What is your *complaint*? Health as moral economy in the long nineteenth century

Christopher Hamlin

Unlike most other forms of historical writing, histories of public health are moral narratives. For more than a century, historians of the infectious diseases that were long its chief focus have been able to unfold the drama of heroic social and scientific achievement over complacency and ignorance. That narrative is possible because author and reader share metrics of progress – through microbiology and epidemiology. One knows what needs to happen. Suffering from faecal-oral diseases? Stop ingesting ... But what and who will facilitate, or retard?

By this standard the pathologies of progress are at a disadvantage. George Beard's neurasthenia, flagship of the conditions considered here (can we even call them diseases?), is no longer a medical entity, only a curious conceptual relic. Given that we have decided that the persons thus diagnosed had no such disease, must we throw out their whining? Without a way to validate what brings suffering persons to clinical encounters, we risk doing that. One sort of validation comes from subjectivity: we have suffered from analogous conditions – perhaps depression, stress, or anxiety. But all these too are controversial terms in negotiations between subjects, practitioners, and societies. For as Charles Rosenberg has pointed out, translation is not always validation.¹

I have no solution to validating general, amorphous, or sub-clinical suffering beyond reorienting the writing of medical history to make such pathologies of progress less anomalous. That means exploring

dynamisms. What, in these cases, evokes response? Not – as elsewhere in public health, fear of catching plague or disgust at rot or ugliness.

This chapter explores the powers of medical expression – i.e., whatever a supplicant must say to elicit an adequate response – in nineteenth-century Britain. Plainly, the responder must know the codes too; coadaptation between supplicants and responders will presumably vary by place and time and perhaps, too, by race, age, gender, or class. Here I focus mainly on class, defined not in terms of objective socio-economic status nor modes of discursive engagement, but in terms of expectations of suffering. And I am concerned not with particular injury but with general affliction – with forms of expression which equate to: ‘I can’t stand it’, ‘I can’t live like this.’ The statements have no definite relation to the afflictions/conditions themselves, which may be life-threatening in the near term or debilitating in the longer. They may be intensely irritating or involve incursion of risks.

Historians of medicine will find context for such concern in classic works by Michel Foucault and by Nick Jewson: both explore how social and professional structures affect the expression of affliction and perhaps the experience of it too.² Some voicings of pain bring sympathy and soup. Others bring indifference, impatience, or contempt (especially if there are significant costs in responding to my whining). In that case I may learn to deny or suppress those pains.

Of the seven parts of this chapter, the first four are foundation, the next two application, and the last an assessment. My first task is to expand/adapt E. P. Thompson’s concept of a ‘moral economy’, developed to explain features of social relations at the beginning of the long nineteenth century, to the domain of social medicine. Next, à la Raymond Williams, I begin to consider ‘keywords’, here verbs of existential unacceptability. These are probes for social practices, and good ways to chart change.³ The first is the ‘complaint’ of my title. Sections three and four explore the nineteenth-century antecedents of general patho-physiological processes that served, and in some cases still serve, as currency in the moral economy of health: we use versions of them to validate suffering. Sections five and six are literary-historical case studies. With the help of Charles Dickens, I seek to show the limits of a medical moral economy in the 1830s and 1840s; with the help of D. H. Lawrence, I explore dynamic aspects of that moral economy in

late-century public health/social medicine: its use not merely to enforce standards but also its potential to raise them. In the conclusion I assess this sort of analysis as a narrative foundation for the social history of health.

Health as moral economy

The protests I have alluded to are equally moral and economic expressions (they involve assertions of obligation and appeals for resources to relieve). For my period and for Britain, E. P. Thompson's concept of 'moral economy' is a good starting point. Thompson was seeking to explain so-called 'bread riots' of the late eighteenth and early nineteenth centuries – episodes in which crowds, largely led by women, acted against purveyors who had raised the prices of staple foodstuffs. These crowds did not loot; they took what they needed and paid what they saw as the just price.⁴ Thompson was challenging narrative and analytic practices prevalent in one wing of Marxist historiography – that class conflict was incessant and unlimited, a zero-sum game, and that such explosions simply reflected a critical mass of tension and a circumstance. This Thompson challenged with two points. First that riots occurred not at the height of desperation but in anticipation of the price changes that would lead to it, and second that they were restorative not revolutionary. While, in Chapter 1 of this volume, we saw the shock of revolution interpreted and treated within emergent psychiatric practice as a form of therapy, here the crowds were not maximisers but moral enforcers, acting conservatively to maintain familiar social relations and stations of life.

Thompson did not extend the concept to health, yet such extension is implicit. Bread prices are proxies for survival; rioters were acting rationally, recognising that the debility of hunger would ultimately make it impossible to act.⁵ And the concept is particularly apt for health. Unlike markets generally, where the marginal utilities are morally neutral and the participants value them as they please, health assessments involve perceptions of obligation and entitlement as well as allocation of scarce communal resources. In the broader terms of welfare, such assessments are familiar – treatment and experience of children in the child reform movement discussed in Chapter 3; in the endless debates

in charity organisation societies or about poor laws; in tergiversations about sturdy beggars or the deserving poor; and about moralising or demoralising forms of relief.

Thompson, however, was focusing not on obligation but entitlement. Concerned to humanise the writing of social history by directing it toward subjects and cultures rather than material conditions and determinisms, he did not consider what particular moral code rioters were seeking to enforce; 'moral' was important chiefly as a category. Prices, however, are quantitative; not so states of health. Here real questions arise about what the operant moral principles were on which people made medical claims. For rioters were taking risks. Their actions might be grudgingly tolerated by the magistracy or might not: a 'moral economy' might as readily be invoked to sanction price rises, not only by political economists defending the market, but by merchants passing on wholesale price increases. Why did rioters think they would be successful?

First, probably, because their demands were specific, modest, transitory, and local. To be deliverable, entitlements (or, more directly, 'rights'), must be well defined. The 'state of complete physical, mental and social well-being and not merely the absence of disease or infirmity', which the World Health Organization (WHO) obliges states to guarantee their citizens is indefinite.⁶ The mandate offers no way to move from an expressed deficit of well-being to mediatory medicalisation, nor of prioritising harms to health. Nor does it acknowledge trade-offs in which delivering the right to some might require taking it from others. Instead, health is treated as an inalienable entity, akin to the right of conscience. The point is important: for 'moral' does not come as the antithesis of 'economic'; we should recognise that bargains are being struck, and allocations of costs and benefits will be occurring.

To make sense of the nineteenth-century medical moral economy – and the bread riots – would require a sharper definition of cultural conditions. Two sorts of explorations would be critical – one conceptual, and the other rhetorical, but also sociological. There must be an authoritative conceptual metric into which suffering may be translated, and hence claims of entitlement assessed and adjudicated – that is, a moral economy must have a currency. Since obligation, not price, is at issue, we cannot expect a market to make incommensurables commensurable, but something must do so. In fact, there were integrative

biomedical concepts that did, though they changed radically over the course of the century. (By contrast, the WHO's 'well-being' lacks a clear currency.) But we also need to understand the situations and speech acts through which people could successfully invoke those conceptual frameworks. In the absence of objective tests of suffering – and there were more of these than we may realise – by what magic words does one establish one's claim? And how does this vary by speaker, place, and conditions? We might hope to discover too the determinants of the quality of response a claim elicited – minimal, grudging, and brief, or sympathetic, long-term support? For my goal here is to explore not only the kinetics of the medical moral economy but also its dynamics for progressive change. How was that moral economy made to grow in terms of the modestly rising entitlements and obligations for the public's health that occurred during the period (though never to the asymptotic levels imagined by WHO visionaries in 1948)?

This approach differs from a common view in which public health provision is a gift of policy made in the aftermath of social investigations to those too dull to demand it themselves. The questions it involves are formidable. Many historians have avoided them, or have looked at them from one side only – that of the providers of relief, with their concerns about epidemic diseases and their institution-building practices. Mathias in Chapter 5 demonstrated various means by which fictions of the period provoked and explored imaginative extensions of public health concerns. But 'moral economy' points us toward mandated exchanges, exchanges that are not merely permissible but obligatory.⁷

An essential beginning is the status of 'complaint'. Any claim on the moral economy will come as a complaint – bread rioters were complaining unambiguously about unacceptable prices. To complain, however, requires many things: recognition of suffering, the energy and capacity to express it, and perhaps the presumption of social sanction for the complaint's legitimacy. For we must not mistake complaint for power. Along with the question of who can complain is the question of what they can complain about and to whom.

