Research Article

Received: 1 June 2024 / Accepted: 21 October 2024 / Published: 05 November 2024

Phthisis and Romantic Sensibility: The Social Construction of the Idea of Illness

Carlos Miguel Ferreira[1]

André Costa[2]

Sandro Serpa[3]

Jorge Ferraz[4]

[1]*Interdisciplinary Centre of Social Sciences, CICS.NOVA, Portugal*
[2]*Polytechnic Institute of Castelo Branco, Castelo Branco, Portugal*
[3]*University of the Azores, Faculty of Social and Human Sciences, Department of Sociology, Portugal; Interdisciplinary Centre of Social Sciences, CICS.UAc/CICS.NOVA.UAc, Portugal; Interdisciplinary Centre for Childhood and Adolescence, NICA, UAc, Portugal*
[4]*Estoril Higher Institute for Tourism and Hotel Studies, Estoril, Portugal*

DOI: https://doi.org/10.36941/jesr-2024-0156

Abstract

This article aims to understand the process of social construction of the idea of phthisis as a "romantic" illness. The construction of the discursive space on phthisis expresses the conjuncture coalitions of interests that shape the different discursive registers produced by various agents from diverse social spaces (political, medical, religious, literary), making it possible to recognise, legitimise and promote the social visibility of the idea of phthisis as a "romantic" illness. Phthisis, associated with a romantic aesthetic, was seen as a hereditary disease or an illness associated with fate that affected the sensitive souls of the romantic elites, namely young people, women and fragile beings who were consumed by "sad passions".

Keywords: *Social construction, Illness, Disease, Tysica, Romanticism*

1. Introduction

An illness only acquires meaning through its connection to the interdependent relationships between individuals and society, present in interpreting this phenomenon, in a specific time and space. Thus, an illness expresses, on the one hand, living conditions, values and belief systems, medical knowledge and representations in a given space-time; on the other hand, an illness is only "resented" by

individuals when the signs they perceive in themselves correspond to symptoms that are socially recognised as indicators of disease. The problem to address is the idea of illness: the question is what it means to classify and designate someone as ill, how signs and symptoms are classified or diagnosed as an illness, how an individual is designated ill and how social behaviour is shaped by the diagnosis process. What is said about the illness cannot be analysed without examining the social, professional and political position of those who say it in historical terms.

There are two dimensions to the concept of illness: the biological and the social. In its social form, illness is a meaning attributed to behaviour by the actor or those around them, and sick behaviour is arranged by this meaning. The human, and therefore social, evaluation of what is normal, appropriate or desirable is as inherent in the notion of illness as it is in the notion of morality (Freidson, 1970). The concept of illness is inherently evaluative. Illness, in its social dimension, is linked to people's beliefs, assessments and actions, as well as to their social and cultural conditions. In society, calling something a disease has consequences that are independent of the biological state of the organism. The course and outcome of the illness may be biologically the same, but the interaction between the patient and others is significantly different.

Disease in its biological dimension refers to abnormalities in the biological functioning of the human body. Illness can be considered a kind of deviation from a set of norms that represent health or normality. The norm is never universal. By replacing the popular dichotomy of health and illness with the scholarly dichotomy of normal and pathological, medical theory has endeavoured to construct these notions as purely descriptive, referring to a state of affairs independent of our desires and opinions (Gayon, 2004). Making normal and pathological objective categories of thought meant, on the one hand, interpreting the pathological state as a simple change in the intensity of a normal phenomenon, a variation by excess or defect, and not a qualitative change (Gayon, 2004; Canguilhem, 1984). On the other hand, the criterion for the normal state was taken to be the statistical average, while the pathological state would be a significant deviation from the statistical average. Canguilhem (1984) believes that the categories of normal and pathological are based on the "normativity" of life itself. Normal and pathological only take on a negative or positive value depending on how the individual experiences them regarding the environment, in other words, regarding their own normative power.

We are also dealing with the axiological dimension of illness: illness has "a negative biological value". Health is not just normal. Being healthy and normal are not completely equivalent, because the pathological is a kind of norm. To be healthy is not only to be normal in a given situation but also to be normative, in this situation and other possible situations (Canguilhem, 1984). The impossibility of defining health as statistical normality has led many doctors to recognise that all judgements about health and illness include value judgments. This is diffuse normativism. In its strong version, normativism maintains that, in all judgments about health and illness, the classification of anything as an illness always implies a value judgment (Gayon, 2004). This position entails considering that illnesses do not exist as things in themselves, there are no "sick people" independently of contexts, and social and symbolic worlds (Gayon, 2004; Carapinheiro & Correia, 2015).

It is not, therefore, possible to draw a continuous line between health and illness, not only because this boundary varies but also because there is no such line. The analytical category "state of non-health" allows for a wide margin of autonomy, free will and self-reflection in life and health choices. It makes it possible to overcome the dominant normativity of the defence of the boundary that separates health from illness, such as the boundaries that separate normal from pathological, order from disorder, natural from social, rational from irrational, reason from emotion, among others (Carapinheiro, 2011).

Health and illness have several simultaneous meanings depending on various types of knowledge. Even medical knowledge, like any other scientific knowledge, is based on certain assumptions and, in the light of different assumptions, other positions are enunciated. It is also relevant to recognise that knowledge is not, and cannot be, applied neutrally and independently of who applies it (Carapinheiro & Correia, 2015; Conrad & Barker, 2010; Freidson, 1970).

Illness and health, regardless of the biological and physiological dimensions that make up their medical and clinical realities, can be considered symbolic maps that reveal the political, social and cultural structures that ascribe them meaning and sense, implicated in multiple regulation regimes. Moral boundaries are established that support the process of categorising and labelling diseases, based on the functioning of the binary model which, for example, opposes decent diseases to indecent diseases; shameful diseases to morally acceptable diseases; and pure diseases to impure diseases (Carapinheiro, 2011).

