Care Communities versus Human Infrastructure

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VICTORIAN ideas of infrastructure bore a complex relation to our own, as this special issue demonstrates, but perhaps nowhere is the difference between their assumptions and ours wider than on the subject of care.

In the twenty-first century in the United States, care infrastructure seems like a self-evidently good idea to me and, I imagine, to many of my readers. We see it as obvious that caregiving should be systematic, wide-ranging, predictable, and structurally supported. Whether we need education, medical care, childcare, eldercare, or care for disabled people, most of us would want to be able to access a stable system with adequate resources.

One reason we need public care is that private forms of care remain drastically unsupported. Family members still carry the brunt of caregiving, and in the United States, they get no pay, training, or support for it. As Emily Kenway remarks, the role of carer "is synonymous with human life," since everyone gets sick, infants and the elderly need care to survive, and everyone has spent time caring for friends or family members.[1] Hence the urgency of instituting human infrastructural support, which aims to extend universal access to decent working conditions for those giving care. It assumes that everyone deserves access to care, and that all caregivers deserve help when caregiving. Care is a system in the public interest, to which everyone merits access, like clean water or safe roads.

In the nineteenth century in Britain, however, many people felt that these private forms of care needed to be protected from public management. In the early nineteenth century, care was a peculiarly intimate expression of personal relations—human ministrations that would be threatened by state infrastructures. When Scrooge endorses workhouses

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in Dickens's *A Christmas Carol* (1843), readers are supposed to find it horrifying that he believes in such institutions instead of giving personal charity. Two years before *A Christmas Carol,* barrister Samuel Richard Bosanquet insisted that state care dehumanized its recipients by its insistence on standardization: "are the feelings of the mind never to be considered or relieved, as well as the body and the appetite, but to be reduced to a uniform measure?"[2] Dickens and Bosanquet both saw the beginning of widespread institutional caregiving as a major threat to the personal relationships that made care function. They were not alone in this attitude; the first development of something like public care in England constituted "the imposition of bureaucratic uniformity on a resistant culture," in Lauren Goodlad's memorable words.[3]

Victorians were accustomed to communities of care. They assumed that people would spontaneously coalesce around someone in need.[4] (This was, of course, the ideal, not necessarily met in reality, as we shall see.) Family members showed affection through care; servants earned pay through care; neighbors and friends consolidated social ties through care. Scrooge's failure to join his nephew Fred's community causes consternation because it violates this expectation. In short, as Florence Nightingale famously remarked in 1860, "Every woman, or at least almost every woman, in England has, at one time or another of her life, charge of the personal health of somebody, whether child or invalid,—in other words, every woman is a nurse."[5]

In the fantasized world of the Victorian novel, scenes of care constitute a profound mechanism for emotional attachments. Through tender touch and patient attention, caring for one in need produced a rich current of feeling. Caregiving repairs relations, reunites suitors, consolidates friendships, and attracts guardianship, from *Persuasion* (1817) to *Ruth* (1853) to *Great Expectations* (1861) to *Middlemarch* (1871–72).[6] The pleasure of watching a care community form is one of the joys of any Dickens novel, as we watch social ties interweave to support David Copperfield, Oliver Twist, Florence Dombey, Esther Summerson—or even Scrooge himself, reminded of the pleasures of care communities when the Ghost of Christmas Past allows him to revisit the Fezziwig ball. In fiction, and sometimes in lived experience, Miriam Bailin explains that "relations between sickroom attendants and patients were thus in general characterized by intimacy, informality, and shared meaning, and the experience and treatment of illness were deeply bound up with community norms and values."[7]

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Yet in reality, care communities are not always the best mode of caregiving. Their small scale, voluntary nature, and personal bonds can make them unreliable and often render their care substandard. Having one's parents, siblings, and neighbors care might be emotionally gratifying but not necessarily medically ideal. Voluntary caregivers can change their minds and stop, leaving cared-fors in the lurch—or they can stay on so long that they get exhausted, particularly in the case of complex and severe needs that tax their abilities. In treating people they love, carers may be reluctant to administer protocols that might be hurtful. In speaking back to people they love, cared-fors may be reluctant to criticize problematic treatments.

Moreover, the system has obvious inequities. Some people have supportive communities, and others do not; should those without friend groups also be denied basic access and medicine? Should the favorites of the local clergy and gentry receive disproportionate relief?

