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The Victorian 'Change of Air' as medical and social construction

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ABSTRACT

The 'Change of Air' was a nineteenth-century tourism form premised on the restoration of health. Although widely accepted as a precursor to the modern pleasure holiday, the Change of Air has received limited direct attention in the area of tourism research. Drawing on the medical literature of the time as well as modern scholarship, this study explores the British Change of Air as a phenomenon rooted in the medical and social construction of disease. It argues that not all diseases were constructed in the same way, so some diseases acquired social prestige at the expense of others and their associated Change of Air regimens were more highly esteemed in the public eye. These constructions of disease had conspicuous consequences for Victorian perceptions of health and pleasure as well as for the rise of commercial tourism in the closing decades of the century, most significantly the commercial abandonment of the Change of Air as a climate therapy in the early 1900s.

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1. Introduction

Although health travel and pleasure travel were both known to the ancients, it was not until the modern era that they became culturally prominent. Health travel came into vogue in the mid eighteenth century, when European physicians began to recommend a CHANGE OF AIR to patients suffering from such nervous ailments as melancholy and hypochondriasis. The purpose of the Change of Air was to revitalise the patient by coaxing a focus on 'new objects' in new locales. Patients who followed through on these recommendations typically returned to their workaday lives refreshed and invigorated. An early Victorian advocate of the Change of Air was Irish surgeon James Johnson, whose very successful book *Change of Air, or the Diary of a Philosopher in Pursuit of Health and Recreation* chronicled a self-prescribed treatment that Johnson undertook through France, Switzerland, Germany, and Belgium in the years 1823 and 1829. In his book, Johnson did more than just narrate his journey. He also enumerated several principles of health travel that would set the standard in the nineteenth century. One of these was an explicit statement regarding 'wear and tear', a health disorder that resulted from 'over-strenuous labor or exertion of the intellectual faculties'.¹ The antidote Johnson

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¹James Johnson, *Change of Air, or the Diary of a Philosopher in Pursuit of Health and Recreation* (London: Highley, 1831), 3.

proposed for these ‘evils’ was the pursuit of their opposite, thus going to a place for ‘pure air, rural relaxation, and bodily exercise’.² As Johnson saw it, everyplace from ‘the green hills of Erin’ to Mont Blanc was a possible place of renewal. Around the same time that Johnson and others were defining the Change of Air, the old Roman ‘sea-voyage cure’ was enjoying renewed interest among such physicians as Ebenezer Gilchrist, who believed it was good for tuberculosis.³ By the end of the 1700s, the sea-voyage cure was a popular tuberculosis treatment in Britain.

Although widely accepted as a precursor to the modern pleasure holiday, the Change of Air has received limited direct attention in the area of tourism research.⁴ Research has typically treated it in as a proto-holiday form, less so as a medical or social construction. Drawing upon the medical literature of the time as well as modern scholarship, this study explores the Change of Air as it was practised by Britons during the Victorian period. Its premise, that the Change of Air was rooted in the medical and social construction of disease, draws sway from characterisations of disease as a complex interplay of cultural forces that influence the way diseases are named, understood, and treated.⁵ In this study, the cultural forces include not only medical and social perceptions of disease but also social class, gender, motivation to travel, and the rise of commercialisation. It will be shown that under pressure from these forces, some diseases acquired social prestige at the expense of others, and their associated Change of Air regimens became more highly esteemed in the public eye. The resulting constructions of disease had conspicuous consequences for the way health and pleasure were viewed and pursued over the course of the nineteenth century, particularly with the rise of commercial tourism in the century’s closing decades.

2. Wear and tear or last resort?

British physicians of the nineteenth century distinguished two classes of invalids: those who suffered from a clear physiological disease and those who suffered from a disease without a clear physiological cause: more of a nervous exhaustion. Though a Change of Air was felt to be beneficial for both groups, the medical consensus was that the physiological invalid had sensitive needs and therefore required a specially regimented Change of Air. The nervous invalid, on the other hand, was usually not at death’s door and therefore had a broader range of therapeutic options. Dr. James Clark explained:

In that numerous class of persons, indeed, who are merely suffering from residence in the city, without any decided disease, the simple change to the country may be all that is requisite to restore their health, and it is less of a consequence to what part of the country they go.⁶

²Ibid., 20.

³Ebenezer Gilchrist, *The Use of Sea Voyages in Medicine* (London: Cadell, 1771).

⁴Key studies on the Change of Air include Maria Frawley, *Invalidism and Identity in Nineteenth Century Britain* (Chicago: University of Chicago Press, 2010), chapter 3; Susan Barton, *Healthy Living in the Alps: The Origins of Winter Tourism in Switzerland, 1860–1914* (Manchester: Manchester University Press, 2008); Simon Kevan, “Quests for Cures: A History of Tourism for Climate and Health”, *International Journal of Biometeorology* 37 (1993): 113–24; Simon Kevan, “Biometeorology: Yesterday, Today and Tomorrow” (paper presented at the AGU-CMOS meeting, Toronto, 22–27 May 1980); Christopher Hoolihan, “Health and Travel in Nineteenth Century Rome”, *Journal of the History of Medicine and Allied Sciences* 44, no. 4 (1989): 462–85; Jonathan Andrews, “Letting Madness Range: Travel and Mental Disorder, c1700–1900”, in *Pathologies of Travel*, ed. Richard Wrigley & George Revill (Amsterdam: Rodopi, 2000): 25–88.

⁵*Encyclopaedia of Pestilence, Pandemics, and Plagues*, ed. Joseph P. Byrne (Westport, Conn.: Greenwood, 2008), s.v. “Disease, Social Construction of”.

⁶James D. Clark, *The Influence of Climate in the Prevention and Cure of Chronic Diseases* (London: Murray, 1830), 9.

This section explores two orientations to the Change of Air – as a regimented climate therapy and as a treatment for nervous exhaustion – alongside their associated challenges and progressions. The goal is to develop a comprehensive model of the Change of Air as a medically and socially constructed tourism form.

Climate therapy and ‘White Death’

There was no consensus among physicians as to which geographic locations were better for which diseases, or which symptoms improved in which locales. Most nineteenth-century doctors did agree, however, that one disease was more fearsome than any other: tuberculosis, then known as phthisis, consumption, or more poetically, as ‘The White Death’. The disease at one time encompassed – in addition to tuberculosis – a host of illnesses identified today as silicosis, histoplasmosis, emphysema, and lung cancer.⁷ The label CONSUMPTION was derived from its characteristic wasting, debilitating, and *consuming* progression.⁸

Consumption was a destroyer of lives and livelihoods. Before 1850, it was responsible for one in four deaths worldwide.⁹ Until the 1870s it was the number one killer of Britons.¹⁰ Because consumption was so rampant, the medical and social perceptions of the disease influenced where and when consumptive patients went for the Change of Air, if they were able to move about at all. Not at all surprisingly, consumptive patients dominated the travelling invalid scene; in 1850, an estimated 90% of travelling British invalids suffered from consumption.¹¹ Because consumption had no cure, all its treatments were palliative; they involved making the patient as comfortable as possible in the right climate, so the body could, in the fulness of time, *possibly* heal itself.¹²

Consumption was imagined as a ‘wet’ disease; it flourished in damp environments and abated in dry ones.¹³ Its ideal treatment, therefore, was envisioned as removal to a place that was dry.¹⁴ For this reason, climate therapists not only took the phrase ‘Change of Air’ literally, but also saw it as a challenge to distinguish ‘good air’ from ‘bad air’ scientifically. Dr. Robert Hull, a physician to the royal family, wrote that the ‘great object’ of the consumptive’s search for health was ‘the best air’.¹⁵ For most of the century, the prevailing belief was that good air was clean, free of foul odors (i.e. miasma), and well-circulated.¹⁶

⁷Katherine Ott, *Fevered Lives: Tuberculosis in American Culture since 1870* (Cambridge, MA: Harvard University Press, 1996), 2–3.

⁸Ibid., 9, 13.

