to a marvelous extent, the symptoms of disease, its causes, its goings in and its comings out; its eyes are perpetually fixed on disease (for it) becomes the main fact of the world, and the main object of its worship.33

Many historians of science, including Wootten and Bashford, have argued that this kind of suspicion and hostility to medical practitioners rose dramatically during the 1860s, when a rash of deaths in lying-in hospitals and private residences from puerperal fever made it clear that physicians themselves, especially physicians who moved, unwashed, amongst living and dead patients, were somehow contaminating and killing women during labor.34 But it is also the case that the proliferation of medical specialties, of doctors who focused on parts of patients and bits of bodies, rather than on whole, autonomous persons, was significantly at odds with a philosophy of human life defined by the promise of social and spiritual perfectibility.

Fellow Fabian George Bernard Shaw agreed, arguing in an 1917 article, “What is to be Done with the Doctors?” that medical specialism was commercially motivated, and just as lawyers will distort any legal case they encounter to fit their own field, “so specialists in a particular treatment . . . will try that treatment or operation on all sorts of complaints.”35 Shaw’s own infamous specialty surgeon, Cutler Walpole, appears in his 1911 play The Doctor’s Dilemma: A Tragedy; Dr. Walpole has discovered, with the help of chloroform, that “a man’s body’s full of bits and scraps of old organs he has no mortal use for,” and studied anatomy until he found something “fresh to operate on; and at last he got hold of something he calls the nuciform sac, which he’s made quite the fashion.”36 According to Walpole, the nuciform sac is like a physiological fever nest, “full of decaying matter—undigested food and waste products,” and patients, especially women with the “hygienic instinct,” eagerly line up to have the sac surgically removed (Shaw, The Doctor’s Dilemma 14–15). In the introduction to this certainly noncanoncial play, Shaw insists that the tragedy of being ill at the current bacteriological phase of human history is that you are subjected to a profession that has normalized cruelty in the search for knowledge, and has done so primarily for money: “It is simply unscientific to allege or believe that doctors do not under existing circumstances perform unnecessary operations and prolong lucrative illnesses” (Shaw, The Doctor’s Dilemma xv). Moreover, what seems to anger Shaw most pointedly here is that now-familiar concept of surgery as a kind of artistic performance: like
Cobbe, he goes to some length to disparage the experience of surgical *aisthesis* described by vivisectionists like Bernard and Cyon.

An actor, a painter, a composer, an author, may be as selfish as he likes without reproach from the public if only his art is superb. . . . In sacrificing others to himself he is sacrificing them to the public he gratifies; and the public is quite content with that arrangement. The public actually has an interest in an artist's vices.

It has no such interest in the surgeon's vices. The surgeon's art is exercised at its expense, not for its gratification. We do not go to the operating table as we go to the theatre, the picture gallery, to the concert room, to be entertained and delighted; we go to be tormented and maimed lest a worst thing should befall us. (Shaw, *The Doctor's Dilemma* xxxi)

For Shaw, doctoring was an art only when it devoted itself to keeping people in health rather than curing illness, a kind of holistic sanitary medicine that is disappearing, he fears, under the new bacteriology. Under the new reign of surgical science and reductionist medicine, we can “be as dirty as we please.” Our expensive sewerage systems can be dismantled, and nature can once again be allowed to wreak havoc on our water and milk supply. Under the germ theory of disease, Shaw snarked in a 1915 article called “Sanitation vs. Inoculation,” we will be able to “enjoy the blessed relief of getting rid of sanitary questions altogether.”³⁷ In other words, cure will render prevention altogether unnecessary.

