THE REFORMER AND THE EUGENICIST: REPRESENTATIONS OF DISEASE IN
JANE EYRE AND *BLEAK HOUSE*

A Thesis
by
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Abstract

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JANE EYRE AND *BLEAK HOUSE*

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My thesis applies the critical lens of disability studies to the public health crisis, and examines the novels *Jane Eyre* and *Bleak House* within that framework. It joins Tobin Siebers, Alison Kafer, and others in criticizing the medical model's negative view of disability, and asks, Is it possible to view medical intervention as necessary without stigmatizing a person disabled by contagious disease?

The Victorian government passed the Public Health Act of 1848, establishing a General Board of Health to oversee the country's sanitary habits in response to epidemics that were decimating the population; however, the Board of Health was retired in 1858 for being ineffective. *Jane Eyre* was written in 1847, a year before the Public Health Act passed, and *Bleak House* in 1853, at the height of the Board's greatest ineffectiveness.

In my chapter on *Jane Eyre*, I argue Brontë uses the Lowood school epidemic to advocate for the creation of a Board of Public Health. She portrays Lowood as a place where the teachers and girls are doing all they can to stay healthy, but, thwarted by the school administration's neglect, succumb to typhus, a disease associated with laziness and dirtiness.

When the typhus outbreak finally subsides, Brontë notes that the epidemic has drawn public attention to the bad conditions at the school. As a result, a nebulous force associated with this public attention is described as bringing about improvements at the school by investigating the situation, making new rules, and providing the girls with better food and clothing. I argue that this is Brontë's portrayal of a formation of a Board of Public Health.

With Helen Burns, Brontë depicts an archetypal Evangelical invalid. This character serves as a contrast to counterbalance the emotionless way Brontë writes about the other Lowood girls, which she uses to convey that the girls are not just a narrative tool to make the reader sad, but rather, are highlighting the reality that clean, well-behaved girls can contract a disease associated with filth and laziness when their needs are neglected.

In my chapter on *Bleak House*, I argue that Dickens uses Jo's and Esther's illness to discuss his society's mistreatment of the ill. In his description of Jo, Dickens at first glance appears to buy into all the worst stereotypes of his era; however, I show he is actually playing on prevalent negative clichés to force his readers to face their own prejudices.

Then, with the help of an incompetent public health bureaucracy, Dickens passes Jo's illness to Esther. In doing this, he uses another tactic to remove the stigma from the illness by infecting a respectable middle class woman with a disease from the slum, thus showing that all people are subject to illness, no matter what their social class. Finally, although

Dickens frames contagious disease as the revenge of the poor on society, he concludes with some small optimism for the future by placing the good Dr. Woodcourt in a government office, thus offering a bit of hope for official regulation of public health in England.

Acknowledgments

First, I would like to thank my thesis committee members Dr. Staub and Dr. Hall for the time they took to read my thesis and to help me improve it. Second, I would like to thank the librarians at Belk Library, Pam Mitchem and Scott Rice, for teaching me how to use the software and helping me work out the technical glitches in the digital map. Finally, I would like to thank my thesis director Dr. Ehnenn for reading *many* drafts, not just of this thesis, but of papers, personal statements, and CVs, always providing prompt, helpful advice, and being an all-around excellent mentor.

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Foreword

A supplement to this project is a digital map with annotations of places that are of interest to the themes discussed in the chapters. There are thirteen entries, and they are divided into four categories: rivers, places of resistance, schools, and London. Each entry provides information that gives context for the novels and the public health reforms in general. Seeing places such as Leicester, Attercliffe, the Thames, and Cowan Bridge Clergy Daughters' School on a map gives a better sense of the actual physical reality of the problems the people of Victorian England were facing. A sense of geography provides an added dimension of historical context that one cannot get from simply reading the texts in isolation.

The map entries may be read all at once, or as they take the reader's fancy, but at the beginning of each chapter, I have listed the names of the entries in the order I recommend, which complements the material in the chapters. The map is hosted on the Belk Library server Omeka, so in order to access it, please go to the following web address:

http://omeka-dev.library.appstate.edu/

From there, click on the link entitled The Geography of the Victorian Public Health Crisis." At the time this thesis was submitted, Omeka had never been used to host a student project before, and Neatline, the program used to create the map, was brand new to Appalachian State, so the library was still trying to decide what was the best way to display students' digital projects on the library's website. Therefore, the actual URL may change after a year or two. Provided Appalachian State continues to use Omeka, the project should be available through the library.

Introduction: The Victorian Public Health Reforms and Disability: An Overview of the

Historical and Critical Context

MAP: The River Tees, Bradford Beck, Rivers Cherwell and Lea, Thames River, Leicester,

Leeds, Attercliffe

The literature of the Victorian era is known for its tendency to sentimentalize or politely ignore the harsh realities of life. In many Victorian novels, even a careful reader could scan every page and never realize that during this time period, tens of thousands of people all over the country were dying from diseases such as small pox, cholera, typhus, and typhoid fever. Hidden behind this squeamishness was a judgmental view of sick people that viewed those who contracted so-called "filth diseases" as responsible for their own misfortunes because of their dirty or immoral lifestyles.

Unlike many of their contemporaries, Charlotte Brontë and Charles Dickens made it a point to bring contagious diseases to their readers' attention and to challenge their culture's stigmatization of the ill. In *Jane Eyre*, Brontë depicts contagious disease in the section of the novel devoted to the young Jane's education at Lowood School, while in *Bleak House*, Dickens forces his readers to acknowledge the power of deadly epidemics in his portrayal of Jo, the homeless offspring of Tom All Alone's, a London slum. Brontë and Dickens both ask their readers to face the danger and prevalence of deadly epidemics, particularly by drawing attention to the way those diseases harmed innocent people. In their novels, these two authors demand something be done to solve the problem, even though they come to different conclusions about what solutions would most effectively serve that purpose. My thesis will

investigate their ideas about the best way to control the public health crisis, and I will

examine their advocacy for the sick through the lens of disability studies.

Historical Context

To begin, it is important to understand the historical setting of the health reforms.

Influenza, small pox, cholera, tuberculosis, typhoid, typhus, scarlet fever, and diphtheria

were the main diseases responsible for the public health crisis in Britain during the 19th

century, particularly before 1850. The numbers are astounding. The list that follows

comprises only a few of the worst epidemics; there were many more: The first cholera

epidemic killed 32,000 people between the years of 1831 and 1832, then small pox claimed

the lives of 42,000 more between the years of 1837 and 1840; an influenza epidemic killed

50,000 between the years of 1847 and 1848, and another cholera epidemic killed 62,000 just

a year later between the years of 1848 and 1849; finally, tuberculosis accounted "for one-

third of all deaths from disease in the Victorian period" (Wohl 128, 130, 133, 118).[1] Illness

and death from illness are common tragedies, as old as civilization; but as growing

populations began moving to the cities, and the disease rates began to rise correspondingly,

the ruling bodies of Victorian England began to realize that epidemics had the power to

wreak disaster on the cities of the industrial era unless the sanitary habits of the public were

somehow controlled.

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[1] Records are not as good for tuberculosis since Wohl reports that, oddly, TB "was not a fully notifiable disease until 1912," meaning that doctors did not have to report cases to the board of health and that official records were not kept on it (Wohl 130). One possible reason might be that TB was a disease common in factories and mines (130). Therefore, requiring TB cases to be reported would have threatened important industries. And of course, it was also considered to be a rather romantic disease of artists, poets, and unrequited lovers, so it could be that the Victorians had difficulty regarding it in the same light as disfiguring, fast-killing diseases such as small pox and cholera.

The Victorian Public Health movement found itself faced with two extremely difficult tasks. First, there was the problem of figuring out how to halt the spread of disease. Each of the diseases that was laying waste to the country had a different cause, usually affected by a combination of factors. What's more, sometimes solving one problem created other problems that were even worse. For example, who could have predicted that a law designed to protect children by ensuring that they attended school would result in the spread of scarlet fever and diphtheria (Wohl 13)? Parents fearing the consequences of the new law sent sick children to school while they were still contagious, thus spreading deadly childhood diseases. Worse still, how were the reformers to know that in combating typhus, they would end up worsening both typhoid and cholera (Wohl 126-127)? The Waterworks Clauses Act of 1847 required that water companies had to supply constant piped water to all dwellings in London, meaning that in slums where running water was newly available, the poor were finally able to wash the body lice out of their clothes effectively on a regular basis, thus greatly reducing the risk of contracting typhus (Hardy 79; Wohl 3). Unfortunately, ready access to running water meant ready access to water closets, which filled the Thames with sewage, creating a perfect breeding ground for waterborne illnesses. Small wonder, then, that the severest of the cholera epidemics took place in that year. Victorian medicine, still largely concerned with the theory of miasma as the chief mode of spreading disease, was ill-equipped to deal with a vicious cocktail of viruses and bacterial infections that would still be intimidating to 21st century doctors. However, one thing they knew needed to change, and that was the filth. Edwin Chadwick writes:

> Such disease, wherever its attacks are frequent, is always found in connexion with
>
> [damp and filth, and close and overcrowded dwellings], and that where those

circumstances are removed by drainage, proper cleansing, better ventilation, and

other means of diminishing atmospheric impurity, the frequency and intensity of such

disease abated; and where the removal of noxious agencies appears to be complete,

such disease almost entirely disappears. (Chadwick 422)

Although they were not always agreed on who was to blame for it, and however ham-

handedly they went about fixing it, the reformers were on this point correct: Environmental

pollution was spreading the epidemics.

The second difficult task they had to face was the tricky business of getting the public

to acknowledge and obey public health legislation. As early as 1427, there had been some

form of governmental regulation of public sanitation in the form of the Assize of Nuisance, a

county court to which people could make formal complaints about nuisances—that is, bad-

smelling things that were thought to be unhealthy, such as middens (domestic waste dumps),

tanneries, pig farms, etc. (Barnett 135). The game changed after the first cholera epidemic.

Cholera, in spite of the fact that there were definitely deadlier diseases and more common

diseases, was the illness that awoke the public to the need for sanitation reform because of

the speed with which it killed its victims, its high fatality rate (40-60% of those who

contracted cholera died), the grotesquerie of its symptoms, and perhaps most unnerving of

all, the fact that no one seemed to be able to figure out what was causing it (Wohl 118). In

response to the first cholera epidemic, temporary local Boards of Health were set up by the

Privy Council to try to address the individual concerns of each town.

About ten years later, Parliament took another important first step towards legislating

public health, and that was making the small pox vaccine available. They passed the

Vaccination Act of 1840, which "enabled everyone to be vaccinated at public expense"

(Wohl 133). Small pox, like cholera, was a terrifying disease—it caused severe permanent scarring from lesions that opened all over the body, and it had roughly a 50% mortality rate, so Parliament did not expect to have trouble attracting people to be vaccinated now that the vaccine—Jenner's lymph—could be had free of charge (133).

Meanwhile, Edwin Chadwick, one of the founders of the infamous Poor Laws, became the instigator of the Public Health movement when, during an investigation for the Poor Law Commission, he came to the conclusion that "ill health, not just laziness, was responsible for destitution" (Barnett 146). He then went on to pen *A Report on the Sanitary Condition of the Laboring Poor*, the report responsible for the formation and passage of the Public Health Act of 1848. This Act empowered local authorities to establish local boards of health, as well as establishing the General Board of Health to oversee the sanitary condition of the whole country (Wohl 149).

As I have mentioned previously, local Boards had already been created by the Privy Council in response to the first cholera epidemic. These first Boards of Health in the early 1830s, such as the one overseeing Islington, one of the outer Boroughs of London, had fairly limited powers. The Board at Islington could oversee springs and rivers, but not drains or sewers since they were privately owned (Kearns 100). There was a single medical officer who could conduct inspections for the entire parish (Kearns 114). And when, much as they had with the Assize of Nuisance, residents brought complaints to the Board of Health, the Board of Health could employ paupers to remove the nuisances and wash the streets (Kearns 106). By contrast, with the passage of the Public Health Act of 1848, Local Boards that applied to the General Board for expansion of their powers had authority over sewers, drains, wells, water supplies, gas works, slaughter houses, cemeteries, parks, etc. (Wohl 149). They

could even purchase land, and most significantly of all, they had control over "houses unfit for human habitation" and "offensive trades" (Wohl 149). And of course, there was the ever present obsession with "nuisance removal"—with the definition of "nuisance" growing ever broader so that it could include virtually any kind of mess the public desired to be removed. Those who did not cooperate with nuisance removal procedures were not tried before a jury, but could be forced to pay the costs (Kearns 103).

The Public Health Act of 1848 had the potential to be extremely powerful— frighteningly so, in fact. Thus, there was substantial public resistance to the Public Health Reforms. Pamela Gilbert argues that one reason for this had to do with the political conflicts over the right to suffrage that were going on at this time. In the early 1800s, only one in six adult males were allowed to vote, and the middle and lower classes were demanding suffrage with increasing urgency (Gilbert 3). Therefore, the sudden onset of a mysterious disease caused some to wonder whether cholera was nothing more than "a bugbear invented to let the powerful take control of the poor's few belongings" (3). Consequently, Gilbert argues, the poor and middle classes embraced varying levels of paranoia in response to the limited ministrations of church, government, and medicine. They feared, among other things, that their dead bodies might be stolen for medical students to dissect, and that government mandates that they clean up nuisances would ruin their businesses and empty their wallets (3-4).

Another instance of resistance took place when Parliament passed the Compulsory Vaccination Act in 1853 requiring all children to get a small pox vaccine. Many felt that the state had overstepped its bounds with health legislation, and in Leicester there was so much

opposition to the Act that the Board of Health received 28,524 conscience clause waiver requests from individuals asking to be excused from getting the vaccine (Wohl 134).