⁹Sheila Rothman, *Living in the Shadow of Death: Tuberculosis and the Social Experience of Illness in American History* (New York: HarperCollins, 1994), 131.

¹⁰John Pemble, *The Mediterranean Passion: Victorians and Edwardians in the South* (Oxford: Clarendon, 1987), 88.

¹¹James E. Pollock, “Considerations of the Climate of Italy”, *London Medical Gazette* 11 (1850): 1017; Hoolihan, “Health and Travel”, 468.

¹²Ott, *Fevered Lives*, 73; Jane M. Adams, *Healing with Water: English Spas and the Water Cure, 1840–1960* (Manchester: Manchester University Press, 2015), 157, 163; Pemble, *Mediterranean Passion*, 89.

¹³Susan Sontag, *Illness as Metaphor* (New York: Vintage, 1978), 15; James Clark, *Sanative Influence of Climate* (London: Murray, 1846), 53–7; James Alexander Lindsay, *Climatic Treatment of Consumption: A Contribution to Medical Climatology* (London: Macmillan, 1887), 37–44; Rothman, *Shadow of Death*, 20.

¹⁴Lindsay, *Climatic Treatment*, 20.

¹⁵Robert Hull, *A Few Suggestions on Consumption* (London: Churchill, 1849), 31; George Bodington, *Essay on the Treatment and Cure of Pulmonary Consumption* (London: Longman, Brown, Orme, Green, and Longmans, 1840), 16.

¹⁶Dormandy, *White Death*, 43; Lindsay, *Climatic Treatment*, 21; Thomas John Graham, *The Manual for Invalids* (London: Edward Bull, 1829), 219; Thomas M. Madden, *The Principal Health-Resorts of Europe and Africa for the Treatment of Chronic Diseases* (London: Churchill, 1876), 10.

These criteria marked swamps, marshes, lowlands, and densely populated cities as inherently unhealthy. They also helped mould a therapeutic geography that was of great use to consumptives and their doctors. This geography was informed further by detailed climatological descriptions of specific locales, which included other relevant meteorological factors besides air, such as moisture, rainfall, sun, heat, etc.¹⁷

For much of the century, medical opinion orbited the idea that consumption responded favourably in three broad climate types: high altitude, ocean/seaside, and dry inland/desert.¹⁸ Belfast physician James Lindsay, a leading authority on consumption, identified several resorts in the Alps (Davos, Wiesen, St. Moritz, and Maloja), Andes (Bogotá, Quito, Jauja, Huancayo, and Arequipa), and Rockies (Manitou, Denver, and Colorado Springs) as being well-suited to consumption therapy.¹⁹ It was, however, the ocean/seaside resorts that gained earliest prominence in the treatment of the disease; in the British Isles these included Ventnor, Bournemouth, Torquay, Hastings, Grange Rothesay, Queenstown, and Glengariff; and in continental Europe Cannes, Nice, Menton, San Remo, and numerous others throughout the Mediterranean as well as the Atlantic islands of Tenerife and Madeira.²⁰ The dry inland/desert resort areas were located primarily in Egypt, Algeria, South Africa, Australia, and various districts of the western United States.²¹

Although each of these areas drew large bodies of health-seekers, climate therapists disagreed – often heatedly – on which climates were best suited to treating consumption. Part of this discord was due to evolving views on the relationship between climate and health. In 1830, Dr. Clark had given unqualified praise to the southern British seaside resort of Torquay, claiming that it ‘possesses all the advantages of the South-Western climate in the highest degree’.²² In 1887, however, Dr. Lindsay discarded Torquay as having a climate ‘too relaxing to be generally suitable for consumption’.²³ Lindsay’s abandonment of Torquay reflected a general devaluation of seaside resorts in consumption therapy and a growing appreciation for mountain resorts, inland resorts, and the traditional sea voyage.²⁴

Lindsay readily acknowledged problems with the therapeutic geography of consumption. He conceded the variability of all three climate zones, particularly that of the higher elevations, where moisture, fog, and wind were unpredictable and therefore able to undermine therapeutic benefit.²⁵ Lindsay also puzzled over how ocean air and high altitude air could be so meteorologically different and yet have such similar effects on the health of the consumptive.²⁶ To be sure, the therapeutic geography outlined by Lindsay

¹⁷John Beckerson, and John K. Walton, “Selling Air: Marketing the Intangible at British Resorts”, *Histories of Tourism: Representation, Identity and Conflict*, ed. John K. Walton (Clevedon, UK: Channel View, 2005), 55.

¹⁸Lindsay, *Climatic Treatment*, 196; Charles Theodore Williams, *Pulmonary Consumption; Its Etiology, Pathology and Treatment* (London: Longmans, Green & Co., 1887), 362–73.

¹⁹Lindsay, *Climatic Treatment*, 55; Weber, “On the Influence of Alpine Climates”, 43.

²⁰Lindsay, *Climatic Treatment*, 38–9; John F. Travis, *The Rise of the Devon Seaside Resorts 1750–1900* (Exeter: Univ. of Exeter Press, 1993), 27–8. According to Travis, it was the political turmoil of the French Revolution (1789–1799) that shifted the focus of British invalids from the south of France to Britain’s own coasts and boosted interest in ‘wintering’ closer to home.

²¹Lindsay, *Climatic Treatment*, 41; Clark, *Sanative Influence of Climate*, 54.

²²Clark, *Influence of Climate*, 50.

²³Lindsay, *Climatic Treatment*, 189.

²⁴Pemble, *Mediterranean Passion*, 244; Lindsay, *Climatic Treatment*, 40; Thomas Henry Burgess, *Climate of Italy in Relation to Pulmonary Consumption* (London: Longman, Brown, Green, and Longmans, 1852), 24, 55.

²⁵Lindsay, *Climatic Treatment*, 54.

²⁶*Ibid.*, 45; Clark, *Change of Air*, 22–3.

was not universally accepted; more than a few climate therapists regarded the low temperatures of high mountains as harmful for the consumptive's delicate lungs and constitution.²⁷ Still others fretted over the high consumption mortality rates in locales such as Nice, where the disease was supposedly allayed.²⁸

As a consequence of these uncertainties, the choice of destination for the Change of Air was seen as vitally important for the patient's recovery and, perhaps, survival. Once at their destination, the patient's cooperation was deemed essential, even if it meant doing nothing except waiting for health to return. At resorts catering to consumptives, guests might be required to become perfectly immobile, refraining altogether from walking, talking, writing, and even reading.²⁹ Proponents of this therapeutic model believed quite literally that recovery would come only from leading a 'quiet, vegetative, and dolce far niente sort of life'.³⁰

Plenty of other physicians, however, advocated a Change of Air that balanced the explicit pursuit of health with refreshing routines and explorations indoors and out. Dr. Lindsay, for example, believed in removing the consumptive not just to a healthier climate but also 'to an out-door life of healthful activity'.³¹ More importantly, however, he maintained that the treatment of consumption required a 'change of air, change of diet, change of scenery, change of daily routine, change involving the abandonment of many an injurious habit which has long been the secret minister of disease'. Lindsay was convinced that this 'great boon of change' benefitted the consumptive more than any other aspect of the Change of Air.³²

Not all physicians were so open-minded, however. More than a few were suspicious of all that exciting 'change' and how it might play out in actual practice. Stories circulated of invalids seeking change in the form of questionable if not reprehensible pleasure activities including dancing, gambling, theatre-going, drinking, and 'irregular sexual enjoyments'.³³ Many doctors perceived antagonism between therapy and pleasure and drew a sharp line between the two. In 1880, the *British Medical Journal* urged doctors to warn their patients 'not to endeavour to combine sight-seeing with health-seeking', since combining the two often proved 'a fatal mistake'.³⁴ The *BMJ*'s advisory was not unreasonable. Travelling consumptives often took the therapeutic value of the Change of Air for granted and lived too indulgently for their own good, only to return home worse for the wear and pin the blame on their doctor. At the same time, the demands of climate therapy could be cumbersome

²⁷Hermann Weber, "On the Influence of Alpine Climates on Pulmonary Consumption", *British Medical Journal* 2, no. 342 (1867), 42.