Physician William Osler expressed his own concerns about specialty doctoring from a medical perspective clearly enough in 1905, when he declared that the “battle against polypharmacy” and specialism was far from over, insisting that doctors needed wider contact with medical men in other fields to correct an “inevitable tendency to a narrow and perverted vision,” and to restore a subdivided and atomized organism into “a complex whole.”³⁸ But Fabian texts like Shaw's and Carpenter's are especially interesting because they make explicit what most sanitary literature, including fiction, takes for granted: as I pointed out in the second chapter of *The Sanitary Arts*, there is a direct correlation made in these texts between the social body and the individual body, and in both models health manifests itself as a simple unity of parts while disease signifies “the loss of physical unity which constitutes health and so takes the form of warfare or discord between the various parts.”³⁹ I've already discussed this passage from Carpenter's *Civilisation* as evidence that sanitary philosophy was invested in an understanding of social harmony partly inherited from traditional eighteenth-century aes-
hetics; in this chapter, however, it is also important to see that Carpenter’s words underscore the fact that these aesthetic values were thrown into ideological confusion when germ theory threatened a vitalist concept of health. We may remember that Carpenter’s description of social discord in *Civilisation* resembles a medical diagnosis: “in our modern life we find the unity gone which constitutes a true society, and in its place warfare in classes and individuals, abnormal development of some to the detriment of others, and consumption of organisms by masses of social parasites” (2). But medical diagnosis itself is the primary antagonist in *Civilisation*; cellular medicine fractures, fragments, and reduces the body, repressing the whole in favor of parts. Sanitation reform may not be Carpenter’s primary or most explicit goal in *Civilisation*, but the holistic remedies promoted by sanitarians for individual and communal cleanliness are identical to Carpenter’s solution to the problem of civilization.

Fresh air and reasonable garments, cleanliness in the full sense of the word, pleasant work and varied exercise, wholesome and abundant food, the healthful play of our secretions and excretions—these are the things that will enable us to resist while others succumb. . . . The key word of our modern methods is not cure but prevention, and while the task is more complex, it is also far easier. It is to a gigantic system of healthy living, and by a perpetual avoidance of the very beginnings of evil, that our medical science is now leading us. 

Leaving aside, if only temporarily, the eugenic implications of preventive medicine in the hands of Fabians like Shaw, Ellis, and Carpenter, it is important to see that what prevention promised was a “gigantic system,” a bureaucratic control of health and health discourse that was very much defined against the chaos, confusion, and terror represented by the amoral and seemingly unpredictable germ. The sanitary discourse of wholeness, harmony, and discipline that emerged from late-century preventive theories of medicine also continued to represent a social program as an aesthetic feeling, carried out by public policy and governmental control, certainly, but inspired by the emotional and spiritual love of beauty. Shaw, in fact, was deeply committed to the idea that sanitation was itself the dominant aesthetic mode of Socialism: “We owe almost all our immunity from the ancient plagues to the sanitary engineer, to sunshine and fresh air, and soap and water. And the effect of these . . . is purely aesthetic.” Shaw, with the help of his friend Sir Almroth Wright, a leading bacteriologist of the day, apparently even invented a new word to describe this philosophy of sanitation as an aesthetic: Aesthodic.
Importantly, moreover, this Fabian sanitary aesthetic was also invested in preserving the intellectual seat of beauty, the command and control of human beings over lesser organic creatures, the fundamental power of the mind over the body to control the circumstances of existence and the harmonious workings of social life. Announcing “The Need of a Rational and Humane Science” in 1896, Carpenter is clearly envisioning a kind of science directed and restrained by the government, but endorsed and underwritten by Ruskinian, and now Shavian, aesthetics:

If, on the other hand, the science is approached from a quite different side—from that of the love of health, and the desire to make life lovely, beautiful and pure; if the student is filled not only with this, but with a great belief in the essential power of Man, and his command in creation, to control not only all these little microbes whose name is legion, but through his mind all processes of the body; then it is obvious enough that a whole series of different fact will arise before his eyes and become the subject of his study—facts of sanitation, of the laws of cleanly life, diet, clothing, and so forth, methods of control, and the details and practice of the influence of the mental upon the physical part of man—facts quite real with others, equally important, equally numerous perhaps and complex, but forming a totally different range of science.43

Carpenter relies here on the higher intellectual capacity of mankind to subordinate and control the animal pleasures and pains of the physical body. Like Ruskin and profoundly unlike Pater, he equates beauty with health, not just the individual enjoyment of a regular heartbeat and a steady pulse, but an aesthetic pleasure in the laws, methods, and facts that regulate public vitality and produce a harmonious society.