Michael Sigsworth and Michael Worboys in "The Public's View of Public Health in Mid-Victorian Britain" show that plenty of resistance to the health reforms was in fact justified. Health interventions such as nuisance removal and street cleaning were often carried out incompetently, or didn't address the most pressing needs of the people they were intended to help. For example, during the 1849 cholera outbreak, when the fire brigade was sent to sanitize the village of Attercliffe, it disrupted the neighborhood by failing to successfully distinguish between the homes of the sick and the homes of the healthy (Sigsworth and Worboys 243). Worse still, the brigade smashed the village's main source of water, emptied "the contents of privies and middens" onto the streets, and used water from a nearby canal to wash them (243). Consequently, "a second wave of cholera developed in Attercliffe along the route taken by the cleansing team" (243).

As Sigsworth and Worboys record, when the poor were given the opportunity to say what really ailed them, their answer was not a lack of cleanliness, but malnutrition and starvation. At a mass meeting in Merthyr Tydfil, a workers' spokesman said, "The high rate of mortality. . . was caused by the mode of life of the people, working underground, and by want of sufficiency of food, and not by the want of sanitary laws. What we want is more meat" (Sigsworth and Worboys 249). Contrast this to Edwin Chadwick's *Report*, where Chadwick writes:

> high prosperity in respect to employment and wages, and various and abundant food,
>
> have afforded to the laboring classes no exemptions from attacks of epidemic disease,

which have been as frequent and as fatal in periods of commercial and manufacturing

prosperity as in any others. (422)

Chadwick believed that cleanliness was the key to conquering the epidemics, but the

"Laboring Poor" about whom he reported knew that starvation and terrible working

conditions were just as much of a problem as the dirt.

Despite the panic it caused in certain areas of the country, the Public Health Act itself

as well as the General Board of Health it created ended up being rather toothless. Out of all

the towns and cities of England, Wales, and Scotland, only 284 submitted applications to

establish local boards of health during the first five years that the General Board of Health

was in session (Wohl 150). Individual cities were not eager to use the new expanded powers

that were available to them to help them control epidemics. Gerry Kearns provides some

answers as to why that might have been the case in his article about what the General Board

of Health's new rules looked like in practice in Islington after the Public Health Act of 1848.

He writes that residents listed dirty streets as the main threat to public sanitation, and that one

of their main complaints for nuisance removal was their own neighbors' dirty houses (115).

So, Kearns writes that the main responses to cholera carried out by the Board of Health were

"the tremendous number of filthy houses cleaned. . . and the extensive watering of all roads"[2]

(Kearns 118).

Why so much concern with smaller matters when river pollution and industrial waste

were such severe problems? First, there was the simple fact that while it took relatively little

time to remove filth from the roads or to clean a house, it could take weeks to clear a filthy

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[2] In all fairness, cleaning the streets was not as superficial a health concern as it might sound to 21st century readers. Richard Barnett records that there were "3 million tonnes of horse dung deposited on the streets each year," and Kearns points out that one of the biggest environmental concerns of Islington was the live cattle market (Barnett 144; Kearns 98).

drain or to clean up an overflowing privy, let alone to make arrangements for the complete

overhauls of sewerage systems that were actually needed (Kearns 112). Additionally, health

legislation, as it was framed by the Public Health Act—that is, legislation that gave the state

authority to manage the personal habits of the public—was impossible to implement. For

example, Kearns points out that it was unclear who was supposed to pay for the nuisances to

be removed. Landlords refused to be held responsible for the slatternly habits of their

tenants, yet tenants often lacked the funds to clean up whatever nuisances had been attributed

to them (Kearns 122-123). In the end, after the manner of Jarndyce and Jarndyce, legal costs

ended up eating all the funds required to do any major improvements (Kearns 124). The

General Board of Health wasn't even allowed to intervene until the death rate in a district

exceeded 23 per thousand, and even then it was only allowed to force local authorities to

establish a local board, not to actually step in and take action (Wohl 149-50). Wohl

concludes that "the Board's main influence undoubtedly lay in the advice it offered. . . and its

inspections which could scare or shame communities into activity" (153). In other words, the

General Board of Health was Edwin Chadwick's *Report* in human form. All it could do was

draw attention to the shameful circumstances that were staring everyone in the face, and it

was prone to the same problems that Chadwick himself was famous for—an overly self-

righteous tone and an unwillingness to listen to criticism. When the Privy Council finally

dismantled the General Board in 1858, Medical Officer John Simon admitted that they had

exhibited

> a tendency to build overmuch on foundations of small experience, a liability to one-
>
> sidedness on questions of science and administration, a failure to listen duly to

dissenting voices, a deceptive trust in central dictation as the short and ready road to

success, and a too despotic tone in the affairs and personal interest. (Wohl 153)

The General Board of Health was replaced by the medical department of the Privy Council,

which was much more effective at implementing public health legislation.

Charlotte Brontë wrote *Jane Eyre*, which I argue contains an earnest plea for

government involvement in public health management, in 1848, a year before the first Public

Health Act was passed in response to Chadwick's *Report.* Meanwhile, Dickens's *Bleak*

House, which was written in installments between the years 1852 and 1853 at the height of

the General Board of Health's greatest ineffectiveness, is a cynical condemnation of the

continued failure of reform to help the poor.

The Victorian Public Health Reforms and Disability Theory

How does one address contagious illness through the lens of disability studies? The

question has proven to be more difficult than it first appeared on the surface.

Tobin Siebers provides a good starting place in *Disability Theory* when he states that

disability studies' "reason for being is to speak about, for, and with disabled people" (Siebers

5). Siebers views disability, not as "statistical, fixed in time, or exclusively biological, but as

a politicized identity possessing the ability to offer social critiques" (22). He argues that

people with disabilities are needlessly marginalized from society, and needlessly pitied or

feared. Siebers writes, "Many disability theorists—and I count myself among them—would

argue that disability as an identity is never negative" (4). He adds that the ideal of a perfectly

able body is nothing but a myth, and that sooner or later, virtually everyone, as old age sets

in, will find themselves disabled in some way. In addition to articulating his own positive

view, Siebers writes that disabled people also ought to take a positive view of their own disabilities: "In almost every case, however, people with disabilities have a better chance of future happiness and health if they accept their disability as a positive identity and benefit from the knowledge embodied in it" (27). However, it is when Siebers describes his approach in contrast to what he calls "the medical model" that we see the difficulty of addressing contagious epidemics through a disability studies lens:

> Unlike the medical approach, the emerging field of disability studies defines disability not as an individual defect but as the product of social injustice, one that requires not the cure or elimination of the defective person but significant changes in the social and built environment. Disability studies does not treat disease or disability, hoping to cure or avoid them; it studies the social meanings, symbols, and stigmas attached to disability identity and asks how they relate to enforced systems of exclusion and oppression, attacking widespread belief that having an able body and mind determines whether one is a quality human being. (4)

Siebers reserves some harsh words for the medical approach to disabilities. He writes that the medical model "labels individuals as defective," and worse still, "defines disability as an individual defect lodged in the person, a defect that must be cured or eliminated if the person is to achieve full capacity as a human being" (25, 3).

Alison Kafer elaborates on the critique of the medical model in *Feminist, Queer, Crip*. She writes:

> in the. . .medical models, disability is cast as a problematic characteristic inherent in particular bodies and minds. Solving the problem of disability, then, means correcting, normalizing, or eliminating the pathological individual, rendering a

medical approach to disability the only appropriate approach. The future of disability

is understood more in terms of medical research, individual treatments, and familial

assistance than increased social supports or widespread social change. (5)

Kafer also challenges an overly extreme view in the other direction, which "can marginalize

those disabled people who are interested in medical interventions or cures" (7). She adds:

This is not to say that medical intervention has no place in my political/relational

model. . . . [R]ather than simply take such intervention for granted, it recognizes

instead that medical representations, diagnoses, and treatments of bodily variation are

imbued with ideological biases about what constitutes normalcy and deviance. (6)

A public health perspective, particularly one as heavily based in statistics as the

Chadwickean perspective, definitely did view contagious illnesses, and by extension, people

who had contracted those illnesses, as problems that needed to be fixed. Siebers and Kafer

would most certainly have taken issue with the Victorian Sanitary Reformers' attitudes, but

what would they have put forth as an alternative? As I have shown in the last section, the

situation was quite urgent. Is it really possible to do what is necessary to protect public

health in such extreme circumstances *and* respect the rights of the disabled?

Diane Price Herndl offers a tentative solution when she argues that disease does not

fall into the same category as disability in her article "Disease versus Disability." Therefore,

people with contagious illnesses are simply not entitled to the same rights as people with

disabilities. She writes:

There are important reasons to maintain a distinction between the two states, if only

so that we do not dilute the definition of disability to the point that it loses its political

efficacy. If we are all disabled in some way, then we cannot possibly discriminate

against the disabled, and there can be no legal protections and no serious attempts at
making venues accessible. By the same token, if all disabilities are seen as illnesses,
then it becomes almost impossible to refuse medical interventions aimed at
eliminating difference. (594)

Instead, she distinguishes between disease and disability by defining disabilities as conditions
that are ontological rather than temporary, that are defined by the patient rather than the
practitioner, that are accommodated rather than cured, and that are represented as a difficulty
or a change of mode (594). By contrast, diseases are temporary, defined by the practitioner,
are to be cured rather than accommodated, and are represented as a tragedy or the "end-of-
life-as-we-know-it" (594).

There are some problems with these definitions. At the beginning of the article,
Herndl writes of the difficulty of classifying various conditions as either diseases or
disabilities: "There are some obvious conditions that are easily distinguished—the flu is not a
disability, and a missing a limb is not a disease—but how should we classify post-polio
syndrome? cancer? AIDS?" (593). Herndl's list of five ways to distinguish between disease
and disability is important, pragmatically speaking, since she is endeavoring to delineate
when it is reasonable for the disabled to demand accommodation for their needs; however,
the criteria feel rather shaky, particularly in contrast to Kafer's generous inclusivity, which
even finds a place for the able-bodied "claiming crip" (Kafer 13). The shakiness becomes
shakier still when the illnesses addressed are from the 19th century rather than the 21st. As I
have already pointed out (and as will serve a greater significance in subsequent chapters),
many different diseases were infecting the populace of 19th century England at the same time,
and Victorian medical practitioners hadn't yet learned how to distinguish effectively between

them, let alone how to cure them. In the Victorian Public Health Crisis, patients who became ill very likely did not know the time or duration of their illness, let alone how the disease would affect them if they survived. Additionally, when Herndl writes that the goals of disease and disability are different—cure vs. accommodation—that is once again based on the 21st century assumption that a cure is readily available. Pre-penicillin, pre-germ theory, accommodation with a hope for recovery was the only option for most illnesses, and many people who contracted severe illnesses such as small pox or typhoid could expect to experience scarring, weakness, or difficulty breathing for the rest of their lives. With these factors eliminated, Herndl's definition of who is sick versus who is disabled is much less conclusive. All that is left are her assertions that diseases are defined by the doctor and are represented as tragedies, while disabilities are defined by the patient and are represented as changes to which one must adapt (Herndl 594). In light of the fact that complete recovery was so unpredictable for most sick people, even the distinction between tragedy and change becomes increasingly hazy. Herndl's attempts to draw some sort of line between disease and disability provides the beginnings of a framework for considering how to define disability in legal terms, but it fails to produce any consistent system of categorization.

Meanwhile, a closer look at some studies of illness during the Victorian era provides another angle from which to view the problem of contagious illness as a disability. Maria Frawley's *Invalidism and Identity in Nineteenth-Century Britain* offers some useful patterns for understanding Victorian attitudes about illness. One of Frawley's central observations is that the invalid "almost by definition signified medicine's inability to ensure recovery" (Frawley 5). Frawley discusses the ways that some invalids, as figures beyond the reach of professional help, could occupy either a somewhat mystical status, or could get away with

idleness by faking illness (17). Thus, their narratives usually "opt[ed] not to provide specifics about their medical histories," making it difficult for a reader "to reconstruct their experiences through a medical model of symptom diagnosis, treatment, and response" (4). In spite of this, we can still gather a little information about what ailed the invalids: Frawley generalizes that they were incapacitated by a few specific illnesses—gout for the very rich, overwork or "shattered nerves" for the middle classes, and, of course, the ubiquitous consumption for everyone (31). Additionally, she writes that many writers of invalid narratives viewed their sickness through an Evangelical lens of finding meaning in suffering. This perspective "suggests that extended or acute illness was assumed to be conducive to the self-examination and soul-searching necessary to those charting the progress of their spiritual journeys" (36).

As for the Public Health movement, Frawley argues the advent of a less personal and more scientific method of medicine changed the way invalids viewed themselves, their doctors, and their illnesses. She writes, "Even though nineteenth-century patients may have felt diminished as persons in the eyes of their physicians, the increased scientific attention to their internal sensations seems likely to have legitimized self-scrutiny of their aches and pains" (58). Consequently, "To the extent that many Victorian invalids were deemed incurable and hence beyond the reach of medicine, they must be regarded as very particular kinds of patients," and accordingly awarded the status of a special person with special wisdom (59). This special wisdom meant that "Whereas some invalids opted to take on the persona of the confessor, others appropriated the role of spiritual counselor" (61). For many invalids their identity as invalids "supersede[d] other dimensions of their personhood" (12).