Here I shall use 'complaint' and 'annoyance' as the terms traders use in the moral economy of medicine – they express conditions crowds (including crowds of one) find morally objectionable. In turn, I shall use 'stress' and 'overwork', and their nineteenth-century predecessors as the integrative conceptual metrics that serve as currency. Effacing the

border between subjectivity and biomedical objectivity, these validate and delimit the complaint.

Irritations and agonies

Much of the history of moral economies is encapsulated in the changing valences of 'complain' over the course of the long nineteenth century. Earlier uses enforce seriousness and subjectivity: to 'complain' was 'to give expression to sorrow or suffering' (*OED* #1). It was linked to lamentation and wailing. This heritage lives on in the 'plaintive' 'pleading' of our 'plaint', registering pain and powerlessness.⁸ There is nothing accusatory here, no grounds to second guess the suffering of the term's user. In medicine, too, a complaint is taken at face value as an existential expression: the recording medic writes, 'patient complains of' (#4a) and in further references translates these into the patient's 'complaint'. Usually the term is a hybrid between the conditions the patient objects to and the healer's understanding of the (quasi-diagnostic) entity to be remedied.⁹ Here, medicalisation helps to legitimise: the complaint is recognised as a departure from well-being, a situation that may be fixable and perhaps could have been prevented.¹⁰

The most familiar modern usage is quite different: 'To give expression to feelings of illusage, dissatisfaction, or discontent; to murmur, grumble' (#6). These all point to blameworthy external causes: the complainer is simultaneously alluding to an injury, identifying responsibility for it, and appealing to a presumed entitlement. The valences differ from other ways of expressing injury and reparability: 'I have a suggestion', 'I have a problem that needs fixing', or even 'this case falls under the moral precept' may all be respected, even welcomed.

Yet with its overtones of sulkiness, 'grumble' suggests that by designating one's expression as a 'complaint' one has pushed a presumed 'moral economy' too far. We lose even more legitimacy if expressing a 'complaint' puts us on the slippery slope from 'subject who has complained' to the identity of 'complainer', a term for a habitual maker of such statements. Hence to have one's dissatisfaction registered as 'complaint' may be so counterproductive as to be the basis for dismissing one's imperative, as the *OED*'s illustrations suggest. Thus Robert Burns writes of one 'always compleenin frae mornin to e'enin' (4b). Evelyn Waugh writes: 'Everyone I met complained bitterly about the injustice

of having to earn a living and the peculiar beastliness of his own profession' (6c). Here 'complaint' is self-indulgent kvetching.¹¹ However *discontented* we may be, no one wants to be labelled a '*malcontent*'.

And those who say 'X is complaining again' are themselves complaining – expressing exhaustion and exasperation at being expected to fix what is too hard to fix, or to deliver special treatments that the complainers have no right to ask for. Though they may have the greater complaints, theirs may go unvoiced if, in the economy of exchanged rather than essential deference, they are paid to hear ours, as persons in customer service certainly are.

What shall we make of this evolution of heartfelt distress into barely tolerated moaning? I think the change reflects the coming of equality. 'Complaint' has become less moral and more economic. The tone of powerlessness (at least of some) in the face of misfortune – human or divine – is gone, replaced by a jealousy about status in societies that purport to deride class and deny station. The situation is that depicted by Norbert Elias in his famous analysis of the history of manners. According to Elias, in complaining we are expressing aspirations appropriate to the imperial (and imperious) identity we would like to be granted.¹² A lump under a mattress will no longer register if someone can respond: 'you're not a princess; you're lucky to have a bed at all'.

Complaining then may represent not a rebalancing of the moral economy, but its collapse, through an amplifying infection of irritability as people complain about complaining – a 'mood contagion', as Kowalski puts it.¹³ The 'moral' in 'moral economy' was fragile. The equilibration Thompson's actors seek depended on some shared notion of the legitimacy of some complaints. These were in part functions of the supposedly objective biomedical currencies that circulated in this 'moral economy'. If current enlistments of 'complaint' often bring loss of social capital, it behooves us to look more closely at the conditions of its creation. Perhaps those very ripples of dissatisfaction we label as complaint can, in other circumstances, generate rising expectations that translate into healthful aspiration.

The afflictive world

Probably the most common contemporary expression for medicalised complaining is 'stress'. And, as Waugh suggests, its chief cause is the

grind of (over) 'work', not merely from paid employment but as manifestation of the composite exhaustion of modern living (the titular 'pathologies of progress'). Used together, the terms are especially helpful in uniting physical conditions with emotional responses.¹⁴ And both refer, sometimes simultaneously, to conditions and causes, and to perceptions, interpretations, and expressions. Both are critical terms. As with 'complaint' itself, an utterance of 'stress' signifies not only as diagnosis, but as accusation and explanation. Some nineteenth-century medical writers who spoke of stress were borrowing the notion of the forces that reshaped an object, while others drew from the vernacular 'distress'.¹⁵ 'Work' too was an activity, a human identity, and a physical quantity.

Given these foundations, it is easy to see how the terms might translate subjectivity into objectivity. In doing so they functioned on three levels: to the individual they provided a way to articulate a state of being and adopt an appropriate identity on the basis of a self-assessment; to society they represented a demand for renegotiation of the terms of participation; and to the physician they offered a generic explanation that may guide both that sense of identity and that negotiation.

For contemporary scholars, that generic explanation is based in mid-twentieth-century physiological research chiefly by Walter Cannon of Harvard and Hans Seyle of McGill. They translated the heritage of 'neurasthenia', the quintessential pathology of progress, into hormone biochemistry. That translation broadened symptoms. In addition to providing a biomedical underwriting of subjective elements – mood changes, fatigue, trouble sleeping – it objectified and quantified injury in terms of elevated blood pressure, arthritis, ulcers, cancer, autoimmune conditions, coronary disease, or even suicide, though none was exclusive to 'stress'.¹⁶

There were other changes. First, some of these harmful changes were imperceptible. Thus stress validated complaint but was not limited to the ability to express. Second, physiological research provided a better conceptual basis for distinguishing recovery – the 'homeostasis' that allowed mammalian bodies to maintain stability in changing and in extreme situations – from irreversible damage: for overstressed bodies lost their ability to re-equilibrate. Remarkably, Cannon–Seyle managed to be explanatory and validating without being reductive. Just as there were stressors and manifestations of stress measurable but not felt, so

there were some that might be felt but not measured: stress was emotional as well as physiological. Remarkable too is the cultural credit the concept acquired. In terms of declarations of illness accepted without biomedical confirmation, stress and anxiety come close to carrying the power of nausea or diarrhoea.

Discovery of 'stress' was not accidental. Concerned with understanding the dynamics of human performance, Seyle and Cannon drew from medical history and saw themselves as elaborating an equilibration agenda that had dominated classical (or 'humoural') clinical medicine since Hippocrates.¹⁷ In turn their concept may serve as a currency. The explorations below suggest how it might be possible to apply that concept despite lack of confirmation from the usual epidemiological sources. For usually these concentrate either on immediate causes of death or on incidence of particular diseases. They obscure integrative conditions manifest in dissatisfaction or dysfunction. And leaving aside categories, the high incidence of infections will have masked stress-related conditions that would become visible only after an epidemiologic transition made so-called 'lifestyle-related' causes of death more prominent.¹⁸

'And all must have prizes'¹⁹

A medicalised 'stress' may seem the solution to the complainer's problem of how to register one's distress without being branded a malcontent. Yet it is equally possible that, linked to 'complaint', 'stress' will be swept into the same abyss. If it is to liberate or legitimise, medicalisation must first overcome a filtering based in class (and perhaps in gender, life stage, or race).

The irony is especially sharp for class. If those who complain the most about stress *also* possess the greatest means to avoid it, what of those without such means? Presumably they must be suffering more acutely. One may filter claims in two ways, both de-legitimising. One is to view 'stress' (or 'complaint') as peevishness. The other is the exoticisation of some persons as too dull to experience the refined anguish that plagues the more sensitive and vocal.