III. Aisthesis, Surgery, and Medical Fiction

Without dismissing too wantonly the profound philosophical and cultural differences between Shaftesbury and Kant on the one hand, and Ruskin, Shaw and Carpenter on the other, what is nevertheless important about this particular strand of aesthetic history is the fundamentally social capacity of art: the shared assumption that art has the power to move the collective pleasures of humankind in the service of orderly and ethical behavior. Over the course of the long nineteenth century, moreover, it seems that the byproduct of this aesthetic philosophy, as Buck-Morss and Leach have argued, was a
compensatory anaesthetic mode. In any aesthetic theory, there is both indulgence and repression: either the “high” intellectual pleasures of the mind must be privileged or the “low” sensations of the physical body must be gratified. While the sanitary commitment to spiritual, environmental and public health anaesthetized the likes and dislikes, pleasures and pains peculiar to individuals, the new physiology had resuscitated the primacy of bodily feeling in aesthetic experience by making the ephemeral and atomized sensations of human existence the definition of life itself. Ideological conflicts like this one between aesthesia and anaesthesia are particularly provocative in fiction, where whole genres are sometimes invented in order to give philosophical struggles narrative form. If the late-Victorian sanitary narrative simply privileges clean art over dirty art and thus forges a new social order based on aesthetic harmony, the medical narrative fundamentally challenges that social order by challenging the faith in mutual pleasures and collective pains that stabilized and sustained the sanitary aesthetic.

Victorian fiction often dramatizes this philosophical conundrum in the personal conflicts of individual characters that are particularly sensitive to personal pleasure and its social meaning. Cherry Underwood, our heroine and painter from *The Pillars of the House*, reappears in Yonge’s 1895 *The Long Vacation*; after a marriage to a now-deceased sculptor, Mr. Grinstead, and a life in the hub of the London art community, Cherry has returned to the bosom of her family, most immediately to nurse her brother Clement through a strange bout of blood poisoning contracted during missionary work in a pestilential village. Cherry is glad that the seaside house they’ve rented for the invalid is a bit shabby, a bit homely, and contains nothing more than is necessary, cleanly, and comforting: “Don’t let us get too dependent on pretty things,” Cherry decides. “They demoralize as much or more than ugly ones. I really get confused sometimes as to what is mere lust of the eye, and what is regard for whatever things are lovely. I believe the principle is really in each case to try whether the high object or the gratification of the senses should stand first.”

The narrative result of Cherry’s philosophical struggle in *The Long Vacation* is that she must eventually cope with the problem of how to display a vulgar and physically graphic terra cotta statue of a “Dirty Boy” that was donated to a charity bazaar. She eventually hides it behind an elegant Monkey Puzzle tree, leaving it to Philistine Cousin Marilda to find the contextual “high object” that saves art from lowness and corruption: Marilda offers to buy “Dirty Boy” to decorate a public bath and wash house that her wealthy husband has recently endowed (Yonge, *The Long Vacation* 209).

*The Long Vacation* solves the problem of vulgar art by cheekily redirecting it to the service of sanitation and the public good; like many sanitary
fictions I’ve discussed in previous chapters, dirty art in Yonge’s novel can be neutralized and cleansed in the service of social and human perfectibility. But the crisis represented by physiological pleasure in medical fiction is seldom dispatched so easily or with such sanitary panache. Dr. Edward Berdoe, antivivisectionist author of *The Rise and Growth of the Healing Art* also contributed a novel to the genre of medical fiction in 1887 with the pseudonymous publication of *St. Bernard’s: The Romance of a Medical Student* by Aescalapius Scalpel. Here, in dark confirmation of all George Bernard Shaw’s suspicions, a group of doctors at a large and well-respected London hospital deliberately prolong diseases and perform unnecessary surgeries for the sake of physiological *aisthesis*, indulging decadent sensory feelings through the work of dissection, vivisection, and variously ineffective therapies. Harrowby Elsworth, our hero and junior physician, is given an initial overview of St. Bernard’s by the house surgeon, Dr. Wilson, that resembles a guided tour at a museum. Making it clear that the doctors always conspire to operate on dying poor patients simply for the sake of experiment, Wilson first shows Elsworth the room of a girl with a rare and interesting skin condition:

No active treatment has been yet suggested as it is much too pretty to spoil by any attempt at a cure just yet. Several surgeons are expected to come from other hospitals to see it, so she has an ounce of peppermint water three times a day and full diet, and the cure is postponed till a sufficient number of interested people have seen it. Drawings must be made; the artist to the hospital could not attend for a week to come; then there were photographs to be taken, and it would never do to commence anything so effective as a cure.⁴⁵

In fact, the surgeons at St. Bernard’s are all amateur artists themselves who sketch and frame the results of their labors for later edification, and even hire professional artists and photographers to make more appealing, emotionally resonant studies. One doctor is hurrying off to sketch a “beautiful optic neuritis” on a dying woman before it disappears forever; another is blistering patients on purpose to see the impact of lithic acid on the blood, and counseling his students to carefully mount their photographs of the pretty acid crystals with an artistic black circle around the covering glass (Berdoe, *St. Bernard’s* 213). A third, Dr. Stanford, forces poor women to undergo gynecological examinations in a medical theater packed with male students in order to give the students “a chance of learning that, for which, they might have paid large sums of money” (290). A fourth, the highly malevolent Dr. Crowe, is described as an “epicure of pain” who prescribes his beautiful Italian wife
chloral at addictive levels, and contemplates her eventual murder as he com-
pletes his rounds (145). Indeed, a patient’s term of residence in the hospital
is understood to be just like “an artist’s model’s visit to a studio,” and the cal-
lousness to pain displayed by most of the senior doctors at St. Bernard’s is
described by our narrator as a reflection of “the true spirit of the artist” (284).

Elsworth is horrified and eventually retreats to Spain, where he travels
through the countryside on a bicycle with a good medicine chest packed with
basic medical appliances. Finding that “healthy life invited healthy thoughts,”
he pursues a cholera epidemic to Granada with little fear for his life: “with the
confidence of God and the wisdom of sanitary precautions which he should
adopt, he decided to do what he could to help the dreadful misery that hung
over the unfortunate city” (255). By chance in Granada he meets the vacation-
ing Mildred Lee, an heiress whose father just happens to be the consulting
physician to St. Bernard’s, and who is, of course, soon joined by potential
suitor and would-be wife murderer, Dr. Crowe. Convinced by Elsworth that
“drugs were nothing but a delusion and a sham, and that nothing but nature
and a good nurse were wanted to cure any complaint amenable to treatment,”
Mildred decides, to the disdain of Crowe, to revolutionize the hospitals of
London, first by endowing Nightingale House, a temperance hospital, and
by hiring Elsworth to work there. They marry (but not before the nefarious
surgeon Crowe successfully murders his wife with experimental poison mush-
rooms, proposes to Mildred, and is ultimately fired), and work together to
reinstate sanitary medicine to its status as the only true form of medical art.

“The psychological mania, the drug mania, and the operative furor will pass
away in time like the craze for bleeding,” these newlyweds believe, “and it
will ultimately be found that it is perfectly possible to cure the sick and save
the limbs of the injured by merciful, honorable and rational means” (473). Of
course, this interesting conclusion to St. Bernard’s returns us to the sanitary
narrative, pitting the virtuous and ultimately triumphant forces of sanitation
against both disease and morally reprehensible aesthetic pleasure. But it also
adds another level of ideological struggle to the story, depicting and resolving
an antagonistic relationship between prevention and cure that closely tracks
those contemporary debates in public health circles about the future of medi-
cal science.