²⁸James Clark, *The Influence of Climate in the Prevention and Cure of Chronic Diseases* (London: John Murray, 1830), 108; Edward I. Sparks, *The Riviera: Sketches of the Health Resorts of the North Mediterranean Coast of France and Italy* (London: Churchill, 1879), 247; Pemble, *Mediterranean Passion*, 244; Dubos & Dubos, *White Plague*, 143–44.

²⁹Ott, *Fevered Lives*, 74; Douglas Peter Mackaman, *Leisure Settings: Bourgeois Culture, Medicine, and the Spa in Modern France* (Chicago: University of Chicago Press, 1998), 105.

³⁰John Patterson, *Egypt and the Nile* (London: Churchill, 1867), 61; Thomas Clouston, *Clinical Lectures on Mental Diseases* (London: Churchill, 1883), 188; Arthur Bentley, and C.G. Griffinhoofe, *Wintering in Egypt* (London: Simpkin, Marshall, Hamilton, and Kent, 1894), 176; A. Samler Brown, *Madeira and the Canary Islands* (London: Samson Low, Marston & Co., 1894), 7; William Farr, *A Medical Guide to Nice* (London: Churchill, 1841), 83; James L. Siordet, *Mentone in Its Medical Aspect* (London: Churchill, 1863), 82–3. *Dolce far niente* is Italian for 'sweet idleness.'

³¹Lindsay, *Climatic Treatment*, 20.

³²*Ibid.*, 21.

³³Thomas J. Graham, *Manual for Invalids*, 53; Edward W. Harcourt, *A Sketch of Madeira, Containing Information for the Traveller, or Invalid Visitor* (London: Murray, 1851), 49.

³⁴"Winter Holidays and Foreign Health-Resorts", *British Medical Journal* 2, no. 1031 (1880): 553; "The Medical Aspects of Continental Tours", *British Medical Journal* 2, no. 1340 (1886): 465.

or even oppressive, and the consumptives who seasoned their therapy with unprescribed amusements often did so out of desperation.

There is a reason why so many Victorian physicians were loath to plant ideas in their patients' heads about 'great boons of change'. From the beginning, the Change of Air involved more than just physical or mental improvement. If properly practised, it would fortify body and mind and also elevate the individual morally. Part of this characterisation was rooted in a traditional belief that the maintenance of health required discipline, presumably furnished by virtue.³⁵ This moral emphasis was not accidental; the Change of Air came of age, as it were, alongside the Grand Tour, a travel form built around reconnecting the well-to-do (usually Britons) with Europe's Classical past. Although the Tour was enjoyed by anyone and everyone, Grand Tourists were usually young, healthy, wealthy, and inadequately supervised, conditions that set the stage for, among other things, sexual adventure.³⁶ In practice, the Grand Tour was often an occasion for British (mostly male) youth to sow their wild oats away from society eyes.³⁷

Even though the Change of Air and Grand Tour 'itineraries' did not directly coincide, Dr. Johnson recognised the potential antagonism between the two. Of primary concern to him was the 'youth who travels – and more especially he who sojourns for some time in foreign countries', and who brought home unseemly new habits.³⁸ Rather than providing a platform for moral dissipation, Johnson argued, the Change of Air was to birth virtue, specifically cleanliness, delicacy, industry, patriotism, and religion.³⁹ That the Change of Air was, at its core, a moral counterpoint to the Grand Tour is essential to making sense of its development, particularly in the morally heady years of the Victorian period.

In this context, it was fully expected that the Change of Air would involve systematic regulation of the invalid's daily existence, including not only his food, exercise, rest, and amusements, but also his 'morbid caprices' and 'over-sanguine tendencies'.⁴⁰ The Change of Air as climate therapy was more than just a prescription to travel; it was a moral contract between doctor and patient. As healers of the psyche, doctors fashioned themselves also as protectors of the soul and took on a pastoral function.⁴¹ Invalids were perceived as lacking moral strength and therefore in desperate need of it. 'Proper' treatment of consumption therefore meant helping the patient achieve victory over not just bodily illness, but also over some known or concealed sin.⁴² It also entailed a firm insistence that the consumptive avoid temptation, which included not just worldly vice but also anything that might encourage neglect of the therapy.

Because this model left so little room for error, climate therapists took a rigidly didactic approach to the most basic therapeutic activities. According to Dr. Robert

³⁵ Adams, *Healing with Water*, 153; Janet Oppenheim, *Shattered Nerves: Doctors, Patients, and Depression in Victorian England* (Oxford: Oxford University Press, 1991), 41.

³⁶ Jeremy Black, *The British and the Grand Tour* (London: Croom Helm, 1985), 109.

³⁷ *Ibid.*, 123.

³⁸ Johnson, *Change of Air*, 280.

³⁹ *Ibid.*, 281–94.

⁴⁰ Burney Yeo, *Climate and Health Resorts* (London: Chapman & Hall, 1885), 588–89.

⁴¹ Michael Clark, "The Rejection of Psychological Approaches to Mental Disorder in Late Nineteenth-Century British Psychiatry", in *Madhouses, Mad-Doctors, and Madmen: The Social History of Psychiatry in the Victorian Era*, ed. Andrew Scull (Philadelphia: University of Pennsylvania Press, 1981), 292; Andrew Scull, "The Social History of Psychiatry in the Victorian Era", in Scull, *Madhouses, Mad-Doctors, and Madmen*, 9.

⁴² Ott, *Fevered Lives*, 36.

Scoresby-Jackson, for example, sea-bathing was a meticulous ‘process’ that demanded extreme caution and planning:

Invalids ought not bathe in the sea before breakfast; nor soon after a meal. About ten o’clock in the forenoon is a convenient time, especially if the tide be nearly at its height. A hard, sandy sloping beach, with the tide at two-thirds flood, is the best place for bathing.⁴³

Once in the water, the invalid was to move about briskly for at most five minutes (longer was ‘injurious’), then dry himself with ‘rough towels’ and quickly ‘cover the body’.⁴⁴ Other physicians were still more reproofing than Scoresby-Jackson. For Dr. A.L. Wigan of Brighton, ‘the mischief done every season by premature, excessive, or improper, bathing is enormous’, and the chance of benefit gained from it rarely justified the risk, especially for young females.⁴⁵

The climate therapists did not stop at sea bathing. Tourist sites, with their inevitable walking, temperature fluctuations, and questionable ventilation all posed potential health risks to consumptives, who were instructed to avoid ‘chilly cathedrals’, ‘hot picture galleries’, and ‘dusty streets’.⁴⁶ Mingling with other hotel guests was also frowned upon for physical as well as moral reasons.⁴⁷ The *salon* of the typical French Riviera hotel was too crowded and poorly ventilated for consumptives and was a locus of immoral enticement to be scrupulously avoided. As Edward Sparks saw it, invalids who rubbed elbows with ‘ordinary’ hotel guests might acquire a false sense of wellness and over-exert themselves ‘in walking and dancing’, ‘frequent hot rooms’, and ‘sooner or later, to run over to Monte-Carlo and try their luck at the gambling-tables’.⁴⁸ It went without saying that the invalid was to avoid all such ‘vain amusements’ as theatre, a ‘luxurious table’, and any activity that might birth ‘evil and corrupt thoughts’.⁴⁹

A ‘proper’ Change of Air exacted sacrifice from those who pursued it, and the type and degree of sacrifice varied along gender lines. For much of the nineteenth century, the travelling female was viewed as an aberration even under the best of circumstances.⁵⁰ Travelling with an escort, such as her husband, was the standard; if she travelled alone, she was classified as ‘unprotected’, a term which implied eccentricity, and she was furthermore liable to be pinned with any number of negative epithets, including ‘spinster abroad’, ‘adventuress’, ‘lady on the loose’, ‘globe trotter’, or ‘fair amazon’.⁵¹ If in the company of her husband, her ‘natural’ function was to accompany him, not to be waited on by him.⁵² In virtually all cases, therefore, the Change of Air did not fall within the bounds of ‘proper’ women’s behaviour.⁵³ That being so, it is hardly surprising that in 1879

⁴³Robert Scoresby-Jackson, *Medical Climatology* (London: Churchill, 1862), 43.