Illness is also socially defined. Illnesses differ according to time and social conditions, incorporating a plurality of meanings and connotations that convey a certain representation of the world and the social order. This plurality of meanings can be analysed based on the relationship between three distinct but interdependent components: disease, illness and sickness (Twaddle, 1994a, 1994b; Susser, 1990; Hofmann, 2016; Carapinheiro & Correia, 2015). *Disease* refers to the biological condition; the physiological, biochemical, genetic and mental deviations observed, examined, measured and certified by medical knowledge; health professionals develop strategies aimed at classifying, detecting, controlling and treating disease. *Illness* concerns the patients' disturbance inherent in their experiences and emotions of a particular malaise, the way individuals evaluate and feel a disease. The discomfort, strangeness, anxiety, fear, pain and suffering patients may feel stem from their experiences of the conditions they perceive as illness and from the social context. *Sickness* regards the process by which biological signs or disturbing behaviours are recognised as conditions with socially significant consequences, i.e., refers to the social recognition of the illness as legitimate and its consequences, namely whether a person is entitled to treatment and economic rights, exemption from social duties, but also whether a person is legally responsible for their actions. The nosological categorisation and social qualification of a particular "disease" are not socially neutral processes; medical management is characterised by the close link between legitimacy and stigma. Considering someone to be ill immediately has consequences for their identity and the medical classification of an illness, even if it is a mistake, can be enough to introduce the individual into a career as a patient. Even if the illness has had its legitimacy recognised – having the right to be ill – the patient is not always able to avoid stigmatisation (Herzlich, 1991).

The "reality" of illness can be considered a social construction, insofar that it is produced, reproduced and transformed by the actions of individuals, by their experiences in society, over space and time, through social relationships that take place in certain contexts, shaped by interactions, mediated by social norms and roles, and framed by social organisation based on social systems. The various ways in which perceptions, representations and actions about illness are translated are socially constructed, primarily through the interactive processes of socialisation, in which individuals actively internalise social values, norms, rules, practices and behaviours within the framework of certain social constraints. Individuals produce reality and are produced by it. Through their actions, they produce and reproduce social systems and structures. These, in turn, condition their actions through a series of constraints, including norms, rules and social roles (Carapinheiro, 1986; 2011; Conrad & Barker, 2010; Tavares, 2016).

The analytical category "social construction of illness" makes it possible to determine the elements that structure the patient's social identity (social construction of the patient's status): the patient's social relationship with the illness (perception, representation, and subjective and objective experiences of the illness); levels of disagreement between the "patient's illness" and the "doctor's illness"; and possibilities for affirming the patient's perspective (set of ideas about the condition of being ill, autonomous from medical thinking). However, it makes it possible to draw up a picture of the social reality of illness in a precise historical and social context: its social distribution; the illnesses that preceded it and which function as a frame of reference; the changes produced in its qualitative status; the change in systems of social valorisation; the diversity of its social uses (Carapinheiro, 1986). The symbolic effectiveness of this category as a principle for classifying reality and organising common visions of the social world has the effect of "naturalising" a reality that, from a certain point of view, only exists from the moment it is designated (Ferreira, 1996). The sick person,

in this case, the "individual with phthisis" or the "individual with tuberculosis", only exists sociologically from the moment they are named and recognised as such. However, it is not possible to talk about patients without also talking about the illnesses that, in each era, constituted the specificity of the patients' experience and shaped their consciousness and identity.

2. Methods and Techniques

The research strategy followed in this article is intensive. In this type of research, the objectives focus on the dense description and integrated analysis of a case, seeking to characterise the specific articulation established in it between multiple facets of its constitution. The aim is thus to help elucidate what the uniqueness of the case consists of, especially what stems from that specific articulation of dimensions, but also to clarify the ways in which, in some of these dimensions, it relates to broader domains (Costa, 1999). It is a question of understanding the multiplicity of facets and dimensions that characterise this singular polyhedral process of social construction of the idea of illness.

Uniqueness can be understood as a characterising fact, species or thing and not as a particular trait of a fact, species or thing (Hamel, 1992; Hamel et al., 1993). Uniqueness is not empirical nature and cannot be reduced to the status of exception, of the extraordinary. It has a theoretical and methodological status, supported by an "image" or "model" of things, seen as the "theory" of the presumed relationships between things. Its theoretical status is related to an epistemological function because it highlights what is considered global or general *per se*, forcing criticism of the previous generality about which it is singularised (Hamel, 1997a; Canguilhem, 1968).

The case study allows analytical generalisations rather than empirical ones (based on a large amount of empirical data). Case studies, like experiments, can be generalised to theoretical propositions and cannot be generalised to populations or universes. In this sense, the case study, like the experiment, does not represent a "sample"; the aim is to extend and generalise theories (analytical generalisation) and does not aim to enumerate frequencies (statistical generalisation) (Yin, 2003, p. 10). The case(s) chosen is(are) aligned with the object of research and, as a result, the qualities identified are theoretical. These qualities, explained from a disciplinary perspective, from a specific point of view, give the case representativeness. This representativeness does not come from statistics, which it is often reduced to in sociology, but from a representativeness that can be described as theoretical or sociological (Hamel, 1997a; 1997b).

Documentary analysis was the technique favoured in this investigation, developed from diverse types of documentary sources. In a documentary study, documents can be understood as "means of communication", produced with some purpose and for some end. Considering that documents are instruments and supports of communication expressing objectified forms of experience and knowledge related to a certain sector of human practices, this implies that every document can be contextualised within a certain social and cultural framework. Within this framework marked by its complexity, the document enters the framework of social relationships and assumes a certain role in the social relationships game, ascribing value to certain acts or shaping certain relationships (Lalanda-Gonçalves, 2014, p. 2).