Prior to 1700 I find little class-specificity in discussions of constitutional illnesses in European medicine. The predominant notion is that any person will need periodically to rebalance the so-called non-naturals

– air, diet, activity, sleep, excretions and secretions, and passions of mind. The circumstances of stress vary by class and occupation as do the remedies – Mme Sévigné's accounts of mid-seventeenth-century Versailles life allude to the strain of courtly deference. Those of her rank can retire to their châteaux. That others cannot is simple fact, but the lack of any sharp demarcation between normal and pathological existence brings with it a presumption of universalism: we each in our way suffer from more or less the same strains.²⁰

Diseases of affectation, or to James Adair, of 'fashion', begin to be evident shortly after 1700, with the emergence of the 'valetudinarian', one (usually a man) of such delicacy that health requires avoiding any 'annoyance' (a term I explore later). Other terms, 'spleen', 'vapours', 'hypochondriasis', 'hysteria', or merely 'febricula' did much the same work, though many had distinct class, life course, or gender implications. These would evolve by late in the century into a 'nervousness' endemic among wealthy young women and attributed in part to what are recognizably social stresses.²¹

Yet remarkably, these concepts took root first in a Newtonian cultural context, in which cause must have effect.²² That view is even more prominent in another heritage of stress, also recognised in early modern medicine: the environmental, economic, and psychic stresses of poverty. Indeed, these, and not emotional stresses, were Seyle's primary concerns, and they were explored further by postwar physiologists studying starvation.²³ Bodies must respond lawfully to a variety of acute and chronic nutritional stresses, to dehydration, extremes of temperature (both hypothermia and heat stroke are kinds of stress), and sleep deprivation, but also to the anxieties which all of these incur. The manifestations of hunger, for example, are equally somatic, psychic, and social.

Such stress is axiomatic for Karl Marx, for whom health, bodily and mental, is a liquefiable asset, which capital will convert into surplus value. In discussing the working day in the first volume of *Capital*, Marx quotes contemporary investigators of the mid-Victorian workplace. He need not be a diagnostician of overwork, merely a compiler: these authorities recognise the slow destruction – of 'frames dwindling ... faces whitening ... humanity absolutely sinking into a stone-like torpor'. Some note stress-related conditions: 'dyspepsia ... disorders of the liver and kidneys ... rheumatism'.²⁴

All are products of a lengthening work day. Capital burns individuals as fast as it can. It will extract time from eating, resting, or simply living, stopping only when the labouring population is no longer able to reproduce a future workforce. Marx quotes Benjamin Ward Richardson, writing, long before Seyle, on the 'stress of work'. Richardson imagines a blacksmith, capable of some number of hammer blows during a fifty-year working life, being 'made to strike so many more blows, to walk so many more steps, to breathe so many more breaths per day and ... producing for a limited time a fourth more work', and dying earlier by exactly that proportion.²⁵

Yet the protests do not come from the victims who 'silently pine and die', but from humanitarian investigators.²⁶ In his extended treatment, *Diseases of Modern Life* (1882), Richardson embraced the stresses of intellectual and artistic work. In the case of manual labourers, 'who wear out by such action itself, or by the addition of certain surrounding influences which add to the exhaustion', it was plain that work (and thus life) was stress. Of these 'sons of slavish toil', Richardson declared that 'the misery of their lives is only ameliorated by the shortness of the trial' – the hammer blows should be struck as rapidly as possible. As Rabinbach has shown, commodifying human lives had become a fetish by the end of the century.²⁷

In converting stress into a currency of historical assessment – and not merely a crotchet of self-indulgent modernity, we face three central challenges.

I have considered the first, the palaeo-epidemiological. That the term 'stress' is grounded both in experiment and expression; that something like it was diagnosed in severe cases does not necessarily allow us to link the expression of stress to physiological stress in sub-clinical cases. Stressors manifest in many ways and over a long period; and surely we can't fit eighteenth-century persons with blood-pressure cuffs.

The second concerns expressibility. Can we assume that there will be languages for stressed persons to say they are stressed? We have no basis for thinking that what is felt can and will be stated, much less recorded, nor any right to expect a transparent or uniform language of pain. Perhaps, if verbalising distress is forbidden, there will be other forms of protest, biomedical analogues to James Scott's 'weapons of the weak'.²⁸

Last, and most important here, are the conditions outlined earlier with regard to successful enlistment of the moral economy: issues of universality, targeting, and responsiveness. If language is available, who gets to use it, on which targets, and with what expectations of response?

These questions may be asked of any illness, but are harder to answer for stress. Yet we can find bodies of evidence that bear on them in periods before the modern era of stress-expressibility. For various reasons, late medieval and early modern historians have been more comfortable exploring such issues.²⁹ Indeed, by integrating religious anxieties, their studies have sometimes approached the asymptote of a comprehensive accounting of stresses – psychic, physical, and spiritual. By contrast, nineteenth-century historians have often reduced the biomedical to epidemic infections – notably to cholera and tuberculosis. In British history in particular, the public health movement dominates. It is (correctly) seen as preoccupied with faecal-oral diseases.

But public health, as the WHO reminds us, involves more. One of the two cases I explore below concerns the desperation of unsettledness; the other the stultifying stuckness of settledness in a dehumanising environment. In each I use contemporary fiction to interrogate an ambiguous historical record. Literary artists claim access to characters' senses of self and world, including individuals' understandings of and responses to the stresses of their lives. Historians rarely aspire to such intimacy; rarely do our sources encourage it.

Cold women

To illustrate the importance and potential of 'complaint', it may help to consider its absence in conjunction with a minimalist concept of a moral economy. Thus: in the aftermath of the infamous New Poor Law of 1834, a nameless gravid woman is found 'lying in the street' by a local overseer. She has evidently 'walked some distance' and has been admitted to a workhouse where she gives birth, asks to see her baby, states that she will then die, and does so. She is overworked ('labouring' may apply equally to birthing, labouring under fever, and to walking and carrying – all heavy caloric demands). That she has undertaken a long journey on foot during her third trimester suggests desperation – mental as well as physical stress. Knowing what we know of contemporary mores and bastardy laws we may assume ostracism too: she is in

need among persons who may despise her. Tea and sympathy might help but no one offers. How does she die? Not apparently from any single disease entity: the sequence of events rules out puerperal fever, but it is plausible to understand her death in some broadly accumulative sense. She suffers from exhaustion and exposure compounded with abjection and hopelessness. She has neither strength nor will to live.

You may know this woman as Agnes Fleming, mother of Oliver Twist, and the events as those of the first two pages of Dickens's novel. The modern reader only learns her name and background hundreds of pages later, while the first readers of this serialised novel were presented with her effective anonymity: they had to wait *two years* for a scanty backstory.

It is hardly possible to acknowledge, and yet dismiss, deadly stress more effectively than Dickens does here. In contrast with the 'well-being' guaranteed by the WHO, here obligation is asymptotic as it approaches nullity. Dickens comes close to denying her the personhood of speech. Agnes gets seven words. 'Let me see the child, and die.' Her postpartum condition and behaviour get fewer than 200 words, her background (discovery by the overseer, shoe wear indicating long journey, lack of identity), only forty-six. Her social status – 'No wedding-ring, I see' – takes just five. Here Dickens, perhaps sharing contemporary views, permits Agnes no complaint, except perhaps about herself, evident in her intent to die.³⁰ Not so David Lean, who concentrated on her complaint in filming the book. He opens with a tiny figure cresting a hill, with rising wind followed by rain and thunder. We see a thorn-bush, an exhausted face, a distant light toward which she staggers, and later a waking Agnes who smiles with delight at her baby.³¹

Here, none of the three conditions are met: the group to which Agnes is assigned – fallen women – is one in which complaint is forbidden; she is too stressed even to muster the strength to complain, and the targets of her complaint would be diffuse. Finally, this is a legal, not a moral economy: the parish officials do only what the poor law requires.³² To the degree that a moral economy underwrites this, it is that of Thomas Malthus, whose analysis of human population dynamics indicated a need to minimise the population-inflating stimulus of obligation.³³

Given Dickens's outrage at the physical and nutritional stress the New Poor Law imposes on Oliver, his neglect of his mother is striking.

But the very absence of a moral economy here invites consideration of the enormous range of obligations that might be recognised. Given a slug of brandy, and then asked, as a parish surgeon might, 'what is your complaint', where would Agnes begin? She might say, 'Isn't it obvious?' But what would she be targeting? Would she be admitting that she is, as Dickens later labels her, a 'weak and erring' fallen woman? Or might she fulminate at the sources of stress – God, men, or a society that so signally despises isolated pregnant women? Or perhaps she would be protesting a more general frailty of nature – the cold and exhaustion that bring on hopelessness, or even the nature of the body of a fertile female.

Accrediting Agnes's experience requires giving her a vocabulary. What might be the keywords for converting experience into protest? Two would be 'misery' and 'miserable'. Yet, as with 'complain' and 'complaint', the *OED* chronicles confusion: both conflation and inversion of moral valences. Originally 'misery' was objective: 'A condition of external unhappiness, discomfort, or distress; wretchedness of outward circumstances; distress caused by privation or poverty.' (*OED* 'misery', #1a). The subjective version, 'Great sorrow or mental distress; a miserable or wretched state of mind; a condition characterized by a feeling of extreme unhappiness', only begins to be (ambiguously) evident in the seventeenth century and takes hold only in the mid-nineteenth (#3a).³⁴ If this evolution may seem to humanise the physical condition of misery, it also allows its trivialisation: the well-off can now claim 'misery'.