⁴⁴*Ibid.*, 44.

⁴⁵A.L. Wigan, *Brighton, and Its Three Climates; With Remarks on Its Medical Topography* (Brighton: Folthorp, 1845), 53; Graham, *Manual for Invalids*, 210–11.

⁴⁶Lindsay, *Climatic Treatment*, 213; Scoresby-Jackson, *Medical Climatology*, 69; Joseph T. Dayrell, *Change of Climate Considered as a Remedy in Dyspeptic, Pulmonary, and Other Chronic Affections* (London: Churchill, 1853), 45–6; Archibald D. Walker, *Egypt as a Health-Resort* (London: Churchill, 1873), 74–5; Hoolihan, “Health and Travel”, 470.

⁴⁷Sparks, *Riviera*, 218–19; Siordet, *Mentone in Its Medical Aspect*, 82–3.

⁴⁸Sparks, *Riviera*, 158, 164; Dayrell, *Change of Climate*, 45.

⁴⁹Graham, *Manual for Invalids*, 39, 53; Thomas Trotter, *A View of the Nervous Temperament* (London: Longman, Hurst, Rees, and Orme, 1807), 43–4.

⁵⁰Pemble, *Mediterranean Passion*, 78.

⁵¹Pemble, *Mediterranean Passion*, 77–8; Janice Schroeder, “Strangers in Every Port: Stereotypes of Victorian Women Travelers”, *Victorian Review* 24, no. 2 (1998): 122.

⁵²Schroeder, “Strangers in Every Port”, 122.

⁵³Rothman, *Shadow of Death*, 77; Schroeder, “Strangers in Every Port”, 43, 118.

Dr. Sparks observed more consumptive men than women in the south of France and attributed the disparity to the ‘expense and difficulty of arranging matters’ faced by women travellers generally.⁵⁴

When circumstances did permit a woman to seek a Change of Air, it was anything but an emancipatory escape.⁵⁵ For much of the century, women were not acculturated to look after themselves financially or logistically, so for most women, solo travel was not a viable option even if the ways and means existed. By the dawn of the twentieth century, the solo woman traveller would become the norm, at least in southern Europe’s most popular resorts.⁵⁶ Until then, however, the female invalid’s best if not sole option was to remain home.

The rise of fashionable maladies

Despite all its dreadfulness, consumption had a fashionable side. In the eighteenth century, consumption had been seen as a corollary of refined artistic tastes and aesthetic pleasures. It was, in the terminology of historians Clark Lawlor and Akihito Suzuki, ‘the romantic disease par excellence’ and as such was a way to ‘sell oneself to the public as an artistic genius’.⁵⁷ Though consumption was constructed *medically* as a path to death, it was constructed *socially* as a vehicle for self-glorification. This was especially true of women, for whom consumption was seen as adding to, rather than subtracting from, natural feminine delicacy; consequently, the consumptive woman was aestheticised in her own right.⁵⁸

This particular social construction peaked early in the century (Lawlor and Suzuki place the peak around 1820)⁵⁹ before gradually giving way to a less charitable view of consumptive invalids. At the outset, the Romance of consumption was dampened by simple competition: in the eighteenth century, the malady of nervous exhaustion had come to the fore, wielding a Romantic prestige of its own. Brought on by the burdens and stresses of ‘modern life’, nervous exhaustion was soon assigned a wide range of clinical names, including spleen, cachexia (sometimes called cachexia *londinensis* to underscore its urban genesis⁶⁰), melancholy, hypochondriasis, hysteria, and (later on) neurasthenia.⁶¹ Each was associated with some degree of overexertion yet lacked a clear physiological basis, and each was perceived, at least initially, as endemic to the polite social strata.⁶²

One nervous disorder that became particularly fashionable in the nineteenth century was melancholy. Dr. Robert Burton had brought awareness to melancholy in 1621 as a disposition of heightened or disproportionate

⁵⁴Sparks, *Riviera*, 104.

⁵⁵Schroeder, “Strangers in Every Port”, 123.

⁵⁶Pemble, *Mediterranean Passion*, 78.

⁵⁷Clark Lawlor, and Akihito Suzuki, “The Disease of the Self: Representing Consumption, 1700–1830”, *Bulletin of the History of Medicine* 74, no. 3 (2000): 487–88; René Dubos, and Jean Dubos, *The White Plague: Tuberculosis, Man and Society* (Boston: Little, Brown, 1952), 59; *Encyclopaedia of Pestilence, Pandemics, and Plagues*, s.v. “Tuberculosis and Romanticism”.

⁵⁸Dubos, and Dubos, *White Plague*, 54–5; Lawlor, and Suzuki, “Disease of the Self”, 480; *Encyclopaedia of Pestilence, Pandemics, and Plagues*, s.v. “Tuberculosis”.

⁵⁹Lawlor, and Suzuki, “Disease of the Self”, 492.

⁶⁰Clark, *Influence of Climate*, 9.

⁶¹George Cheyne, *The English Malady* (London: Strahan, 1733); Oppenheim, *Shattered Nerves*, 5, 92, 142–44, 163; Roy Porter, and Dorothy Porter, *In Sickness and in Health: The British Experience 1650–1850* (London: Fourth Estate, 1988), 63, 142, 203–9, 225–29; Adams, *Healing with Water*, 162–63; Ott, *Fevered Lives*, 72–3; Barbara Sicherman, “The Paradox of Prudence: Mental Health in the Gilded Age”, in Scull, *Madhouses*, 220–21; Hoolihan, “Health and Travel”, 466; Andrews, “Letting Madness Range”, 32, 41.

⁶²Oppenheim, *Shattered Nerves*, 13.

sorrow, need, sickness, trouble, fear, grief, passion, or perturbation of the mind, any manner of care, discontent, or thought, which causeth anguish, dulness, heaviness and vexation of spirit, any ways opposite to pleasure, mirth, joy delight, causing frowardness [sic] in us, or a dislike.⁶³

The medical men of Burton's time were powerless to treat such a complex disorder, so the customary therapy was a Change of Air. 'There is no better physic for a melancholy man', Burton wrote, 'than change of air, and variety of places, to travel abroad and see fashions', because it delighted the senses 'with such unspeakable and sweet variety'.⁶⁴

Burton's treatise probably owed its popularity to its presentation of melancholy as an everyman's (and everywoman's) illness. 'And who is not a Foole', Burton inquired, 'who is free from Melancholy? Who is not touched more or lesse in habit or disposition? ... And who is not sick, or ill-disposed, in whom doth not passion, anger, envie, discontent, fear & sorrow raigne?'⁶⁵ Unlike grief and sadness, which normally come and go, melancholy held on to its targets tenaciously. It also seemed to choose them carefully. Aristotle had remarked that it afflicted mostly philosophers, statesmen, poets, and artists.⁶⁶ French poet La Fontaine rhapsodised that melancholy was imparted only to the 'moral and aesthetic connoisseur'.⁶⁷ A diagnosis of melancholy therefore carried with it an affirmation that one possessed certain refined and admired qualities. Not surprisingly, Burton's *Anatomy of Melancholy* enjoyed a surge in popularity during the nineteenth century and went through 48 editions by century's end.⁶⁸

Though patients diagnosed with melancholy or one of the 'new' disorders were not necessarily medically demanding, some were insufferable enough to earn the label *invalid*. This was especially true of hypochondriacs. Obsessed with their state of health, hypochondriacs both craved and resisted medical intervention.⁶⁹ This embattled mental state compelled physicians to classify hypochondriacs as invalids in their own right and send them travelling mainly to be rid of them.⁷⁰ Dr. Scoresby-Jackson delicately explained that for the hypochondriac, it was 'travelling from place to place amongst attractive scenery, and in cheerful society', that ultimately relieved the 'real or imaginary' distresses that weighed upon the mind.⁷¹ In such cases, the Change of Air was useful primarily to provide geographic and psychological distance from whatever stresses, excesses, or fears had caused suffering, so that the overtaxed mind (or imagination) could reset.⁷²

Initially, the therapeutic geographies of consumption and the nervous disorders overlapped. As medical understanding of these diseases grew, however, they were assigned increasingly distinct therapeutic spaces. Whereas consumption was seen as an affliction requiring a 'stimulating' climate, nervous disorders (in whatever form) were viewed as

⁶³Robert Burton, *The Anatomy of Melancholy* (Oxford: Cripps, 1621), 321 [Here I cite an American edition, Philadelphia: Claxton, 1883].