The type of documentary sources favoured are medical journals, manuals, academic theses and articles produced in the fields of medicine and social sciences and humanities, and literary works, which, by expressing different positions and interests in the medical, political, literary and societal fields, were important for understanding the construction of the discursive space on phthisis. These documents constitute and manifest the politics of cognition: language is used to construct an "official" reality, often around classifications that produce the promotion or marginalisation of ideas, and current concepts, which selectively define situations and shape readers' preferences, perceptions and cognitions (Carvalho, 2000). These documents can be seen as sites of symbolic struggles over the perception of the social world.

3. Phthisis: Consumptive Disease

Phthisis is an affliction of an organ, the lungs, which causes the body to wither, continuous fever, fatigue, coughing and expectoration of blood. In ancient Greek, the term phthisis means a state of diminution, of weakening. When Aristotle mentioned the "phthisis" of the moon, he meant that this celestial body was in its waning phase. In the technical vocabulary of Greek physicians, this term retained its original meaning: the expressions phthisis *dorsalis*, phthisis *nephritica*, phthisis of an eye or phthisis of a limb were used to designate not tuberculosis, but the atrophy of these organs (Grmek, 1994).

In the Hippocratic texts, the term phthisis is narrowed down and becomes more precise, presenting an anatomical and clinical meaning that is both richer in detail and narrower in its delimitation of the nosological field. Phthisis is the ulceration of the lungs, chest or throat, causing coughs and mild fevers, with the body consumption; this ulceration has three phases: "rawness, cooking and elimination". The disease comes from the flow of phlegm from the head to the lungs, which causes suppuration, or from the accumulation of phlegm and bile, humours that, being in excess, settle in the lungs, gather there and become corrupted, forming "tumours", collections of pus; the extravasation of this pus through expectoration transforms the agglomerations into cavities, which can be completely dry once the patient is cured, or continue to suppurate with a fatal outcome, marked by the consumption of the body. The Hippocratic physician based his reasoning on a theory of the nature of the body, *physis,* on complex physiological concepts, which made it possible to represent objects and operations, such as virtue (*dynamis),* cause (*aitía),* movement (*kinésis),* elements (*stoicheia)* and opposition (*enantiosis),* seeking to clarify the separation between diseases of chance *(tiché)* and diseases of necessity (*anaké)*; He was thus able to construct clinical pictures or forms of clinical presentation (*katástasis*) of diseases and make a diagnosis, based on the known morbid species or eidos. The model of therapeutic intervention presupposed an understanding of the sense of opportunity, of the good occasion, the *kairos, the* obligatory intersection between the natural history of the disease, the *kronos of the* disease and the doctor-patient encounter (Marques, 1999).

The Hippocratic doctors knew that phthisis could affect countless people, but they did not advocate the possibility of contagion. To explain the epidemic emergence of phthisis, Hippocrates appealed to the harmful influence of certain ecological factors and particularly to the determining role of climatic conditions. However, the latter were the same for all people living in the same places, so it was necessary to justify that only a proportion of individuals exposed to morbid factors became ill. For Hippocrates, illness resulted from the combination of external factors (e.g., weather conditions, earthly influences, diet and exercise) in individuals with a particular predisposition, a personal "constitution" that reacted pathologically to certain variations in the environment.

For most Greek physicians of classical times, the constitution of an organism was the overall expression of the individual combination of bodily humours. Physiological predisposition depended on age, sex, state of mind, heredity and previous lifestyle. In the *Aphorisms*, Hippocrates considered that phthisis mainly affected people between the ages of 18 and 35, pregnant women and women in labour. Although the favourable role of certain psychic states such as sadness and "melancholy", mentioned by Galen, Arab authors, the Salerno school and many doctors until the 19th century, was pointed out (Biraben, 1988).

Table 1: Constitutional types and diseases

Constitutional types	Physical characteristics and main psychological	Most common diseases	Critical stations
Phlegmatic or pituitary	Fat, moist and soft; quiet, distracted and lazy	Diarrhoea, chills, Winter fevers, haemorrhoids, bleeding in women, sterility, abortion, asthma and epilepsy	Winter
Melancholy	Dry, not corpulent, dark, sad and fearful nature	Epilepsy, mental disorders, high fevers, brain inflammations, diarrhoea, leprosy	Autumn

Choleric or bilious	Vigorous, dry and lean; dark skin; wild, passionate, hard-working, tireless	Nasal haemorrhages, dry and violent ophthalmia, frequent sterility in women, scarce and painful menstruation, difficult births, dropsy of the testicles in boys	Summer
Blood	Wet body, fast growth, pinkish colour, tendency to melancholy	High fevers, brain inflammation, diarrhoea, tenesmus, intestinal catarrh and nosebleeds	Spring
Splenic	Very weak, hard body, dry and hot; glutton	Diarrhoea, quartan fevers, dropsy in Summer; in Winter, pneumonia, fevers, vascular spasms and leg ulcers (in men); oedema, chlorosis, sterility, difficult births, false pregnancy (in women).	Summer, winter
Phthisis	Weak, fragile, smooth white skin, young people in general	Phthisis	Autumn, Spring

Source: Rebollo, 2006, p. 59.

The notion of *habitus phtisicus* defended by Hippocrates, and continued by Celsus and Areteus of Cappadocia, has influenced the diagnosis and prognosis of pulmonary tuberculosis to this day (Grmek, 1994). Areteus of Cappadocia pointed out an important characteristic of phthisis: the insensitivity of the lung. The lung deteriorates without causing pain, which explains some of the difficulties in making an early diagnosis. For Avicenna, pulmonary tics went through three successive stages: inflammation, ulcer and cave. In therapy, special importance was given to dietary and hygienic prescriptions: soft drinks, cold food, milk, old wine and water with honey. It was advisable to live in places of recognised health, in the countryside, among pine and olive trees.