'Miserable' evolves on a similar schedule (*OED*, 'miserable', #1a, #1c), but acquires even more nuances.³⁵ It can refer to external stressors as in 'miserable weather' or 'miserable working conditions' (#2b) but also to opposing representations of a person: either as 'contemptible, despicable' (#3b) or as 'poor, unhappy, or wretched' (#5b). The opportunity for confusion/inversion is evident. Both Agnes and a poor law official might call her 'miserable', but the first would mean 'unhappy' and the second, 'contemptible'. Even more sharply than with 'complaint' the very word with which one makes a claim on a moral economy subverts the claim.

For two reasons we should not regard Agnes an 'everywoman', even for early nineteenth-century Britain. Her pregnancy and marital status are factors in the operation of a moral economy; so too is the New

Poor Law itself, which in England, but not Scotland (or yet in Ireland) transferred much of the domain of entitlement/obligation into public policy. Agnes (and later Oliver) get care from the infamous workhouse of the New Poor Law, where an 'experimental philosophy' is in operation to determine the minima of human survival. But one may ask how other overworked and stressed persons – friendless, travelling on foot, perhaps in bad weather – negotiate their complaints with themselves and with medical or charitable institutions? How did this moral economy work for them? For here too there were gatekeepers and magic words.

This is a matter both of ideas and of institutions. With regard to ideas, a holistic Hippocratic-Galenic heritage, still ascendant in British medicine in the first half of the nineteenth century, emphasised individualistic causation of illness and gave exhaustion primacy as a cause. The key theorist was the popular Edinburgh medical teacher William Cullen. He and his successors trained many of the practitioners active in the north of England and in Scotland and Ireland.³⁶ Though his integrating entity is 'debility', a condition jointly physical and mental, Cullen's model anticipates Seyle's 'stress'. For Cullen 'cold' (a term implying too the lack of nutriment needed to withstand it) effectively stands for physical, and 'fear' for psychic stressors, with the latter including anxiety about meeting physical needs as well as 'watching' or sleeplessness, whose significance has been highlighted by modern stress theorists.³⁷ When these factors, operating collectively, reached a threshold, fever would result. That misery-induced fever might then spread to non-miserable persons. Via the emergent-contagion doctrine the poor became a threat to the rich.³⁸

In the first half of the nineteenth century the most important medical institutions of a moral economy of health were dispensaries, infirmaries, and fever hospitals, particularly in Scotland and Ireland, where no legal obligation to support the destitute existed for most of the period. It may seem that this Cullenian paradigm will underwrite any complaint Agnes might make: to be exhausted, hungry, cold, or scared is to be dangerously ill. Therapy too was commonsensical – provision of the 'necessaries' (food, warmth, and shelter).

But there are ambiguities. With respect to expressibility, exhaustion exhausts reflection; fever (or hypothermia) undermines reason and behaviour – the very dignity we need if we expect accreditation of our

protests. While acute irrationality would be noticed as delirium – itself interpreted as exhaustion – less serious cases might be unrecognised and unarticulated.³⁹

Nor, even when it became serious enough to trigger a clinical response, did that composite debility imply culpability. Indeed, ‘soup kitchen’ medicine – the common practice during epidemics of distributing soup, blankets, and coals – has been denigrated as temporising: a patching-up that neglects underlying causes of social problems.⁴⁰ And yet there are hints that even where no legal provision existed, soup kitchens and other ‘medical charities’, providing relief – rest and food – did come to be seen as entitlements, as one would expect in a conservative and restorative ‘moral economy’. Without acknowledging the agenda of culpability, they compensated reliably for oscillations in the conditions of survival. I have examined patient records from Dublin, Glasgow, Edinburgh, and Carlisle. In them are bits of Agnes-like stories, with Cullenian detail of exposure/exhaustion. Thus some examples from 127 cases described in Dominic Corrigan’s service at the Hardwicke Hospital, Dublin, in 1840–41, and in 1844.⁴¹

A servant, 28, unable to shake a cold, with debility and loss of appetite, reports much ‘mental anxiety and bodily exertion’.

A servant, 19, attributes lightness and giddiness, loss of appetite to a cold from sleeping in a damp room. A laundry maid, 37, attributes pains, cough, and cold feet to going out in the cold while hot. Two others refer illnesses to neglecting to change from wet clothes (had they a change available?). So too does a groom, ill from cold and wet on a February crossing from England.

A tailor, 24, having caught cold from wet, reports ‘cold trembling all over, and general weakness. He wishes for something to eat’. The medic writes: ‘he has merely to complain of weakness and thinks appropriate nutriment would quickly restore his health’.

A shoemaker, 27, has headaches and abdominal pains from ‘falling asleep outside’.

An ‘intemperate’ cabinet maker, 29, of ‘wretched appearance and feeble emaciated frame’, has chest pain, but was ‘observed not to suffer so much from cough as from want of food for which he had a good appetite’.

A woman, 39, having recovered from bronchitis, is discharged, but returns four days later with a relapse. On readmission she is found to have 'slight symptoms of common inflammatory fever – [but] to suffer more from the effects of want of care and of food'. Following a treatment of 'warmth. Food and some diaphoretic medicines, ... she was discharged well' two-and-a-half weeks later.

A shoemaker, 26, with pain in small of back and 'extreme mischief all over' cannot sleep. 'His Countenance ... expressive of distress rather than of illness'.

And, finally, an Agnes, 22, eight months pregnant, delivers and dies on the day of admission. She is described as 'cross and irritable', the only occasion in these notebooks where mood is mentioned.

How should we hear such summaries? Are patients accusing or simply explaining? Are doctors hinting that such problems are social and political, not medical, or simply acquiescing in the realities of their practices? Or even, does the privilege of hearing 'complaint' inhere only in critics, distant in time, situation, or both?

Usually we don't know. In July 1840 a woman, 21, attributes her fever, by then pretty well over, 'to having over-worked herself, and when very much heated ... having exposed herself to cold'. The language (if we can trust the recorder) seems to assert choice, to admit error. Yet how free is she? Depending on the expectations of an employer or the demands of a market in which she engages, not overworking may not be an option.

The Hardwicke was a state fever hospital. Because it might be, or become, contagious, incipient fever was taken especially seriously. And yet few of these patients have the most serious fever, typhus, and several have no fever at all. Some stay for weeks. A woman, 28, described as 'almost convalescent on admission ... [and] without any particular complications' stays two weeks.

Dublin's fever hospitalisation practices are unique, reflecting an over-supply of beds subsidised by a state fearful of masses of hunger-generated fever moving across the Irish Sea. Institutional responses differed in Glasgow, Edinburgh, and Carlisle. With fewer beds, they relied more on organised home care (as with Edinburgh's Society for the Relief of the Destitute Sick), or on intermediate institutions (like Glasgow's Town's Hospital).

Nosy neighbours

My second case explores the vocalising of chronic complaint rather than the negotiation of desperation. Do people come to recognise and protest the invisible stresses of debilitating conditions? To challenge the responsible moral economy when sudden changes threaten survival is not especially remarkable; to challenge it on a broad front in times of normality is more so.

Yet imagine a truly complaint-encouraging world. 'I am annoyed', I say, 'and stressed too, by rubble in the street, or the smell of sausage-making, or simply by filth'. A minor official, possessed of some obscure quasi-medical authority by virtue of the title of 'inspector of nuisances' appears, confronts the irritating parties, and makes their nuisance stop – by summons, fines, and mandamus action if necessary.

The Victorian nuisances inspector was the foot soldier of sanitary reform. What ultimately became the profession of Sanitary, or later Environmental Health inspector, was not wholly the brainchild of Edwin Chadwick, but he had much to do with ensuring the universal appointment of such officers by English local authorities in the two decades after the pioneering Public Health Act of 1848. Their odd work was not only to respond to complaints, but also to declare conditions to be nuisances.⁴²

That their pronouncements were seldom contested is less a matter of expertise than of the cultural capital with which they operated. 'Nuisance' was both a vague and a powerful term. Its derivation is from 'annoyance', which, in turn, went well beyond private pique or insufferable affectation to refer to real condition. Thus, well into the eighteenth century, we see references to roads 'annoyed' by trash.⁴³ They are not being personified with capacity for taking offence; rather, 'annoy', like 'injury' or 'harm' united human with non-human. To the degree that nuisances were real, their discovery was a matter of perception, not of heightened sensibility.