Meanwhile, this exalted view of invalids was in stark contrast to the Victorians'

horror of the actual details of disease. Disease is spread through excrement, sex, corpses, insects, and rats, and Peter Stallybrass and Allon White, and David Pike analyze these most denigrated realities of human existence in their studies of the abject. Stallybrass and White open up the conversation in their chapter "The City: the Sewer, the Gaze, and the Contaminating Touch" in *The Politics and Poetics of Transgression*. In this chapter, Stallybrass and White examine the ways the bourgeois concept of the inherent filthiness of the lower classes caused them to equate the people themselves with the waste and excrement they created, and they outline some insights into Victorian views of prostitution which David Pike goes on to explore in greater detail. As evidence, they reinterpret Freud's accounts of patients who were obsessed with sewer rats or feces. Freud identified these patients' oddities as various types of anal fixations, but Stallybrass and White argue that their stories are manifestations of the ways the bourgeois were both fascinated and repelled by the filth they were always trying to tidy away (113).

Pike borrows heavily from Stallybrass and White in "Sewage Treatments: Vertical Space and Waste in Nineteenth-Century Paris and London," in which he analyzes the symbolism of the sewer in French and British writing during the nineteenth century. In Britain, while the Victorians in general hated thinking about filth, their society's affirmation of the productivity of the sewer could be seen in conventional wisdom about sewer workers, and in the unexpected respect Henry Mayhew shows in *London Labour and the London Poor* to those who make their living by searching the sewer for valuable things others have thrown away—in Victorian slang, "toshers," "pure-finders," and "mudlarks." Pike concludes that the sewer, in providing the opportunity to control waste, makes it possible for society to come to terms with and accept the reality of filth without being threatened by it (67).

Unfortunately, the Victorian reformers' efforts to contain the abject by consolidating sewage into the Thames and flushing it from their houses actually ended up sacrificing the lives of thousands of people who lived in the slums to cholera and typhoid. As Stallybrass and White observe, the most important aspect of the symbolism of filth is the way it caused the reformers to dehumanize the poor.

Martha Stoddard Holmes calls these overly emotional Victorian attitudes to account in *Fictions of Affliction: Physical Disability in Victorian Culture*. In melodramatic narratives, Stoddard Holmes writes, "Disability is melodramatic machinery, a simple tool for cranking open feelings, and everyone involved—disabled and nondisabled, viewers and actors—is somehow placed and defined by what floods out" (3). This oversimplification and sentimentalization distorted the actual experience of disability. Thus, she argues that melodramatic depictions of disability perpetuated the Victorians' discriminatory treatment of the disabled: "Emotional excess makes and marks the distinction between able and disabled bodies, building a boundary that helps assess such questions as who is fit to work or receive poor relief, or who is fit to marry and reproduce" (31). Her final criticism is that melodrama gives a false sense of resolution. She adds, "the formulaic endings of melodrama, in which the emotional overflow of the middles is neatly put to rest, offered a mode in which to imaginatively resolve tensions that in reality were much too complex to settle with a closing curtain or final chapter" (5).

Stoddard Holmes and Frawley provide us with a good framework for thinking about individual invalids through the lens of disability studies, but how does one view an entire epidemic? A closer parallel exists in the form of current disability studies scholarship on AIDS.

Cindy Patton's article "Rights Language and HIV Treatment: Universal Care or Population Control?" goes into more depth as it outlines some of the problems with our current methods of dealing with AIDS. It is remarkable how closely the actions we take today mirror the actions of the Victorian public health reformers. Patton begins by quoting the list of rights to which World Health Organization director General Margaret Chan declared people living with HIV were entitled. She said, "People living with HIV should not only enjoy their right to health but also their right to access crucial social services such as education, employment, housing, social security and even asylum in some cases" (251 quoted in Patton). Patton replies, "Incommensurable with this hard won and nearly three-decade-old approach to health and human rights in the context of AIDS is the newly minted rubric of treatment-as-prevention" (252). She later goes on to add, "Treatment-as-prevention programs require testing and mandatory treatment on a scale seen only in dictatorships" (263). Patton is not arguing that people with AIDS should not get treated, but that the rhetoric of treatment-as-prevention allows society to sweep people with AIDS out of sight with the promise of a quick fix, when they really need protection from discrimination. This dismissive view she describes as "witnessing disease" (255). She writes,

> *Witnessing disease* is the observation of the epidemic from the point of view of those who imagine themselves not subject to disease, a disembodied meta-vision characteristic both of epidemiologists and research scientists who 'see' the epidemic through statistical means, and also of the public officials who deploy that science as policy by speaking from the point of view of "the public." (255 emphasis hers).

As evidence, she quotes the following paper, entitled "Expanding access to HAART: a cost-effective approach for treating and preventing HIV," as an example of a soulless money-centered approach to controlling AIDS:

> Objective: HIV continues to present a substantial global health burden. Given the high direct medical costs associated with the disease, prevention of new transmission is an important element in limiting economic burden. . . . In addition to providing therapeutic benefit, treatment with HAART has potential to prevent transmission of HIV. The objective in this study was to perform an economic evaluation of the incremental net benefit associated with an intervention to expand treatment with HAART in British Columbia, Canada.
>
> Results: Over 30 years, the HAART expansion scenario was associated with a net benefit of US $900 million. . .
>
> Conclusion: Increasing the HAART treatment rate from 50 to 75% of clinically eligible individuals in British Columbia appears to be a cost-effective strategy based on this model. (253)

As Patton, Sigsworth and Worboys, and Wohl have all pointed out, and as the disability theorists have hinted at with their criticisms of the medical model, the prevention as treatment plan is too simple. It assumes that the cause of the illness can be pinned down to a single factor or two, that a quick fix is possible, that the sick person can be shunted to one side once a simple cure is administered, and that if a person becomes ill when prevention is available, then the sick person must be at fault for the disease.

Still, it is too easy for us to blame the reformers in hindsight. For example Patton writes indignantly that some legislation for the rights of people living with AIDS was

unenforceable, but then ends her essay with the clarion call, "justice is justice, regardless of the price tag," without considering that unenforceable legislation is usually impractical because it is too expensive (264). Patton doesn't acknowledge that justice always has a price tag, or that saving funds actually does save lives. This is particularly clear in the odd way her essay skates over sub-Saharan Africa, where the vast majority of people with AIDS live. Though she talks about the World Health Organization, and about AIDS in South Africa, China, America, and Europe, she only vaguely mentions "the third world" in passing at the end of the essay. The survival of people living with AIDS in the third world depends on keeping the price tag of justice low. It was the same for the poor of Victorian England. Compare the quote from Patton's study to the following statement Thomas Southwood Smith made in 1839 about the economic effects of the epidemics:

> It is plain this disease [fever] is one of the main causes of the pressure on the poor rates. This pressure must continue and the same large amount of money spent year after year for the support of families afflicted with fever, as long as the dreadful *sources* of fever which encompass the habitations of the poor are allowed to remain. (quoted in Wohl 146)

In Victorian England, too, the prevention-as-treatment approach was thought of as a means of saving money as well as lives, but Southwood Smith realized that the costs of taking care of poor people when they were sick were impossible for the state to pay for. Preventing their illness meant they could survive. As my thesis will demonstrate, Brontë's and Dickens's novels are so remarkable because they identified the complexities behind the attitudes of the people who wanted to help the sick, and they passed their own verdicts on whether the systems that were in place had a chance of success.

Emily F. Nye's article "The Rhetoric of AIDS: A New Taxonomy" provides another effective parallel for regarding a deadly epidemic through the lens of disability studies. In her section entitled "AIDS the Reformer," Nye discusses the way people living with AIDS and the gay community in the United States tried to manage the spread of disease in the 1980s. She writes:

> Studies by the Centers for Disease Control revealed that the virus was passed through sex at bathhouses in New York and San Francisco, and that multiple sexual contacts quickly spread AIDS. As gay men saw increasing numbers of deaths in their communities, they began to change their behavior, have fewer sexual partners, and partake in "safe sex." (238)

These efforts then had consequences on the ways both communities viewed themselves and each other. Nye adds, "the gay movement shifted from self-exploration (and self-alienation) to an outward and politically focused movement," giving as examples such creative awareness-raising endeavors as the AIDS quilt, *Angels in America*, and *A Silver Lake Life*. She then concludes, "In some ways, AIDS has forced communities to see their divisions and make changes" (238).

Nye also gives some examples of how to view people with contagious diseases as a disability community. She writes, "People with AIDS experience loss of control: control of their bodies and often their lives" (239). Part of the work of advocating for people with AIDS and other illnesses is to help restore that control. She then offers the opinion, derived from Norman Cousins, that everyone "must accept responsibility for recovering from a disease or dealing with a disability. . . . A sense of purpose, along with a will to live, are also crucial qualities for survival, as are peace of mind and acceptance" (239). Finally, she

concludes with a view of AIDS patients that bears a little resemblance to Frawley's description of the Victorian view of invalids. She writes, "Many people with AIDS have shown great heroism and have taught others about death. . . . These educators, in effect, help keep down the number of new members of the community, while trying to make others more sensitive to those who have AIDS" (241). Clearly, communities of people living with AIDS are different from other disability communities. While, like most disability communities, people living with AIDS advocate for accommodations, unlike other disability communities, they also try to raise awareness to help keep AIDS—the disability that defines their community—from spreading. In the disability perspective Nye describes, the attitudes of advocacy, community support, and disease prevention are not contradictory. It is a happy medium between the medical model and the disability studies model.

Chapter Outline and Justification

With this historical research and theoretical framework informing my thesis, I plan to explore how Dickens and Brontë interact with the debates about the public health reforms taking place around them. These two authors wanted their readers to see it was possible for blameless people to become ill, but they also understood the origins of their society's prejudice. They acknowledged the realities that at times, those who helped the sick became sick themselves, and that some people truly did become ill because of their unwise life choices. Dickens and Brontë show their nuanced understanding of disability in the ways they discuss a major force in the lives of their contemporaries, and they use remarkably similar techniques to get their respective points across.

My thesis is comprised of three parts: a chapter on *Bleak House*, a chapter on *Jane*

Eyre, and a digital map of public health events.

In Chapter I, entitled "*Jane Eyre*: Charlotte Brontë as Public Health Activist," I will argue that in *Jane Eyre* Charlotte Brontë combats the stigma her society placed on the body disabled by disease by advocating for a Board of Health to be created. From her perspective, when people became ill because their basic needs were neglected, the primary purpose of the Board of Health would be to protect these people by regulating the environmental factors that were beyond the sick person's control. Brontë goes about this by depicting the typhus epidemic at Lowood School, which carries off a few dozen nameless girls, almost without comment. However, while Brontë uses this impersonal, emotionless tone to convey the gravity of the girls' plight, in the same chapter she tells the sentimental story of the passing of Helen Burns, an archetypal Victorian invalid in virtually every respect, except, perhaps that we know the origin of her sickness. Brontë dispatches the Lowood girls with an economy of words that would have done credit to Hemmingway, but she does not miss the opportunity to play to Victorian melodramatic sensibilities in the forms Martha Stoddard Holmes most criticizes. Because of this narrative decision, the reader remembers the Lowood girls. As I will show, Brontë uses the invalid as a melodramatic tool, but she does so as a means of advocating for those disabled by disease.

In Chapter II, entitled "*Bleak House*: The Pragmatism Behind the Melodrama," I point out that while *Jane Eyre* was written in 1847, the year before the first significant health reform law—the Public Health Act of 1848—was passed, *Bleak House* was written in 1853, after five unproductive years of health reforms. No improvements would be made on the Public Health Act for a further thirteen years. Therefore, Dickens's much more cynical *Bleak House* concludes government intervention had been unsuccessful. He does something

similar to what Brontë does with the Lowood girls in his characterization of Jo; Jo is intentionally made unremarkable, while also being absolved from any blame for his sad fate. However when Jo dies, it is not because of a lack of government intervention, but because the government forces set up to take care of him failed to do their duty. And, again, like Brontë, Dickens follows up this unconventional characterization of an invalid with a much more conventional invalid in the person of Esther Summerson. Both authors ensure that they draw as many sympathetic tears as possible in order to effectively persuade their readers.

Finally, I will end with a short concluding chapter in which I express these two books' relationships to each other, discuss the future of the health reforms, and suggest the theoretical implications of the study.

I believe my thesis makes some important contributions to the field. While there is plenty of scholarship about reform, and plenty of scholarship about *Bleak House* and *Jane Eyre*, there is not as much about the public health reforms. The historical aspects of my thesis, I believe, will help to fill some of those gaps. However, I think the most promising scholarly contribution my thesis will make is its take on disability studies. Disability studies centers around accepting disabled bodies and reining in society's insistence on controlling and changing bodies that fail to fit the norm. Naturally, then, a difficult topic for disability studies is contagious disease. The problem my topic poses to disability studies is that society's desire to control bodies disabled by contagious disease is based on more than just prejudice—contagious diseases, unlike other disabilities, really can affect and under extreme circumstances (such as those of 19th century England) even kill people who come into contact with them; nevertheless, people with contagious diseases also need advocates. I analyze the ways the Victorians attempted to address those realities, and I show that even

though their concerns about contagion were valid, their methods and their assumptions concealed a sinister compulsion to enforce sameness, and to punish those who did not conform. At the same time, I also ask the question, "Is it possible to control an epidemic without stigmatizing the non-normate body, and if so, how?" I provide two possible answers for that question by describing what I think Dickens and Brontë believed, based on what they wrote in *Jane Eyre* and *Bleak House*.

Chapter 1: *Jane Eyre*: Charlotte Brontë as Public Health Activist

MAP: Woodhouse Grove School, Drouet's Orphanage, Cowan Bridge Clergy Daughters'

School

Invalids abound in *Jane Eyre*, from the unrepentant Aunt Reed to the angelic Helen

Burns, and many scholars have analyzed these characters through a disability studies lens.

However, one group of invalids in *Jane Eyre* has not received extensive critical attention: the

victims of the typhus epidemic at Lowood school. These girls inhabit bodies disabled by a

stigmatizing disease—bodies their society insisted on either cleansing away or changing. In

this chapter, I argue that the Lowood school epidemic represents Brontë's conclusions about

the right way to manage public health.