Medieval physicians, both Western and Arab, essentially reproduced the positions of the classical authors. Concerning the great endemic epidemics of the Middle Ages, phthisis remained a discrete, secondary disease, perhaps because it was often unknown and killed more slowly (Sournia & Ruffie, 1986). Mirko Grmek believes that tuberculosis and leprosy, as their etiological agents are microorganisms (*Mycobacterium tuberculosis* and *Mycobacterium leprae*), belong to the same biological genus, which allows us to assume that both mycobacteria have established a relationship of antagonism through immunological competition. It is thought that phthisis inhibited the occurrence of leprosy, a phenomenon that would explain the change in the European epidemiological profile that occurred in the final moments of the Middle Ages, when the increase in cases of phthisis coincided with a decrease in patients affected by leprosy (Grmek, 1994; Bertolli Filho, 2001; Vieira, 2012).

If mycobacteria are identified in medical discourse, from the last third of the 19th century onwards, as the etiological agents of different diseases, namely tuberculosis and leprosy, in Classical Antiquity and the Middle Ages there was proximity between medical and "profane" ideas about the nature and treatment of leprosy and other swellings that affected different parts of the body. Among these swellings, scrofula, which refers to a chronic increase in volume, mainly in the lymph nodes of the neck, gained great importance due to its frequency, causes, evolution and the "miraculous" cure inherent in the king's touch.

The term scrofula, from the Latin *scrofula*, diminutive of *scrofa* "sow", expresses hypertrophy, inflammation and possible fistulisation of the lymph nodes, similar to the appearance of ganglion tumours in pigs. It should be noted that alporca means "scrofula" and has its origins in *al-* associated with the Latin word *porca*, *ae,* "furrow, gully through which water flows" (Barcala, 2015; Duarte & Chuaqui, 2016). Scrofula were described in medical discourse as rounded bodies implanted in tendons, arteries, veins and muscle membranes. It was considered that their development in the glandular areas on both sides of the throat caused pain, making the neck look bulky. They were considered difficult to cure. They originated in formations occupied by an unhealthy humour. For Galen, the condition could emerge from an ulcer that occurred in a plethoric patient, which later turned into a bubo, and this into a scrofulous condition (the scrofula) (Duarte & Chuaqui, 2016). Another type of scrofula was identified, which was not very adherent to the skin but rather floated.

Treatments included ointments, emollients and poultices. Another form of treatment recommended by doctors was to take the patient to the king, arguing that scrofula, also known as *morbus regius*, the "king's disease", could be cured by the monarch touching the patient with his hands.

From the 11th century until the beginning of the 19th century, ceremonies developed in Europe whereby kings, believed to be endowed with the gift of thaumaturgy, could heal the sick with scrofula by the touch of their hands. This miraculous nature of the royal touch expresses the mystery of the transcendence of the crown regarding its holder, "the two bodies of the king": human by nature and divine by the grace of God (Bourdieu, 2014; Kantorowicz, 1989). The royal miracle is presented as the expression of supreme political power (Bloch, 1961). It is an affirmation of the symbolic dimension of the king's power that is part of a process of transformation of the king's private monopoly into a public monopoly, accompanied by a process of monopolisation of the king's monopoly of legitimate physical and symbolic violence and taxation (Bourdieu, 2014). The symbolic power of the king, seen as hereditary heritage, is a power of consecration or revelation, a power to consecrate or reveal things that already exist. This symbolic power is based on the possession of symbolic capital. This capital stems from knowledge and recognition. The subjects, the dominated, know and recognise: the act of obedience presupposes an act of knowledge, which at the same time is an act of recognition. In recognition, there is "knowledge", whoever submits, whoever obeys, and whoever submits to an order, operates a cognitive action. Acts of submission and obedience are cognitive acts that make cognitive structures, categories of perception, schemes of perception, principles of vision and division (Bourdieu, 2014).

Scrofula patients flocked in large numbers to the ceremonies of the king's touch, attended by a significant number of people, held on special occasions, on sanctified dates, in a rite in which the king touched the patients one by one and then made the sign of the cross. The rite of the royal touch followed a sequence. The court physicians would select patients affected by scrofula in advance, discarding those affected by another ailment. The king prepared himself, sometimes by fasting the day before. The rite began with the celebration of Mass, at which the king took communion. After Mass, he would approach the previously chosen patients, touch the face or neck of each patient, make the sign of the cross over them and say a short prayer. Then, the king's chaplain would give some of the sick, especially those who had come from far away, giving them alms. Finally, parts of the Gospel were read, in particular the passage in which Jesus told his disciples to "lay their hands on the sick and they [would] heal them" (Ignacio Duarte, 2014, p. 461).

Failures were the responsibility of the patient, not the inefficiency of the touch. Anyone who was not cured would come back with more faith for the next ceremony. Power is based on personal relationships and socially established affective relationships. Fidelity, love and belief were virtues and dispositions that constituted the foundation of order and real power (Bourdieu, 2014; Duby, 1981). The choice of scrofula may have been due to its high morbidity, its evolution with phases that could be interpreted as a cure, and the comprehensiveness of the notion of scrofula, which could include other lesions with a spontaneous tendency to remission episodes. The available historical data and current knowledge of tuberculous lymphadenitis do not support the belief in massive miracle cures (Duarte & Chuaqui, 2016).