Nuisances were legally real too. Under the broad heading of trespass, common law underwrote annoyance. A nuisance might be private or public, remediation of the latter being the responsibility of the magistracy or other appropriate local authority. One need not show harm to health, merely transgression of public standards. In many towns, moreover, there was a centuries-long tradition of citizen-based environmental

enforcement through courts leet or assizes of nuisance. These relied on juries to inspect and adjudicate. To physical, customary, and legal authority, Chadwick added biomedical authority. The stench from next door was not just a violation of community standards or an impairment of one's enjoyment of property, but potentially deadly under the 'all smell is disease' maxim.

By ingeniously grafting a central government functionary onto the heritage of local self-government and common law, Chadwick and his successors were creating a role rife with a tension common to many forms of policing. As its appointed 'nose', the inspector was to represent the community; however, as representative of state- and science-based biomedical expertise, the inspector must be outside it, able to dictate the standards necessary for collective (and individual) well-being.

Inspectors were not miracle-workers transforming industrial towns into garden suburbs. The grand question is not so much *what* they did but *how* – both how they mitigated distressing conditions in nineteenth-century towns and transformed expectations and attitudes, instilling a culture of complaint. As with food riots, enlistment of communal standards was essential – as Elias and Mary Douglas remind us, 'dirt' is a communal declaration and a powerful social motor, just as a proper sense of annoyance was a key mark of class identity. By marshalling these forces the inspectors, prodding and praising on behalf of health, beauty, decency, and community, might hope gradually to produce change.⁴⁴

Survival of inspectors' records is spotty, but among the best series is that for the east Midlands brewing and coal town, Worksop, for which there are weekly summaries in fine hand from 1871 to 1886. There the first inspector we meet is Henry Mellars, who shares a surname peculiar to the region with D. H. Lawrence's fictional gamekeeper, Oliver Mellors, aka Lady Chatterley's lover.⁴⁵ Lawrence's Mellors hails from the fictional Tevershall, a Nottinghamshire coal town based on Lawrence's boyhood home of Eastwood, about thirty miles from Worksop. However facile, juxtaposing the fictional Mellors with the real Mellars is a fruitful way to explore responses to the stresses of life in industrial towns.

Lady Chatterley's Lover is a novel of oppositions: living and dead, nature and artifice, beauty and ugliness, masters and servants, capital and labour, cleanliness and squalor, hope and despair, and, of course

sensual engagement and dull acceptance. 'Tevershall' applies equally and interchangeably to town, coal pit, and people. There what Marx anticipated has come to pass: work drives out all else, including ability to challenge the conditions of existence.⁴⁶

To outsider Connie Chatterley, Tevershallian conditions preclude the 'spontaneity' and 'intuition' of full 'humanness' (205). Not only is a stroll in the woods impossible, to feel annoyance and to complain, preconditions of any moral economy, are too. Describing 'blackened brick dwellings ... black slate roofs ... mud black with coal-dust ... pavements wet and black', she reflects: it seemed 'as if dismalness had soaked through and through everything. The utter negation of natural beauty, the utter negation of the gladness of life, the utter absence of the instinct for shapely beauty which every bird and beast has, the utter death of the human intuitive faculty was appalling' (204).

For Connie, horror gets the better of any sympathy, for it is she, not the Tevershallians, who experiences stress. Of 'the industrial masses', she is 'absolutely afraid'. They seem 'so *weird*' – 'incarnate ugliness'. All this brings 'a queer feeling ... all over her, like influenza' (213). But 'if you were poor and wretched you *had* to care', insists insider Mellors. In fact, there was too much life, 'a terrible, seething welter of ugly life' (146) behind the 'flat drabness'; lives of 'misery, bitterness, and ugliness', and of 'futility, futility to the nth power'. His pathology was not, like flu, a dangerous corruption of passing innocents, but internal – a malignancy, a 'great cancer' (193).

Capitalists Connie and Clifford Chatterley may choose how to engage with Tevershall – Connie with revulsion; Clifford, as a progressive industrialist, creatively. The responses of Mellors and of the other main character, the nurse Ivy Bolton, are necessarily more complicated. Being of Tevershall and dependent on it, they have fewer degrees of freedom. Yet each, crossing boundaries of class, encounters the same ambiguities that inspectors experienced. Like the inspectors, game-keeper Mellors is expert yet servile. His education and experience would allow a middle-class career of local civic leadership, yet as much as possible he has abandoned Tevershall for a life in the woods raising pheasant chicks.

Not so Ivy Bolton, miner's widow, parish nurse, and finally nurse-companion to Clifford, a role in which she is both above and of Tevershall. Her story is complicated. Were Sophocles in charge, it might be

one of vengeful karma. Ted, the husband she loved, had died in an explosion in Tevershall pit (before Clifford inherited). On the grounds of his independence – he stood while others crouched – compensation had been minimal (122–3). Ted had hated that life; he could not escape it even in sex with a caring partner seeking to relieve his anguish (217). After his death, Ivy finds the means to train as a nurse and reintegrates into Tevershall as ‘one of the governing class of the village’ (122) until her appointment to care for the paraplegic Clifford.

Here questions do arise about moral economies. ‘What justice will she enforce?’ Lawrence wonders. Her relationship with Clifford is deep, intimate, and multidimensional, yet ultimately she is a labourer, though one who, like Thompson’s riot leaders, controls in quiet ways the terms of the relationship. And, like the inspectors, she mediates as a double agent, interpreting Tevershall for Clifford. If she is his spy, she is also its advocate, defending the workers against the masters. As to what stresses *she* feels from being a sounding board of Clifford’s complaints and being chiefly responsible for Clifford’s well-being (no less than Mellors is for his baby pheasants), Lawrence is silent.

In Worksop, Henry Mellars too must be both outsider and insider, dictator of propriety for the public’s good and sensitive to the practicalities of life in a coal town. Worksop had about 11,000 people by the mid-1880s. Even before discovery of coal in the 1860s, it had been viewed as a sanitary disaster, a place of high death rate and squalor.⁴⁷

It is in the first instance as a physical entity that Mellars confronts Worksop: persons appear in regard to structures. His moral economy must bypass any *grand mal* issues of class conflict. Wages and strikes, rents and prices, those factors that concentrate humans into small and dirty spaces and their most important means of protests, are off-limits for him. Instead, he will disturb this universe by modest architectural alterations, public and private. Want to stop the contemptuous gesture of male public urination? Remove corners to piss in, thus dulling the edge of class conflict by, literally, removing edges. Yet prostates and distended bladders still rule and urban settings must accommodate.⁴⁸

The surviving notebooks begin in 1871. They show Mellars already busy seeking a standard of acceptable living – how many persons per privy? One, for twenty-one people on Church Walk, is too few. So are two for more than thirty, and ‘the tenants are strongly of this opinion’, he notes.⁴⁹ Indeed.

Water quality is a common complaint:

- ‘unfit to drink ... has been ... for some months. The tenants declare that the drainage gets into the well’. This affects seven cottages, fourteen adults, and twenty-three children.
- Again, ‘The tenants declare’ – ‘unfit to drink, being muddy and of nasty taste’, with ‘soap suds’. ‘Tenants are much distressed to procure that required for drinking and cooking’.
- Or the ‘inhabitants of the row ... complain much’.
- Or tenants ‘complain greatly of the water ... It makes “*awful*” tea. ... I examined a large pot which had been filled over night; (the owner assured me that it was previously perfectly clean), a greasy, filthy smelling sediment was collected. Forty Two persons ... are supposed to drink the water’.
- Or water ‘green in colour and nasty smell ... inhabitants are at ... wits end ... Several children have had slight fever’.⁵⁰

This last is not epidemiology: that residents – who have not, we may presume, read John Snow – find the water that bad is authority enough for Mellars, though his successor Sampson White will routinely seek the authority of analysis. If, sometimes, Mellars associates bad water with disease, it is more as reminder: behind the work of defending decencies that should need no defense are health dangers too.