By the second half of the nineteenth century, care community practices had largely been superseded by something more like modern state-based care. The Old Poor Law of 1601 had laid out the parish relief system, which presumed, in Goodlad's words, "a society of stable communities and face-to-face relationships," but the New Poor Law of 1834, which set up workhouses and authorized magistrates to call in doctors, introduced a new set of fixed institutional regulations.[8] The New Poor Law, for all its problems, moved toward a system in which everyone could access some sort of shelter, food, and medical attention guaranteed by centralized authority, regardless of their personal ties. This was the system to which Dickens and Bosanquet objected.[9]

During the period, medical practice also became more systematic. In the first half of the nineteenth century, as we see in many mid-Victorian novels, good doctors tend to be enmeshed in the social networks of the town, offering care as part of an ongoing relationship that includes friendships, courtships, hospitality, neighborliness: Trollope's Dr. Thorne, Oliphant's Dr. Marjoribanks, Gaskell's Mr. Gibson. However, as doctors began to professionalize, they began to see their patients less as neighbors than as "cases."[10] Resentment and uneasiness about these new medical priorities are evident when locals mistrust innovative young doctors like Tertius Lydgate.[11] Indeed, "the focal point of a career in medical innovation shifted away from the network of primary relationships with the sick toward a network of secondary relationships with other clinicians."[12]

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From the 1830s through the 1870s, two important trends coincided to promote nationwide structural care. Doctors increasingly tended to regard themselves as participants in a national or even global scientific practice rather than members of a local care community, while workhouses and their medical attendants spread throughout the country. At every class level, then, care was systematized and depersonalized.

Nearly two hundred years later, we take that infrastructure for granted, aiming to improve it rather than remove it. But implicit in our desire for systematic carework is a tacit recognition of the justice of the Victorians' complaint. For in one sense, they were right: state systems did eclipse home care (which is to say that home care still occurs everywhere, but we don't see or support it). Today, then, we need to reassert the value that Dickens and Bosanquet saw slipping away.

Spare a thought, then, for that group of Victorian thinkers for whom Dickens and Bosanquet spoke: those who saw it coming, who could not gainsay the real advantages of a system that treated everyone, and yet who mourned the loss of their own. For those worried people, care communities constituted the opposite of infrastructure because they believed fervently that care had to arise spontaneously from local social networks, personal ties, people's relationships over time.[13] When a care community becomes human infrastructure, its care might improve, but its community might dissolve.

What they have to teach us is a stance outside infrastructure, a faith in the shifting, fluid, voluntary, hyperlocal social enmeshment of small communities of care. Idealistic, partial, and patchy as this may be, it nonetheless offers a kind of intimate care that we cannot do without. At last, after the pandemic, the individualist-oriented United States is beginning to catch up to other cultures who have long recognized the advantages of mutual-aid groups, chosen families, care collectives.[14]

Human infrastructure was, to many Victorians, a sign of the degradation of their own moral fabric, a brutal way of administering uniform treatments without recognizing and honoring people's individual situations. In fiction, it was possible to undo this. *A Christmas Carol* ends when Scrooge learns to support the Cratchits personally instead of relying on state structures. "Scrooge was better than his word. He did it all, and infinitely more; and to Tiny Tim, who did NOT die, he was a second father."[15] After all, personal care worked better than institutions. As Bosanquet warned readers, "nice discrimination cannot enter into the operations and practice of officials . . . nor that fine elastic touch be applied of sympathy and vital charity, which discriminates the pulse of

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misery in its infinite variety."[16] Were care communities really always finely discriminating, infinitely kind, and literally lifesaving? Certainly not. But is there something to be gained from believing that they might be, and fighting for support to make them as successful as possible? We want more infrastructure and they wanted less, but on the desperate need for better care, we and the Victorians can surely agree.

Notes

1. Kenway, "Family Caregiving."
2. Bosanquet, *Rights of the Poor*, 216.
3. Goodlad, *Victorian Literature*, 35.
4. "Care" applies to multiple interactions, most notably teaching, parenting, and nursing, but given space constraints, I've chosen to focus on medical care in this piece.
5. Nightingale, *Notes on Nursing*, v.
6. A more extensive account can be found in *Communities of Care* and *Romance's Rival*.
7. Bailin, *The Sickroom in Victorian Fiction*, 9.
8. Goodlad, *Victorian Literature*, 34.
9. Edwin Chadwick was the main architect of the New Poor Law, but opponents included early nineteenth-century evangelical Scottish clergyman Thomas Chalmers as well as English barrister Samuel Richard Bosanquet, both of whom advocated for personal relations with the poor rather than centralized relief.
10. Frawley, *Invalidism and Identity*, 52–55.
11. See Rothfield's reading of Lydgate's clinical attitude (*Vital Signs*) and Sparks's account of medical men's growing scientific empiricism (*Doctor*).
12. N. D. Jewson, cited in Frawley, *Invalidism and Identity*, 54.
13. Bosanquet, for instance, mentions a woman whose problems derive from her disastrous first three years of marriage. He points out that taxpayers would have no way to know the particulars of her story (*Rights of the Poor*, 229).
14. For recent American innovative care practices, see Piepzna-Samarasinha, *Care Work;* and Spade, *Mutual Aid*.
15. Dickens, "A Christmas Carol," 116.
16. Bosanquet, *Rights of the Poor*, 222.

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