While England was still reeling from the first cholera outbreak, Charlotte Brontë

wrote *Jane Eyre* in 1847, one year before the Public Health Act was passed. Her portrayal of

the typhus epidemic in Lowood School addresses the assumptions driving public resistance

to the health reforms and presents us with her take on how best to prevent the spread of

disease. In this chapter, I argue Brontë uses a spare, blunt description of the girls with typhus

to shock readers with the terrible consequences of institutional neglect. Meanwhile, her more

familiar melodramatic portrayal of Helen Burns supplies the pathos missing from such a

description, thereby making the scene more palatable to her readers. Finally, I show how the

actions the wealthy people of Lowton take to help the school provide a possible vision of a

Board of Health, which I argue advocates for the disabled as a community, while still managing to control the spread of contagious disease.

Surprisingly, the role of public health in *Jane Eyre* has invited little critical attention; nevertheless, a few scholars have analyzed the Lowood epidemic. Criticism on this topic generally falls into two camps: the historical and the narratological.

First, Miriam Bailin provides a narratological perspective in *The Sickroom in Victorian Fiction*. The trends she notes in her chapter on *Shirley* clearly apply to *Jane Eyre* as well. Bailin writes that the role of disease in Brontë's novels demonstrates how the

heroine's advancement and accommodation are achieved not through a fundamental

alteration of the established order, but through its inversion. Thus, deprivation and

dependency are portrayed as fulfillment, confinement as liberty, the latent as the

manifest, the periphery as the center, and incapacitation as power. (51-52)

Bailin applies this paradigm to *Jane Eyre* first by examining Brontë's curious choice to have Jane's happily-ever-after home be in the unhealthy Ferndean with a maimed husband. Bailin writes that she will analyze

. . .not so much the symbolic significance of his disability as its outcome—the

'perfect concord' of the sickroom relation which here, as elsewhere, seems be

predicated on the exorcism of all potential sources of discord in a fusion of identity so

complete and so secluded from others that it appears invulnerable to rival affections,

breaches of trust, or even differences of perception. (71)

Bailin argues that this use of the sickroom as the locus of perfect, sheltered unity, and illness as the means of attaining happiness, reflects the Brontë sisters' own shyness, shelteredness, and inability to mix with society. Within this framework, Bailin spares a sentence or two for

the epidemic at Lowood. She writes, "Even the typhus fever that killed the elder Brontë sisters. . . could, according to this emotional and experiential logic, be represented in *Jane Eyre* as the occasion for liberation from the enforced deprivations of Lowood School" (72). In other words, every sickness in *Jane Eyre* has its corresponding positive result.

Although Bailin correctly argues the epidemic eventually produces positive benefits for Jane, this is the only way the Lowood epidemic bears any resemblance to the other illnesses she discusses in her study. Brontë tells us "semi-starvation and neglected colds"— in other words, deprivation and dependency—"predisposed most of the pupils" to contract the disease that will kill them (85). The girls who become sick are not empowered, liberated, or fulfilled by their illness; instead, they die anonymous deaths and are listed as a statistic: "Forty-five out of the eighty girls lay ill at a time," Jane tells us (85). Helen, too, dies in isolation. Her father and whatever other family are said to be waiting for her in Scotland do not come to visit her, and she is buried "in Brocklebridge churchyard," by the school (91).

While Bailin examines *Jane Eyre* in the context of Brontë's other novels, Jerome Beaty examines it in the context of Victorian school stories in general. Beaty objects to the common interpretation of Lowood school as a purely autobiographical incident, and instead argues that this unpleasant school and the illness that spreads through it participate in a particular literary convention. He gives several examples of how closely Lowood School resembles the schools in Dickens's novels, such as Dotheboys Hall in *Nicholas Nickleby*. As for the epidemic, Beaty focuses exclusively on Helen Burns's death from consumption, arguing that she is not just an autobiographical parallel to the death of Charlotte Brontë's sister Maria at Cowan Bridge Clergy Daughters' School, but also that she participates in the Victorian habit of featuring tragic infant deaths in their novels (38). He points out that Helen

is "preternaturally informed on religious matters," and that her death seems to exemplify the kind of reproach issued by the Reverend William Carus Wilson that "the greatest part of the human race die at infancy" (38). In response, he alleges that Carus Wilson "may be exaggerating just a little," and concludes rather cynically that "child deaths in Victorian novels are as common as explicit sex in modern novels" (38).

Although Beaty's arguments about *Jane Eyre* are persuasive, the concepts he applies to the Lowood epidemic do not entirely fit. For example, he focuses so heavily on ways in which Brontë's account parallels archetypal literary patterns that he misses the things that set it apart. First, he neglects to mention the most obvious difference: Lowood is a girls' school, and thus a completely different education experience from the schools in Dickens' novels. Dickens portrays school as an environment where the boys are isolated, abused physically, and pitted against instructors who are either hostile or helpless. By contrast, Brontë's Lowood depicts an environment where teachers and students ally with each other against patriarchy. Most of the actual teachers at the school are portrayed as sympathetic: although Miss Scatcherd and Mrs. Harden the cook are disagreeable, Miss Temple is supportive and kind, the French teacher Madame Pierrot is "not a bad sort of person," and Miss Miller "praised [Jane] warmly" when she "reached the top of [her class]" (61,77). Meanwhile it is Mr. Brocklehurst who humiliates Jane and starves the students. The camaraderie between the women in opposition to Mr. Brocklehurst is most evident when he shames the student with natural curls. Brocklehurst requires the other girls to turn around so he can inspect their hair, but rather than cowering in fear of his judgment, the girls show their contempt for him the minute he can no longer see their faces:

Miss Temple passed her handkerchief over her lips, as if to smooth away the involuntary smile that curled them; she gave the order, however, and when the first class could take in what was required of them, they obeyed. Leaning a little back on my bench, I could see the looks and grimaces with which they commented on this maneuver: it was a pity Mr. Brocklehurst could not see them too; he would perhaps have felt that, whatever he might do with the outside of the cup and platter, the inside was further beyond his interference than he imagined. (73)

This passage contains the key to *Jane Eyre*'s stance on public health: The women who run the school and the students themselves are doing everything they can to create a healthy educational environment. Yet despite their best efforts, the administration's disregard for the students' basic needs disrupts the classroom and causes the epidemic.

The other significant difference between Lowood and Dickens's oppressive schools is the typhus outbreak. Firstly, Beaty compares Helen Burns's demise to a sentimental infant death, and pokes fun at her for being "preternaturally informed on religious matters," but he addresses neither the fact that Helen is "a great girl" and an avid reader rather than a child, nor the multitude of other child deaths surrounding hers—deaths from typhus, a stigmatized disease associated with poverty, dirtiness, and laziness (Beaty 38; Brontë 62). The purely narratological approach is missing something important about the story.

In "Was It Really Typhus," Jack Roberts takes a more historical approach to the Lowood epidemic when he examines Lowood's real-life counterpart—Cowan Bridge Clergy Daughter's School. Roberts tells us the Victorians conflated typhus and typhoid fever and could not distinguish between the two until 1869 (Roberts 49; Wohl 125). Some kinds of typhus can be spread by ticks and rat fleas, but the only form that could become a deadly

epidemic was spread by body lice. Roberts maintains that the emphasis placed on grooming and bathing in both the real Cowan Bridge and the fictional Lowood School makes it unlikely the girls would have been susceptible (50-51). Instead, Roberts argues Brontë and the authorities of Cowan Bridge made the same mistake most physicians of the first half of the 19th century made, and misidentified as typhus the much deadlier typhoid fever, which was spread through contaminated food and water. As evidence, Roberts observes that there was only one privy for all of Cowan Bridge, and their water was probably provided by a well (51). He also takes note of a cringeworthy example of poor kitchen sanitation: "A letter from a contemporary of Charlotte's at Cowan Bridge records being sent to fetch a cup of tea for a teacher, and the cook, having no teaspoon to hand, stirred the tea with her finger whilst being engaged in the cutting up of raw meat at the time" (52-53). Thus, Roberts concludes, while little evidence suggests the girls at Charlotte's school had body lice, there is plenty of evidence their food and water were contaminated. The poor conditions at Cowan Bridge are mirrored by the conditions at Lowood: Brontë lists "the brackish, fetid water used in [the] preparation [of food]" as one of the factors responsible for spreading the epidemic (91). Therefore, Roberts concludes the "typhus" at Cowan Bridge, and by extension, the "typhus" at Lowood were most likely typhoid fever, rather than actual typhus.

The distinction is significant because while typhus was a disease caused by inadequate bathing, and therefore carried the stigma of slovenliness, typhoid fever, like cholera, was part of what is now known as "The Water Crisis" in England—or the results of a growing population using the same water sources for drinking and sewer. In other words, before Victorian physicians understood that what they thought was typhus could be caused by factors beyond the patient's control, Brontë saw that this supposed "filth disease" could

afflict clean-living, well-behaved girls. Consequently, she portrays the Lowood students as such and lays the blame for the epidemic not on the girls themselves, but on the person who was supposed to be taking care of them—Mr. Brocklehurst.

Meanwhile, in "*Jane Eyre* and Victorian Medical Geography," Alan Bewell addresses how Victorian ideas about disease, bad and good air, and imperialism all play an important part in a complete reading of *Jane Eyre*. Arguing that bad air causes the epidemic, Bewell writes, "in the 1870s, the dominant model of disease transmission was not that of contagion, but of contamination, as people were believed to become sick from the noxious *air* produced by the *places* where they lived. It was not so much people, therefore, but places that were sick" (776). He shows how reformers such as Richard Miller and Edwin Chadwick believed the spread of disease could be controlled by keeping people away from unhealthy places, such as "cemeteries, cesspools, marshes, tanneries, or slaughterhouses," as well as "narrow, airless, and crowded" places (777). Bewell suggests Brontë, too, believed disease was caused by unhealthy places. As evidence, he points to the passage in the novel where Jane tells us:

> That forest-dell, where Lowood lay, was the cradle of fog and fog-bred pestilence;
> which, quickening with the quickening spring, crept into the Orphan Asylum,
> breathed typhus through its crowded school-room and dormitory, and, ere May
> arrived, transformed the seminary into an hospital. (85)

While this quote indicates Jane viewed miasma as a means for disease transmission, Bewell does not give either Brontë or Victorian doctors enough credit for understanding how diseases like typhus were spread. When he writes, "in the 1870s the dominant model of disease transmission" was miasma, he only acknowledges one side of what was a heated

debate as early as the 1840s, when *Jane Eyre* was written. As Sigsworth and Worboys have

shown, the working class believed exhaustion and lack of food made them vulnerable, while

Barnett's *Sick City* and Chadwick's *Report* show the Victorian upper classes believed

dirtiness, intemperance, and laziness contributed to the spread of disease (Barnett 146). By

contrast, Brontë's understanding of other factors is quite sophisticated (85). First, she reports

that "some died at the school, and were buried quietly and quickly; the nature of the malady

forbidding delay," thus indicating that the authorities running the school realized it was not

merely the unhealthy places that were causing the disease, but also proximity to infected

bodies. Also, when Brontë observes that "the brackish fetid water used in [food]

preparation" and "the pupils' wretched clothing" attracted "public attention," she accurately

describes the ways both typhoid fever and typhus were spread—water contaminated by fecal

matter, and the body lice and ticks that lived in unwashed clothes and hair. Brontë's

assessment is so accurate that Jack Roberts speculates she may have read her father's copy of

Graham's Domestic Medicine, published in 1826, which had extensive entries on typhus and

typhoid fever (50). The epidemic was caused not simply by an unhealthy location as Alan

Bewell argues, or by unhealthy personal habits, as Charlotte Brontë's contemporaries would

have argued, but by neglect.

In response to this neglect, Brontë envisions how a Board of Public Health might help

to prevent such outbreaks in the future. We can see this most clearly in her account of the

epidemic's impact on the future of the school. Brontë has already established that the

teachers and the girls themselves are not to blame for the unhealthy conditions at Lowood, so

when the school finally attracts the public eye, the administration rightly takes the fall. Once

it becomes known that the caretakers of Lowood School have failed to fulfill their duty, a

heroic unspecified force, referred to largely in the passive voice, comes to save the day. The process begins when the typhus epidemic "draw[s] public attention on the school" (Brontë 91). As a result, "Inquiry [is] made into the origin of the scourge," which then "excite[s] public indignation in a high degree" (91). Next, "Several wealthy and benevolent individuals in the county subscribed" for a better building to be built. And finally, "new regulations were made; improvements in diet and clothing introduced;" and Mr. Brocklehurst is divested of his administrative duties when "the funds of the school were entrusted to the management of a committee" (91). This passive voice force, affiliated with "public attention" and "wealthy and benevolent individuals," which investigates the situation, makes new rules, and improves the girls' food and clothing, is Charlotte Brontë's picture of what a Board of Health might look like for the town of Lowton, ———Shire.

What's more, the Board of Health Brontë imagines is quite different from the Boards that attempted to enforce sanitation before and after the Public Health Act of 1848. Instead of making loaded suggestions or sending ineffective cleanup teams to the school, the intervening passive-voice force examines potential causes and makes concrete improvements (91). By offering these solutions as ways to combat disease, *Jane Eyre* supports the viewpoint that adequate food, accommodations, and rest were just as important as personal hygiene and good housekeeping.

This take on public health has interesting implications for the field of disability studies. Martha Stoddard Holmes writes that most discourse on disability considers disability to be:

> melodramatic machinery, a simple tool for cranking open feelings, and everyone
>
> involved—disabled and nondisabled, viewers and actors—is somehow placed and

defined by what floods out. . . Thus, while emotion is undoubtedly a part of the

individual and social experience of disability, it disproportionately defines those

experiences in ways that inform not only the popular imagination, but also, as a

consequence, public policy. (3)

She adds that Victorian literature is a notorious offender on this score because it so often

depends on "formulaic endings in which the emotional overflow of the middles is neatly put

to rest, offered a mode in which to imaginatively resolve the tensions that in reality were

much too complex to settle with a closing curtain or final chapter" (5).