Accident prevention is a concern. Parents and Mellars worry about children falling into open wells. Or loose bricks or a sign may fall. Sometimes Mellars endorses tenants’ direct action, as when, during a dry summer, they have ‘wisely filled up the gullies with soil’ as ‘the stench was unbearable’. Yet they may need tutelage: women throw ‘soap suds and dirty water into a field opposite houses, ... causing a Nuisance. ... Asked ... to *discontinue the same*’. Or he may mediate: whose turn to clean a common privy? The inspector must intervene.⁵¹

We should not assume that rules of sanitary propriety are obvious – to anyone. Why, after the stable has burned, can the horse not be buried in the garden? Are doors on privies the public’s concern? Yes, his Board declares.⁵² That raises the question: ‘whose decency does Mellars enforce?’ He respects local power, giving much time to the bishop’s complaint of an obscure smell, while insinuating its frivolousness. But he also pushes, suggesting policy initiatives (the banning of

pigsties), challenges developers of unsound housing – ‘a discredit to the Town and its Sanitary Authorities’, demands major repairs (‘entire reconstruction’ of a row of privies and wash-houses), and regulates nuisance industries (gas lime must be instantly barged out of town).⁵³ Ironically, among the malefactors is a non-complying landlord, Mr. Edward (not Edwin) Chadwick. (And Connie Chatterley visits Chadwick Hall.)⁵⁴

Mellars defies classification. He is more than policeman, yet not quite activist. It may help to think of him as a live-in architect, always alert to what might be changed. Consider the following assessment of structure, circumstance, and use. A set of wash-houses and privies in the afternoon sun: ‘in one corner of the Wash-house (that next to the privy pit) is a small ... set-pot for heating water for washing [But] when used, the fire warms ... the contents of the pit, making the whole place unbearable. The ventilation also is inefficient. When the collier ... retires into the wash-house to strip and wash, for decency’s sake the door is closed. The effect on an empty stomach may be imagined.’⁵⁵

‘Imagined’, perhaps, but evidently not complained of. Much like Connie, Mellars has imported sensibility into a setting where it has been blunted by familiarity and lack of possibility. But here that sensibility generates not revulsion, but sympathy and possibility. Will (and should) anyone care if he gets these privy-wash-houses rebuilt? No grand sanitary problem will have been solved. Lawrence, who ignores sanitation in Tevershall, will still sneer: more fiddling with nth degree futility.

Here, however, the half-century separating Mellars from Lawrence’s novel may matter. Whether or not class stratification was sharper in Lawrence’s day, it was different: unions, a Labour Party, and concepts of inevitable struggle had transformed class consciousness. By contrast Mellars’s notebooks remind us of an earlier paternalism in which seemingly incidental elements of the physical environment were both mark and means of moral progress. The idea of nuisance inspectors as counter-revolutionary cadres may seem far-fetched, but Chadwick’s 1842 *Sanitary Report* was presented to a government terrified of Chartism, and for good reason: later in the summer the ‘plug plot’ rioters would make parts of the north ungovernable. Such a ‘moralising’ thrust continued: it would be central in late-century reformism – evident in

the Charity Organisation Society and in Beatrice Webb's career as a lady rent collector.⁵⁶

Given the emphasis in modern public health on the quality of communities, best known in the Healthy Cities movement, we should not dismiss such work.⁵⁷ However, I am less concerned with the impossible task of measuring Mellars's social-capital production, than simply with the recognition implicit in the public work that nuisance inspectors did – that the built environment (like the natural one that soaked and chilled Dubliners) strains health and may become a domain of moral economy.

Conclusion: recovering bodies

Each of the bodies of documents I have explored reaches randomly into matters both quotidian and intimate. Each of the many persons who come into our gaze arrives bearing some complex burden of exigency, which has precipitated a crisis. Each asks to be taken seriously. Often the tragedies they describe move us in their familiarity – travellers overcome by cold, wet, and worry; parents worrying about accident-prone play-spaces. These records remind us of irritants that always assail existence – hunger and thirst; weariness and the need for darkness, quiet, and rest; the many impediments and distractions to our movement, efforts, or attention; the discomforts of convenient elimination; the gasping for breath; the shivering and sweating from sun, cold, humidity, rain, or wind; and the incessant demands of impatient others. All these come with varying doses of fear. Rarely are the backstories detailed but we do the in-filling. We can overcome, too, the literary practices of probing junior doctors or officious inspectors. They bypass the most immediate and powerful expressions of pain, despair, or frustration – sobbing or yelling – though, inadvertently, the effect of their omission may dignify their subjects.

But what to *do* with these records? Learning what the Dublin doctors or Mellars did is all very well, but I am more concerned with those with whom they were interacting, persons often overlooked as too ordinary to be interesting, as if, in such lives, nothing happens that might be registered in complaint and/or stress. How they have come to be lost may be understood by considering two axes of interpretive practice: the axis separating social history from the social history of medicine, and

that separating 'soft' from 'hard' Marxist interpretive practices. I will touch briefly on each, then on their intersection.

At the risk of over-generalisation, it is probably right to say that a commonplace of contemporary historical narrative is the awarding, and even the fetishising, of full 'agency' to historical subjects, as if all are wholly healthy mid-life adults living in constitutional polities and accountable accordingly. By contrast, the subjects of medical history (even after two generations of social historians seeking access to the experience of illness), remain largely doctor-defined. Usually being recognised as a medical subject has required diagnostic confirmation, whether by modern or by past professional standards, no matter how poorly that diagnostic status registers the existential complaints these persons may have had. Those poles suggest a missing middle – of people who complain and who have much to complain of, like those we meet in these records, and who live lives that are strained, but who cannot be written off as 'diseased'. Susan Lynn Smith's wonderful title, *Sick and Tired of Being Sick and Tired*, captures that existence. If the latter 'sick and tired' represents a draining of agency, the former reminds us of the further stress that comes from reflecting on that despair.⁵⁸

We have invited ourselves into these lives via the bridging concepts of stress and overwork. But these terms, especially the former, a product of mid-twentieth-century physiology, are not fully adequate to liberate the experience of sufferer/complainer from the categories imposed by states or doctors. There is first the epistemic problem. Even were stress (or overwork) well defined, we have no obvious way to measure them in past populations, particularly for acute episodes.⁵⁹

Marx's analytic, the presumptive monetisation of lives through conversion into surplus value, was too crude for that purpose – biologically, because life histories cannot be reduced simply to energy, and historically because struggles to control lives could not be reduced to that conversion either. Rather, as so-called 'soft' Marxists pointed out, class relations were contingently historical. Each formation of class relations would constitute a unique 'political culture' that would mediate historical processes. As a part of this more fluid approach, Thompson's 'moral economy' concept fostered rich empirical studies of how identities and interests emerged and evolved, but it went further. The 'cultural turn' of the 1980s, evident in the history of medicine as well as in social history, replaced bodies and conditions with linguistic practices, for

articulation and restoration of the just balance of misery was a linguistic achievement.⁶⁰ To some radical medical historians, however, notably Roger Cooter, the cultural turn gave up far too much.⁶¹

For many of its latter day explicators, the subject and substance of justice of the moral economy was unimportant: what mattered was that there was a moral economy. Not so for Thompson. The moral economy concerned food. He saw himself as supplementing economists and old-style social historians – ‘ineducable positivists’ for whom behavior was a function of grain prices – but not as denying the biological foundation of their concern. ‘*Of course* food rioters were hungry’, Thompson thundered, ‘but this does not tell us how their behavior is modified by custom, culture, and reason’ – factors which mediated the psychic and physical aspects of stress.⁶² Yet practitioners of the cultural turn would go further. Consider James Vernon’s view: ‘that even hunger, that most material of conditions, was also the work of culture’; ‘that how hunger was understood shaped who actually experienced it, and how’.⁶³

For Thompson, culture ‘modified’; for Vernon, it comes close to supplanting. What then to do with nine-year-old Oliver Twist, taken from the baby farm where he was ‘atrociously presuming to be hungry’ and transported to the workhouse, where the boys, ‘voracious and wild with hunger’ and contemplating cannibalism, pick him to lead a food riot by asking for more gruel? Both Thompson and Vernon can show us that Oliver has violated the moral economy of ‘hunger’ as Bumble and his Board understand it, but to stop there leaves us without access to Oliver’s experience. Simply to say he has misunderstood that experience would be the height of callousness. Or one could respond that there is no issue: we are hearing only Dickens; Oliver is only words on paper. Yet the same applies to the representations of Thompson or of Vernon. In part these omissions reflect choices of gaze, for one may examine ‘hunger’ without denying hunger. Yet they reflect also the broader problem I have alluded to of the dependence of imagination on expressibility.

For Thompson, more than historical precision was at stake in correcting the economists. He was seeking an approach both sympathetic and analytic. Yet in the rarefied atmosphere of ‘political culture’, the morality of ‘moral economy’ simply evaporated: people acted and they talked about why they acted; that talk, coupled with the mysterious magic stimulant of ‘agency’, became a sufficient accounting.