Many Victorian novels similarly thwart the rise of laboratory medicine
with a swift dose of sanitary prevention. One of best known and cruelest
vivisectionists in Victorian fiction, Wilkie Collins’s Dr. Benjulia from the 1883
Heart and Science, is eventually defeated by sensitive physician (and lover of
truth) Ovid Vere, who discovers a manuscript proving that a whole range of
brain and nervous conditions can be cured without experimental medicine,
and consequently, without the practice of vivisection. At the end of the nineteenth century, however, as bacteriology and pathology were gradually normalized, the nightmare of surgical rendition becomes less tractable and less easily ameliorated by cleanliness or a found manuscript; in frightening novels about medical experimentation like Robert Louis Stevenson’s *Dr. Jekyll and Mr. Hyde* (1886) and H. G. Wells’s *The Island of Dr. Moreau* (1896) reductionist science can no longer simply be banished by the sanitary aesthetic. What we more frequently discover in medical fiction published at the end of the nineteenth century is that the aesthetic has been thoroughly co-opted by the sensualists, and that Paterian physiology has only empowered the decadent pleasures of the mutable body. In Ouida’s 1895 *Toxin*, young Sicilian Prince Adrianis falls in love with the Countess Zaranegra in Venice, and initially fears no romantic rivalry from his constant companion, the English doctor Frederic Damer. For a beautiful woman to actually interest Damer, “she must be lying, dead or alive on an operating table” according to Adrianis. The conversation continues:

“Alive by preference,’ said Damer, “the dead are little use to us; their nervous system is still like a stopped clock.”

“A creature must suffer to interest you?”

“Certainly.” (Ouida 42)

Ouida’s Venice here resembles Chadwick’s scene of degradation and decay rather than Ruskin’s aesthetic paradise: the lagoons are home to ancient crimes and corpses that date from the days when the “white marble of St. Marks had been red with blood” (17), and the house that serves as Damer’s laboratory is “obscure and uninviting, standing amidst the clang of copper-smiths’ hammers and the stench of iron-foundries . . . befouled, blackened, filled with smoke and clamour, and vileness” (75). Damer has moved to this degraded neighborhood so that he can practice vivisection without the concern that people will hear the anguished cries of dogs coming from his home; he also conveniently dumps “the dead or half-dead mutilated creatures” (92) into the already polluted water when his experiment is complete. Veronica Zaranegra soon discovers she loves Adrianis and fears Damer; she wants to accept Adrianis’s advances, but finds that Damer exerts a mysterious magnetic influence that paralyzes and prevents her from doing so. She tries to encourage the doctor to leave on the grounds that his medical vocation must require attention and tending: “Aren’t you losing time?” she inquires, reminding us of the image of the stopped clock of the human nervous system. “I never lose time,” replied Damer. “A man of science is like an artist; his art is everywhere, wherever natural forms exist” (80).
The importance of the physical life to Damer’s brand of *aisthesis* is central to the ideological anxiety of *Toxin*, a novel that is deeply suspicious about the power of the anatomical gaze to find art everywhere, except in harmonious and whole, unified and complete, beauty. Wandering in St. Mark’s Square one afternoon, Adrianis is surprised to see Damer contemplating the statuary. “It is too frivolous a scene for you.” Adrianis remarks, “Are you longing to dissect the horses of St. Marks?”

Damer smiled slightly.

“I fear I should find their anatomy faulty. I am no artist, or critic either, or I should venture to say that I object to their attitude. Arrested motion is a thing too momentary to perpetuate in metal or stone.” (99)

Soon after this exchange, a small child falls into the dark, murky water around St. Marks, water that is fetid with sewage, and, of course, dissected animal carcasses. Adrianis jumps in after him, but Damer knows that the child is already infected with “Boulogne Sore Throat,” and that Adrianis will soon catch “what the vulgar call diphtheria” as well (132). No cleansing mechanism or sanitary physician comes to the aid of poor Adrianis, who is sequestered by Damer in a hotel room, and repeatedly inoculated with his so-called cure for the diphtheria virus that is actually just a distilled form of the diphtheria toxin itself. Adrianis dies, and while the novel concludes with a marriage, it is hardly a form of social reconciliation: the deadly Dr. Damer marries a stunned and permanently hypnotized Countess Zaranegra, and the titular “toxin” proves to be a synonym for the irrevocable progress of experimental medicine and the futility and failure of sanitary perfectibility. Art that articulates completion and finish, wholeness without the possibility of decay, is itself dead; while the precarious beauty of the impressionistic body is, for Ouida at least, the future of *aisthesis*. 