Stoddard Holmes's criticisms seem to apply to Helen Burns's illness in almost every

aspect; still, I would argue instead that Brontë uses a juxtaposition of melodrama and sparse,

cold description to bring home her points about public health. Helen Burns is not a tragic

infant death, as Beaty argues, but rather something along the lines of the Evangelical invalid

of the type Maria Frawley describes in *Invalidism and Identity in Nineteenth-Century Britain*.

In her study, Frawley gives examples of "the power of Evangelicalism not only to shape

invalids' own assumptions about their personal experiences with suffering, but also to confer

upon them the moral authority to share their hard-won wisdom with others" (34). Thus,

Helen has the authority to tell Jane "I am sure there is a future state; I believe God is good; I

can resign my immortal part to him without any misgiving. God is my father; God is my

friend: I love him; I believe he loves me" (Brontë 90). Then, when Helen dies, Jane tells us

her tombstone reads, "Resurgam": I shall rise again (91).

With this tombstone, one might argue that Brontë has "neatly put to rest" the problem

of the origin of the girls' illness (Stoddard Holmes 5). After all, if Helen Burns will rise

again, what does it matter how she died? The problems of this world are not important in

comparison to her eternal reward, and therefore do not need to be resolved. Some scholars, such as J. Jeffrey Franklin have argued that killing off Helen Burns puts to rest a number of troubling possibilities. In "The Merging of Spiritualties: Jane Eyre as Missionary of Love," Franklin argues that Helen is the ideal: "the emblem in the novel of a Christ-like love and forgiveness" (465). He also adds, "Indeed, Helen represents an ideal that the novel suggests is too good to live, and perhaps her necessary death is symptomatic of the trend in Victorian fiction according to which female communion generally is required to give way eventually to the 'maturity' of marriage" (466). One could argue from these perspectives that Helen's death is simply a neat way for Charlotte Brontë to segue into the next chapter of the story without any offending leftovers from previous episodes getting in the way.

While this interpretation may be partly true, the context of Helen's death—the epidemic—also plays an important role in how we are to understand her death from illness. I argue that Helen's death is included as a reassuring contrast to the death of the girls that surround hers. The contrast serves two purposes: to act as a theological buffer to make the other girls' deaths easier to understand and to provide an opportunity for the audience to mourn for the other sick girls that Brontë eliminated in just a few words. First, Helen's deathbed homily provides an Evangelical framework through which to make sense of death from illness. Helen repeats again and again, "God is good," "God is my father," "God is my friend," "universal Parent," "he loves me," thereby emphatically asserting the benevolence of God during a very dark time in the novel (90). She elaborates that she believes in a Maker "who will never destroy what he created," meaning that though she knows she is about to die from illness, rather than fearing perdition, she has hope that she is "going to God" (90). More directly still, in answer to Jane's question, "And shall I see you again, Helen, when I

die?" Helen replies, "You will come to the same region of happiness: be received by the same mighty, universal Parent, no doubt, dear Jane" (90). In other words, she assures Jane that she is not going to hell and that Jane will see her again (90). While Brontë largely refrains from attempting to find any overarching moral or meaning in the Lowood School epidemic, by allowing Helen to deliver this small sermon, she basically offers the reader the kinds of condolences one would offer to a grieving friend or family member: you will see them again. This one meaningful death makes it easier to deal with the deaths of the other girls.

The second purpose of Helen's death is to provide an emotional outlet of mourning for the sick. Two reviews from the time period reveal that on this score, the episode was extremely successful: Victorian audiences were indeed deeply moved by Helen's death. Two articles, both written in 1848, from *The Trumpet and Universalist Magazine* and *Robert Merry's Museum* have actually reprinted long passages from Helen's death scene for their readers' edification under the headlines of "Beautiful Sentiments" and "A Touching Story," respectively. The writer of the article in *The Trumpet* is so enthusiastic that he or she interrupts the story halfway through to interject, "Are not these sentiments precious? Do they not cause the soul to expand with love?" ("Beautiful Sentiments"). Helen Burns and her virtuous death evidently caused many readers to mourn alongside Jane.

What was it about the other girls' deaths that Brontë needed to tone down by setting it alongside a more conventional invalid narrative? A quick analysis of the differences between the two types of deaths reveals some important contrasts. First, while Helen dies of consumption—the glamorized death of artists and virtuous people—the other children die of typhus—a disease associated with filthy habits, laziness, and poverty. Helen dies mourned

by her best friend, while the other nameless children are dispatched without any of the usual reassurances that they have "become one of the host of 'angels of little children,' " and without any tombstones inscribed with "Resurgam" (Beaty 40). Helen's death leaves Jane a better person, but nothing can be said of the girls' deaths except that they could have been avoided.

Additionally, in narrating the Lowood girls' deaths, Brontë's narrative voice is so spare that it is almost clinical. She devotes only about five paragraphs to the epidemic, and this narrative is interrupted by Helen's death of consumption. Indeed, the young Jane seems to be hardly aware of the epidemic at all except as a background to her relative freedom and comfort in the absence of classes. Linda Schlossberg supports this view when she makes the connection between *Jane Eyre* and Victorian social reform in " 'The Low, Vague Hum of Numbers': The Malthusian Economies of *Jane Eyre*." In this article Schlossberg explores the theme of childhood hunger and ties it into the economical theories of Thomas Malthus. In a nutshell, Malthus argued "that a nation's population growth, generally considered to be a reliable index of national health and prosperity" would actually become the source of the nation's downfall, since as he observed, "the human race increases exponentially, [but] crops can only grow arithmetically" (493). From this perspective, Schlossberg provides a closer look at the grim world of Lowood school and shows how *Jane Eyre* engages with the problems of famine, child labor, and infant mortality in the first half of the nineteenth century. At the end of the article, Schlossberg addresses the epidemic directly. She writes,

> For Jane, counting the surviving bodies of her fellow schoolmates is not simply an
> intellectual or academic exercise: her strength, the reader slowly realizes with horror,
> is inversely proportional to that of the dying children. It is during this season of 'fog-

bred pestilence' that Jane, and the rest of the institutionalized children who stay

healthy actually grow stronger (503).

Schlossberg argues that Charlotte Brontë uses this reference to Malthusian economics to

draw attention to how the dearth of resources at Lowood forces the children to actually prey

on each other in order to survive. Far from sentimentalizing disease, Brontë shows how

extreme privation creates a dynamic in which one person's tragedy is another's lucky break.

True, Brontë is representative of her time period in the way she tidies up the loose ends when

the proto-Board of Health intervenes and makes the necessary changes, but this does not

mean she "neatly put[s] to rest" the problems raised by the epidemic as neatly as she puts

Helen Burns to rest. After all, the girls are still unceremoniously dead, and the proto-Board's

actions can do nothing to remedy that. Instead, Brontë's description of justice being served

represents her take on what Boards of Health *should* have been doing a year before the Public

Health Act was passed.

As I have hinted at in the introduction, it is a bit complicated to address an epidemic

through the lens of disability studies. Since epidemics are often deadly and fast-spreading, it

is easy to buy into the problematic tendency of the medical model to treat "disability as an

individual defect lodged in the person. . . that must be cured or eliminated if the person is to

achieve full capacity as a human being" in the name of saving lives (Siebers 3). Still, it is

important not to go too far in the other direction by not acknowledging that it is possible to

desire a cure without necessarily denigrating the disabled person or considering them less

than a "full capacity" human being. Although Alison Kafer by no means lets the medical

model off the hook, she recognizes, for example, "the possibility of simultaneously desiring

to be cured of chronic pain and to be identified and allied with disabled people" (Kafer 6).

Kafer's and Siebers's work sets the stage for discussion of deadly epidemics through a disability studies lens. Emily Nye and Cindy Patton begin that discussion with their articles about AIDS, the twenty-first century parallel to the Victorian water crisis. Their observations closely resemble the proto-Board of Health Brontë imagines. Cindy Patton takes issue with placing economic concerns above the needs of sick when she warns: "We should never allow costing arguments to cloak themselves in the language of human rights" (Patton 264). Brontë criticizes Mr. Brocklehurst for taking the nineteenth-century version of that very tactic when he says, "Oh madam, when you put bread and cheese, instead of burnt porridge into these children's mouths, you may indeed feed their vile bodies, but you little think how you starve their immortal souls!" (72). Meanwhile, her proto-Board of Health solves the problem specifically by taking away Mr. Brocklehurst's control of the school's finances. Brontë writes:

> The funds of the school were entrusted to the management of a committee. Mr. Brocklehurst, who, from his wealth and family connections, could not be overlooked, still retained the post of treasurer; but he was aided in the discharge of his duties by gentlemen of rather more enlarged and sympathizing minds: his office of inspector, too, was shared by those who knew how to combine reason with strictness, comfort with economy, compassion with uprightness. (91)

These measures would both have supported children who were already sick as well as preventing other children from becoming sick. This solution resembles the picture Emily Nye paints of an AIDS disability community in "The Rhetoric of AIDS: A New Taxonomy." Nye writes that "People with AIDS are needed to teach others. These educators, in effect, help keep down the number of new members of the community, while trying to make others

more sensitive to those who have AIDS" (Nye 241). The Victorians of the 1830s couldn't be

educators since they knew they didn't fully understand how diseases such as typhus were

spread; nevertheless, by acting on the knowledge they *did* have and making every effort to

prevent disease by caring for both sick girls' and well girls' general health, they cared for the

disability community of the typhus epidemic.

Lennard Davis points out that one of the central concerns of disability studies is the

ideal of the "norm," and this word began to be used with its current meaning around the year

1840, just seven years before *Jane Eyre* was published and eight years before the Public

Health Act of 1848 was passed[3] (Davis 10). The "norm" became popular as statistics became

more prevalent, and, as Davis points out, "The rather amazing fact is that almost all the early

statisticians had one thing in common: they were eugenicists" (14). The eugenics movement

followed closely on the heels of the public health reforms, and in many ways, both

phenomena were based around what Davis describes as "the idea that a population can be

normed" (14). Although the health reformers saved thousands of lives and made great strides

in the formation of modern medicine, their whitewashing, vaccinating, and removal of

nuisances masked a sinister compulsion to enforce sameness on the population.

For example, the first official efforts at combating deadly diseases involved the local

authorities issuing "brooms, chloride of lime, whitewash" and other cleaning materials free

of charge, as well as providing lots of helpful advice; for example, an 1831 issue of *Bell's

Life in London and Sporting Chronicle* records an early Board of Health's suggestion that

citizens should protect themselves from cholera with "abstinence from spiritous liquors,

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[3] This is not a coincidence. William Farr and the Statistical Society of London worked
closely with Edwin Chadwick and the General Board of Health (Wohl 143). Farr wrote that
statistics were "an arsenal for sanitary reformers to use" (144).

wholesome food, and cheerfulness," (Sigsworth and Worboys 242, "Board of Health in the City"). The Board of Health's recommendations implied that the victims of cholera brought the disease upon themselves through poor personal hygiene, drunkenness, and a bad attitude. The Public Health Act of 1848, with its emphasis on environmental factors, should have been an improvement on this approach, but it was still based on the belief that cleanliness was synonymous with health and dirtiness with disease, which meant those who became ill were stigmatized as dirty. Chadwick writes of the sick, in particular, the poverty-stricken sick:

> the population so exposed is less susceptible to moral influences, and the effects of education are more transient than with a healthy population. . . .[T]hese adverse circumstances tend to produce an adult population short-lived, improvident, reckless, and intemperate, and with habitual avidity for sensual gratifications. . . [which] leads to the abandonment of all the conveniences and decencies of life, and especially leads to the overcrowding of their homes, which is destructive to the morality as well as the health of large classes of both sexes. (Chadwick 423)

Significantly, Chadwick explicitly places their moral inferiority in contrast to the condition of "a healthy population," as if the state of having typhoid or cholera made them more prone to intemperance.

It should not surprise us then that when the public objected to health reforms, it was because the reforms the Board of Public Health enforced on the whole country were not relevant to every part of it, and those who needed more food, better work, and a different water supply derived no benefit from teetotalism or free brooms, as Sigsworth and Worboys have shown. Similarly, the stigma assigned to certain diseases associated with poverty and filthiness, such as small pox and typhus, was just another way of shaming difference; the

stigma implied the sick person lacked the moral fortitude to stay clean and healthy. Susan Sontag's description of the AIDS epidemic in the United States provides some interesting parallels: "From the beginning, the construction of the illness had depended on notions that separated one group of people from another—the sick from the well, people with ARC from people with AIDS, them and us—while implying the imminent dissolution of these distinctions" (234). In the same way, the Victorians distinguished between the sick and the well, the poor and the rich, the city and the country, typhus and consumption. Similarly, when Sontag writes that the rhetoric of AIDS was based around a fear of "the imminent dissolution of these distinctions," one can imagine an exponentially larger fear of this dissolution in Victorian England when the means by which diseases were spread were not well-understood, and when several different kinds of epidemics were decimating the population at the same time.

In contrast, Charlotte Brontë's portrayal of an epidemic removes the stigma from disease by depicting the epidemic as a result of neglect, rather than of slovenliness, ignorance, or poor hygiene. While Brontë portrays Helen Burns as a classic Evangelical invalid after the manner described by Maria Frawley, her stark description of the Lowood epidemic forces the reader to come to terms with the harsh realities of the consequences of neglect and privation. Then, she advocates for the Lowood girls as a community of the disabled by offering concrete solutions to the problem specific to their needs, and that do not enforce conformity, but rather see to it they have the things they need to take care of themselves. The epidemic allows Brontë to articulate how extreme neglect was harming school-aged girls during her time period, and to argue for the appointing of a Board of Health so that the administrations of schools like Lowood were held accountable.