What Thompson had overlooked was the need for a moral economics, a circulating currency.⁶⁴ Here it is worth keeping in mind the limits of relying on *Capital* for an understanding of the stakes in converting humans into surplus value. Marx (and Engels) were appallingly ignorant of the medicine of their day, particularly the post-Cullenean medicine relating poverty to disease, and being practised in Scotland and Ireland. Rarely too have later Marxist theorists appealed to biomedical metrics, though social (or social medical) theorists certainly have done.⁶⁵

This chapter has explored whether stress might play a role akin to that of 'marginal utility' in economics. The complaints which express our stress are, after all, expressions of desire that presumably reflect determinations of marginal utility. Expressing and responding to them has both costs and benefits. Might we then theorise the pursuit of low-stress 'health and happiness hours' as the primary motor of moral economies? In recognising positive and negative forms of stress, Seyle and others were exploring such a possibility. Yet however tempting, this will not quite work (other than by definition). While marginal utility is an axiom in economics, stress is an empirical entity, loosely defined though supported by plausible theorizing. Conceiving it as a currency is complicated by its ambiguous relation to complaint. It might be nice if complaining were a proxy of harm, but it is not. Expressibility is problematic, equally between soma and psyche and between self and culture. Moral economies of complaint do matter, but as noise rather than signal.

How to respond? The current polarisation between biomedical objectivity and cultural interpretation omits an enormous missing middle of embodied subjectivity. Historians have been baffled to know what to make of someone who says 'I'm hungry', 'I'm cold' (hypothermia and heatstroke are invisible in histories of medicine and public health), 'I'm tired', 'I'm sad', or 'I'm afraid.' A phenomenologist's perspective may help, but the issue ultimately is an acceptance of embodiment: 'experience' should open a door to explaining, not merely to explaining away.

Notes

- 1 C. E. Rosenberg, 'The tyranny of diagnosis: specific entities and individual experience', *The Millbank Quarterly*, 80 (2002), 237–60; C. E. Rosenberg,

- 'Contested boundaries: psychiatry, disease, and diagnosis', *Perspectives in Biology and Medicine*, 49:3 (2006), 407–24, <https://doi.org/10.1353/pbm.2006.0046>.
- 2 M. Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception* (New York: Pantheon, 1973); N. D. Jewson, 'The disappearance of the sick-man from medical cosmology, 1770–1870', *Sociology*, 10 (1976), 225–44.
 - 3 R. Williams, *Keywords: A Vocabulary of Culture and Society* (Oxford: Oxford University Press, 1976).
 - 4 E. P. Thompson, 'The moral economy of the English crowd in the eighteenth century', *Past & Present*, 50 (February 1971), 76–136.
 - 5 E. P. Thompson, 'Moral Economy Reviewed', in *Customs in Common* (New York: New Press, 1991), 259–305, esp. 262–3.
 - 6 'Appendix 1. World Health Organization, "Mission Statement"', <http://healthydocuments.org/appendices/doc49.html>. Accessed 14 March 2017.
 - 7 An exception are the finely grained analyses of S. King, "'Stop this overwhelming torment of destiny": negotiating financial aid at times of sickness under the English Old Poor Law, 1800–1840. Author Abstract', *Bulletin of the History of Medicine*, 79:2 (22 June 2005), 228–60, <https://doi.org/10.1353/bhm.2005.0072>; S. King, 'Regional patterns in the experiences and treatment of the sick poor, 1800–40: rights, obligations and duties in the rhetoric of paupers', *Family & Community History*, 10:1 (1 May 2007), 61–75, <https://doi.org/10.1179/175138107x185256>; S. King, 'Negotiating the law of poor relief in England, 1800–1840', *History*, 96:324 (2011), 410–35, <https://doi.org/10.1111/j.1468-229X.2011.00527.x>
 - 8 Notably, the French *se plaindre* is reflexive and there were once reflexive uses in English too (see *OED* 'complain' #2, 4a), including in a medical context, but they have disappeared: I may 'feel myself discontented', but to say 'I complain myself' will bewilder – certainly it does not mean 'I complain about myself'.
 - 9 Rosenberg, 'Tyranny of diagnosis'; Rosenberg, 'Contested boundaries'; A. Kleinman, *The Illness Narratives: Suffering, Healing, and the Human Condition* (New York: Basic Books, 1988).
 - 10 In law, too, a 'complaint' is a technical term for dissatisfaction dire enough to undertake the expense of civil litigation (*OED* #8a).
 - 11 This is the primary context in which Kowalski understands 'authentic' complaining. R. M. Kowalski, *Complaining, Teasing, and Other Annoying Behaviors* (New Haven, CT: Yale University Press, 2003), 25–52.
 - 12 N. Elias, *The History of Manners* (New York: Pantheon Books, 1982).
 - 13 Kowalski, *Complaining*, 47–8.
 - 14 J. W. Scott, 'The evidence of experience', *Critical Inquiry*, 17 (1991), 773–97.

- 15 M. Jackson, *The Age of Stress: Science and the Search for Stability* (Oxford: Oxford University Press, 2013), 38.
- 16 Jackson, *The Age of Stress*, 3, 11.
- 17 Jackson (*The Age of Stress*, 2, 14, 63, 81–5, 97) notes the interest of the early twentieth-century pioneers of stress physiology, including Cannon, Henderson, and Seyle in ‘Hippocratic ideas of balance and self-regulation’. For broader continuities, see K. Faber, *Nosography in Modern Internal Medicine* (New York: Paul Hoeber, 1922); W. Riese, *The Conception of Disease: Its History, Its Versions, and Its Nature* (New York: Philosophical Library, 1953).
- 18 D. Fox, *Power and Illness: The Failure and Future of American Health Policy* (Berkeley: University of California Press, 1993).
- 19 Lewis Carroll, *Alice’s Adventures in Wonderland*, Chapter 3.
- 20 C. Hamlin, *More than Hot: A Short History of Fever*, Johns Hopkins Biographies of Disease (Baltimore, MD: Johns Hopkins University Press, 2014).
- 21 J. Adair, *Essays on Fashionable Diseases* [...] (London: Bateman, n.d.); R. Porter, ‘Nervousness, Eighteenth and Nineteenth Century Style: From Luxury to Labour’, in M. Gijswijt-Hofstra and R. Porter (eds), *Cultures of Neurasthenia from Beard to the First World War* (Amsterdam: Rodopi, 2001), 31–49; H. Beatty, *Nervous Disease in Late Eighteenth-Century Britain: The Reality of a Fashionable Disorder* (London: Pickering and Chatto, 2012).
- 22 A. Guerrini, *Obesity and Depression in the Enlightenment: The Life and Times of George Cheyne* (Norman: University of Oklahoma Press, 2000).
- 23 Jackson, *The Age of Stress*, 81–2; University of Minnesota: Laboratory of Physiological Hygiene, *The Biology of Human Starvation* (Minneapolis: University of Minnesota Press, 1950); R. Dirks, ‘Famine and Disease’, in K. Kiple (ed.), *Cambridge World History of Human Disease* (Cambridge: Cambridge University Press, 1993), 157–63.
- 24 K. Marx, *Capital: A Critical Analysis of Capitalist Production, trans from the 3rd German Edition by Samuel Moore and Edward Aveling* (New York: International Publishing Co, 1939).
- 25 *Ibid.*, 366–7, quoting Richardson (1863).
- 26 *Ibid.*, 365, quoting *Morning Star*.
- 27 B. W. Richardson, *The Diseases of Modern Life* (New York: Bermingham, 1882); A. Rabinbach, *The Human Motor: Energy, Fatigue, and the Origins of Modernity* (New York: Basic Books, 1990).
- 28 J. C. Scott, *Weapons of the Weak: Everyday Forms of Peasant Resistance* (New Haven, CT: Yale University Press, 1985).
- 29 K. Thomas, *Religion and the Decline of Magic* (New York: Scribner’s, 1971); R. Porter (ed.), *Patients and Practitioners: Lay Perceptions of Medicine in*