The growing visibility of the imbrication between phthisis and the lung organ meant that, in the 17th and 18th centuries, phthisis came to be called "phtisie pulmonaire" by French-speaking doctors and "pulmonary phthisis" by English-speaking doctors. At the end of the 19th century, Anglo-Saxon doctors often used the term "consumption" to designate the disease, a term that became generalised throughout the 19th century (Bernier, 2005).

Between 1780 and 1890, "pulmonary phthisis" became more and more widespread in Europe, first in England, and then in France and the rest of the continent. The increased visibility of the disease is linked to the production of health statistics, to the new situation of medicine that was established in Europe throughout the 18th century and in the early years of the 19th century, based on three phenomena: the birth of the clinic, which established a hospital reform in Vienna and Paris, with the generalisation of exploration practices, such as percussion and medical auscultation, with

systematic reference from the observation of symptoms to anatomopathological data; the persistence and development in Austria, as in France, of a pondered attitude of therapeutic scepticism; the advent of physiology as an autonomous medical discipline "progressively freed from its subordination to classical anatomy, which had begun to situate its problems at the tissues level, without supposing that these problems would soon be dealt with at the cell level, while at the same time looking to physics and chemistry for as many examples as aids" (Canguilhem, 2000, p. 58). This greater visibility is also intertwined with the emergence of a new sensibility regarding the body and illness, parallel to the affirmation of the individual entity.

A large number of works on the disease were published during the 17th, 18th and 19th centuries, expressing various positions on pulmonary dysentery before it was recognised in official discourse as a contagious disease. Four major explanatory schemes can be distinguished: those that focus on contagion or transmission from one person to another; those that maintain that the disease is the result of physiological disorders; those that place the cause in hereditary predispositions; and those that favour a link between the disease and behaviour and lifestyles (Bernier, 2005).

The constitutional thesis explained phthisis as a change in the normal state of the body. The disease would be attributed to a malfunction or disorder of the body. This inability of the organs to function normally was often associated with physical malformations, the after-effects of certain diseases and the rigours of the climate. Phthisis was more likely to develop in people who, at birth or during adolescence, had malformations of the chest or a weakness of the lungs. Certain diseases, such as asthma, pneumonia and pleurisy, including neglected colds, but also gout, scurvy, diabetes, epilepsy or even childbirth could "ulcerate the lungs" and lead to phthisis. The cold was referred to as very harmful to the chest because it stagnated the humours, made it impossible for the body's purification work to take place normally, and the lungs were overloaded, leading to ulcers and then tubercles.

The contagionist thesis was marked by Girolamo Fracastoro's work *De contagione et de contagionis morbus et curatione,* published in 1546, which placed phthisis on the same level as "big pox" and claimed that, like syphilis, it was spread by invisible particles, which he called "seminaria", by direct contact, by fomites or by diffusion over a distance. Benjamin Marten argued that the cause of syphilis was due to the existence of "animacula" that invaded the lungs (Bernier, 2005). These "animacula" could move through the air and reach people's lungs. His theory was part of the work of Leeuwenhoek and Nicolas Andry. The French doctor attributed the origin of epidemics such as the plague, smallpox, venereal diseases, typhus and even diseases such as gout, scurvy and rheumatism to "animacula", which moved from place to place. Marten thought that phthisis could be transmitted from a sick person to a healthy person through a pathogen (Bernier, 2005). Other doctors, although they attributed the origin of the disease mainly to heredity and certain constitutional problems, believed that phthisis became contagious when it reached an advanced stage, when "the nauseating odour of sputum" was felt (Bernier, 2005, p. 43). Others argued that there were three causes of phthisis: heredity, weak lungs and diseases that left sequelae in the lungs (Bernier, 2005).

The explanatory scheme that favoured the hereditary "disposition", the diathesis, took up the positions of Hippocratic and Galenic medicine. Hippocrates and Galen affirmed that pulmonary tympany was hereditary and transmitted from father to son, who thus had a disposition to tympany at birth. The importance of hereditary predisposition was balanced between the centrality of the "hereditary vice" transmitted directly from parents to children and the relative importance of the hereditary factor, which was one factor among others, in the same way as very salty air, poor diet, city fumes, cold, melancholy, contagion and the effect of other diseases.

One of the theories most often invoked to account for the nature of phthisis was behaviour and the "arts of living". Medicine made a distinction between what concerned the nature of the organism (what was beyond one's control, such as the functions of the organs: breathing, circulation and digestion, among others) and what the individual could intervene in by observing certain rules of life. This issue of the "art of living" was at the root of several treatises in the Middle Ages (Bernier, 2005). These *tacuinum sanitatis*, these *ars vivendi*, were concerned with the "six unnatural things": the

proper use of food and drink, physical exercise, air quality, controlling emotions and passions, rest and sleep, and the adequate functioning of bowel movements and excretions. The basic idea of the "art of living" was to avoid excesses and deviations and to practise moderation. Otherwise, the individual experienced a state of apathy, melancholy and fatigue, a loss of vitality and temperament that slowed down the suppression of bowel movements and caused blood acrimony, increased lung fat, ulceration and the formation of tubercles. From the end of the 18th century onward, the "arts of living" also began to focus on the new ways of life produced by modernity, which questioned the traditional social order and were seen as disruptive elements that favoured the individuals' physical and moral weakening. On a physical level, poor diet, excessive consumption of "fermented liquors", foods that were difficult to digest and alcoholism were seen as responsible for depriving individuals of vitality and resistance. On a moral level, the indolence of children, nervous disorders associated with growing urbanisation, emotionalism, competition, disappointments and promiscuity contributed to the "pituitary and catarrhal constitution" (Bernier, 2005).