Chapter 2: *Bleak House*: The Pragmatism Behind the Melodrama.

MAP: Broad Street Pump, Islington, The Fleet

Charles Dickens often expressed his frustration with his country's ruling bodies, but there were few novels in which he did so as vociferously as he did in *Bleak House* when he lampooned the Court of Chancery. Using the infamous case *Jarndyce and Jarndyce*, he publicly criticized his nation's inability to give justice to the people who needed it most. In addition to the Court of Chancery, Dickens also harshly criticized the Sanitary Authorities. He begins this critique by illustrating the government institution's failure to help the crossing sweep, Jo, because of its members' incompetence, prejudice, and corruption. He brings home the pathos of this failure with Jo's melodramatic death, and then demonstrates the terrible consequences by depicting the virtuous heroine, Esther Summerson, catching the same illness that killed Jo. Meanwhile, *Jarndyce and Jarndyce* constantly lingers in the background, an enticing promise of wealth and prestige to the participants that never comes through. The wisest party in the case, its namesake Mr. Jarndyce, refuses to have anything to do with it, but sits in his room, the Growlery, complaining of the East Wind, the bearer of ill fortune, whenever the case is in session.

This chapter will demonstrate that Dickens's portrayal of Jo's death from disease participates emphatically in the melodramatic usage of disability to make a point that Martha Stoddard Holmes criticizes in *Fictions of Affliction.* However, Dickens plays on these clichés to challenge his society's preconceived notions of the disabled and to articulate a

position of advocacy for their rights. Then he interprets Esther Summerson's consequent disfiguring illness as the revenge of the disenfranchised on society, and uses her respectability to demonstrate that there should be no stigma placed on those disabled by the diseases associated with the slum. Finally, despite Dickens's overwhelmingly negative portrayal of the government, in the final chapter he still manages to offer something of a positive vision of official health regulation.

Understandably, *Bleak House* has attracted quite a bit of critical attention addressing its condemnation of the Victorian government's slow, bureaucratic systems, and in any discussion of bureaucracy in *Bleak House*, one must begin with D.A. Miller's foundational study *The Novel and the Police*. Although the book's chapter on *Bleak House* doesn't explicitly address the Sanitary Movement, it does address the novel's methods of critique in a way that other scholars have built upon. He begins by writing that "while a major effort of *Bleak House* is to establish Chancery as an all-pervasive system of domination," the novel also carries a warning that if this seemingly invulnerable institution does not change, it will eventually "collapse from its own refusal to release what is unhealthily accumulating in its system," much as Krook spontaneously combusts due to an overaccumulation of alcohol in his own system (Miller 63). The real evil of Chancery is that even though it is useless, it ensures its continued existence through false promises (68).

Miller then goes on to argue that Chancery's frustrating refusal to ever come to a decision creates in the novel a desire for the efficient, unambiguous answers provided by a detective story: "For, unlike Chancery, the detective story is fully prepared to affirm the efficacy and priority of personal agency, be it that of the criminal figures who do the work of concealment or that of the detective figures who undo it" (69). At the same time, Miller is

quick to point out that the police are not a wholly benevolent force; their representative

Inspector Bucket, charming as he is, executes justice for murderers, but also enforces the will

of Chancery (80-81). Miller concludes by writing that while the novel differentiates itself

from the despairing interminability of Chancery by insisting on "its own closure as revelation

and fixed repose," it also "is driven to admit the *inadequacy* of this closure" by

differentiating itself from the quick fixes provided by the police (93, 97 emphasis his).

Dickens concludes that neither institution holds all the answers.

Although Miller does not address the sanitary reforms at all in his chapter on *Bleak

House*, Lauren Goodlad writes about them specifically in "Is There a Pastor in the *House*?:

Sanitary Reform, Professionalism, and Philanthropy in Dickens's Mid-Century Fiction." In

this essay, Goodlad builds on many elements of Miller's thesis to describe Dickens's

complex approach to the notion of state pastorship in *Bleak House*. Goodlad argues that

Dickens depicts several different methods of pastoring the populace: Chancery, the police,

do-gooders like Mrs. Pardiggle and her ilk, expert lawyers, and finally, the gentle domesticity

epitomized by Esther and Woodcourt. Goodlad writes that Dickens's stance towards state

pastorship is conflicted but generally negative: While he soundly thrashes Chancery for its

inefficiency, he shows the police to be quite effective, even as they work to enforce the status

quo. She writes, "As Dickens represents it, mid-century deadlock so fundamentally favors

selfish interests—the elite privilege of the aristocrat or professional, the acquisition of

entrepreneurial bourgeois—that no pastoral authority can escape capitulation in one form or

another" (540). Additionally, she points out that Dickens also felt conflicted about the

Sanitary movement:

Dickens's own position [on the Sanitary movement] is, as so often, complicated and

contradictory. . . .[W]hile Dickens's respect for Southwood Smith's well-rounded

knowledge suggests a model sanitary agency, *Bleak House* almost entirely refrains

from representing it. Bucket's circumscribed and negative power is the novels' only

fleshed-out representation of official agency. While the latter is an obvious tribute to

Field[4], there is no comparable attempt to portray Southwood Smith's role as

physician-reformer. . . . What Dickens represents instead is Allan Woodcourt who, . .

.for all his symbolic potential. . .is no more (or less) than an exemplary neighborhood

doctor, his "patient ministration" cherished by rich as well as poor. (537)

She also points out that Dickens's negative stance towards "organized philanthropy" appears

to miss the happy medium "between feminine domesticity and professionalism" that would

seem to be the natural alternative (542). Goodlad concludes, then, that the conservative

solution posed by *Bleak House* is that "the only benevolent institution is the home" (543).

Thus, the healing power of domesticity as exemplified by Esther and Woodcourt provides the

only kind of good pastorship in the novel.

Surprisingly, Goodlad does not mention Jo's story in her article, focusing instead on

Dickens's criticisms of the philanthropists like Mrs. Jellyby and Mrs. Pardiggle. The

philanthropists are an easy target since they directly articulate the most pernicious

assumptions behind the Victorian horror of people who were both poor and sick, but they are

only one side of the problem Dickens was attacking in his massive novel. Even though

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[4] Charles Field was a police detective acquaintance of Dickens's and the real life model for
Inspector Bucket (Goodlad 537). Sir Thomas Southwood Smith was an evangelical doctor
and early General Board of Health member (Wohl 145-146).

Goodlad does not address it, Dickens does give the Board of Health a piece of his mind in *Bleak House*, and he does it in the story of Jo's death.

Dickens depicts Jo's death as a consequence of the combined incompetence, prejudice, and corruption of the sanitary authorities. The story centers around the ever-present combination of bureaucracy and the police that Miller has observed running throughout the novel. When the sick Jo first comes across Esther's path, he has been forced to leave Jenny's house in anticipation of her abusive husband's return and possible violent hostility to the presence of an unexpected lodger. As compassionate people, Jenny and her friend try to make sure Jo is taken care of by attempting to deliver him to the care of the appropriate authorities, but are stopped cold by a tangle of red tape. Esther tells us:

> At first it was too early for the boy to be received into the proper refuge, and at last it
> was too late. One official sent her to another, and the other sent her back again to the
> first, and so backward and forward; until it appeared to me as if both must have been
> appointed for their skill in evading their duties instead of performing them. (382)

Jo is turned away by the officials who were supposed to help him—probably workhouse medical officers—because of sheer bureaucratic incompetence. Fortunately (or unfortunately), at this point he meets Esther, who rather than ordering Jo to "move on," as so many other characters have throughout the novel, says instead, "we must not leave the boy to die" (383).

Once Jo comes back to Bleak House with Esther, Dickens shows us the prejudice and corruption of the sanitary authorities in addition to their incompetence. A casual remark by Mr. Jarndyce lets us know that not only is government bureaucracy inefficient, it also shamelessly favors the rich. Jarndyce says, "I can ensure [Jo's] admission into the proper

place by merely going there to enforce it, though it's a bad state of things when, in his condition, that's necessary" (385). The sanitary authorities refused to help Jenny, a resident of the slum Tom-All-Alone's, but Jarndyce is confident that if he, a respectable wealthy bachelor, makes the same request, it will be granted.

Jo's story is not finished yet. The halt of bureaucracy is always, as Miller observes, quickly followed by the unilateral action of the police—in this case, an action enforced with a bribe. Just when we think Jo is finally safe, Inspector Bucket bribes Mr. Skimpole to hand Jo over into his custody. He arrests him as if he were a "convicted prisoner," even though he has done nothing wrong, and the boy is whisked away to his death (Dickens 384). When Jarndyce expresses his confidence that he "can ensure [Jo's] admission to the proper place by merely going there to enforce it," he identifies one kind of prejudice within the system, while underestimating that system's corruption; his influence and good reputation cannot help Jo at all once a bribe has taken the boy out of his care. Skimpole sums up the arrangement aptly when he says, "The State expressly asks [Skimpole] to trust Bucket. And he does. And that's all he does!" (729). The picture Dickens paints of the Sanitary Authorities is pessimistic indeed.

Dickens, in the classic Victorian fashion described by Martha Stoddard Holmes, uses the disabled Jo to get a quick emotional reaction from his readers; however, I assert he uses that emotional reaction to advocate for poor people disabled by illness. Robert F. Lougy offers an interesting interpretation of Jo's character in his article "Filth, Liminality, and Abjection in Charles Dickens's *Bleak House*." Building on Stallybrass and White's discussion of the abject mentioned in my intro, Lougy argues that "*Bleak House* is a novel obsessed with the possible failure or collapse of barricades or gates, haunted by the fear that

what does not belong might somehow find a way in" (480). He closely examines the

characters of Nemo, Lady Dedlock, and Jo, pointing out how Nemo's decomposing corpse

will barely stay contained in the shallow pauper's grave, and how Lady Dedlock's sexual

transgressions are constantly on the verge of making themselves known. Lougy argues

Dickens places Jo himself in the category of the abject, along with Nemo's corpse and the

filth of the city. He writes, "Like Nemo, he too is filth" (482).

Although he gives *Bleak House* credit for being "one of the age's most scathing

critiques" of "the nineteenth century's 'great dream of disinfection'," Lougy writes that

Dickens's portrayal of Jo as part of the abject implicates him in his era's obsession with

tidying away unpleasant things (Lougy 484). Lougy writes, "Thus, while the text mourns

Jo's death and condemns those various forces that have conspired to bring it about, it also

kills him off, finding no way of accommodating him or keeping him alive" (484).   Instead,

Lougy concludes Dickens, despite his frank discussion of sludge and disease in *Bleak House*,

still participates in his society's troubled relationship with the abject, a relationship

characterized by both horror and desire.

Patrick Chappell builds on this approach in "Paper Routes: *Bleak House*, Rubbish

Theory, and the Character Economy of Realism." He writes that

> Dickens's structural incorporation of the recycling patterns of paper waste registers
>
> on two levels, the first of which is the lingering presence of deceased characters who
>
> continue to haunt the novel's elaborate metaphorics long after we expect them to
>
> disappear. . . . The second [level is] the return of lapsed or forgotten characters we
>
> expect to have outlived their narrative utility. (785)

Within this framework, Chappell analyzes Krook, Nemo, and Jo. He continues, "these characters become individuals who, like documents, cannot be easily disposed of or eliminated—figures who after their deaths turn out to have a lingering influence and even a perverse use value in the narrative economy" (794). As for Jo, although Chappell admits that the boy's illiteracy and homelessness distance him from the world of papers that the others inhabit, he argues that the cart to which Dickens's compares him at his death could well be a waste paper cart. He writes, "Jo's cart draws heavier due to the increasing burden of paper waste loaded into it. For a character famously confused and encumbered by written language, it might be said that the dross of writing ends up figuratively destroying his vitality" (800). Jo's character then continues to haunt the novel after his death through "the most conspicuous instance of his afterlife: [Esther's] scarred face" (800). Chappell shows that Jo's demise is brought about by the interminable paperwork of blackmail and bureaucracy, but rather than advocating for him, Chappell, like Lougy, views Jo as a minor character and connects him with refuse.

   As I have said, Dickens's treatment of Jo is most certainly an example of what Stoddard Holmes calls the rhetoric of affliction, or the habit of able-bodied people to cast disabled narratives unequivocally in terms of suffering and affliction. At the same time, his narrative also participates in an interesting way in another pattern she observes:

> Nineteenth-century writing often articulates the need to find out how people with disabilities feel not only in order to find out how to feel about disability, but also in order to decide in a century of frequent, often severe unemployment which individuals with disabilities deserve public or private help. (Stoddard Holmes 31)

From this perspective, disabled individuals were generally viewed either as "innocent sufferers—afflicted children grateful for charitable assistance—or they were embittered, suspicious, and emotionally and morally degraded begging imposters willing to counterfeit suffering in excess of reality in order to gather alms" (30). Victorian writing about disability, she argues, was often designed to designate which disabled people deserved to receive help, and which could be neglected.

So, into which category does Dickens place Jo? At first, it is tempting to agree with Chappell's and Lougy's rather chilling decision to lump Jo into the abject along with Nemo's corpse, waste paper, and the very dirt of the city. The description Lougy refers to as evidence seems to leave little doubt:

> [Jo] is not softened by distance and unfamiliarity; he is not a genuine foreign-grown savage; he is the ordinary home-made article. Dirty, ugly, disagreeable to all the senses, in body a common creature of the common streets, only in soul a heathen. Homely filth begrimes him, homely parasites devour him, homely sores are in him, homely rags are on him: native ignorance, the growth of English soil and climate, sinks his immortal nature lower than the beasts that perish. Stand forth, Jo, in uncompromising colours! From the sole of thy foot to the crown of thy head, there is nothing interesting about thee. (564)

Dickens calls Jo a heathen, worse than an animal. Additionally, when Jo swears to tell the truth, he always does so with the oath, "Wishermay die," as if Dickens is telling us that Jo would be better off dead (564). How could such a stance be described as advocacy?