⁶⁴Ibid., 306–7; Andrews, "Letting Madness Range", 28, 30.

⁶⁵Burton, cited in Charles Rosen, *Freedom and the Arts: Essays on Music and Literature* (Cambridge, MA: Harvard University Press, 2012), 342.

⁶⁶Rosen, *Freedom and the Arts*, 344.

⁶⁷Ibid., 344–45; Porter, and Porter, *In Sickness and in Health*, 64.

⁶⁸Rosen, *Freedom and the Arts*, 340.

⁶⁹Porter, and Porter, *In Sickness and in Health*, 206.

⁷⁰Frawley, *Invalidism and Identity*, 70; Jill Steward, "Representations of Spa Culture in the Nineteenth-Century British Media: Publicity, the Press and the *Villes d'Eaux* (1800–1914)", in *Spas in Britain and France in the Eighteenth and Nineteenth Centuries*, ed. Annick Cossic, and Patrick Galliou (Newcastle: Cambridge Scholars Press, 2006), 385; M.R.C.S., *Confessions of a Hypochondriac* (London: Saunders & Otley, 1849), 75.

⁷¹Scoresby-Jackson, *Medical Climatology*, 79; Dayrell, *Change of Climate*, 70.

⁷²Hoolihan, "Health and Travel", 464.

overly excited states in need of a ‘sedative’ climate. So, Dr. Sparks proposed, nervous cases were ‘rather injured than improved by the climate of the Western Riviera’.⁷³ A resident of the Riviera, Sparks argued that he had witnessed too many nervous conditions – especially among young females – to accept that the coastal Mediterranean climate was well-suited to nervous afflictions.⁷⁴ For these afflictions, a sedative desert climate was preferable.

That nervous afflictions were widely seen as *female* afflictions was no coincidence. Dr. Graham noted that women were especially vulnerable to ‘severe mental affections’ and that their ‘high nervous sensibility’ made their feelings ‘more acute’.⁷⁵ This vulnerability was associated with menstrual and reproductive irregularities and was therefore placed under the ancient Greek label *hysteria*.⁷⁶ Though no one theory of hysteria prevailed in the nineteenth century, it was widely supposed that diseases of the female organs had neurological effects, including eccentricity and extreme emotionality.⁷⁷ For the female nervous patient, therefore, a Change of Air might be limited to destinations where female complaints were known to be rare, such as Menton or Cairo,⁷⁸ or where they could be directly treated, such as at any number of inland spas specialising in women’s health, including Franzensbad (Bohemia), Schwalbach (Prussia), and others.⁷⁹ The mineral baths at Ussat (southwestern France) were said to ‘exert a special action’ on the uterus and boasted ‘great success’ in the treatment of dysmenorrhoea and menorrhagia.⁸⁰

If the nervous disorders of the 1700s–1800s were associated with the stresses of life, it was specifically *bourgeois* stress, such as might be caused by long hours of industrious work or disciplined academic study, that gave birth to them. They were consequently perceived, for most of the Victorian period, as *polite* disorders. The labels *spleen*, *melancholy*, *hypochondriasis*, *cachexia*, *hysteria*, and *neurasthenia* contributed to what Roy Porter and Dorothy Porter call a ‘faddish language’ that ‘conveyed allure and mystique’.⁸¹ Nervous disorders – real or imagined – responded well to the Change of Air, some of them so well that the Change of Air became among Britain’s polite society an ‘item of conspicuous consumption’.⁸²

3. Therapies in conflict

So far two orientations to the Change of Air have been described in this paper: one for physiological diseases like consumption, and one for such nervous disorders as melancholy. Whereas the Change of Air as climate treatment for consumption was medically (and therefore morally) regimented, the Change of Air for nervous restoration was

⁷³Sparks, *Riviera*, 142.

⁷⁴*Ibid.*, 141.

⁷⁵Graham, *Manual for Invalids*, 237; Edward Jarvis, *On the Comparative Liability of Males and Females to Insanity* (Utica: New York State Lunatic Asylum, 1850), 16.

⁷⁶Clark, *Sanative Influence*, 383; Annick Cossic, ‘The Female Invalid and Spa Therapy in Some Well-Known 18th-Century Medical and Literary Texts’, in *Spas in Britain and France*, ed. Cossic and Galliou, 115–38; Porter, and Porter, *In Sickness and in Health*, 63; Mark S. Micale, *Hysterical Men: The Hidden History of Male Nervous Illness* (Cambridge, MA: Harvard University Press, 2008), 91. It should be noted that the label ‘hysteria’ was highly gendered but, in fact, men were just as liable to present with ‘hysterical’ symptoms as women.

⁷⁷Caroline Roberts, *The Woman and the Hour: Harriet Martineau and Victorian Ideologies* (Toronto: University of Toronto Press, 2002), 113; Robert Brudenell Carter, *On the Pathology and Treatment of Hysteria* (London: Churchill, 1853).

⁷⁸Siordet, *Mentone in Its Medical Aspect*, 38; Walker, *Egypt as a Health Resort*, 86.

⁷⁹Matthew Charteris, *Health Resorts at Home and Abroad* (London: Churchill, 1885), 36, 96.

⁸⁰Dayrell, *Change of Climate*, 313.

⁸¹Porter, and Porter, *In Sickness and in Health*, 209.

⁸²Vladimir Yankovic, *British Airs and the Making of Environmental Medicine* (New York: Palgrave-MacMillan, 2010), 121.

somewhat freeform. Dr. Lindsay advocated an ‘out-door life of healthful activity’ without stating what exactly that might entail.⁸³ Perhaps he was unsure or it simply did not matter. As Lindsay saw it, it was the ‘new objects’ encountered in the Change of Air, more than climate or the therapy itself, that brought ‘renewed vigour of mind and body’.⁸⁴

This freeform approach to the Change of Air stood in potential conflict with the Victorian principle of rational recreation. From the early decades of the nineteenth century, British middle classes increasingly rejected the frivolous excesses of the aristocracy, as well as the perceived rough and rowdy amusements of the lower classes.⁸⁵ Consequently, they perceived as respectable only those activities that were ‘rational’, i.e. that built character or increased knowledge in some way.⁸⁶ Travel afforded long gaps of free time, and this free time needed to be spent in rational, not frivolous, ways. For middle-class Victorians, how one spent one’s free time was never left to chance, but rather always demanded moral self-scrutiny, and, when appropriate, self-denial.⁸⁷

Because of its explicit regimentations, climate therapy was easy to classify as ‘rational’, especially since it extended a strong medical-pastoral hand to keep patients on track. Climate therapy involved large measures of self-scrutiny and self-denial as a matter of course, and many of its patients were so immobilised by sickness that there was little reason to worry that they might wander morally off course. However, the Change of Air as a ‘great boon of change’ for the mind and body invited the nervous patient to embrace novelty and interaction with unfamiliar people and surroundings and therefore raised all sorts of questions. What ‘variety of places’ would the patient be visiting, and in what social venues would the patient be ‘seeing fashions’?⁸⁸ Though some physicians continued to insist on a Change of Air that was socially and physically inert, others kept an open mind, since the whole point of the Change of Air was to break the patient free from stagnant patterns of thinking and doing.