In the first decades of the 19th century, Laennec reiterated that phthisis was a specific disease producing its own alteration, the tubercle, and demonstrated that there was only one form of phthisis – tuberculosis –, making him the founder of the so-called unitary theory. Developments in pathological anatomy and diagnosis, spearheaded by doctors such as Corvirsat, Bayle and Laennec at the beginning of the 19th century, led to changes in the aetiology of phthisis and tuberculosis. After analysing the tuberculated organs, it was found that pulmonary tuberculosis did not originate from inflammation or pneumonia. Tuberculosis was a specific disease that evolved in several stages, from the cyst to the pulmonary cavern.

Virchow refuted the unitary perspective of the tubercle by countering the dualist theory, according to which tuberculosis and caseous pneumonia were two distinct entities. He argued that the tubercle was a lymphoma formed by the proliferation of connective tissue that transformed into small cells with a large nucleus or multinucleated giant cells. The tubercle could undergo a fatty metamorphosis that extended to the entire cell, producing caseification, i.e., a necrobiosis with the transformation of the tissues into a cheese-like substance that could evolve into softening and cavitation. Thus, phthisis was considered a dual pathology and could be tuberculous phthisis if it originated from tubercles, or caseous tysiogenic pneumonia if it was determined by the caseification of the products of inflammation (Vieira, 2012). Virchow's style of thinking, which favoured cellular pathology, was characterised by a high degree of scepticism at first about the role of contagion in certain diseases. Later, Virchow acknowledged the importance of bacteria in causing disease. However, at the same time, he considered that not all infectious diseases could be attributed solely to bacteria (Virchow, *cit in.* Schipperges, 2005; Santos, 2008). This position expresses the opposition between styles and collectives of thought and political positions, in which the central authors were the democratic cell pathologist Virchow and the conservative bacteriologist Koch (Santos, 2008).

In 1865, French military surgeon Jean-Antoine Villemin announced that he had succeeded in transmitting tuberculosis by inoculating animals. Villemin described the transmission of this disease from humans to rabbits, from cows to rabbits and from rabbits to each other. He concluded that tuberculosis was a specific infection and its cause was an inoculable agent (Villemin, 1868). However, in 1857, Buhl, a German doctor, argued that tuberculosis was an infectious disease. In an anatomopathological study of the miliary form of tuberculosis, he argued that tuberculosis had an infectious nature, caused by the entry into the blood of a special "poison", which he called "tubercular matter". William Budd also argued that tuberculosis was a specific disease, like typhoid fever or syphilis, considering that the "tubercular matter" was responsible for contagion from person to person, and could be destroyed "on leaving the body, with appropriate chemical means", which, combined with better sanitary conditions, could lead to the irradiation of the white plague. This English doctor was one of the first to correlate typhoid fever to a "live virus" (an expression that at the time meant "live poison") transmitted by mediate or immediate contagion (Benchimol & Sá, 2005, p. 118). In the history of bacteriology, Budd seems to have always remained in the background. In the case of cholera, he proclaimed aquatic transmission by a specific microscopic object, two months

after Snow, and advocated the idea of contagion by the inoculation of "tubercular material" two years after Villemin (Ledermann, 2003, p. 43).

4. The "*Mal de Vivre*" of the Sensitive Souls of the Romantic Elites

In the literary and artistic fields and some medical discourses, phthisis was presented as the disease of the rich, the young, women and fragile beings who were consumed by "sad passions" (Laennec, 1826; Pierret & Herzlich, 1984). Phthisis was considered an illness of passion and was praised to such an extent that it became the morbid aspiration of youth, representing the evil of the century, whose heroines were Mimi and the Lady of the Camellias (Lucas & Mata, 1951). Phthisis was related to qualities attributed to the lungs, which belonged to the upper, spiritualised part of the body. Metaphorically, a disease of the lungs was a disease of the soul (Sontag, 1984). Consumption was understood as a way of appearing and this appearance became the main element of 19th-century customs (Sontag, 1984). Looking ill was something sensual. It was good form to be pale and exhausted. The idea of the body, influenced by phthisis, was a new model of aristocratic appearance, at a time when aristocracy ceased to be a condition of power and began to be primarily a problem of image (Sontag, 1984).

The "*mal du siècle*" – the indefinable illness of the romantics' souls, to which pessimism, mental fatigue, despair and the lust for pain were associated – was understood differently in the romantic space. In general, it can be said that romanticism in the 19th century was a reaction against the rationalist objectivism of the bourgeoisie. However, ideologically, it retained two faces, one conservative and the other revolutionary. For many romantics of aristocratic origin and counter-revolutionaries, the "*mal du siècle*" expressed a reaction and a protest against rationalism and the Enlightenment (Hauser, 1998), the consequences of the political, economic and social revolution developed by the bourgeoisie, and was manifested by a feeling of loneliness and exile and by an attitude of rejection of the bourgeois and bourgeois society; in other romantics, however, the "*mal du siècle*" was linked to an anti-bourgeois stance aimed at replacing the institutions and values of capitalist and industrial society.

A dichotomous conception of romanticism as an essentially conservative or revolutionary movement can be heuristically questioned by favouring a typological analysis of the configuration of romanticism. Various types can be identified: *retrograde romanticism*, aimed at re-establishing the previous social order; *conservative romanticism*, aimed at maintaining societies and states, as they existed in the countries "untouched" by the French Revolution (England and Germany at the end of the 18th century); *disenchanted romanticism*, which assumed that a return to the past is impossible, underlying resignation to the idea that industrial capitalism is irreversible; and *revolutionary romanticism*, which simultaneously refused the illusion of a return to the communities of the past and reconciliation with the capitalist present, seeking a way out in the hope of the future (Löwy, 1990).