A closer look reveals that Dickens is doing something very similar to what Brontë does with the Lowood girls. Brontë deliberately strips away all characterization from the

girls so that we can see them as nothing more than a horrifying statistic. We are meant to distance them from the traditional figure of the invalid Frawley describes as a character with special wisdom or meaning so we can see their plight for what it is: an instance of societal neglect that needs to be resolved quickly, not romanticized. In lumping Jo in with the beasts and stating that "There is nothing interesting about thee" (still, I would argue that far from being uninteresting, the sections telling Jo's story are some of the most hair-raising in the novel), Dickens is attempting to do the same thing: to show that Jo is not the kind of invalid who would traditionally receive charity: he is not "an afflicted [child] grateful for charitable assistance," and we shouldn't expect to find in him a "spiritual counselor," an amusing "semiprofessional" fraud, or any of the other traditional characterizations of invalids that run throughout Victorian fiction (Stoddard Holmes 30; Frawley 61, 25). Instead, the description we are given is the description that leads Inspector Bucket to conclude that he is "as obstinate a young gonoph[5] as I know" (Dickens 238).

Thus, everything Dickens has described of the sick Jo who has just been arrested appears to indicate that he is about to dismiss him as one of the "morally degraded begging imposters willing to counterfeit suffering in excess of reality in order to gather alms" Stoddard Holmes describes (30). Instead, Dickens turns that judgmental attitude back on the reader by writing Jo's death as a tragedy. In Chapter 47, Jo is back on the streets, and his health is getting worse and worse. The controlling metaphor of the chapter compares him to a "cart" that "is shaken all to pieces," "but labours on a little more," despite being "very near its end" (Dickens 570-571). Jo comes across Woodcourt (a surgeon) who does the best he can to help the boy, but soon realizes he is beyond the aid of medicine. So, instead, he tries

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[5] Thief

to pray with him. Jo, who we have already established, is basically a heathen, doesn't

understand the prayer and dies before he can finish it. Dickens then concludes the chapter

with a powerful use of anaphora: "Dead, your Majesty. Dead, my lords and gentlemen.

Dead, Right Reverends and Wrong Reverends of every order. Dead, men and women, born

with Heavenly compassion in your hearts. And dying thus around us every day" (572). The

story of the corrupt, incompetent sanitary authorities resulting in a boy's death ends with a

ringing political statement, addressed to all levels of power: the citizens, the clergy, the

nobility, and even the queen herself. Dickens appeals to all of them to raise awareness about

and advocate for the people like Jo, disabled by illness, who are "dying thus around us every

day."

In her treatment of the Lowood School epidemic, Charlotte Brontë offers no attempt

to find an overarching meaning in the nameless girls' deaths. Dickens, on the other hand,

uses his depiction of the public health crisis to convey a grim moral: contagious disease is the

revenge of the poor on society. He writes of the slum Tom-All-Alone's:

> Much mighty speech-making there has been, both in and out of Parliament,
>
> concerning Tom, and much wrathful disputation how Tom shall be got right.
>
> Whether he shall be put into the main road by constables, or by beadles, or by bell-
>
> ringing, or by force of figures, or by correct principles of taste, or by high church, or
>
> by low church, or by no church; whether he shall be set to splitting trusses of
>
> polemical straws with the crooked knife of his mind, or whether he shall be put to
>
> stone-breaking instead. . . .
>
> But he has his revenge. Even the winds are his messengers, and they serve
>
> him in these hours of darkness. There is not a drop of Tom's corrupted blood but

propagates infection and contagion somewhere. It shall pollute, this very night, the

choice stream (in which chemists on analysis would find the genuine nobility) of a

Norman house, and his Grace shall not be able to say Nay to the infamous alliance.

There is not an atom of Tom's slime, not a cubic inch of any pestilential gas about

him, not an ignorance, not a wickedness, not a brutality of his committing, but shall

work its retribution, through every order of society, up to the proudest of the proud,

and to the highest of the high. Verily, what with tainting, plundering, and spoiling,

Tom has his revenge. (553)

This is an interesting passage because it is so clearly about *contagious* diseases, spread (in

keeping with the Victorian theory of miasma) on the wind. There are plenty of symbolic

diseases, such as the illnesses that claim the lives of Richard, Gridley, and Krook. These

characters' diseases are framed as the direct results of their individual mistakes, whether it be

obsessing with *Jarndyce and Jarndyce* or drinking to excess. Their illnesses are unique to

them and are not contagious. By contrast, contagious diseases originate in the slum and

infect whoever comes near, regardless of the virtuousness of their character.

Dickens has set up for us a clear depiction of what wrongs the slum might want to

avenge. He sums up the failure of the government to deal with the problem in one of his

meditations on Bucket's constant injunctions to Jo that he "move on":

Do you hear, Jo? It is nothing to you or to any one else, that the great lights of the

parliamentary sky have failed for some few years, in this business, to set you the

example of moving on. The one grand recipe remains for you—the profound

philosophical prescription—the be-all and the end-all of your strange existence upon

earth. Move on! You are by no means to move off, Jo, for the great lights can't at all

agree about that. Move on! (238)

In other words, the ruling bodies agree in the abstract that something must be done to

preserve the lives of the poor (or to keep them from "moving off"), but they still want them

out of the way. They, like the medical model Alison Kafer criticizes, believe "Solving the

problem of disability, then, means correcting, normalizing, or eliminating the pathological

individual," but they cannot agree on how to do it (572). Skimpole, however, grasps the real

implications of such an attitude. Skimpole tells Jarndyce that Jo has "a very bad sort of

fever," and that they "had better turn him out" (384). Yet, when Jarndyce asks him what Jo

will do if he is turned out of the house, Skimpole replies, "I have not the least idea what he is

to do then. But I have no doubt he'll do it" (384). The quip sounds like just another of

Skimpole's empty witticisms, but it masks the cold pragmatism that underlies his character:

while "the great lights of the parliamentary sky" order Jo not to move off, Skimpole has "no

doubt he'll do it" (238, 384). Skimpole knows very well that sending Jo out while he is sick

is as good as killing him, yet he accepts Bucket's bribe and does it anyway since he believes

"[Jo] will be no worse off than he was, you know" (384). Kafer writes that the able-bodied

often assume disabled people would be better off dead, or can only "imagine a future that is

both banal and pathetic" (2). When Skimpole accepts the bribe from Bucket, he is essentially

euthanizing him. In the face of such coldness from the citizens and from the government,

Tom-All-Alone's exacts a harsh payment by killing off good people, thereby doing a terrible

injury to the society which created it.

Therefore, even though Dickens does give us some troubling descriptions of Jo that

suggest he is subhuman, an examination of the story as a whole reveals that the purpose of

such language is not to dehumanize Jo. Charles Dickens was simply not above a little

manipulation. After using this dehumanizing language to thoroughly establish that Jo is

undesirable, Dickens turns right around and appeals to every possible authority and tugs on

every Victorian heartstring (the unfinished prayer would have been a sure tear-jerker), in

order to make his audience feel compassion for a character they normally would have

dismissed with disgust, or even euthanized like Mr. Skimpole. Then, he brings before his

readers the hard facts: People like Jo die from illness every day, and something must be done

about it. Brontë's description of the Lowood girls is so brief and restrained it is possible to

miss its significance. Dickens, by contrast, deliberately uses Jo's death as a "simple tool for

cranking open feelings," but with the intention of advocating for the demographic he

represents (Stoddard Holmes 3). Any reader would remember the tragic death; a reader who

was paying attention would remember that the tragic death was perfectly needless. The

organizations that were supposed to take care of Jo were uninvolved when they were needed

most, and the long arm of the law came after him when he had done nothing wrong.

Meanwhile, like Brontë, Dickens also juxtaposes the character he uses to make a

political point with another invalid: Esther Summerson. Dickens uses the unquestionable

respectability of Esther's character to remove the stigma from the disease she catches.

Scholars have come up with many different interpretations of Esther's illness, and

two important theorists stand out in particular: Helena Michie and Gail Houston. In " 'Who

Is This in Pain?': Scarring, Disfigurement, and Female Identity in *Bleak House* and *Our*

Mutual Friend," Helena Michie argues that Esther's illness, and particularly her scarring,

become a means for her to gain agency. She writes, "Certainly, the first two-thirds of the

novel gives Esther no place for self-examination or introspection"; however, as soon she gets

the opportunity in the form of her sickness, "Esther's removal of herself from Ada's presence

creates a space in which she can focus, narratively and psychologically, on her own interior

life" (204, 205). Michie then goes on to add that Esther's disfigurement also provides her a

way to differentiate herself from her burdensome resemblance to her mother, and that it

forces characters who had ignored her to pay attention to her: "each character in Esther's

drama of self is arrested in the act of looking at her. For Esther, who has walked invisible

through the novel's first three hundred pages, those confrontations are moments of painful

triumph" (207). Michie sees the illness as a means for Esther to look after her own needs for

a change, and the scarring as a way for her to assert her individuality.

Meanwhile, in *Consuming Fictions: Gender, Class, and Hunger in Dickens's Novels*,

Gail Houston uses Esther's illness to reinforce her main point that the perpetual fasting of so

many of Dickens's women characters can be interpreted as a metaphor for the way Victorian

society required them to suppress their sexual appetites. She then analyzes Esther's fever

dreams as the most explicit expression of this tension. She writes,

> Esther's feverish state mimics the climax of erotic sexual encounter at a moment
>
> when she seems to be choosing whether to survive the illness or die. Thus, as I read
>
> the dream, illness acts as a rite of passage confronting Esther with the 'cares and
>
> difficulties' of womanhood, that is the necessity of reconciling her innocence with her
>
> adult sexual desire. (132)

While Houston applauds Dickens's attempt to portray a more complex female character, she

concludes that he "ultimately represents but cannot resolve the conflict between market and

female economies, for he has only the conventional female role to offer his heroines after all"

(124). Both Houston and Michie view the illness as a pretext for Esther's greater character development, rather than analyzing the significance of the disease itself.

So, why does Esther fall ill with the same disease that killed Jo, and does it matter? While it is tempting to follow Houston and Michie's example and treat the illness as nothing more than a narrative prosthesis, a closer inspection of Esther's experience as an invalid reveals that although she fits the typical demographic of most invalids in literature—middle class female—her situation is actually quite different from that of other invalids.

First of all, Maria Frawley writes that most invalids do not "provide specifics about their medical histories" (4). Esther, by contrast, tells us all about her blindness, her hallucinations, and of course, her subsequent facial scarring, thus suggesting that the disease itself is actually quite important to the story. She writes in some confusion of her decision to describe her symptoms:

> Perhaps the less I say of these sick experiences, the less tedious and the more
> intelligible I shall be. I do not recall them to make others unhappy, or because I am
> now the least unhappy in remembering them. It may be that if we knew more of such
> strange afflictions, we might be better able to alleviate their intensity. (432)

Well, Esther, which is it? Is it better to say less of "sick experiences," or will knowing more about them make it easier to alleviate their intensity?   Esther does not know what she is supposed to learn from her illness; however, relentless optimist that she is, her final conclusion at the end of the chapter is that there is a positive benefit to her ordeal: now that her face is scarred, the prospect of her love will no longer be a burden to Woodcourt:

> O, it was so much better as it was! With a great pang mercifully spared me, . . .he
> could go his nobler way upon [duty's] broader road; and though we were apart upon

the journey, I might aspire to meet him, unselfishly, innocently, better far than he had

thought me when I found some favour in his eyes, at the journey's end. (443)

The sentiment fits in well with Frawley's observation that "Much of the iconography of

invalidism suggests that extended or acute illness was assumed to be conducive to the self-

examination and soul-searching necessary to those charting the progress of their spiritual

journeys" (Frawley 36) Unlike Frawley's invalid's, though, Esther's insights turn out to be

quite mistaken. Woodcourt is not put off at all by her scarred face, and they are married at

the end of the novel.   As Helena Michie notes, she does the soul-searching invalids were

supposed to do, but the conclusions she comes up with are wrong.

What purpose, then does Esther's brief stint as an invalid serve?   In *Feminist, Queer,*

Crip, Alison Kafer criticizes American disability theorists for not addressing disabilities such

as asthma and diabetes that affect poor people and racial minorities. She writes:

This oversight is all the more troubling given the fact that diabetes occurs

disproportionately among 'members of racial and ethnic minority groups in the

United States,' and asthma is a common side-effect of living in heavily polluted

neighborhoods, which unsurprisingly, are more likely to be populated by poor people.

(Kafer 12)

Similarly, Victorian invalid narratives usually were not about people with the types of illness

that could be caught from those who lived in the slums (Frawley 31). Most people agree the

illness Esther catches from Jo is probably small pox; still, whatever it is, by describing the

pain, incapacitation, and disfigurement it causes Esther, Dickens makes it quite clear that he

is not writing a narrative about a picturesque consumptive, but rather about a disabling,

stigmatized disease from Tom-All-Alone's. Once again, Dickens uses Esther's illness to do

something similar to what Brontë does: he takes the stigmatized illness out of the stigmatized demographic, and depicts a clean, well-behaved girl contracting a disease associated with the marginalized poor. Thus, while Dickens has already conveyed the pathos that Brontë needed to add in the character of Helen, he now adds the respectability that was missing from Jo by passing his disease to Esther. So, through the workings of the official machine set up for dealing with illness, Dickens tells us the story of how the very government institutions set up to help people recover from and prevent the spread of disease ensure that all of Esther's desire and ability to help Jo are wasted. All she gets for her trouble is a permanently scarred face, Jo dies anyway, and Tom-All-Alone's has his revenge: a particularly vicious conclusion for a Dickens novel. However, in so doing, Dickens depicts the important reality that anyone, including clean, well-behaved girls, can contract a "filth disease" under the right circumstances, thus taking an important step towards removing the stigma of contagious illness.