- Pre-Industrial Society* (Cambridge: Cambridge University Press, 1985); L. M. Beier, *Sufferers and Healers: The Experience of Disease in Seventeenth-Century England* (London: Routledge and Kegan Paul, 1987); R. K. Rittgers, *The Reformation of Suffering Pastoral Theology and Lay Piety in Late Medieval and Early Modern Germany* (Oxford: Oxford University Press, 2012); S. C. Karant-Nunn, *The Reformation of Feeling: Shaping the Religious Emotions in Early Modern Germany* (Oxford: Oxford University Press, 2010).
- 30 S. Zlotnick, "‘The law’s a bachelor’: Oliver Twist, bastardy, and the New Poor Law’, *Victorian Literature and Culture*, 34:1 (2006), 131–46; U. R. Q. Henriques, 'Bastardy and the New Poor Law', *Past & Present*, 37 (1967), 103–29.
 - 31 David Lean et al., *Oliver Twist* (Independent Producers: Criterion Collection, 1948).
 - 32 Here, too, Lean’s film is more positive than Dickens in depicting a sympathetic nurse and surgeon. Persons like Agnes may have often had more of a clear sense of what to request and what to expect than Dickens allocates to Agnes (King, 'Negotiating').
 - 33 R. A. Soloway, *Prelates and People: Ecclesiastical Social Thought in England 1783–1852* (London: Routledge and Kegan Paul, 1969); P. Mandler, 'The making of the New Poor Law redivivus', *Past & Present*, 117 (1987), 131–57; P. Mandler, 'Tories and paupers: Christian political economy and the making of the New Poor Law', *Historical Journal*, 33 (1990), 81–101.
 - 34 At least on a regional basis, 'misery' had a specific medical meaning – like 'complaint', it was shorthand for a particular bodily pain (*OED* 'misery', #6).
 - 35 Notably, there is not only no reflexive form, but no verb. If one could once say 'I complain myself', one cannot 'miserate' though, oddly, one can 'co-miserate'.
 - 36 R. Emerson, 'Numbering the Medics', in *Essays on David Hume, Medical Men and the Scottish Enlightenment: Industry, Knowledge and Humanity* (Burlington VT: Ashgate, 2009), 163–224; A. Chitnis, *The Scottish and Early Victorian English Society* (London: Croom Helm, 1986).
 - 37 Jackson, *The Age of Stress*, 41.
 - 38 J. Pringle, *Observations on the Diseases of the Army* (London, 1752); Hamlin, *More than Hot*.
 - 39 H. Marland, *Dangerous Motherhood: Insanity and Childbirth in Victorian Britain* (New York: Palgrave Macmillan, 2004).
 - 40 C. Hamlin, *Public Health and Social Justice in the Age of Chadwick: Britain, 1800–1854* (Cambridge: Cambridge University Press, 1998); C. Hamlin, 'The "necessaries of life" in British political medicine, 1750–1850', *Journal*

- of *Consumer Policy*, 29 (2006), 373–97; C. Hamlin, 'William Pulteney Alison, the Scottish philosophy, and the making of a political medicine', *Journal of the History of Medicine and Allied Sciences*, 61 (2006), 44–86.
- 41 Royal College of Physicians in Ireland, DC 2/4/2–3, 'Hardwicke Fever Hospital case books', 1840–46 and 1843–45. The actual entries are by anonymous students. Each of the seven handwritings in these books reflects a distinct case-recording approach. On Irish medical charities, see R. D. Cassell, *Medical Charities, Medical Politics: The Irish Dispensary System and the Poor Law, 1836–1872* (Woodbridge: The Royal Historical Society/The Boydell Press, 1997), 4–15; L. Geary, *Medicine and Charity in Ireland, 1718–1851* (Dublin: University College Dublin Press, 2004); P. Gray, *The Making of the Irish Poor Law, 1815–43* (Manchester/New York: Manchester University Press, 2009).
 - 42 I have explored these issues in 'Public Sphere to Public Health: The Transformation of nuisance', in S. Sturdy (ed.), *Medicine, Health and the Public Sphere in Britain, 1600–2000* (London: Routledge, 2002), 190–204; C. Hamlin, *Sanitary Reform in the Provinces*, vol. 2 of M. Allen-Emerson, *Sanitary Reform in Victorian Britain*, 5 vols (London: Pickering and Chatto, 2012); 'Nuisances and community in mid-Victorian England: the attractions of inspection', *Social History*, 38 (2013), 346–79. See also T. Crook, 'Sanitary inspection and the public sphere in late Victorian and Edwardian Britain: a case study in liberal governance', *Social History*, 32:4 (2007), 369–93; T. Crook, *Governing Systems: Modernity and the Making of Public Health in England, 1830–1910* (Berkeley: University of California Press, 2016).
 - 43 OED 'annoy', ## 4a, 5.
 - 44 Elias, *History of Manners*; M. Douglas, *Purity and Danger: An Analysis of the Concepts of Pollution and Taboo* (London: Routledge and Kegan Paul, 1966); M. Douglas, 'Environments at Risk', in B. Barnes and D. Edge (eds), *Science in Context* (Cambridge, MA: MIT Press, 1982), 260–75.
 - 45 Bassetlaw Museum, East Retford, 2004. 3260, 3526; 'Workshop Inspectors' Notebooks'. Mellars was succeeded in June 1876 by Sampson White. My general views draw from both. On Mellars see www.genuki.org.uk/big/eng/NTT/Workshop/workshop_PLU. Accessed 22 August 2016.
 - 46 Page numbers from D. H. Lawrence, *Lady Chatterley's Lover* (New York: Grove Press, 1962).
 - 47 Workshop Heritage Trail, 'Workshop History, Part 4: 19th and 20th Century Workshop', www.workshopheritagetrail.org.uk/index.asp?page=history. See also W. Lee, 'Workshop Public Health Inspection, 1850', www.workshopheritagetrail.org.uk/resources/workshop_public_health_inspection_1851.pdf. Both accessed 29 March 2017.

- 48 'Workshop Inspectors' Notebooks', 7 August 1871, 4; 18 October 1875, 3; 18 September, 1876, 3; 30 October, 1876, 5.
- 49 'Workshop Inspectors' Notebooks', 17 April 1871, 6; 15 May 1871, 5.
- 50 'Workshop Inspectors' Notebooks', 29 May 1871, 3; 7 August 1871, 6; 4 September 1871, 2, 7; 2 October 1871, 1.
- 51 'Workshop Inspectors Notebooks', 7 August 1871, 2; 3 September 1871, 3; 26 June 1876, 1; 18 September 1876, 2; 13 November 1876, 1; 5 February 1877, 3.
- 52 'Workshop Inspectors Notebooks', 7 August 1876, 5; 15 May 1871, 5.
- 53 'Workshop Inspectors Notebooks', 21 August 1871, 4; 2 October 1871, 5; 30 October 1871, 2; 28 June 1875, 1; 1 November 1875, 1.
- 54 'Workshop Inspectors Notebooks', 2004.3258, 1 May 1882, 5; 15 May 1882, 7; 25 September 1882, 6; Lawrence, *Lady Chatterley*, 207.
- 55 Workshop Inspectors Notebooks', 7 August 1871, 5.
- 56 A. M. McBriar, *An Edwardian Mixed Doubles: The Bosanquets versus the Webbs: A Study in British Social Policy 1890–1929* (Oxford: Clarendon, 1987); B. Webb, *My Apprenticeship* (New York: AMS Press, 1977).
- 57 www.euro.who.int/en/health-topics/environment-and-health/urban-health/activities/healthy-cities/who-european-healthy-cities-network. Accessed 2 April 2017.
- 58 S. L. Smith, *Sick and Tired of Being Sick and Tired: Black Women's Health Activism in America, 1890–1950* (Philadelphia: University of Pennsylvania Press, 1995). J. C. Riley's *Sick, Not Dead: The Health of British Workingmen during the Mortality Decline* (Baltimore, MD: Johns Hopkins University Press, 1997) similarly reminds us of the unhelpful fixation of many historians on mortality as the foundation of medical signification.
- 59 For populations, an exception is skeletal evidence. See C. B. Ruff, E. Garofalo, and M. A. Holmes, 'Interpreting skeletal growth in the past from a functional and physiological perspective', *American Journal of Physical Anthropology*, 150:1 (January 1, 2013), 29–37, <https://doi.org/10.1002/ajpa.22120>. For a very different approach, see R. Wilkinson and M. Marmot, *Social Determinants of Health*, 2nd edn (Oxford: Oxford University Press, 2006).
- 60 C. Kent, 'Victorian social history: post-Thompson, post-Foucault, post-modern', *Victorian Studies*, 40:1 (1996), 97–133; R. Cooter, '“Framing” the End of the Social History of Medicine', in J. H. Warner and F. Huisman (eds), *Locating Medical History* (Baltimore, MD: Johns Hopkins University Press, 2004), 309–37.
- 61 Cooter, '“Framing”'.
- 62 E. P. Thompson, 'Moral Economy Reviewed', in *Customs in Common* (New York: New Press, 1991), 259–305.

- 63 J. Vernon, *Hunger: A Modern History* (Cambridge MA: Harvard University Press, 2007).
- 64 N. Götz, “Moral economy”: its conceptual history and analytical prospects, *Journal of Global Ethics*, 11 (2015), 147–62, <https://doi.org/10.1080/17449626.2015.1054556>.
- 65 This is well developed in D. Porter, *Health, Civilization and the State* (London: Routledge, 1999). See also my *Public Health and Social Justice in the Age of Chadwick: Britain, 1800–1854* (Cambridge: Cambridge University Press, 1998). For an example of how this might be done, see J. Livingston, *Debility and the Moral Imagination in Botswana* (Bloomington: Indiana University Press, 2005). See also R. Levins and C. Lopez, ‘Toward an ecosocial view of health’, *International Journal of Health Services*, 29 (1999), 261–93.