Romanticism can be defined as a type of cultural critique of modernity inspired by pre-modernist values. The disenchantment of the world, the quantification and reification of social relationships, the destructive force of mechanisation, the centrality of abstract rationality and the dissolution of community ties are some of the aspects criticised or rejected by the romantics while valuing imagination, subjective experience, fantasy, community and reintegration with nature (Sayre & Löwy, 1996).

Romanticism gave rise to various artistic and literary currents in the second half of the 19th century. One of these currents was decadentism. The cult of the fatal man, the romantic hero (the one who feels unique and superior due to his exceptionality), was opposed, in decadentism, by the cult of the fatal woman. The fashion of aristocratic *femmes fatales* and young people who aspired to be artists finally became the fashion sphere. Twentieth-century women's fashion, with its cult of thinness, was the last bastion of the metaphors associated with the romanticisation of phthisis in the late 18th and early 19th centuries (Sontag, 1984). During the Romantic era, a discourse of exalting

femininity and the differences between men and women prevailed. The representatives of the Enlightenment maintained that there were no innate differences between the sexes and that all observable differences were the result of different upbringings. On the other hand, the romantic philosophers of the early 18th century argued exactly the opposite: upon analysing the characterological differences between men and women, they argued that the fundamental differences were the result of innate biological and physiological differences, and insisted that these differences would subsist in any imaginable civilisation (Fromm, 1971).

The appearance of the phthisis patient, essentially the woman, was considered attractive and sensual, a sign of distinction. Ethereal beauty, paleness and transparency were celebrated, facts that justify their identification with the White Plague. In the literary and artistic imagination, even in the context of late Romanticism, as in the cases of the Spaniards Miguel de Unamuno or Antonio Machado, the topic of beauty was associated with romantic phthisis.

On coughing
When you got the cough, with the handkerchief
You covered your mouth
And I read in your eyes, in my sky
all the mad anguish.
You hid from me the roses of your breast,
Flower of your pure blood.
(Miguel de Unamuno)

Women with phthisis were languid, their bodies long and frail, their faces thin, their skin transparent, their faces hollow, but with a diaphanous complexion, thin skins and flushed cheeks. The writer Júlio Diniz described Madeira's phthisis patients as pale, emaciated, pensive figures, marching slowly; they were cadaverous Englishmen, diaphanous Germans, gaunt Portuguese; they were old men, adults, children, vaporous female beauties from all over the world (Lucas & Mata, 1951).

Patients affected by phthisis were described in medical books and novels by the following characteristics: "[...] the slender figure, the disproportionate height for the width, the flat chest with very acute angles of the ribs, the drooping heart, the angular profile, the moist, large and shiny eyes, the black hair, with creased eyebrows, this is the fusion of the asthenic and athletic types in which phthisis especially chooses its victims" (Neves, 1940, p. 5).

Phthisis was an indicator of distinction, delicacy and sensitivity. Social position is also affirmed through new attitudes towards illness. Both clothing (the external garment of the body) and illness (a kind of internal decoration of the body) (Sontag, 1984) become arguments for new attitudes:

You coughed so much that day
that you reddened your handkerchief:
and leaping for joy,
you said, as you gave it to me; Come
and look!... thank heaven!
I have phthisis too!
(Francisco Villaespesa, Las Viejas gemas)

Phthisis was conceived as a variant of the disease of love. The symptoms of the disease were nothing more than a disguised manifestation of the power of love; the whole disease was just love transformed. Phthisis was the result of excessive passion, which attacked sensual people. As the disease progressed, the sick resigned themselves when they lacked physical strength and when they sweetly seemed to sleep and dream:

And I die so young! Not even a month ago
I asked the Doctor: - Well? I will cure you.

But I do not care anymore, it is good to die, let it be
That to die - is to sleep... to sleep... to dream perhaps.
(José Duro)

Illness was a way of making the person "interesting" – which is how the romantic was originally defined. Novalis wrote, in 1799-1800, "The ideal of perfect health is of purely scientific interest; what is really interesting is illness, which belongs to individualisation" (Sontag, 1984, p. 42). Keats and Byron also exalted the senses of feeling, the depth of feelings toward faith in Reason. Byron would like to die of consumption because then all the women would find him interesting. Phthisis was considered a disease of the soul. The death of those with phthisis had an aesthetic dimension. It was a magnificent death but it was also a soft and silent death:

One summer night
- the balcony and the door of my house were open -
death came into my house.
She came closer to her bed
- she did not even look at me -,
with very slender fingers, something very faint broke.
Silently and without looking at me,
death again passed
before me. What have you done?
Death did not answer.
My child was quiet, my heart ached.
Oh, what death has broken
was a thread between the two of us!
(António Machado)

Romanticism changed the criteria for aesthetic judgment. Romantic subjectivism and melancholy brought out the beauty in horror and in everything repulsive in the eyes of the classicist aesthetic taste. The association between the beautiful and the horrible, between beauty and physical illness and, consequently, between beauty and death became a constant, something we can recall in Rosalia de Castro's evocation:

[...] And that her black eyes stare at me
Her languid gaze
And I dream in the silence of the silent night
That she approaches my bed
Like a voluptuous and white shadow,
That kisses me on my forehead, [...]
(Rosalía de Castro)

However, for Susan Sontag, the Romantics' main gift to sensibility was perhaps not the aesthetics of the cruelty and beauty of the morbid or even the demand for unlimited personal freedom, but the nihilistic and sentimental idea of the "interesting" (Sontag, 1984, pp. 42-43). Sadness produced the "interesting". It was a sign of refinement, of sensitivity: being sad. Sadness and lousiness became synonymous. However, a person had to be sensitive to feel this sadness or, implicitly, to contract phthisis. The myth of phthisis is the almost ultimate episode in the long career of the ancient idea of melancholy – the artist's illness according to the theory of the four humours. The nature of the "melancholic" or "phthisis patient was superior:" sensitive, creative, a being apart.