A few went so far as to accept the idea – revolutionary at the time – that amusement might afford its own health benefits. ‘Relaxation and amusement’, proclaimed Dr. Joseph Davis in 1836, ‘are really as useful objects in the end as the direct pursuit of any good’.⁸⁹ For Dr. Archibald Walker, giving the invalid pleasant things to do was a matter of simple practicality. ‘The ennui of doing nothing is unbearable’, he wrote in 1875, ‘and the thoughts of the individual, instead of being removed from thinking of the disease, appear to be more concentrated. This forms no slight hindrance to the return of health’.⁹⁰

Other physicians did not explicitly seek to reconcile health and pleasure in the context of the Change of Air but clearly felt that fresh physical surroundings could benefit the

⁸³Lindsay, *Climatic Treatment*, 20.

⁸⁴*Ibid.*, 33.

⁸⁵Michael Thompson, *The Rise of Respectable Society: A Social History of Victorian Britain 1830–1900* (Cambridge, MA: Harvard University Press, 1988), 263; Brad Beaven, *Leisure, Citizenship and Working-Class Men in Britain, 1850–1940* (Manchester: Manchester University Press, 2005), 90.

⁸⁶Geoffrey Best, *Mid-Victorian Britain, 1851–1875* (London: Fontana, 1971), 232; Thompson, *Rise of Respectable Society*, 257, 274; Hugh Cunningham, *Time, Work and Leisure: Life Changes in England since 1700* (Manchester: Manchester University Press, 2014), 86, 155; Beaven, *Leisure, Citizenship and Working-Class Men*, 18–9.

⁸⁷Oppenheim, *Shattered Nerves*, 131; Cunningham, *Time, Work and Leisure*, 167; Pemble, *Mediterranean Passion*, 253.

⁸⁸Burton, *Anatomy of Melancholy*, 306.

⁸⁹Joseph E. Davis, *A Popular Manual of the Art of Preserving Health* (London: Whittaker, 1836), 108–9.

⁹⁰Walker, *Egypt as a Health Resort*, 75.

patient on multiple levels. Take, for example, Dr. Charles Williams' breathless description of the 'cheering influence' of the French Riviera:

Owing to the freedom of climate from rapid and constantly recurring changes of frost, rain, mist, and mild weather, the invalid spends the greater part of the day in the open air, and scarcely knows what confinement within doors means. The exciting causes of his complaint being removed, and the long spell of propitious weather enabling the full influence of genial atmosphere to act on his frame, his bodily vigour gradually returns, and he finds himself able to enjoy a fair amount of exercise, whether walking, riding, or driving, in a region in which earth, sea, and sky present to his observation phenomena so varied in form, so brilliant in colour, and so wondrous in beauty, that an inexhaustible feast unfolds itself before his astonished gaze, in the enjoyment of which his attention is withdrawn from the contemplation and oftentimes the exaggeration of his own symptoms, and directed to higher and nobler objects.⁹¹

Although travel was considered beneficial for virtually all forms of chronic disease, the success rates of physiological diseases and nervous disorders were lopsided. Nervous patients were far more likely to go home from from their Change of Air feeling revitalised than their consumptive brethren, who typically went home no better off, if not actually worse.⁹² This disparity infuriated the climate therapists, who tended to blame any failure on the invalids themselves.⁹³ Over time, however, the parade of climate therapy failures spoke for itself, and climate therapists came to terms with the idea that it was the principles of climate therapy, not the invalids, that had failed. In 1900 the *British Medical Journal*, the same periodical that had decried the mixing of health and pleasure, effectively conceded the defeat of climate therapy:

It is probable that the least significant factor in a 'change of air' as a remedial means is the air itself. A change of air is good—whether for the overworked, the weakling, or the convalescent. The active agents are doubtless, in most instances, the change of scene, of mental atmosphere—in a word, of environment. ... The chief thing unquestionably is the relief from the monotony of accustomed surroundings.⁹⁴

Climate therapy was, by now, in steep decline. This decline altered the social mien of tourist spots: fewer consumptives meant a lower profile for health-focused tourism and a higher profile for pleasure seeking. The decline was also mediated by the rise of 'germ theory' in the last few decades of the nineteenth century. Germ theory introduced the medical world to new vectors of disease transmission and moved climate-based theories of disease to the back burner. The discovery in 1882 of the tuberculosis bacillus (TB) had marked the beginning of the end of climate therapy, though admittedly not all physicians abandoned it right away. Even with all the evidence emerging of tuberculosis as an infectious disease, many continued to insist that it was caused by foul air and damp climates. 'Whether the bacillus is related to tubercle as accident or concomitant', Lindsay wrote in 1887, 'is still quite uncertain'.⁹⁵ Despite such holdouts, over the ensuing decades climate therapy took on a very different tone. Whereas climate therapists had

⁹¹Charles Williams, *The Climate of the South of France* (London, Churchill, 1867), 3–4; George Cheyne, *English Malady*, 182; James Adair, *Medical Cautions for the Consideration of Invalids* (London: Dilly, 1786), 112–13; Porter, and Porter, *In Sickness and in Health*, 207.

⁹²Ott, *Fevered Lives*, 49; Pemble, *Mediterranean Passion*, 244; Hoolihan, "Health and Travel", 468, 471.

⁹³Pemble, *Mediterranean Passion*, 246; Sparks, *Riviera*, 218–19; Trotter, *View of the Nervous Temperament*, 43–4.

⁹⁴"The Physiology of Change", *British Medical Journal* 1, no. 2058 (1900): 1428.

⁹⁵Lindsay, *Climatic Treatment*, 16; Ott, *Fevered Lives*, 89. Germ theory was not immediately accepted by the general public either; as late as 1909, it was still widely believed that one could contract tuberculosis by 'catching a chill.'

previously situated their patients at spa resorts so they could be healed, quite literally, by the air, they now herded them into sanatoria to control contagion.⁹⁶ As sanatoria became increasingly abundant, tubercular patients no longer felt compelled to travel long distances for treatment.⁹⁷ There would be no definitive cure for tuberculosis until 1946.⁹⁸

4. 'New invalidism' in the pleasure ranks

If affluent Victorians chalked up the nervous disorders to varying degrees of human 'fallibility', they were markedly less charitable towards those who suffered from consumption. Consumption's Romantic lustre faded rapidly. In the decades before the rise of germ theory, the disease was seen as hereditary, and by the 1870s it was widely held that one did not inherit the disease but rather a disposition toward it; the disease itself was activated by any number of environmental factors, including squalid living conditions and sinful excess.⁹⁹ As a result of this medical refocusing, the social construction of the disease shifted from a 'disease of the self' to a 'disease of the other'; in its new guise as tuberculosis, consumption lost any remaining shine and came to be seen as a threat to public health and public decency.¹⁰⁰

Not surprisingly, this shift impacted the ways in which consumptives travelled for health. It was stated earlier that until the 1870s, consumption was the biggest killer of Britons and that it dominated the travelling invalid scene.¹⁰¹ Those who suffered from it, especially the well-to-do, came under increasing pressure to dissemble its bodily symptoms and emphasise its more benign mental ones, especially in public settings.¹⁰² This practice became even more prevalent after the discovery of the tuberculosis bacillus. That discovery birthed public fears about infection, and such telltale practices as coughing and spitting became both medically and socially anathema.¹⁰³ The result was what Ott calls a 'new invalidism' that sought to conceal the harsh face of the disease behind a façade of healthy respectability.¹⁰⁴ In America, this façade included the increased use, from the 1880s, of such stigma-neutral clinical labels as *neurasthenia* to replace the stigma-heavy labels *tuberculosis* and *consumption*.¹⁰⁵

The emerging stigma no doubt prompted many travelling consumptives to defy the conspicuous diets, therapies, and routines emblematic of its treatment, and to pursue activities that might allow them to escape the consumptive (or later, tubercular) classification. To the casual observer, the movements, habits, and routines of these individuals might have seemed rich with pretence. Evidence for this pretence is, however, circumstantial. In his 1841 *Medical Guide to Nice*, Dr. William Farr declared that health travellers on the Riviera typically arrived with two motives, 'an avowed one and a concealed one; the avowed motive is health—the concealed one, pleasure', and

⁹⁶Rothman, *Shadow of Death*, 179–80. For a good overview of the climate therapy endgame, see Pemble, *Mediterranean Passion*, 240–55.