Dickens makes plenty of criticisms, but does he provide any solutions? I argue that he does, and that even though he is so critical of government bureaucracy, he still has a vision of effective regulation of public health.

But what does his vision look like? Lauren Goodlad writes that Dickens refuses to institutionalize a desirable pastoral agency such as Allan Woodcourt," or in other words, that he refuses to depict good doctors in the government (540). Instead, she writes that Woodcourt, "for all his symbolic potential. . .is no more (or less) than an exemplary neighborhood doctor, his 'patient ministration' cherished by rich as well as poor" (537).

However, this turns out to be a rather weak point in light of a scene in one of the last chapters of the book when Mr. Jarndyce tells Esther of Woodcourt's newest job opportunity.

"About half a year hence or so, there is a medical attendant for the poor to be appointed at a certain place in Yorkshire. It is a thriving place, . . .and seems to present an opening for such a man. I mean, a man whose hopes and aims may sometimes lie. . .above the ordinary level, but to whom the ordinary level will be high enough after all, if it should prove to be a way of usefulness and good service leading to no other. . . .It is Woodcourt's kind."

"And will he get this appointment?" I asked.

"Why, little woman," returned my guardian smiling, "not being an oracle, I cannot confidently say; but I think so. His reputation stands very high. . . and, strange to say I believe the best man has the best chance. You must not suppose it to be a fine endowment. It is a very, very commonplace affair, my dear; an appointment to a great amount of work and a small amount of pay; but better things will gather about it, it may be fairly hoped."

"The poor of that place will have reason to bless the choice, if it falls on Mr. Woodcourt, guardian." (717)

What position could Woodcourt have been nominated for that would call for a little ambition, a great deal of work for the poor, and would not yield much in the way of money? The fact that it is an "appointment" suggests it is a government position, and in fact, there are at least two positions that would fit the description Mr. Jarndyce provides. In 1831 and 1832, the Privy Council helped to establish local boards of health all over the country, and one of the most important stipulations they made was that there had to be a medical professional of some sort on the board (Wohl 123). Alternatively, workhouses were required to have medical officers as well (Kearns 113). Neither the position of regional medical officer nor of

workhouse medical officer was a particularly high-paying position. The medical officers at Islington were paid £80 a year (Kearns 115). For context, this is about as much as the salary of a female telegraph clerk, who would have made between £80 and £100 a year, or a butler, who would have made between £40 and £100 (Jackson). With the assumption throughout Chadwick's writings and throughout *Bleak House* that poverty and sickness go hand in hand, it seems more than likely that Dickens and his audience would have associated the office of regional medical officer (and certainly of workhouse medical officer) with the poor, so it would not be at all unreasonable to describe such a position as "attendant for the poor." Whatever Woodcourt is going on to do, it definitely appears to be a government-appointed position in Yorkshire, which complicates Goodlad's assertion of Dickens's "refusal to institutionalize a desirable pastoral agency such as Allan Woodcourt." Woodcourt's appointment to a position of a little authority seems to be one of the few optimistic visions for a better future.

In *Bleak House*, Dickens offers a sweeping condemnation of all levels of Britain's sluggish bureaucracy. In the narrative of Jo's sickness and death, followed by Esther's sickness and recovery, he shows us the problems with the bureaucracy behind the sanitary movement in particular, drawing attention to its corruption, inefficiency, and prejudice. Like other Victorian authors critiqued by disability theorists today, Dickens takes advantage of the melodramatic potential of disability; yet as I have shown, he uses the pathos of Jo's death to challenge his society's preconceived notions about people disabled by contagious disease, and then addresses a call for greater advocacy of their rights directly to the political leaders of Britain. He then frames Esther's subsequent illness as the revenge of the poor on society while simultaneously using her respectability as a virtuous young woman to remove the

stigma from the types of contagious diseases associated with the slum. Dickens was losing

faith in his government, yet, he still attempts to provide some hope for the future by

portraying a good doctor stepping up to take on a state position. Esther comments wryly that

"it was not the custom in England to confer titles on men distinguished by peaceful services. .

. unless occasionally, when they consisted in the accumulation of some very large amount of

money," but while Dickens may have given up on the people with the titles, his novel still

ends with some hope that good leaders will find their way into the government (442). *Bleak

House* concludes, oddly, in the middle of a sentence. Esther writes, "they can very well do

without much beauty in me—even supposing—" (770). Dickens doesn't tell us what cut her

off. Has she been called away to some more important errand? Has she fallen ill again?

Whatever causes the cut off, the words "THE END" immediately after let us know that no

other information will be provided (770). The novel refuses to offer us easy answers about

anything, not even about what the heroine is doing at the very end of the novel. Instead,

Dickens leaves his readers to draw their own conclusions about how best to serve a society

infected by bureaucracy, heavily leaning on the good examples of the industrious Esther and

Woodcourt as possible models. Yet, the ominous fact that many of the characters are still

sick, poor, or have unresolved conflicts suggests that even being good and industrious may

not be enough. For Dickens, the wind was surely in the East when he was writing *Bleak

House.*

Conclusion: Advocating for the Sick in Years to Come

In a time when their contemporaries were writing about picturesque consumptives and wise invalids, Charlotte Brontë and Charles Dickens advocated for people disabled by contagious diseases by depicting small pox and typhoid in grim detail. While they used the melodramatic characterization of disabled people that their society had grown to expect and that Martha Stoddard Holmes heavily criticizes, they also matched these characterizations with stark, unflinching depictions of the Public Health Crisis: Esther Summerson's smallpox-scarred face, Jo's death-by-bureaucracy before he can even finish his prayer, and the almost unremarked passing of the typhus-infected Lowood girls. Both authors then conclude with strong demands that something be done to help the people who were dying from epidemics all around them; they use character choices that remove the stigma from diseases associated with poverty, slovenliness, and laziness, and even provide constructive visions of what their government could do to help solve the problems. Dickens and Brontë took the Public Health Crisis very seriously, and were doing everything in their power to fight for the rights of the sick.

As I have shown with the map and with the intro, the health reformers needed all the help they could get. There was not just one river to clean, but many. There were hundreds of towns to be regulated, spread all over a wide geographical area, many of which wanted no part of the process. Therefore, however much we may criticize the public health reformers, we must admire them for finally getting the epidemics under control in the 1870s. Barnett records that Joseph Bazalgette and his working team built the 1500-mile London sewer

system in 17 years, finishing the project in 1875 (Barnett 150). Additionally, by the 1870s, clean running water was available in almost every area of London (Kearns 87). More importantly, the medical establishment had begun to learn what was causing some of the worst diseases, so they were also learning how to prevent them. In the last half of the 19th century, it was finally widely understood that typhoid was caused by dirty water, so when there was a typhoid outbreak, towns knew to hold the water companies that supplied them responsible (Wohl 128). While tuberculosis would remain a problem well into the twentieth century, water-born epidemics became a thing of the past in most areas of the country (Wohl 130). Local governments began to think of ways to improve cities so that they were healthier, more comfortable places to live; they introduced public parks and moved factories further out into the country (Wohl 336)

Unfortunately, neither Brontë nor Dickens lived to see the water crisis fully resolved. Dickens died in 1870 before the sewers were finished, and Brontë in 1855 at the height of the cholera epidemics. However, despite the resolution of the water crisis, a subtle yet sinister change of political rhetoric in the last half of the 19th century indicated that the advocacy for the disabled represented in their novels would remain relevant long after the deaths: the concern for public health became a concern for "the standard of national physique" (Wohl 337). The health reformers were actually subjected to criticism for helping to preserve the lives of "feeble," "sickly," people, thereby "weakening the national stock" (332). The eugenicists were beginning to make their presence known. While the small pox that killed Jo and the typhoid that carried the Lowood girls to their early graves were all but eradicated, the dehumanizing attitudes that prompted Brontë and Dickens to have to push for the rights of the disabled were still alive and well. And, as Nye, Sontag, and Patton have noted, those

dehumanizing attitudes towards people with contagious diseases persist even today in the way people with AIDS are treated. Until the disabled and the able-bodied are treated equally, Jo, Esther, Helen, and the Lowood girls will continue to make their voices heard.

My project makes a contribution to disability studies since, it appears to be the first study of contagious disease through a disability studies lens that is not about AIDS in the 20th and 21st centuries. While Cindy Patton, Emily Nye, and Susan Sontag paved the way for this study with their examinations of the AIDS epidemic, my thesis contributes something new by using disability studies to examine representations of contagious diseases in other time periods. This historical approach is important because it provides a starting place for the study of even more epidemics from the past such as the Black Death, leprosy, or small pox before Jenner's lymph, and even other epidemics of the present, such as Ebola, polio, or malaria. I can even envision applications to pop culture and film studies in examining depictions of the contagiously sick in horror films and science fiction in order to question the way our society stigmatizes and punishes people who are ill. In contrast to Tobin Siebers's unequivocal rejection of the medical model, my approach interrogates the dehumanizing assumptions the medical model makes about people infected with disease, without dismissing the need for containing the spread of deadly epidemics and maintaining public health. Meanwhile, like Alison Kafer, I acknowledge the need to criticize the medical model while still leaving room for treatment. Finally, I arrive at a position that views the sick in terms of communities, so that the best way to contain the spread of disease is to provide accommodations, education and empowerment to those communities. In Victorian Britain, this meant controlling the spread of disease by providing the sick with accommodations such as clean running water, deep wells, sufficient food, and better working conditions, rather than

punishments such as scolding pamphlets, fines for nuisances, cleaning implements, or forced "cleansing" interventions. Thus, although the goal would still be for the disability that defines these sick communities to soon disappear, my hope is that in viewing the sick as a community to be accommodated, rather than a group of irresponsible people to be castigated, or worse still, as a group of pariahs to be ostracized, that the stigma could be removed from the illness, even though my vision views contagious illness as a condition that needs to be treated.

There are some problems with my approach, namely, the age-old question of ethics theories everywhere: Where do we draw the line? Which contagious diseases need to be given special accommodations and which can be safely and humanely left to their own devices? AIDS, as we have established, definitely needs to be accommodated. Also very serious diseases like Ebola. Probably malaria, too. Maybe H1N1? Maybe meningitis? Not strep. Not the common cold. Definitely not athlete's foot. Perhaps a better question for my thesis to pose to future scholars would be, is there a way to view all contagious illnesses—from the plague to the common cold—through this humane lens in a way that prevents one from having to make such distinctions? As I found with Diana Price Herndl's article in my introduction, such attempts to come up with clear-cut lines where there were none before are in general not terribly productive.

Another problem that is making itself back into the public eye is the Leicester question. Resistance to vaccines is becoming an issue once again. In the 19th century, much of the resistance to the public health reforms was justified because Victorian doctors did not have a very good understanding of what caused illnesses. Now, we understand such things much better than we did, so popular resistance to public health regulations becomes a more

complex affair. The scientific consensus is that vaccines prevent deadly diseases, and that refusing to get a vaccine puts others at risk; yet, as the people of Leicester protested, forcing people to get compulsory vaccines, as does any measure that forces a person to make a change to his or her body, definitely smacks of tyranny. I conclude now, as I did with the Victorians, that compulsion is not the right way to go about maintaining public health, even in the worst circumstances. Compulsory health measures of any kind return to the medical model's old problem of viewing the person and his or her disability as a threat, rather than viewing the disabled person as a human being with rights who deserves to be treated as such. Instead we should distribute vaccines and other important public health measures by empowering people through education and wide availability.

My project leaves plenty of room for future scholars to build on. First of all, more could be written on this topic about *Jane Eyre* and *Bleak House*. *Bleak House* in particular is rife with infectious diseases, and they deserve thorough critical attention. Additionally, *Jane Eyre* contains other sick people (even Jane herself becomes sick after fleeing from Mr. Rochester) and it would be worthwhile to view these illnesses from a public health standpoint, a disability studies lens, or both. If I had more time, I would also want to examine ways in which these two novels foreshadow the coming eugenics movement. Additionally, the role of statistics in both disability studies and public health deserves a more thorough analysis. Finally, the digital map could become a thesis-length project all on its own.

There is work to be done, but I believe my thesis has taken a useful step toward expanding disability studies and scholarship on Victorian literature and history. Charlotte Brontë wrote specifically in her preface to the second edition to *Jane Eyre* that her novel

contained more than one "protest against bigotry," and I have endeavored to show that one of the groups she defended against bigotry were the Lowood girls disabled by typhoid (18). Meanwhile, the final line of Dickens's preface to *Bleak House* reads, "I have purposely dwelt upon the romantic side of familiar things," thus indicating that the reality of Victorian Britain was even bleaker than the world depicted in the novel (4). Both authors had the courage to face hard truths, and the pragmatism to use whatever narrative means to make their audience face those truths as well.

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Vita

Frances Thielman was born in Augusta, Georgia, to Sam and Sara Thielman. After completing her studies at George Mason High School in Falls Church, Virginia, she entered Wheaton College, Illinois, where she earned her Bachelor of Arts degree in 2009 with a double major in English Literature and Music. She is a pianist. In the fall of 2012, she accepted a teaching assistantship in English at Appalachian State University and began working toward a Master of Arts degree. She was awarded her M.A. in May 2014. In August 2014, she was admitted to the doctoral program in English Literature at Texas A&M University.

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