Underlying these discourses is a beneficial representation of illness (Laplantine, 1986). While in the disease-badness model, individuals experience illness as harmful, unbearable and responsible for the loss of their credibility, in the beneficial model, symptoms are not seen as a deviation to be contained but as a message to be listened to and decoded. Illness is a reaction that has, if not a value, at least a meaning since it is seen as an attempt to restore the disturbed balance and even, in some

cases, as an episode that exalts and enriches. The dominant beneficial representation of illness is that of illness-salvation, from a religious perspective, as a grace, holiness, which exalts, liberates and enriches (Laplantine, 1986). Illness is perceived as "liberating" when it offers the individual the possibility of escaping from a social role perceived as suffocating and unbearable. Far from representing misfortune or destruction, illness is seen as an opportunity to find meaning in one's life, to affirm "new norms of life" that lead to personal enrichment and fulfilment (Laplantine, 1986).

These romantic discourses produced in the literary field seem to express the affective and social frustrations resulting from the insertion of individuals into a network of interdependent, institutional and undifferentiated relationships that characterise the societal transformations at the time. Faced with the relative institutionalisation of individual relationships, they sought a freer and more emotional existence, less subject to obligations, hierarchies and powers of society in the process of development and socio-cultural integration (Almeida et al., 1990).

Other speeches put forward positions that questioned this romantic conception of phthisis, pointing to other causes for the development of the disease, namely "inheritance", poorly directed education – in which exposure to the outdoors and body exercises were not properly used –, effeminate habits, poor quality or insufficient nutrition, chest tightness, sad passions, tiredness, "derangement of fortune". Another very relevant cause was colds and "defluxions", caused by the change in temperature, exposure to cold air, and leaving warm houses, dances and theatres to go out into the street with insufficient and "inauthentic" clothing (Barral, 1854, p. 190). For the hygienists, the "atmospheric variants" of the climate and the living conditions of the working classes, who lived in the cities, were the central elements in the development of the disease. Various reports produced by the Lisbon Society of Medical Sciences pointed out that among the predominant causes of this disease, the lymphatic temperament, inheritance and age deserve particular mention; the density of population in large cities produced an alteration in the "circumfuse", as yet unknown in itself, and was the main agent of the high frequency of phthisis in large cities (Mira, 19479). For the director of the Lisbon Permanent Military Hospital and corresponding member of the Royal Academy of Sciences, the terrible conditions of the soldiers in the Lisbon garrison were identical to those of the "lower classes". It was the absence of a restorative diet that explained the frequency of phthisis in the "lower classes" of society, among labourers and artists, who often lacked the most indispensable things in life. These classes were the most damaged by the disease because the accumulation, filth and narrowness of the dwellings vitiated and corrupted the air (Mendes, 1861).

This awareness focused on the social issue, in conjunction with technology of intervention on populations developed around social statistics, are the fundamental elements of what can be defined as hygienism (Fassin, 2001). This technology manifests itself simultaneously in the measurement of health, made possible by statistics, and in the health measures, expressed in countless reports and treatises. Hygienists' interventions generally focused on a central problem: the material and moral misery of the working classes. In response to this problem, hygienism promoted reforms in social organisation and hygiene measures aimed at moralising the dangerous classes and bringing them back into social "normality".

These various discourses express cognitive evaluations that reflect the *illness semantic network* (Good, 1977; Massé, 1995), the symbolic links that individuals establish between their various life experiences, particularly critical events and experiences. The logic inherent in the semantic network allows us to go beyond the representations underlying etiological and therapeutic models, enabling individuals and groups of individuals to interpret illness within their social and cultural contexts (Massé, 1995).

5. Conclusion

Phthisis, especially acclaimed in the literary field by various writers and poets who produced a romantic aesthetic, was seen as a hereditary disease or associated with destiny that affected the sensitive souls of the romantic elites, namely young people, women and fragile beings who were

consumed by "sad passions. Being "a phthisis patient" was also a way of life of luxury and idleness that marked the sanatorium experiences of the wealthy classes until the end of the 19th century, and which continued into the 20th century, particularly in the Magic Mountain(s). From the end of the 19th century onwards, the symbolic representations of phthisis conveyed by romantic literature – the "*mal de vivre*" of sensitive and romantic souls – gave way to social representations of tuberculosis, the "white plague", a disease of misery that affected the poor, indigent and workers, as a result of the industrialisation process interdependent with the development of capitalism. There was a process of social and medical qualification of tuberculosis as a contagious disease – the emergence of the theory of specific aetiology, according to which each disease was due to the specific action of a germ – and the subsequent metamorphosis of its social meanings, giving rise to a discursive polarisation. On the one hand, there was the celebration of the phthisis of the sensitive souls of the romantic elite, which was the disease of the rich, the young, women, and the fragile beings who were consumed by "sad passions"; on the other hand, there was the fear of the "scourge of tuberculosis" and the stigmatisation of the working classes, the sowers of the bacillus (Ferreira, 2008).

The worker's body was irremediably marked by illness. In the case of tuberculosis, the worker's beauty and languor associated with romantic phthisis was terrifying only in appearance: cadaverous, sordid and rotten. However, in the case of "workers' tuberculosis", the appearance of the sick body has other meanings. The misery and dangers associated with the worker emerged from this "frightening" appearance: promiscuity and contamination, alcoholism, immorality and crime. Once ignored, proletarians and the sick, poor and indigent were now perceived as the agents of contagion. The "tubercular", proletarian and poor individual embodied absolute evil in the eyes of the wealthy classes – they were identified as a dangerous revolutionary who sowed germs and were a source of contagion – whom it became urgent to control and isolate in hospitals and sanatoriums.

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