⁹⁷Dormandy, *White Death*, 125; Barton, *Healthy Living in the Alps*, 182.

⁹⁸Dormandy, *White Death*, 347.

⁹⁹Dubos, and Dubos, *White Plague*, 65, 197; Dormandy, *White Death*, 42–3; 77–8; Ott, *Fevered Lives*, 17, 73.

¹⁰⁰Lawlor, and Suzuki, "Disease of the Self", 461; Marc Arnold, *Disease and Social Change: Tuberculosis in Folkestone and Sandgate, 1880–1930* (Newcastle: Cambridge Scholars, 2012), 12.

¹⁰¹Pemble, *Mediterranean Passion*, 88; Pollock, "Climate of Italy", 1017; Hoolihan, "Health and Travel", 468.

¹⁰²Dormandy, *White Death*, 77; Mitman, "Landscapes of Exposure", 100; Pope, "Role of the Sanatorium", 328.

¹⁰³Ott, *Fevered Lives*, 71, 113.

¹⁰⁴*Ibid.*, 71.

¹⁰⁵Adams, *Healing with Water*, 162; Ott, *Fevered Lives*, 72.

that ‘there are more lovers of the latter than the former’.¹⁰⁶ Although the pretentious invalid described by Farr surely existed in large numbers, there were also plenty of travellers whose avowed motive was pleasure and whose concealed motive was health. Motivated by a desire to escape the stigma of consumption, such individuals concealed their illness and feigned wellness.

The obvious way to feign wellness at a tourist destination was by acting like a healthy tourist. In 1867, Dr. Williams observed that consumptive invalids on the French Riviera blended into the pleasure scene to such an extent that it was ‘often impossible for a casual observer to detect any difference in them from the healthy’.¹⁰⁷ Again, this evidence can be read two ways: though some invalids acted in reckless disregard of their medical orders, others chose to blend in for a far less obvious reason: to avoid the social stigma that their disease, if disclosed, would wage against them. The sum of these pretences swelled the ranks, as it were, of tourists who dabbled in more or less innocent amusements without apparent interest in improving their health, thereby raising the profile of pleasure-related tourism.

5. The polarisation of health and pleasure

Though tourists may have been sensitive to the ways their holiday-making practices were perceived by others, they apparently did not worry themselves much over which activities better embodied ‘the pursuit of health’ or ‘the pursuit of pleasure’. From the eighteenth century, health and pleasure were both medically constructed; Heather Beatty points out that even the more flippant motivations to travel tended to be medically grounded.¹⁰⁸ In the nineteenth century, as we have seen, this medical grounding took on a moralistic tone. Middle-class approaches to pleasure were similarly charged.¹⁰⁹ Even so, ‘pursuit of health’ and ‘pursuit of pleasure’ were not categorical in the minds of most Victorian travellers; consequently, any activity from sea-bathing to pier-promenading could have been viewed as furnishing a health benefit *and* a pleasure benefit, though one of the benefits may have been more immediately obvious – or more explicitly sought after – than the other. Drawing a sharp distinction between the two pursuits is therefore problematic. According to Jane Adams, cultural context, personal motivation, and norms of behaviour, not to mention ‘the variety of purposes and meanings that can be attributed to specific actions’ are essential in making sense of health travel and pleasure travel.¹¹⁰ Simply put, Victorian travellers positioned their own fulcrum between health and pleasure on a case-by-case basis, often (though by no means always) within received bounds of therapeutic discipline and social decorum.

¹⁰⁶William Farr, *Medical Guide to Nice*, 5; Morell MacKenzie, “Health-Seeking in Tenerife and Madeira”, *The Royal College of Surgeons of England* (July 1889): 123; Frawley, *Invalidism and Identity*, 120.

¹⁰⁷Williams, *South of France*, 4.

¹⁰⁸Heather Beatty, *Nervous Disease in Late Eighteenth Century Britain: The Reality of a Fashionable Disorder* (London: Pickering & Chatto, 2011), 124.

¹⁰⁹Cunningham, *Time, Work and Leisure*, 86, 155; Thompson, *Rise of Respectable Society*, 257, 274; Nigel Morgan, and Annette Pritchard, *Power and Politics at the Seaside: The Development of Devon’s Resorts in the Twentieth Century* (Exeter: University of Exeter Press, 1999), 22; Martin Hewitt, “Why the Notion of Victorian Britain Does Make Sense”, *Victorian Studies* 48, no. 3 (2006): 424; Peter Burke, “The Invention of Leisure in Early Modern Europe”, *Past & Present* 146 (1995): 148–49; Charles Walter Masters, *Respectability of Late Victorian Workers: A Case Study of York, 1867–1914* (Newcastle: Cambridge Scholars, 2010), 226–28; Thompson, *Rise of Respectable Society*, 263.

¹¹⁰Adams, *Healing with Water*, 185; Frawley, *Invalidism and Identity*, 137; Mackaman, *Leisure Settings*, 5; Beatty, *Nervous Disease*, 172; Tania Woloshyn, “La Côte d’Azur: The *Terre Privilégiée* of Invalids and Artists, c. 1860–1900”, *French Cultural Studies* 20, no. 4 (1989): 393.

The fluidity of what was perceived as health-giving and pleasurable was surely difficult to reconcile with moralistic appeals from above not to combine the two.¹¹¹ After all, the subtitle of Dr. Johnson's treatise on the Change of Air was *The Pursuit of Health and Recreation*, suggesting that health and recreation were somehow interconnected. Other climatists seemed to view them as one and the same. Dr. Archibald Walker, for example, proclaimed in 1873 that 'few remedies are so pleasurable' as the Change of Air.¹¹² Dr. Matthew Charteris advocated pleasure through nature, art, and music as a staple of consumption treatment.¹¹³ The continuity of health and pleasure was even made explicit in advertisements for Thomas Cook's high-profile continental tours, which delivered not 'mere pleasure' but also 'increased health and information'.¹¹⁴

If a health-pleasure dichotomy existed at all, it was in the realm of commerce. As tourist crowd sizes grew, resort entrepreneurs increasingly allocated social and medical functions to separate physical spaces.¹¹⁵ Resort guests may have expedited this progression, though unwittingly: bigger crowds tended to drive guests away from the public areas where health-seekers and pleasure-seekers had in earlier decades mingled more or less freely, and into smaller, insular groups where motivations and objectives tended to be more uniform.¹¹⁶ The illusion of disunity between the pursuit of health and pleasure was augmented further by market forces, which tended to rally around the cultural polarities of health and pleasure rather than explore their middle ground.¹¹⁷ In 1852, at least one Scottish hydropathic resort – Smedley's – posted separate rate schedules for 'patients' and 'visitors', with patients paying three times as much as visitors, though the distinction between patients and visitors at Smedley's and other resorts like it was not clear-cut.¹¹⁸

These facts shed light on the relationship between health/pleasure and commercialisation. Commercialisation was a player not only in the polarisation of health and pleasure in tourist locales, but also in the growing emphasis on pleasure generally. As we have seen, however, the tourist gaze and the commercial gaze did not tidily coincide. How, then, are we to connect the Victorian tourist with the rise of pleasure tourism except as a hapless subject?

In Cold-War era Czechoslovakia, spa resorts were unique in that they were built by the state for both health and pleasure, and because of the centralised socialist economy of the time, they were not subject to market forces.¹¹⁹ Under these conditions, a resort culture emerged in which the pursuit of health and the pursuit of pleasure were viewed as concomitants. In the aftermath of socialism and with the rise of free-market capitalism, this balance became polarised, though not strictly in favour of pleasure. Amy Speier interprets this evolution not as a shift from health to pleasure but rather as a shift from health and pleasure to the *consumption* of health and pleasure.¹²⁰ Commercialisation of Czech resorts

¹¹¹"Winter Holidays", 553; "Medical Aspects", 465.

¹¹²Walker, *Egypt as a Health Resort*, 7.

¹¹³Charteris, *Health Resorts*, 9, 22.

¹¹⁴Thomas Cook, "Excursions! Excursions!" *The Excursionist* (1870): 7–8; Michele Strong, *Education, Travel and the 'Civilisation' of the Victorian Working Classes* (Basingstoke: Palgrave-MacMillan, 2014), 17.

¹¹⁵Jill Steward, "The Role of Inland Spas as Sites of Transnational Cultural Exchange in the Production of European Leisure Culture (1750–1870)", in *Leisure Cultures in Urban Europe, c.1700–1870: A Transnational Perspective*, ed. Peter Borsay and Jean Hein Furnée (Manchester: Manchester University Press, 2016), 240.

¹¹⁶Steward, "Role of Inland Spas", 254; Travis, *Devon Seaside Resorts*, 73.

¹¹⁷John K. Walton, *The English Seaside Resort: A Social History, 1750–1914* (Leicester: Leicester University Press, 1983), 187.

¹¹⁸Alastair Durie, "The Business of Hydropathy in the North of England, c. 1850–1930", *Northern History* 39, no. 1 (2002): 45; Alastair Durie, *Water Is Best: The Hydros and Health Tourism in Scotland, 1840–1940* (Edinburgh: John Donald, 2006), 91.

¹¹⁹Amy Speier, "Czech Balneotherapy: Border Medicine and Health Tourism", *Anthropological Journal of European Cultures* 17, no. 2 (2008): 148.

exerted influence on *all* the ways health and pleasure were practised in the context of tourism. At the Victorian era resort, however, commercialisation came to embrace pleasure to the virtual exclusion of health. The difference between these two scenarios was the medical construction of disease at the time commercialisation occurred. At the close of the nineteenth century, the chief factor in the spread of consumption/tuberculosis was poverty, not as a direct cause but rather as an abetting factor, since poverty brought with it a range of privations that tended to exacerbate the unsanitary conditions in which the disease flourished.¹²¹ It was then seen, in the words of contemporary American social scientist Lilian Brandt, as ‘pre-eminently a disease of the tenements’.¹²² This recasting of the disease as an affliction of the poor spelt doom for the invalid tourism market. Whereas consumptive invalids had once been admired as wealthy and refined, they were now perceived as victims of their own squalor and they were, furthermore, contagious. As Gregg Mitman observes, for resort investors of the time, ‘contagion and poverty were certainly less attractive than wealthy invalids’.¹²³ By the early 1900s, investors had acquiesced to the new medical-social construction of consumption and had shifted their energies to pleasure palaces, music halls, and amusement rides.

6. Conclusion

This research has explored the medical and social construction of the Change of Air in the nineteenth century in the context of the prevalent physiological and nervous diseases of the time. The Change of Air was supposedly beneficial for all types of disease, but certain diseases, most prominently tuberculosis, seemed to require a more heavily regimented therapy premised on medical theories of climate. From a social standpoint, tuberculosis was stigmatised and became increasingly so as the century wore on, thus making its associated climate treatment far less socially appealing. On the other hand, nervous diseases like melancholy acquired a peculiar social cachet and their associated Change of Air regimens, which were generally more pleasure-focused than climate treatment, gained a reputation for being medically successful and grew in popularity.

These developments were accelerated by the increasing stigma-driven trend of consumptive patients to feign wellness, thereby driving most forms of climate therapy below the threshold of social visibility. The social stigma of consumption not only accelerated the demise of climate therapy but also increased the relative visibility of pleasure pursuits at resorts, thus modifying the therapeutic landscape.

It is well established that commercial forces expedited the development of resorts as pleasure centres at the end of the nineteenth century. This research has proposed that the commercial trend to ‘favour’ pleasure pursuits over health ones was rooted in the emergent construction of consumption as a disease of the poor. Faced with a choice between catering to ‘impoverished’ invalids or hale pleasure-seekers, entrepreneurs chose the latter. In the post-communist Czech Republic, entrepreneurs took a different direction, embracing health and pleasure both because poverty was not a part of the construction of disease.

¹²⁰Ibid., 149.

¹²¹Ott, *Fevered Lives*, 70; Ann Hardy, *The Epidemic Streets: Infectious Disease and the Rise of Preventive Medicine, 1856–1900* (Oxford: Clarendon Press, 1993), 263; Arnold, *Disease and Social Change*, 21, 29; Lilian Brandt, “Social Aspects of Tuberculosis”, *Annals of the American Academy of Political and Social Science* 21 (1903): 68.

¹²²Brandt, “Social Aspects of Tuberculosis”, 67.

¹²³Mitman, “Geographies of Hope”, 100.

A connection can be drawn between the commercialisation of tourist resorts and the commercialisation of pilgrimage sites. Some historians have described the effect of commercialisation at traditional pilgrimage sites like Lourdes and Santiago de Compostela as an erosion of authenticity in which pious motives have devolved into secular ones.¹²⁴ Others have argued that this characterisation is based on untenable distinctions between the categories of ‘tourist’ and ‘pilgrim’. Suzanne Kaufman, for example, maintains that the idea of erosion from pious to secular ‘accepts the nineteenth-century discourse that produced the two activities as binary oppositions’, rather than asking the more academically interesting question of how pilgrimage and tourism have mutually constructed each other.¹²⁵ According to Noel Salazar, it is equally problematic to suppose that commercialisation has caused the categories ‘tourist’ and ‘pilgrim’ to encroach upon each other, as this implies that pure categories of pilgrims and tourists actually exist, and furthermore, it allows pilgrimage to be imagined, ‘in an evolutionary fashion, as “ancestral” to tourism’.¹²⁶

These remarks have powerful implications for the study of health and pleasure travel. Only if one assumes the pure categories of ‘health seeker’ and ‘pleasure seeker’ can one envision an evolutionary progression from one to the other. Attempts to connect Point A to Point B have variously envisioned a ‘popularisation’ of boisterous working-class amusements (or, conversely, a ‘coming to terms’ with them), a ‘relaxing of morals’, a ‘learning to embrace the notion of fun’, or even an acceptance of the ‘carnavalesque’.¹²⁷ This study submits that the commercialisation of nineteenth-century tourism was medically constructed in the same manner as disease and prompts us to ponder a question: If the diseases of the nineteenth century had been other than what they were, or if they had been medically constructed some other way, then might not tourism today look very different?

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¹²⁴Dean McCannell, *The Tourist: A New Theory of the Leisure Class* (New York: Schocken, 1976); Paul Fussell, *Abroad: British Literary Traveling Between the Wars* (New York: Oxford University Press, 1980); Daniel J. Boorstin, *The Image: A Guide to Pseudo-Events in America* (New York: Atheneum, 1987), 77–117.

¹²⁵Suzanne K. Kaufman, “Selling Lourdes: Pilgrimage, Tourism, and the Mass-Marketing of the Sacred in Nineteenth-Century France”, in *Being Elsewhere: Tourism, Consumer Culture, and Identity in Modern Europe and North America*, ed. Shelley Baranowski and Ellen Furlough (Ann Arbor: University of Michigan Press, 2001), 80–1.

¹²⁶Noel B. Salazar, “To Be or Not to Be a Tourist: The Role of Concept-Metaphors in Tourism Studies”, in *Challenges in Tourism Research*, ed. Tej Vir Singh (Bristol: Channel View, 2015), 63.

¹²⁷Adams, *Healing with Water*, 185; Gary S. Cross and John K. Walton, *The Playful Crowd: Pleasure and Places in the Twentieth Century* (New York: Columbia University Press, 2005), 59; Walton, *English Seaside Resort*, 163, 169, 214; Michael J. Huggins, “More Sinful Pleasures? Leisure, Respectability and the Male Middle Classes in Victorian England”, *Journal of Social History* 33, no. 3 (2000): 593; Rob Shields, *Places on the Margin: Alternative Geographies of Modernity* (London: Routledge, 1992), 89–100.